Clinicians know how intractable these trauma effects can be—perhaps because we have been using psychological tools to fix a physiological problem.

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 abuse disorders.

Questionnaire Results as Conversation-Starters
So how does this inform our treatment? Clearly we can't go back and provide corrective childhood experiences for adult clients. Ernest Johnson, LCSW has been using the ACEs Survey with his clients at the Crisis Response Center of the Tulelake-Koshare Health Corporations in Tulelake, CA. A recent two-months sample of 13 patients revealed an average ACEs score of 4.6. Five respondents had scores of 5 or above, and three clients endorsed 5 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 abhorrent experience when the client realizes that they aren't the only person these things have happened to—indeed, they are statistically common.

Mary Johnson, Coordinator of the Suicide Prevention Program for Tulelake, has found similar results in a voluntary sample of community members attending an open workshop on Healing Pain. Of 45 respondents, 50% had an ACE score of at least 4, and 60% reported a 7 or higher. The most common ACEs were growing up with a substance abuse (70%), living with someone who was mentally ill or attempted suicide (57%), a family member who went to prison (54%), and emotional abuse (60%).

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

Selecting Appropriate Tools to Redesign Responses
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 rapid and long-lasting this ANS hyper-activation 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 lumpy ride that will permanently wear out your engine, clutch and brakes...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., prazosin) 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 their clients to the saying "It's never too late to have a happy (ex) childhood."

Michael G. Bledsoe is a Jefferson Health Clinician with the Drug Court Team of Lutheran Community Services in Tulelake, CA. He is also a consultant in recovery from addiction and addiction disorder through the STAR Program, and is leading research-based treatment with Native smoke-tobacco. Michael and his colleagues have developed a version of the ACE questionnaire more specific to Native health. For more information about that version, or for other related information, contact him at michael.bldsoe@lccog.org.

Bedrock
For reference:

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