Adverse Childhood Experiences, Trauma and Resilience – A brief introduction to trauma-informed approaches

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Defining Trauma

SAMHSA describes individual trauma as resulting from

"an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

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What is Trauma?

"Traumatisation occurs when both internal and external resources are inadequate to cope with external threat" – Bessel van der Kolk (1989)

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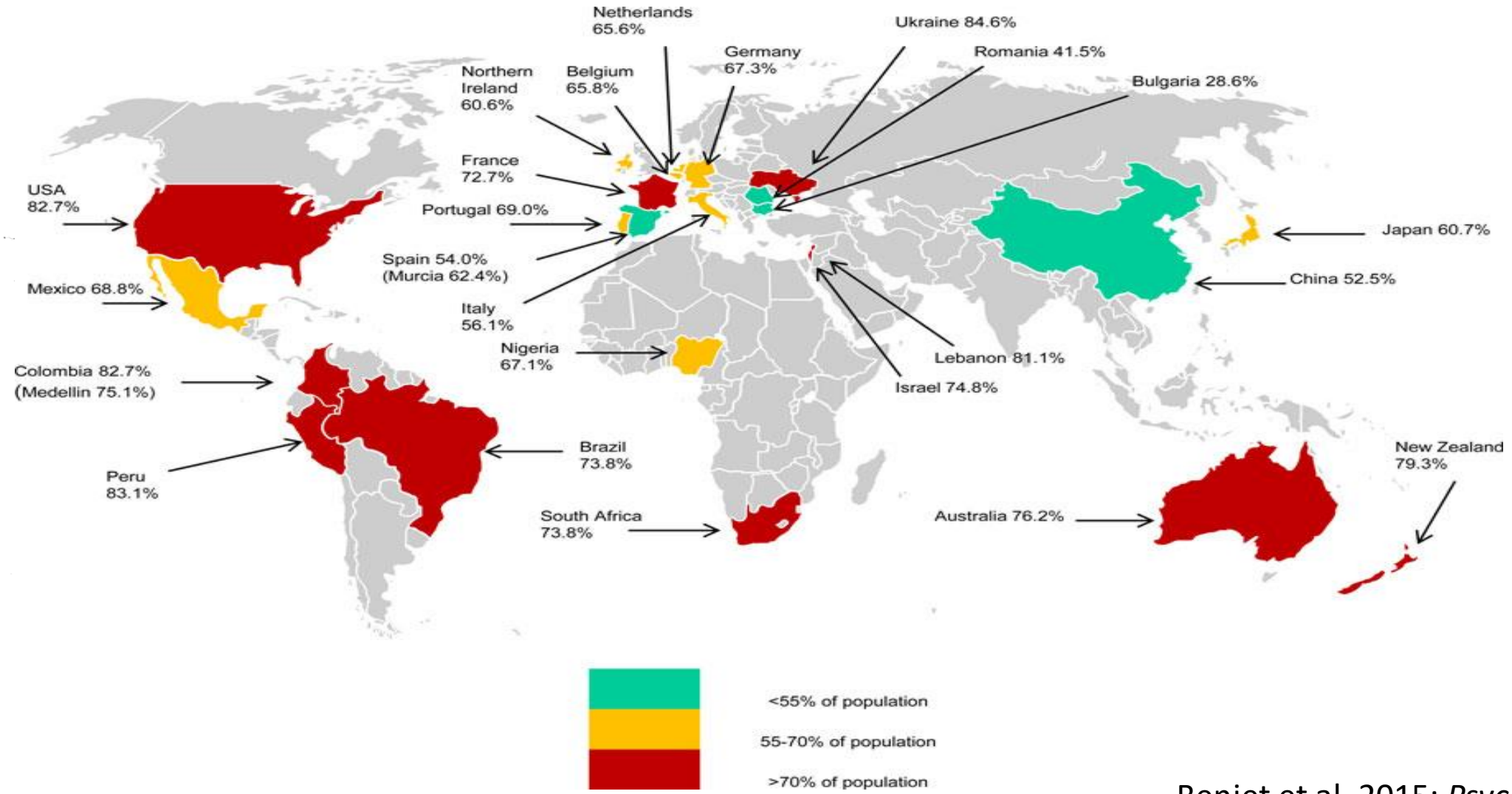
How common are traumatic experiences?



Benjet et al. 2015; *Psychological Medicine*

Adverse Childhood Experiences - (*Developmental Trauma*)

- Physical abuse
- Sexual Abuse
- Emotional Abuse
- Living with someone who abused drugs
- Living with someone who abused alcohol
- Exposure to domestic violence
- Living with someone who was incarcerated
- Living with someone with serious mental illness
- Parental loss through divorce, death or abandonment
- Neglect

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Adverse Childhood Experiences – key findings

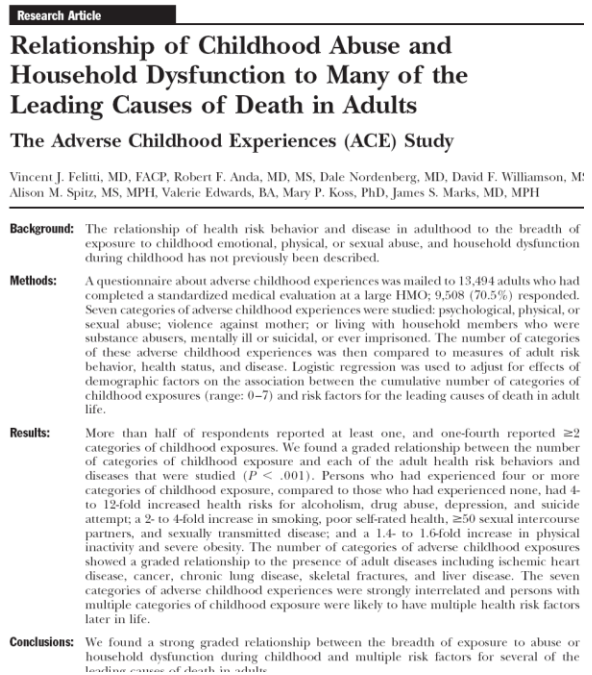
1. **In the English National ACE study, nearly half (47%) of individuals experienced at least one ACE with 9% of the population having 4+ ACES**
   (Bellis et al 2014.)

2. **There is a strong and proportionate (dose-response) relationship between ACE and the risk of developing poor physical health, mental health and social outcomes**
   (Skehan et al 2008; Kessler et al, 2010; Varese et al 2013; Felitti & Anda, 2014.)

3. ACEs increase the risk of adult-onset chronic diseases, such as cancer and heart disease, as well as increasing the risk of mental illness, violence and becoming a victim of violence

4. ACEs are associated with poor educational outcomes, increased utilization of health care, emergency response, mental health services and criminal justice involvement

5. Adverse Childhood Experiences are unfortunately common yet **rarely asked about in routine practice** (Felitti et al.,1998, 2019; Read et al 2007.)



Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS
Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

Background: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0–7) and risk factors for the leading causes of death in adult life.

Results: More than half of respondents reported at least one, and one-fourth reported ≥2 categories of childhood exposures. We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ($P < .001$). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the

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Health & Financial Burden of Adverse Childhood Experiences in England & Wales

Open access Original research

BMJ Open

Health and financial burden of adverse childhood experiences in England and Wales: a combined primary data study of five surveys

Karen Hughes ,[1,2] Kat Ford,[3] Rajendra Kadel,[1] Catherine A Sharp,[3] Mark A Bellis[1,2]

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ABSTRACT

Objective To estimate the health and financial burden of adverse childhood experiences (ACEs) in England and Wales.

Design The study combined data from five randomly stratified cross-sectional ACE studies. Population attributable fractions (PAFs) were calculated for major health risks and causes of ill health and applied to disability adjusted life years (DALYs), with financial costs estimated using a modified human capital method.

Setting Households in England and Wales.

Participants 15 285 residents aged 18–69.

Outcome measures The outcome measures were PAFs for single (1 ACE) and multiple (2–3 and ≥4 ACEs) ACE exposure categories for four health risks (smoking, alcohol use, drug use, high body mass index) and nine causes of ill health (cancer, type 2 diabetes, heart disease, respiratory disease, stroke, violence, anxiety, depression, other mental illness); and annual estimated DALYs and financial costs attributable to ACEs.

Results Cumulative relationships were found between ACEs and risks of all outcomes. For health risks, PAFs for ACEs were highest for drug use (Wales 58.8%, England 52.6%), although ACE-attributable smoking had the highest estimated costs (England and Wales, £7.8 billion). For causes of ill health, PAFs for ACEs were highest for violence (Wales 48.9%, England 43.4%) and mental illness (ranging from 29.1% for anxiety in England to 49.7% for other mental

Strengths and limitations of this study

- Adverse childhood experiences (ACEs) are known to increase individuals' risks of poor health across the life course, yet the financial burden they impose on national economies is largely unmeasured.
- We combined primary data on ACEs and 13 health outcomes from five general population ACE surveys undertaken in England and Wales.
- For each outcome, we generated population attributable fractions for cumulative ACE exposure and applied these to disability adjusted life years, which in turn allowed calculation of financial burden of ACEs using a modified human capital approach.
- ACE data were retrospectively reported and may be affected by recall bias, while general household surveys by their nature are likely to exclude those that have suffered the greatest impact of ACEs (eg, homelessness, incarceration or premature death).
- Although many major health outcomes were included in the study, data are not yet available on all health outcomes potentially associated with ACEs and financial estimates are likely to be conservative.

behaviours and the development of mental and physical illness has burgeoned in recent

We need a public health approach preventing & addressing the impact of childhood adversity

- Multiple Public Health Organisations have reviewed the evidence for 'what works' and agree that in order to transform the health and wellbeing of future generations

- We can and must:
- a) **Prevent** adverse childhood experiences (ACEs)
- b) **Support** child and family wellbeing/ parenting
- c) **Detect and mitigate** the impact of Trauma & Adversity
- d) **Promote resilience** across the life course

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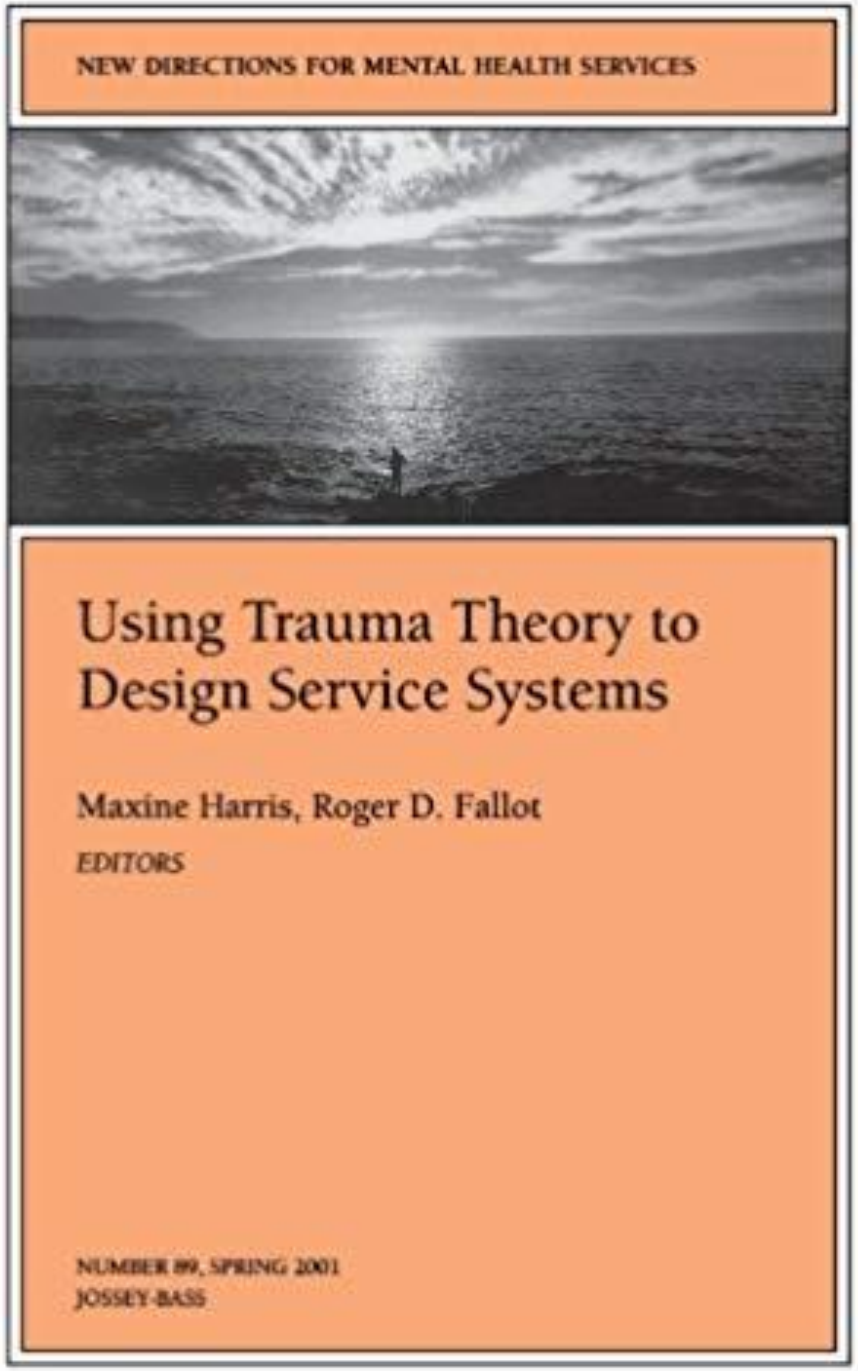

The 4 R's – of Trauma Informed Care

- A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**. (SAMHSA, 2014)

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SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Sensitivity to Cultural, Historical, and Gender Issues

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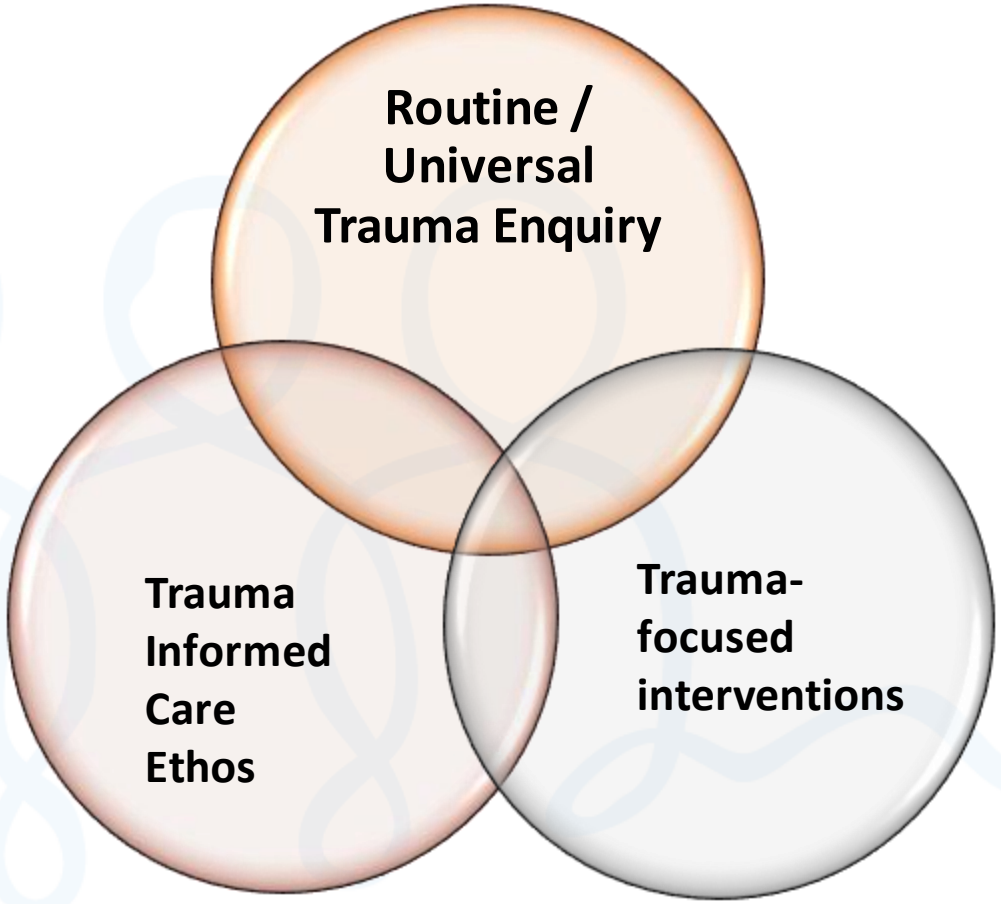
The 3 Pillars of Trauma-Informed Services



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Waiting to be told doesn't work!

The cost of delayed disclosure

The average time span for disclosure from the start of abuse in our 2018 study.

NB: the youngest four survivors (aged between 19-24 years) had disclosed 7-11 years after the onset of abuse.

Focus on Survivors, 2018

Denial, Disbelief and Delays (2023)

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What helps children tell/report abuse?

1. Recognising that it isn't normal
2. Inability to cope with the emotional distress
3. Wanting something to be done about it
4. Access to a trusted person (adult)
5. Expecting to be believed
6. BEING ASKED!!!

(Brennan & McElvaney, 2020 – A qualitative meta-analysis of studies conducted between 1998 and 2018)

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REACh Training (Routine Enquiry about Adversity in Childhood) **Key Findings** (2015-2022)

- REACh **training increases confidence** for staff
- Routine Enquiry is **acceptable** to service users **across settings**
- People can access **the right help sooner**
- Children & vulnerable adults are **protected from ongoing harm**
- Service users show **increased motivation** to make **positive life changes**
- **Parents** have report that they have **considered the impact of their own childhood** experiences **in relation to parenting their own children**

(Real Life Research 2015; McGee et al, 2015; Simpson-Adkins et al (2015); Hardcastle & Bellis 2018; Pearce et al, (2019); Better Start Blackpool, 2020; Quigg et al, 2022)

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Resilience

Resilience is “the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress.”(APA, 2014)

Biological, psychological, social and cultural factors interact with one another to determine how a person reacts to stressful life events.

Changes over time and according to context

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Having some resilience resources more than halved risks of current mental illness in those with 4+ ACEs

Childhood resilience resources

Percent with current mental illness

Childhood resilience[b]

Low 29% | High 14%

Trusted adult relationship

Never 28% | Always 19%

Regular sports participation

No 25% | Yes 19%

Adult resilience resources

Percent with current mental illness

Adult resilience[b]

Low 37% | High 13%

Perceived financial security

<1 month 35% | 5+ years 11%

Community engagement[c]

No 23% | Yes 11%

The Solution….

- **Cross-sector commitment** to trauma-informed & prevention focused practice
- **Training to increase awareness** of ACEs, trauma-informed practice and resilience science should be mandatory across sectors
- **Educate parents & carers** about child brain development, parenting and the impact of ACEs and toxic stress
- **Train professionals to ask about Adverse Childhood Experiences** (ACEs) & to respond therapeutically and to coordinate care
- **Ensure every child has positive relationships & social support** - which are the best predictors of lifelong health and happiness, resilience and recovery from trauma

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Thank you…

- Thank you for your contributions!
- Is everyone ok?
- Please reach out if you want to discuss anything:
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