Adverse Childhood Experiences and Trauma

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Trauma is any event, usually a non-ordinary one, that harms the body, self, or spirit. It covers a broad range of hurtful experiences, including traumas that involve the physical, sexual, mental, or emotional realms of our being.[1,2] In their article in this issue, Felitti et al.[3] report various common and less common kinds of trauma that occur regularly in this and other countries today. They call these traumas *adverse childhood experiences* (ACEs).

Until recently, medicine has focused mostly on physical trauma, which many physicians, nurses, and allied health professionals think is the only kind. But the field of trauma psychology has been developing for the past century. We first learned of it from Janet, Breuer, and Freud, and later from numerous observers of combat trauma.[2,4] More recently, we have begun to fine-tune our knowledge by observing different kinds of trauma, from physical violence to child sexual abuse to growing up in an alcoholic or other dysfunctional family.[1,5]

If the trauma is accepted as real and the victim's or survivor's experience is validated and its expression supported, as happened in the Oklahoma City bombing incident, its short-term effects, also know as acute traumatic stress (American Psychiatric Association, 1994), can be expressed, processed, ameliorated, or "metabolized" in a healthy way so that eventually few or no lasting detrimental effects remain.[5] However, if the reality of the traumatic experience is denied or invalidated by the victim, or by close or important others, such as family, friends, or helping professionals, then the person may not be able to heal completely from the adverse effects of the trauma. If the trauma continues, with still no validation and support in expressing its associated pain, it may develop into post-traumatic stress disorder (PTSD), which Rowan and Foy[6] and others believe is a core disorder among unrecovered survivors of trauma.

To heal from trauma, the experiencer has to be able to grieve the associated pain. To grieve, the person must remember the trauma well enough to name it accurately (for example, "I was mugged or beaten up on the street last night.") Thus, remembering is a key to resolving the effects of the trauma.[2,5] But remembering and grieving a past trauma may be difficult, since there are often roadblocks from others.

For example, most of us tend not to believe that a parent or other close person could or even would abuse or neglect their own child or a child relative. Perhaps this is one explanation for the plethora of disbelief and support in our national media and court system in favor of those accused of molesting or otherwise abusing their child or others close to them.[2,7,8] But we know that over 90% of child abusers know the child well before they abuse them, and that most are related to them. Those others in the family or community who choose not to intervene to stop the abuse can be called *co-abusers* or *co-offenders*.[2] Indeed, there are lay advocacy groups in this country and abroad that claim to protect the "falsely accused," and some have even raised the possibility that they may in fact be a front for many actual child molesters.[2] Some of us may unknowingly assist or enable abusers, as painful as this may be to contemplate.

The Felitti et al.[3] study found that the second most common ACE or trauma was overt child sexual abuse, reported in 22% of the 9,508 adults whom they medically evaluated. For the past few years some of their accused child molesters have cried "false memory" when their victims have finally recovered and disclosed their ACEs to others. We know that child molesters usually try to silence their victims by threats of violence or major loss, and that as a result most of these victims do not talk of their adverse experience to others. We also know that PTSD is likely to be their core disorder,[6] and that traumatic amnesia is common among people with PTSD, no matter what their major trauma may have been. So we have to consider that some of the people whom we survey or from whom we've taken a history regarding childhood sexual abuse or any other trauma may have traumatic amnesia and not be able to recall their specific adverse childhood experience.[2,9–11] Thus, the Felitti et al.[3] findings probably underestimate the magnitude of some of the reported ACEs as trauma in their survey population. In addition, their figures do not include higher risk populations such as patients attending psychiatric clinics and in psychiatric hospitals and institutions, prisons, the homeless, and others who

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have a very high rate of child abuse and neglect in their histories.

In Figure 2 of the Felitti et al.[3] article, ACEs or childhood traumas are shown to be the basis of these 9,508 people's impairment, high-risk behaviors, disorders and disease, and likely early death if they do not change these behaviors. From observing trauma survivors clinically, I and others have noticed and reported that they tend to have a variety of disorders or diseases at a prevalence that is higher than the general population.[9,10] These disorders and conditions read almost like the DSM-IV, and include: addictions (alcoholism, other chemical dependence, eating disorders, relationship, and sexual addictions), dissociative disorders, including dissociative identity disorder (formerly MPD), depression and suicide attempts, borderline personality disorder, somatization disorder, psychosis, PTSD, self-harming behaviors, violent behaviors, prostitution, and pedophilia. Thus, in addition to being frequent among general medical populations, trauma survivors are often found in psychiatric and psychological outpatient clinics and practices, as well as in inpatient psychiatric settings in a high frequency; it has been reported that from 50% to 70% of the patients in these settings are trauma survivors.[9,10]

These diagnoses and their potential causal connection to childhood trauma require skillful history taking that often goes back decades and deals with painful material for the patient to disclose and the clinician to hear. On the other hand, physicians, nurses, and some allied health professionals all once were revulsed by seeing blood or exposure to internal organs and, with time and learning appropriate clinical skills, adjusted to it. Now it is time for the general medical and public health communities to begin to directly address the occurrence of ACEs and their long-term effects, rather than relegating this responsibility to social services, psychiatrists, psychologists, and trauma specialists. The number of these latter specialists is far too small to treat the large numbers of trauma survivors as evidenced from the ACE study data.

Unrecovered trauma survivors also tend to exhibit high-risk behaviors, as shown in Tables 4–6 and Figure 2, some of which are related to the above disorders, such as excessive risk-taking, tobacco, alcohol and other drug use, illegal and injected drug use, promiscuity, and a variety of other harmful and/or unusual behaviors. One way of understanding these coping behaviors constructively from a perspective of trauma psychology is to view them as being *re-enactments* of their original traumas, also called repetition compulsions by psychoanalysts. By engaging in these high-risk behaviors, the trauma survivor is not simply acting "crazy" or "antisocially," but is rather unconsciously re-enacting aspects of their original trauma in order to master it and in hopes of eventually healing from it. When I and other trauma specialists offer this as a possibility to our patients, they are often eventually able to re-frame their otherwise "crazy" behavior into a dynamic that now makes experiential and cognitive sense to them. Some are even able to see that many of these behaviors represent strategies for surviving the trauma of family and community dysfunctions. As a result, they are frequently able to focus more on their past traumatic experience, name it more accurately, and eventually grieve from its painful effects.[2,12]

When health professionals make these kinds of observations and diagnoses in some of their patients, they can lead to a more accurate assessment of the origin and dynamics of the patient's symptoms, signs, and problems, which may include a history of one or more ACEs. This kind of clinical detective work can at times be analogous to what lawyers call circumstantial evidence, as opposed to *direct* evidence, which, as the California jury instructions read, "proves a fact without an inference, and, if true, conclusively establishes the fact. [By contrast] . . . *Circumstantial* evidence proves a fact from which an inference of the existence of another fact may be drawn. The law makes no distinction between direct and circumstantial evidence as to the degree of proof. Each is respected for such convincing force as it may carry" (author's emphasis).[13]

The Felitti et al.[3] study and others like it[14,15] provide more of both direct and circumstantial evidence to me that a substantial portion of medical and psychological illness may be in large part trauma-based. If this is true, then health professionals and HMOs allowing people to work to identify, name, and grieve their past traumas would likely contribute to their ability to heal from some of their trauma-associated diseases, disorders, and problems, thereby lessening the impact of these associated illnesses and problems and the ultimate higher dollar cost of not treating them in this way.

Felitti et al.[3] and others[14,15] have also shown that common organic diseases often have their origins not merely in childhood, but in the unprocessed traumatic emotional experiences of childhood. How this unhealed grief translates into organic disease is in large part the result of the various behavioral coping mechanisms put into play to gain relief: smoking, excess drinking, drugs, promiscuity, overeating, toxic relationships, and violence. These self-medicating mechanisms usually work to some degree for a time, and their risks seem so remote, that they are indeed seductive when the need for relief is acute. It is not surprising that ACEs have prominent long-term psychological effects. What is unexpected is that adverse experiences of childhood should be associated with common organic diseases, decades later.

Over the past 30 years grassroots Twelve Step self-help recovery fellowships such as AA, Al-Anon, Adult Children of Alcoholics, and Co-dependents Anony-

mous have noticed some of these ACEs and many of their connections. These inexpensive but effective groups have been a part of the recovery movement of the 1980s and 1990s. Many of their members have also taken advantage of using bibliotherapy in the form of selected self-help books that simplify some of the more effective principles of psychology and recovery.

The Twelve Steps of AA, now used by over 100 other self-help fellowships, from Smokers Anonymous to Overeaters Anonymous have added a spiritual dimension to recovery. This addition has resulted in such success that some have suggested that we expand George Engel's whole person observation of bio-psycho-social to bio-psycho-social-spiritual. By using the term spiritual I am not referring to organized religion. Rather, I begin to define spirituality as having to do with the deeper dimensions of our relationships with self, others, and the Universe (Higher Power, God, or whatever term is most comfortable for the individual).

These grassroots self-help fellowships and other recovery aids have also assisted countless health professionals, many of whom have a personal history of one or more ACEs or traumas, in working an effective program of their own recovery. In doing so they have gone beyond the more conventional limitations of medicine, psychiatry, and psychology with such success that even a CEO of a managed care company might approve. These now-recovered health professionals in turn are able to offer their own patients and clients a wider range of therapeutic choices to employ in their recovery work. By so doing, they are expanding and improving the standard of care for many of their patients.

Given the above overview, how can we prevent ACEs from afflicting people so adversely as Felitti et al.[3] show in the data and figure 2 of their article? The answer to this crucial question may be limited only by our own creativity. Some examples follow. First, health professional organizations might consider addressing the physical and mental health of their members, including their recovery from the harmful effects of any ACEs. Second, other journals might consider and encourage more basic and clinical research on trauma for publication. Third, HMO and managed care companies should pay for appropriate short- and long-term treatment of the adverse effects of ACEs in trauma survivors, which would likely save them money in the long run. Also, every training program for health professionals should include information about the effects of trauma, such as child abuse or other ACEs, how to ask about them, and what to do with a patient who has experienced such trauma.

Fourth, we should stop treating our children as though they were our property. We should treat them with compassion and love, not with shame and fear. More effective parenting programs have been available for several decades, such as the work of Thomas Gordon[16] and Haim Ginott.[17] We should be teaching these skills in our schools. Some communities have had excellent results in eliminating child abuse and neglect by establishing parenting centers that visit every new parent and child weekly for the first 2 years.[18] The training of every health professional should include the recognition of ACEs and techniques to treat their long-term effects. Fifth, we should give more monetary and political support to organizations that work to prevent child abuse, such as child abuse councils and child protective services. We should look to selected national and state organizations for training and guidance.* Finally, we should support such groups as the Alliance for Children and Healthy Families America, which are working creatively to improve parenting and child rearing and prevent child maltreatment.[18] Federal organizations could also increase their efforts and funding to improve the health and well-being of children.

In all our history, ours is the first generation to recognize the ravages of child abuse and neglect and begin to do something about it. We are also the first generation to begin to heal ourselves physically and psychologically from the harmful effects of ACEs. Through trial and error and research like that of Felitti et al.[13] and its publication and then wider dissemination to the public, we can constructively apply our new knowledge and skill to our children. Some have suggested[19] that if we would raise one generation of healthy children we could go far in eradicating social violence, war, and many other problems of our world. Through research like that of Felitti and colleagues we can develop important new knowledge that, if put to use, promises to foster future generations of healthy children, healthy adults, and healthy societies.

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*Some examples of such organizations include the American Professional Society on the Abuse of Children (APSAC), the American Coalition for Abuse Awareness (ACAA)/One Voice, the International Society for Traumatic Stress Studies (ISTSS), the International Society for the Study of Dissociation (ISSD), the National Center for Prosecution of Child Abuse, and the Sidran Foundation in Baltimore.

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