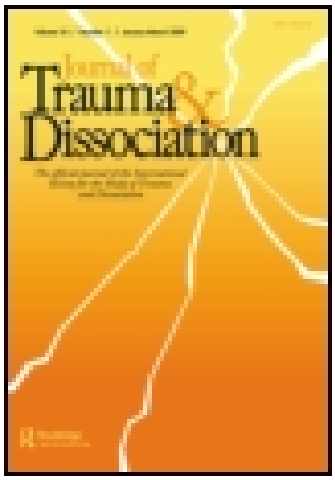
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Differences in trauma experience between patients with bipolar I disorder, major depressive disorder and healthy controls

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Abstract

The aim of this study was to compare differences in traumatic experiences between patients with bipolar I disorder, patients with major depressive disorder (MDD), and controls. The traumatic experiences (as measured by the Trauma Experience Questionnaire) of 40 participants with bipolar I disorder were compared with those of 38 participants with MDD and 92 controls participants. Participants with bipolar I disorder exhibited a significantly higher frequency of traumatic experiences and higher impact ratings of traumas when they occurred than did patients with MDD and controls. In addition, the present impact of past trauma for patients in the bipolar I disorder and MDD groups were significantly higher than those for controls. The bipolar I disorder group reported more severe traumatic experiences than did both the MDD and control groups, and the MDD group, in turn, reported more severe traumatic experiences than did the control group.

Post-traumatic stress disorder (PTSD) is a serious mental disorder that causes high levels of anxiety and a decline in daily function. The disorder is often associated with a single, severe trauma (American Psychiatric Association, 2013). However, researchers who study trauma however hypothesize that severe mental disorders are not typically formed in response to a single traumatic event (American Psychiatric Association, 2004), but rather may manifest over time in response to exposure to multiple traumatic events.

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A recent case study about the impact of traumatic experiences on bipolar disorder symptoms reported that type of trauma has a significant influence on the depressive symptoms of patients with bipolar I disorder (Gershon, Johnson, & Miller, 2013). Although this study concluded that traumatic experiences do not significantly affect manic symptoms, other case studies have reported that experiences of common traumas or sexual abuse have a marked effect on auditory hallucination symptoms, which are among the most common psychotic symptoms in bipolar disorder (Paul et al., 2003). Another study on the traumatic experiences of bipolar disorder patients reported that the intensity of such experiences significantly influences frequency of hospitalization, life satisfaction, and the residual symptoms of patients in remission; in these cases, interpersonal difficulties serve as mediating variables (Maguire, McCusker, Meenagh, Mulholland, & Shannon, 2008).

According to a study of 786 bipolar disorder patients, 80% of the participants were exposed to stressful life events in childhood or adolescence, of whom 24.9% experienced sexual or physical abuse. In particular, 29.8% of female participants were exposed to sexual abuse (Philippe et al., 2010). One review paper of the relationship between bipolar disorder and early traumatic experience indicated that an increasing number of studies support the notion that bipolar

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disorder patients have experienced more severe trauma in childhood than have healthy individuals (Bruno, Chantal, Frank, Flavie, & Marion, 2008). The traumatic experiences of bipolar disorder patients have also been shown to moderate the severity of psychotic symptoms (Ozkose et al., 2011).

Our preliminary study examines aspects of traumatic experience in mood disorder patients and controls. If the hypothesis that more severe and repetitive traumas are associated with more severe mental disorders is correct, then the bipolar disorder group should report the most severe traumatic experiences, followed by patients with major depressive disorder (MDD) and then controls.

In summary, the purpose of this study is to investigate past traumatic experiences in patients with bipolar disorder in order to establish whether trauma severity is more associated with this population in comparison to patients with MDD and controls.

Methods

Participants

A total of 170 participants took part in the study. Prior to undertaking the study, the researchers explained the study plan to the chiefs of psychiatry at three

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hospitals. These psychiatrists then decided which patients to refer for inclusion in our study based on DSM-5 criteria. Forty participants had been diagnosed with bipolar I disorder, 38 had been diagnosed with MDD, and 92 participants had no known diagnosis or history of mental illness. For participants in the bipolar I and MDD groups, a structured clinical interview based on DSM-5 was employed in order to confirm their diagnoses. All candidates were interviewed directly by the researchers. While all participants in the bipolar I and MDD groups were receiving medication as part of maintenance pharmacotherapy, patients with active psychotic symptoms were excluded. We also applied exclusion criteria to rule out the possibility of participants having bipolar II or chronic depressive disorders. The control group was recruited from the general population. Demographic variables were presented Table 1. All participants provided written informed consent before participation and the Research Ethics Committee of Ha-Eun Counseling Research Center approved the study.

Measurements

The Trauma Experience Questionnaire was adapted by Seung-mi (2008) from the Post-Traumatic Growth Inventory, which was developed by Tedeschi and Calhoun (2004). Items pertaining to negative events taken from the Social Readjustment Rating Scale developed by Han-ah (2011) were also used.

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The Trauma Experience Questionnaire contains 16 items that assess a variety of traumatic experiences, ranging from accidents to childhood abuse. Participants were asked to rate the severity of their traumatic experience when the event occurred and the present degree of impact of the most salient traumatic event on a 7-point Likert scale. Test-retest reliability of these two items within a six-week interval in this study was .76. A translated version of the Korean Trauma Experience Questionnaire is included as Appendix 1.

Procedure

Characteristics of the traumatic experiences of patients diagnosed with bipolar I disorder were compared with those of patients with MDD and controls in order to test the hypothesis that traumatic experiences in patients with bipolar disorder are more severe. In order to make this comparison, ANCOVA was conducted with education level included as a covariate. Education level is one of the important measurements of socio-economic status and has been shown to affect environments in trauma, and thus must be controlled.

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Statistical Analysis

ANCOVA was conducted with frequency of trauma, degree of impact of trauma when the trauma occurred, and the present impact of trauma as dependent variables. Patient group was set as the independent variable and had three levels: bipolar I, MDD, and controls. Scheffé's test was applied for post hoc analysis.

A stepwise logistic regression analysis was also conducted, with traumatic event frequency, degree of impact of trauma when it occurred, and present impact of trauma as independent variables; furthermore, we used a dummy variable, coded as 0 for the control group and 1 for the bipolar disorder group, as the dependent variable in order to calculate effect sizes for increases in trauma-related variable scores. The same analysis was applied to the MDD group.

Results

The frequency of traumatic experiences was significantly higher for the bipolar disorder group compared with control groups ($F(2,168)=5.6$, $p<.01$); furthermore, there was no difference between the MDD and control groups in this measure (see Table 2). The initial degree of impact of the trauma reported by the bipolar I group was significantly greater than that reported by control groups

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(F(2,168)=3.2, p<.05). However, there were no differences between the MDD and control groups. The present impact of the traumatic experience was comparable for the bipolar I and MDD groups, but both disorder groups experienced a significantly greater present impact of trauma compared to the control group (F(2,168)=20.1, p<.01). These results are presented in Table 2.

According to the results of the logistic regression analyses, the frequency of traumatic events (odd ratio(1)=1.264, p<.05) and the initial degree of the impact of trauma (odd ratio(1)=1.785, p<.01) were statistically significant predictors of a diagnosis of bipolar disorder (see Table 3).

The second result of the logistic regression analysis demonstrated that the degree of the present impact of trauma was a statistically significant predictor of a diagnosis of MDD (odd ratio(1)=1.672, p<.01) (see Table 4).

Discussion

The present study was conducted in order to investigate whether bipolar I disorder is associated with the severity of traumatic events. Trauma is thought to underpin the pathogenesis of PTSD (Breslau, 2001) and many researchers support the hypothesis that several other mental disorders are also related to traumatic experiences. In an effort to lend further support to this hypothesis, we conducted

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a comparison of the impact of traumatic events, measured by one item of the Likert scale, between patients with bipolar disorder, patients with MDD, and controls. If patients with bipolar disorder can be shown to have experienced more severe trauma than have those with other disorders, psychotherapists treating patients with bipolar disorders should pay more attention to individual traumatic history; in conjunction with pharmacologic treatment.

This study demonstrated that previous traumatic experiences are more frequent for patients with bipolar I disorder than for patients with MDD or for controls. The same was true for the degree of impact experienced at the time the trauma occurred. Moreover, the present degree of impact resulting from trauma was higher in the bipolar I and MDD groups than it was for the controls. This suggests that patients with bipolar I disorder have experienced both a greater number of, and more severe, traumas than have patients with MDD or controls. These results are consistent with the hypothesis that, in general, more severe traumas coincide with more severe mood disorders.

It is perhaps true that all disorders, at least in part, result from a psychosocial stressor, the so-called "precipitating factor." If the stressful experiences of a patient are considered to be a type of psychosocial stressor or trauma, then trauma-focused psychotherapy perhaps may be used to reduce

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vulnerability to recurrent episodes of illness. Such an interpretation could be consistent with results from a preliminary case study on trauma-focused treatments for bipolar disorder (Landin-Romero et al., 2013). This implies that residual symptoms may be ameliorated when trauma-focused psychotherapy is provided as an adjunctive treatment.

Studies measuring the intensity of traumatic experiences might also employ more elaborate methods for measuring the impact of traumatic events. Single-item Likert scale measures were used in the present study to ascertain the impact of trauma at both the time of its occurrence and in the present; however, such scales are not particularly in-depth, even though their test-retest reliability and validity have been verified in preceding studies. Thus, it will be important to provide multiple-item measures that can probe various sub-issues pertaining to the degree of impact of trauma (both when it initially occurred and in the present). In other words, it will be necessary to devise a new inventory to measure the intensity of traumatic experiences, and to administer it to a sufficient number of participants. It would be possible to measure the degree of trauma more precisely with multiple-item measures, given that increments in explanatory variance increase to a greater extent than do increments in error variance as the number of items increase.

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A limitation of this study is that income was not included as a covariate as controlling for socio-economic status would certainly be appropriate when investigating differences in traumatic experiences. Furthermore, the traumatic experience questionnaire employed in the study includes many events that would be broadly considered adverse, but not necessarily traumatic according to conventional psychological definitions of trauma (such as setbacks at work or school, ill relatives, or interpersonal failures). In addition, a number of genuinely traumatic events are not included in the list, such as witnessing violence, and the impact of the most severe types of trauma were measured using only two items. Thus, this questionnaire must be revised to better cover the whole range of possible traumatic events and to measure the multiple aspects of trauma in future studies. Finally, the present study was cross-sectional and so no causal relationships can be inferred. As the presence of a severe mental disorder could make participants more vulnerable to traumatic events, such as the loss of a job, future studies should only include traumas that occurred before the onset of mood disorders. Ideally speaking, a longitudinal design should be employed in order to begin to assess whether multiple severe traumas are able to cause later development of mood disorders.

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Table 1. Demographic variables

		Control	MDD	Bipolar	Total N=170
Age (years): M (SD)		32.48 (11.16)	35.87 (10.19)	32.47 (8.56)	33.06 (10.59)
N	Male	34	18	18	70
	Female	58	20	22	100

Note: MDD = major depressive disorder

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Table 2. Differences in traumatic experiences by patient group

	Variable	Normal (n = 92) M (SD)	MDD (n = 38) M (SD)	Bipolar (n = 40) M (SD)	F		Post hoc
Severity of trauma	Frequency	2.4 (1.9)	3.1 (1.8)	3.7 (2.3)	*5.6*	**	Bipolar > Normal
	Past impact (Initial impact)	6.0 (1.0)	6.1 (1.4)	6.7 (0.6)	*3.2*	*	Bipolar > Normal
	Present impact	3.0 (1.8)	4.6 (1.6)	4.7 (1.7)	*20.1*	**	Bipolar = MDD > Normal

Note: MDD, major depressive disorder; **P < .01, *P < .05.

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Table 3. The effect of trauma severity on bipolar I disorder diagnosis

	Variable	*B*	*SE*	Wald	df	*p*	Exp (B)
Severity of trauma	Frequency	.234	.105	5.014	1	.025	1.264*
	Present Impact	.580	.132	19.151	1	.000	1.785**
	Constant	-3.857	.701	30.234	1	.000	.021

**$P < .01$, *$P < .05$.

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Table 4. *The effect of trauma severity on major depressive disorder diagnosis*

	Variable	*B*	*SE*	Wald	df	*p*	Exp (B)
Severity of trauma	Present Impact	.514	.126	16.689	1	.000	1.672**
	Constant	-2.896	.562	26.559	1	.000	.055

**$P < .01$, *$P < .05$.

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Appendix 1. Traumatic Events Questionnaire

Traumatic Events Questionnaire

1. Think about traumatic experiences that you remember to be harsh, tragic, and severely shocking. Please select ALL the numbered items that apply to you in the below:

1	Accident or injury (such as a car accident, industrial accident, or fire)	9	Difficulties in adjustment (such as being bullied at school, work, or the army)
2	Natural disasters (such as a flood, earthquake, or heavy snow)	10	Personal or parental divorce or separation
3	Physical violence (such as being beaten, witnessing violence)	11	Academic or professional failures (such as failing an examination or discouragement)
4	Sexual abuse or sexual violence	12	Shock of betrayal (such as lying, an extramarital

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			affair, or deception)
5	Personally experienced severe physical disease	13	Financial difficulties (such as bankruptcy, insolvency, or credit delinquency)
6	Severely ill loved one	14	Unemployment
7	Death of a loved one	15	Childhood abuse
8	Interpersonal failure (such as a distressing break-up or broken relationships)	16	Other

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2. Please choose ONE that you remember to be the most severe event from the selected items above and write the number here: ___ Please explain briefly: _____

Please answer the questions below in relation to the event described in Question 2 (herein referred to as the "traumatic event").

3. How long ago did the event take place?

① less than a month ② 1–6 months ③ 7–12 months ④ 1–2 years ago

⑤ 2–3 years ago ⑥ 3–10 years ago ⑦ 10–20 years ago ⑧ 20+ years ago

4. How painful was the traumatic event for you at the time?

① ② ③ ④ ⑤ ⑥ ⑦

Not at all painful somewhat painful extremely painful

5. How painful is the traumatic event for you now, in the present?

① ② ③ ④ ⑤ ⑥ ⑦

Not at all painful somewhat painful extremely painful

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