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When Time Doesn't Heal All Wounds

Adverse Childhood Experiences and Behavioral Health

An emerging issue in the healthcare field concerns the impact of "Adverse Childhood Experiences" (ACE) on chronic health problems and early mortality. Based on research from Kaiser Permanente and the Centers for Disease Control and Prevention (CDC), there appears to be a linear correlation between nine specific traumatic events and increased incidence of heart disease, diabetes, early onset drinking, high-risk sex, and other risk factors for early death.

The Adverse Childhood Experiences survey was conducted by Kaiser Permanente, and perused the childhood experiences of over 17,000 adult HMO patients seeking routine medical services (Felitti, 2004). These patients were over 50 years old, and not seeking behavioral health treatment, but were dealing with medical challenges such as diabetes, chronic obstructive pulmonary disease (COPD), and obesity. The impetus for the study was the observation that, when patients in the obesity program began successfully losing weight, a large proportion of them inexplicably dropped out of treatment. This phenomenon is familiar to any addiction counselor who has watched their client "snatch defeat from the jaws of victory."

Felitti and his colleagues came to the realization that obviously destructive adult medical conditions can be understood as maladaptive efforts to manage childhood trauma. Again, no surprise to any mental health clinician. What is unique—and promising—is the discovery of an almost linear progression between the childhood "trauma dose" and adult addictions to alcohol, nicotine and IV drugs as well as other chronic disease processes.

The ACEs Survey adapted by the author examines 10 categories of childhood experiences: emotional, physical and sexual abuse, emotional and physical neglect, substance abuse or mental illness in the home, parental violence, incarceration of a household member, and both biological parents not being present. Each category is scored "1" if present or "0" if absent before age 12. The working hypothesis for this age cut-off is that children lack both the cognitive and developmental coping skills to reframe and deal with traumatic experiences, leaving them more vulnerable to the trauma

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response. The simple scoring method results in a "trauma load" of zero to ten. This version of the ACEs Survey also examines the client's assessment of the current impact of the trauma: lifetime hospitalizations, suicide attempts, treatment for mental health and substance use disorders.

Questionnaire Results as Conversation-Starter

So how does this inform our treatment? Clearly we can't go back and provide corrective childhood experiences for adult clients. Bruce Johnson, LCSW has been using the ACEs Survey with his clients at the Crisis Respite Center of the Yukon-Kuskokwim Health Corporation in Bethel, AK. A recent two-month sample of 13 intakes revealed an average ACEs score of 4.6. Five respondents had scores of 5 or above, and three clients endorsed 9 ACEs. Johnson is investigating the correlation between ACE score and re-admissions to emergency psychiatric care. "The main value of the questionnaire is to open a conversation with the client—helping them see there are reasons for the subconscious responses they make today based on what happened long ago," Johnson explains. It tends to normalize an abnormal experience when the client realizes that they aren't the only person these things have happened to—indeed, they are tragically common.

Mary Johnson, Coordinator of the Suicide Prevention Program for YKHC, has found similar results in a voluntary sample of community members attending an open workshop on Healthy Parenting. Of 45 respondents, 69% had an ACE score of at least 4, and 40% reported a 7 or higher. The most common ACEs: growing up with a substance abuser (76%), living with someone who was mentally ill or attempted suicide (67%), a family member who went to prison (64%), and emotional abuse (60%).

A more recent sample from MH Screenings of referrals to the Lutheran Community Services Drug Court Program reveals a similar profile. Most of the referrals to the program are for methamphetamine-related disorders; some of the clients are from third-generation meth impacted family system, i.e. both the client's parent(s) and grandparent(s) were involved with meth. The author is in the process of analyzing two years' worth of data; initial review indicates an average ACE trauma score of 5.1 for 62 respondents. There is a high incidence of emotional and physical neglect, domestic violence and sexual abuse in this sample.

Selecting Appropriate Tools to Regulate Response

What treatment interventions might be helpful in dealing with ACEs? Current research is focused on the hypothesis that repeated trauma somehow resets the baseline of autonomic arousal in the developing central nervous system (ANS). The earlier—and more frequently—this happens, the more robust and long-lasting this ANS hyper-arousal becomes. It's like having your foot on the gas all the time, and working the clutch and brake with your other foot—a rough and bumpy ride that will prematurely wear out your engine, clutch and brake...and probably cause some accidents along the way!

Clinicians know how intractable these trauma effects can be—perhaps because we have been using *psychological* tools to fix a *physiological* problem. Insight alone can do little to mediate a hard-wired, unconscious hyper-arousal, which has been the "new normal" for many years. This suggests that interventions helping to down-regulate the sympathetic ANS (e.g. visualization, breath work, meditation, Tai Chi) may help to reset the client's baseline arousal, and give them tools to use to manage both emotional and physiological stress. Perhaps the use of medications to lower physiological arousal (e.g. propranolol) as an adjunct to psychotropics might be explored. Clinicians should be aware that clients may find this new and lower set-point to be paradoxically uncomfortable. We need to educate and support our clients as they forge a "new normal" for themselves.

Various forms of the ACEs Questionnaire are available on the Web. Clinicians are encouraged to explore this emerging awareness of ACEs with their clients, and help bring truth to the saying "It's never too late to have a happy (er) childhood."▼

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Reference:

Felitti, V.J. (2004). *Origins of addiction: evidence from the Adverse Childhood Experiences study.* San Diego, CA: Kaiser Permanente Medical Care Program.