



Epidemiology of trauma: Childhood adversities, neighborhood problems, discrimination, chronic strains, life events, and daily hassles among people with a severe mental illness



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ABSTRACT

Trauma during childhood and adolescence is a common event among people with a serious psychological disorder. Few studies assess a wide range of stressors for this population. This is surprising given that these stressful events are implicated in poorer outcomes related to course and treatment of mental health problems. This study of 214 people with serious mental illness examines the prevalence of childhood traumas, perceived neighborhood problems, discrimination, chronic strains, negative life events, and daily hassles. We use regression analyses to determine if these stressors are associated with quality of life. Results show that 95% of the sample report at least one childhood adversity. Perceived neighborhood problems, experiences of discrimination, chronic strains, life events, and daily hassles were also common. Examining the relationship between demographic factors and stressors suggests that older respondents, Whites, those who have never been married, and people diagnosed with Schizophrenia reported fewer stressors compared to those who are older, non-White, ever married, or suffering from other types of mental health problems. Finally, three of the six types of stressors were related to lower quality of life and depression. We discuss the implications of these findings for the treatment of severe psychological problems.

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1. Introduction

Since social scientists began to systematically examine social factors related to mental health and illness (e.g., Durkheim, [1897] 1951; Faris and Dunham, 1939; Simmel, 1964), they have typically started with the notion that a person's place in the stratification system (e.g., social class, race/ethnicity, or gender) influences the likelihood of encountering difficult situations or experiencing traumatic/stressful events (Turner et al., 1995; Brewin et al., 2000; Hill et al., 2005; Thoits, 2013). These studies suggest that people in lower socioeconomic statuses, women, and racial/ethnic minorities experience a greater number of and more severe stressful events compared to the wealthy, males, and Whites (Kessler et al., 1997; Pearlin, 1999; Aneshensel, 2009; Thoits, 2013). They have also shown a strong association between the number of traumatic and stressful events and poor mental health (Neria et al., 2002; Shevlin et al., 2008; Subica, 2013).

Most of this research, however, has focused on non-institutionalized community samples who may or may not have severe mental health problems (e.g., Adams et al., 2006; Galea et al., 2008; DiGrande et al., 2011). Studies assessing traumatic events and their impact on the well-being of individuals with severe mental illness who live in a community setting are less common (Draine et al., 2002; Shevlin et al., 2008; Allott et al., 2013). Severe mental illness is predominantly characterized by the combination of several factors including prolonged duration of illness and severe functional impairment or disability (Kessler et al., 2005; Demyttenaere et al., 2004). Such conceptualizations of severe mental illness are inclusive of any psychiatric disorders, not just psychotic disorders, provided there is an extended duration of the illness (e.g., at least 12 months), and it is substantially disabling or limiting (Demyttenaere et al., 2004).

Those that do study this population have found that these individuals are poorer and live in communities with more violence and other social problems, such as poor city services, crime, and abandoned buildings, than their psychologically healthier counterparts (Faris and Dunham, 1939; Draine et al., 2002; Mueser and McGurk, 2014). Individuals with severe mental illness are also

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subjected to stigma and discrimination due to their mental health problems (Link et al., 1999; Thoits, 2011; Whitley and Campbell, 2014).

Further, a large percentage of people in this population are survivors of trauma and experience numerous negative life events and daily hassles (Cusack et al., 2004, 2006; Alvarez et al., 2011). Trauma and stressful events in childhood and adolescence are found to be extremely prevalent among individuals diagnosed with schizophrenia and other psychotic disorders (Cristofaro et al., 2013; DeRosse et al., 2014). For example, Alvarez et al. (2011) collected data on about 100 individuals diagnosed with a severe mental health problem and found that just under half (47.5%) suffered from some form of child abuse, and that those who reported such abuse had an earlier diagnosis and more hospitalizations compared to those without a history of abuse. Likewise, Cusack et al. (2006) found an 87% lifetime exposure to child and adult trauma in a community sample of 142 mental health consumers with a severe mental illness (See also Carmen et al., 1984; Edward et al., 2003; Bendall et al., 2008).

Traumatic events, negative life events, and daily hassles are major sources of stress (Pearlin et al., 1981; Thoits, 1983, 2013; Turner et al., 1995; Ross et al., 2001). However, most of these studies again assess the association between challenging events and physical/mental well-being in samples of the general population, rather than focusing on those individuals with severe mental illness. Serido et al. (2004), for instance, examine chronic stress such as constant work demands, home demands, or lack of control and daily hassles (e.g., minor disruptions of daily life) among a community sample and found that each type of stressor had a unique effect on psychological well-being (see also DeLongis et al., 1982). Studies on traumatic events and negative life events in community samples report similar negative associations between these experiences and positive mental health (Breslau et al., 1991; Turner et al., 1995; Adams et al., 2006, 2011; Shevlin et al., 2008).

Lastly, few studies have attempted to measure the full range of possible stressful events experienced by persons with a severe mental illness living in the community. For example, Tse (1999) collected data on 50 community residents suffering from long-term psychiatric disabilities, focusing on negative life events and daily hassles, coping behavior, and symptoms. According to participants, the ten most stressful events tended to be daily hassles (e.g., thoughts about the future, low energy, raising price of common goods, not enough money for entertainment, etc.), rather than more severe negative life events. This is, in part, because the hassles occurred more frequently. Childhood traumatic events or chronic strains were not, however, assessed in the study.

The present study examines how a wide variety of stressful events impact the quality of life for people with severe mental illness. We control for demographic characteristics that past research shows to be important in the quality of life among this population (Boschi et al., 2000; Phillips et al., 2009). More specifically, we include sex, race, marital status, and parent status in our multivariate analyses, since stress has been associated with these social status characteristics (Pearlin et al., 1981; Breslau et al., 2004; Thoits, 2013). These statuses are also an aspect of our general research interest on the role of social stratification in the exposure to traumatic and stressful life events.

Based on the above discussion, this study has three research questions which we answer using data collected on a sample of individuals with a severe and persistent mental illness. First, what is the prevalence of traumatic events reported by people with a severe mental illness? Second, does the number of traumatic events differ by age, sex, race, psychiatric diagnosis, or by one's social roles (i.e. marital and parental status)? Third, to what extent do traumas, negative events, chronic stressors, perceived

discrimination, and daily hassles negatively affect quality of life in this population?

2. Methods

In this cross-sectional study, participants were recruited from a random sample of individuals with a severe mental illness receiving services from a community mental health clinic (CMHC) in a large Midwestern city. More specifically, we drew a random sample of 1500 active clients who had received at least one unit of service (beyond case management) within the previous 120 days. The client base for this CMHC are chronically ill, with an average time of treatment about 12 years. In addition, all participants had a severe mental illness as their primary diagnosis (see Results section). We excluded clients who were not able to be interviewed in English, less than 18 years old, incarcerated, or residents at a nursing home or state psychiatric hospital. A member of the team contacted only those clients who expressed interest in participating, scheduling a face-to-face interview and a screening session to measure health indicators (blood pressure, height, weight, and waist circumference). Interviewers provided a complete description of the study and obtained written informed consent. Interviewers also screened clients to make sure that they were competent to understand the informed consent document and voluntarily agree to participate. Those individuals who completed the interview, which averaged 1.5 h, were given a small monetary compensation for their time. All interviews were conducted between November 2011 and June 2012. Institutional Review Boards at Kent State University and Northeast Ohio Medical University reviewed and approved the research protocols, and approval was also granted from the review board at the CMHC.

Of the 1500 individuals we attempted to contact about the study, the research team received interest in participating in the study from 262 individuals (17%). Interviewers scheduled and completed interviews with 223 of them (85%). Those not scheduled either could not be reached after multiple attempts ($n=27$) or declined to participate, withdrawing themselves from the study ($n=12$). Compared to the larger CMHC client base, our sample contained a higher proportion of women (sample 88% vs. population 44%) and Medicaid eligible individuals (sample 88% vs. population 80%). For all other variables in the analysis, there were no statistically significant differences. Thus, it does not appear that our sample differed from the population of interest on any of the key variables in this research report. Due to missing data,¹ our final analytic sample was 214.

2.1. Dependent variables

The analyses focus on two different dependent variables assessing well-being. First, the survey measured depression with a 7-item short form of the Center for Epidemiological Studies' Depression Scale (Mirowsky and Ross, 1992). Respondents were asked the number of days in the past seven days "you have felt this way": (1) could not "get going"?; (2) had trouble getting to sleep or staying asleep?; (3) felt like everything was an effort?; (4) had trouble keeping your mind on what you were doing?; (5) felt that you couldn't shake the blues?; (6) felt sad?; (7) felt lonely? Responses are averaged to produce an index of depression scored 0–7 ($\alpha=.85$). Second, subjective quality of life, adopted from Lehman (1988), is the average of one item asked twice—once at the

¹ Regrettably, an interview software glitch resulted in the loss of 8 interviews, and one participant was excluded from the study as an ineligible participant (not a current client of the CMHC).

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