Risk Factors for the Development of PTSD

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Abstract
There have not been a great deal of studies done on all of the risk factors for Posttraumatic Stress Disorder (PTSD), however the research that has been done has provided copious amounts of information to our understanding of what exactly increases the risk for developing this disorder. Some of the most well known risk factors for PTSD are genetics, ethnicity, previous trauma, previous psychological conditions, personality, and social support. Eight studies were reviewed to gain a stronger understanding of the role each of these factors play in the development of PTSD.
Risk Factors for the Development of PTSD

Traumatic events occur often within our society, and it is likely that most people will be exposed to such an event at some point during their lifetime. Although the majority of our population will experience trauma, only a handful of those people will actually develop Post Traumatic Stress Disorder, or PTSD. According to Xie, Kranzler, Poling, Stein, Anton, Brady, Weiss, Farrer, & Gelernter, 2009, PTSD is a “complex and multi-factorial anxiety disorder. According to the DSMIV, it requires the presence of symptoms from each of three clusters, reexperiencing, avoidance, and increased arousal, that occur following exposure to a life-threatening traumatic event (p.1201)”.

Numerous factors can put an individual at increased risk for developing this disorder, and the factors that influence who gets the disorder may be different from the factors that determine who recovers from the disorder once it develops. Not all people are affected equally by traumatic events, because different things cause stress for different people. Because of this, not all individuals who possess one or more risk factors will be affected by trauma and subsequently develop PTSD. Some of the most researched risk factors for PTSD include genetics, ethnicity, previous trauma, previous psychological conditions, personality, and social support. Each of these factors play a role in the susceptibility to one’s developing PTSD, which can be developed at any age. Several studies will be examined to conclude the effects of these risk factors on one’s development of PTSD.

One study, titled “Interactive Effect of Stressful Life Events and the Serotonin Transporter 5-HTTLPR Genotype on Posttraumatic Stress Disorder Diagnosis in 2 Independent Populations” by Xie et al. (2009) examined the effects of adversity in childhood, adult traumatic events, the 5-HTTLPR genotype, and the interaction between genes and environment on the
cause of PTSD. There have been few studies about molecular genetics, because it is difficult to identify PTSD-related genes; Xie et al. examined the interaction of genes and the environment, during a traumatic situation. The genotype 5-HTTLPR is a polymorphism in the promoter region of SLC6A4, which is a serotonin transporter gene. Together, these genes help regulate emotional response. When stress occurs, serotonin is released and the S allele from SLC6A4 may be less able to up regulate the expression of and keep serotonin at a normal level than the L allele. The S allele works with the environment to create effects on behavior, and if it is not performing correctly in the event of stress, one’s emotional expression may be unable to protect against the development of a disorder, such as PTSD.

Method

Participants

This study consisted of 1252 subjects, whose mean age was 38.9 years. The participants were 52% male and were of European American and African American descent. Participants were recruited from 4 places: Yale University School of Medicine, University of Connecticut Health Center, Medical University of South Carolina, and McLean Hospital of Harvard Medical School.

Procedure

DNA was extracted from participants and polymerase chain reaction amplification was used to determine whether participants had a short allele or long allele from the 5-HTTLPR polymorphism (Xie et al., 2009). Each participant was genotyped with a panel of 41 ancestry informative markers and interviewed with the Semi-Structured Assessment for Drug Dependence and Alcoholism (SSADDA), which looked at any existing psychiatric or substance use disorders, along with information about the participant’s childhood environment.
Results and Discussion

Of the 1252 participants, about half who reported experiencing adverse events in childhood and trauma as an adult, met the criteria for PTSD. Women received a significantly higher diagnosis for PTSD than men. The genotype and adult traumatic situation interaction significantly associated with risk for PTSD in both European Americans and African Americans. Likewise, the genotype and childhood traumatic event interaction was significantly associated with the risk for PTSD, but only in European Americans (Xie et al., 2009). It was also found that the more childhood adversities experienced, the more likely it was the individual developed PTSD. Similarly, none of the psychiatric conditions were found to be comorbid with 5-HTTLPR genotypes. In addition, these interactions suggested that the effect of traumatic events on the onset of PTSD was increased among people with an S allele and not increased with people without an S allele (Xie et al., 2009). Although these findings of gene and environment interaction suggest that they put individuals at risk for PTSD, genotype alone had no significant impact on the development of PTSD.

Critique

Few studies assess the risk that genes may play on the development of PTSD, because it is so difficult to examine specific genes. This study attempted to investigate the impact of a serotonin genotype and how it was involved with an individual’s reaction to a traumatic event. Unfortunately, the researchers were unable to determine that the gene itself had an affect on development of PTSD, but they were able to show that the interaction of the gene with environmental traumas did put an individual at increased risk. A limitation of this study was the recall of childhood traumas. The recall may have been inaccurate or biased, and would have skewed the interaction. Also, the researchers might better have accounted for any adverse effects
other than PTSD, that may have been caused by these previous traumatic experiences. Moreover, the interaction between genes and the environment may have differed if the study specified the environmental trauma. Future genetic studies should focus more specifically on genes and their sole impact on the risk for PTSD; if researchers continue to look at interactions, they should address the bias in the recall of life events.

The second study titled, “Ethnoracial Variations in Acute PTSD Symptoms Among Hospitalized Survivors of Traumatic Injury”, investigated ethnicity as a risk factor for PTSD. Prior research suggests an increased risk for developing PTSD in ethnoracial minorities. This has been associated with prior exposure to trauma, severity of trauma, lack of access to mental health treatment, simultaneous medical problems, and other factors (Stephens, Sue, Roy-Byrne, Unutzer, Wang, Rivara, Jurkovich, & Zatzick, 2010). Also, ethnic minorities tend to experience and witness more violence, putting them at greater risk for a traumatic experience. In this experiment, it was hypothesized that African Americans, American Indians, Asians, and Latinos would develop the highest levels of PTSD symptoms when compared with Whites.

Method

Participants

English-speaking survivors of either accidental or intentional injury were the only patients eligible for this study. Participants also had to be aged 18 or older and live within 50-100 miles of the Harborview Trauma Center, where participants were gathered. After approaching patients for consent, only 623 agreed to participate and a PTSD Checklist was used to screen for PTSD symptoms. The patients who agreed to participate were significantly younger than those who refused and were found to have less severe injuries. Of those included, 28% were female and had a mean of 4.9 previous traumatic experiences. The ethnicities of the participants were
61.8% White, 15.2% African American, 13% American Indian, 5.6% Asian, and 4.3% Latino. (Stephens et al., 2010).

Procedure

To measure PTSD symptoms, each participant was interviewed with the PTSD Checklist Civilian Version. The checklist consisted of 17 self-report questions that evaluated intrusiveness, avoidance, and arousal. Next, patients were asked to report the ethnic group they most closely identified with, and the choices were African American, American Indian, Asian/Pacific Islander, Latino, White, or other. Participants were asked to provide their age, gender, years of education, household income, and insurance status, as well. Researchers used a modified version of the Traumatic Event Inventory to assess prior traumatic events in the patient’s history. They also looked to see if patients developed PTSD from a prior incident and not the one that motivated their visit to the trauma center. The center provided the experimenters with information about patient’s Injury Severity scores and comorbid chronic medical conditions. A 3-item Alcohol Use Disorders Identification Test was given to review the patient’s alcohol use within the 12 months prior to their current injury. They were also screened for drug use. All of the participants were interviewed while in the surgical ward of the Harborview Medical Center and were compensated with either $10 or $15, based on the length of the interview. The list of people to interview was randomly generated each weekday morning, during new admittance, and patients were interviewed within a week of their injury (Stephens et al., 2010).

Results and Discussion

African American and American Indian patients were found to have higher levels of previous risk factors for PTSD, but African Americans had the highest overall rate of violence-related injury and White participants had the lowest rate of violent injuries. American Indians
had a high percentage of intentional, violent injuries compared to Whites and had a significantly higher amount of past traumas than any other group (Stephens et al., 2010). Of all groups, Asians had the lowest number of preexisting PTSD symptoms and American Indians had the highest.

As hypothesized, a main effect was found for ethnoracial groups; American Indians and African Americans had the most reported PTSD symptoms. American Indians had the highest number of past traumas, compared to all other participants. Also, patients who had been admitted because of violence-related injury had significantly more past traumatic experiences, suggesting that their previous environments were loaded with violence and put them at initial increased risk for PTSD.

Critique

Overall, there were no significant differences between Whites, Asians, Latinos, and American Indians. However, African Americans appeared most at risk for PTSD. These findings verify the role of ethnicity in risk for PTSD. A limit of this study was the small sample size and the fact that all participants were patients who had recently been admitted to a trauma center. In future studies, researchers should try to have equal numbers of each ethnic group and compare those who had recently been injured with individuals who had experienced past trauma only. Furthermore, future studies should look at the specific living environments of these different groups because they could have a strong effect on their risk for developing PTSD. Finally, acculturation should be accounted for in future studies, because these various groups have different cultural backgrounds that could affect one another.

The third study was titled “Assaultive violence and the risk of posttraumatic stress disorder following a subsequent trauma”, by Breslau and Peterson (2010). It is nearly impossible to evaluate the effect of previous trauma in the absence of PTSD on the relation of its risk for
developing PTSD. Pre-exposure precipitates PTSD, but does not support the notion that previous trauma increases risk of PTSD. However, previous research suggests that different types of trauma might be more potent in sensitizing victims to PTSD effects of a subsequent trauma, (Breslau & Peterson, 2010).

The current study discussed the topic of previous trauma and its effects on the risk of PTSD from a subsequent trauma. The researchers hypothesized that exposure to trauma would increase the risk of PTSD in a later traumatic event and it would make people with “normal” reactions to stress more susceptible to PTSD (Breslau & Peterson, 2010). Specifically, the studies focused on three traumatic events: 1) events that had been reported as the worst, which was the one most likely to cause PTSD, by the respondent; 2) events randomly selected from a list by the respondent; 3) the earliest traumatic events that the respondent experienced.

Method

Participants

Participants for this study were of ages 18 to 45 and were located in the primary metropolitan area of Detroit. Random dialing of household phones was used to select the sample, and of the 6110 people called, 2181 agreed to participate.

Procedure

Interviewers administered a 30-minute computer-assisted telephone interview, beginning with a list of 19 types of traumatic events accompanied by questions about how many times a similar event had occurred to the respondent, and at what age. After participants reported which events they had experienced, the interviewer read them back and the respondent identified the most upsetting one, or the “worst trauma”. Next, the World Health Organization Composite International Diagnostic Interview (CIDI) was used to evaluate PTSD in connection with the
respondents “worst traumatic experience” (Breslau & Peterson, 2010). Following this, a computer-selected event from the complete list that had previously been reported by each participant was evaluated in connection to PTSD. Finally, researchers examined PTSD in connection with the earliest traumatic event that participants reported.

Results and Discussion

Only 1939 of the 2181 participants reported ever experiencing a traumatic event, so analysis incorporated only these respondents. The researchers found that previous trauma exposure to assaultive violence, which included things like military combat, rape, and being badly beaten-up, in the absence of PTSD did not have an effect on the development of PTSD in an ensuing trauma (Breslau & Peterson, 2010). Furthermore, there was no distinguishing factor between type or previous trauma or whether it was assaultive or not on the risk of PTSD. In the absence of PTSD, neither assaultive nor non-assaultive subsequent traumas increased the risk for PTSD. However, previous development of PTSD, that resulted from either type of trauma in an individual before age 18 or later, did show a significantly increased risk for PTSD after a succeeding trauma. Overall, the hypothesis that previous trauma exposure would increase one’s risk of developing PTSD was not supported (Breslau & Peterson, 2010).

Critique

A limitation of this study was that it was a cross-sectional design. Although this method is quick and less effortful, it does not allow for assessment of the participant’s traumatic experiences over time. Had the researchers taken more time to truly examine the previous trauma their participants had experienced, their findings might have been more conclusive. Another limitation was that the whole interview process took place over the telephone. Participants may not have been completely truthful with their responses and they may not have taken the process
seriously. Future studies should conduct the interviews in person, so that participants are more immersed in the interview. Also, it is important to consider the pathological responses to prior trauma unassociated with PTSD and how that may increase the risk for PTSD, following a succeeding trauma.

The next study built upon the previous one and was based on a follow up period related to participants’ previous traumatic experiences (Breslau, Peterson, & Schultz, 2008). In “A Second Look at Prior Trauma and the Posttraumatic Stress Disorder Effects of Subsequent Trauma” the researchers assessed a group of young adults during a 10-year follow up to examine whether stressors associated with preceding trauma and the event named in their first interview increased their risk for PTSD.

Method

Participants

A randomly selected sample of 1200, 21 to 30 year old people, was selected at a health maintenance organization in Michigan. Demographic information taken from the original interview from 1989, changed over the follow up period. Interviews were done in 1992, 1994, and 1999 to 2001, to assess the participants PTSD symptoms. Only 899 participants went through the entire process and were completely accounted for in the data.

Procedure

To diagnose PTSD and any other psychiatric disorders, researchers used The National Institute of Mental Health Diagnostic Interview Schedule, III. The original interviews included participant’s lifetime history of disorders and at each follow up, participants were asked about disorders that had occurred in the time since their previous evaluation.
Results and Discussion

In total, there were 990 respondents to the follow up interviews, including 63.2% women, 80% White, 46.1% married, and 29% respondents who had completed college (Breslau et al., 2008). In the 10 years since the first interview, 498 participants reported being exposed to at least one DSM-III-R traumatic event. At the baseline interview, the risk associated with people who reported experiencing trauma during childhood was 23.2% and if they reported the experience during an older age, the risk was 23.9% (Breslau et al., 2008). After new exposure during the follow up periods, the estimated risk of PTSD “was 3-fold higher among respondents who had experienced prior PTSD, compared with respondents with no prior exposure” (Breslau et al., 2008). Those who had actually developed PTSD from previous trauma were the most likely to experience trauma during the follow up periods. Overall, researchers found an increased risk for PTSD in subsequent trauma only in individuals who had developed PTSD from previous trauma (Breslau et al., 2008). They also determined that the risk of subsequent trauma was increased in people who had previous trauma experience.

Critique

This study seemed to find more concrete answers to risk factors for PTSD than the study from the original interview. A limitation of this study was that the sample consisted of a narrow age range of people. It would be more effective to study a larger age range, because it would increase the range of stressors too, allowing researchers to broaden their sample. Future studies should take into account the different stressors and what other disorders or problems they might be causing, and how they can affect the risk for PTSD. Similarly, it would be necessary to consider one’s PTSD response to previous trauma more than the presence or characteristics of the previous trauma.
One’s personality could put him or her at risk for PTSD, as described in “Self-efficacy in acutely traumatized patients and the risk of developing a posttraumatic stress syndrome”, by Flatten, Walte, and Perlitz (2008). Self-efficacy is a belief that one is capable of performing in a certain manner to attain certain goals; this would be considered a stable personality characteristic, since not all people would possess this type of thought. This study aimed to compare perceived self-efficacy in patients soon after having emergency surgery and then again four months later, as well as how it is associated with the development of PTSD. The researchers hypothesized that low perceived self-efficacy would predict an increased risk of developing posttraumatic stress symptoms and posttraumatic stress syndrome following physical injury” (Flatten et al., 2008).

Method

Participants

In this study, 108 patients, who were hospitalized in the department of plastic, hand, and burn surgery at the University Hospital, RWTH Aachen University, all had an acute physical trauma. These participants were, on average, 20 years younger than the patients who chose not to participate in the study. Also there were twice as many males as females in the sample. At the four-month mark, 43 patients had dropped out of the study. The final sample included more women, better educated participants who had suffered more severe trauma, and had more posttraumatic stress symptoms (Flatten et al., 2008). Also, this end sample was comprised of mostly native Germans, then some immigrant Germans and other nationalities.

Procedure

Patients were examined immediately or after release from the intensive care unit, and then again four months later. The four month follow up was chosen because the DSM-IV criteria
for PTSD note that PTSD must persist for three months or more to be considered chronic (Flatten et al., 2008). They used the General Competence Expectancy Test to measure participant’s perceptions of self-efficacy, along with the Aachen Self-Efficacy Questionnaire. Posttraumatic stress symptoms were assessed with the Aachen Trauma Processing Questionnaire.

Results and Discussion

After four months, experiments separated participants into two groups. The group that exhibited posttraumatic stress syndrome contained 20 people and the group of those not exhibiting the syndrome contained 45 people. Results supported the aim of the study, overall: self-efficacy was a significant factor in identifying a risk for developing PTSD in traumatized victims (Flatten et al., 2008). Also, low perceived self-efficacy was most strongly linked with tendencies to avoid when processing the traumatic experience. Impairment of psychosocial functioning was not found to correlate with self-efficacy and unexpectedly, there was no significant relationship between body-related self-efficacy and PTSD. Findings also indicated that the “degree of recovery from physical injury four months post-trauma also predicted recovery from PTSD” (Flatten et al., 2008).

Critique

In summary, Flatten et al. (2008) supported the idea that self-efficacy, or personality characteristics, served as a risk factor for PTSD. More specifically, low self-efficacy was linked to both avoidance and increased risk for PTSD. A limitation of this study was that the sample wasn’t very diverse. Future studies should try to incorporate a wider variety of people, and look at different types of personalities to get a better feel for how personality plays a role as a risk factor for PTSD.
“Associations of pre-trauma attributes and trauma exposure with screening positive for PTSD: Analysis of a community-based study of 2085 young adults” was an examination of personality as a risk factor for PTSD. The researchers, Parslow, Jorm, and Christensen (2006), focused on demographics, pre-trauma risk factors, level of trauma exposure, and immediate reaction to the traumatic experience. They hypothesized that “when all predictor variables were taken into account, symptoms of PTSD would be positively associated with being female, having less education, reporting higher levels of pre-trauma psychopathology, less social support, and with being more distressed and upset during the disaster” (p. 388). Furthermore, they suggested that “after adjusting for pre-trauma risk factors…more PTSD symptoms would be associated with…more uncontrollable traumatic events, but not with having experienced controllable traumatic events or threat of trauma” (p. 388). The traumatic experience of interest in this study experienced was a bushfire in Australia.

Method

**Participants**

There were 2404 (ages 20 – 24 years) participants who took part in Wave 1 of this study. Between refusal to participate in Wave 2, death, and inability to contact participants, 2139 people took part in the re-interview, or Wave 2 of the study, 52.6% of which were female.

**Procedure**

Participants answered 11 questions about their encounter with the fires: five of these questions were about uncontrollable events, two questions were about controllable events, and three were used as representing trauma threats. A final question was about the participants’ subjective response to their encounter with the fires. Goldberg’s Depression and Anxiety Scores and Eysenck’s Personality Questionnaire-Revised were used to assess participants’ depression
and anxiety scores. A list of 20 questions was used to view the adverse childhood experiences and child abuse experiences in participants’ lives. In the second interview, participants were asked questions about 10 different types of trauma; if they had experienced any of the traumas, they were asked to briefly describe them. The Trauma Screening Questionnaire (TSQ) was given to participants to measure PTSD related symptoms re-experienced at least twice in the week previous to the interview (Parslow et al., 2006).

Results and Discussion

Of the 1652 participants reporting experience with a bushfire, just under half of them had experienced or witnessed damage done by the bushfires. About half (746) individuals said they had PTSD re-experiencing or hyperarousal symptoms at least twice in the previous week. Positive screening for PTSD was declared in 104 of the patients (Parslow et al., 2006). Several factors were significantly associated with screening positive for PTSD: being female, having previous trauma, depressive and anxiety symptoms, level of neuroticism, and having prior trauma experience. Interviews conducted three months after the fire found that 5% of the participants had symptoms of PTSD. Overall, depression, anxiety, and neuroticism, were associated with experiencing later PTSD symptoms (Parslow et al., 2006).

Critique

This study connected personality as a risk factor for PTSD. Findings supported the notion that depression, anxiety, and neuroticism put individuals at increased risk for PTSD. There were a few limitations to this study. First, a handful of participants did not return for Wave 2 of the study and others didn’t fully answer the questions. This limited the data because full sets of interviews for all participants were lacking. Second, the time between the two interviews was considerable. Participants might not have had the event as fresh in their mind during the second
interview, considering the long stretch of time since the first interview. Finally, much of the information was obtained from the participants before the traumatic event even occurred. This is useful to compare and contrast the person before and after the event, but it would seem difficult for participants to accurately express their views about trauma, if they haven’t experienced it. Future studies could interview participants before the traumatic experience, right after it, and then at a later time to get a more accurate account of what was really affecting the participant’s risk for PTSD.

Another study titled, “Coping Strategies in Daily Life as Protective and Risk Factors For Posttraumatic Stress in Motor Vehicle Accident Survivors”, was another assessment of personality factors as a risk for PTSD. The researchers, Dorfel, Rabe, and Karl (2008), used vehicle accidents as a traumatic experience because they are so common. Coping styles have been shown to be a risk factor for PTSD in past research. Specifically, avoidant coping styles and wishful thinking strongly predicted development of PTSD (Dorfel et al., 2008). Personality traits like neuroticism, anxiety, pessimism, and deviance all played a role in developing PTSD, as well. In this study, the authors assessed coping styles in response to daily stressful events, to investigate whether there was an increased risk for PTSD, hypothesizing that coping style would be a significant risk factor in developing PTSD.

Method

Participants

The sample was comprised of 44 severe motor vehicle accident (MVA) survivors, who were recruited by the local newspaper and by the Accident Research Department of the University of Technology Dresden. All participants had experienced a MVA at least 6 months before the study. At the start of the study, 18 of the participants met the DSM-IV criteria for full
or subsyndromal PTSD (Dorfel et al., 2008). Participant’s age ranged from 19 to 63 years, averaging 31.89 years and no significant differences were found between age, sex, and time since the accident.

Procedure

To begin with, telephone interviews were administered to screen for PTSD and to look for any reasons to exclude the participant. Subjects eligible to continue in the study received an invitation to the next interview and a packet of questionnaires in the mail. The second interview took 2 to 3 hours and along with the questionnaires, assessed the accident and any PTSD symptoms, cognitions, coping styles, and other possible Axis I disorders (Dorfel et al., 2008). To measure PTSD, anxiety, and depression, participants took the Impact of Event Scale-Revised, the State-Trait Anxiety Inventory, and the Beck Depression Inventory. A severity score and a diagnosis of PTSD were assessed with the Clinician Administered PTSD Scales (CAPS) interview, which was based on DSM-IV criteria for PTSD. The Stress Coping Inventory (Stressverarbeitungsfragebogen [SVF]), a 114-item questionnaire, was used to look at coping styles of individuals during stressful situations. The Posttraumatic Cognitions Inventory (PCI) assessed negative thoughts and beliefs about the traumatic event. The Motor Vehicle Accident Severity Interview (MVA), which contained 43 questions, examined the participant’s objective and subjective views of the accident. The Abbreviated Injury Scale (AIS) was applied to rate each participant’s severity of injury. The Eysenck Personality Inventory (EPI) assessed extraversion and neuroticism in each respondent.

Results and Discussion

PTSD was strongly negatively correlated with situation control, positive self-instruction, and extraversion, and significantly positively correlated with drug use, depression, trait anxiety,
neuroticism, and negative self-thought (Dorfel et al., 2008). All in all, subjective trauma
characteristics, cognitive factors, coping strategies, and personality traits foretold PTSD severity.
This research about personality traits produced mixed results. Extraversion was seen as a
protective factor against PTSD, but neuroticism, anxiety, depression, and negative coping styles
were all appraised as being risk factors for PTSD.

Critique

There was a small sample size for this study (only 44 participants), and a larger sample
could have allowed for more significant results. Furthermore, participants’ coping styles prior to
the MVA were not examined. Future studies should address this because coping style might
change after a traumatic situation, showing that overall personality could shift, too.

The final study, “Cumulative Interpersonal Traumas and Social Support as Risk and
Resiliency Factors in Predicting PTSD and Depression Among Inner-City Women”, was an
evaluation of child abuse and adult rape; it explored the idea that social support may lessen the
risk for PTSD. In past research, social support was found to be an important resiliency factor
(Schumm, Briggs-Phillips, & Hobfoll, 2006). Social support is “the perception that help will be
available when needed” (Schumm et al., 2006). Researchers suggested that the more social
support available, the better the psychiatric adjustment. They hypothesized that adult rape would
be more common in women who reported child abuse. They also predicted that women who
experienced both traumas would perceive less social support, report greater depressive mood and
PTSD severity, as well as be at greater risk for a diagnosis of depression and PTSD, when
compared to women who experienced neither or only one trauma. Finally, women who had low
perceptions of social support would show higher depressive mood, more severe PTSD, and be at
greater risk for a diagnosis of depression and PTSD.
Method

Participants

This study consisted of 777 women recruited from two obstetric-gynecological clinics serving low-income women, located in a mid-sized city in the Midwest. The average age of the participants was early 20s, all of who were single, unemployed, and had one child. The ethnicities of the participants included 64% African American; the remainder were European American or other. With respect to education, 39% did not graduate high school, 33% finished high school, and 28% had education beyond high school. Their yearly household income was low, with 57% making $10,000, 33% making $10,000 to $25,000, and 13% making over $25,000 (Schumm et al., 2006).

Procedure

A condensed version of the Childhood Trauma Questionnaire (CTQ) assessed child sexual abuse and child physical abuse of the participants up to age 16. The National Woman’s Study used 4 items to investigate various forms of physical sexual abuse of the participants at age 16. The Social Provisions Scale used 10 items, like “Can you depend on others to help you, if you really need it?” to measure social support (Schumm et al., 2006). Depressive mood severity in the week prior to the interview was evaluated by the 20-item Center for Epidemiologic Studies-Depression Scale. To measure severity of abuse and assault-related PTSD symptoms two weeks prior to the interview, the PTSD Symptom Scale-Self Report was used. A female interviewer, who approached participants while in the waiting room of the clinic, administered each of these measurements. Fifteen dollars was offered to each participant for their completion of the interview. Minors were allowed to participate with the consent of their parents. Overall, the interview lasted about 45-minutes and took place in a private clinic room.
Results and Discussion

The women in this particular study had higher levels of psychiatric distress when compared with women of other samples. Within the sample, 22% of the participants met the criteria for a diagnosis of PTSD (Schumm et al., 2006). Seventy percent of the women reported experiencing at least one traumatic event, but it was most common that they had experienced child abuse and not adult rape. After categorizing the women into high and low social support groups, the high social support group reported lower depressive moods and exhibited lower PTSD scores. There was no significant impact of social support on PTSD of women who had not been abused. All of the hypotheses were largely confirmed and both types of trauma--child abuse and adult rape--were associated with compromised perceptions of social support (Schumm et al., 2006).

Critique

For women who have experienced traumatic events, especially over multiple developmental periods, social support may be extremely important for coping. This study had a few limitations. The sample consisted of mainly African American women, who were living in poverty. This is a very narrow group of people, and there may be pre-existing factors that affect their coping and perceived social support. Future studies should include women of many different ethnicities and income levels to get a better sense of how social support affects all women, and not just one group. Also, a study involving men, especially single fathers, would be pertinent to this area of research in order to be able to generalize the findings to both genders. In addition, the emotional states of the women during the time of interview may have interfered with their views of social support. In the future, studies could approach participants elsewhere,
instead of at a gynecological clinic specifically for low-income families. This again, would aid in getting a wider variety of participants.

In sum, based upon the current review, it appears that traumatic events are widespread, and the majority of individuals will be exposed to such events during their lifetime. However, not all of these individuals will develop a disorder as a result of the trauma. Posttraumatic Stress Disorder is one of the most common disorders that people who have experienced trauma develop. Numerous and diverse factors put people at increased risk for developing PTSD, a few of which include genetics, ethnicity, previous trauma, previous psychological conditions, personality, and social support. Each of the aforementioned studies took a deeper look at these risk factors and provided us with a more detailed look as to why these issues pose such a great risk for the development of PTSD.
References


