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Multiple Interpersonal Traumas and Specific Constellations of Trauma Symptoms in a Clinical Population of University Females

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ACCEPTANCE

This dissertation, MULTIPLE INTERPERSONAL TRAUMAS AND SPECIFIC CONSTELLATIONS OF TRAUMA SYMPTOMS IN A CLINICAL POPULATION OF UNIVERSITY FEMALES, by ABBY MYERS, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

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ABSTRACT

MULTIPLE INTERPERSONAL TRAUMAS AND SPECIFIC CONSTELLATIONS OF TRAUMA SYMPTOMS IN A CLINICAL POPULATION OF UNIVERSITY FEMALES

by

Abby M. Myers

Female survivors of multiple forms of trauma are increasingly found to be a significant portion of the university population (Briere, Kaltman, & Green 2008). While there is a strong literature base for understanding the effects of individual trauma on psychological functioning (e.g., Briere, 1992; Kaltman, Krumnick, Stockton, Hooper, & Green, 2005), little is known about specific symptom constellations for those who have experienced multiple traumas (Rich, Gingerich, & Rosén, 1997). Using a clinical population of 500 female university students, this study explored the rates of multiple interpersonal traumatic experiences, the connection between multiple traumas and symptom severity, and the association of specific constellations of multiple types of traumas with specific constellations of trauma symptoms. The Trauma Symptom Inventory-Alternate (Briere, 1995) and self-report measures of demographic data and abuse histories were used to collect data, which was analyzed with frequencies, Multivariate Analysis of Variance, and a Canonical Correlation to explore the interrelationships of abuse and trauma symptoms. Multiple abuse was common, with 81% of participants experiencing two or more types of abuse. Multiple trauma generally predicted more severe trauma-related symptoms than those with no trauma or single

traumas. A Canonical Correlation revealed a moderately significant relationship between participants with aggressive types of abuse (e.g., childhood physical, adult physical, and adult sexual abuse) with higher symptoms of intrusive experiences, defensive-avoidance, and dissociation. These findings suggest a differential model of trauma effects, particularly for trauma types characterized by aggression. Implications for future research and clinical practice are addressed.

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ABBREVIATIONS

AA	Anxiety
AI	Anger/Irritability
AEA	Adult Emotional Abuse
AMA	Adult Multiple Abuse
APA	Adult Physical Abuse
ASA	Adult Sexual Abuse
CEA	Childhood Emotional Abuse
CMA	Childhood Multiple Abuse
CPA	Childhood Physical Abuse
CSA	Childhood Sexual Abuse
D	Depression
DA	Defensive Avoidance
DESNOS	Disorders of Extreme Stress, Not Otherwise Specified
DIS	Dissociation
IE	Intrusive Experiences
ISR	Impaired Self-Reference
MA	Multiple Abuse
TRB	Tension Reducing Behaviors
TSI-A	Trauma Symptom Inventory-Alternate

CHAPTER 1

MULTIPLE TRAUMATIC EXPERIENCES AND THE RELATED SYMPTOM EXPRESSION AMONG WOMEN: IMPLICATIONS FOR CLINICIANS

This paper is a review of the field of multiple interpersonal trauma research, specifically examining the symptomatic impact of both childhood and adult types of abuse, which includes the most recent and significant research on multiple traumatic experiences. In addition, it explores the extensive nature of multiple traumas in our society, the current understanding of how cumulative or multiple traumas produce a more complex symptom expression than individual trauma, and an examination of gaps in our current knowledge of specific consequences of multiple types of abuse. Accurately understanding how clients experience trauma and the related symptoms is important to clinical practice. Practical implications for clinical practice with survivors of multiple abuse are discussed throughout.

Many clients have a history of some type of interpersonal abuse, including emotional, physical, and sexual abuse in childhood or adulthood (Browne & Winkelman, 2007; Stinson & Hendrick, 1992). Of those clients, many have experienced repeated abuse and/or multiple types of abuse (Edwards, Holden, Felitti, & Anda, 2003). In fact, multiple abuse appears to be a more typical experience than individual abuse (Arata, Langhinrichsen-Rohling, Bowers, & O'Farrill-Swails, 2005; Goldberg & Matheson, 2005). Rates from 20%-29% for multiple types of trauma have been found among female non-clinical populations (Arata et al., 2005; Briere, Kaltman, & Green, 2008; Edwards et

al., 2003), and as high as 55% among clinical populations (Edwards et al.). Of those who have already experienced one type of abuse, 34% to 60% reported experiencing two or more types of abuse (Arata et al.; Edwards et al.). The impact of traumatic events in the lives of clients is complex and multifaceted. However, much of the trauma literature examines the frequency and impact of individual trauma types in isolation from other traumatic experiences (Feerick & Snow, 2005; Wyatt, Guthrie, & Notgrass, 1992). This type of research, while informative, becomes problematic when clinicians attempt to apply the theoretical findings to clinical practice, as clients' experiences are far more complex, overlapping, and dynamic in nature (Briere & Scott, 2006).

Trauma related symptoms are as complex as the histories of traumatic experiences of survivors. Different people exposed to the same or similar traumas can respond quite differently. Many factors of risk and resiliency have been discussed elsewhere to explain variances in the human response to trauma. For instance, in a 2007 study of disaster rescue and recovery personnel who worked at the World Trade Center site, the development of PTSD ranged from 6%-21% (Perrin et al., 2007). In this example, a group of people was exposed to the same traumatic event, but only a portion of them developed PTSD, while the majority did not. One especially relevant aspect of risk is an individual's unique history of previous traumatic experiences. The effects of multiple abuse are qualitatively different from those of a single trauma or non-interpersonal traumatic incidents (Herman, 1992). For survivors of multiple abuse, traumatic events interfere with their typical developmental milestones and emotional attachments, resulting in symptoms that are based in problems with self-regulation (Courtois et al., 2009). The common symptoms of complex trauma include alternations in: emotional

regulation, consciousness, self-perception, perception of the perpetrator, relationships with others, medical problems, and systems of meaning (Herman; Courtois et al.). Because people who have experienced one trauma have often experienced multiple traumas (Arata et al., 2005; Briere & Scott, 2006), trauma and related symptoms must be studied in a cumulative fashion for the research to be applicable and generalizable to clinical settings.

Defining Trauma

For the purposes of this paper, only traumatic events of an interpersonal nature are considered. However, there are many other common forms of non-interpersonal trauma such as natural disasters, war, car accidents, etc. that can result in post-traumatic symptoms. There are several types of interpersonal trauma, which are described by a variety of labels and categories in the literature. Emotional abuse refers to any experience where someone overly criticized, focused on failures, yelled, screamed, and/or swore at another person (Unites States Department of Health and Human Services, 1989). The distinctions between emotional, verbal, and psychological abuse are rarely defined, and the three labels are often lumped together or used interchangeably in the literature, with emotional abuse considered the most comprehensive (Loring, 1994). Physical abuse refers to someone being punched, bitten, kicked, burned, or beaten (US Dept. of Health, 1989). Sexual abuse refers to someone being fondled, feeling frightened when someone exposed him or herself, being sexually exploited, or having someone attempt unwanted sexual contact (US Dept. of Health). Each of these three types is then divided into experiences that occurred during childhood or adulthood, for six discrete categories of abuse. Neglect typically describes only childhood experiences where important resources

were withheld from a child. These resources include emotional support, love and validation, along with physical resources such as food, shelter, protection, medical attention, and clean clothing (Dong, Anda, Dube, Giles, & Felitti, 2003). Witnessing violence is another type of interpersonal trauma and typically refers to a child witnessing some type of physical violence in their home or among their relatives (Dong et al., 2003).

Defining Multiple Trauma

Definitions. Multiple trauma, used here to refer to either multiple instances or multiple types, is variably defined in the literature. Some use the word "multiple" to refer to only one of the above concepts (Briere et al., 2008; Dong et al., 2003). Revictimization (Briere & Spinazzola, 2009), cumulative trauma (Briere et al.), complex trauma (Herman, 1992), chronic trauma (Courtois & Ford, 2009a), and multiple maltreatment (Arata et al., 2005) are additional terms used to describe or explain the experience of surviving more than one instance or type of trauma. As with individual trauma descriptors, these terms vary in definition, which makes comparing studies and applying the findings to clinical work a challenge.

There is a wide range of terminology used to refer to the concepts covered here. There are the different types of abuse, such as emotional, physical, and sexual. These are sometimes sub-divided into concepts like sexual assault and rape (Briere et al., 2008). Neglect (Arata et al., 2005), witnessing domestic violence (Edwards et al., 2003), psychological abuse (Loring, 1994), household dysfunction (Dong et al., 2003), adverse experiences (Dong et al., 2004), maltreatment (Edwards et al., 2003), and trauma (Briere & Scott, 2006) are additional related terms or experiences examined in empirical research. Studies often do not define these terms, define them using different behavioral

descriptors, or define them broadly without providing examples of the behavior (Briere, 2004; Freedy, Monnier, & Shaw, 2002). Trauma is sometimes defined as Type I or Type II trauma. Type I traumas are single-incident traumas, while Type II traumas are complex or repetitive (Ford & Courtois, 2009). This variation across a foundational issue such as defining terminology makes the study, and the comparison of multiple studies, difficult. Further, it may complicate and confuse clinicians about which client experiences are traumatic or abusive when clinicians are developing treatment plans or reporting abuse to authorities.

Severity. Trauma severity can be defined multiple ways, including by number of types of trauma (Briere, 2004), frequency (Elhai & Simmons, 2007), intensity, duration, and age of occurrence (Ney, Fung, & Wickett, 1994). Trauma can occur in discrete, isolated situations, or chronically over a period of time (Briere & Scott, 2006). In clinical settings, therapists must make decisions about how much information to request from a client on the initial paperwork and during the initial assessment about a client's psychosocial history. Since much of the details around severity have been shown to impact resiliency, symptom levels, and healing (Ford & Courtois, 2009), those items not detailed on the initial paperwork should be followed up on in future sessions due to the significance of these issues in treatment.

With high correlation rates between abuse types (Braver, Bumberry, Green, Rawson, 1992; Briere et a., 2008), one is forced to consider if in reality, trauma actually occurs in distinct, segmented events. For instance, can sexual abuse occur without some level of physical, emotional, or psychological abuse? If not, does sexual abuse, by definition, include some aspects of physical and emotional abuse? Edwards et al. (2003)

suggests that while emotional abuse may not necessarily be inherent in all other types of abuse, it does exacerbate the effects of other types of abuse. As research on multiple types of trauma becomes more common, the overlap among different types of trauma will become more evident. The implications of such questions impact the ways in which trauma is defined, which impacts how trauma is researched, and this in turn impacts the clinical implications of the empirical literature.

Relationship Between Multiple Abuse and Symptoms

Complex, or multiple, trauma is defined as traumatic stressors that are repetitive or prolonged, involve direct harm and/or neglect, occur at developmentally sensitive times, and could potentially severely interfere with a child's development (Courtois & Ford, 2009b). This definition references development and children, and as the research examines experiences of complex trauma in children (see the following literature review), adult abuse is frequently not acknowledged or explored as a significant factor in the potential cumulative effects of trauma.

Comparing the sparse literature on multiple traumas is difficult because the articles are so different from one another in regards to how they define trauma, which types of trauma are included, how many other variables are included, and the statistical methodology that is used. This is further complicated by subtle differences in the above listed factors and contradictory or confusing findings. The most prominent and relevant articles on the effects of multiple types of maltreatment are reviewed below in chronological order to highlight the process of development in the field of multiple trauma research, the significant progress that has been made, current problems in the research, and recommendations of ways to address these shortcomings in the future.

In a particularly important early article, Ney, Fung and Wickett (1994) examined the effects of various kinds of abuse, along with which combinations of abuse had the most impact, in long term research studying 167 children and adolescents between the ages of seven and 18. Participants were selected from several settings, including a private psychiatric clinic, an adolescent unit, a young offender center, and a high school. The Child Experience Questionnaire was used to determine the child's "feelings of enjoyment, purpose in life, future expectations, chances of having a happy marriage, of being a good parent, perspectives on world problems and nuclear war, and reflections on his/her childhood" (p. 707). Mistreatment was grouped into five categories, including physical abuse, physical neglect, verbal abuse, emotional neglect, and sexual abuse. For each type of abuse, the nature, age of onset, severity, duration and frequency were assessed, along with the relationship of the perpetrator. The child also reported his/her views of the effect of the mistreatment, whose fault they believed it to be, if the abuse was abnormal, and his/her suspected reasons for being mistreated.

Ney et al. (1994) found that of the children who were mistreated, 95% of them experienced multiple types of mistreatment, indicating that in this population multiple maltreatment is common, and that experiencing a single type of maltreatment is rare. The researchers found that the combination of physical neglect, physical abuse, and verbal abuse was the "worst combination" of abuse (p. 706) in regards to the child's lack of enjoyment of living. However, all types of abuse negatively impacted the child's enjoyment of living to some degree. Further, they found that when neglect began at an earlier age of onset than other types of abuse, the effects of neglect were intensified. The

authors suggest that a foundation of not getting one's basic physical needs met leaves a child feeling vulnerable, which therefore exacerbates the impact of other types of abuse.

The reason that Ney et al. (1994) made an early and significant contribution to the literature was due to the thoroughness of their assessment of maltreatment by including neglect and abuse, as well as descriptors such as frequency, severity, age of onset, etc. and their approach would serve well as a model for all future research. The examination of the effects of combinations of multiple types of maltreatment is significant, as it establishes the various ways that particular combinations of maltreatment effect people. Ney et al. also examined outcomes in the form of participants' enjoyment of living and hopes for the future. Unfortunately, they did not assess for general symptoms of psychological distress or impairment, nor did they assess for the newly established (at the time the article was published) list of symptoms for Complex PTSD. Yet, their findings still hint at the differential effect of the combinations of maltreatment types on survivors' views of their own wellbeing and future. Later researchers would pursue whether a similar phenomenon occurred with multiple types of maltreatment.

Higgins and McCabe (2001) conducted a review of 29 studies of multi-type maltreatment. To be selected for inclusion, the article needed to be empirical, published in an English language peer-reviewed journal, examine more than one type of maltreatment, and provide data on maltreatment prevalence, the relationship between maltreatment types, or the relationship between maltreatment types and an outcome. For each article, the authors provided an overview of the study, data on the relationship between maltreatment types, and outcomes associated with maltreatment types. While all the studies reported on more than one type of maltreatment, only 14 of the studies

actually included participants who experienced multiple types of maltreatment (the others reported on different types of maltreatment in different groups of participants). Of those, only 12 used outcome measures to assess for adjustment problems. Overall, experiencing multiple maltreatment types resulted in poorer psychological adjustment and increased psychological distress, which Higgins and McCabe indicate points towards an additive model of trauma. An additive model suggests that it is the number of traumas, rather than any specific combination of traumas, that impacts the increased severity of symptoms. In other words, as someone experiences more types of trauma, they are more likely to experience more symptoms than those with fewer types of trauma. Said another way, the effects of multiple traumatic experiences accumulate over time, gradually worsening as the person continues to experience more trauma. However, the lack of consistency between the studies that Higgins and McCabe examined makes it difficult to determine specific effects of specific traumas. Therefore, support for an additive model could simply be a factor of the variation in hypotheses proposed, variables assessed, and methodologies utilized in the studies that were reviewed.

A differential model, where specific combinations of trauma types lead to specific combinations of symptoms, could also be considered. In a differential model, different or unique combinations of trauma are related to specific combinations of symptoms. Whereas the additive model suggests that the increase in the number of trauma types leads to more symptoms, the differential model suggests that something dynamic and exponential happens when specific types of traumas are combined that lead to specific types of symptoms above and beyond that found in other combinations of traumas.

There were several studies in the review that found specific consequences for combinations of maltreatment types (Bagley & McDonald, 1984; Briere & Runtz, 1990; Bryant & Range, 1995; Fox & Gilbert, 1994; Gross & Keller, 1992; Higgins & McCabe, 2000; Milner et al., 1990; Rorty et al., 1994; Roth et al., 1997; as cited in Higgins & McCabe, 2001). For instance, the combination of sexual abuse and physical abuse were found to have significantly higher rates of sexual dysfunction, psychopathic deviance (Scale 4 of MMPI), suicidality, bulimia, PTSD and Complex PTSD than other combinations or single traumas. Likewise, the combination of physical abuse and psychological abuse were correlated with lower self-esteem, dysfunctional sexual behavior, anger and aggression, and depression significantly more than other combinations of abuse or single traumas. This is consistent with the findings of Ney et al. (1994), that physical abuse and verbal abuse (which is often used interchangeably with psychological and emotional abuse) is a particularly dangerous combination of abuse types. To find support for a differential model, several studies that examine similar types of abuse and that measure similar outcomes would need to be compared. The significant results found in the studies described above provide initial support to the need for additional examination of differential effects of multiple traumas on psychological well-being.

Overall, Higgins and McCabe (2001) summarized that multiple types of maltreatment occur frequently (although they were not able to provide any general prevalence rates because of the lack of compatibility between studies), that multiple types of maltreatment result in greater psychological distress than single types, and that there needs to be improved future research to have a more accurate picture of the consequences

of multiple types of maltreatment. They suggested that future research designs include outcome measures, the assessment of maltreatment types on a continuous scale measuring frequency and/or severity to allow for the partitioning of effects for each type of maltreatment, and the inclusion of all five maltreatment types (i.e., psychological abuse, physical abuse, sexual abuse, neglect, and witnessing violence). Yet, like Ney et al. (1994), Higgins and McCabe also limited their review to childhood maltreatment. Both articles neglected the potentially compounding effects that adult abuse has on one's general functioning and psychological distress.

Dong et al., (2003) conducted a large-scale population study with 17,337 male and female HMO health plan members to examine the relationship of childhood sexual abuse (CSA) to other types of Adverse Childhood Experiences (ACEs). While this study again was limited to childhood experiences, it did expand the amount and types of maltreatment included in the study. However, no outcome measure was used to assess for the impact of multiple types of maltreatment. Dong et al. assessed for severity of CSA by examining the frequency and duration of the abuse, age of onset, the relationship to the perpetrator, and type of sexual contact. The relationship between CSA and emotional or physical abuse, emotional or physical neglect, and household dysfunctions (e.g., battered mother, substance abuse, mental illness, criminal behavior, and separation or divorce) were examined.

The study found that 25% of women and 16% of men reported CSA. Experiencing CSA increased the odds of experiencing another ACE to 2.0 to 3.4 for women and 1.6 to 2.5 for men. Women who reported CSA were two to three times more likely to experience an additional ACE than women who did not report CSA. Men have

slightly better odds, although experiencing CSA still increased their chances of experiencing another ACE by one to two times that of men without CSA. Emotional abuse was most highly associated with CSA, followed by physical abuse, physical neglect, and having a battered mother. All measures of severity of CSA significantly increased the overall ACE score for both men and women. In other words, the more severe CSA a person experienced, the more likely they were to experience other types of ACEs than those with less severe CSA. The sequence of experiences of ACEs was not assessed, so the authors caution against drawing any causal conclusions. However, the high odds ratio of the co-occurrence of CSA and emotional and physical abuse indicate the importance of assessing for all possible types of maltreatment to more fully understand the factors affecting one's functioning. Dong et al. (2003) followed some of the recommendations by Higgins and McCabe (2001) by assessing for a broader range of childhood maltreatment types, by examining the frequency of experiencing multiple types of maltreatment, and by examining important factors of severity as related to CSA (but not other types of trauma). Their findings support the existing literature's findings on the frequency of multiple abuse in the general population. However, Dong et al. failed to identify any outcome measures associated with the problems related to experiences of multiple abuse.

Edwards et al. (2003) conducted a study using 8,667 male and female members of an HMO. They assessed for childhood sexual abuse, physical abuse, emotional abuse, and witnessing maternal battering, as well as overall mental health. The frequency or intensity of each type of adverse event was measured. Edwards et al. found that more than half of the women who reported CSA also reported one or more other types of

abuse. As the number of types of abuse increased, the overall mental health scale decreased (lower scores indicated worse mental health).

Edwards et al. (2003) provided additional empirical support for experiences of multiple traumas as more common than individual traumas. They also assessed for a broad range of maltreatment types (except for neglect) and utilized an outcome measure to assess for overall mental health. However, while they replicated the dose-response effect, or additive model, of more types of maltreatment leading to decreased mental health scores, they failed to provide any more information on the specific types of trauma-related symptoms experienced. They did report on the effect of specific types of maltreatment combinations, noting that emotional abuse alone led to lower scores of mental health, and when emotional abuse was combined with other types of abuse, the effects were heightened above what was found for individual types of abuse. This is again consistent with the results of Ney et al. (1994) and Dong et al. (2003) that verbal abuse and psychological abuse (respectively) led to poorer mental health scores either alone or in combination with other types of abuse. Emotional abuse seems to be an integral type of abuse when it comes to the particular combinations of abuse that are most damaging. Future research needs to continue to explore which combinations of multiple abuse are most harmful, and new lines of research should examine what symptom clusters are likely when those particular combinations are experienced.

In 2005, Arata et al. examined the effects of multi-type maltreatment in childhood. They sought to remedy some of the weaknesses of previous research by including multiple types of abuse (e.g., neglect, emotional abuse, physical abuse, and sexual abuse), along with several different outcome measures to assess for the effects of

cumulative abuse (e.g., self-esteem, depression, suicidality, substance use, number of sexual partners, and delinquency). Participants were 384 male and female college students sampled from introductory psychology classes. Arata et al. made several hypotheses. They hypothesized that participants reporting fewer types of abuse would have fewer symptoms than those with more types of abuse, and particular types of abuse would predict particular types of symptoms. They also sought to determine if the effects of cumulative abuse were additive or differential. They found that multiple types of abuse were more common than single types, which is consistent with previously reported findings. They also found that people with two or more types of abuse experienced greater psychological distress (as measured by the several different types of outcomes described above) than those with one or no types of abuse. However, when the participants were grouped into specific categories of multiple abuse types, there was not much difference from those with single types of abuse. The researchers hypothesized that this was a result of the high specificity in the way the abuse types were combined and the resulting small numbers of participants in some of the groupings of abuse. In other words, the researchers believed that the methods used for this statistical analysis were not the most appropriate to capture the effects of multiple abuse.

The researchers reported mixed results about the additive and differential effects of cumulative trauma on the outcome measures. As mentioned above, the addition of multiple types of abuse leads to the increase in symptoms, supporting an additive model. Differential effects were found for both individual types of trauma and certain combinations of trauma. For instance, when considering individual types of trauma, neglect was related to lower self-esteem and more depressive symptoms; sexual abuse

was related to sexual and suicidal behaviors; and physical abuse was related to depression, self-esteem, delinquency, life-threatening behaviors, suicidal thoughts/attempts, and sexual behaviors. When multiple trauma types were considered in combinations, the researchers found that physical and sexual abuse combined led to the greatest impact (in the same symptoms as were found with physical abuse alone). While emotional abuse alone was not related to any symptoms, when it was combined with other types of trauma, it was significantly related to self-esteem and depression. When neglect was combined with other types of trauma, it was significantly related to substance use and delinquency, and when combined specifically with sexual abuse, it predicted the number of sexual partners.

In sum, Arata et al. (2005) found both general and specific effects of both individual and cumulative trauma types. These findings support both an additive and a differential model of trauma and point to the need for additional studies to replicate this one to attempt to clarify and further explain the nature of the relationship between cumulative trauma and trauma symptoms. Their study followed some of the previous studies' recommendations by expanding the types of trauma examined and using statistical analyses to look at both individual and combined effects from multiple trauma types. The study used multiple outcome measures, which represent a wide range of problem areas associated with experiencing trauma. However, the study failed to include witnessing violence as one of Higgins and McCabe's (2001) suggested five trauma types. It also did not assess for many of the unique symptoms associated with Complex PTSD such as dissociation, biological self-regulation, relationships with others, and systems of meaning, despite the fact that it is assessing complex traumatic experiences. Further, like

all of the other studies described above, it only examined the effects of childhood abuse, neglecting to account for the impact of abuse experienced in adulthood.

Several years later, Briere et al. (2008) examined cumulative childhood trauma and symptom complexity (measured by the total number of types of symptoms) in 2,453 female university students. Each participant completed the Stressful Life Events Screening Questionnaire (SLESQ; Goodman, Cocoran, Turner, Yuan, & Green, 1998) to assess for traumatic events, the Trauma Symptom Inventory (TSI; Briere, 1995) to assess for symptoms, and a demographic questionnaire. Briere et al. critiqued the existing literature for not addressing if survivors of multiple traumas experience more different kinds of symptoms than those with single traumas. They reported that the current literature demonstrates that the sequelae of multiple traumas result in more severe symptoms, but that those findings have not been extended to examine potential differences in symptom presentation and complexity. They hypothesized that the relationship between the number of childhood traumas and symptom complexity would be represented in a linear relationship, that childhood abuse would result in more complex symptoms than non-abusive traumas, and that the cumulative effects of childhood trauma would predict symptom complexity. Briere et al. found that as the number of trauma types increased, so did symptom complexity. This adds support for a general, or additive, model of trauma exposure. However, they also found that childhood rape, physical abuse, threats with a weapon, attempted rape, and other childhood sexual contact each individually predicted more complex symptoms. Yet when each of these individual trauma types were controlled for, cumulative trauma in general continued to predict symptom complexity. Therefore, while the specific traumas of childhood rape and

physical abuse significantly predicted symptom complexity, the general effects of cumulative trauma also predicted more symptom complexity, which lends further support for an additive model of trauma.

Briere et al. (2008) used a strong measure of both trauma experiences and symptoms. Specifically, the SLESQ assesses for emotional, physical, and sexual abuse, along with witnessing violence and several other forms of traumatic experiences. It does provide a general question for "other" events that might cause one to feel extremely frightened or helpless, but does not assess for emotional or physical neglect. The SLESQ does assess for detailed descriptors of the severity of each event, including frequency, perpetrator, age of onset, nature of event, etc. While the SLESQ assess for *exposure* to trauma, the TSI assesses for trauma-related *symptoms* that represent some of the symptoms present in the symptom constellations for both traditional PTSD and Complex PTSD, which is an improvement over all of the studies described above.

Although the SLESQ measures both childhood and adult stressors, Briere et al. (2008) chose to only examine childhood stressors because of the younger age range represented in their sample. While the mean age of participants was 19.4 years, data was collected on women aged 18-24 years old. Ignoring the traumatic events that are likely to occur to college women during this six-year age range (Bernat et al., 1998; Owens & Chard, 2006; White & Koss, 1991) is a weakness in the research. The participants' symptom complexity may in fact be related to their more current traumas. Briere et al. did not report on the threshold of the number of cumulative traumas needed to experience more complex symptoms. If they had included adult traumas, they might have been able to provide more detailed and accurate results. While their results lend support for an

additive model of trauma, they did not examine the data in a way that might have provided support for or against a differential model of trauma. If the researchers had looked at specific combinations of trauma and their relationship to specific combinations of symptoms, they could have provided a more accurate explanation and understanding of additive versus differential effects of cumulative trauma exposure.

Despite the various beliefs about how exactly trauma symptoms cumulate over time, there is consensus in the field of trauma regarding the general set of symptoms associated with multiple abuse. These symptoms are represented by the proposed diagnosis of Complex PTSD (Herman, 1992). However, understanding the development of Complex PTSD and the barriers to its official acceptance in the Diagnostic and Statistical Manual (DSM-IV-TR; American Psychiatric Association, 2000) is aided with an understanding of the history of traditional Post Traumatic Stress Disorder (PTSD). Both diagnoses, and their similarities and differences, are described below to highlight the clinical importance of the Complex PTSD diagnosis for survivors of multiple trauma.

Traditional PTSD

As defined by the Diagnostic and Statistical Manual (DSM-IV-TR; American Psychiatric Association, 2000), the diagnoses for trauma-related experiences are limited to Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD). PTSD was created to capture the experiences of adult, male combat veterans of war, even though there was a lack of theoretical literature or empirical evidence about associated symptoms (van der Kolk, 2007). Women and children (both male and female) are more affected by interpersonal violence than combat, and demonstrate a different set of symptoms than are accounted for by the diagnoses of PTSD or ASD (van der Kolk). These symptoms are

often diagnosed as other unrelated disorders and consequently treated as such (van der Kolk). If counselors are addressing disorders that are not accurate descriptions of clients' experiences, therapy is unlikely to be beneficial. Identifying the impact of particular clusters of abuse, recognizing a wider variety of symptoms to define trauma related disorders as suggested by Herman (1992), and professionally endorsing additional trauma-related diagnoses to more accurately describe the experiences of interpersonal violence, particularly with women and children, could greatly enhance the current literature about, and practice implications for, survivors of multiple interpersonal trauma.

The diagnostic criteria for trauma-related disorders in the current version of the DSM-IV-TR are unique from almost all other diagnoses in the manual. Except for disorders caused by substance use or a medical condition, PTSD and ASD are the only diagnoses that require criteria to be met for both etiology and symptoms (Briere, 2004). To be diagnosed with PTSD, a person must display a particular symptom set *and* have experienced one DSM-approved trauma that occurred before any of the symptoms began. If a person has all of the symptoms, but their experience of trauma does not meet DSM criteria, that person cannot receive a diagnosis of PTSD or ASD (Briere). Further, if a person has experienced multiple traumatic events with a gradual increase in types of symptoms as a cumulative effect of their past experiences, a diagnosis of PTSD or ASD cannot be given (Briere). Clearly, this is problematic when, as discussed previously, most people who have experienced one interpersonal trauma have experienced multiple interpersonal traumas (Briere & Scott, 2006). The current diagnostic model does not account for the well-documented experiences of those with multiple traumas (Herman, 1992). In fact, people with multiple traumas are frequently given multiple, and often

stigmatizing, Axis I and Axis II diagnoses to account for all of the various symptoms they exhibit (Herman). This has led many clinicians and researchers to develop more refined diagnoses that account for the actual experiences of trauma survivors.

DESNOS/Complex PTSD

Disorders of extreme stress not otherwise specified (DESNOS) and Complex PTSD are two names of a proposed disorder that accounts for the more typical symptom presentation of people who have experienced multiple, chronic, or cumulative traumas (Herman, 1992; Roth et al., 1997; van der Kolk, McFarlane, & van der Hart, 1996). Both names will be used interchangeably throughout. The diagnostic criteria include alterations in affect regulation, biological regulation, consciousness, self-perception, perception of perpetrator(s), relationships and systems of meaning (Ford & Courtois, 2009; Herman, 1992). However, Complex PTSD does not include the traditional PTSD symptoms of reliving, avoidance, and hyperarousal (Briere, 2004). Therefore, it is possible for someone to be diagnosed with both PTSD and Complex PTSD (Briere; Courtois et al., 2009a). The Complex PTSD diagnosis describes many Axis I and Axis II types of symptoms to more thoroughly account for the typical reactions to multiple traumatic experiences in a single diagnosis. The Complex PTSD diagnosis encompasses seven categories of symptoms: alternations in 1) emotional regulation, 2) consciousness, 3) self-perception, 4) perception of the perpetrator, 5) relationships with others, 6) medical problems, and 7) systems of meaning (Herman, 1992; Courtois et al., 2009a).

One comprehensive diagnostic category that adequately explains a person's reactions to chronic, or multiple, trauma aides in the treatment planning and healing process by making treatment goals and therapy more accurate, unified and effective.

Herman (1992) explains that mental health professionals sometimes replicate the relationship difficulties often experienced by survivors of multiple trauma when treatment does not recognize the survivors' experiences of distress. By acknowledging the etiology of a person's interpersonal difficulties, rather than implying an individual has personality deficits, some of the stigma related to trauma and therapy may be lessened. With fewer stigmas come increased opportunities to utilize healing resources such as therapy, psychiatry, and psychoeducation. However, because these proposed diagnoses defy the current categorical structure of the DSM by including Axis I and Axis II symptoms together in one comprehensive diagnosis, the disorders' inclusion in the DSM has met barriers. Herman (2009) explains that despite successful field trials identifying Complex PTSD symptoms as unique to survivors of multiple traumas, highly inter-correlated, and prevalent in the population, along with the recommendation for inclusion by the PTSD Working Group, the diagnosis was not included in the last revision of the DSM-IV-TR, because it did not easily fit into any of the pre-existing diagnostic categories. However, research on Complex PTSD and the clinical application of the proposed diagnosis continues (Herman, 2009).

Assessing Complex Trauma

When assessing clients during a clinical interview or with intake paperwork for experiences that are traumatic, there are several general guidelines that are important to follow. Researchers have indicated that asking clients (verbally or in writing) *directly* if they have experienced any of the following *behaviors* (Briere, 2004), without using *labels* (Freedy et al., 2002**)** yields the most robust responses (Briere; Resnick, Falsetti, Kilpatrick & Freedy, 1996).

Clients are less likely to spontaneously self-disclose a history of interpersonal trauma for several reasons. Clients may not label certain experiences as "abusive" or "traumatic," as there is wide variation in how people define these terms (Briere, 2004; Hanson, Kilpatrick, Falsetti, and Resnick, 1995). For instance, some people may not label spousal rape, harsh disciplinary spanking, or parents who excessively scream and criticize their child as "abuse" despite all of these examples falling under the professionally accepted definitions. Additionally, many clients do not see a connection between past abusive experiences and their current problems in functioning or their distressing symptoms. Therefore, they do not believe there is a need to disclose such personal and vulnerable information. Depression and anxiety are consistently in the top five presenting concerns at many college counseling centers (Benton, Robertson, Tseng, Newton, & Benton, 2003; Furr, Westefeld, McConnell, & Jenkins, 2001). Therefore, given the high reported rates of both childhood and adult trauma experienced by this population, one can hypothesize that students often do not identify past experiences of abuse as impacting their current feelings of distress. By asking about specific behaviors that are considered abusive, a clinician is more likely to have an accurate understanding of each client's exposure to interpersonal abuse. Therefore, it is vital that terms like "abuse" and "rape" not be used during the assessment process (Briere, 2004), while direct questions listing specific behavioral experiences should be used instead.

Briere (2004) provides several detailed chapters in his text, *Psychological assessment of adult posttraumatic states*, reviewing and evaluating measures to assess an individual's lifetime exposure to trauma and level of trauma-related symptoms. Most instruments assess either trauma exposure or trauma symptoms, therefore each category

of assessment is presented separately here. For trauma exposure, structured clinical interviews and measures are both described, along with the reliability and validity information and relative strengths and weaknesses. Briere acknowledges that most of the measures presented, while currently the best in the field, are research oriented, do not behaviorally define traumatic events, and are too long for practical use in a clinical setting. He urges clinicians to take the specific needs of their population into consideration when selecting which method or combination of methods are most appropriate. Therefore, based on the literature on the prevalence of multiple abuse among those that report at least one type of abuse, clinicians should view the report of any type of abuse as a red flag to assess for the potential of additional types of trauma.

Additional measures and diagnostic interviews are available to assess a client's level of trauma-related symptoms and distress. There are several effective structured clinical interviews to choose from, including the Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS; Briere, 2004) to assess for symptoms of PTSD, and only one choice, the Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al, 1997, as cited in Briere,) to assess for symptoms of DESNOS. Neither interview assesses for symptoms of the other diagnosis, however (Briere). There are more options when using standardized measures, however. The Trauma Symptom Inventory (TSI; Briere, 1995) is one of the few multi-scale inventories available for trauma (Briere, 2004), and it assess for symptoms of both traditional PTSD and Complex PTSD (Briere & Spinazzola, 2009). Multi-scale inventories are important in assessing trauma responses because of the variety of symptoms and types of responses that clients experience. If a

scale yields a single, overall score, rather than individual scale scores, then elevations of particular symptoms would get overlooked (Briere).

Overall, Briere and Spinazzola (2009) recommend using at least two assessment instruments tailored to the needs of each client, beginning with a broad, general instrument to assess psychological functioning, followed by a trauma specific measure to determine trauma symptomatology. In addition, Courtois, Ford, and Cloitre (2009) advise the use of some additional guidelines when assessing complex trauma. Their recommendations are to 1) include the assessment of trauma in general screening and assessment procedures, 2) remember that some clients will not disclose trauma, dissociation or attachment issues even when directly asked, 3) use sensitivity and support when inquiring about traumatic events, 4) remember that the discussion of trauma can lead to the emergence of symptoms, and 5) repeat assessment throughout treatment to recognize the emergence of new symptoms or symptoms initially overlooked.

Treating Complex Trauma

At this point, there are no formal, published treatment guidelines for Complex PTSD (Courtois et al., 2009). Treatment guidelines for traditional PTSD and dissociative identity disorder, along with theoretical models and clinical experience with Complex PTSD, are combined to form "preliminary treatment recommendations and provisional best practices for complex traumatic stress disorders," (Courtois et al., p. 84). Courtois et al. and Herman (1992) advise that treatment should begin with several foundational concepts. First, they highlight the importance of recognizing the individuality of the client and approaching treatment in a holistic manner, ensuring her welfare, recognizing her symptoms of distress, and reinforcing her resources and resiliency. Next, personal

empowerment of the client is emphasized, with the therapist focusing on collaboration, reducing power differentials, using power to advocate for the client, and maintaining appropriate therapeutic boundaries. Finally, therapists should have appropriate and specific training, skills and supervision in posttraumatic conditions, along with the emotional maturity to cope with the dynamics, transference and counter-transference, and vicarious traumatization inherent in a therapeutic relationship accented by multiple and complex trauma and co-morbid issues.

Therapeutic goals for clients with histories of multiple or complex trauma should be tailored to meet each client's unique needs, but in general should address any symptoms of traditional PTSD, along with the common developmental/attachment difficulties and the symptoms of Complex PTSD (Courtois et al., 2009). Specifically, Courtois et al. recommend the following treatment goals for clients who suffer from the implications of multiple traumas: "overcoming developmental deficits; acquiring skills for emotion experiencing, expression, and self-regulation; restoring or developing a capacity for secure, organized relational attachments; enhancing personality integration and recovery of dissociated emotion and knowledge; restoring or acquiring personal authority over the remembering process; and restoring or enhancing physical health," (p. 90).

The most widely used and commonly accepted model of trauma therapy for adults is the three phase model developed by Herman (1992) and elaborated on by Briere and Scott (2006) and Courtois et al. (2009). The three phases are establishing safety, processing traumatic memories, and reintegration. The three stages should be completed in a generally linear fashion; however, therapy with survivors of complex trauma is a

fluid process and may often resemble a spiral more than a straight line with resolved issues resurfacing at later times (Herman).

Stage One: Safety and Stabilization. The initial stage of safety and stabilization can take months to years for chronically abused clients (Herman, 1992), but is the most important stage in the journey to recovery (Courtois et al., 2009). Survivors of single or less complicated traumas may experience a reduction in symptoms after this stage and may not need to complete the following stages of therapy, while severity, duration and earlier age of onset make this stage more complicated for survivors of chronic trauma (Courtois et al.; Herman). Safety is established with several different tasks. Herman recommends the importance of naming the client's problems, which includes a thorough assessment and diagnosis that is shared with the client, education around symptoms of Complex PTSD (including personality changes), and education on the therapeutic process. The client should be recognized for her courage to seek therapy, which is an important step in the process of regaining control in her life (Herman).

Establishing safety begins by first restoring control within the client and then moves outwards to the client's environment (Courtois et al., 2009; Herman, 1992). Important tasks during this phase include learning to manage emotional arousal, the mastery of internal and external triggers of re-experiencing, numbing, and dissociation, and enhancing relational capacities (Courtois et al.). In general, the improvement or establishment in the client's capacity for self-care and self-soothing abilities is vital to reducing distress (Herman). This can be accomplished by the client increasing her positive social support system, gaining medical care, taking medications, learning stress management techniques, practicing cognitive-behavioral strategies and developing a

trusting therapeutic relationship (Herman). Herman explains that establishing a safe environment is important not only for the client's physical safety, but also for her psychological healing to take place. This task can range from helping the client develop a safety plan if she remains in an abusive relationship to mobilizing her support system. At the completion of this stage, a client with Complex PTSD should have the confidence to protect herself, the ability to control most of her symptoms, know who she can rely on for support, maintain appropriate boundaries in relationships with others (including her therapist), and believe that she both can and deserves to take good care of herself (Herman).

Stage Two: Processing Traumatic Memories. The primary goal of the second stage of trauma therapy is to create a coherent and detailed narrative of the client's experience (Courtois et al., 2009; Herman, 1992). While it is important to remember and share each of the traumatic experiences, that is often not possible for survivors of chronic trauma (Herman). Herman explains that in the case of complex trauma, it is acceptable for one episode to represent many others of a similar nature. The therapist's role throughout this phase is to bear witness to the client's experiences and serve as her ally, to maintain balance between the pacing and timing of the narrative and the client's safety, to be in solidarity with the client, to normalize the client's reactions, and to repeatedly affirm the client's dignity and value (Courtois et al.; Herman).

It is necessary that the reconstruction of the client's narrative begin before the traumatic event(s) and includes the recitation of facts, the client's emotional and bodily response, and the response of others to the trauma (Herman, 1992). The therapist should ask detailed questions about the client's memory of thoughts, feelings, sounds, sensations

and any other details of the trauma to help the client remember the events with feeling rather than in a dissociated state (Courtois et al., 2009). Asking for more information will help the therapist guard against making assumptions as to which aspects are most significant or distressing to the clients (Herman). During the reconstruction task, the client should address the questions of "Why?" "Why me?" and "What do I do now?" as she begins to understand how these events impact her and her values. The next task in this stage is transforming the traumatic memories (Herman). Particularly for clients with Complex PTSD, simply describing a detailed narrative is insufficient for healing because it does not sufficiently address the damaging relationship aspects of chronic trauma (Herman). While there are several different techniques often used to assist in transforming memories from intolerable to tolerable (e.g., flooding, testimony, hypnosis, etc.), Herman recommends the use of simply focusing in detail on the client's existing memories to help fill in some of the gaps that exist and discover what aspects of the trauma are significant to the client's current distress. Mourning traumatic loss is the final task of stage two, and Herman describes this task as the "most necessary and most dreaded" (p. 188). Herman emphasizes the need to remind clients that allowing oneself to mourn and grieve the multiple losses caused by their traumatic experiences is an act of courage, rather than humiliation.

Stage Three: Reconnection/Reintegration. The overarching goal of this stage of trauma therapy is for the survivor to create a future that involves a new conception of self, a new quality to relationships, and new beliefs that account for the changes she has experienced during her recovery (Herman, 1992). In the beginning of stage three work, it is common to return to some of the tasks of stage one, including self-care, maintaining

safety in the environment and working on relationships (Courtois et al., 2009). However, this is all done with an engaging, rather than protective, perspective (Herman). One task of this stage is learning to fight. Herman explains that it is the practice of approaching danger and fear in a controlled, planned encounter and can be accomplished with activities such as self-defense courses or wilderness trips. Other suggested ways of accomplishing this task include self-examination of personality traits of the survivor. However, it is imperative that this exercise not be undertaken until the survivor has firmly accepted that the perpetrator is solely responsible for the abuse (Herman). Family confrontations or disclosures are other ways of fighting against the secrecy inherent in abuse, but the survivor should be in a place where she is well-prepared for the confrontation and is ready to accept all responses of her family, as the goal is for her to speak of her experience and to break the silence, not to achieve a particular outcome from others (Herman).

Another task of stage three is reconciling with oneself (Herman, 1992). This is accomplished with a new sense of imagination, play, and trial and error as the survivor learns to let go of her identity as a victim (Herman). Reconciliation with oneself is demonstrated when "compassion and respect for the traumatized, victim self join with a celebration of the survivor self," (Herman, p. 204).

Reconnecting with others is a particularly important task for survivors of multiple abuse, as the abuse has often interfered with developmental tasks of childhood (Courtois et al., 2009; Herman, 1992). During this task, clients learn how to understand when to trust and when not to trust others (Herman). This impacts the therapeutic alliance, which may become less intense but more secure (Herman). Clients may also experience what

Herman calls a "second adolescence" (p. 205) due to often missing much of the first one, where their friendships and coping styles may look like that of teenagers. It is important for clients to address issues of intimacy in this stage, both individually and with a partner if she currently has one (Courtois et al.; Herman). Survivors may also begin to show a renewed interest and concern for others, particularly children, at this point where they may feel more comfortable being around children or feel compelled to protect children for the abuse they experienced (Herman). This often manifests in addressing past and current parenting issues for survivors (Courtois et al.).

The next task of stage three entails finding a survivor mission. Herman (1992) explains that while many people accomplish this internally, some survivors have a desire to engage the political or religious structures in their world. Social action, raising public awareness, and seeking justice for the perpetrator are common ways of acting on a mission (Herman).

The final task of the reconnection stage is resolving the trauma. It is important for client's to remember that this process is dynamic and never finalized (Herman, 1992). Part of terminating trauma therapy should be preparing the client for the likely need to return to therapy in the future as new stressors may bring up new issues (Herman). A client's completion of trauma therapy will be marked by her ability to enjoy life and take pleasure in her relationships (Herman).

There are other types of therapeutic approaches that have recently been developed to treat survivors of complex trauma, and are either empirically supported, or empirically informed with additional studies on their efficacy underway or recommended. *Treating complex traumatic stress disorders* (Courtois & Ford, 2009b) devotes a chapter to each of

the following therapeutic approaches: contextual therapy (Gold, 2009), cognitive-behavioral therapy (Jackson, Nissenson, & Cloitre, 2009), contextual behavior trauma therapy (Follette, Iverson, & Ford, 2009), experiential and emotion-focused therapy (Fosha, Paivio, Gleiser, & Ford, 2009), sensorimotor psychotherapy (Fisher & Ogden, 2009), and pharmacotherapy (Opler, Grennan, & Ford, 2009). Many of the techniques described by Briere and Scott (2006), as well as in the relevant chapters found in Courtois and Ford (2009b) are appropriate for use with Herman's (1992) three-phase model described above.

Conclusion

Our understanding of interpersonal trauma has developed significantly over the past several decades. Just less than 40 years ago, this quote was published in a leading psychiatry textbook:

> [Incest is thought to occur] in approximately 1 out of 1.1 million women. There is little agreement about the role of father-daughter incest as a source of serious subsequent psychopathology. The father-daughter liaison satisfies instinctual drives in a setting where mutual alliance with an omnipotent adult condones the transgression... The act offers an opportunity to test in reality an infantile fantasy whose consequences are found to be gratifying and pleasurable... The ego's capacity for sublimation is favored by the pleasure afforded by incest…such incestuous activity diminishes the subject's chance of psychosis and allows for a better adjustment to the external world.
>
> There is often found little deleterious influence on the subsequent personality of the incestuous daughter…one study found that the vast majority of them were none the worse for the experience (as cited in van der Kolk, 2002, Freedman and Kaplan, Comprehensive Textbook of Psychiatry, 1972).

Twenty years later, Herman (1992) published her groundbreaking book on trauma, which included the proposal of a new diagnosis, Complex PTSD, along with a model of therapy that continues to be the foundation of most current therapeutic approaches to treating

survivors of trauma. However, despite the additional research and empirical studies by a myriad of professionals over the past 17 years since the initial proposal of Complex PTSD, it is still not a well-known or well-utilized diagnosis and approach outside of the specialty sub-field of traumatology. Clinical training and supervision in trauma, and especially complex trauma, is difficult to come by (Courtois, 2001). Individual types of abuse continue to be studied with little to no mention of other abuse types (Aspelmeier, Elliott, & Smith, 2006; Feiring, Simon, & Cleland, 2009; Luo, Parish, & Laumann, 2008; Soloff, Reske, & Fabio, 2008), and treatment efficacy studies targeting PTSD often exclude potential participants due to their "co-morbid" diagnoses. However, given that co-morbidity is common in Complex PTSD, or that clients may have actually been misdiagnosed, many participants who would benefit from this treatment modality are not studied (Courtois et al., 2009). Given the high rates of multiple interpersonal abuse, all clinicians should be trained in the now decades old information regarding multiple abuse and Complex PTSD.

The newest, most recent publication on complex trauma and the associated disorders is filled with comments by leading experts in the field about the current state of experimentation and lack of certainty regarding the most effective treatment approaches (Herman, 2009), the expectation that the features of Complex PTSD and the assessment and treatment standards will change as research evolves (Courtois & Ford, 2009a), and the lack of specific assessment measures for complex trauma available (Briere & Spinazzola, 2009). Although the publication of a high quality, comprehensive text addressing a wide range of issues related to clinical work with complex traumatic disorders is an important development in the field, there remains work to be done. The

newest, most groundbreaking work does not adequately address some of the problem areas that interfere with the application of multiple trauma research. Some issues that need to be addressed involve defining trauma, measuring severity and factors of specificity of trauma, and the differential effects of cumulative trauma on symptoms. When researching the effects of cumulative trauma in the future, adult traumatic experiences should be considered in addition to childhood experiences of trauma. This is particularly important given the high prevalence of adult types of traumas, as well as the understanding that childhood traumas serve as a risk-factor for future traumatic experiences (Briere, 2004).

Many clinicians have balked at the relatively recent 1972 quote from the Comprehensive Textbook of Psychiatry and the social system in place at the time that allowed such a public and authoritative statement to be made. However, if the current researchers, clinicians, and academics of our time continue to study, treat, and teach about trauma as if it primarily occurs in discrete, isolated events, then is the field not recapitulating the errors of our colleagues from the past by diminishing the seriousness and prevalence of complex trauma? Clinical and academic training in posttraumatic stress, particularly complex traumatic stress, is rare (Courtois, 2001). It is imperative that clinicians-in-training to seasoned practitioners all act on their responsibility of utilizing what is available of the most current, accurate, and theoretically and empirically sound research and treatment modalities to help facilitate growth, healing and change in our clients.

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CHAPTER 2

MULTIPLE INTERPERSONAL TRAUMAS AND SPECIFIC CONSTELLATIONS OF TRAUMATIC SYMPTOMS IN A CLINICAL POPULATION OF UNIVERSITY FEMALES

Introduction

Female survivors of multiple forms of trauma are increasingly found to be a significant portion of university populations (Briere, Kaltman, & Green 2008). While there is a strong literature base for understanding the effects of individual trauma on psychological functioning (e.g., Briere, 1992; Kaltman, Krumnick, Stockton, Hooper, & Green, 2005), little is known about specific symptom constellations for those who have experienced multiple traumas (Rich, Gingerich, & Rosén, 1997).

While the current literature discussed will be limited to the college population, one should keep in mind that this sub-group of the broader population is strikingly similar in regards to their traumatic experiences. College students are often considered a special segment of the population when empirical studies are conducted, as it is assumed that college students, in general, represent people with more resiliency, greater economic privilege, positive social support, and higher levels of education, among other things (Arata, Langhinrichsen-Rohling, Bowers, & O'Farrill-Swails, 2005). This is an important aspect of research that limits the generalizability of findings. However, it is significant to note that despite the differences between college students and a general population, the rates of exposure to all types of traumatic experiences in college students are similar to

the rates of exposure found in the general population, and range from 36% to 69% (Resnick, Kilpatrick, Dansky, Saunders, Best, 1993; Freedy, Monnier, & Shaw, 2002).

The literature regarding interpersonal trauma in female college student populations is reviewed below, beginning with each type of childhood abuse, followed by each type of adult abuse, and then specifically examining the rates of multiple abuse.

Childhood Abuse

Studies of non-clinical samples of college females indicate a 5%-28% prevalence rate of childhood sexual abuse (CSA), sexual assault, or sexual coercion (Arata, et al., 2005; Bernat, Ronfeldt, Calhoun, & Arias, 1998; Braver, Bumberry, Green, Rawson, 1992; Brener, McMahon, Warren, & Douglas, 1999; Browne & Winkelman, 2007; Harter, Alexander, & Neimeyer, 1988; Owens & Chard, 2006). In a 2003 study of Latina college students, reported rates of sexual abuse reached 38% (Clemmons, DiLillo, Martinez, DeGue, and Jeffcott). Some studies suggest that the rates of CSA for clinical samples of college females may be as high as 50% (Browne & Winkelman; Stinson & Hendrick, 1992). According to this body of research, as many as a quarter of all female college students and half of the female clients at college and university counseling centers may have histories of childhood sexual abuse. With such high rates of sexual abuse, one is led to explore the rates of physical and emotional abuse as well.

Childhood Physical Abuse (CPA) in non-clinical samples of college students ranges from 7%-21% in multiple studies (Arata et al., 2005; Bernat, Ronfeldt, Calhoun, & Arias, 1998; Briere et al., 2008; Browne & Winkelman, 2007; Bowers, & O'Farrill-Swails, 2005; Clemmons et al., 2003; Elhai & Simons, 2007; Owens & Chard, 2006). Although less frequently studied, childhood emotional abuse (CEA) is at least as

common as physical abuse, with 24%-44% of students endorsing such experiences (Arata et al., 2005; Browne & Winkelman, 2007; Clemmons et al., 2003). Braver et al. (1992) found that in their clinical sample of college students, 36% of participants experienced abuse in general, with 83% of those students reporting emotional abuse. The research literature clearly indicates that many college students have experienced childhood interpersonal abuse.

Adult Abuse

Adult sexual abuse (ASA) among college students ranges from 6%-23% depending on the study and the definition used (e.g., rape, sexual assault, sexual coercion; Bernat et al., 1998; Owens & Chard, 2006). A national study of over 6,000 college students in a heterosexual relationship found that about 88% of females both inflicted and received verbal aggression, while 35% of females inflicted physical aggression and 32% received physical aggression (White & Koss, 1991). Very little literature about prevalence rates of physical and emotional abuse in college students was available, but some general population studies provide rates for female adults. A World Health Organization (WHO) study of fifteen sites in ten countries around the world found that the lifetime prevalence rate of partner violence was generally between 23%-49% (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005). Campbell (1997) found that in various medical settings, prevalence rates for physical domestic violence ranged from 11% to 45%. Thirty-seven percent of women studied in a large-scale Swedish population study reported adult physical assault (Frans, Rimmo, Aberg & Fredrikson, 2005). Eighteen percent of women reported psychological abuse in a separate large-scale population study in Sweden (Wijma, Samelius, Wingren & Wijma, 2007). Children and adults are exposed

to various types of interpersonal abuse. Often, the same person will experience several different types, or multiple, abuse.

Multiple Abuse

Multiple studies of clinical and non-clinical populations both in the United States and other countries have found rates of over 40% for people who report experiencing two or more types of abuse (Claussen & Crittenden, 1992; Higgins & McCabe, 2000; Moeller, Bachman, & Moeller, 1993; Westen, Ludolph, Misle, Ruffins, & Block, 1990). In a 2003 study of over 17,000 adults, Dong et al. found that women with a history of CSA were two to three times more likely than women without CSA to experience CEA or CPA. Ninety-five percent of the children studied by Ney, Fung, and Wickett (1994) who experienced one type of abuse also experienced multiple types of childhood maltreatment. Briere et al. (2008) found in a large-scale study of university women that 28% reported multiple forms of trauma. Clearly, experiencing multiple traumas is a more common experience than single traumas are in the college student population, and the implications should be carefully examined.

The research on interpersonal trauma examines the impact of distinct, individual, traumatic experiences, which is not representative of how abuse is perpetrated, resulting in severe limitations in the implications of such research. Although studies of multiple types of trauma are becoming more common, and there is an increased understanding that the effects of multiple types of abuse are cumulative, there remains a dearth of details regarding what specific symptom presentations can be expected as consequences of specific constellations of multiple types of childhood and adult abuse reference.

Abuse and Symptoms

Traumatic experiences often have a negative impact on one's psychological functioning through distressing symptoms such as anxiety, depression, fear, dissociation, drug and alcohol abuse, eating disorders, medical problems and impaired interpersonal relationships (Briere, 1992; Kaltman et al., 2005; Yuan, Koss, & Stone, 2006). More specifically, previous research on single types of abuse demonstrates that women with childhood sexual abuse histories demonstrate elevated scores on depression on the Trauma Symptom Inventory (TSI) and other measures of symptomatology (Briere, 1995; Neumann & Houskamp, 1996; Wonderlich, et al., 2007). More than 90% of women with somatization disorder reported a history of emotional, physical or sexual abuse and 80% reported sexual abuse (Pribor, et al., 1993). Runtz and Roche (1999) showed that women with histories of physical maltreatment, but no sexual abuse, experience elevated anxiety. Of all the adverse childhood experiences studied by Chapman et al., (2004), emotional abuse was found to have the strongest relationship with depressive symptoms. Chu and Dill (1990) found that anxiety was higher in those who were physically abused. Wonderlich et al. (2007) found that childhood abuse, in general, was associated with elevated anxiety, yet no specific, individual type of abuse demonstrated significance. One possible explanation for this association between general childhood abuse and anxiety might be the interaction of multiple types of childhood abuse, although this explanation was not tested by Wonderlich et al.

Research that has addressed various forms of abuse has primarily examined symptom severity and comorbidity (Briere et al., 2008; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), yet fails to identify any correlational relationship between

specific constellations of multiple types of abuse with specific constellations of symptoms. For instance, Clemmons et al. (2003) found that in a population of Latina college students, those who experienced multiple types of abuse experienced more severe psychological symptoms. Briere et al. (2008) found a significant relationship between multiple types of trauma and symptom complexity, as measured by multiple elevated scales on the TSI. However, while childhood rape and physical assault were found to have unique predictive abilities on the total number of symptoms, no specific symptom constellation is described. Large scale population studies of adverse childhood experiences (ACE) have found that as the number of ACE increases, the risk of depression increases and mean scores of general mental health decrease (Chapman et al., 2004; Edwards, Holden, Felitti, & Anda, 2003). Heaving drinking in women has been associated with combined CSA and CPA but not to either type alone (Bensley, Van Eenwyk & Simmons, 2000). Suicidality was found to be higher in college women who have been sexually abused in childhood and also either physically or emotionally abused (Bryant & Range, 1995).

More recent research on Complex Post Traumatic Stress Disorder (Complex PTSD) and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) has identified associated common symptom clusters, including altered self-capacities, cognitive symptoms, mood disturbances, overdeveloped avoidance responses, somatoform distress, posttraumatic stress, interpersonal relations, and systems of meaning (van der Kolk et al., 2005; Briere & Spinazolla, 2005). In other words, people with complex trauma may have some or all of the above types of symptoms, in addition to symptoms traditionally associated with PTSD. These and other studies on multiple

traumas examine symptom type, symptom severity (van der Kolk et al.) or general wellbeing, but fail to identify specific symptom presentations as a consequence of specific cumulative trauma. The literature on cumulative and complex trauma lacks in specificity. No links have been established between certain types of trauma and the expected types of symptoms associated with those traumatic experiences. For instance, do women with childhood emotional and physical abuse and adult emotional abuse present with a different symptomatic picture than women with childhood sexual abuse, adult sexual abuse and adult physical abuse? What, if any, common connections are there between certain types of traumas and certain types of symptoms?

There are several research questions that this study sought to explore. First, the present study sought to identify rates of multiple childhood and adult interpersonal traumatic experiences in a population of female, university counseling center clients. Second, this study examined whether clients with multiple types of interpersonal trauma will experience more severe symptoms of psychological distress than those with single traumas or no traumatic experiences. Finally, particular clusters of multiple traumas were analyzed in relation to specific clusters of symptoms.

Method

Procedures

Over 1,000 male and female students who presented for counseling services at a large, urban, Southeastern University Counseling Center over a three-year period completed initial assessment paperwork. After all data was cleaned and incomplete data removed, the sample came to a total 500 female participants. The decision to study only females was made to increase the results' consistency and comparability to other studies,

as much of the current literature on interpersonal trauma examines female populations (Braver et al., 1992; Briere et al., 2008; Browne & Winkelman, 2007; Stinson & Hendrick, 1992). Further, because women have unique psychological needs and experiences (*Guidelines for Psychological Practice with Girls and Women*, APA, 2007), examining only a female population will strengthen the focus and application of the current study.

The present study used data that was initially collected for clinical purposes. All clients signed an informed consent form regarding clinical services. Because all data was initially collected for clinical purposes, no research related consent form was required. All data was collected in the initial paperwork that clients completed before being seen by a counselor. Clients responded to the Trauma Symptom Inventory – Alternative Form (TSI-A; Briere, 1995), a demographic questionnaire, and six self-report questions about their own experiences of childhood and adult physical, emotional, and sexual abuse. An administrative staff person reviewed paperwork for completeness and potential crisis indicators. The initial assessment counselor scored the TSI-A and entered this data into a record keeping system. All other data was entered into secure databases by administrative staff. The researcher eliminated client data from the study if the TSI-A scores, all abuse questions, or all demographic questions were missing.

Participants

For the 500 female participants the demographics were as follows: 54% identified as Caucasian, 30% as African-American, 7% as Asian, 7% as Latino/a, and 2% as Native American, Multiracial, or other ethnicity. Eighty-two percent identified as mostly heterosexual (12% identified as gay, lesbian, or bisexual, and 8% did not indicate sexual

orientation). Seventy-four percent were undergraduate students and 26% were graduate or professional students. Most were single, while 20% were married or partnered, and 3% were divorced, widowed, or separated. Finally, 46% were 17-22 years old, 42% were 23-30 years old, 6% were 31-40 years old, and 3% were over 41 years old.

Measures

Trauma Symptom Inventory – Alternate Form. The Trauma Symptom Inventory-Alternate Form (TSI-A; Briere, 1995) measures posttraumatic symptomatology on eight clinical scales, including Anxious Arousal (AA), Anger/Irritability (AI), Depression (D), Defensive Avoidance (DA), Dissociation (DIS), Intrusive Experiences (IE), Impaired Self-Reference (ISR), and Tension-Reduction Behaviors (TRB) and contains three validity scales, including Response Level (RL), Atypical Response (ATR), and Inconsistent Response (INC). Eighty-six items are rated on a 4-point Likert-scale ranging from 0 (never) to 3 (often) over the previous six months.

The TSI is the most frequently used self-report instrument for posttraumatic symptom assessment with adults (Elhai, Gray, Kashdan, & Franklin, 2005). It has good reliability and validity, as demonstrated by the multiple studies used for the development of the measure and in multiple studies both utilizing and evaluating the TSI in various populations (Briere, 1995; McDevitt-Murphy, Weathers, & Adkins, 2005).

The TSI scales have moderate to very good internal consistency reliabilities with mean alphas ranging from .84 to .87 (Briere, 1995). Specifically, reliabilities for individual TSI scales range from .64 to .89 in a university population (Runtz & Roche, 1999), .74 to .91 in the standardization sample, .69 to .90 in a university sample, .74 to .90 in a clinical sample, and .76 to .88 in a Navy recruit sample (Briere, 1995).

The TSI has demonstrated good construct validity, as it has been shown to differentiate between PTSD and non-PTSD groups on the PTSD-focused scales of the TSI (AA, DA, D, IE, and DIS) with significant effect sizes of .26 to .53 (McDevitt-Murphy et al., 2005). The PTSD-focused scales were significantly correlated with the total severity scale (.36 to .66) and their corresponding symptom cluster (.56 .to 67) of the Clinician-Administered PTSD Scale (McDevitt-Murphy et al.), which is the most frequently used clinician administered instrument for PTSD (Elhai et al., 2005). In the normative standardization sample, all four trauma scales of the TSI were significantly associated with four trauma types: childhood and adult interpersonal violence and disaster (Briere, 1995). In a University sample, CSA, but not CPA, was related to elevated scores on AA, AI, and IE scales (Briere). In a clinical sample, those reporting interpersonal trauma had higher scores on all TSI scales than those not reporting interpersonal trauma (Briere).

The TSI has good convergent and discriminant validity (.36 to .73) with other self-report measures of PTSD (McDevitt-Murphy et al., 2005). Briere (1995) demonstrated that the validity scales correlate with the validity scales of other measures. Specifically, ATR was correlated with the Negative Impression Management scale of the Personality Assessment Inventory (PAI) and the F scale of the MMPI-2; RL was correlated with the Positive Impression Management scale of the PAI and the K scale of the MMPI-2, while the INC scale was not correlated with the INC scale of the PAI (Briere).

Convergent and discriminant validity is reasonable with the clinical scales (Briere, 1995; Runtz & Roche, 1999). The TSI scales all correlate significantly with the

scales of the Brief Symptom Inventory (BSI) (Briere). Women with CSA who had sought counseling had higher scores on all scales (except the AA and AI) than women who sought counseling for CPA (Runtz & Roche). General health symptoms, number of stressful life events in the past year, daily hassles in the past month, and perceived stress in the past month were all significantly correlated with all TSI clinical scales (Runtz & Roche).

Incremental validity was measured with the stratified normative sample of the TSI and two trauma scales (IES and SCL) and one general measure of psychological symptoms (BSI) (Briere, 1995). The TSI demonstrated additional variance, or predictive incremental validity, for females beyond that of all three scales, while it predicted incremental validity for males on the BSI (Briere).

Criterion validity was also assessed using the standardization sample. In one study, all of the TSI scales accurately predicted over 90% of those with PTSD in the sample (Briere, 1995). Furthermore, the TSI accurately predicted 89% of those diagnosed with Borderline Personality Disorder in another study of psychiatric patients (Briere).

Experiences of Abuse. Clients read six questions about interpersonal abuse and were asked to respond to how often they had experienced the specific behaviors in the questions by rating a one to five scale, with one indicating "never," two indicating "once," three indicating "a few times (2-15)," four indicating "many times (1-12 times/year)" and five indicating "almost all the time (> 12 times/year)." Three questions addressed childhood abuse (emotional, physical, and sexual), and three questions addressed adult abuse of the same types. Questions, as developed in previous research by Brack et al. (2002) and Brack, McCarthy, Brack, Hill, and Lassiter (2005), were asked by

providing examples of behaviors of each type of abuse as defined by the U.S. Department of Health and Human Services (1989). This method is consistent with the recommendations and research of Briere (2005), Freedy, et al., (2002), and Resnick et al., (1996).

Clients read each question, which asked them to circle how often they had experienced any of the listed behaviors for each of the six types of abuse. Note that the terms "rape" or "abuse" are not utilized in any of the questions, as using these psychologically loaded words can result in underreporting (Briere, 2004). Emotional abuse was defined as someone else being overly critical, focusing on failure, yelling, screaming, and/or swearing. Physical abuse was defined as being punched, bitten, kicked, burnt, or beaten. Sexual abuse was defined as any type of unwanted—actual or attempted—sexual touching, fondling, or exposure.

Demographic Questionnaire. Clients reported basic demographic information, including age, ethnicity, marital status, gender, sexual orientation, history of previous counseling, and academic information on a questionnaire form. Demographic categories and labels were selected to be consistent with the standards currently used by the university where the data was collected. The two exceptions to this were the inclusion of sexual orientation (with given categories to select from) and gender identity (fill in the blank), both of which were optional questions on the paperwork. This exception was made to reflect the personal importance of these aspects of identity to the students who are served in this counseling center.

Research Questions

The richness of this data set allowed for a variety of research questions and hypotheses to be tested. However, in an effort to focus the results and implications to a manageable size, the following research questions were explored. First, the researcher sought to identify the frequency that female clients experience multiple types of childhood and adult interpersonal traumas. Second, the researcher determined if multiple traumas impact the severity of psychological distress differently than those with no trauma or one trauma. Lastly, and most importantly, the researcher examined which constellations of multiple abuse types predict which constellations of trauma-related symptoms.

Statistics

All analyses were computed using Statistical Packaging for the Social Sciences (SPSS) for Windows Version 16.0. Frequencies for each type of abuse and multiple abuse combinations were determined by analyzing the mean, median, mode, minimum and maximum for each. Possible differences in level of symptom(s) for participants with no trauma, one trauma, or multiple traumas were assessed with multivariate analysis of variance (MANOVA). Pillai's criterion is used for statistical inference because it is the most robust criterion in regards to violations of assumptions of variance, particularly with unequal cell sizes (Tabachnik & Fidell, 2007). None of the demographics were used as covariates. This decision was based on Briere's (1995) findings in the descriptive and normative information of the TSI-A manual. Although age differences were found on the TSI-A during standardization, the cutoff used for a different scoring sheet is age 65 and older, and the oldest participant in this data set was 58. There were also small racial

differences found on the instrument, however, Briere recommends not adjusting the scoring in clinical practice for different racial groups because of the small magnitude of the difference and the potential impact of requiring more distress to indicate an elevated score. The relationship between multiple types of abuse and current symptomatology was examined using canonical correlation. Specifically, the canonical correlation matrix looked at which combination(s) of the six abuse types predict which combination(s) of the eight trauma-related symptoms, as measured by the eight scales of the TSI-A. A canonical correlation was selected as the most appropriate statistical analysis, because it allows for multiple independent and dependent variables, and has predictive power (Tabachnick & Fidell). Wilks Lambda was selected as the criteria for inference, because it is most widely used and moderate in its assumptions, while the Tukey test was selected for post hoc comparisons because it is one of the more conservative estimates that allows pairwise comparisons of all means (Tabachnik & Fidell).

Results

Normality was assessed in SPSS. Linearity was assumed between the dependent and independent variables. While there was a slight bi-modal distribution found in CEA, no transformation was performed. This ensures that the results error on the side of being conservative by potentially missing some aspects of the relationship between variables, but not overestimating any results (Tabachnik & Fidell, 2007). Multicollinearity was checked with a correlation matrix. The correlation coefficients revealed that multicollinearity was not a concern within this data set, as no variables were correlated above .90 (Tabachnick & Fidell). Outliers were not removed, as they are considered a "legitimate part of the sample" (Tabachnick & Fidell, p. 77) due to the nature of the

variables being studied. Multiple forms of abuse in a clinical population and elevated scores on a measure of symptom level would logically represent more extreme scores than might typically be found in a non-clinical population.

Frequency of Abuse

Severity of abuse was measured in two different ways. First, the frequency that participants experienced each type of abuse was measured and is displayed in Table 1. During childhood, approximately 68% of participants experienced emotional abuse, 46%

TABLE 1. *Frequencies of Abuse Experiences by Type of Abuse*

	Never		Once		A Few Times		Many Times		Almost All The Time	
	N	%	N	%	N	%	N	%	N	%
Type of Abuse										
CEA	157	31.6	60	12.1	119	23.9	92	18.5	69	13.9
CPA	269	53.8	62	12.4	95	19.1	60	12.0	12	2.4
CSA	272	54.7	97	19.5	78	15.7	44	8.9	6	1.2
AEA	171	34.4	62	12.5	144	29.0	92	18.5	28	5.6
APA	323	64.9	54	10.8	72	14.5	45	9.2	3	0.6
ASA	317	63.4	78	15.6	58	11.6	41	8.2	6	1.2

experienced physical abuse, and 45% experienced sexual abuse. As adults, approximately 65% of participants experienced emotional abuse, 35% experienced physical abuse, and 36% experienced sexual abuse. The number of different types of abuse each participant experienced was measured and is shown in Table 2. More than 81% of the participants

TABLE 2. *Frequency of Different Types of Abuse*

	None	One Type	Two Types	Three Types	Four Types	Five Types	Six Types
	N %	N %	N %	N %	N %	N %	N %
Multiple Abuse	40	51	114	101	92	50	42
	8.2	10.4	23.3	20.6	18.8	10.2	8.6
Childhood MA	82	148	151	112			
	16.6	30.0	30.6	22.7			
Adult MA	104	182	130	80			
	21.0	36.7	26.2	16.1			

experienced two or more types of abuse, while 39% experienced four or more types. Emotional abuse was the most common type of abuse experienced for both children and adults. Both physical abuse and sexual abuse were experienced in childhood by almost half of the participants. In order to examine multiple abuse, categories of frequencies were combined creating three groups (never, once, and more than once). Most startling are the high rates of multiple abuse found in this population, with 39% reporting multiple types of abuse in both childhood and adulthood. While it was suspected that multiple trauma would be more prevalent than individual trauma, it was shocking to find that over 80% of female clients in a college counseling center had experienced multiple abuse. Another surprising finding was the extensive spread of abuse. Of the 64 possible combinations of abuse types, ranging from no abuse to all six types of abuse, every type

was endorsed at least once. There were more people who reported all six types of abuse (N = 42) than no abuse (N = 40). Table 3 illustrates the descriptive statistics of the mean, median, mode, standard deviation, and range for all variables. Childhood and adult emotional abuse were the most commonly occurring types with means of 2.71 and 2.48, respectively. A score of two indicates that abuse was experienced once, while a three indicates abuse was experienced more than once. Therefore, most people endorsed experiencing more than one instance of emotional abuse. There was a mean of 2.96 types of abuse for multiple abuse across all ages. Therefore, participants experienced, on average, almost 3 different types of abuse.

Relationships between types of abuse and symptoms

Table 4 displays the inter-correlations between the eight trauma-related symptoms, which are all statistically significant ($p < .01$, range of .483-.778). All eight symptom scales were highly related to each other, consistent with the development and reliability of the TSI as discussed in the manual (Briere, 1995). The findings of the trauma symptom scores in this study are reliably consistent with the findings of the TSI manual.

Table 5 displays the inter-correlations between the six abuse types and three categories of multiple abuse. All abuse types were statistically significantly ($p < .05$) correlated with each other, with the exception of childhood emotional abuse with adult emotional and physical abuse. Multiple abuse was correlated with all other individual types of abuse ($p < .01$; range of .427-.638). The high correlations indicate that when someone experiences one type of abuse, it is very likely that they have experienced other types of abuse. The exception to that is CEA, which does not have a significant

TABLE 3. *Mean, Median, Mode, Range, and Standard Deviation for Abuse Types and Trauma Symptoms*

	Mean	Median	Mode	Standard Deviation	Minimum	Maximum	Range
CEA	2.71	3.00	1	1.430	1	5	4
CPA	1.96	1.00	1	1.196	1	5	4
CSA	1.82	1.00	1	1.067	1	5	4
AEA	2.48	3.00	1	1.284	1	5	4
APA	1.70	1.00	1	1.062	1	5	4
ASA	1.68	1.00	1	1.043	1	5	4
MA	2.96	3.00	2	1.015	0	6	6
CMA	1.59	2.00	2	1.015	0	3	3
AMA	1.38	1.00	1	0.989	0	3	3
D	58.00	58.00	65	12.938	0	83	83
AA	57.09	58.00	53	12.151	1	79	78
AI	55.51	56.00	65	13.418	0	82	82
IE	55.24	55.00	43	13.544	0	85	85
DA	56.06	56.50	63	13.391	0	78	78
DIS	57.43	55.50	51	14.056	1	93	92
ISR	57.74	59.00	64	13.483	0	85	85
TRB	57.17	54.00	48	15.710	0	100	100

TABLE 4. *Trauma Symptoms Correlations*

	Symptoms							
	D	AA	AI	IE	DA	DIS	ISR	TRB
D	-	.647**	.535**	.576**	.569**	.712**	.754**	.563**
AA		-	.609**	.659**	.550**	.709**	.635**	.576**
AI			-	.552**	.483**	.551**	.586**	.701**
IE				-	.778**	.670**	.619**	.544**
DA					-	.597**	.577**	.538**
DIS						-	.732**	.569**
ISR							-	.644**
TRB								-

* Correlation is significant at the 0.05 level (2-tailed).

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

relationship to adult emotional or physical abuse, but does highly correlate with all other childhood types of abuse and ASA.

Table 6 displays the correlations between abuse types and symptoms. CEA is not correlated to any trauma-related symptoms. However, CPA is correlated to almost all of the trauma-related symptoms (except for anxiety). Multiple abuse is statistically significantly correlated ($p < .01$) with Anger/Irritability (.137), Intrusive Experiences (.185), Defensive Avoidance (.190), Dissociation (.161), and Tension Reducing Behavior (.123). The statistical significance demonstrates that there is a weak relationship

TABLE 5. *Abuse Types Correlations*

	Abuse Types								
	CEA	CPA	CSA	AEA	APA	ASA	MA	CMA	AMA
CEA	-	.336**	.130**	.422**	-.001	-.056	.427**	.564**	.138**
CPA		-	.329**	.217**	.358**	.246**	.638**	.718**	.336**
CSA			-	.114*	.251**	.269**	.522**	.606**	.255**
AEA				-	.151**	.107*	.495**	.288**	.535**
APA					-	.445**	.608**	.326**	.686**
ASA						-	.553**	.250**	.672**
MA							-	.833**	.824**
CMA								-	.373**
AMA									-

* Correlation is significant at the 0.05 level (2-tailed).

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

indicating that as someone experiences more types and more severe abuse, they are more likely to experience higher rates of these five symptoms.

Severity of Abuse on Severity of Symptoms

Multivariate Analysis of Variances (MANOVA's) were conducted for each of the six types of individual abuse and the three types of multiple abuse. Multivariate tests were conducted with an independent variable of abuse type and dependent variables of the eight trauma-related symptoms. The Pillai's Trace criterion showed that the combined

TABLE 6. *Abuse Types and Trauma Symptoms Correlations*

	Symptoms							
	D	AA	AI	IE	DA	DIS	ISR	TRB
Abuse Type								
CEA	.031	.083	.049	.079	.053	.062	.018	.034
CPA	.099*	.084	.133**	.156**	.174**	.155**	.099*	.125**
CSA	.062	.017	.070	.101*	.111*	.093*	.029	.028
AEA	.096*	.096*	.066	.102*	.088	.126**	.088	.076
APA	.139**	.117*	.192**	.167**	.178**	.176**	.123**	.148**
ASA	.115**	.095*	.096*	.202**	.206**	.177**	.108*	.110*
MA	.102*	.093*	.137**	.185**	.190**	.161**	.091*	.123**
CMA	.050	.035	.087	.117**	.127**	.098*	.044	.057
AMA	.120**	.120**	.140**	.190**	.189**	.170**	.108*	.148**

* Correlation is significant at the 0.05 level (2-tailed).

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

trauma symptoms were significantly affected by CSA, $F(16, 966) = 1.1876$, $p = .019$; APA, $F(16, 968) = 2.234$, $p = .004$; and ASA, $F(16, 972) = 1.929$, $p = .015$. Adult multiple abuse, $F(24, 1446) = 1.753$, $p = .014$; (but not childhood multiple abuse) and multiple abuse across age groups $F(48, 2856) = 1.507$, $p = .014$, both significantly affected combined trauma symptoms. In other words, students who experienced sexual abuse or adult physical abuse experienced more trauma-related symptoms. Additionally, experiencing multiple types of abuse predicted greater symptom severity on all eight

symptom scales. Particularly, the differences in symptoms were found between those with no or one trauma and those with two or three traumas. The more types of abuse someone experienced predicted more severe symptoms.

To investigate the impact of the main effect of trauma type on each of the independent variables, Tukey's Post Hoc test was performed. Significant results of the multivariate and post hoc tests are summarized in Table 7. Students who endorsed two or more experiences of CSA scored significantly higher than those without CSA or with only one instance of CSA only on the scale of Defensive Avoidance ($p = .034$; mean difference of -3.75). Students who reported two or more instances of APA or ASA scored significantly higher on all eight symptoms than students who reported none or one instance of those types of abuse ($p < .02$, $p < .05$, respectively). These findings indicate that there is no significant difference in symptom severity between people who experience no abuse and one instance of abuse. However, people who experience two or more instances of childhood sexual abuse, adult sexual abuse or adult physical abuse do experience more severe trauma symptoms than people with either no abuse or one instance of abuse. The more recent abuse appears to have a stronger impact on elevated levels of distressing symptoms than does childhood abuse.

For multiple abuse types, adults that experienced two or more types of abuse scored significantly higher on all eight symptom scales ($p = .014$). Significant results of the multivariate and post hoc tests are summarized in Table 8. Students who experienced multiple types of abuse, regardless of age, scored significantly higher on all symptom scales except for AA and TRB ($p < .05$).

TABLE 7. *Means, Standard Deviations, Degrees of Freedom, F-test, and Significance of Symptoms and Individual Abuse Types*

	No Abuse		One Time		Two or More Times				
Symptom	M	SD	M	SD	M	SD	Hyp(Error)df*	F	Sig.
CSA							16(966)	1.88	.019
D	57.19	12.98	58.70	12.78	59.14	13.02	2	1.15	.318
AA	57.08	12.83	56.38	10.91	57.55	11.80	2	.253	.777
AI	54.50	13.81	56.95	12.61	56.50	13.40	2	1.64	.194
IE	53.96	13.90	55.73	13.18	57.43	13.01	2	2.91	.055
DA	54.86	13.53	55.75	14.22	58.62	12.25	2	3.40	.034
DIS	56.16	13.96	58.15	14.29	59.10	14.05	2	2.13	.120
ISR	57.27	14.11	58.46	12.71	58.10	12.82	2	.344	.709
TRB	56.02	15.77	60.29	16.74	56.86	14.53	2	2.65	.072
APA							16(968)	2.23	.004
D	56.82	14.31	58.48	9.57	60.95	9.95	2	4.47	.012
AA	55.95	13.42	58.02	9.41	59.48	8.93	2	3.89	.021
AI	53.61	14.18	57.19	11.18	59.93	11.36	2	10.36	.000
IE	53.57	14.51	57.83	12.48	58.37	10.40	2	6.72	.001
DA	54.38	14.52	57.93	11.43	59.71	10.07	2	7.64	.001
DIS	55.71	14.72	58.04	12.04	61.39	12.15	2	7.34	.001
ISR	56.53	14.54	58.35	10.68	60.69	11.30	2	4.21	.015
TRB	54.99	15.60	61.65	16.11	60.94	14.81	2	8.98	.000

ASA							16(972)	1.93	.015
D	57.18	13.36	57.26	13.82	61.08	10.66	2	3.71	.025
AA	56.29	13.10	56.76	11.75	59.64	8.92	2	3.02	.050
AI	54.83	14.25	54.45	13.07	58.38	10.87	2	3.01	.050
IE	53.35	13.97	56.38	13.63	60.10	10.87	2	10.34	.000
DA	54.32	13.73	56.67	14.74	60.81	9.85	2	9.54	.000
DIS	55.97	14.78	65.41	12.26	62.24	11.96	2	8.21	.000
ISR	56.95	13.85	57.01	14.88	60.83	10.85	2	3.39	.035
TRB	56.06	15.58	56.94	15.98	60.47	15.54	2	3.12	.04

* Error df were only available for abuse type on the overall symptoms

Relationship between multiple abuse and specific symptom clusters

Canonical correlation was performed between a set of interpersonal abuse variables and a set of trauma-related symptom variables using SPSS CANCORR. The interpersonal abuse set included childhood emotional abuse, childhood physical abuse, childhood sexual abuse, adult emotional abuse, adult physical abuse, and adult sexual abuse. The trauma-related symptom set measured depression, anxious arousal, anger/irritability, intrusive experiences, defensive avoidance, dissociation, impaired self-reference, and tension reduction behaviors. Higher numbers reflect more frequent abuse and more severe symptoms.

The first canonical correlation was .305 (9% overlapping variance). The first pair of canonical variates accounted for the significant relationships between the two sets of variables, Wilks = 0.865; F(48, 2321.58) = 1.44, p = .025. Total proportion of variance

TABLE 8. *Means, Standard Deviations, Degrees of Freedom, F-tests, and Significance of Symptoms and Multiple Abuse Types*

	None	One Type	Two Types	Three Types	Four Types	Five Types	Six Types			
Symptom	M SD	M SD	M SD	M SD	M SD	M SD	M SD	df	F	Sig.
Adult Multiple Abuse										
D	56.77 12.70	56.47 14.86	59.13 12.02	61.29 9.71				3	3.17	.024
AA	56.33 12.79	55.13 14.13	58.34 10.07	60.20 8.50				3	3.93	.009
AI	54.47 13.85	53.09 14.61	57.60 12.91	59.08 10.03				3	5.10	.002
IE	53.56 13.90	52.14 14.82	57.43 11.63	60.30 10.87				3	8.84	.000
DA	53.32 13.46	54.18 14.64	57.82 12.62	60.66 9.97				3	6.65	.000
DIS	55.04 14.13	55.28 15.54	59.10 11.92	62.01 12.27				3	5.96	.001
ISR	56.64 13.47	56.18 14.83	58.40 13.05	61.38 10.49				3	3.05	.028
TRB	54.30 13.99	55.19 16.25	60.09 15.84	60.39 15.41				3	4.79	.003

Multiple Abuse										
D	55.70	59.00	57.80	55.32	57.24	62.46	62.05	6	2.69	.014
	12.28	12.70	12.89	14.08	14.97	8.78	9.92			
AA	54.35	57.37	56.26	57.84	55.61	57.86	61.78	6	1.78	.102
	14.19	12.58	12.61	12.27	13.22	7.86	9.15			
AI	51.08	54.12	55.59	54.58	54.96	59.60	59.29	6	2.23	.039
	15.52	12.91	13.65	13.06	15.46	10.24	10.38			
IE	51.50	54.78	52.74	55.06	54.01	59.44	62.88	6	4.41	.000
	16.60	14.37	13.22	12.72	14.26	10.02	11.07			
DA	51.42	54.96	54.69	55.34	55.12	59.42	64.15	6	4.30	.000
	15.18	13.93	13.55	11.82	14.43	13.23	8.90			
DIS	54.12	56.08	56.42	55.83	56.39	60.72	65.10	6	3.40	.003
	15.97	13.43	14.25	13.71	14.87	10.02	13.40			
ISR	55.02	58.39	57.93	55.82	55.89	60.76	62.85	6	2.33	.032
	14.46	13.71	13.76	13.13	15.47	9.61	10.55			
TRB	53.15	56.94	55.50	57.19	56.38	60.46	62.17	6	1.75	.109
	14.20	15.89	16.17	15.66	16.77	14.17	14.77			

and total redundancy indicate that the first pair of canonical variates was moderately related, while all others were not.

Data on the first pair of canonical variates appears in Table 9. Shown in the table are correlations between the variables (types of abuse and symptoms) and canonical variates (linear combinations of both sets of variables), standardized canonical variate

coefficients (indicates the significance of each individual variable contributing to the overall variate), within-set variance accounted for by the canonical variates (proportion of variance accounted for by same set of variables), redundancies (percent of variance in variables predicted from the other set of variables), and canonical correlations. According to Tabachnick and Fiddell (2007), the canonical correlation is the overall score indicating if there is a significant relationship between the two sets of variables. The canonical variates represent each of the significant relationships between possible combinations from the independent variables with possible combinations from the dependent variables.

With a cutoff correlation of .300, (based on guidelines for interpretation in Tabachnik & Fidell, 2007), the variables in the interpersonal abuse set that were correlated with the first canonical variate were childhood physical abuse, adult physical abuse, and adult sexual abuse. Among the trauma-related symptom variables, anxious arousal, intrusive experiences, defensive avoidance, dissociation, and impaired self-reference correlated with the first canonical variate. The first pair of canonical variates indicate that those with more frequent childhood physical abuse (-.356), adult physical abuse (-.322), and adult sexual abuse (-.489) are associated with more severe symptoms of intrusive experiences (-.330), defensive avoidance (-.496), and dissociation (-.735), and less severe symptoms of anxious arousal (.498) and impaired self-reference (.432). People with the combination of childhood physical, adult physical, and adult sexual abuse experience an increase in three symptoms and a decrease in two symptoms.

TABLE 9. *Correlations, Standardized Canonical Coefficients, Canonical Correlation, Proportions of Variance, and Redundancies between Trauma and Symptom Variables and Their Corresponding Canonical Variates*

	First Canonical Variate	
	Correlation	*Coefficient*
Symptom Set		
Depression	-.527	-.011
Anxious Arousal	-.436	.498
Anger/Irritability	-.585	-.297
Intrusive Experiences	-.791	-.330
Defensive Avoidance	-.827	-.496
Dissociation	-.764	-.735
Impaired Self Reference	-.473	.432
Tension Reducing Behaviors	-.531	-.017
Percent of Variance	.401	
Redundancy	0.37	
Trauma Set		
Childhood Emotional Abuse	-.211	-.042
Childhood Physical Abuse	-.689	-.356
Childhood Sexual Abuse	-.517	-.167
Adult Emotional Abuse	-.347	-.132
Adult Physical Abuse	-.729	-.322
Adult Sexual Abuse	-.777	-.489
Percent of Variance	.340	
Redundancy	.032	
Canonical Correlations	.305	

Discussion

This study examined multiple, interpersonal, childhood and adult abuse in a female, university counseling center population. First, this study identified the rates of individual and multiple abuse in this population. Abuse is extremely common, with 92% of participants reporting at least one type of abuse, and 81% reporting two or more types. These rates are much higher than Briere's (2008) findings, where 28% of (non-clinical) university women had experienced two or more types of trauma. Over half (53%) of the women in this study experienced two types of childhood abuse, and 42% have already experienced two types of abuse as adults. The average participant experienced three different types of childhood or adult abuse, and 39% experienced four or more types. Clearly, clients who present with a history of multiple abuse are more of the norm than the exception at this particular counseling center. Further, these rates of abuse are slightly higher than those found in other clinical college student populations and much higher than in non-clinical populations (Arata et al., 2005; Briere, Kaltman, & Green, 2008; Edwards et al., 2003).

Second, this study examined whether clients with multiple types of interpersonal trauma experienced more severe symptoms of psychological distress than those with single traumas or no traumatic experiences. Multiple abuse was examined three different ways: multiple childhood abuse, multiple adult abuse, and total multiple abuse. Participants with childhood multiple abuse did not have significantly different trauma symptoms than participants with no childhood abuse or one type of abuse. Participants with adult multiple abuse had significantly elevated trauma scores on all eight symptom scales. Note that the significant differences in symptoms were found between those with

all three types of abuse and those with either no abuse or one type of abuse. Participants with one type of abuse generally presented with similar symptoms as those with no abuse. This suggests that this population is resilient to single incidents of trauma, while the effects of multiple abuse are cumulative and lead to significantly greater psychological and interpersonal distress. Arata et al. (2005) found similar results, where people with two or more types of abuse experienced greater distress than those with no abuse or one type of abuse. When multiple abuse that occurred in both childhood and adulthood were considered together, generally the more types of abuse a participant experienced, the higher she scored on all abuse scales except for AA and TRB. These findings may indicate a threshold effect, or additive model of trauma, where symptoms are manageable until a certain number of experiences or types of abuse are reached. Again, these findings are consistent with some of Arata et al.'s findings which support an additive model of trauma. This could also contribute to an explanation of why multiple adult abuse seems to have a stronger effect on symptoms than multiple childhood abuse.

Finally, particular clusters of multiple traumas were analyzed in relation to specific clusters of symptoms. There was one cluster of abuse types that were moderately related to one cluster of symptoms. The abuse types most likely to be characterized by aggression (childhood and adult physical abuse and adult sexual abuse) predicted elevated scores on the symptoms of an intrusive or numbing nature (intrusive experiences, defensive avoidance, and dissociation). Arata et al. (2005) also found specific effects of trauma when physical and sexual abuse were combined. That combination led to the greatest impact on psychological distress. Higgins and McCabe (2001) reviewed several studies and found that this same combination of abuse resulted

in significantly higher rates of PTSD and Complex PTSD, among other symptoms. Ney et al. (1994) reported that physical and sexual abuse was the "worst" combination of abuse types. This canonical variate suggests that those who experience a combination of interpersonal abuse types that are characterized by aggression (childhood and adult physical abuse and adult sexual abuse) is associated with a combination of trauma-related symptoms that are higher in an intrusive and numbing nature and lower in regards to sense of self. Intrusive Experiences are characterized by unwanted thoughts, flashbacks, and nightmares of traumatic events. Therefore, it makes sense that someone with IE would also score high on Defensive Avoidance, the conscious, intentional attempt to cope with memories of trauma (Briere, 1995) and Dissociation, the unconscious attempt to reduce trauma related stress (Briere). Further, Briere describes the presentation of IE, DA, and DIS as a "classic posttraumatic presentation," (p. 15), so these empirical findings are consistent with the theoretical literature. If both conscious and unconscious means of avoiding trauma-related stress are utilized, it is expected that anxiety would be reduced by these coping mechanisms. However, the lower score on ISR is unusual, as it is commonly elevated in conjunction with DIS (Briere). This could be explained by Briere's conceptualization of ISR as an indicator of poor coping mechanism. It seems that the grouping of clients who utilize DA and DIS are effectively coping with negative memories of their trauma. This would be consistent with the high-functioning nature of the population (i.e., university students).

These symptom scales represent several of the symptom domains of Complex PTSD, including alterations in consciousness and relationships with others. Although researchers continue to debate the additive or differential effects of trauma on symptoms,

and findings such as these find support for both models, most researchers and clinicians agree that multiple traumas produce a general set of symptoms described by Complex PTSD (Herman, 1992). The intrusive experiences scale taps one criteria of traditional PTSD, signifying that this group of people would meet at least some of the diagnostic criteria for both traditional and Complex PTSD. Additionally, the group of participants with this cluster of multiple abuse simultaneously experienced significantly less anxiety and tension reduction behaviors. Practically, this is consistent with the expectation that dissociation would lower one's feelings of anxiety, and therefore reduce the need for negative behaviors to modulate tension. The factor of aggression appears to be the significant link between these variables of abuse and symptoms. These findings suggest a differential model of trauma, consistent with Arata et al. (2005), where particular trauma types lead to particular types of symptoms.

The perpetration of trauma, particularly multiple traumas, is very dynamic. The unique experiences are likely to vary greatly from survivor to survivor. Each survivor begins with her own unique cultural, relational, and spiritual set of circumstances that can have a negative or positive impact on how well or how poorly she copes with the resulting symptoms from traumatic experiences. The complexity of these experiences makes it difficult to establish a pattern or predictable response. Briere (2004) cites research that suggests the diagnostic criteria for DESNOS/Complex PTSD represent a possible range of symptoms that varies with each individual, rather than a full set of diagnostic criteria. This leads us to expect that different people will experience different combinations of the seven symptom domains based, in part, on the combinations of abuse they have experienced. As our understanding of the patterns between trauma types and

symptom expression evolve, we also gain an increased understanding to the nuanced role of how certain aspects of abuse, such as aggression, impact a victim's distress level. This insight into the process of how and why certain combinations of traumatic experiences impact the sequelae of symptoms allows clinicians to more effectively tailor their treatment approaches.

Limitations

The questionnaire used to assess abuse was designed specifically for clinical use by the counseling center where data was collected. Because of the brevity of this form, many important aspects of abuse, such as the age of first occurrence, relationship to perpetrator, severity of abuse, if different abuse types were perpetrated by the same or different persons, if abuse was previously disclosed, and if so, how others responded to the disclosure, were not assessed. Additionally, other significantly impactful forms of interpersonal abuse, such a neglect and witnessing intimate partner violence were not assessed. These factors are therefore not included in the statistical analysis and might have influenced the results in ways for which the analysis did not account.

The population consisted of female, university, counseling center clients. While this is a clinical population, it is also a university population where clients voluntarily requested counseling and chose to self-disclose their histories of abuse. This group likely represents a different segment of the general population than those who are not in college or college-educated, that would not choose to - or do not have the resources to - attend counseling, and that would not identify or disclose themselves as victims of abusive experiences. Although the results of this study are very applicable to other college and

university counseling center clients, the results should be used with caution when applying them to a general, non-clinical population.

The independent variables were distributed bi-modally and outliers were included for theoretical purposes, therefore the statistical analyses utilized may have underestimated the full relationship inherent between abuse types and symptom presentation (Tabachnick & Fidell, 2007).

Implications

Treatment. Specifically for college counseling centers, clinicians should expect that a high percentage of the women seen will have experienced multiple traumatic experiences during both childhood and adulthood. This primarily emphasizes the importance of clinicians having specialized training in treating the complex issues associated with multiple traumas. These issues include the appropriate assessment of trauma experiences and trauma-related symptoms. Trauma-related symptoms should not be confined to the symptoms of traditional PTSD, but should also consider the symptom domains of Complex PTSD.

Clinicians should use Herman's (1992) three-stage treatment model, as it is currently the most accepted approach (Courtois et al., 2009). Stage One emphasizes safety and stabilization. This is accomplished by helping the client gain a sense of control over her own life and then her environment. Some important ways of increasing this sense of control include educating the client on her symptoms and diagnoses and the therapeutic process (Herman), teaching her to manage emotional arousal, and enhancing her relational capacity (Courtois et al.). Stage One often takes the longest amount of time to complete, but is the most important of all the stages in the client's healing process

(Herman). The goal of Stage Two is to process traumatic memories through the development of a coherent and detailed narrative (Courtois et al.; Herman). For survivors of complex trauma, one traumatic episode can represent other instances of trauma, as there may be too many instances of abuse to incorporate each one into the narrative (Herman). The therapist's role during this stage is to witness the client's experience, provide balance between the development of the narrative and the client's safety, normalize the client's reactions, and affirm the client's dignity and value (Courtois et al.; Herman). The final task of this stage is mourning the traumatic loss, which can be particularly difficult for survivors of complex trauma due to the relational aspect of their abuse (Herman). Stage Three is the final stage and emphasizes reconnection and reintegration. The goal is to help the survivor create a new conception of self, a new quality to relationships, and new beliefs to support the changes she experienced during her recovery (Herman). Courtois et al. explains that many tasks of Stage Three look similar to those of Stage One, but are accomplished with a goal of engaging, rather than protecting. Reconnecting with others in a way that facilitates trust, intimacy, and playfulness is another important task (Herman). The last tasks including finding a mission (often accomplished through social justice or political action) and resolving the trauma, which is often an on-going, dynamic process (Herman).

However, other types of therapeutic approaches can be integrated into Herman's model (Briere & Scott, 2006; Courtois & Ford, 2009). It is vital that clinicians understand the difficulties associated with chronic trauma and how this is different from those of traditional PTSD. Clinicians should include the recommendations regarding complex traumatic reactions of Herman (1992) and Courtois et al. (2009) in treating clients with

histories of multiple trauma. The most important clinical implication of the research stems from Courtois' (2001; 2009) assessment that training in trauma, particularly complex trauma, is uncommon. College counseling center clinicians should seek out resources, training, and supervision in working with clients who have experienced multiple trauma and symptoms of Complex PTSD.

Research. Future research on the effects of multiple trauma should address several key issues. First, researchers and clinicians should work together to determine common terminology to define trauma-related experiences and behavioral descriptors of that experience. Next, researchers should always assess for all five types of childhood trauma (i.e., emotional, physical, and sexual abuse, neglect, and witnessing violence). Given the high prevalence rates of adult abuse in this population and the statistically significant relationships between adult types of abuse and symptoms, it is recommended that future studies include both childhood and adult experiences of trauma to more fully account for potential factors in symptom presentation. Finally, more research needs to examine the relationship between multiple abuse and symptom constellations to improve our knowledge base of the additive and differential effects of trauma. An increased understanding of how and why particular types of trauma lead to particular types of symptoms can improve the assessment, diagnosis, and treatment of trauma-related problems.

Research on Complex PTSD needs to continue to include both clinical and non-clinical populations and both childhood and adult experiences of abuse. Currently, the proposed diagnosis of Complex PTSD emphasizes abuse that occurred during childhood (Courtois et al., 2009). Given the findings of this current study, abuse that occurs during

the early adult years in a college population is significantly related to symptom expression. The traditional college-aged population may represent another vulnerable developmental period, as this is a time of individuation and relationship development. Abuse that occurs while such significant developmental tasks are taking place seem just as likely to interfere with relationship development, consciousness, beliefs about oneself, affect regulation and systems of meaning in similar ways as childhood abuse. Adult types of abuse, including emotional and physical abuse, should be examined when exploring the relationship between multiple trauma and symptom expression, and should be used to improve the understanding and accuracy of Complex PTSD.

Conclusion

Experiencing multiple types and instances of childhood and adult interpersonal abuse is common among college females. The consideration of how different types of abuse interact with each other to influence different types and levels of symptoms has implications for both research and treatment. Multiple trauma often leads to symptoms beyond those of traditional PTSD and are best described in the proposed diagnosis of Complex PTSD. In this study, female college counseling clients were assessed for their childhood and adult abuse history, along with their presentation of trauma-related symptoms to determine the prevalence rates of individual and multiple trauma, if there are differences in symptom severity based on amount of trauma, and if certain combinations of multiple trauma are associated with certain combinations of symptoms.

There were high rates of multiple traumas among this population. Experiencing multiple types of traumas was more common than experiencing individual types of trauma. Multiple traumas led to more severe symptoms than single or no trauma. This

was especially true for adult multiple traumas. There was a moderate relationship found for people who experienced trauma that is typically of an aggressive nature with several symptoms. People who experienced childhood physical abuse, adult physical abuse, and adult sexual abuse also experienced significantly higher symptoms of intrusive experiences, defensive avoidance, and dissociation, and lower symptoms of anxiety and tension reducing behaviors.

Due to the high rates of multiple trauma in this college student population, clinicians should be well trained and supervised in assessing and treating symptoms of traditional and Complex PTSD. Research should include experiences of multiple traumas in adulthood in the future. The findings of this study suggest that both an additive model of trauma and a differential model of trauma experiences on symptomatology should both be explored in the future.

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