Trauma and Resilience Informed Practice

What it is, what it isn't, and how it can change the world…

Dr Warren Larkin

Consultant Clinical Psychologist

Managing Director – Warren Larkin Associates Ltd

wlarkin@warrenlarkinassociates.co.uk

@warren-larkin

www.warrenlarkinassociates.com

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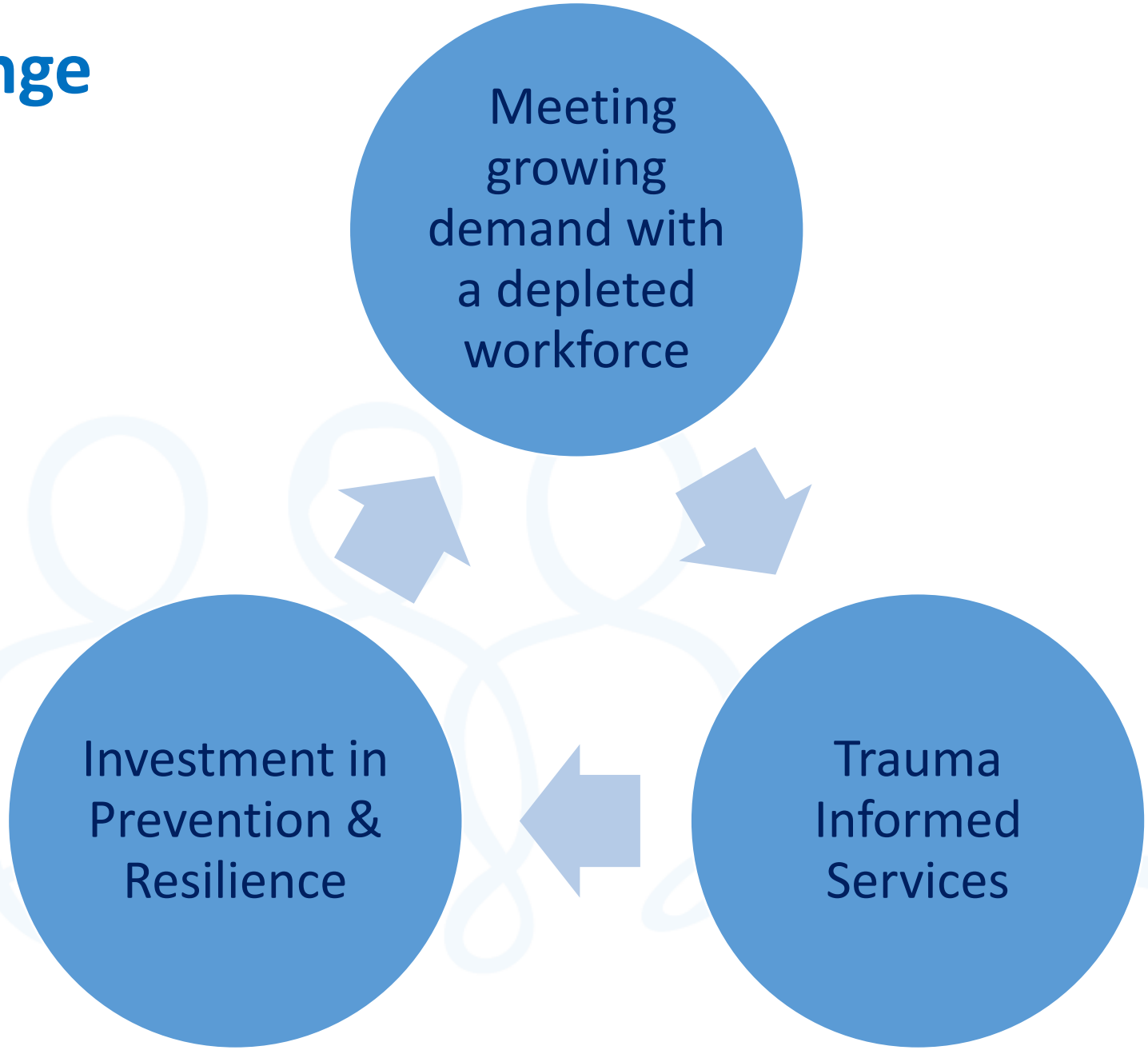
The Challenge



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We have to start with stress…

- "**Stress** is the nonspecific response of the body to any demand for change." Hans Selye, The Stress of Life (1956)
- He borrowed the term from engineering – **"..the effects of force acting against resistance."**
- Hans Selye introduced the concept of "stress" as **a biological and psychological phenomenon** and described the General Adaptation Syndrome (GAS), which outlines the body's response to stress.
- ***Injurious, traumatic or toxic stress*** *occurs when the demands made on an organism exceed it's reasonable capacity to meet them*

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Not all stress is equal…

- **Positive Stress** – Brief physiological state –activation of hypothalamic-pituitary-adrenal (HPA) axis in response to a mild or moderate stressor. Homeostasis is restored once threat has passed. Children need this for healthy development
- **Tolerable Stress** – Physiological response to greater level of threat and longer in duration. Buffering effects of supportive caregiver or resilience assets & coping strategies mean we can adapt and return to homeostasis
- **Toxic Stress** – Frequent, intense & prolonged activation of HPA axis and autonomic nervous system in absence of adequate buffering/ resilience assets

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Defining Traumatic Stress

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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Defining Traumatic Stress

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

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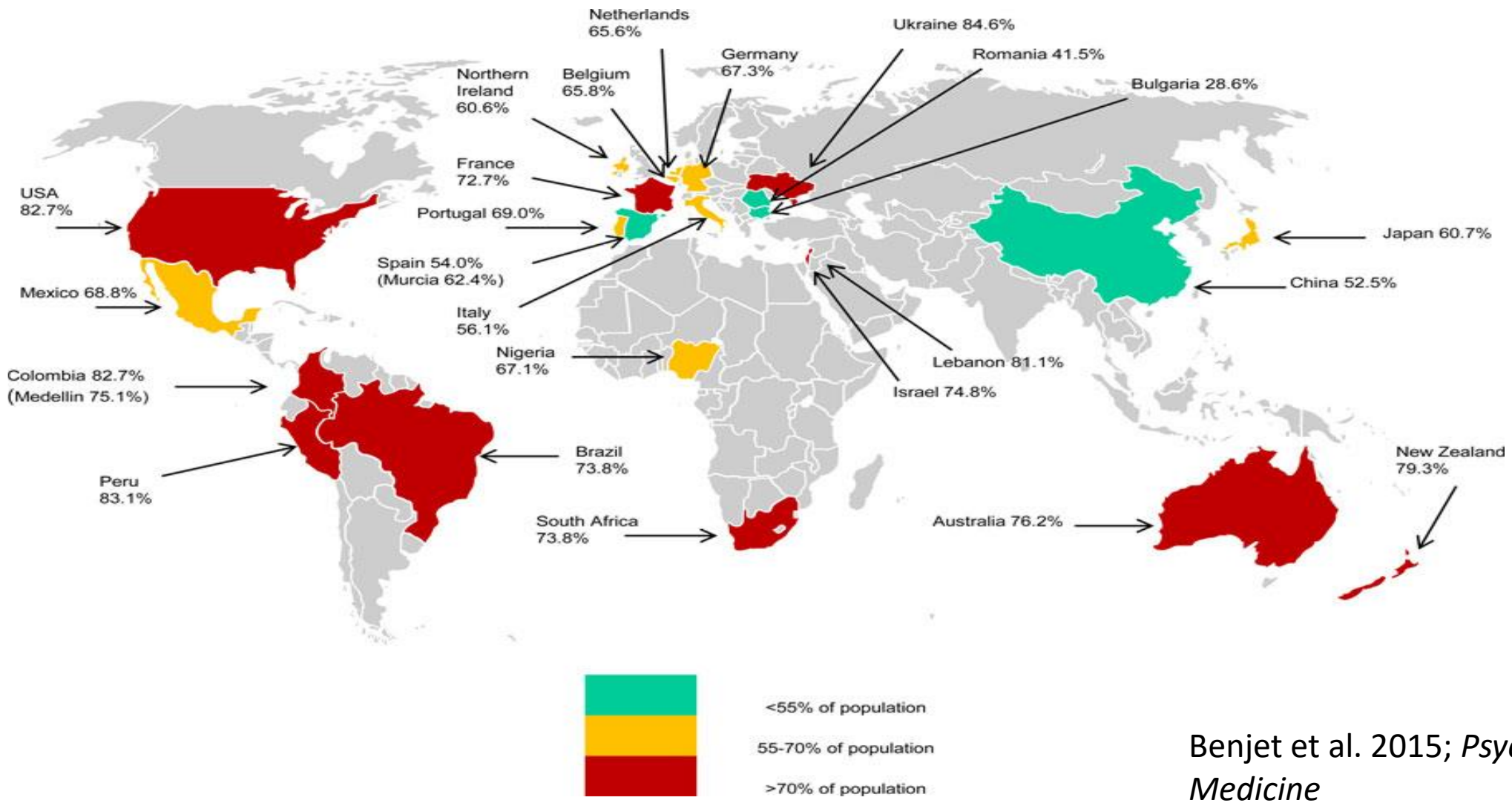
How common are traumatic experiences?



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

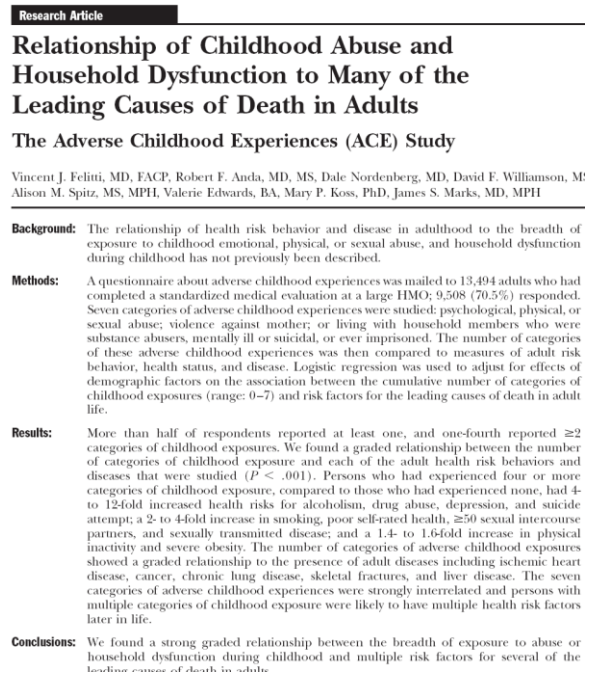
1. **In the English National ACE study, nearly half (47%) of individuals experienced at least one ACE with 9% of the population having 4+ ACES**
   (Bellis et al 2014.)

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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Examples of the most "definitive" meta-analyses linking childhood adversities / trauma and subsequent risk of developing mental health difficulties

(Filippo Varese, 2018)

Depression	Mandelli et al (2017)
Anxiety	Lindert et al. (2014)
Obsessive compulsive ~~disorder~~	Miller & Brock (2017)
Suicidal behaviour	Zatti et al. (2017)
Non-suicidal self-harm	Liu et al. (2017)
Functional neurological (conversion) ~~disorders~~ / medically unexplained symptoms	Ludvig et al. (2018)
Dissociation	Vonderlin et al. (2018); Rafiq et al. (2018)
Eating ~~disorders~~	Molendijk et al. (2017)
Substance misuse (illicit drugs, alcohol etc.)	Norman et al. (2012)
Psychosis	Varese et al. (2012)
Bipolar ~~disorder~~	Palmier-Claus et al. (2016)
Borderline personality ~~disorder~~	Porter et al. (2020)

Over a 12 month period, compared to people with no ACEs, those with four or more ACEs were:

2x more likely to have frequently visited a GP**

3x more likely to have attended A&E

3x more likely to have stayed overnight in hospital

Up to the age of 69 years, those with four or more ACEs were 2x more likely than those with no ACEs to be diagnosed with a chronic disease*$

For specific diseases they were:

4x more likely to develop **Diabetes (Type 2)**

3x more likely to develop **Heart Disease**

3x more likely to develop a **Respiratory Disease**

Levels of health service use were higher in adults who experienced more ACEs*#

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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► Prepublication history and additional material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2019-036374).

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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.

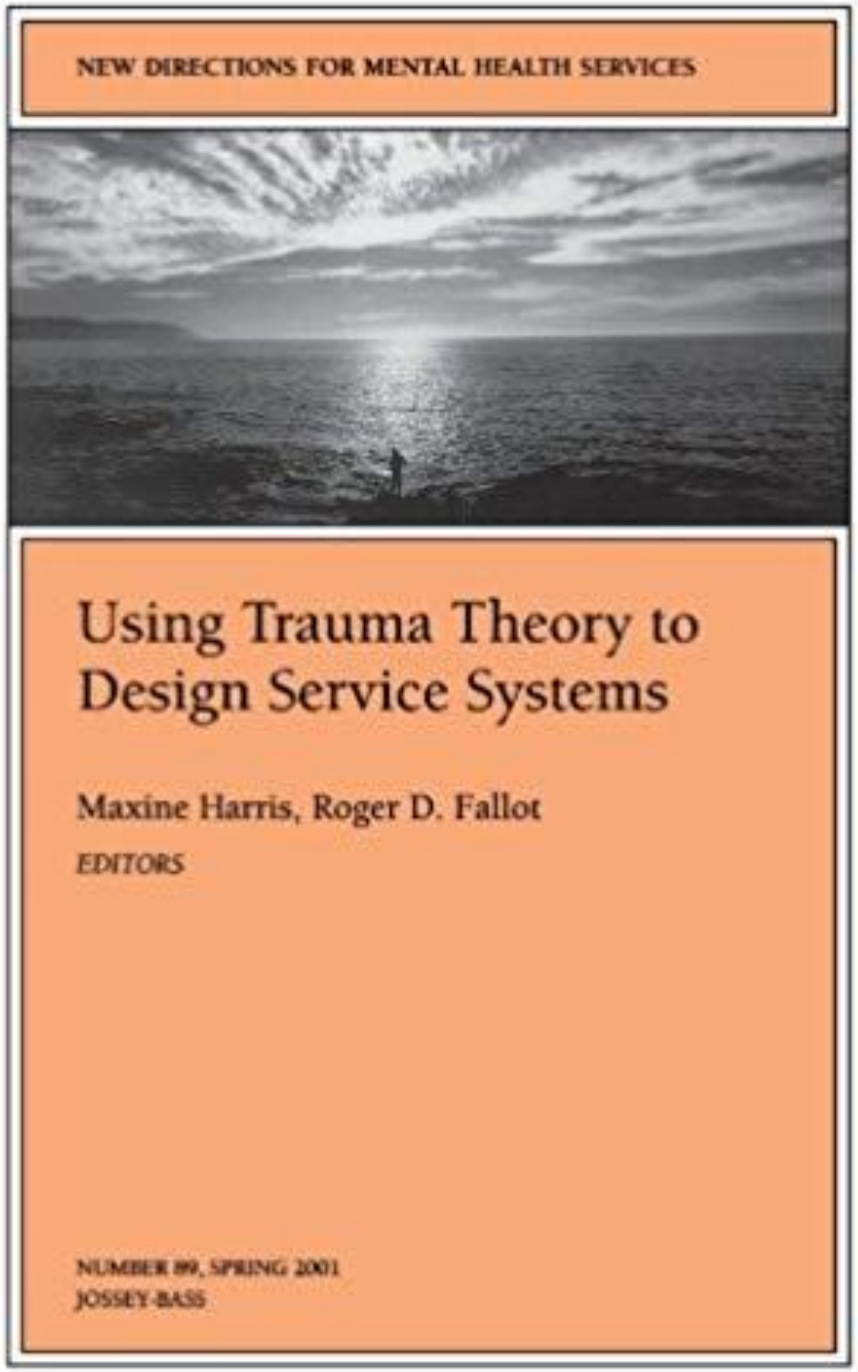
Outcome measures The outcome measures were PAFs for single (1 ACE) and multiple (2–3 and ≥4 ACEs) ACE exposure categories for four health risks (smoking, alcohol use, drug use, high body mass index) and nine causes of ill health (cancer, type 2 diabetes, heart disease, respiratory disease, stroke, violence, 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



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. Cultural, Historical, and Gender Issues

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Key Lessons from the last 7 years

Problem	*Solution*
1. Each place has unique strengths & needs & assumptions are often wrong	1. Its crucial to listen, engage and understand the ‘as is’ position
2. Knowledge of TIP is overestimated	2. Make basic ATR training mandatory (like safeguarding)
3. Routine enquiry about ACEs is rare & inconsistent	3. Train staff how to ask & respond
4. Few workers in relational roles have training in ‘therapeutic’ skills	4. Provide training in role-appropriate ‘therapeutic’ skills & concepts
5. Burnout has become the ‘common cold of helping roles’	5. Educate re the early warning signs, self-care, rest & resilience
6. Excessive workload = no time to process events or reflect on them	6. Introduce peer-group reflective practice
7. We measure too many things that don’t benefit staff staff or those served	7. Measure the stuff that makes a difference & incentivises good practice

7-part Trauma Informed Change Methodology

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1. **Collaborative Enquiry** – a system, place, organisation or service level enquiry to establish ‘as is’ position

2. **Foundational Knowledge** - High quality, well evaluated training, sustainable, delivered with fidelity

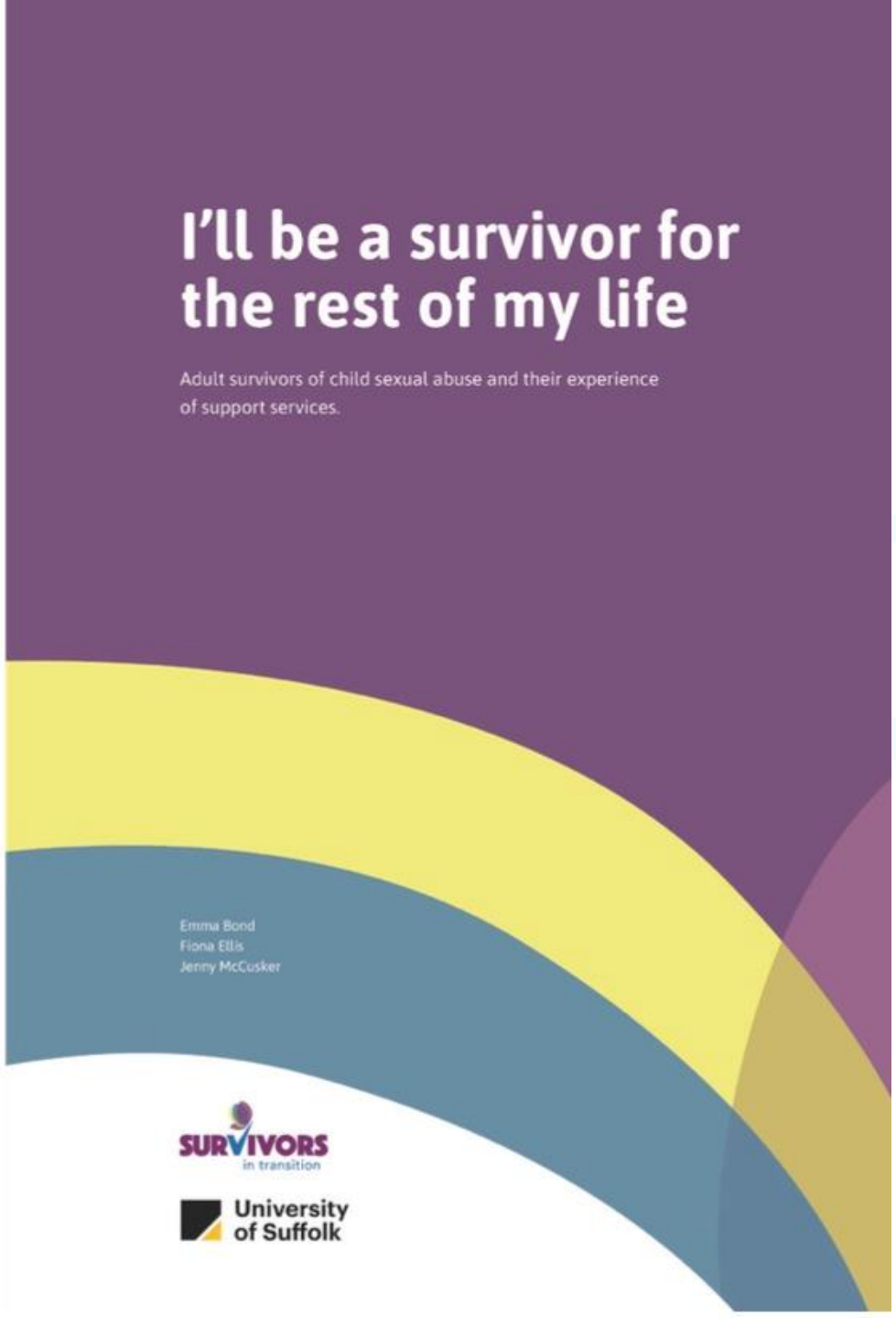
3. **REACh (Routine Enquiry about Adversity in Childhood)** training with support to embed practice change and ensure sustainability

4. **Therapeutic skills and ideas for workers with a relational role** - (managers & leaders' version also)

5. **Compassion fatigue, burnout and secondary trauma** – knowledge and skills for staff & managers

6. **Reflective practice** – training, support & model co-production for staff and coaching for facilitators

7. **Trauma informed metrics and standards** – measuring the right things…



Waiting to be told does not work!

"Unbelievably, my nurse practitioner was the first person to ask what the underlying reason for my depression was. It was the first time in 22 years that anyone asked..."

Survivor, 2018

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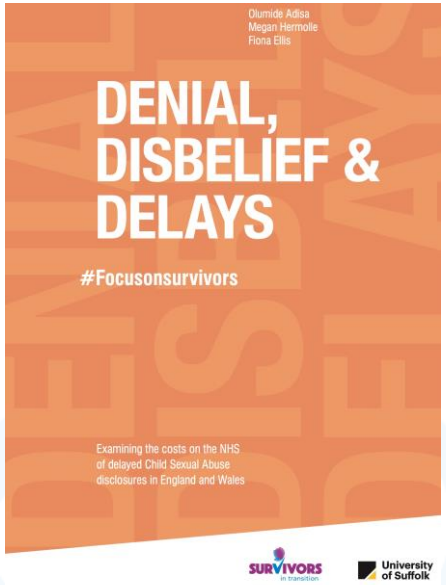
The cost of delayed disclosure



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

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Denial, Disbelief and Delays (2023)

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 building - a public health approach

Source: www.acesaware.org/resources/

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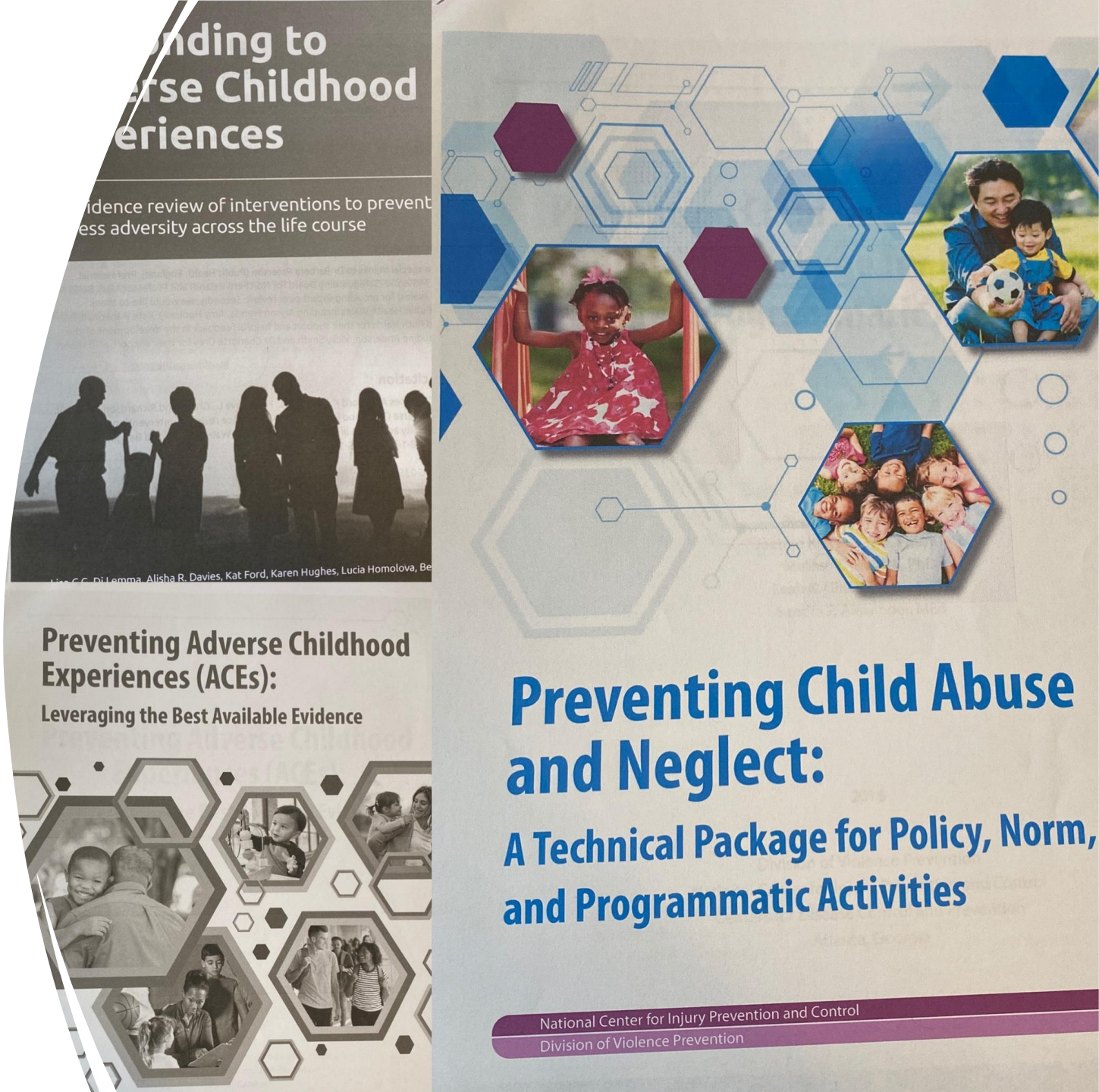
‘Transforming outcomes (for the next generation) is possible with long-term, cross-sector commitment.’

- Prevent adverse childhood experiences (ACEs)
- Support child and family wellbeing/ parenting
- Detect and mitigate the impact of ACEs
- Promote resilience across the life course



Recommendations for services & systems

1. **Secure cross-sector, long-term commitment** to trauma-informed & prevention focused practice
2. Conduct a **listening & engagement** exercise – co-produce the plan
3. **Foundational knowledge** of ACEs, trauma-informed practice & resilience building should be mandatory across sectors
4. Train professionals to **ask about Adverse Childhood Experiences** (ACEs) & **create the conditions for children to tell** a trusted adult
5. Empower workers & leaders in helping organisations with **therapeutic ideas & skills**
6. **Reflective practice – '**Look after the people, who look after the people'
7. **Measure the right things** & evaluate our interventions, programmes & outcomes.

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Relationships are the best medicine…

Harvard Study of Adult Development - Relationship satisfaction was a better predictor of longevity & happiness, than social class, IQ, or genes.

“Strengthened relationships are a key resource in times of acute stress. Indeed, the perceived absence of supportive relationships is one of the strongest predictors of post-traumatic stress disorder” (Chris Brewin, 2000)

Quality of the relationship is the most consistent predictor of change in psychosocial interventions.

If healing trauma relies on relationships, then we must, “look after the people, that look after the people.”

It’s the relationship that heals, the relationship that heals, the relationship that heals...(Irvin D. Yalom)

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Thank you…

Please get in touch

wlarkin@warrenlarkinassociates.co.uk

Twitter: @Warren_Larkin

Linked-In: Dr Warren Larkin

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