The Relationship Between Childhood Sexual Abuse, Complex Post-Traumatic Stress Disorder and Alexithymia in Two Outpatient Samples: Examination of Women Treated in Community and Institutional Clinics

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ABSTRACT. Relationships between trauma variables, complex post-traumatic stress disorder (complex PTSD), affect dysregulation, dissociation, somatization, and alexithymia were studied in 70 women with...
early-onset sexual abuse treated in community-based private (n = 25) or clinic outpatient settings (n = 45). Measures were the Toronto Alexithymia Scale-20 and the Psychological Trauma Assessment Program. Compared with the community sample, the clinic sample (1) met diagnostic criteria for both lifetime and current complex PTSD; (2) showed correlations between current affect dysregulation, dissociation, and somatization with alexithymia; and (3) higher levels of alexithymia. Results suggest the clinic sample continued to experience current forms of suffering, risk, and vulnerability associated with early-onset sexual trauma. The findings may have implications regarding types of treatment available in community versus clinic settings. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Alexithymia, childhood sexual abuse, complex post-traumatic stress disorder

Affect and emotional regulation are considered fundamental to mental health and functioning (Gross & Munro, 1995). Conversely, affect dysregulation is associated with childhood trauma (van der Kolk, 1996) and in turn, with the constructs of alexithymia, Post-traumatic Stress Disorder (PTSD), and Borderline Personality Disorder (BPD) (McLean & Gallop, 2003; van der Kolk, 1996). The phenomenological interface between PTSD and BPD has been linked to the common features of affect dysregulation and impulsivity (van der Kolk, 1996) in populations of women drawn from outpatient clinics with early-onset (i.e., ≤12 years of age) sexual abuse (McLean & Gallop, 2003). It has been suggested that comorbid disorders, and in particular, BPD, may mediate the relationship between alexithymia and PTSD (Zlotnick, Mattia, & Zimmerman, 2001). Most studies have examined alexithymia and PTSD in select samples of trauma survivors (Zlotnick et al., 2001). We are interested in exploring the relationship between childhood sexual abuse and alexithymia in samples of women drawn from outpatient community and clinic samples to determine if source of recruitment influences outcome measures.

Alexithymia, a term Sifneos coined in 1973 to characterize individuals who had no words to describe their feelings, is defined by deficits in the identification, communication, cognitive processing, and elaboration of affect (Nemiah, 1977). Krystal (1982) linked alexithymia to PTSD in
his observations of concentration camp survivors. He suggested that in the face of overwhelming trauma, there is a rapid regression of affect to a preconceptual level of organization or “affect regression” (Krystal, 1988). At this level of functioning, it is purported that individuals, impaired in the capacity to express feelings in words and to tolerate affect, are prone to action against self and others. Alexithymia is also associated with dissociation, somatization (van der Kolk, 1996), substance use disorders, eating disorders (Taylor, 2000), victims of repeated rapes (Zeitlin, McNally, & Cassidy, 1993) and may be an underlying mechanism that accounts for the emotional and behavioral instability of BPD (Zlotnick et al., 2001).

Alexithymia can begin very early in life. A vast literature indicates attachment figures play critical roles in facilitating the developing child’s capacity to modulate affective and physiological arousal (van der Kolk & Fisler, 1994). Stern (1985) referred to maintaining a critical balance between soothing and stimulation in the parent and child relationship as “affect attunement.” In contrast, early disturbances in the parent-child attachment relationship of abused children may impact underlying biological substrata and result in enduring difficulties in affect regulation (Bremner, 2003; De Bellis et al., 1999, 2002; van der Kolk, 2003; van der Kolk & Fisler, 1994). Cicchetti and White (1990) demonstrated that maltreated toddlers use fewer words to describe their feelings as compared to peers without a history of abuse. Research has implicated repeated stress in both neurochemical and neuroanatomical changes in the brain (Bremner, 2003; De Bellis et al., 1999, 2002; Rauch et al., 1996; Sifneos, 1996; van der Kolk, 2003). These findings offer empirical support for the notion that neuropsychological changes may account for alexithymia and the speechless terror (van der Kolk, 1996) observed in some individuals.

More recently, Zlotnick and colleagues (2001) examined the relationship between childhood trauma (i.e., physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect), PTSD, BPD, and alexithymia in an outpatient sample of men and women who attended a hospital-based outpatient practice. Results demonstrated that childhood physical and emotional neglect were significantly related to higher levels of alexithymia. Further findings from this study showed that alexithymia is a central feature of both PTSD and BPD in comparison to other psychiatric disorders (e.g., panic disorder, any substance use, eating disorder). The finding of a strong relationship between alexithymia, PTSD, and BPD is consistent with the notion that affect dysregulation is central to all three (van der Kolk et al., 1996).
A vast amount of literature associates early childhood trauma (i.e., sexual abuse, physical abuse, emotional abuse and/or parental neglect) with the diagnosis of PTSD and of BPD (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk et al., 1996; Yehuda, 2002); both diagnoses are classified in axis I and axis II of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), respectively (APA, 1994). A notable blurring of the diagnostic boundaries between PTSD and BPD disorders is represented by complex PTSD as a new nosological classification. Committed to the belief that repeated trauma in childhood both forms and deforms the personality, Herman (1993) argued that neither PTSD nor BPD adequately portray the distinctive characterologic adaptation observed among those exposed to prolonged early childhood trauma. The construct of complex PTSD is not yet included as a diagnostic entity in the DSM; however, it is in part described in the Associated Features and Disorders of PTSD in association with an interpersonal stressor (APA, 1994). Complex PTSD integrates disorders of affect regulation, dissociation, chronic difficulties in self-concept, and alterations in negotiating interpersonal relationships, physical symptoms, and somatization (van der Kolk, 2003).

Recent research (McLean & Gallop, 2003) examined the diagnostic overlap between symptoms associated with BPD and complex PTSD in women with histories of sexual abuse to determine if a subset of individuals with BPD may be subsumed under complex PTSD. When women with early (i.e., ≤ 12 years of age) onset sexual abuse were compared with late (i.e., ≥ 13 years of age) onset sexual abuse, 94% of the early-onset women met criteria for both BPD and complex PTSD as compared to 0% among late-onset women. Early-onset paternal sexual abuse was the sole significant predictor of meeting diagnostic criteria for BPD, and for both BPD and complex PTSD.

Based on the implications of the empirical trauma literature (McLean & Gallop, 2003; Roth et al., 1997; van der Kolk et al., 1996; Zeitlin, McNally, & Cassidy, 1993; Zlotnick et al., 2001), the current study examined descriptive statistics in women with early (i.e., ≤ 12 years of age) onset sexual abuse who were involved in either community-based private practice treatment settings or institutional-based outpatient clinics. We are not aware of any studies that have examined if the source of recruitment is a factor in the endorsement of complex PTSD and/or alexithymia. In fact, the inclusion of a community-based sample in the current study was prompted by the outbreak of SARS in Toronto during data collection, and constituted a unique opportunity to explore two out-
patient samples. The first hypothesis was that there would be a significant positive relationship between the diagnoses of complex PTSD and alexithymia in both groups of women. A second hypothesis was that there would be significant positive correlations between the current (i.e., past month) and/or lifetime complex PTSD subscales of affect dysregulation, dissociation, and somatization, and alexithymia. Finally, we wanted to delineate the differential role of specific types of early trauma in the degree of alexithymia. Trauma variables (i.e., safety, bi-parental neglect, emotional abuse, physical abuse, paternal incest, family secrets, and witnessing of violence), selected on the basis of prior empirical support (Bach, de Zwaan, Ackard, Nutzinger, & Mitchell, 1994; Cicchetti & White, 1990; Herman, 1993; McLean & Gallop, 2003; Roth et al., 1997; van der Kolk, 1996; van der Kolk et al., 1996; Yehuda, 2002; Zeitlin et al., 1993; Zlotnick et al., 2001), were entered into a logistic regression equation to determine predictors of alexithymia.

**METHOD**

**Participants**

A total of 70 women (≥ 18 years of age) were selected as a convenience sample based on their history of early (i.e., ≤ 12 years of age) onset sexual abuse, their ability to read or speak English, and their current involvement in outpatient therapy. Forty-five women were invited to participate from their telephone response to flyers posted in six Canadian urban mental health clinics and comprised the clinic sample. Each participant was actively engaged in treatment in a tertiary care center. Twenty-five women were invited to participate from their telephone response to the broad and diverse distribution of a community newspaper advertisement and comprised the community sample. The community sample was involved therapeutically in a variety of community-based private-practice settings. Exclusion criteria for participation included acute medical or mental health crisis, acute suicidal ideation, psychosis, current substance abuse, and current criminal charges. The content of advertisement for both clinic and community participants did not differ.

The mean age at onset of sexual abuse in the total sample was 4.49 years (SD = 3.03). There were few significant demographic differences between the groups. A substantial proportion of the participants were Caucasian (86%) with an average age of 43.57 years (SD = 11.63, range =
23-64); most had some university or college education (67%). Almost half (46%) were never married, while 33% were divorced.

Procedure

After a complete description of the study was presented to the participants, written informed consent was obtained. An investigator then administered the study measures during a one-time interview. A psychology doctoral student provided sequential and independent validation scores on all measures, and interrater reliabilities of 97% were achieved.

Measures

Toronto Alexithymia Scale-20. Alexithymia was evaluated with the Toronto Alexithymia Scale-20 (TAS-20; Bagby, Parker, & Taylor, 1994). The TAS-20 is a 20-item self-report measure with good test-retest reliability (Bagby, Taylor, & Parker, 1994) and good convergent and discriminant validity (Bagby, Parker, & Taylor, 1994). A cut-off score of 61 or higher has been established to indicate alexithymia. A series of factor analyses of the TAS-20 has yielded three factors: difficulty identifying feelings, difficulty describing feelings, and externally-oriented thinking (Parker, Bagby, Taylor, Endler, & Schmitz, 1993).

Structured Interview for Disorders of Extreme Stress. A diagnosis of current and/or lifetime complex PTSD was assessed by the Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997), included in the Trauma Assessment Package (van der Kolk, 1997). The SIDES is a self-report measure consisting of 45 items that address symptoms often seen in response to extreme stress of an interpersonal nature. Six subscales include alterations in regulation of affect and impulses, alterations in attention or consciousness, chronic characterological changes in the area of self-perception and perception of others, alterations in relationships with others, somatization, and alterations in systems of meaning. For each item, the presence of the symptom at any time is noted (yes or no), and for yes responses, severity over the past month is determined by a four-point Likert Scale, with 0 (Not at all) to 3 (Extreme severity). Scores show both lifetime presence and current presence and severity of symptoms, thus, a participant can have a diagnosis of either current or lifetime complex PTSD, or meet criteria for both. Psychometric properties are reported in the Trauma Center Assessment Package (van der Kolk, 1997). Inclusion of subscale scores has been the norm in other research with the SIDES (van der Kolk et al., 1996).
**The Traumatic Antecedents Questionnaire.** The Traumatic Antecedents Questionnaire (TAQ; van der Kolk, 1997), included in the Trauma Assessment Package (van der Kolk, 1997), is a self-administered assessment of trauma variables that occur across four lifetime stages of development (i.e., ≤ 6, 7-12, 13-18, ≥ 19 years of age). This measure consists of 11 domains including competence, safety, neglect, separation/loss, family secrets (i.e., outsiders did not know what went on within the family), emotional abuse, physical abuse, sexual abuse, witnessing violence, other traumas, and family and/or participant alcohol and drug use. Items are rated on a four-point Likert Scale of intensity/frequency ranging from 0 (never at all) to 3 (often or very much). Scores of 3 on each variable over the four stages of development measured can result in a total score of 12. Scores from the TAQ are significantly related to symptoms of PTSD and symptoms of complex PTSD (van der Kolk, 1997).

**Data analyses.** Quantitative data were analyzed by SPSS 11.0 for windows. For all analyses, alpha was set at \( p < 0.05 \). In the case of continuous measures (e.g., trauma variables measured by the TAQ), independent-samples t-tests compared between-group differences in total lifetime mean scores. The clinic and community participants were compared using Pearson’s \( \chi^2 \) tests and Spearman’s rho tests with continuity adjustment for categorical data (e.g., perpetrators of sexual abuse [yes/no], adult alexithymia [yes/no], and lifetime and/or current complex PTSD [yes/no]). For effect size calculations (e.g., Cramer’s V), small effects were considered to have a range of 0-0.39, medium effects had a range of 0.40-0.70, and large effects were considered to fall above 0.70. Predictors of adult alexithymia were determined through logistic regression analysis.

**RESULTS**

Descriptive statistics explored similarities and differences in diagnoses, trauma and outcome variables by source of recruitment. Endorsement of alexithymia was found to be significantly higher in the clinic sample (84%, \( N = 45 \)) as compared to the participants from the community sample (16%, \( N = 25 \); Pearson’s \( \chi^2 = 20.45, df = 1, N = 70, p < 0.001 \), two-tailed; Cramer’s V = 0.538, \( p < 0.0001 \), two-tailed). The diagnosis of lifetime complex PTSD, in contrast to both current and lifetime complex PTSD, was endorsed significantly more often in participants from
the community than in the clinic sample (73%, N = 25 versus 37.8%, N = 45; Pearson’s $\chi^2 = 7.112$, df = 1, N = 70, $p < 0.01$, two-tailed; Cramer’s $V = 0.476$, $p < 0.0001$, two-tailed). Significantly more women in the clinic sample met diagnostic criteria for both current and lifetime complex PTSD as compared to those from the community (51.1%, N = 45 versus 4%, N = 25; Pearson’s $\chi^2 = 20.167$, df = 1, N = 70, $p < 0.005$, two-tailed; Cramer’s $V = 0.476$, $p < 0.0001$, two-tailed). Women sampled from clinics show more current symptoms of complex PTSD.

In regard to the 11 domains measured by the TAQ, overall, the clinic sample showed higher mean total scores when compared to the community sample on the variables of trauma. The independent-samples t-test was significant for two trauma variables only: lifetime physical abuse, $t(68) = 2.064$, $p = 0.043$ (two-tailed) and lifetime witnessing of violence, $t(68) = 2.081$, $p = 0.041$ (two-tailed). Participants in the clinic sample (M = 5.80, SD = 3.92) endorsed more lifetime physical abuse than those in the community sample (M = 3.89, SD = 3.29). Similarly, participants in the clinic sample (M = 5.89, SD = 3.30) endorsed more lifetime witnessing of violence than those in the community sample (M = 4.17, SD = 3.30). Eta-squared ($\eta^2$) indicated that 6% of the variance of the physical abuse variable and of the witnessing of violence variable was accounted for by whether a participant was from the clinic sample or the community sample. Descriptive analysis of similarities and differences by source of recruitment in relation to variables of trauma including: the duration of sexual abuse (i.e., single acute = 1 episode, acute = > 1 and ≤ 10 episodes, chronic = ≥ 11 episodes), paternal sexual abuse, sexual re-victimization over the lifetime, paternal alcoholism and bi-parental alcoholism in both recruitment samples are found in Table 1. In addition, outcome variables of trauma in both recruitment samples are also reported in Table 1 including history of learning disability, current long-term medical disability, participant alcohol abuse, participant polysubstance abuse, number of psychiatric hospitalizations, eating disorders and endorsement of prescription drug use.

The first hypothesis was not supported; the diagnosis of complex PTSD was not associated with alexithymia in the overall sample (Spearman’s rho = 0.189, N = 70, $p = 0.117$, two-tailed). Further analysis by source of recruitment showed no relationship between complex PTSD and alexithymia in either the clinic (Spearman’s rho = −0.021, N = 45, $p = 0.893$, two-tailed) or the community samples (Spearman’s rho = −0.089, N = 25, $p = 0.672$, two-tailed).
In contrast to hypothesis one, hypothesis two was supported by the data. Correlations between the complex PTSD SIDES subscales measuring current and lifetime affect dysregulation, dissociation, somatization, and alexithymia were calculated. First, an examination of the affect dysregulation subscale indicated significant relation between alexithymia and current affect regulation (Spearman’s rho = 0.600, N = 69, \( p < 0.0001 \), two-tailed), modulation of anger (Spearman’s rho = 0.444, N = 68, \( p < 0.0001 \), two-tailed), self-destructive behavior (Spearman’s rho = 0.390, N = 63, \( p = 0.002 \), two-tailed), suicidal preoccupation (Spearman’s

<table>
<thead>
<tr>
<th>Variable</th>
<th>Clinic (N = 45)</th>
<th>Community (N= 25)</th>
<th>( \chi^2 ) (two-tailed)</th>
<th>df</th>
<th>( p )-value</th>
<th>Cramer’s V (two-tailed)</th>
<th>( p )-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic sexual abuse(^1)</td>
<td>95.7</td>
<td>95.7</td>
<td>0.002</td>
<td>1</td>
<td>0.961</td>
<td>0.006</td>
<td>0.961</td>
</tr>
<tr>
<td>Paternal incest(^1)</td>
<td>55.8</td>
<td>48.0</td>
<td>0.006</td>
<td>1</td>
<td>0.961</td>
<td>0.004</td>
<td>0.971</td>
</tr>
<tr>
<td>Re-victimization(^1)</td>
<td>84.0</td>
<td>84.0</td>
<td>0.002</td>
<td>1</td>
<td>0.961</td>
<td>0.006</td>
<td>0.961</td>
</tr>
<tr>
<td>Paternal alcoholism(^1)</td>
<td>31.0</td>
<td>52.0</td>
<td>19.600</td>
<td>4</td>
<td>0.005**</td>
<td>0.292</td>
<td>0.225</td>
</tr>
<tr>
<td>Bi-parental Alcoholism(^1)</td>
<td>31.0</td>
<td>12.0</td>
<td>13.111</td>
<td>4</td>
<td>0.025*</td>
<td>0.292</td>
<td>0.225</td>
</tr>
<tr>
<td>Eating disorders(^2)</td>
<td>64.0</td>
<td>60.0</td>
<td>0.594</td>
<td>1</td>
<td>0.799</td>
<td>0.092</td>
<td>0.988</td>
</tr>
<tr>
<td>Learning disability(^2)</td>
<td>40</td>
<td>20</td>
<td>5.14</td>
<td>1</td>
<td>0.023*</td>
<td>0.204</td>
<td>0.088</td>
</tr>
<tr>
<td>Long-Term disability(^2)</td>
<td>67</td>
<td>33</td>
<td>12.74</td>
<td>1</td>
<td>0.0005**</td>
<td>0.333</td>
<td>0.005**</td>
</tr>
<tr>
<td>Current anxiolytic(^2)</td>
<td>73</td>
<td>40</td>
<td>12.3</td>
<td>1</td>
<td>0.0005**</td>
<td>0.328</td>
<td>0.006**</td>
</tr>
<tr>
<td>Current antidepressant(^2)</td>
<td>76</td>
<td>44</td>
<td>9.80</td>
<td>1</td>
<td>0.0025**</td>
<td>0.316</td>
<td>0.008**</td>
</tr>
<tr>
<td>Current antipsychotic(^2)</td>
<td>38</td>
<td>0</td>
<td>17.0</td>
<td>1</td>
<td>0.0005**</td>
<td>0.422</td>
<td>0.000**</td>
</tr>
<tr>
<td>Past antipsychotic(^2)</td>
<td>49</td>
<td>12</td>
<td>14.44</td>
<td>1</td>
<td>0.0005**</td>
<td>0.369</td>
<td>0.002**</td>
</tr>
<tr>
<td>Participant alcohol Abuse(^2)</td>
<td>11.1</td>
<td>32.0</td>
<td>11.940</td>
<td>4</td>
<td>0.020*</td>
<td>0.315</td>
<td>0.074</td>
</tr>
<tr>
<td>Polysubstance Abuse(^2)</td>
<td>64.4</td>
<td>44.0</td>
<td>12.598</td>
<td>4</td>
<td>0.020*</td>
<td>0.315</td>
<td>0.074</td>
</tr>
<tr>
<td>No psychiatric hospitalization(^2)</td>
<td>23.0</td>
<td>60.0</td>
<td>9.000</td>
<td>1</td>
<td>0.003**</td>
<td>0.476</td>
<td>0.001**</td>
</tr>
<tr>
<td>&gt; 3 psychiatric hospitalizations(^2)</td>
<td>60.0</td>
<td>12.0</td>
<td>19.200</td>
<td>1</td>
<td>0.0005**</td>
<td>0.476</td>
<td>0.0001**</td>
</tr>
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</table>

\* \( p < 0.05 \), two-tailed. \** \( p < 0.01 \), two-tailed.
rho = 0.338, N = 60, p = 0.008, two-tailed), sexual dysregulation (Spearman’s rho = 0.524, N = 66, p = 0.0001, two-tailed), and excessive risk taking (Spearman’s rho = 0.467, N = 58, p = 0.0001, two-tailed).

Second, the examination of the dissociation subscale demonstrated significant relationships between alexithymia and current amnesia (Spearman’s rho = 0.551, N = 63, p = 0.0001, two-tailed). A significant relationship was also found between transient dissociative episodes and de-personalization (Spearman’s rho = 0.516, N = 69, p = 0.0001, two-tailed).

Analysis of the somatization subscales showed significant relationships between adult alexithymia and current digestive symptoms (Spearman’s rho = 0.293, N = 55, p = 0.030, two-tailed), chronic pain (Spearman’s rho = 0.402, N = 49, p = 0.004, two-tailed), cardiopulmonary symptoms (Spearman’s rho = 0.391, N = 49, p = 0.005, two-tailed), conversion symptoms (Spearman’s rho = 0.313, N = 55, p = 0.020, two-tailed), and sexual symptoms (Spearman’s rho = 0.382, N = 53, p = 0.005, two-tailed).

A logistic regression analysis was conducted to predict the differential role of specific variables of early childhood trauma in the degree of alexithymia. The analysis included seven trauma variables derived from the TAQ as predictors that were entered into the regression in the following order: safety, bi-parental neglect, family secrets, emotional abuse, physical abuse, paternal sexual abuse, and witnessing of violence. Results shown in Table 2 indicated that paternal sexual abuse was the most significant predictor of alexithymia in the overall sample. All other variables were nonsignificant (p > 0.05) and are not included in the table. Further analysis examined predictors of alexithymia for each group and showed that paternal sexual abuse and bi-parental neglect were significant predictors in the clinic sample, while bi-parental neglect was found to be the one significant predictor in the community.

<table>
<thead>
<tr>
<th>TABLE 2. Logistic Regression Table Showing Predictors of Adult Alexithymia</th>
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<tbody>
<tr>
<td><strong>R^2</strong></td>
</tr>
<tr>
<td>---------</td>
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<tr>
<td>Overall</td>
</tr>
<tr>
<td>Hospital</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Community</td>
</tr>
</tbody>
</table>

* p < 0.05, two-tailed.  **p < 0.01, two-tailed.
Paternal sexual abuse increased the odds of meeting criteria for alexithymia by 9% in the clinic sample, while bi-parental neglect increased the odds by 10%. For the community sample, bi-parental neglect increased the odds of meeting criteria for alexithymia by 7%.

**DISCUSSION**

An exploratory comparison of women with histories of early (i.e., ≤ 12 years of age) onset sexual abuse recruited from outpatient clinics and the community was conducted. This study extended findings of earlier work (McLean & Gallop, 2003; Zlotnick et al., 2001) and served to illustrate noteworthy results related to childhood trauma variables, complex PTSD, and alexithymia. A number of differences that we did not anticipate were found between the clinic and community samples, which highlight the importance of examination of source of recruitment as a variable in future large-scale studies. At the same time, regardless of source of recruitment, it is remarkable to note similarities in the experiences of women with early-onset sexual abuse that included age at onset of sexual abuse, duration of sexual abuse, paternal sexual abuse, bi-parental neglect, and the prevalence of sexual re-victimization over the lifetime.

The fact that differences did emerge when examining each source of recruitment, suggests that women drawn from the clinic continue to suffer from long-term effects from the impact of early-onset sexual abuse. The majority of the women in the clinic sample met criteria for alexithymia whereas the women from the community did not. Endorsement of alexithymia in the clinic sample is informative; alexithymia has been associated with higher attendance at primary health care facilities, heightened psychological distress (Lumley & Norman, 1996), substance abuse, eating disorders (Taylor, 2000), PTSD, BPD (Zlotnick et al., 2001), and a number of other physical and psychiatric conditions and illnesses (Bagby et al., 1994; Nemiah, 1977; Sifneos, 1973; van der Kolk, 1996). Consistent with extant literature, our findings demonstrated higher current severity on the SIDES somatization subscale in the clinic sample, with endorsement on current measures of digestive symptoms, chronic pain (e.g., fibromyalgia), cardiopulmonary symptoms, conversion symptoms, and sexual symptoms. Physicians and clinicians working with medically ill and somatizing patients need to be aware of high levels
of alexithymia and affective disturbance, which may contribute to presenting symptoms (Anastasi & Urbina, 1997; APA, 1994; Taylor, 2000).

The majority of individuals with early-onset trauma drawn from clinic settings also endorsed either current or lifetime complex PTSD. These findings replicate our previous results that highlighted lifelong symptoms in a subset of women with early-onset sexual abuse, who experience both BPD and complex PTSD (McLean & Gallop, 2003). Collectively, the findings indicate that women with later-onset (i.e., \( \geq 13 \) years of age, \( M = 15.56 \) years) childhood sexual abuse, drawn from tertiary care clinics (McLean & Gallop, 2003), share some characteristics with the women with early-onset sexual abuse drawn from the community. Specifically, both groups endorsed lifelong complex PTSD in contrast to both lifetime and current complex PTSD. This may represent a second subset of women who show a diminution in their experience of current distress in spite of their history of childhood sexual abuse, and therefore a degree of recovery and/or resilience in their capacity to process and regulate affect. Our findings do not identify the factors that may have contributed to the group differences on measures of alexithymia, complex PTSD and significant differences in hospitalizations, substance use, history of learning disability, current long-term medical disability, and prescription drug use. Future exploration of these factors in larger-scale, multicenter studies would be informative in determining the role that such variables may play in different degrees of lifetime suffering and recovery. Life events that may contribute to differences in adult outcome can include: age at first intervention; access to therapy; type of therapeutic intervention (i.e., an individual therapeutic relationship in contrast to multiple and different therapeutic interventions); a statistically significant lower overall index of lifetime trauma (Roth et al., 1997; van der Kolk et al., 1996); the presence of one trusting individual in the person’s early years (van der Kolk & Fisler, 1994); and individual differences in vulnerability or resilience (Bonanno, 2004; van der Kolk, 1996).

In terms of our hypotheses, the finding that there was no significant relationship between complex PTSD and alexithymia was surprising. This raises the issue of whether variability of response on diagnostic measures may decrease the magnitude of the correlation (Anastasi & Urbina, 1997). Not withstanding this overall finding, particular current SIDES subscales correlated significantly with the diagnosis of alexithymia, supporting earlier reports that alexithymia is associated with affective, dissociative, and psychosomatic sequelae of early-onset trauma.
Anastasi & Urbina, 1997; Bach et al., 1994; Bonanno, 2004; Sifneos, 1973; Taylor, 2000; van der Kolk, 1996; Zeitlin et al., 1993; Zlotnick et al., 2001).

In our earlier work (McLean & Gallop, 2003), logistic regression analysis showed that paternal sexual abuse was the most significant predictor of both BPD and complex PTSD. The current findings demonstrate that early-onset paternal sexual abuse and bi-parental neglect predict alexithymia; this supports Krystal’s (1988) observation that survivors of trauma have an impaired capacity to utilize affect in the mobilization of adaptive responses.

There are several clinical implications from this research. First, consideration of complex or chronic PTSD provides latitude to consider co-occurring symptoms (APA, 1994; Herman, 1993; van der Kolk et al., 1996) that the initial trauma sets into motion. Both paternal sexual abuse and bi-parental neglect that begin early in life profoundly impact attachment of the child to significant caretakers and may be central to affect dysregulation. The trajectory of treatment in such cases then takes on particular meaning. It is possible that women attending outpatient clinics are offered various and specialized interventions targeting specific presenting symptoms, such as eating disorders or substance abuse, whereas interventions in a private-based community setting may address the spectrum of an individual’s co-occurring symptoms. Second, because alexithymia has been associated with a higher attendance at primary health care facilities (Lumley & Norman, 1996), it may be that individuals presenting with psychological distress and various medical illnesses have not linked their early trauma history with their current methods of regulating affective distress. Maladaptive behaviors may negatively impact physical health and morbidity (Taylor, 2000).

There are several limitations to this study. First, the small overall sample size along with the difference in the numbers of women classified as “clinic” as opposed to “community” participants may limit generalizability. Second, the use of an all female convenience sample limits generalizability of the results to women with a history of sexual abuse. Third, reliance on self-report without external validation of retrospective data is a point of contention in the research on the chronic effects of trauma. However, adult participants who have survived childhood trauma can only report retrospectively and while several studies present some independent corroboration of such early childhood memories (Williams, 2004), such reports remain the primary type of data currently employed in trauma research (Figueroa & Silk, 1997; Sabo, 1996). The use of standardized measures in this study helps to attenuate this con-
cern. Furthermore, while not reported in this study, qualitative data collected concurrently with the quantitative measures were examined for consistency of participant response on several outcome variables (e.g., memory disturbance/amnesia, age of onset of symptoms).

There are several directions for future research that emerge in consideration of the results. Clearly, the profound impact in most of the women over their lifetime that is associated with childhood sexual abuse leads us to conclude that this remains a critical area for further empirical inquiry. Autonomy-dependence issues around childhood attachment may particularly re-emerge as a specific challenge of the aging and dependence process in the older adult survivor and represents another vulnerable population for future research. Replication of the present study with larger clinic and community sample sizes, with even between-group distribution, is important to both incorporate measures of and to determine factors that contribute to recovery and/or resilience in some, and lifelong risk and vulnerability in others. Finally, expansion of the present study to primary and tertiary health care centers would address questions surrounding the relationship between alexithymia and a history of childhood trauma.

AUTHOR NOTE

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