Published in final edited form as:
Psychol Trauma. 2013 January ; 5(1): 77–83. doi:10.1037/a0022214.

Optimism, Coping, and Posttraumatic Stress Severity in Women in the Childbearing Year

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Abstract

PTSD symptoms in pregnancy may cause adverse effects on both mother and infant child. Identifying and addressing PTSD in pregnancy may help to alleviate the impact of PTSD on pregnancy. Optimism has been examined as a protective factor in the development of PTSD; however no study to date has looked at the relationship between optimism and PTSD in pregnant women. The current study examined the role of optimism on PTSD symptom severity, coping and somatization among women in the childbearing year. We examined data from 1581 completed interviews with nulliparous, pregnant women from the first wave telephone interview conducted as part of a longitudinal outcomes study, “Psychobiology of PTSD & Adverse Outcomes of Childbearing” (NIH NR008767; common name “the STACY project”). Four trauma exposure group cohorts (PTSD-positive, trauma-positive, non-exposed, and partial PTSD) were differentiated and two coping variables (active and avoidant) were examined. The relationships between demographics, trauma exposure groups, optimism and PTSD were examined. In addition, we examined the impact of these factors on coping and somatization. In general, the PTSD-positive group reported significantly less optimism than the trauma-positive and non-exposed groups. SES and number of reported traumas contributed to PTSD severity, as well as optimism. For those women reporting more optimism, they reported more use of active coping, less engagement in avoidant coping, and less somatization.

Keywords

posttraumatic stress disorder; pregnancy; trauma; optimism; coping; resilience

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As a global disposition, optimism is viewed as a stable personal characteristic that plays an important role in self-regulation of behavior (Scheier & Carver, 1985). Scheier and Carver (1985) operationalize optimism as a personal disposition defined as a tendency or propensity to expect that good things rather than bad things will happen. Findings across many studies suggest that optimism serves an important function in adaptation to a wide variety of life stressors (Miller et al., 1996). The predominant mechanisms through which optimism is theorized to work include coping strategies (Fontaine et al., 1993; Scheier & Carver, 1987; Scheier et al., 1986), social support (Brissette et al., 2002), and to some extent perceptions of stress (Scheier et al., 1986). On the other hand, low levels of optimism are linked with unhealthy mental and physical health outcomes such as depression and increased frequency and intensity of somatic complaints (Scheier & Carver, 1992). A person low in optimism, or high in pessimism, tends to use more avoidant coping strategies that are related to distress, such as disengagement from social situations and denial. Using such avoidant coping behaviors is part of the symptomology of PTSD. Because optimism is a factor that is thought to play a role in the expression and experience of PTSD, it may be used as a predictor for problematic response to trauma. It is thought that optimism can play a protective role against negative health outcomes because persons high in optimism are more likely to engage in efforts to manage a stressor (Carver & Gaines, 1987).

Recently, optimism has been examined as a protective factor in the development of PTSD following trauma. Zeidner and Hammer (1992) examined the relationships between optimism, perceived control, and coping strategies to anxiety, physical symptoms and depression in Jewish adults (N= 261) during the SCUD missile attacks in Israel. Optimistic people were less anxious, had fewer physical symptoms and reported less depression. Further, palliative coping demonstrated an inverse relationship between these outcomes. In another study, Costello (1997) found that that optimism and insight protected against illness burden (i.e., psychological distress, neuroendocrine, immune, and health responses) following Hurricane Andrew in 43 patients with Chronic Fatigue Syndrome and 114 healthy adults. In addition, this effect was mediated by less use of negative coping strategies (i.e., avoidance and denial). Dougall et al. (2001) longitudinally examined optimism, social support, coping strategies and posttraumatic stress in a sample of 159 rescue and recovery workers from an air disaster. Higher optimism was associated with less distress in rescue workers at 12 months following their work at the crash site. Both social support and more positive coping strategies mediated the relationship. Fauerbach and colleagues found that optimism moderated the relationship between subsyndromal PTSD severity following a severe burn injury and post-burn physical but not mental health functioning (Fauerbach, Lawrence, Munster, Palombo, & Richter, 1999). However, no studies to date have looked at the relationship between optimism and PTSD in pregnant women.

Women are at increased risk for developing PTSD following trauma exposure (Breslau, 2001; also reviewed in Norris, Foster, & Weisshaar, 2002). Women have a lifetime prevalence rate of PTSD twice that found in men and a mean duration of symptoms four times greater than in men (Breslau, 2001). In women, the potentially traumatic experience with the highest conditional risk of developing PTSD is rape and sexual molestation (Breslau, 2001). Qualitative studies suggest that experience with rape or sexual molestation can trigger increased PTSD symptoms during pregnancy (Courtois & Riley, 1992; Seng,

Sparbel, Low, & Killion, 2002), a finding confirmed in the parent study (Seng, Low, Ronis, Sperlich, & Liberzon, 2009). Also of note is that prior exposure to trauma increases risk for developing PTSD from subsequent traumatic events. Compared with non-pregnant samples of women (4.6%; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), rates of current PTSD appear to be higher in pregnant samples (6.5% to 8.1%) (Ayers & Pickering, 2001; Cook et al, 2004; Harris-Britt, Martin, Li, Casanueva, & Kupper, 2004) inclusive of the current sample (7.9%; Seng et al., 2009).

Pregnancy, childbirth and becoming a new parent are life experiences that require significant change and adjustment, which can create both positive and negative stress for an individual. In a series of studies, Lobel and colleagues (Lobel et al., 2000; Lobel, Yali, Zhu, DeVincent, & Meyer, 2002; Yali & Lobel, 2002) demonstrated the association between an operationalized variable of optimism and improved childbearing outcomes. PTSD symptoms can cause adverse effects on both the mother and infant child making the identification of risk for PTSD in pregnancy of critical importance. In a large epidemiological study by Seng and colleagues (Seng et al., 2001) women with PTSD were more likely to experience ectopic pregnancy, spontaneous abortion, hyperemesis, preterm contractions and excessive fetal growth after controlling for relevant demographic and psychosocial factors. Symptoms of avoidance, depression, anxiety and possible substance abuse or dependence can interfere with health seeking behavior such as prenatal care. In order to determine who could benefit from early treatment interventions for PTSD, optimism and other measures of coping may be used to identify at-risk pregnant women. Studies have demonstrated that optimism has both direct and indirect beneficial influence on maternal and infant outcomes for both low-risk and high-risk childbearing women (Lobel et al., 2000; Lobel et al., 2002; Yali & Lobel, 2002) and on infant birth weight and length of gestation (Rini et al., 1999).

Another potentially related consequence of trauma exposure is somatization, or the development of physical symptoms for which no organic cause can be found. In a prospective study of PTSD and somatization, Andreski et al. (1998) found that PTSD increased the risk of somatization but that new PTSD cases were not elevated in people with a somatization disorder. As such, it appears that the development of somatization following trauma is mediated somehow through PTSD. In addition, among a sample of factory accident survivors, PTSD severity was related to somatization and a greater sense of incompetence was related to somatization (Elklit & Christiansen, 2009). Therefore, examination of trauma, somatization, and PTSD together may provide insight into the factors involved in help seeking and coping during pregnancy.

Given the importance of understanding PTSD and the importance of understanding the course and progression of PTSD in women in the childbearing year, the current study examined the roles of optimism in PTSD as well as the influence of optimism on help seeking and somatization among women in the childbearing year. Based on the literature to date, we assert several hypotheses. First, women with PTSD will report less optimism as compared to women with trauma and no PTSD and women without trauma. Second, PTSD severity will be inversely related to optimism. Third, when predicting current mental health (MH) symptom severity, after accounting for basic demographics and trauma exposure, higher optimism will be related to lower MH severity. After accounting for basic

demographics and trauma exposure, higher optimism will be related to a higher likelihood to report therapy, medication, and active coping. Higher optimism will also be related to lower avoidance coping and somatization.

Method

Participants and Procedure

Data presented are from the first wave telephone interview conducted as part of a prenatal survey in a longitudinal outcomes study, "Psychobiology of PTSD & Adverse Outcomes of Childbearing" (NIH NR008767; common name "the STACY project"). Participants were recruited to the study from eight maternity clinics at three health systems in the Midwestern United States, one serving predominantly privately insured patients in a small university city and two serving predominantly Medicaid recipients in an urban center. Approval for this study was granted by the Institutional Review Boards of the three health systems. Eligible participants were English speaking adults, 18 years or older, expecting a first infant, less than 28 weeks gestation. All women who met eligibility criteria from August 2005 through May 2008 were invited to participate in a survey about "stressful things that happen to women, emotions, and pregnancy." Interested women (n=2689) were given a written information document. A survey research organization (DataStat, Inc. of Ann Arbor, Michigan) completed follow-up telephone contact (for additional details on methods see Seng et al., 2009). Interviewers were unable to reach 758 of the interested women, and another 278 were not actually eligible when the interviewer verified age and parity. Thus 1653 were reached and eligible. At the start of the interview 58 declined. Another 8 interviews were interrupted and not completed. Thus 96% of those reached and apparently eligible (n=1587) completed interviews. Of the 1587 completed, 6 were eventually excluded from this analysis (n=1581) due to ineligibility discovered upon chart abstraction. Participants were paid $20 for the initial interview.

Materials

Several instruments were used for this analysis, including assessment of lifetime trauma and violence exposure, past and current PTSD symptoms and diagnoses, depression and generalized anxiety diagnoses, substance use, mental health treatment history, and optimism. The mean time for interview completion was 32 minutes. Algorithmic scoring by DataStat's computer aided telephone interview program differentiated four cohorts: 1) PTSD-positive, defined as trauma-exposed and meeting criteria for PTSD diagnosis at some point in their lifetime to date; 2) trauma-positive, defined as trauma-exposed, but a negative history of PTSD; 3) non-exposed, defined as neither trauma-exposed nor PTSD-diagnosed; and 4) partial PTSD, characterized as primarily women with trauma exposures or a history of PTSD symptoms but who did not meet diagnostic criteria for PTSD. The partial PTSD group was dismissed from the additional waves of the study. They are included in the regression models but excluded from the ANOVAs below.

We used 29 relevant items from the Life Stressor Checklist to assess trauma exposure. To be considered "trauma-exposed," the participant had to either meet the diagnostic criterion of feeling "intense fear, helplessness, or horror" *or* they had to have disclosed a history of

childhood maltreatment. The Life Stressor Checklist asks about details of the two worst events. This measure is considered to have high sensitivity to trauma among women (Norris et al., 2004). Test-retest reliability has been reported in one study that used a revised and adapted version with 186 participants over a seven day interval. Percent agreement ranged from a low of 79% for illness to 98% for miscarriage (Norris et al., 2004). We followed disclosure of adult abuse with items from the Abuse Assessment Screen, a measure specific to violence during pregnancy (McFarlane et al., 1992).

We used the National Women's Study PTSD Module to assess PTSD. The National Women's Study PTSD Module attained a sensitivity of 0.99 and specificity of 0.79 in comparison with face-to-face, clinician-administered Structured Clinical Interview for DSM-III-R (SCID) (Kilpatrick et al., 1994; Resnick et al., 1993). It measures all 17 symptoms of PTSD for past and current diagnoses, and assesses distress and impairment. Comorbid depression and anxiety were assessed using the Composite International Diagnostic Interview short form, a structured psychiatric diagnostic tool designed to be used by trained interviewers who are not clinicians. It is supported by extensive field trial data on cross-national reliability and validity (Wittchen, 1994). The Perinatal Risk Assessment Monitoring Survey (PRAMS), an epidemiological surveillance instrument created by the Centers for Disease Control, was used for assessing income, education, race/ethnic identity, and health risk behaviors, including quantitative assessment of substance use during pregnancy (Beck et al., 2002). Crime exposure is a demographic risk factor for PTSD. This risk factor was characterized by the total crime index from the most recent (2000) FBI uniform crime report for each participating woman's zip code using SimplyMap (accessed 5/20/09). We dichotomized this to higher or lower crime area residence based on her index number's relation to the U.S. average crime rate (EASI Demographics).

Mental health treatment and coping were queried with questions examining positive and negative coping and treatment before and during pregnancy. Two coping variables were created from the survey responses. Active coping was the count of how many of the following strategies the woman endorsed: self help, talk to a friend, cry to cope, pray to cope, light exercise (walking), or strenuous exercise. Active cope ranges from 0 to 6. Avoidance cope was the count of how many of the following strategies the woman endorsed: alcohol, tobacco, other recreational drugs, entertainment to distract, work to distract, or sleep to cope. Avoidance cope ranges from 0 to 6.

The Revised Life Orientation Test (LOT-R; Scheier et al., 1994) was used to examine the personal disposition of optimism. The LOT-R is a 10-item scale with 3 positive items, 3 negative items and 4 filler items. An example of a positive item is "In uncertain times, I usually expect the best" and a negative item is "If something can go wrong for me, it will". Negative items are reverse scored and higher summed scores indicate more optimism. LOT-R scale yielded acceptable internal consistency with a Cronbach's alpha of .78 and test-retest reliability of .68 at four months (Scheier et al., 1994).

Results

Overall, 1,581 participants competed the initial prenatal survey. To assure power after potential expected attrition for race-specific outcome modeling, we over-sampled African American women, achieving 45% participation. Other minority women included Latinas (4.2%), Asians (7.1%), Native American/Alaska Natives (1.5%), Native Hawaiian/Pacific Islanders (0.4%), and others (3.2%). Women ranged in age from 18 to 47 (M = 26, SD = 5.9). With regard to yearly income, 22.6% reported making less than $15,000, 17% reported between $15,000 and $24,999, 17.5% reported between $25,000 and $49,999, and 37.9% reported over $50,000. Sixty percent of the sample reported working. Forty six percent of the sample reported high school education or less. Thirty percent reported an associate or bachelor's degree. Twenty four percent of the sample reported a master's or doctorate degree. As previously reported (Seng et al., 2009), women with current PTSD are younger and later to prenatal care than women in the other groups. They are most likely to have socioeconomic risk factors associated with stress and PTSD: being African American, a teen, living in poverty, with high school education or less, and living in a higher than average crime area. They also carry the most cumulative sociodemographic stress (mean = 3.1). The cohort who were trauma-exposed but PTSD-negative has the fewest sociodemographic risk factors (mean = 1.3). Types of potentially traumatic events (PTE) were grouped into six categories: family context (e.g., not having enough money for food, family member jailed, having been fostered or adopted), event (e.g., being in an accident, disaster, or war zone), reproductive, characterized as "having a difficult time because of an abortion or miscarriage" in this sample of nulliparous women, sexual/physical abuse, emotional abuse/neglect, and "other", usually left unspecified. Thirty percent of the sample reported no significant PTEs. Forty nine percent of the sample reported family context events as their worst PTE. Five percent reported a reproductive loss as their worst PTE. Twelve percent reported psychical or sexual abuse or rape as their worst PTE. Three percent reported emotional abuse or neglect as their worst PTE. Three percent reported another event as their worst PTE. Optimism scores ranged from 0 to 44 with a mean of 16.6 (SD = 4.4). This mean is similar to the means ranging from 14–15 that have been reported for college women and bypass patients (Scheier, et al., 1994).

A three-way ANOVA found that the three different trauma exposure groups differed significantly in self reported optimism, F (2, 1049) = 45.9, $p < .0001$. Follow up t tests with Bonferroni correction for family wise error found that the PTSD+ group (M = 15.0, SD = 4.6) reported significantly less optimism than both the trauma/no PTSD (M = 17.5, SD = 3.9) and no trauma groups (M = 17.9, SD = 4.2, $p < .05$) though this difference is not clinically significant. No other groups significantly differed.

In order to examine the influence of demographics and optimism on mental health severity, several multiple regression analyses were conducted one for each outcome (PTSD lifetime severity, current severity, and depression severity). In step one, demographic variables were entered (SES risk variable and trauma count). In step two, optimism score was entered. In the model predicting current PTSD severity, the overall model was significant, F (3, 1580) = 277.2, $p < .0001$, $Adj\ R^2 = .34$. In the model predicting lifetime PTSD severity, the overall model was significant, F (3, 1580) = 335.8, $p < .0001$, $Adj\ R^2 = .39$. In the model predicting

current depression severity, the overall model was significant, but the proportion of variance explained was smaller, F (3, 1580) = 14.3, p <.0001, *Adj* R^2 = .03. Table 1 presents the results of the regression analyses for the predictors in the final models.

In order to examine the influence of demographics, optimism, and mental health severity on coping, several multiple regression analyses were conducted one for each coping outcome (active coping, avoidance coping, mental health care seeking, and somatization). In step 1, demographic variables were entered (SES risk variable and trauma count). In step 2, optimism score was entered. In step 3, current PTSD severity and depression were entered. In the model predicting avoidance coping, the overall model was significant, F (4, 1580) = 48.1., p <.0001, *Adj* R^2 = .11. In the model predicting active coping, the overall model was significant, F (4, 1580) = 61.5, p <.0001, *Adj* R^2 = .13. In the model predicting mental health service use, the overall model was significant, F (4, 1580) = 115.9, p <.0001, *Adj* R^2 = .23. In the model predicting somatization, the overall model was significant, F (4, 1580) = 128.6, p <.0001, *Adj* R^2 = .24. Table 2 presents the results of the regression analyses for the predictors in the final models.

In order to examine whether optimism scores are related to specific help seeking strategies or somatization, several logistic regression models were conducted to predict use of both medications and therapy, use of medication at all, and use of therapy at all. Only the model examining the influence of optimism on lifetime psychoactive medication use was significant, [χ^2 (N = 1581, df = 1) = 12.7, p < .0001, *Exp (B)* = .94]. Higher optimism was related to less likelihood to use medication. No other model reached significance.

Discussion

Among women in the childbearing year, higher reported optimism is related to lower reported PTSD symptoms, such that those women with trauma, but no PTSD, reported similar levels of optimism to women who had not experienced trauma. While the cross sectional nature of our design does not allow for cause and effect inference, this finding supports the assertion that certain patterns of thinking following trauma are related to maintenance of PTSD symptoms over time and increased incidence of PTSD. These thought patterns may represent either a preexisting protective factor that predates the trauma exposure or a response to trauma exposure. Of importance and consistent with previous studies, socioeconomic status appears to be the largest single contributor to increased PTSD severity and less helpful coping styles following trauma. Despite the large influence from SES, optimism also appears to influence the severity of PTSD and the use of more positive coping and less negative coping. Further, as evidenced in the minimal change in predictor contributions in the model steps, PTSD and optimism appear to account for independent variance in these coping and symptom outcomes suggesting that they are both important, non-overlapping factors influencing the use of these coping and symptom patterns.

In the model predicting PTSD severity (lifetime and current), SES and number of reported traumas significantly contributed to PTSD severity accounting for over 30% of the variance. However, reported optimism contributed a significant additional three percent of the variance in current and lifetime PTSD severity after accounting for these factors. This

influence appears to be specific to PTSD as the model predicting depression found minimal influence of number of traumas and optimism on increased depressive severity accounting for only two percent of the overall variance with optimism adding negligible variance. In addition, reported optimism contributed additional variance to the model predicting avoidance coping beyond that accounted for by SES and trauma count. While this contribution is significantly reduced when PTSD severity is added to the model, it remains a significant contributor with the model accounting for 11% of the overall variance in avoidance coping. Thus, women reporting more optimism reported less engagement in avoidance coping. With regard to active coping, the influence of optimism appears to be more significant. While SES and trauma count still account for the majority of the variance in active coping, optimism adds an additional 1% of the variance and remains a significant contributor to the model after PTSD severity is added. The model accounts for 13% of the overall variance in active coping. As such, while SES remains the largest contributor to the models beyond trauma exposure, optimism also contributes. Further, in the model examining somatization, optimism and PTSD severity mediate the relationship between SES and somatization. Thus, once PTSD severity and reported optimism are included in the model, the strong relationship between SES and somatization disappears.

Several caveats are evident in our study design. First, due to the collection of all data at a single time point, cause or effect is unknown. We cannot determine whether the levels of optimism reflect a predisposing PTSD vulnerability factor that was already apparent prior to trauma or if the optimism reported is a change that occurred as a result of trauma exposure. Further, research has supported that specific negative thoughts about the self and world are related to the development and maintenance of PTSD (Foa et al, 1999). Significant overlap between optimism and these previous constructs, such as negative thoughts about the self, which includes thoughts about ability to manage adversity, is apparent. The amount of relative overlap between optimism scales and these established cognitive predictors of PTSD is unknown. Finally, it is possible that the influence of SES on PTSD and optimism reflects a reality of living in areas of higher violence and lower opportunity.

Strengths of methods are also apparent. The large sample size and diverse ethnic and SES representation are strengths. In addition, comprehensive assessment of PTEs allows for a broad examination of the impact of these events. Comprehensive examination of optimism and coping in a large sample of women also provides a unique opportunity to examine reactions to PTEs.

With these caveats and strengths, the current study provides strong support for the role of socioeconomic status in the maintenance of PTSD following trauma exposure. The relationship holds for PTSD severity as well as for problematic coping styles. Those women reporting more SES risk factors (lower income, lower education, etc.) were more likely to report more severe PTSD and more likely to report less positive coping and more negative coping. In addition, the current study provides additional support that higher optimism is related to lower levels of PTSD, more use of active coping and less use of avoidance coping and less somatization. Together, these results suggest that examination of coping and low optimism may help to identify those women most likely to be dealing with significant PTSD symptoms. Identification of these women through non-invasive discussion may then allow

providers of prenatal care the opportunity to discuss the potential impact of PTSD and negative coping on the woman and the child and provide intervention or assistance to try to minimize its impact. Finally, continued examination of optimism and its possible role in resilience and problematic adjustment following trauma exposure is warranted. Such examination must include the use of truly prospective designs that follow high risk populations to obtain data on optimism prior to trauma as well as how it may or may not change following trauma exposure and finally how optimism is related to negative mental health outcomes.

Acknowledgments

Funding for this study was provided by a National Institute of Health grant to Dr. Seng, R01 NR008767.

Drs. Rauch's work was supported by the Department of Veteran Affairs, Veterans Health Administration, Office of Research and Development, Clinical Sciences Research and Development.

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Table 1

Regression analyses predicting mental health outcomes (N = 1581).

	B	SE	β	p	R^2Chg	F Chg	p
Current PTSD Severity							
Step 1							
SES	.45	.04	.26	<.001	.31	361.5	<.001
Trauma Count	.52	.02	.45	<.001			
Step 2							
SES	.39	.04	.22	<.001	.03	74.8	<.001
Trauma Count	.49	.02	.43	<.001			
Optimism	−.13	.02	−.18	<.001			
Lifetime PTSD Severity							
Step 1							
SES	.20	.05	.09	<.001	.36	450.7	<.001
Trauma Count	.90	.03	.58	<.001			
Step 2							
SES	.12	.05	.05	.01	.03	63.2	<.001
Trauma Count	.86	.03	.56	<.001			
Optimism	−.16	.02	−.17	<.001			
Current Depression Severity							
Step 1							
SES	.02	.01	.05	.06	.02	18.2	<.001
Trauma Count	.03	.01	.13	<.001			
Step 2							
SES	.01	.01	.04	.18	.004	6.3	.01
Trauma Count	.03	.01	.13	<.001			
Optimism	−.01	.004	−.06	.01			

Note. SES = Socioeconomic Status; PTSD = Posttraumatic stress disorder

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Table 2

Regression analyses predicting coping (N = 1581).

	B	SE	β	p	R^2Chg	F Chg	p
Avoidance Coping							
Step 1							
SES	−.14	.02	−.19	<.001	.09	76.7	<.001
Trauma Count	.13	.01	.26	<.001			
Step 2							
SES	−.16	.02	−.21	<.01	.01	12.4	<.001
Trauma Count	.13	.01	.25	<.001			
Optimism	−.03	.01	−.09	<.001			
Step 3							
SES	−.18	.02	−.24	<.001	.01	23.2	<.001
Trauma Count	.10	.01	.19	<.001			
Optimism	−.02	.01	−.06	.02			
Current PTSD	.06	.01	.14	<.001			
Active Coping							
Step 1							
SES	−.21	.02	−.32	<.001	.12	109.2	<.001
Trauma Count	.08	.01	.19	<.001			
Step 2							
SES	−.20	.02	−.31	<.001	.01	17.6	<.001
Trauma Count	.09	.01	.21	<.001			
Optimism	.03	.01	.10	<.001			
Step 3							
SES	−.21	.02	−.32	<.001	.004	6.9	.009
Trauma Count	.07	.01	.17	<.001			
Optimism	.03	.01	.12	<.001			
Current PTSD	.03	.01	.08	.009			
Mental Health Care							
Step 1							

	B	SE	β	p	R^2Chg	F Chg	p
SES	−.25	.02	−.35	<.001	.22	223.4	<.001
Trauma Count	.19	.01	.39	<.001			
Step 2							
SES	−.26	.02	−.36	<.001	.002	3.4	.07
Trauma Count	.18	.01	.38	<.001			
Optimism	−.01	.01	−.04	.07			
Step 3							
SES	−.27	.02	−.38	<.001	.005	10.1	.001
Trauma Count	.16	.01	.34	<.001			
Optimism	−.01	.01	−.03	.26			
Current PTSD	.04	.01	.09	.001			
Somatization							
Step 1							
SES	.15	.07	.05	.03	.17	162.7	<.001
Trauma Count	.80	.05	.40	<.001			
Step 2							
SES	.05	.07	.02	.49	.03	49.4	<.001
Trauma Count	.75	.05	.38	<.001			
Optimism	−.21	.03	−.16	<.001			
Step 3							
SES	−.14	.07	−.05	.05	.05	104.4	<.001
Trauma Count	.52	.05	.26	<.001			
Optimism	−.14	.03	−.11	<.001			
Current PTSD	.48	.05	.28	<.001			

Note. SES = Socioeconomic Status; PTSD = Posttraumatic stress disorder