“Trauma exposure: Frameworks, limitations and expansion"

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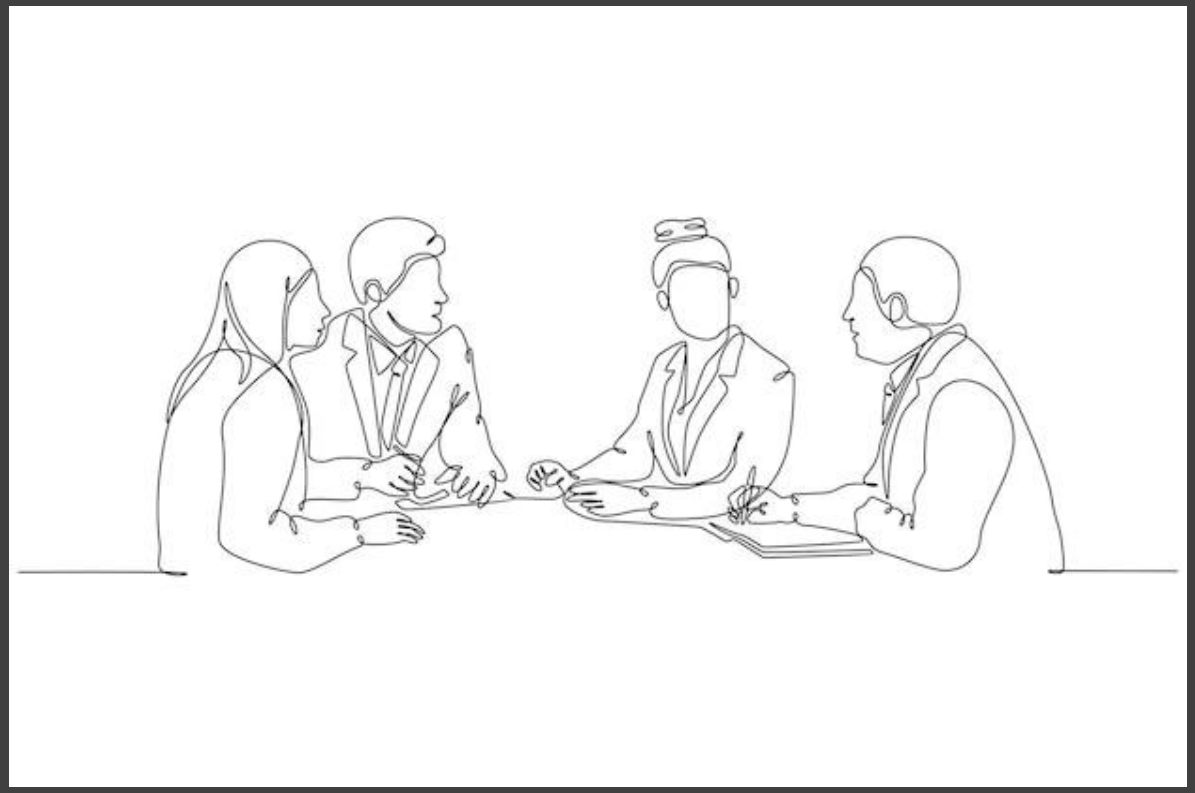


The status of the trauma field with neurodiverse populations

- Trauma is enjoying something of a renaissance period
  - New Diagnoses
  - Frameworks ‘Trauma informed Care’
- Expansion hasn't necessarily reflected or considered the needs of the populations who are disproportionately exposed to, or impacted by, trauma

BUT: we have limited
A) Theoretical models & understanding of mechanisms of trauma
B) Testing of theoretical models
c) presence in field tests of new treatments
D) Minimal presence in trauma policies and guidance

For Neuro diverse populations

The aims of this presentation

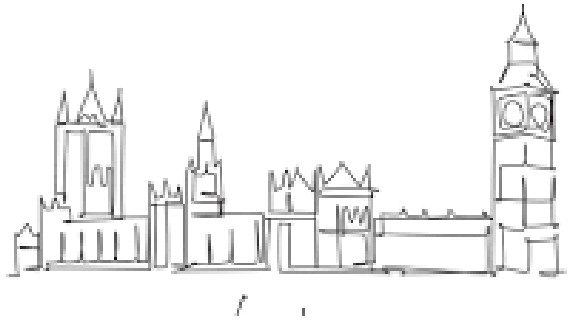
- Describe current dominant trauma 'exposure' Frameworks and their ability to describe (potential) trauma experiences of neurodiverse/ divergent people

- ACEs
- Wider sources of trauma exposure
- RE-TRAUMASATION

- Suggest some practice implications for frameworks of trauma exposure

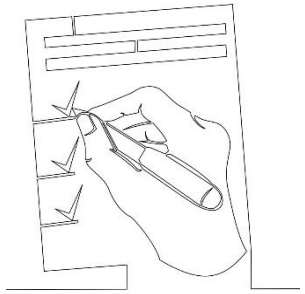
Current frameworks for describing trauma exposure: Their impact in shaping clinical practice

The importance frameworks: The implications of what is defined as 'adverse' or 'traumatic'



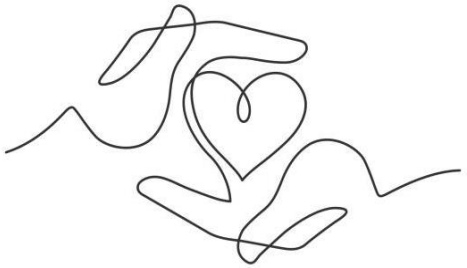
- Government policies
- National Guidance

- The recognition and visibility of different populations



- Service Provision & design
- Research agenda's

- Treatments offered and their content
- *We can also miss entirely, or mis-formulate significant life events* and perpetuate adverse conditions
- Influence Individual support programmes



- Validate or invalidate peoples life experiences
- Impact on sense of self
- Inadvertently 'normalize' adverse conditions

Part 1: Trauma exposure framework: Adverse Childhood Experiences

Direct (5)

‘Household’ – exposed to / witnessing

Abuse (3)

Neglect (2)

Attachment ruptures (2)

Parental behaviour (3)

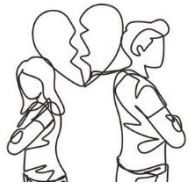
Physical Abuse

emotional abuse

Sexual Abuse

Physical neglect

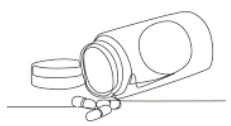
Emotional neglect



Parental separation

Parental incarceration

Intimate Partner violence



Parental Substance misuse

Parental mental health difficulties

Prevalence of ACEs in neurodiverse populations

	Learning Disability / Mixed population	Autism	Neurotypical peers
Community adults	87.5% ≥ 1 (Community) 50% ≥ 4	Parental Divorce ASD=28%, C=20% Household Mental health ASD=18%, C=7%	43.1% ≥ 1 8.3% ≥ 4 2.7% ≥ 6
Residential Services	81.7% 1≥ 20% 4≥	Houshold -Substance ASD=14%, HC=10% 4 or more ACEs ASD =10.2% vs. C=5.1%)	
Secure (forensic) Services or prison	**CAMHS** 97% ≥ 1 ACE 58% ≥ 4 ACEs 36% ≥ 6 ACEs **Adult** 72% ≥ 1 ACE, 66% multiple		83%≥ 1 34% ≥ 5

The Adverse Childhood Experiences Framework

Direct (5)

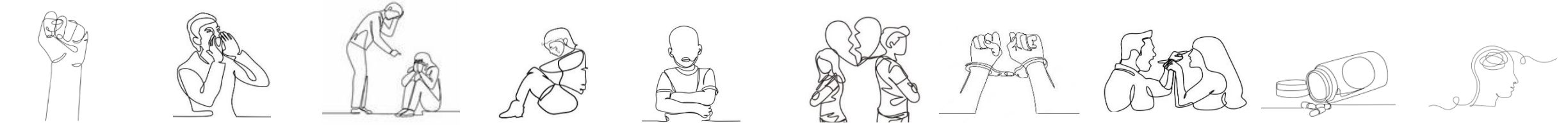
‘Household’ – exposed to / witnessing

Abuse (3)

Neglect (2)

Attachment ruptures (2)

Parental behaviour (3)



- Physical Abuse
- emotional abuse
- Sexual Abuse
- Physical neglect
- Emotional neglect
- Parental separation
- Parental incarceration
- Intimate Partner violence
- Parental Substance misuse
- Parental mental health difficulties

Direct ACEs are more likely to be investigated

Abuse ACEs more likely to be investigated than neglect ACEs

- Reviews suggest ‘household’ ACEs are highly prevalent and often more prevalent than direct ACEs
- They are ‘gateway’ ACEs to direct ACEs
- Often stronger predictors of negative outcomes than direct ACEs

Key conceptual questions for neurodiverse populations

(i) Developmental considerations of the ACEs framework

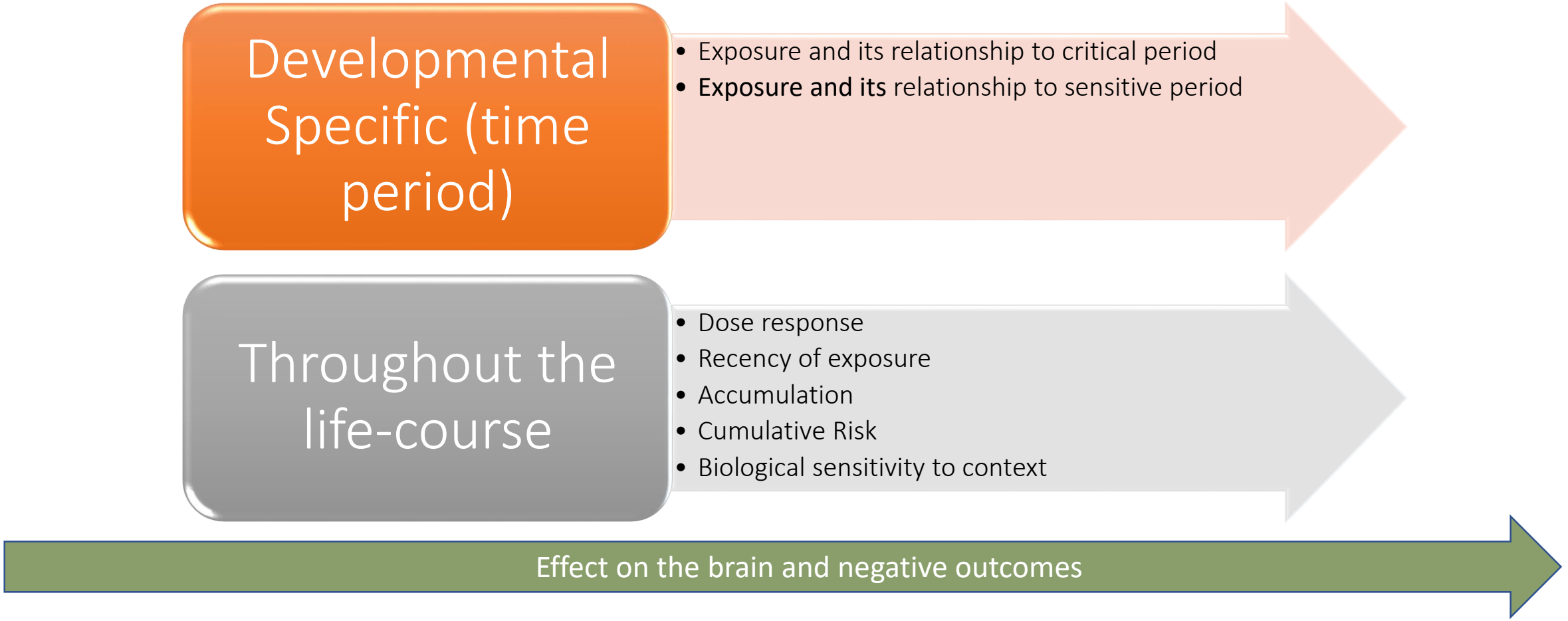
- The cut off for 'ACE's' is based on chronological (18 years) rather than developmental periods

- Should the 18 years cut off apply to ND populations?
  - Developmental periods are different for neurodiverse populations
  - Existing diagnostic guidance of ID suggests 21+ as a cut off for 'adulthood'

- Growing evidence of the critical role of age at exposure for differentiating impact of ACEs
  - Earlier the neglect (e.g. 3-4 months), bigger the impact on neurological development
  - Elevated Allostatic Load (AL)index, implicated in psychosis and other presentations, is associated with very early ACE exposure and multiple ACE exposure in neurotypical populations
  - Physical & emotional neglect at age 4-5 may have a greater relationship to symptoms of dissociation
  - Emotional neglect at age 8–9 may be related to level of depression in adulthood**

- Evidence is framed as reflecting chronological vs developmental milestones, can't assume this evidence applies in the same way to ND populations

Developmental factors and the impact of ACEs



Taken from Gabard-Durnam & McLaughlin (2019)

Key conceptual questions for neurodiverse populations (ii)Are ACEs inclusive of different sources of adversity?

- The breadth of ACEs has already been questioned across different cultural groups
- Fail to acknowledge the social, economic, health access and political contexts of individuals (newer versions of ACE Framework acknowledge community context)
- Do ACEs capture critical forms of adversity for ND populations?

Part 2: Sources of adversity associated with neurodiversity
Considerations for children and adults

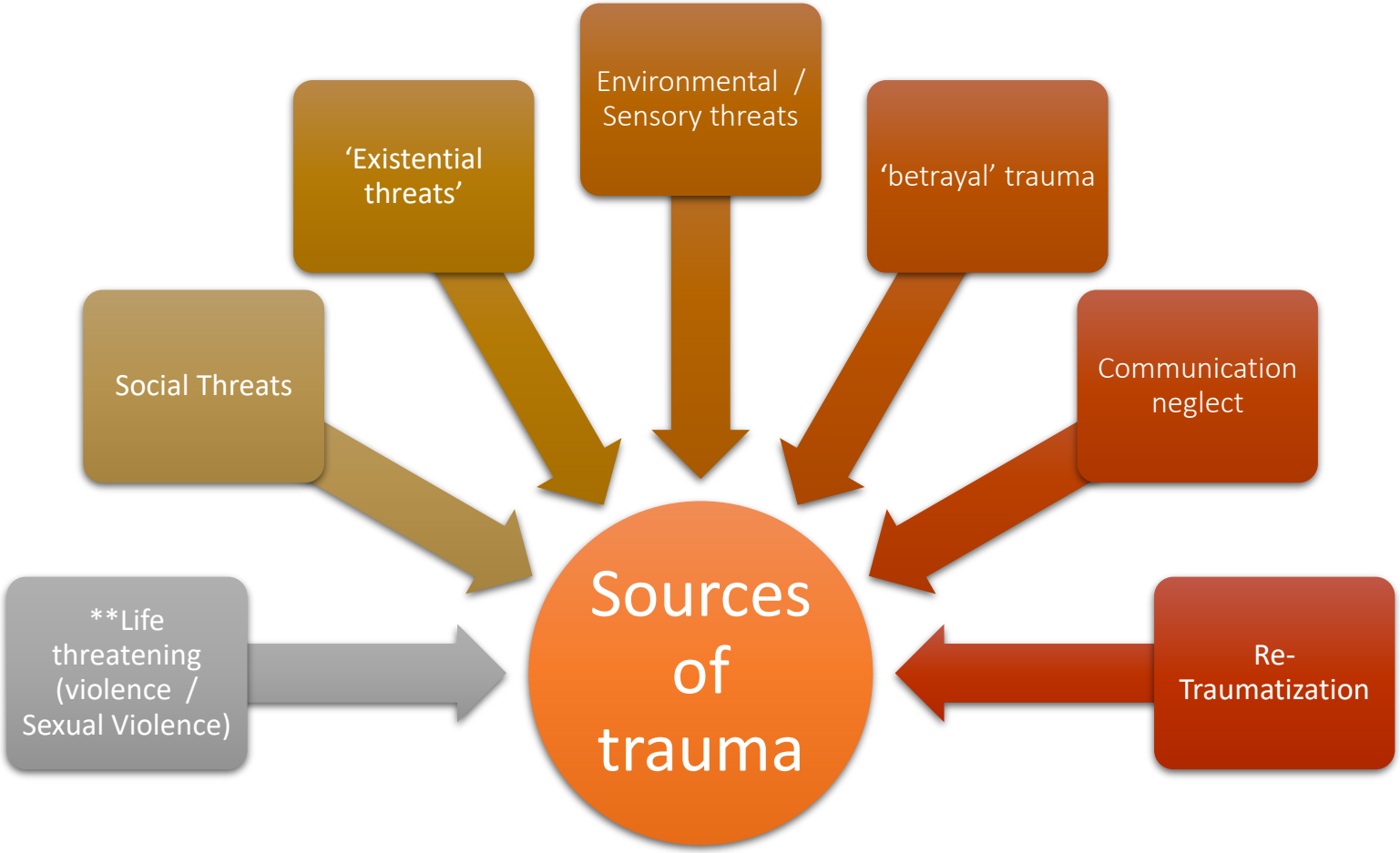
Kerns et al., 2022 –Autistic adults	Kerns et al., 2015 – 'traumatic conditioning processes'-autism	Wigham & Emerson, 2015
(a)Trapped "Traumatic restriction" Physical restraint and sedation: Act itself, predicting behaviour of others, understanding their actions Psychologically trapped (ST: loss of autonomy, opportunity, self determination* & constant scrutiny, monitoring and control, being forced into psychological therapy) (b)Social Exclusion Bullying, Social isolation / alienation, Stigma, discrimination and betrayal** (C) Traumatic incongruities Sensory*, Transitions / change & Social confusion*	• Social confusion • Peer rejection • Prevention or punishment of preferred behaviours • Sensory sensitivity to daily stimuli	Environmental stressors • Increased exposure to determinants of poor health • Risk of paternalism and over pathologizing Additional potential sources • 'mate crime' 'multiple victimisations' • Physical health e.g. Epilepsy • Multiple placements • **Information neglect / communication deprivation • **Placed in residential school • **Parental negative view of developmental status • **Punished for alternate means of communication / special interests

Adversity associated with neurodiversity

* Focus of dominant trauma models relates to traditional (life threatening) conceptions of trauma

For ND populations social traumas may contribute a significant role to trauma related presentations and needs

The PAST (Physical and Social Trauma; Neuner, Nov 2022) framework, could hold some utility and gives parity of esteem to physical and social threats in terms of psychopathology and memory processes



Part 3:‘re-traumatisation’

- Emphasis in childhood frameworks is placed on 'original' or primary trauma exposure and measuring impact in a linear 'dose responsive' way.
- An assumption that ‘ACEs’ or original traumas that bring people into contact with services will have the greater impact than subsequent trauma’s / re traumatisation
- This [assumption] has not been extensively tested with ND populations
- Given the higher levels of ongoing exposure to adversity across the lifespan, including arising from contact with services, we can’t assume (without testing) this is the case.
- Principles of trauma informed care stress the critical importance of reducing the risk of ‘re traumatization’

Re considering ‘re-traumatisation’

- Events or practices that propagate or maintain collective / previous traumas that activate trauma responses, and is reticent of the initial trauma(s)
- Re traumatisation are broadly considered as reflecting ongoing lack of [psychological and physical] safety
- Healthcare systems may inadvertently re traumatise, through re creating the conditions of 'original' traumas
- Given that people with intellectual disabilities often have long relationships with services, the concept of re-traumatisation is particularly relevant
- Experiences that can be framed as 're traumatisation'
  - Experience caregiver disruption
  - Enter the 'looked after' children's system
  - Out of area placements
  - Experience abuse / harm / neglect within institutional care
  - Experience placement breakdowns / Experience multiple placement breakdowns
- Within care systems that are also likely to be exposed to the distress of peers, to restrictive practices, medications

Re considering ‘re-traumatisation’ (I)

It is commonly assumed that ACEs or original traumas have a disproportionate / bigger impact than subsequent traumas

CAMHs Developmental Disorder Secure services paper series (Morris et al.,) questions this

- Mixed Gender, Mixed Developmental needs group (n=34)

88.2% had experienced at least one type of ACE

58.8% had experienced 4+ ACEs, with an average of 4.53 ACEs

38.2% had experienced 6+ ACEs

- Mental Health Diagnoses
- Removed from the home with a care order
- Predicted BMI / Obesity
- Failed placements

47.1% had experienced a placement breakdown

87.5% of whom experienced multiple, with an average of 3.94 breakdowns

Re considering ‘re-traumatisation’ (II) Do ACEs have a greater impact than re traumatisation on BMI?

DIRECT ACES & BMI

Variable	ß	t	R2	ΔR2
Step 1			.14	.14
Direct ACEs	.37	2.24*		
Step 2			.24	.10
Direct ACEs	.06	.27		
Placement Breakdowns	.45	2.05*		
Step 3			.24	-.00
Placement Breakdowns	.49	3.16**		

HOUSEHOLD ACES & BMI

Variable	ß	t	R2	ΔR2
Step 1			.12	.12
Household ACEs	.35	2.13*		
Step 2			.25	.13
Household ACEs	.15	.82		
Placement Breakdowns	.41	2.31*		
Step 3			.24	-.02
Placement Breakdowns	.49	3.16**		

- When entered alone, both direct and household ACEs were significant predictors of BMI.
- Addition of placement breakdowns into the model nullified their effect, and accounted for 24% of the variance in BMI
- No interaction effect of ACEs and placement breakdowns on BMI was found.

Clinical Implications?

- Small N and needs replicating with wider ND populations
- ‘Re-traumatisation’ has a significant impact, greater than the original traumas on BMI
- Should re traumatisation have parity of esteem with ‘original trauma’s’ in trauma frameworks? (prevention & Management)
- Given that ND populations are likely are more likely to experience living in [multiple] institutions, the role of placement failures on physical wellbeing needs further investifation
- Multiple placements have a negative impact on a range of psychological constructs (attachment, sense of safety) and psychopathology, as well as physical health outcomes

Summary: Practice Implications for trauma [exposure] frameworks

- Ensure that household as well as direct ACEs are considered when formulating clinical needs
- Consider a developmental rather than chronological approach to recording and formulating childhood adversities
- Assess for re traumatisation, especially institutional, especially if there have been multiple placements
- Sources of trauma are likely to reflect 'threat to life' (anxiety / fear) as well as Social, existential, betrayal, sensory Threats, need to ensure we consider both ‘bodily’ and ‘social’ when formulating needs
- Existing trauma questionnaires for trauma diagnoses (ITEM / TALE)do not capture the range of sources of trauma for ND populations and should be augmented with social threats

And finally….