



# Childhood adversity and trauma: experiences of professionals trained to routinely enquire about childhood adversity



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## ABSTRACT

Research indicates that adverse childhood experiences play a causal role in the development of poor health and social outcomes in adulthood. Despite this, research suggests that such experiences go undetected since spontaneous disclosure is unlikely, and practitioners are unlikely to ask. A project was developed in which practitioners were trained to routinely enquire about adversity in their daily practice. Four pilot services took part that worked directly and indirectly with children and young people, many of whom were exposed to multiple adverse experiences. The aim of this study was to construct an understanding of the experiences of these practitioners. Seven interviews were conducted, and the data was analysed using thematic analysis. The emerging themes were: change in knowledge, perception and practice; the emotional impact of hearing and responding to disclosures; confidence in asking and responding appropriately; making sense of the impact for clients; how and when to ask. Findings indicate that participants' change toward more adverse-experience-informed formulations of clients' difficulties ensure commitment to routine enquiry and changes in referral patterns and therapeutic practice. Suggestions are made with regard to the practicalities of routine enquiry and how services can best support practitioners who are embedding this skill into their practice.

## 1. Introduction

Adverse childhood experiences (ACEs), along with related terms such as childhood trauma and maltreatment, refer to a range of negative childhood experiences. The World Health Organisation defines childhood trauma and adversity as all forms of physical and emotional abuse, neglect or exploitation that results in actual or potential harm to a child (Butchart et al., 2006). ACEs may include, but are not limited to, physical, sexual and emotional abuse, bullying, parental death or loss, neglect and poverty (Felitti et al., 1998).

The negative impact that ACEs have on health and social outcomes is now widely accepted. ACEs have been found to increase the risk of poor health behaviours including smoking, alcohol and substance misuse and severe obesity (Anderson and Teicher, 2009; Dube et al., 2002; Dube et al., 2002; Felitti et al., 1998; Ford et al., 2011). There is strong evidence that ACEs increase the risk of a range of chronic and life-limiting health conditions including cancer and pulmonary, liver and cardiac disease (Anda et al., 2008; Brown et al., 2010; Dong et al., 2004; Felitti et al., 1998).

Overwhelming evidence for the impact of ACEs on outcomes in adulthood is also apparent within mental health literature and it has been estimated that in the absence of childhood adversity there would be a 22.9% reduction in mood difficulties, 31% reduction of anxiety, 41.6% reduction of behavioural difficulties, 27.5% reduction of substance-related difficulties (Kessler et al., 2010) and a 33% reduction in psychosis (Varese et al., 2012). ACEs have also been found, for example, to be associated with severity of hallucinations and delusions in people experiencing psychosis (Bailey et al., 2018), suicide attempts (Xiang et al., 2018), and risk of depression along with increased risk of relapse and poorer treatment response (Nanni et al., 2018).

To begin to reduce the impact of ACEs it is essential that we identify them early in a child's life, however, a major barrier is that early detection currently relies primarily on the voluntary disclosure of adversity by people who are in contact with services. Research suggests that those who have experienced trauma and abuse are unlikely to spontaneously disclose them, particularly to services (Read and Fraser, 1998). Young et al. (2001) suggest that, since spontaneous disclosure is unlikely, it is clinicians' responsibility to ask about trauma and adversity. Indeed,

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research reports significant increases in disclosure if people are asked. For example, [Read and Fraser \(1998\)](#) found that 82% of psychiatric inpatients disclosed trauma when they were asked, compared to 8% who were not asked. Similarly, [Lothian and Read \(2002\)](#) found that, of seventy-four people receiving input from mental health services, 64% had experienced ACEs and 78% of those had never been asked about them.

[Young et al. \(2001\)](#) qualitatively explored why clinicians continually failed to ask about ACEs. They identified two main themes related to feeling that there were more pressing issues to attend to, and fear of causing distress to both the client and to themselves. The former may be indicative of a biological model for understanding psychological difficulties, in which childhood adverse experiences are often dismissed when considering aetiology ([Bentall, 2003](#); [Read et al., 2006](#)). The latter theme may be a problem for some clinicians since vicarious trauma caused by empathically engaging with clients' traumatic histories has been identified to impact upon wellbeing ([Michalopoulos and Aparicio, 2012](#); [Pearlman & MacLan, 1995](#)). However, vicarious trauma impacts only a minority of clinicians, and services should have adequate support systems in place to prevent such experiences, such as clinical and peer supervision ([Trippany et al., 2004](#)). Fear of causing distress to clients, again is a possibility, however, [Felitti et al. \(1998\)](#) demonstrated that people are unlikely to become distressed by such questions and may often find the experience therapeutic.

[Toner et al. \(2013\)](#) explored the experiences of professionals within Early Intervention services who were trained to ask about ACEs to identify how clinicians can be supported to feel more confident to ask about ACEs. Based on their findings, the authors suggest that providing clinicians with the skills to ask is not enough, and that in order to ensure commitment and confidence, it is essential that there is a fundamental shift toward psychological, formulation-driven, trauma-based understanding of clients' experiences, which, in turn, facilitates commitment to asking about adversity.

In light of this evidence one of the authors (WL) developed, and implemented, a pilot project that has trained practitioners who work directly and indirectly with children and young people to routinely enquire about adversity; this approach and methodology became known as REACH: Routine Enquire about Adversity in Childhood ([Larkin and Simpson-Adkins, 2018](#)).

### 1.1. The routine enquiry into adversity in childhood (REACH) project

The REACH project involved five key elements in planning and delivery for each services ([Larkin and Simpson-Adkins, 2018](#)). This involved an initial evaluation of each organisation's readiness to engage in routine enquiry, which helped to identify any systemic barriers. The second stage involved a review of the organisation's management processes required to support effective and safe enquiry. The third stage involved the delivery of the REACH training, which was tailored to each organisation's specific needs. Within the fourth stage organisations were offered follow-up support including consultation and supervision to staff and leadership teams to ensure effective implementation. The final stage involved an evaluation of the implementation of REACH to assess changes in practice and the impact on services and service users. The present study was one part of the final evaluation stage.

The Adverse Childhood Experiences (ACE) Awareness training specifically aimed to help practitioners develop confidence to routinely ask about adversity as part of their standard assessments, to increase knowledge and awareness of the potential consequences of adversity and to develop skills in responding appropriately to disclosures of adversity, including appropriate referrals ([Larkin and Simpson-Adkins, 2018](#)). Following the two-day training event practitioners began to embed routine enquiry into their practice and were provided with regular follow-up sessions with a REACH trainer to allow space for reflection and skill development. Alongside this, the project supported organisations and teams to consider potential risks and challenges, and to ensure that

appropriate support for staff was in place.

Four sites were selected to pilot the REACH project, which consisted of one NHS service, two services from the charitable sector, and one from a local authority, all of whom worked directly or indirectly with children and young people. All of these services were within one locality in the North West of England, providing services to one of the most disadvantaged populations in the UK. According to the English Indices of Deprivation ([Department of Communities and Local Government, 2011](#)), this locality, with a population of 147,489, has some of the UK's highest rates of child smoking, pregnancy and death, has higher than average rates of self-harm and hospital admissions for intentional and accidental injuries, and more than a quarter of the young people in this locality are thought to use illicit substances.

### 1.2. Aims of the present study

The literature suggests that ACEs significantly increase the risk of poor health, social and psychological outcomes in adulthood. It is, therefore, essential that such experiences are identified early in a child's life to ensure that appropriate support can be provided to minimise the impact they may have. Despite this, there is also evidence that people do not spontaneously disclose ACEs, which suggests it should be the practitioner's responsibility to ask about them. However, it seems there are significant barriers to practitioners asking about early adverse experiences. The REACH project addressed these barriers and trained practitioners within four pilot sites who were working with children, young people and families to ask about ACEs and to provide appropriate support following disclosure. The aim of this research was to construct an understanding of the experiences of practitioners who were trained to routinely enquire about ACE experiences. It was hoped that insights into their experiences would further our understanding of what better facilitates, and hinders, routine enquiry, allowing for recommendations to be made with regard to the future of embedding routine enquiry in to practice.

## 2. Method

### 2.1. Participants

Participants invited to take part in this study were health and social care practitioners from four pilot sites involved in the REACH project. To meet the inclusion criteria of the study, participants had to have been ACE-trained at least three months prior to the study.

It is important to note that despite each service having received the same REACH training, each of the four services that took part in the REACH project provide a range of services to different client groups. Therefore, the experiences of practitioners embedding routine enquiry may be different between services. The following section will, therefore, describe each service in more detail to provide an overview of the context in which each of the participating practitioners worked.

### 2.2. Health visitors

The NHS service that took part consisted of Health Visitors who worked with families following the birth of a child and provided follow-up visits throughout the first year of the child's life, and then provided continued support as needed. As part of their role, Health Visitors encouraged healthy lifestyles and addressed any concerns regarding the physical, mental or social wellbeing of children. Health Visitors also lead on the Healthy Child Programme: Pregnancy and the First 5 Years of Life ([Department of Health, 2009](#)), a policy designed to ensure that all new parents have access to immunisations, health screens, development reviews, and advice around health, parenting and well-being.

This service was chosen as a suitable pilot site primarily since identifying ACEs within families during pregnancy and during the very early years of a child's life families could receive the appropriate help, which

would aim to prevent poor outcomes for the child. Furthermore, Health Visitors work with all new families within a population, and will, therefore, work with many families experiencing adversity.

Prior to the REACH training, Health Visitors used the Health Needs Assessment (Wright et al., 1998), which is a comprehensive initial assessment tool that includes items related to ACEs such as those associated to domestic violence and substance use. Following the REACH training, the service included more in-depth ACE questions relating to a more diverse range of ACEs and with a more in-depth questioning style, which aimed to ensure that ACEs were not overlooked.

### 2.3. Drug and alcohol charity for young people

A charitable service offering support to children and young people up to the age of eighteen who were experiencing difficulties with substance use also took part in the REACH project. Support Workers within this service worked individually with young people, their families and their communities to prevent and reduce substance use and to promote recovery and wellbeing. This service was chosen to pilot routine enquiry since the practitioners worked closely with help-seeking young people experiencing significant difficulties and adversity in their lives.

Prior to the REACH training, the Support Workers within this service did not include any questions relating to ACEs within their initial assessment. Therefore, following the REACH training, the service added a new section covering adversity in childhood.

### 2.4. Charitable family support service

Family Advocates took part in the REACH project who worked within a local charitable service offering support to families within the local community. The service aimed to offer support to those experiencing a range of difficulties including unemployment, addictions, domestic violence, relationship difficulties, mental and physical health problems. The support that the Advocates offered was wide ranging including individual emotional support, parenting interventions, practical support, advocacy and signposting.

Prior to the REACH training, practitioners within this service had not considered ACEs within their work with families, and developed a new section in their initial assessments that covered adverse childhood experiences.

### 2.5. Local authority family support service

Family Wellbeing Practitioners took part in the REACH project working within a local authority service providing an outreach service to families who were experiencing a range of difficulties. The service works within a framework developed locally and approved by the Health and Wellbeing Board and the Local Safeguarding Children Board. The framework is based on a stepped model involving four levels. Family Wellbeing Practitioners within this service work within Level Three of the model, which identifies health, social, educational, emotional and behavioural, environmental and parenting needs and aims to work closely with families to reduce specific targeted problems.

Family Wellbeing Practitioners were chosen to take part in the pilot since they work closely with families who often have high numbers of ACEs and their primary aim is to reduce adversity in families. Similarly to the Health Visitors, this service also used the Health Needs Assessment (Wright et al., 1998) as part of their screening prior to the REACH training, and included a broader range and more in-depth questioning to their assessment following the training.

In total, sixteen practitioners across these four services were informed of the study by the researcher during meetings: five Family Advocates working for the local authority family support service, three Family Wellbeing Practitioners from within a charitable organisation, three Support Workers within the charitable drug and alcohol service, and five Health Visitors within the NHS Trust. Of these, seven participants

contacted the researcher and volunteered to take part: three Health Visitors (given the pseudonyms Jen, Sarah and Zoe), two Family Advocates (given the pseudonyms Sam and Tara), one Family Well-Being Practitioner (given the pseudonym Breda), and one Support Worker (given the pseudonym Pete).

### 2.6. Data collection

Initial contact was made via e-mail to the managers of each of the four sites who passed on the study information to their practitioners. The researcher met with those practitioners who wished to take part individually at their places of work. The researcher developed and used a semi-structured interview that was guided by previous research (Read et al., 2007; Toner et al., 2013) and was developed with guidance from both the research supervisor and the two REACH project leads. During the interviews the researcher used this as a guide to ensure topics were covered that were significant to the research questions. However, open questions were used that allowed for the content to develop organically and allowed for the discussion of areas that were pertinent to the individual experiences of each participant. As the interviews progressed, the interview guide developed to include coverage of additional issues that were emerging that had not already been included.

Interviews lasted between thirty and ninety minutes, and were audio recorded. The recordings of each interview were then transcribed and assigned pseudonyms. Identifiers within the interviews were also removed during the transcription process. The research supervisor read the researcher's first transcript to ensure suitability of questioning style and to ensure that appropriate information was being elicited sensitively prior to commencement of the remaining interviews.

### 2.7. Analysis

Stages of thematic analysis, as recommended by Braun and Clarke (2006), were used, with an added element of interpretation. Initially, the researcher ensured familiarity with, and 'immersion' into, the data by reading and re-reading the transcripts (Braun and Clarke, 2006). The researcher then proceeded to make initial notations on the transcripts which included points of interest together with some interpretive thoughts, and were subsequently developed into codes. Similarities in content were then considered between the codes and these were combined into groups of codes. The researcher then created a table consisting of the groups of codes along with their original quotations. In a third column, the researcher wrote a narrative that encapsulated each of the codes within each group, thus developing initial themes. To ensure that each theme was grounded in the data set they were systematically checked back against the transcripts. The researcher then gave each of the initial themes tentative titles. This complete table was then sent to the research supervisor to ensure methodological rigour and reliability. The tentative themes derived from this first transcript were used to guide the remaining analysis process. Upon reaching saturation of coding, the tentative themes were re-read and those that could be collapsed and combined with other pertinent themes were. Finally, to ensure the final themes were representative of the data and the data was accurately captured in the narratives, the whole data set was re-read for a final time.

For transparency, this process can be illustrated as follows. Within the first transcript, the interpretations "difficult disclosures become a burden to self", "fear of not responding adequately" and "hearing disclosures is overwhelming" were combined into the theme: "The pressures and burden of hearing disclosure". In order to encapsulate both individual and shared experiences, initial themes were kept in mind when analysing the remaining six transcripts, while remaining sensitive to new and unique information. As such, the theme above was merged with another theme: "Positive self-experience resulting from disclosure" and renamed: "The emotional impact of hearing and responding to disclosure". Once each of the final themes had been identified, the researcher further analysed each theme to ensure they were distinct in content, whilst

simultaneously overlapping, and that they were clearly and reliably representative of the data set.

The researcher took relevant steps to ensure the quality of the research through regular supervision with the research supervisor and with the use of participant quotes throughout the results section. The researcher kept a reflective diary throughout the analysis process to allow for reflexivity and the identification of researcher bias, which had the potential to impact upon the interpretation of the data.

### 2.8. Ethical considerations

The researcher gained ethical approval from Lancaster University's Faculty of Health and Medicine Ethics Committee, along with approval from the relevant research and development department within the National Health Service.

Due to the potentially distressing content of the interviews, the researcher ensured that procedures were in place for any situation that could arise if the participant became distressed. Information was provided about the possibility of distressing content arising during the interviews and how this would be responded to. Furthermore, a list of other services and contact details were provided for participants to contact in the event of experiencing distress. Additionally, within the application to the ethics committee the researcher outlined a plan of how they would respond to distress during the interviews, ensuring that such issues would be dealt with sensitively and appropriately to ensure minimal distress. Prior to the commencement of the interview, all participants were made aware of their right to withdraw from the study at any time, up to the point of write-up, and the limitations of confidentiality were explained.

## 3. Results

The analysis elicited five themes: (1) change in knowledge, perception and practice; (2) the emotional impact of hearing and responding to disclosure; (3) confidence in asking and responding appropriately; (4) making sense of the impact of disclosure for clients; and (5) how and when to ask about adverse experiences.

### 3.1. Theme 1: change in knowledge, perception and practice

This theme represents the varying degrees of impact that the REACH training had for participants' knowledge and awareness of ACEs and how this impacted on their perceptions of clients and their clinical practice. The extent to which the training impacted upon individual participants ranged considerably from little to considerable.

This varying degree of impact seemed to be predicted by prior experience of considering ACEs within practice. Those with no prior experience described more significant changes: "I don't think that without the knowledge of the ACE questions and the scores I would have picked up on those issues" [Breda], whereas those with prior experience described less change.

Participants talked about experiencing transition toward a more ACE-informed understanding of their clients: "I think because I knew about those ACE questions, I knew where dad was coming from, rather than dad just being a difficult parent, well it just made more sense" [Breda]; and of the difficulties they were experiencing:

It were good for us to understand, when these adverse childhood experiences happen to somebody, how it does go on to lead to alcohol use, mental health problems and things like that, so it made us more aware. [Sam]

Participants identified how this increase in awareness impacted on their practice including, "the referrals we are making, making sure people are getting the support they need...I have sent probably a lot more referrals through for counselling" [Sam], or offering additional support: "We can do some structured listening visits or something like that, and if

we feel it is impacting on their parenting we can do some work on parenting" [Zoe].

One of the most commonly identified changes to practice was related to the therapeutic conversations that participants had with their clients following disclosure. Participants spoke about revisiting disclosures throughout their work, helping their clients to gradually understand the links between their ACEs and current experiences:

I think it's one of those things that you have the knowledge there, I think you hold on to it and I think you kind of go in when you feel now is the time...I revisit it...I might not have explored it at the time but... something come up and you say, oh do you remember when you said that happened and how that you made you feel. [Breda]

Participants acknowledged changes to communication between services and how the ACE information could "help you be a bit more of an advocate for the family" [Sarah], which seemed to facilitate an increase in understanding and empathy among other professionals toward clients: "that then changed the way [the health professional] behaved toward [young person] and then his relationship with her started to improve." [Pete].

Those participants who felt less dramatic changes within their awareness or practice described the inclusion of more in-depth ACE questions to their initial assessments: "with the ACE questions I think it's more thought provoking...a deeper level." [Jen], and facilitated more confidence asking ACE questions: "the training gave me the basis of saying yes you are confident and competent" [Tara].

### 3.2. Theme 2: the emotional impact of hearing and responding to disclosure

This theme represents the different experiences among participants regarding the personal emotional impact of hearing and responding to disclosures. Some participants described feeling "nervous" [Sam] at first and expecting routine enquiry to be a difficult experience, but in practice, clients rarely reported experiencing difficulties. Participants acknowledged some degree of distress as a normal emotional response since "you're only human" [Jen], and that was particularly pertinent for participants with regard to children's ACEs: "you still look at that baby and think that's a brand-new life and already it's come in to this world with a high ACE score" [Breda].

However, participants also acknowledged positive emotional experiences that, for most, seemed to outweigh any negative experiences. Participants spoke about feeling "more determined that I am going to help" [Sarah], and feeling "honoured and blessed that I've been there to get them through whatever they're going through" [Tara]. Furthermore, participants talked about how a more ACE-informed awareness helped to maintain a sense of motivation and drive that seemed to protect them from burnout:

I think that just gives you that drive to keep going...I've taken five steps forward and five steps back, you know, and I think where you kind of go, why am I bothering, you know why you are bothering and you know why it matters. [Breda]

Conversely, one participant expressed increased distress associated with routine enquiry. This participant described talking to clients about their disclosures as a "lost world" [Pete] and felt that disclosures became his "burden as well when they've shared it" [Pete]. This participant felt it difficult "to move on from that after you've closed the session" [Pete] and felt "forced to do that" [Pete] due to time limitations and service restrictions. A significant part of this participant's distress seemed to result from experiencing conflict between feeling obliged to respond to the disclosure since "it's been disclosed to me" [Pete], and feeling that "I'm not qualified to be dealing with that" [Pete]. However, this participant also described emotional responses as positive:

I think if you try and not let it affect you then it's going to stop you from being effective with that person in a way because you're not being genuine, and I think that would come across. [Pete]

### 3.3. Theme 3: confidence in asking and responding appropriately

Much of the variation within the emotional impact that routine enquiry had for participants seemed to be related to the degree of confidence that they felt in their ability to ask the questions and respond to disclosures appropriately.

Participants commonly spoke of an initial concern about asking the questions, feeling they might be “opening a can of worms that we can't deal with” [Breda], and feeling concerned that “we're going in and they're bringing up a lot of stuff and some of it has been very traumatic for them and then we're doing that and then kind of leaving” [Sam]. However, the majority of participants never felt “unable to support someone” [Zoe], and for most this was an initial concern that did not materialise.

Important factors were identified with regard to facilitating confidence in asking and responding to disclosure, including feeling “able to refer that person on when necessary” [Jen], and knowing when not to refer on: “I feel confident that I don't always need to do something about it” [Tara], since participants felt that for some clients “it just helps to talk about their experiences” [Sarah].

One participant, however, described feeling significantly under-skilled to respond to disclosure appropriately: “I don't have the confidence to, and...I get quite emotional about this kind of stuff, and not knowing what to do, it's worse than, I don't know, it's worse because I don't know what to do” [Pete].

Importantly, it seemed that this discrepancy regarding confidence was related, not only to the extent of previous experience of routine enquiry, but also the extent to which they perceived support from within their organisations. Participants spoke about the importance of not only feeling supported by their managers: “we have always got our managers there daily, and you'd never hold on to anything yourself” [Sam]; and finding “clinical case supervision really useful” [Jen]; but also having the opportunity for peer support and “informal supervision in the office” [Zoe]:

We are all out there doing it, and it's like peer supervision, and I think, yeah, it's great to have the expert there, to also have your peers and to be able to share good practice and to say yeah we are out there doing it, we are on the front line and we are actually asking the questions, I think that is really useful. [Breda]

The majority of participants also felt that the training had covered sufficient detail to prepare them for embedding routine enquiry into practice, including detail such as “how we would do it, what a session would look like, how would we start it, when would we do it, how would we ask the questions” [Sam].

Following the training, it seemed important to participants that they were asked to routinely enquire with a limited number of new cases, and then met with the trainer “regularly...where we were coming back and feeding back what our experiences were” [Sam]. Feeling that the ACE trainer was always contactable and “would know what to do if I came to you with a scenario” [Breda] also seemed to facilitate confidence.

### 3.4. Theme 4: making sense of the impact of disclosure for clients

Following the REACH training and subsequent changes to practice, participants reflected on the impact this had for their clients. The range of experiences identified within this theme is reflective of the range of client groups participants worked with, as well the diversity among their individual roles and service focus.

Some participants acknowledged negative aspects of asking people about ACEs, particularly when they felt clients did not want to discuss

their experiences: “they've kind of buried the problem, and so by discussing it with them is bringing it back up to the surface” [Pete]; when they felt their clients were at a particularly vulnerable times in their lives: “it can make people open up about things they don't necessarily want to think about...and it's an emotional time when you've just had a baby” [Sarah]; and when the participant felt it has been unnecessary: “sometimes when people don't want any help or support...and I've just brought it up for no reason” [Jen]. However, for the majority of participants described, these as rare and isolated occasions.

One of the most commonly discussed and most salient experience for participants was related to the therapeutic conversations they had with their clients and how these would often facilitate considerable changes in thinking. Those participants who worked with families often talked about having “in-depth” [Jen] conversations with parents about how they were parented and how this reflects in their own parenting styles, thus helping parents to consider the impact their parenting was having on their children. Participants felt it was important to help parents to “understand what's happened to them in their childhood, if we can stop them repeating those issues then hopefully we can make a better outcome for those children” [Sarah]. It seems these experiences were often dramatic and invaluable for some clients with participants describing them as experiencing “light-bulb” [Tara] moments:

I had a mum the other week and she said, no I were brought up fine, and then the week after I saw her and the little boy were struggling and I said, how did your mum manage with you, and she said, oh she just used to send me upstairs, she just used to ignore us, and I said, hey last week when you said everything were fine and dandy, how did you feel when your mum used to just send you upstairs, and she went [light bulb moment], and I could see it in her eyes...she knew she'd become her mum [Tara]

Furthermore, helping families to understand their situations in relation to their ACEs seemed to empower clients and increase their sense of autonomy over making change: “[parents] are able to identify the things they want to change so they are taking ownership of that and then we are kind of just helping them along with that journey” [Sam].

Participants acknowledged that this change in clients' awareness helped them to feel less “done to” [Breda] by services as they have previously:

Because I think it's so ingrained, well here we go again, I've just got to do what I'm told to do, and then not getting anything out of it because they don't understand why they're there, and this is why we get this cycle and why we get families coming back through agencies and support and why things keep going wrong. [Breda]

Importantly, participants talked about helping clients to address the impact of ACEs as the “missing link” [Tara] in their work since clinically targeting these underlying difficulties seemed to facilitate more lasting change within families:

For the families that have looked at ACE and have been to counselling, them families are actually maintaining which is different to [before] because we weren't addressing any of the underlying issues, and I think the family maintain the changes they make because they look at the underlying issues deeper. [Sam]

Alongside this, participants acknowledged that often parents had never considered the impact their experiences were having on their children: “most parents would just say that the children weren't affected by it, the children don't see it, I cover it up” [Breda]; and that change within families is a gradual process: “the conversation has been had...its food for thought, so it might not be initially, but it might be in the future that there are changes” [Tara]. It seems this gradual process of change is facilitated by parents beginning to question their experiences in relation to ACEs:



It's not suddenly changed thirty odd years of a behaviour...and it hasn't undone all those experiences, but it has made them question now, what are my children going through...what ACEs am I putting in front of my children, and I think it's started that journey for them. [Sam]

However, the significant changes described by participants seemed to remain within a large minority of cases:

I think for some parents you never really get passed that, well it's not going to impact on my children they're fine...I mean, I'd like it to happen more often, but I think if I've got twenty families I work with, and five of them are actually questioning now, you know. [Breda]

However, in addition to the significant and salient experiences participants identified, there also appeared to be subtler positive consequences of routine enquiry. Participants felt that clients have positive experiences from being listened to: "just being aware of that and giving her time to offload and contain her" [Zoe]; that clients feel "grateful for the opportunity to talk about their early experiences" [Sarah]; and that they feel heard since "they have never been asked these questions before" [Jen]. Positive changes in relationships within the families were also noted through an increase in communication and understanding: "that opened up that communication for the two of them...and they said they have understood one another more" [Breda].

### 3.5. Theme 5: how and when to ask about adverse experiences

This theme represents the range of practical considerations that participants made with regard to routine enquiry. A commonly discussed practicality related to asking the questions at the most appropriate point in the assessment. Alongside embedding routine enquiry into every initial assessment, it seems it is also important to consider asking the questions at the most appropriate time and to balance this with the demands of the organisations:

I mean some families it might not be appropriate to ask on that first visit and you know if I've got a mum and she's in floods of tears...I'm not going to start saying to her, you know, so yeah it's about being appropriate, and again this can be hard against what [our organisation] are asking us to do because [our organisation] are saying on the primary visit this is what we need to be doing so that can be a little bit hard, but you know, I could stand up and justify why I didn't do it. [Sarah]

For some participants, preparing their clients for the session was important "because it's no good doing it if she's going to have a house full of children or a friend over who she doesn't want to speak in front of" [Sam]. Furthermore, participants commonly felt it was important to explain to clients why they were asking the questions and "how [ACEs] can impact on us and how...we can try and bring our children up a bit different" [Tara]. Some participants found this to be enough to prompt clients to disclose their ACEs: "very often people open up all sorts and you don't need to trigger anymore" [Zoe].

The development of a working relationship also appears to be important for participants before they ask the questions: "if the person doesn't want to answer the questions we could revisit it later on once we had built up a rapport with them, got a relationship with them" [Pete], and "later, when we've built that relationship, then they do open up" [Tara]. It seemed this was particularly important when working with families who had been in contact with services for a long time and who may have become "guarded against" [Breda] professionals.

Participants acknowledged that using adaptive language was important when asking the questions: "I think for some parents, the way you word [emotional neglect], you know, did you feel supported by your parents, did you feel somebody was there for you emotionally" [Breda]. Furthermore, it seemed often clients would openly disclose the information, whereas others would be more hesitant, and participants spoke

about adapting the way they ask the questions, for example to be "a little bit more probing and try to get it in a different way" [Jen].

There were some discrepancies among participants with regard to how to ask the questions. Some felt asking the questions in a non-structured, conversational style was important to "make it as non-threatening and as informal as [possible]" [Breda]. Others felt that asking the questions in a more structured format was more helpful for clients, "because if you ask it in a different way it wouldn't be as effective, there's only one way, just come out and say it" [Pete]. Others felt directly sharing the questions with clients was most helpful: "so I'll say, you read the questions, and then do you want to share anything" [Tara].

Participants spoke about the importance of revisiting, not only the questions, but also any disclosures later during the course of their work together. It seems that asking the questions and identifying ACEs was often the start of the process for participants and that they would reflect disclosures back to clients during the course of their work together: "I'd often reflect back and say; can you see how this behaviour is maybe due to that" [Sam].

In summary, there were common factors within this theme including asking the questions following the development of a working relationship and having an understanding of why they were asking the questions which in turn allowed them to ensure that clients understood why the questions were being asked. It also seemed important for participants to use adaptive communication skills and professional judgement within each case to make clinical decisions about when and how to ask:

I think it's just about personality, building up a relationship, body language, where they are and being confident in how you do it and why you are doing it, really focussed on why you are doing it, and I don't think you could make it any other way. [Tara]

## 4. Discussion

The aim of this research was to construct an understanding of the experiences of practitioners who were trained to routinely enquire about ACE experiences. A form of thematic analysis was used to elicit five main themes: change in knowledge, perception and practice; the emotional impact of hearing and responding to disclosure; confidence in asking and responding appropriately; making sense of the impact for clients; and how and when to ask.

Following the REACH training, participants described more in-depth, empathic understanding of their clients' difficulties based on an increased awareness that early adversity predicts poorer outcomes, which is in line with the developing empirical literature cited at the outset of this paper. Furthermore, participants expressed commitment to routine enquiry as a result of the REACH training and highlighted the positive impact it has had on their clinical practice. This is reflective of previous (Toner et al., 2013) that described trauma-informed models of understanding psychosis as the core-driving factor that shaped practice for practitioners working with adults experiencing psychosis.

An important finding of this research is that participants commonly spoke about the shift toward more ACE-informed formulations of their clients' experiences leading to changes in clinical practice, which, in turn, facilitated more lasting change for clients. This seemed to be primarily related to three areas of practice; through an increase in therapeutic conversations, an increase in collaborative working, and more empathic, ACE-informed understanding of clients' difficulties.

Within therapeutic conversations participants reported that, as a result of routine enquiry, they helped clients to make links between their ACEs and current situations, difficulties or parenting styles. Participants identified this as a key factor in helping families to make more significant and lasting change. This is consistent with previous findings in which Gumley and MacBeth (2006) found that facilitating clients to make such links helped to normalise experience, reduce distress and increase a sense of control.

Participants also reported that helping clients to make these links increased collaborative working and led to more ACE-informed, formulation-driven intervention plans, both of which have been identified as significant predictors of outcomes in therapy (Wright and Davis, 1994; Larkin and Read, 2008). Participants also described experiencing an increase in empathic understanding of clients' difficulties which may also facilitate more lasting change since client perception of clinician empathy is also one of the most significant predictors of outcomes in therapy (Horvath and Symonds, 1991; Lambert and Barley, 2001).

Increased ACE-informed formulations also predicted a self-reported increase in referrals to counselling services to allow clients to work therapeutically through the impact of their experiences. This is consistent with Felitti and Anda (2014) who, following the introduction of routine enquiry into practice within a primary care setting, found that conversations with clients around their disclosures helped practitioners to better understand what help they could offer.

Consistent with previous research (Young et al., 2001), participants commonly expressed concern prior to routine enquiry with regard to causing unnecessary distress to clients. For the majority, however, this reduced with practice and, consistent with previous findings (Felitti & Anda, 2014; Lothian and Read, 2002), participants often felt that clients were grateful of the opportunity to share and to talk about their ACEs, particularly since they had often never been asked about them before (Read et al., 2006).

One participant experienced personal emotional distress as a result of routine enquiry, which seemed to be linked to feelings of conflict between feeling a need to respond appropriately to disclosure but not feeling competent to do so, alongside feelings of conflict between a sense of obligation to respond personally to disclosure and feelings of guilt with regard to referring clients on to relevant services. These factors may indicate a lack of opportunity for training and supervision for this participant, which seems to be in opposition to the experiences of the remaining six participants. Not only are adequate training and support essential for those practicing routine enquiry to ensure confidence and competence (NICE, 2014), but are also important factors to prevent symptoms associated with vicarious trauma and burnout in those working empathically with trauma histories (Trippany et al., 2004; Azar, 2000).

The majority of participants, however, expressed confidence in their ability to ask and respond appropriately, and also identified positive emotional experiences related to routine enquiry which seemed to buffer the potential for burnout. Interestingly, these participants highlighted peer supervision as one of the most important factors in maintaining confidence and developing skills. This is consistent with previous research that suggests peer supervision is important for those engaging with clients' trauma histories as it allows for the sharing of helpful coping strategies, decreases experiences of isolation, and increases resilience (Choi, 2011; Townsend and Campbell, 2008; Catherall, 1995; Lyon, 1993).

In terms of the practicalities of asking about early adverse experiences, there were commonalities among participants such as the importance of building rapport with clients before asking and using clinical intuition to make decisions about the style of language to use and appropriate times to ask. The use of adaptive language is an important feature in Read et al. (2007) recommendations about how to ask about trauma, who suggest that considering how to frame questions in individual cases is important for eliciting ACE information. Furthermore, the use of clinical intuition to make decisions about language style and appropriate timing is consistent with findings by Toner et al. (2013). These authors go on to suggest that these intuitive aspects are difficult to teach since they are more reflective of underlying personal qualities. This may suggest that it is not only important for practitioners to use adaptive language to suit the needs of the client, but also to use a questioning style that suits their own personal qualities.

The discrepancies among participants in terms of whether they chose to use structured or non-structured approaches to asking the ACE questions seemed to be related to their attempts to create positive working

relationships, to reduce power imbalance, and to ensure collaborative working. One common factor among participants was related to a sense of importance of having a clear sense of why the questions were important to ask, which in turn helped increase confidence in asking. This is again reflective of Toner et al. (2013) research who identified that practitioners felt it more pertinent to know "why ask" than "how to ask", and that this was based on the development of psychological, trauma-based formulations of clients' experiences, which led to increased commitment to, and confidence in, asking ACE questions.

In terms of when to ask, the findings suggested that participants aimed to ask during the initial assessment, however, it was often felt that either this was an inappropriate time due to environmental factors, or that clients felt unable to be open about their experiences due to not yet having developed a rapport. This is inconsistent with Read et al. (2007) recommendations, who suggest that ACE questions should be asked at the initial meeting since a delay in asking decreases the likelihood of them being asked at all. However, the participants in this research did not suggest this was the case, and it seemed they held the questions in their minds throughout their work, always gathering new information and revisiting the questions as their relationships developed. This discrepancy may be reflective of the REACH training, which seemed to instil commitment to the questions by developing ACE-informed models for understanding their clients' difficulties.

In conclusion, the research findings suggest that the REACH training facilitated more ACE-informed formulations for participants of their clients' experiences, which increased empathic understanding, allowed for more collaborative working, and increased therapeutic conversations and self-reported referrals to counselling services. This change in practice, particularly through therapeutic conversations, seemed to help clients gain a better understanding of the impact of their early adverse experiences on their own parenting styles and how these may impact on the future of their children. Importantly, participants viewed this as a fundamental factor in helping clients to make more significant and lasting changes for the future of their children.

Factors that facilitated confidence and competence in asking ACE questions and responding appropriately to disclosure included follow-up training, support from managers and clinical supervision, and informal peer supervision. The competencies that developed through these mediums allowed participants confidence to use clinical intuition to make decisions about when to ask ACE questions, and to feel confident in making decisions in relation to offering more support, allowing the person to share their story, and making appropriate referrals.

#### 4.1. Limitations

A limitation of the research is that it explored the experiences of routine enquiry from the perspectives of practitioners who worked with a range of different client groups. This, therefore, affected participants' experiences of routine enquiry and some of the issues raised may have been unique to working with specific client groups. It is possible that those who experienced more distress associated with routine enquiry did so partly due to the context within which they worked.

Another limitation is with regard to the small sample size used. A larger number of participants within each service would have allowed for more clarity with regard to the previous limitation and allowed for more insight into the different experiences of practitioners working with different client groups. Despite this, the aim of this research was not to establish generalisability, but rather to explore the experiences of participants who were practising routine enquiry.

#### 4.2. Recommendations for future service provision

The most significant finding of this research suggests that change in practice and commitment to asking ACE questions is driven by practitioners' change in awareness toward more ACE-informed formulations of clients' difficulties; an essential aim of all future training.

Another important finding of the present study is that revisiting disclosure at pertinent times for clients throughout a period of work seemed to better facilitate the client to make links between past and present and may be an important predictor of outcomes. Therefore, the authors recommend that future implementation of routine enquiry should ensure that staff are trained to incorporate this revisiting skill into practice.

In addition to ensuring staff revisit disclosure during their work, the findings suggest it is essential that clients who have experienced ACEs have the opportunity to access appropriate psychological support, since this may be a significant factor in helping people to break patterns of behaviour that cause them to be regular users of services, allowing them to make more informed and lasting changes. It is also important to note, however, that the research findings suggest not all parents require, or want, referrals for psychological support, and that in the majority of cases therapeutic conversations with practitioners seemed to be sufficient to encourage change.

Based on the findings of this research, the authors also recommend that services implementing routine enquiry should ensure that support for practitioners includes clinical supervision that focuses on monitoring and maintaining good practice, alongside allowing space for the emotional processing of hearing and responding to clients' adverse experiences, recommendations that are also stated within NICE (2014) guidelines. Furthermore, it is recommended that group and peer supervision be an essential part of continuing practice for practitioners using routine enquiry, as it seems to facilitate the sharing of experiences and competencies, allowing for increased confidence.

The overarching finding within this research suggests that the REACH training, which provides practitioners with ACE information formulations of clients' experiences, and with the skills and confidence to routinely enquire about these experiences, is an invaluable therapeutic enabler for practitioners and clients. Based on the evidence cited at the outset of this paper that identifies ACEs as predictors of poor health, social and psychological outcomes in adulthood, routine enquiry and early intervention appears to be an essential development for future services. Based on the findings of the present research, it is recommended that those implementing routine enquiry in the future should ensure consideration of those factors presented in this paper that facilitate good practice and support for practitioners.

#### 4.3. Recommendations for future research

Future research should consider the specific needs of individual services in terms of the level and content of the ACE-awareness or routine enquiry training they require. Research could explore the experiences of staff working specifically with children and young people to determine if their experiences and training needs are qualitatively different from those working indirectly with children, for example with parents. This would highlight if more individualised training packages are required for different services. Clinical audits of referral patterns and psychological outcome measures following referrals would allow for empirical exploration into the extent to which there are changes in referral patterns and what impact they are having on clinical outcomes. Quantitative research could also explore the long-term impact of routine enquiry through longitudinal, prospective research measuring a range of outcome variables such as quality of life, subsequent service utilisation, psychological difficulties and health and social outcomes. This would provide much needed empirical evidence regarding the clinical, individual and economic impact of approaches such as REACH and inform policy and best practice guidance for all those professionals working directly or indirectly with children and young people.

#### Declarations

##### Author contribution statement

Josie Pearce: Conceived and designed the experiments; Performed the experiments; Analysed and interpreted the data; Contributed reagents,

materials, analysis tools or data; Wrote the paper.

Craig Murray: Conceived and designed the experiments; Contributed reagents, materials, analysis tools or data.

Warren Larkin: Conceived and designed the experiments.

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##### Additional information

No additional information is available for this paper.

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