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## ADVERSE CHILDHOOD EXPERIENCES: A PUBLIC HEALTH NIGHTMARE

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One sobering illustration of the enormity of this public health problem posed by exposure to toxic stress comes from the “Adverse Childhood Experiences Study” done by Kaiser Permanente in San Diego and the Centers for Disease Control in Atlanta, Georgia (Felitti, Anda et al. 1998; Dietz, Spitz et al. 1999; Dube, Anda et al. 2001; Dube, Anda et al. 2001; Dube, Anda et al. 2002; Edwards, Holden et al. 2003; Edwards, Anda et al. 2004). The purpose of the study was to examine the impact of exposure to toxic levels of stress across the lifespan. So far, this is the largest study of its kind to examine the long-term health and social effects of adverse childhood experiences and included almost 18,000 participants. The researchers asked these willing participants – all who were members of the Kaiser HMO in San Diego – if they would take a survey. The majority of those who participated were Caucasian, fifty years of age or older, and were well-educated, representing a solidly white, middle-class population.

An adversity score or “ACEs” score was calculated by simply adding up the number of categories of exposure to a variety of childhood adversities that the person had experienced before the age of eighteen. These categories included: severe physical or emotional abuse; contact sexual abuse; severe emotional or physical neglect; living as a child with a household member who was: mentally ill, imprisoned, a substance abuser; or living with your mother who was being victimized by domestic violence; or parental separation/divorce. So, for example a client comes for treatment or for some kind of help, and you find out that she was sexually abused by an uncle as a child, her parents were divorced, her mother was hospitalized for depression, and her father drank heavily and used drugs. Her ACE score would be at least “4” – one each for sexual abuse, parental divorce, mental illness in her mother and substance abuse in her father. Or, a client tells you that his father spent time in prison when he was growing up, his mother was a drug addict and neglected him, and his stepfather beat him. His ACE score would be five – score 1 for living with someone as a child who was in prison, another for his mother’s drug addiction, one each for emotional and physical neglect, and one for physical abuse.

Of this largely white, middle-class, older population, almost two-thirds of the participants had an ACEs score of one or more, while one in five was exposed to three or more categories of adverse childhood experience (Centers for Disease Control and Prevention 2006). Two-thirds of the women in the study reported at least one childhood experience involving abuse, violence or family strife. Once they had gathered this data, the researchers compared the ACEs score to each person’s medical, mental health, and social health data. What they found was startling and very disturbing. The higher the ACE score, the more likely a person was to suffer

from: smoking, chronic obstructive pulmonary disease, hepatitis, heart disease, fractures, diabetes, obesity, alcoholism, intravenous drug use, depression and attempted suicide, teen pregnancy, sexually transmitted diseases, poor occupational health and poor job performance (Middlebrooks and Audage 2008). Worse yet, the higher the ACE score, the more likely people were to have a number of these conditions interacting with each other. In other words, the higher the ACE score, the greater the impact on a person's physical, emotional and social health.

According to the study findings, if you are a woman and have adverse childhood experiences your likelihood of being a victim of domestic violence and rape steadily increases as the ACEs score rises and if you are a man, your risk of being a domestic violence perpetrator also rises. The study showed that adverse childhood experiences are surprisingly common, although typically concealed and unrecognized and that ACEs still have a profound effect 50 years later, although now transformed from psychosocial experience into organic disease, social malfunction, and mental illness. The authors of the study concluded that *"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 leading causes of death in adults (p.245)* (Felitti, Anda et al. 1998).

A replication of the Adverse Childhood Experiences Study has not yet been attempted, one that would take into account, for example, the other kinds of exposure that inner city children have, besides the existing categories of adversity or whether there is any cross-cultural similarities. We do know however, that many children who live in conditions of urban poverty, are exposed to dreadful experiences. Surveys done in Detroit, Chicago, Los Angeles, and New Orleans suggest that about a quarter of youth surveyed had witnessed someone shot and or killed during their lifetime (Bell and Jenkins 1993; Groves B, Zuckerman B et al. 1993; Osofsky, Wewers et al. 1993; Richters and Martinez 1993). Among children at a pediatric clinic in Boston, 1 out of every 10 children witnessed a shooting or stabbing before the age of 6 (Groves, Zuckerman B et al. 1993). Another group of researchers showed in a 1998 study of 349 low-income black urban children (ages nine to fifteen), that those who witnessed or were victims of violence showed symptoms of posttraumatic stress disorder similar to those of soldiers coming back from war (Li, Howard et al. 1998). We have not even begun to reckon with the long-term public health effects of this kind of violence exposure, nor that in less than twenty years, the number of children with incarcerated parents has increased by 80% (Glaze and Maruschak 2008). We have not yet begun to reckon with the fact that one in six black men, as of 2001, had been incarcerated and that if current trends continue, one in three black males born today can expect to spend time in prison during his lifetime (Mauer and King 2007).

So how fit is our human service delivery system to respond to the overwhelming needs facing it? Not very fit at all. But it gets even more complicated. Remember, the people studied in the Adverse Childhood Experiences Study were fifty or older when the study was done in the 1990's. They are now reaching retirement age, so the exposure of children to adversity is not new and cannot be blamed on recent cultural changes. These are people who are in the workforce, who are making the policies, and directing organizations. These are the judges, the police officers, the hospital administrators, the social workers, the Congressmen and women. Many people who are drawn to a social service environment have experienced overwhelming adversity themselves so let's look at that for a moment.

# Adverse Childhood Experiences and the Workforce Crisis

Given the rate of exposure to adverse childhood experiences in the general population many of us who work in health care, mental health, child welfare, housing and other human services are consumers of those services from time to time. And even if we haven't sought formal assistance, people who work in the social service field are if anything, more likely to have suffered from childhood adversity. Many people go into this work as a helping professional because of their own struggles with loss and injury.

Several years ago we did a very simple survey of the residential staff at Andrus and found that over 80% of the staff had suffered some form of childhood adversity. In our various training experiences, several of our faculty have asked the participants of the Sanctuary Institute trainings (anonymously of course) about their own experiences of childhood adversity as defined in the ACEs Study. Out of three hundred and fifty human service workers with a wide variety of experience, training and professional education, 37% said they had been psychologically abused by their parents and 29% said they had been physically abused. When asked about neglect, 35% of them said they had been emotionally neglected while 12% said they had been physically neglected. A quarter of those surveyed said they had been sexually molested while they were still children. An astonishing 40% said that as children they had lived with someone who was a substance abuser while 41% of them came from broken homes. Over a fifth of them had witnessed domestic violence as children, while 10% of them grew up in households where someone was in prison.

This does not suggest that these social service workers are ill equipped to do their jobs, but it might suggest that they, like our consumers, might be prone to having reactions to stress not unlike the clients that they serve. Add to this the reality that the work in residential care and virtually all social service settings is routinely stressful and it is not always clear who is triggering who when we unpack incidents. Making the assumption that the consumers are the most volatile ingredient in these situations is often wishful thinking.

The issue of childhood adversity is tied to the workforce crisis in social services. There is serious concern for the future in terms of social policy and the impact of exposure to adversity on a significant number of the workforce as discussed in an article published in the Proceedings of the National Academy of Science:

*“A growing proportion of the U.S. workforce will have been raised in disadvantaged environments that are associated with relatively high proportions of individuals with diminished cognitive and social skills. A cross-disciplinary examination of research in economics, developmental psychology, and neurobiology reveals a striking convergence on a set of common principles that account for the potent effects of early environment on the capacity for human skill development. Central to these principles are the findings that early experiences have a uniquely powerful influence on the development of cognitive and social skills and on brain architecture and neurochemistry, that both skill*

*development and brain maturation are hierarchical processes in which higher level functions depend on, and build on, lower level functions, and that the capacity for change in the foundations of human skill development and neural circuitry is highest earlier in life and decreases over time” (p.10155) (Knudsen, Heckman et al. 2006).*

These findings lead to the conclusion that the most efficient strategy for strengthening the future workforce, both economically and neurobiologically, and improving the quality of life for workers is to invest in the environments of disadvantaged children during the early childhood years (Knudsen, Heckman et al. 2006).

## Trauma Touches Everyone

The likelihood is exceedingly high that anyone reading this book not only have experienced adversity in childhood but will endure a traumatic event at some time in their lives (Norris 1992; Resnick, Kilpatrick et al. 1993; Kessler, Sonnega et al. 1995). Epidemiological studies define a traumatic event conservatively as *“an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate”* (p.218-219) (American Psychiatric Association 2000).

But an arguably more useful definition is one that sees trauma as occurring when external and internal resources are inadequate to cope with an external threat (Van der Kolk 1989). People's internal resources include their bodies, minds, and spirits. Their external resources include everyone else. This kind of a definition helps to determine why some people respond to an event in very different ways than other people. However, it is clear from many studies that interpersonal violence is more likely to have long-term consequences than natural disasters or accidents. People who have had adequate childhood development, current social support, have a normally reactive central nervous system, and are without any other psychological disorders are likely to recover relatively well from a single incident, adult onset traumatic event, particularly in the absence of interpersonal violence. But someone whose exposure begins early in their life, occurs repeatedly over an extended period of time, is highly invasive, is associated with a great deal of stigma and is interpersonal, is far more likely to experience long-term consequences of a traumatic event. It is this latter complexity that differentiates post-traumatic stress disorder as it is usually described from more complex problems that are the typical presentation of many of the clients who seek services in the human service delivery systems.

Currently, efforts are underway to expand our understanding of the complexity associated with exposure to repetitive and overwhelming stress that usually begins in childhood by using different terms such as “complex PTSD” or “developmental trauma disorder” (Herman 1992; Van der Kolk 2005; Courtois and Ford

2009). These terms embrace a wide variety of interactive problems that include: alterations in the ability to manage emotions; alterations of identity and sense of self; alterations in ongoing consciousness and memory; alterations in relations with the perpetrator; alterations in relations with others; alterations in physical and medical status; and alterations in systems of meaning.

The bottom line is that there is no clear dividing line between “us” and “them” – between the people who need our help and the people that offer that help. Frequently, the helpers are themselves “wounded warriors” of a different sort. In the next section we will look at the aspects of workplace stress that add – often unnecessarily – to the physical, emotional and moral burdens of caregiving.

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