Psychology 607 Trauma as Etiology
Class Discussion Notes
By Jessica Kieras and Bridget Klest
For 14 April 2003

Chronic Pain: The next frontier in child maltreatment research

by Kathleen Kendall-Tackett

- Pain is very common among abuse survivors
- Studying pain can help us understand the long-term effects of abuse
- Pain, depression, sleep disturbance often co-occur and are all related to serotonin
- Chronic pain patients heavily use the medical system
- Researchers should ask about pain throughout the lifespan

Physiological correlates of childhood abuse: Chronic hyperarousal in PTSD, Depression, and Irritable Bowel Syndrome

by Kathleen Kendall-Tackett

- Abuse and chronic medical conditions can be linked by looking at chronic hyperarousal

- PTSD: low cortisol, high norepinephrine

- MDD: high cortisol, low norepinephrine

- IBS: Pain associated with prefrontal activation

- Trauma may alter CNS including raphe nuclei and locus ceruleus

- Age of onset may play an important role in brain adaptations

Childhood abuse and later medical disorders in women

by Romans, Belaise, Martin, Morris, and Raffi

- Community sample of 354 New Zealand women

- Found links between abuse experiences and physical complaints

- Child sexual abuse: fatigue, athsma, cardiovascular problems
- Child physical abuse: chronic pain
- Adult sexual abuse: chronic fatigue, pelvic pain
- Adult physical abuse: chronic fatigue, pelvic pain, headache

- Many other links marginally significant

- No link found with IBS

- Community sample may differ from clinic sample

Zurbriggen & Freyd, in press.

Dissociation & Betrayal Trauma Theory

- Betrayal Trauma Theory
- Dissociative Tendencies
- Cognitive Environments
- Clinical Implications
- Dissociation Adaptive & Maladaptive

Possible Mediators Between Abuse and Risky Behavior

- Self-esteem
- Reality-Detecting Mechanisms
- Cheater Detectors
- Dissociation, Divided Attention, and Sex
- Damaged CSDMs

Feletti, 1991

- Study Group Participants: Persons who answered yes to: "Have you ever been raped or sexually molested" during a complete medical examination.
- Average time between abuse and evaluation: three decades
- 90% of Participants: First time ever discussed
- Most seemed grateful to discuss abuse
- 96% of Study group were female (males underreported?)

Abuse group shows more of:

- Depression (sleep disturbance, chronic fatigue, despondency, crying spells, attempted suicides, ECT, panic attacks)
- Obesity (more severe, more frequent)
- Doctor Office Visits
- Recurrent Gastrointestinal Distress (IBS most common)
- Chronic Headaches
- Asthma
- Augmentation Mammaplasty

Other Factors

- Extraordinary Degrees of Family Dysfunction

Worth Mentioning (this list *not* exhaustive)

- Questions about sexual abuse almost never before been asked
- In past psychiatric hospitalizations, abuse history had not surfaced
- Forced participation in a social taboo = loneliness, low self-esteem, not talking about the event

Fiction Reading Suggestion: She's Come Undone by Wally Lamb

1. Felitti says doctors should ask their patients about trauma history, and Kendall-Tackett says psychological researchers should ask their participants about pain. Should therapists ask their clients about physical health symptoms such as pain?

Yes—there is a strong mind/body connection.
Asking opens up this connection. Therapist could possibly provide some psycho-education on this topic—explain the function pain may serve.
It is sometimes easier to discuss somatic complaints rather than mental health, and this could help further the therapeutic relationship.
We should bridge the gap between physicians and mental health professionals.
If we do ask, it could be done during an intake interview/on an intake form.
Could be used to help facilitate deeper conversation between client and therapist.
However—the problem with a brief therapy model is that there is already so much to do is such a short time. It is possible that asking would bring up issues and leave them unresolved.
For kids and younger people, chronic pain may not be an issue, and may not be relevant.

2. Is there a difference between a somatization disorder and a physical disorder with a strong psychological component? Is every physical disorder with a psychological cause a somatization?

Most physical disorders have a psychological component, whether in the cause or the outcome.
Having a chronic medical condition can lead to psychological distress.
There is a strong link between the psychological and physical disorders and it may be difficult to tease apart.
In some cultures maybe this distinction isn't as strong.
Perhaps people who tend to rationalize and deal with things more cognitively than emotionally are also more likely to somatize.

3. How might culture play a role in the development and/or experience of chronic pain and chronic medical conditions?

It is important to think about how we are defining culture when we answer this question. For example, gender may be thought of as a cultural difference, and women may endure more pain while men may not be inclined to express pain.
Social class may play a role—upper/middle class have more access to services and meds, while lower classes may live with chronic medical conditions as a normal part of life.
Manifestations of trauma may be different in different cultures. For example, in some Asian cultures physical manifestations may be more likely than psychological.
Client/therapist relationships and the cultures of the client and therapist may play a role.
Treatment of medical conditions may be different in different cultures. For example acupuncture may have a psychological component as well as a physical component.

4. How can we distinguish between the attentional effects of dissociation and symptoms of ADHD in children? Are there ways that we can change our current educational system to better accommodate children who show attentional difficulties as a result of dissociation?

Kids with trauma history may not respond the same way to treatment.
Teacher training (but not holding teachers responsible for distinguishing between ADHD and dissociation).
District-level changes.
Biological distinction (attention systems being affected).
Maybe abuse causes ADHD.
Fatigue is associated with prefrontal activation which is associated with attention.
In ADHD there is a decrease in prefrontal activation.
Most if not all kids with ADHD have turbulent homes, some possibly just as a result of having a difficult child.
Perhaps addressing the symptoms is good enough, and distinguishing ADHD from dissociation is not important.
Rebuttal: It is important how we conceptualize the problem—in the child or in the child's environment—because otherwise we are neglecting a root cause of the problem.

5. In Felitti's study of people who had been raped or sexually molested, what sort of people should make up the control group?

In this study the control group consisted of people who answered "no" to the question that the experimental group answered "yes" to. The question was "have you ever been raped or sexually molested?"
It is likely that the control group included some false negatives.
However, this control group is pretty good for this study.
An alternative would be comparing people with sexual trauma and people with non-sexual trauma.

Discussion Questions (Set #2)

1.) Is it possible to provide people with the right medical treatment given our current health care system? If not, how should things change?

2.) Do different pathways lead to different illnesses?

3.) How can we determine the most effective treatment given that any given illness may have resulted from multiple different pathways?

4.) What are some problems in treating disorders that also serve as coping mechanisms?

5.) How could physicians refer patients to counseling without making the patient feel like their physical symptoms are being ignored?

Developmental Pathways From Childhood Trauma to Poor Physical Health

Jessica Kieras & Bridget Klest