

## Overview of the Consequences Trauma

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7 April 2003

## Long-Term Health Effects (Kendall-Tackett, 2000)

- ☞ ↑ Dr. visits, surgery, # symptoms
- ☞ Pain – ↓ threshold (depression controlled)
  - ↑ Headache, back, pelvic pain (↓ surgery success)
  - Fibromyalgia (= rates, but worse)
  - ↑ Irritable Bowel Syndrome

## Long-Term Health Effects (Kendall-Tackett, 2000)

- ☞ Why?
  - ↑ health compromising behaviors (risky sex, substances, eating, seat belt use)
  - ↑ depression (decreases immune system)
  - Self-fulfilling prophecy of poorer health perception (controlling for depression)

## Long-Term Health Effects (Kendall-Tackett, 2000)

- ☞ Timing – child vs. adult (no effect)
- ☞ *There don't seem to be any good studies about exact timing within childhood– somewhat of a new area; also hard to study accurately*
- ☞ Type – physical vs. sexual (no effect)
- ☞ Severity: ↑ overall severity is associated with ↑ problems
- ☞ Treatment implications: integrate mental and physical, Dr. should ask

## Turning Gold into Lead (Felitti, 2002)

- ☞ Huge Adverse Childhood Experiences (ACE) study
- ☞ ≈ 17,000 participants (middle aged, middle class, had insurance)
- ☞ Triggered by findings that for many people obesity not problem but solution

## Turning Gold into Lead (Felitti, 2002)

- ☞ 8 categories of adverse childhood experiences
- ☞ Assessed current and prospective health status
- ☞ Experiences:
  - Over 1/2 experienced 1+ adverse experience
  - Given exposure to 1, 80% chance of having experienced 2

## Turning Gold into Lead (Felitti, 2002)

### Findings:

- ↑ ACE score (0-8), ↑ likelihood of:
  - Smoking
  - Chronic obstructive pulmonary disease
  - Depression
  - Suicide attempts
  - Drug use
  - Other health problems (hepatitis, fractures, diabetes)
  - Self-medication

## Turning Gold into Lead (Felitti, 2002)

### Implications:

- General ignorance of common and destructive experiences
- Rather than focusing on primary prevention, we are currently trying to catch up far down stream and it's not working

## The Trauma Model (Ross, 2000)

### Discrepancies between teachings and observations

1. Comorbidity – polypharmacy (unsupported)
2. Single gene – single disease model (myth of young Johnny)
3. Lip service to bio-social interactions
4. Trauma irrelevant to treatment plan

## The Trauma Model (Ross, 2000)

### Assumptions:

1. Comorbidity is accompanied by high rates of chronic childhood trauma
2. Biology is not irrelevant – genome is dependent on environment
3. Trauma model is designed to be falsifiable – scientifically testable

## The Trauma Model (Ross, 2000)

4. Dissociation (observable phenomenon) is core feature of trauma response
5. Memories for traumatic and non-traumatic events can be true and/or false, recovered and/or continuously held (rather than theorizing, can study scientifically)

## Class discussion points:

*To what extent does it even matter how accurate a memory is? Maybe whatever memory is there is useful for prediction of psychopath. Perhaps CONTEXT is very important: it's therapeutically important to believe your clients, but research needs to corroborate memories as much as possible? Corroboration may also influence the memory itself. In other contexts, perhaps the important part is preventing the trauma in the first place. What effects does recovering a memory have – does it cause trouble or is it validating/useful? Both?*

## To Ask or Not to Ask?

(Read & Fraser, 1998)

- High prevalence of abuse among psychiatric patients when surveyed
- BUT low rates found in medical records
- Clients not asked directly

## To Ask or Not to Ask?

(Read & Fraser, 1998)

- EVEN when question included in admission form (form only used with half, and question only asked in 17/53)
- While overall prevalence = 32%, 82% in those asked
- Males and more severely disturbed may be less likely asked \*

## Class discussion points:

- Asking about trauma elicits a lot of narrative and possibly opens a can of worms. What do you then do with the information? Asking about trauma might also not be relevant to some doctors' views of psychopathology. There might be some tricky legal issues.*
- Shame/taboo/therapist's own history can affect whether and how to ask. Does it violate or validate to ask? Are traumatized people fragile victims or strong survivors? Which is more dangerous, asking or not asking? Perhaps mandated reporting is just an excuse in research settings.*
- Training is very important around issues of trauma. Therapist's gender could be important.*
- The book is not ideal.*

## To Ask or Not to Ask?

(Read & Fraser, 1998)

- Assumptions:
  - Crucial to diagnostic formulation
  - Important for treatment planning
- Considerations:
  - Method of inquiry
  - Preparation/debriefing for questioning

## Discussion topics:

- What are the benefits of ignoring trauma when it may underlie many different forms of psychopathology?
  - Hard to come up with reasons not to address traumatic experiences
  - May be beneficial to not focus on it at first, or when more pressing issues should be addressed first.
  - For clinicians: to avoid possibility of overemphasizing trauma
  - For clients: cultural issues of disclosure
  - Feasibility issues: limited/constrained therapy

## Discussion topics:

- How can we empirically study traumatic memories?
  - Retrospective self-reports
  - Using descriptive items rather than trauma/abuse labels
  - Prospectively – but having experienced acknowledged/corroborated trauma may influence memory for it
  - Implicitly (i.e., using Stroop tasks)
  - Does veracity matter? If experience is real/true to client, then maybe it should be addressed as such

### Discussion topics:

3. Is it fruitful to look into genetic bases of psychopathology?
- *No – next?*
  - *Genetic studies are correlational in nature, and it is extremely difficult (if not impossible with current methods) to disentangle environment from genetics*
  - *Rather than cause, genetic vulnerability may be more promising – but need to be cautious about victim blaming*
  - *Important to differentiate biological from genetic factors*
  - *Best approach is multidisciplinary – allow for different perspectives.*

### Discussion topics:

4. Discuss pros and cons of obtaining abuse history - how would you develop and implement abuse assessment?
- *Pros: conceptualizing symptomatology, treatment planning, research questions*
  - *Cons: more time, discomfort, need to establish rapport first*
  - *Possible areas of improvement: elaborations in SCID, options to pass (not answer question)*

### More in-class discussion:

*Although this class is about trauma as etiology, it's important not to STOP and think that the trauma is the answer to everything. If trauma is seen as the cause of everything, we might miss some real but subtle physical or psychological factors.*