ADVERSE CHILDHOOD EXPERIENCES AND MENTAL HEALTH

KEY FINDINGS

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KEY MESSAGES

In our project, we took advantage of the rich information in the British birth cohorts, to explore the relationship between adverse experiences in childhood and mental health spanning from childhood to middle age.

Project Findings

- Having at least one adverse childhood experience is, on average, associated with persistently worse mental health and wellbeing from childhood up to midlife.
- Every additional ACE increases the risk of poor mental health even further.
- However, most children with ACEs do appear to stay in good mental health throughout their lives.

ACES ARE COMMON

- 60% of children experience at least one adversity.[1]
- 2.3 million children in England live in families experiencing various adversities.[2]

ACES ARE BAD FOR MENTAL HEALTH

- Experiencing two or more ACEs is, on average, linked with over three times higher risk of having high symptoms of depression or anxiety throughout adulthood.[4]

ACES STEM FROM POVERTY

- Children born into poverty have up to nine times higher risk of experiencing multiple adversities, compared to children who were not born into poverty.[3]

ACES TEND TO CO-OCCUR

- ACEs tend to cluster, with parental mental health problems commonly co-occuring with parental separation, convictions, emotional and physical abuse.[3]

BACKGROUND

Adverse childhood experiences (ACEs) are broadly defined as potentially traumatic events occurring in childhood and include aspects of the child's environment that can undermine their sense of safety, stability, and bonding.[5]

ACEs typically include:

Abuse: physical, emotional, and sexual
Neglect: physical, and emotional
Household challenges: parental mental illness, incarceration, substance abuse, domestic violence, and divorce

In our project, we examined the extent to which ACEs co-occur and are linked with subsequent mental health throughout the life course. We used longitudinal birth cohorts based in Great Britain. These included:

- the Avon Longitudinal Study of Parents and Children (ALSPAC), charting the health of 14,500 families with children born in 1991/1992 in the Bristol area,[6]
- the Millennium Cohort Study (MCS), following the lives of 19,000 young people born in 2000-02, [7]
- the 1958 National Child Development Study (NCDS), collecting information on over 17,000 individuals born in one week in 1958.[8]

These datasets include rich information on mental health in childhood and adolescence (MCS), and adulthood (NCDS). The MCS measured internalising and externalising problems between age 3 and 14 years. The NCDS includes the consistent measures of symptoms of depression and anxiety between age 23 and 50, as well as a range of indicators of wellbeing, or utilisation of mental health services collected between age 16 and 55.

Taking advantage of all this information allowed us to produce the most comprehensive analysis of the association between ACEs and mental health-related outcomes to date – with ACEs reported both prospectively and retrospectively, outcomes including various indicators of both wellbeing and mental illness, which spanned five decades, while accounting for a wide range of child and family factors.

FINDINGS

What is the relationship between poverty and ACEs?

Poverty, defined as difficulties in affording food, heating, or accommodation (including homelessness), was strongly associated with an increased odds of all examined ACEs, with the exception of death of a close family member.[3]

Associations were particularly strong between poverty and sexual abuse (odds ratio = 2.38, 95% confidence interval = 1.62, 3.52), mother's mental health problems (odds ratio= 2.30, 95% confidence interval = 1.93, 2.74), and parental separation (odds ratio= 2.63, 95% confidence interval = 2.20, 3.14). Children whose parents reported poverty in pregnancy were more than nine times more likely to report multiple types of adversity (odds ratio = 9.15, 95% confidence interval = 5.77, 14.51) than children whose parents who did not report poverty.[3]

To what extent do ACEs co-occur?

ACEs are highly likely to co-occur. Over half of the ALSPAC participants (55%) had one or no individual ACEs. Among those with multiple ACEs, we statistically identified four, typical, patterns of co-occurring ACEs, all of which included parental mental health:

- Mother's mental health problems and parental separation (with 18% of all participants)
- Parental mental health problems, convictions and separation (with 15% of all participants)
- Mental health problems and abuse and mental health problems (with 6% of all participants),
- "Poly adversity": parental mental health problems, parental separation, interparental violence, physical and emotional abuse, and parental alcohol problems (with 6% of all participants).[3]

What is the relationship between ACEs and mental health in childhood and adolescence?

Harsh parenting and physical punishment were particularly strongly associated with trajectories of externalising problems at ages 3-14. Parental conflict and parental depression showed the strongest associations with trajectories of internalising problems.[9] (Fig.1)

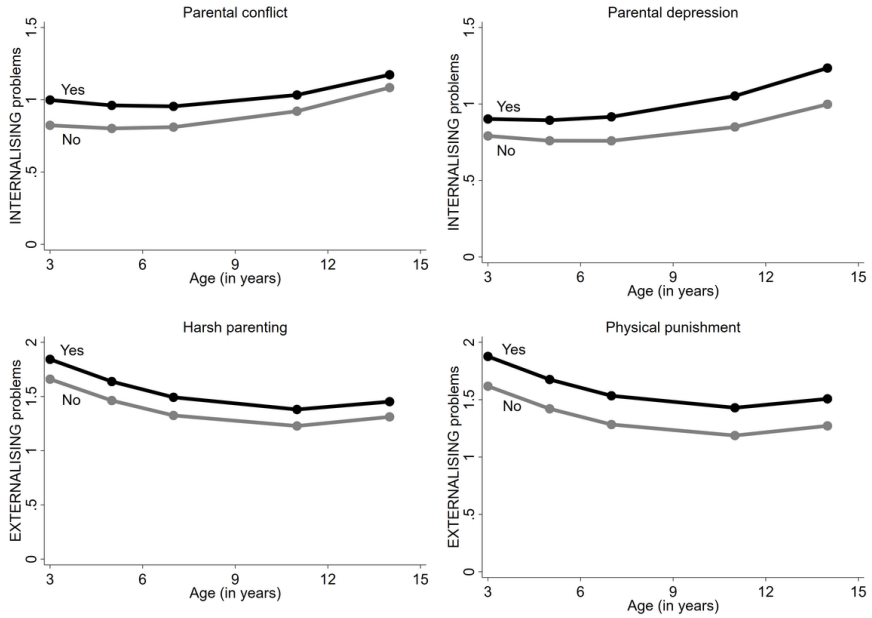

Figure 1. Trajectories of internalising and externalising problems at ages 3-14 among those with and without ACEs.

What is the relationship between ACEs and psychological distress in adulthood?

Those with more ACEs experienced persistently higher trajectories of psychological distress between ages 23 and 50. Those with one ACE compared with none, had on average between 0.27 and 0.39 higher distress throughout adulthood.[4] (Fig.2)

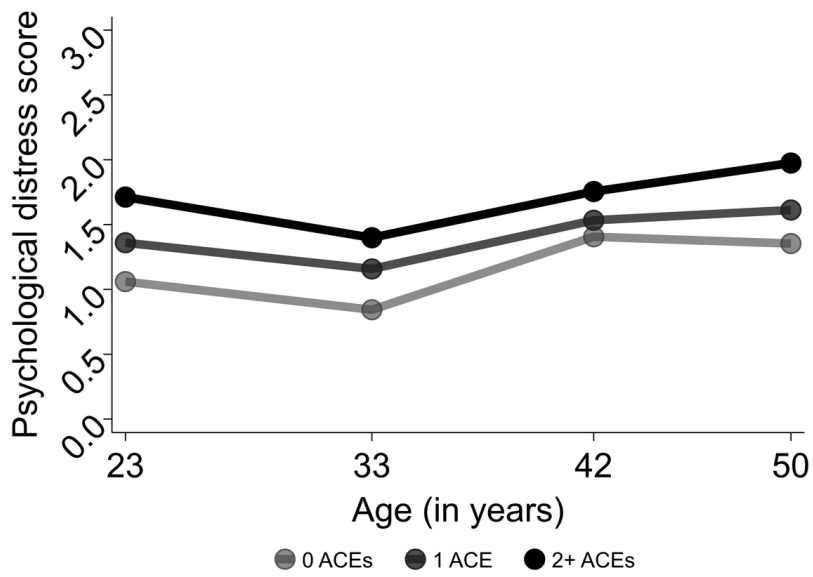

Figure 2. Trajectories of psychological distress at ages 23-50 among those with a number of ACEs.

What is the relationship between ACEs and various mental health outcomes?

The more ACEs experienced, the worse the mental health-related outcomes at ages 16-55 years. For instance, among those with 2+ (vs 0) ACEs, the risk of clinically significant psychological distress was up to 2.14 times higher, and of seeing a mental health specialist up to 2.85 times higher.[10] (Fig.3)

DEFINITION

Risk ratio - compares the risk of having a mental health problem among **those with a given number of ACEs** and **those without ACEs**.

A risk ratio of 1.0 indicates identical risk among the two groups. A ratio of, for example, 2.0 indicates twice as high risk in one group compared with the other.

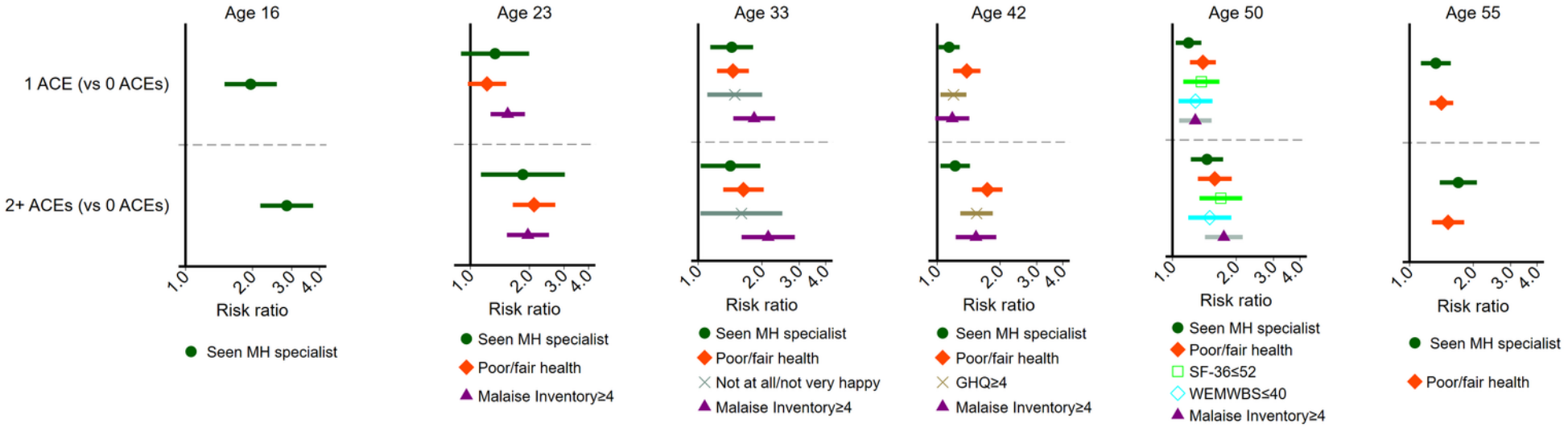

Figure 3. The association between the number of ACEs and a range of mental health outcomes.

Note: ACEs included physical neglect (reported by teacher at age 7, 11), parental separation/divorce, parental substance misuse, family conflict, death of parent, parental mental health problems, parental offending (all reported by health visitor and/or parent at age 7-16).

Abbreviations: ACE = adverse childhood experiences; MH = mental health; GHQ-12 = General Health Questionnaire; SF-36 = Short Form Survey; WEMWBS = Warwick-Edinburgh Mental Wellbeing Scales; CASP = Quality of Life Scale.

RECCOMMENDATIONS

Recommendations for research

- Clearly defining what an ACE is or is not.
- Moving beyond the originally defined 10 ACEs and taking context into account when deciding what ACEs might be important.
- Considering alternative approaches to operationalising adversity beyond ACE scores.
- We need more studies which rigorously examine the effectiveness and safety of programmes such as routine enquiry and trauma informed initiatives.

Recommendations for policy and practice

- More caution in translating evidence from population research to individual risk. This will help to reduce stigma and avoid deterministic messages from being propagated.
- Careful thought as to how and when to record ACEs information in different practice settings.
- Considering whether sufficient evidence is available to support the effectiveness and acceptability of programmes such as screening and trauma-informed initiatives.
- Only routinely enquiring about ACEs where the benefit outweighs any potential harm, and where evidence-based interventions exist and are readily available.
- Looking beyond individuals and families to the broader structural 'causes' of ACEs, such as poverty.

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