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Prevalence and symptomatic correlates of interpersonal trauma in South Korean outpatients with major depressive disorder

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Abstract

Background: There is growing evidence that exposure to severe interpersonal trauma (IPT) has a pivotal role in the development and manifestation of depression. However, it is not clearly understood whether patients with major depressive disorder (MDD) have specifically increased prevalence of IPT than other non-interpersonal traumatic events and whether those with IPT have unique symptom profile within depressed groups. In this study, we investigated the prevalence of past traumatic events and symptomatic features of treatment-seeking outpatients with MDD.

Methods: A consecutive sample of 111 South Korean outpatients with MDD was recruited on their first visit to a psychiatric department of a university-affiliated hospital. Participants completed the Life Events Checklist (LEC), the Symptom Checklist-90-Revised (SCL-90-R), Beck Depression Inventory (BDI), State–Trait Anxiety Inventory (STAI), Dissociative Experience Scale (DES) and Impact of Event Scale-Revised (IES-R). The prevalence of past traumatic events on LEC was compared to medical outpatients.

Results: Compared to medical outpatients, MDD patients had significantly higher rates of IPT (physical and sexual) but not other traumatic events of non-interpersonal origin such as accidents or disaster. Compared to MDD patients without IPT (n = 44, 40%), those with IPT (n = 67, 60%) had higher subscale scores on hostility in SCL-90-R, as well as greater depressive and post-traumatic symptoms. However, multivariate analysis revealed that the best model to discriminate those with IPT was interaction of depressive and posttraumatic symptoms.

Limitations: Limitations include sample characteristics (treatment-seeking outpatients) and possible effects of comorbid conditions, which were not investigated.

Conclusions: Clinicians managing individuals with depressive disorder need to include the assessment of lifetime IPT and its impact on presenting symptoms.

1. Introduction

There is a growing body of literature that suggests exposure to severe interpersonal trauma (IPT) leads to subsequent onset and progression of major depressive disorder (MDD). According to a recent systemic review, average one third of patients with MDD experience physical abuse and another one third report sexual abuse in their lifetime [1]. An epidemiological survey has noted that life-time depressive disorder was diagnosed four times more frequently in individuals with childhood trauma than in those without such a history [2]. The National Comorbidity Survey data also confirmed that subsequent onset of depression was associated with childhood adversity although the diagnostic specificity with depressive disorders were not shown [3].

In addition to the effect of early trauma on the incidence of later depression, its negative impact on the course of depression is even more noteworthy. A recent meta-analysis demonstrated that childhood maltreatment was a salient risk factor for unfavorable long-term course and unsuccessful outcome of treatment in depression [4]. Depressed patients with childhood trauma had earlier onset lifetime depressive episodes and higher frequency of such episodes [5], increased psychiatric comorbidities [5,6], chronicity of depression [7],

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poor treatment response [6], treatment resistance [8], and more frequent psychiatric hospitalization [9].

The results of the previous research described above led us to the conclusion that identifying interpersonal trauma and evaluating its impact in the early phase of treatment is crucial for planning appropriate therapy for individuals with depressive illness. That being said, two integral questions arise: (1) Are interpersonal traumatic events, not non-interpersonal ones more common in depressive disorder compared non-psychiatric control? (2) Do depressive patients with past IPT show distinguishable symptomatic profiles from those without such history?

For the first research question, few studies investigated MDD specifically but it was generally accepted that IPT is more prevalent among various psychiatric disorders and more harmful than other traumatic events such as accidents or disasters [1,3]. In similar context, two studies on survivors of intimate partner violence and psychiatric inpatients independently revealed that non-interpersonal trauma had no effect on self-reported depressive symptoms [10,11]; another study on primary care patients demonstrated that non-assaultive trauma was less related to current depression than IPT [12]. To our knowledge, no studies compared the prevalence of various traumatic events between individuals with MDD and a control group.

Several studies investigated the symptomatic features of MDD patients in association with IPT and noted linkage between childhood trauma and psychotic subtype [13], lifetime IPT and atypical depression [14], lifetime IPT and severe depressive symptoms [10] and childhood trauma and suicide attempts [15]. In contrast to studies that consider only childhood trauma, we included both adult and childhood experiences since some investigations have suggested that adult trauma also contributes to depressive symptom [16,17].

Therefore, in this study we aimed (1) to investigate the prevalence of lifetime traumatic events both interpersonal and non-interpersonal in outpatients with MDD and to compare with those of medical patients attending medical departments; and (2) to compare the symptomatic profile of such individuals with those without IPT to build a model that best discriminates between patients with MDD with and without IPT.

2. Material and methods

2.1. Participants and recruitment process

This was a cross-sectional observational study of patients with MDD who were seeking treatment and visited a psychiatric unit of a university-affiliated hospital. During a three-year period, a consecutive series of new outpatients with MDD was recruited in Hanyang University Guri Hospital, Guri, South Korea. Inclusion criteria were a current diagnosis of MDD, and age between 16 and 64. The diagnosis of MDD was made by a psychiatric specialist with Structured Clinical Interview for DSM-IV Axis I Disorders-Clinician Version [18]. Patients with severe medical conditions, neurological or cognitive disorder, or inability to read or write were excluded. There were a total of 139 eligible patients but 21 (15%) refused to participate in the study, and data of eight patients were excluded because they returned incomplete questionnaires, yielding a final sample of 110 participants.

To develop a control group, we surveyed outpatients at the medical departments of the same hospital; the purpose of current study was explained and the informed consent was obtained when they had no history of psychiatric disorder or treatment and they scored less than 16 on the Beck Depression Inventory to screen out clinical depression [19]. The final sample (n = 98) attended following departments at the time of survey: internal medicine (n = 31, 31.6%), otolaryngology (n = 26, 26.5%), orthopedic surgery (n = 12, 12.2%), dermatology (n = 14, 14.3%), dentistry (n = 9, 9.2%) and others (n = 6, 6.1%). All the participants gave informed and the study was approved by the institutional review board of the hospital.

2.2. Measurement

2.2.1. Life Events Checklist

The Life Events Checklist (LEC) is a self-report measure for screening life-time traumatic events including IPT [20]. This scale is consisted of 17 different types of trauma or life stressors and the respondents are asked to check on yes-or-no formatted items. To measure IPT, we used three items concerning physical or sexual assault: item 6 (physical assault), item 5 (assault with a weapon), and item 8 (sexual assault). If a respondent checked yes (i.e. experienced) to any of these items, he or she was regarded as having IPT.

2.2.2. Symptom Checklist-90-Revised

The Symptom Checklist-90-Revised (SCL-90-R) is a 90-item, self-administered scale to assess multi-dimensional symptoms and distress [21]. Respondents rate their current level of symptoms experienced during the last seven days on a scale 0 to 4. The SCL-90-R has nine subscale symptom domains (somatization, obsessive–compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and three global indices (the Global Severity Index (GSI), Positive Symptom Total (PST), and Positive Symptom Distress Index (PSDI)).

2.2.3. Beck Depression Inventory

The Beck Depression Inventory (BDI) is a 21-item self-applied scale to measure the severity of depressive symptoms [19]. Each item is a multiple choice from four statements that best matches how the respondent has felt during previous two weeks (scoring range = 0–3).

2.2.4. State–Trait Anxiety Inventory

The State–Trait Anxiety Inventory (STAI) consists of two 20-item self-questionnaires that measure either state or trait