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Childhood trauma, trauma in adulthood, and psychiatric diagnoses:

results from a community sample

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Abstract

This study compared the prevalence rates of various psychiatric disorders in persons with first onset of a potentially traumatic event (PTE) in childhood, persons with first onset of a PTE in adulthood, and those with no history of a PTE in a representative sample of Chileans. The Diagnostic of Statistical Manual of Mental Disorders, Revised Third Edition (*DSM-III-R*), posttraumatic stress disorder, and antisocial personality disorder modules from the Diagnostic Interview Schedule and modules for a range of *DSM-III-R* diagnoses from the Composite International Diagnostic Interview were administered to 2390 Chileans. The study found that exposure to a lifetime PTE was associated with a higher probability of psychiatric morbidity than no PTE exposure. A PTE with childhood onset relative to adult onset was related to lifetime panic disorder, independent of the number of lifetime and demographic differences between the 2 groups. Childhood interpersonal trauma compared with interpersonal trauma in adulthood was significantly associated with lifetime panic disorder, agoraphobia, and posttraumatic stress disorder. Our findings suggest that specific disorders are linked to interpersonal trauma and PTEs that occur in childhood rather than later in life.

1. Introduction

A growing literature strongly suggests that early exposure to potentially traumatic events (PTEs) disrupts crucial normal stages of childhood development and predisposes children to subsequent psychiatric sequelae. A series of epidemiologic studies has demonstrated that childhood sexual abuse is associated with a range of psychiatric disorders in adulthood that includes mood, anxiety, and substance use disorders (eg, references [1-3]), even after adjusting for possible confounds, such as familial factors and parental psychopathologic disorders [3] or other childhood adversities [1]. There is little evidence of diagnostic specificity of childhood sexual abuse, although a consistent finding has been that alcohol and drug disorders are more strongly related to childhood sexual abuse than psychiatric disorders [1,3]. Other forms of childhood PTEs have been less well studied. In a national sample of adult women, women with a history of serious physical assault in childhood experienced more lifetime and current

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episodes of depression, posttraumatic stress disorder (PTSD), and substance abuse compared with women reporting no such victimization [4]. In a national sample of adolescents, those who were physically abused, sexually abused, or had witnessed violence had increased risk for current substance use disorders and PTSD [5]. Death of a friend has been found to be related to depression, PTSD, and substance abuse/dependence in a representative sample of adolescents [6].

Another body of research has focused more specifically on PTSD, the disorder that has been identified in the Diagnostic of Statistical Manual of Mental Disorders (*DSM*) that develops after exposure to trauma. Large community-based studies have shown that most of the population reports exposure to PTEs during their lifetime [7-9], and that PTSD is a highly prevalent disorder [10,7] and lifetime rape[7,11,12] is the most likely PTE to be associated with PTSD. In these studies, PTSD was assessed, regardless of whether the PTSD-related trauma was the first PTE experienced or a subsequent PTE. Furthermore, these studies have typically included only the specific childhood PTEs of physical abuse and neglect (eg, reference [7]).

Trauma experts have proposed that early PTEs may be more detrimental than those occurring in later life because children are less capable of organizing their responses to traumatic experiences coherently (eg, reference [13]) and are more vulnerable to adverse brain development that may play a role in psychiatric disorders (eg, reference [14,15]). Although there have only been a handful of studies, research suggests that PTEs experienced in childhood are associated with a greater degree of psychopathology than trauma first experienced in adulthood. For instance, in a community population, those who were sexually assaulted in childhood were more likely than those first assaulted in adulthood to report subsequent major depression, drug and alcohol use disorders, and phobias [16]. In another community-based study of adult women, women with a history of childhood abuse were more likely to exhibit symptoms of depression and anxiety as compared with those who were victims of assault in adulthood [17]. Research using a mixed sample of trauma treatment-seeking and non-treatment-seeking individuals found that those who developed PTSD after interpersonal trauma as adults had significantly fewer symptoms than those with childhood trauma [18]. In a sample of female patients, childhood incest was associated with a significant increase in dissociative symptoms compared with physical and/or sexual assault as an adult [19]. Research that examined the neurobiologic profile of individuals with PTSD also suggests that the timing of the index trauma (childhood trauma vs adulthood trauma) is related to differences in neuroendocrine measures [20].

The current study attempted to address an existing gap in the literature, that is, examine whether a PTE first experienced in childhood relative to one first experienced in adulthood is associated with greater psychiatric morbidity and a higher prevalence of a range of psychiatric disorders in a representative sample of men and women. In addition, given that interpersonal PTEs in childhood increases vulnerability to a host of psychiatric difficulties, especially PTSD [18, 21], we examined whether specific disorders were linked to childhood interpersonal PTEs (ie, rape and physical assault) in contrast to interpersonal PTEs in adulthood.

2. Method

2.1. Sample selection

The Chile Psychiatric Prevalence Study was based on a household-stratified sample of people defined by the health service system to be adults (15 years and older). The study was designed to represent the population of the country. This analysis is limited to 3 geographically distinct provinces, chosen as being representative of the distribution of much of the population: Santiago, Concepcion, and Iquique. The capital city, Santiago, accounts for one third of the

nation's population. Concepción is located in the central region of Chile and is its second largest city. Iquique is in the north of the country and is a desert region, with isolated towns. The population of Chile is mainly urban dwellers.

In Chile, provinces are subdivided into *comunas*, then into districts, and finally into blocks, each of which were selected randomly. The number of households available on each block was counted. Using the 1992 national census, we determined the number of households required on each block. The households were chosen clockwise, starting with the first one on the northern corner of each block. Subsequent households were selected on the basis of a number obtained by dividing the census estimates into the number of residences on the block. A list of inhabitants 15 years and older in descending order by age, with males listed first, was then generated. Using 12 randomly preassigned Kish tables [22], one person per household was selected from the list to be interviewed.

The survey was conducted by the Department of Psychiatry, University of Concepción, Chile, between July 1992 and June 1999. The sites were completed in the following order as funding was secured: Concepción, Santiago, and Iquique. A total of 2359 individuals provided data on their ages when exposed to PTEs, with a response rate of 90.3%. Of the unweighted sample, 56.7% (n = 1338) were female, 31.7% (n = 748) were from Concepción, 55.7% (n = 1314) were from Santiago, and 12.6% (n = 297) were from Iquique. Weighting using the entire sample was used to account for the probability of the *comuna*, district, block, household, and respondent being selected. The data were adjusted to the 1992 national census based on age, sex, and marital status. At the time the study was conducted, the most recent national census in Chile was the 1992 census. Although we used a sampling technique to obtain a representative population, it was necessary to weigh the sample to the census to correct for differences that remained between the national and regional populations and the sampling frame.

2.2. Diagnostic assessment

2.2.1. Assessment of trauma—The Diagnostic Interview Schedule (DIS) [23] based on *DSM, Revised Third Edition (DSM-III-R)*, diagnostic criteria was used to assess PTEs, lifetime PTSD, and antisocial personality disorder. The DIS PTE question is as follows: “A few people have terrible experiences that most people never go through—things like being attacked (if female: or raped), being in a fire or flood or bad traffic accident, being threatened with a weapon, or seeing someone being badly injured or killed. Did something like this ever happen to you?” If the person answers no, then he or she is asked: “Did you ever suffer a great shock because something like that happened to someone close to you?” The event was then categorized into 1 of 11 categories: military combat, rape, physical assault, seeing someone hurt or killed, disaster, threat, narrow escape, sudden injury/accident, news of a sudden death or accident, other event (eg, kidnapping, torture), or other's experience. Information on age at the time of the event and symptoms as a result of the event were also collected.

2.2.2. Assessment of psychiatric diagnoses—The structured DIS used to generate all other diagnoses was the Composite International Diagnostic Interview (CIDI) versions 1.0 and 1.1, conducted by well-trained lay interviewers. This article reports on diagnoses based on the *DSM-III-R* diagnostic criteria [24].

The translation into Spanish was conducted using the protocol outlined by the World Health Organization [25]. The CIDI was similarly translated and validated, with κ values ranging from 0.52 for somatization to 0.94 for affective disorders. The translated DIS sections underwent a validation study and were found to have κ of 0.63 for PTSD and 0.72 for antisocial personality disorder. The CIDI was similarly translated and validated, with κ values ranging from 0.52 for somatization to 0.94 for affective disorders [26].

Diagnoses were generated after double data entry and verification for logical inconsistencies using the CIDI computer programs for versions 1.0 and 1.1. The *DSM-III-R* diagnoses included in this study were major depression, dysthymia, panic disorder, agoraphobia, generalized anxiety disorder, alcohol use or drug use disorder (abuse or dependence), antisocial personality disorder, and somatization disorder.

2.3. Interviewers and training

The interviewers were all university students in their senior year studying social sciences. Medical students were excluded in case respondents might misinterpret questions about last seeing a health care professional. Training was conducted following World Health Organization protocol at the University of Concepción (a CIDI training and reference center), and it consisted of more than 80 hours of instruction and practice sessions. Each interviewer had to conduct practice interviews with adult volunteers (with and without psychiatric disorders) selected from local clinics, as well as a pilot interview on an individual in a nonselected household in the community, as part of the training. These interviews were audiotaped and reviewed with the trainers. Of the 163 students originally trained, only 64 (39%) were accepted as interviewers.

Approximately 80% of the interviews were audiotaped, with the interviewee's consent. About 1 in 5 of the audiotapes were randomly reviewed to maintain quality control, in addition to recordings of the first 3 sessions conducted by each interviewer. Audiotapes were used to correct missing and unclear responses, as well as to confirm the accuracy of the interviews. Interviews were edited according to the guidelines in the CIDI trainers' manual. If edit issues and inconsistencies in the interview could not be clarified, the interviewer was asked to contact the respondents again. In addition, households were randomly selected by the field supervisors for checking to verify that the interview had been conducted in full. This resulted in a number of respondents being interviewed a second time.

2.4. Informed consent

The University of Concepción's institutional review board approved the study. Informed consent was obtained from all respondents. Names of the respondents were not included on the interview schedule to ensure anonymity during data processing. Respondents were given an opportunity to obtain the results of their CIDI.

2.5. Statistical analysis

The SUDAAN statistical package [27], Taylor series linearization method, was used to estimate the standard errors due to the sample design and the need for weighting. The analysis was conducted using procedures without replacement for nonrespondents. The region, province, *comuna*, and district selected were used as the defined strata. All comparisons use significance levels of P less than .05. All results, unless otherwise stated, are presented as weighted data, including sample sizes listed in the tables.

Comparisons of demographic variables among those with no PTE, those with first PTE in childhood, and those with first PTE in adulthood were conducted using χ^2 tests for categorical variables and t tests (with $P < .016$ to adjust for multiple comparisons) for continuous variables. Comparisons of first PTE type for those with first PTE in childhood and first PTE in adulthood were also conducted using χ^2 tests. Rates of lifetime psychiatric disorders among the 3 PTE groups, along with odds ratios, were calculated using logistic regression.

3. Results

3.1. Sample comparison groups

The sample used in these analyses consisted of 2359 individuals (weighted $n = 2577$) with complete PTSD data (98.7% of those who were interviewed about PTSD). For all tables and analyses, the *no PTE* group consisted of 1500 individuals (weighted $n = 1571$; 60.9%, SE, 2.0) who reported no lifetime PTE. The *first PTE in childhood* group consists of 202 individuals (weighted $n = 259$; 10.1%, SE, 1.4) who reported a PTE before 15 years old. In Chile, persons 15 years and older are considered adults within the health service system [28]. The *first PTE in adulthood* group consisted of 657 individuals (weighted $n = 747$; 29.0%, SE, 2.1) who reported a PTE only at 15 years or older. Members of both the *first PTE in childhood* and the *first PTE in adulthood* groups may have reported subsequent exposures to PTEs.

3.2. Demographic differences

Table 1 lists comparisons of demographic variables among the 3 groups (no PTE, first PTE in childhood, and first PTE in adulthood). Groups differed by marital status, education, and age, but not by province, sex, or employment status. The mean age at evaluation for those who experienced their first PTE as adults was 38.2 years (SE, 0.7 years), for those who experienced their first PTE as a child was 30.1 years (SE, 1.3 years), and for those who experienced no PTE was 37.9 years (SE, 0.9 years). Three paired t tests indicated that those who experienced their first PTE in childhood were significantly ($P < .016$) younger than the 2 other groups, but that the other 2 groups were not significantly different from each other. Because of these demographic differences, we accounted for age, marital status, and education in subsequent analyses. Direct comparisons of demographics for those with first PTE in childhood and first PTE in adulthood showed no differences between the 2 groups on province ($\chi^2_2 = 1.5$, $P = .49$), educational status ($\chi^2_3 = 7.3$, $P = .08$), marital status ($\chi^2_4 = 10.3$, $P = .06$), sex ($\chi^2_1 = 0.3$, $P = .62$), or employment status ($\chi^2_1 = 2.6$, $P = .11$).

3.3. Type of PTE

Seeing another hurt or die was the most prevalent first childhood PTE, followed by disaster and rape. Seeing another hurt or die was also the most prevalent first adulthood PTE (for those with only adulthood PTEs), followed by a sudden injury or accident and physical assault (Table 2). Those with first PTE in adulthood were significantly more likely to have combat, physical assault, or sudden injury/accident as their first PTE than those with first PTE in childhood. Those with first PTE in childhood were significantly more likely to have rape as their first PTE than those with first PTE in adulthood.

3.4. Prevalence of lifetime psychiatric disorders

Table 3 shows the prevalence of psychiatric disorders among those with no PTE, first PTE in childhood, and first PTE in adulthood, accounting for demographic differences among the 3 groups (age, education, and marital status). Relative to those with no PTE, those with first PTE in adulthood were more likely to meet lifetime criteria for dysthymic disorder, panic disorder, generalized anxiety disorder, alcohol or drug use disorder, antisocial personality disorder, and any psychiatric diagnosis. Relative to those with no PTE, those with childhood trauma were more likely to meet lifetime criteria for dysthymic disorder, panic disorder, agoraphobia, alcohol or drug use disorder, antisocial personality disorder, and any psychiatric diagnosis. Relative to those with first PTE in adulthood, those with first PTE in childhood were more likely to meet lifetime for panic disorder, agoraphobia, and any diagnosis. Females with childhood trauma were more likely than males with childhood trauma to meet lifetime criteria for each of these 3 disorders (OR = 6.2; 95% CI, 1.7-22.1 for panic disorder; OR = 4.0; 95% CI, 1.2-14.0 for agoraphobia; and OR = 2.6; 95% CI, 1.3-5.4 for any disorder).

To examine the possibility that multiple traumas may have accounted for the differences in psychiatric morbidity between those who experienced their first PTE as children and those who experienced their first PTE as adults, we reran a series of separate regression analyses that controlled for multiple traumas in addition to controlling for demographic differences between the 2 groups (age). Results of these regression analyses showed that when controlling for the number of PTEs (1, 2, or 3 or more), those with first PTE in childhood relative to those with first PTE in adulthood were more likely to meet lifetime criteria for panic disorder. Females with childhood trauma were more likely than males with childhood trauma to meet lifetime criteria for this disorder (OR = 5.5; 95% CI, 2.0-15.4).

3.5. Interpersonal PTEs

To further explore the effects of childhood interpersonal trauma, we compared the rates of psychiatric disorders for those who experienced childhood rape or physical assault with those who experienced rape or physical assault only in adulthood. Unlike the overall child and adult trauma groups, the interpersonal child and adult trauma groups differed by sex ($\chi^2_1 = 4.8$, $P = .03$). Of the 133 males (weighted n) in our group who reported an interpersonal trauma, most (59%) experienced their first interpersonal trauma in adulthood. However, most of the females (70% of 119, weighted n) experienced their first interpersonal trauma in childhood. As a result, we accounted for sex in addition to age and number of traumas experienced. Childhood interpersonal trauma (rape or physical assault) vs interpersonal trauma only in adulthood predicted greater risk of panic disorder (OR = 5.4; 95% CI, 1.1-27.6), agoraphobia (OR = 3.5; 95% CI, 1.2-10.2), PTSD (OR = 10.2; 95% CI, 2.3-46.0), alcohol or drug use disorder (OR = 3.3; 95% CI, 1.2-9.7), and any disorder (OR = 5.7; 95% CI, 2.4-13.3).

4. Discussion

Overall, the present study suggests that exposure to a PTE is associated with a higher probability of psychiatric morbidity than no history of a PTE. More specifically, this study found that exposure at any age, that is, in childhood or adulthood, compared with no exposure to a PTE was significantly related to higher rates of a psychiatric disorder as well as dysthymic disorder, panic disorder, alcohol or drug use disorder, and antisocial personality disorder. Examining differences in prevalence rates of disorders between a PTE first experienced in childhood and one experienced in adulthood, this study found that, controlling for significant demographic variables among the 3 groups, panic disorder, agoraphobia, and any diagnosis were significantly more likely to be associated with childhood onset of a PTE than adult onset of a PTE. No study, to our knowledge, has examined differences in prevalence rates of a range of psychiatric disorders among these 3 groups of individuals. However, other surveys have generally found that individuals exposed to a PTE relative to individuals with no such exposure report elevated levels of comorbidity as well as high rates of panic disorder, alcohol or drug use disorders, and antisocial personality disorder [1,3]. However, unlike the current study, these studies focused on specific PTEs or specific disorders.

This study found that panic disorder was significantly more likely to be associated with a PTE with childhood onset than a PTE with onset in adulthood, independent of the number of PTEs and demographic difference between the 2 groups (ie, age). When comparing rape and physical assault during childhood and adulthood and controlling for sex and number of traumas, the finding for panic disorder was duplicated. In addition, PTSD and agoraphobia were found to be significantly related to childhood rape and physical abuse relative to these experiences in adulthood. All 3 diagnoses (ie, panic disorder, agoraphobia, and PTSD) involve strong autonomic arousal, fear response, and fight-flight action tendencies. Early experiences with uncontrollable stressful events may lead to perceptions of lack of control and helplessness; vulnerability factors for the development of these disorder [29]. Another study using a

nonrepresentative sample also found that physical abuse and sexual assault in childhood rather than such an event in adulthood are more likely to predispose individuals to PTSD [17]. Furthermore, research has consistently found that a history of childhood abuse increases susceptibility to lifetime PTSD (see reference [30] for review). Likewise, exposure to childhood sexual abuse and physical abuse has been shown to be linked to increased rates of panic disorder in adults (eg, reference [31]) and in a large unselected birth cohort of young people studied at the age of 21 years, even after adjustment for prospectively assessed confounding factors [29]. Given the high levels of comorbidity of PTSD with panic disorder and agoraphobia [7], it is possible that childhood rape and physical assault are associated with a constellation of symptoms that transcend a single diagnosis. Longitudinal prospective studies research should examine the temporal relationship of a range of childhood PTEs and trauma-related disorders and how these disorders might covary with one another.

The only other study, to our knowledge, that examined whether individuals exposed to childhood trauma (specifically sexual assault) were more likely to develop disorders than those exposed in adulthood found, in contrast to the current study, that childhood sexual assault was more likely to be followed by onset of depression and substance use disorder [16]. Besides the obvious differences between the 2 studies in terms of trauma populations (childhood sexual assault vs general PTEs) and sites (Los Angeles vs Chile) as well as methodology (eg, *DSM, Third Edition*, verse *DSM-III-R* criteria, no assessment of PTSD) that might have accounted for discrepant findings, the study by Burnam et al [16] did not control for the number of traumas.

Limitations of the present study warrant attention. The study, like most epidemiologic studies, did not use an in-depth or validated index of trauma or a complete list of PTEs, which may have diluted findings. Also, the study omitted disorders that we expect from prior clinical research to be more strongly associated with early trauma than trauma later in life, such as borderline personality disorder. Because this study was cross-sectional, a direct cause-effect relationship cannot be assumed between trauma exposure and subsequent disorders. Confounding factors, such as social, family, and contextual factors, or premorbid factors, such as a preexisting disorder or loss of parent, may account for both trauma exposure (as an adult or in childhood) and risk of certain disorders. The relationship between the trauma and disorder could also have been mediated by any of the aforementioned factors. Also, characteristics of the childhood trauma, which have been proposed to play a key role in the genesis of PTSD and other psychiatric disorders [13,32], were not examined in the current study or the only study, to date, that compared first onset of trauma in childhood compared with first onset in adulthood. Because of inadequate statistical power, the present study was unable to examine if our results were duplicated when comparing child-only traumatized people (with no adult trauma) with adult-only traumatized people (with no child trauma). Another limitation was the reliance on retrospective data, recall of trauma in the distant past, which may be prone to inaccuracies. It also remains unknown if our findings will vary cross-culturally. The political violence of Chile that occurred from toward the end of 1970 until the late 1980s and the economic inequality that exists among Chileans relative to countries in North America might restrict the generalizability of our findings to other countries. Comparing findings on rates of psychiatric disorders in the National Comorbidity Survey conducted in the United States [7,33] with findings in the present study, the rates of panic disorder are similar and the rates of agoraphobia are higher. Rates of alcohol use disorders, PTSD, and trauma exposure are considerably lower in Chile[34,35]. Finally, although the present analyses controlled for demographic variables between trauma in childhood, in adulthood, and no trauma, correcting for these confounds may have eliminated true group differences. For example, early trauma often results in poorer school performance, and in this study (and others), lower education was related to alcohol or drug use. In our analyses, differences between first child and adult trauma for alcohol or drug use were no longer significant once we controlled for educational status.

Despite these limitations, the findings of this study, consistent with the extant empirical literature, demonstrate that a PTE at any time in an individual's life is associated with psychiatric morbidity. Our study extends the literature in that our results suggest that panic disorder rather than a range of other psychiatric disorders is related to a PTE that first occurs in childhood as opposed to adulthood. Furthermore, individuals with childhood interpersonal trauma exposure are more likely to suffer from lifetime panic disorder, agoraphobia, or PTSD compared with those who experience interpersonal trauma as an adult. Research should examine the specificity of these disorders in relation to various types of childhood PTEs.

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Table 1
Demographic comparisons for those with no PTE, first PTE in adulthood, and first PTE in childhood

	No PTE, n = 1571, column % (SE)	First PTE in adulthood, n = 747, column % (SE)	First PTE in childhood, n = 259, column % (SE)	χ^2
<i>Province</i>				
Santiago	39.4 (8.0)	34.3 (8.0)	28.9 (9.7)	5.2 (df = 4)
Concepción	47.0 (9.7)	55.3 (10.3)	47.3 (13.6)	
Iquique	13.6 (10.4)	10.4 (8.0)	23.8 (16.7)	
<i>Marital status</i>				
Married	52.6 (2.6)	55.1 (2.4)	47.1 (4.0)	25.7 * (df = 8)
Widowed	4.9 (.8)	4.9 (1.0)	1.0 (.9)	
Separated/annulled	3.6 (.7)	4.2 (1.1)	3.7 (1.4)	
Never married	34.5 (2.8)	25.7 (2.0)	46.1 (3.3)	
Common law marriage	4.5 (.9)	10.1 (1.2)	2.0 (.8)	
<i>Education</i>				
Illiterate	1.3 (.3)	1.8 (.9)	-	24.1 * (df = 6)
Basic	18.6 (2.4)	18.4 (3.0)	7.2 (3.4)	
Moderate	52.3 (2.0)	49.6 (3.4)	62.5 (4.1)	
High	27.9 (3.5)	30.3 (5.4)	30.3 (4.1)	
<i>Sex</i>				
Male	42.3 (2.1)	56.8 (2.9)	54.2 (4.6)	5.2 (df = 2)
Female	57.7 (2.1)	43.2 (2.9)	45.9 (4.6)	
<i>Employment status</i>				
Employed	85.8 (1.8)	85.2 (2.6)	76.3 (5.4)	3.0 (df = 2)
Unemployed	14.2 (1.8)	14.9 (2.6)	23.7 (5.4)	

* $P < .05$.

Table 2

Type of PTE, not whether any of these PTEs in childhood or adulthood were, encountered by those who had their first PTE in childhood and in adulthood

PTE	First PTE in childhood, n = 259, % (SE)	First PTE in adulthood, n = 747, % (SE)	χ^2_1 for difference
Combat	0	1.3 (0.6)	4.7 *
Rape	15.7 (4.0)	1.0 (0.4)	6.6 *
Physical assault	7.6 (2.3)	17.4 (2.4)	6.9 *
Seen another hurt/die	32.0 (4.3)	26.8 (2.7)	0.8
Disaster	18.9 (5.9)	13.9 (2.4)	0.7
Threat	4.7 (2.7)	6.6 (1.1)	0.6
Narrow escape	1.1 (0.7)	5.0 (1.7)	3.7
Sudden injury/accident	8.9 (2.3)	20.7 (2.1)	5.7 *
News of sudden death, accident	6.3 (1.9)	3.3 (1.0)	2.8
Other (eg, kidnapping, torture)	3.7 (3.0)	1.8 (1.0)	0.4
Other's experiences	1.1 (0.8)	2.2 (0.6)	1.7
Any PTE	100.0	100.0	-

* $P < .05$.

Table 3
Prevalence of lifetime psychiatric disorders for those with no PTE, first PTE in childhood, and first PTE in adulthood

	No PTE, n = 1571, % (SE)	First PTE in adulthood, n = 747, % (SE)	First PTE in childhood, n = 259, % (SE)	OR (95% CI), adult vs no PTE	OR (95% CI), child vs no PTE	OR (95% CI), child vs adult PTE
<i>Affective disorders</i>						
Major depression	8.6 (1.0)	10.5 (1.7)	11.4 (1.8)	1.2 (0.8-1.9)	1.4 (0.9-2.2)	1.1 (0.7-1.8)
Dysthymia	6.6 (1.0)	10.7 (1.1)	10.9 (3.0)	1.6* (1.1-2.5)	2.1* (1.3-3.3)	1.2 (0.6-2.2)
<i>Anxiety disorder</i>						
Panic disorder	0.8 (0.2)	1.8 (0.5)	6.1 (2.5)	2.2* (1.2-3.9)	11.1* (3.2-38.2)	4.4* (1.6-12.0)
Agoraphobia	10.5 (1.6)	12.3 (2.1)	19.8 (4.5)	1.2 (0.8-1.8)	2.1* (1.1-4.1)	2.1* (1.0-4.3)
Generalized anxiety	1.7 (0.5)	4.1 (1.0)	2.2 (0.9)	2.5* (1.3-5.0)	1.9 (0.6-5.7)	0.7 (0.2-2.1)
PTSD	-	10.0 (1.1)	15.8 (3.5)	-	-	2.1 (0.9-4.9)
<i>Substance disorders</i>						
Drug/alcohol disorder	8.5 (1.3)	16.3 (1.4)	18.8 (4.1)	2.0 (1.4-2.9)*	3.0 (1.8-5.0)*	1.3 (0.7-2.4)
Nicotine dependence	3.4 (0.6)	3.0 (0.9)	4.8 (2.2)	0.8 (0.4-1.6)	1.3 (0.5-3.2)	2.1 (1.0-4.4)
<i>Other disorders</i>						
Somatization	2.4 (0.5)	5.0 (1.7)	3.2 (1.4)	2.0 (0.9-4.6)	2.0 (0.7-6.0)	0.7 (0.2-2.3)
Antisocial personality	0.3 (0.1)	3.6 (1.0)	3.5 (1.2)	12.2* (3.7-40.3)	12.5* (3.8-41.9)	0.8 (0.3-2.5)
<i>General</i>						
Any diagnosis	29.0 (2.0)	37.6 (3.2)	46.2 (3.7)	1.4* (1.1-1.9)	2.2* (1.7-2.8)	1.5* (1.0-2.2)

* $P \leq .05$.