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Childhood adversity and trauma: Experiences of professionals trained to routinely

enquire about child 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 disclose is unlikely, and practitioners tend not 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 are exposed to multiple adverse experiences. The present study aimed to explore the experiences of these practitioners. Seven interviews were conducted and the data was analysed using a form of 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 indicated that participants' change toward more adverse-experience-informed formulations of clients' difficulties ensured 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.

Childhood adversity and trauma: Experiences of professionals trained to routinely enquire about child adversity

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, Harvey, Mian, Furniss & Kahane, 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 prevalence of ACEs are difficult to accurately establish. However, according to the National Society for the Prevention of Cruelty to Children (NSPCC, 2013), in March 2013, more than 50,000 children were listed on the child protection register or were subject to a child protection plan in the UK, and were, therefore, at risk of abuse. These statistics, however, only show those children recorded on safeguarding lists and there are many at-risk children who are not reported to services, or to whom services do not respond (Munro, 2011). Radford, Corral, Bradley and Fisher (2013) highlighted the discrepancy between the number of children on the child protection register and the prevalence of childhood adversity in a large population sample. At this time, 0.35% of children were on the child protection register compared to a prevalence of childhood adversity in their sample of 6%.

Global prevalence rates are also difficult to establish. However, Kessler, McLaughlin & Green (2010) reported that 53.4% of 51,945 participants from twenty-one high to low income countries reported experiencing at least one ACE which is consistent with other estimates (Felitti et al., 1998). They reported the following in order of prevalence: parental divorce (17.5%); family violence (14%); economic adversity (10.6%); parental mental illness (10.3%); parental death (9.9%); parental substance misuse (8.5%); physical abuse (8.4%);

parental criminality (7.2%); other parental loss (6.7%); sexual abuse (6%); physical illness (5.8%); and neglect (5.6%). These figures, however, are likely to be significantly lower than the actual prevalence figures due to, for example, the under-representation of lower-income countries and rural areas and the possibility of retrospective-recall bias.

Despite difficulties with establishing prevalence, high estimates have attracted considerable attention resulting in a vast body of literature exploring the impact of adversity on a range of outcomes in adulthood. Research has shown that ACEs are linked to a range of poor social outcomes in adulthood including increased aggression (Sarchiapone, Carli, Cuomo, Marchetti & Roy, 2009), limited education (Scher, Forde, McQuaid & Stein, 2004), adolescent pregnancy and foetal death (Hillis et al., 2004), peer rejection (Anthonysamy & Zimmer-Gemback, 2007) and an increased risk of homelessness (Herman, Susser, Struening & Link, 1997).

Health behaviours and lifestyle factors have also been linked to ACEs, including sleep disturbances (Chapman et al., 2011), smoking (Ford et al., 2011), alcohol abuse (Dube, Anda, Felitti, Edwards & Croft, 2002), severe obesity, physical inactivity and substance misuse (Anderson & Teicher, 2009; Dube et al, 2003; Felitti et al., 1998), factors that are leading causes of morbidity and mortality in the UK (e.g. Khaw et al., 2008; Kvaavik, Batty, Ursin, Huxley & Gale, 2010) and in other parts of the world (Danaei et al., 2009; Knoops et al., 2004; Woo, Ho & Yu, 2002).

In terms of health outcomes, research provides evidence for strong associations between ACEs and, for example, an increased risk of lung cancer (Brown et al., 2010) premature death and chronic obstructive pulmonary disease (Anda et al., 2008), cardiac disease (Dong et al., 2004), sexually-transmitted infections, autoimmune disease (Dube et al., 2009) and liver disease (Felitti et al., 1998). Furthermore, Felitti et al. (1998) provided

evidence that the risk of developing multiple poor health outcomes increased as exposure to ACEs increased, providing evidence of a dose-response, and therefore causal, relationship.

Overwhelming evidence for the impact of ACEs on outcomes in adulthood is also apparent within mental health literature. For example, globally, the World Health Organisation (Kessler et al., 2010) reported in a sample of almost 52,000 participants from twenty-one countries that childhood adversity, including interpersonal loss, parental maladjustment and maltreatment, were significantly associated with the onset of a wide range of adult mental health diagnoses. The authors estimate that in the absence of childhood adversity there would be a 22.9% reduction in mood disorders, 31% reduction of anxiety disorders, 41.6% reduction of behavioural disorders, 27.5% reduction of substance-related disorders, and an overall reduction of 29.8% of mental health diagnoses.

The authors of this research, however, did not include psychosis within their outcome measures, which suggests these statistics are significantly under-representative since childhood adversity is consistently reported to be strongly associated with an increased risk of psychosis in adulthood (Beards et al., 2013; Bentall, Wickham, Shevlin & Varese, 2012; Varese et al., 2012).

Research has also begun to explore the relationships between specific childhood adversities and specific mental health outcomes. In a systematic review of the literature, Carr, Martins, Stingel, Lemgruber and Juruena (2013) found a range of associations including that physical abuse was linked to an increased risk of substance use, mood difficulties, anxiety disorders and eating disorders. The authors reported that sexual abuse was linked to dissociation, psychosis, anxiety and personality difficulties, and emotional abuse was linked to eating disorders, substance misuse and personality difficulties.

Furthermore, much of this empirical research provides evidence of a causal relationship between ACEs and mental health outcomes, reporting that the more severe or

more frequent the adversity experienced, the greater the risk of developing mental health difficulties (Kessler, et al., 2010; Norman et al., 2012; Read, 2006; Van der Kolk & Fisler, 1994). This 'dose-response' relationship provides evidence that adversity predicts poor mental health outcomes and not the reverse.

The literature in this area is subject to limitations. For example, the research is predominantly quantitative and therefore adopts rigid definitions and methods of measuring ACEs. However, there is much variability of these between studies, thus making comparisons difficult (e.g. Bendall, Jackson, Hulbert & McGorry, 2008; Morgan & Fisher, 2007). Another limitation to be noted is that much of the research relies on retrospective self-report measures that are subject to the possibility of recall bias among respondents (Norman et al., 2012). Despite this, there is evidence to support that people experiencing mental health difficulties accurately recall past traumas (Fisher et al., 2011; Kuyen & Brewin, 1995).

Furthermore, the evidence base contains a number of prospective and longitudinal studies with large epidemiological population samples (e.g. Green et al., 2010; Horwitz, Widom, McLaughlin, & White, 2001; Kessler et al., 2012), alongside methodologically sound and rigorous meta analyses (e.g. Afari et al., 2014; Chen et al., 2010; Devries et al., 2014; Hillberg, Hamilton-Giachritsis & Dixon, 2011; Irish, Kobayashi & Delahanly, 2010; Varese et al., 2012), thus providing robust and consistent evidence.

This strong evidence base has led to leading researchers in the field to argue that childhood adversity should be detected early with the aim of preventing these poor outcomes in adulthood (Munro, 2011; Read, Hammersley & Rudegeair, 2007; Read, Os, Morrison & Ross, 2005; Varese et al., 2012). However, a major barrier is that early detection currently relies primarily on the voluntary disclosure of adversity by children, young people and adults who use services.

Research suggests that those who have experienced abuse are unlikely to spontaneously disclose them. For example, Anderson, Martin, Mullen, Romans and Herbison (1993) found, in a sample of 252 women who had been sexually abused in childhood, that 52% waited ten years before they disclosed and 28% never disclosed, which is consistent with other findings (Frenken & Van Stolk, 1990; Read, McGregor, Coggan & Thomas, 2006). Furthermore, evidence suggests victims of abuse are no more likely to disclose to mental health services than to any other systems and often underreport (Dill, Chu, Grob & Eisen, 1991) or never disclose to services (Elliot, 1997; Finkelhor, 1990).

Young, Read, Barker-Collo and Harrison (2001) suggest that, since spontaneous disclosure is unlikely, it is clinicians' responsibility to ask about trauma and adversity. Indeed, 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. Despite this, the authors also found that psychiatrists were unlikely to ask, since 68% ignored a section in their initial assessment referring to childhood adversity.

Similarly, Read, McGregor, Cogan & Thomas (2006) reported that 63% of women who had experienced childhood sexual abuse and had received input from adult mental health services were never asked about childhood abuse. 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. Interestingly, Lothian and Read found that 69% of those participants believed there was a connection between their ACEs and current psychological difficulties, but only 17% of them believed that the mental health professionals involved in their care made the same connection.

Young and colleagues (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 second dominant theme, fear of causing distress to themselves, 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 (Michalopouloa & Aparicio,

2012; Pearlman & MacIan, 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, Kress & Wilcoxen, 2004).

With regard to fear of causing distress to clients, again this is a possibility, however,

Felitti and colleagues (1998) demonstrated that people are unlikely to become distressed by

such questions. As part of a research project, Felitti and colleagues asked participants about

ACEs and then offered them further support if they had been distressed by the questions. The

authors found that no one took up the offer, suggesting they were not distressed by the

questions. Furthermore, the authors reported that one participant sent them a letter following

the study in which they wrote, "thank you for asking. I feared I would die and no one would

ever know what had happened" (Felitti & Anda, 2014, p204-205).

This raises the question of how do we help mental health professionals feel more

committed to, and confident in, asking about ACEs. Read and colleagues (2007) responded to

this question highlighting the importance of considering the practicalities of asking ACE

questions, and published clear guidelines covering who, when and how to ask about ACEs.

The authors suggest it is essential that questions are asked during the initial assessment to

prevent later avoidance, and recommend that practitioners should provide an explanation as

to why the questions are important and also make clear the importance of adaptive language

to ensure elicitation. These guidelines have been used as a training model in both New Zealand and Early Intervention services in the UK, however, difficulties in embedding routine enquiry in everyday practice remained.

Toner, Daiches and Larkin (2013) explored the experiences of professionals within Early Intervention services who were trained 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.

The National Institute for Clinical Excellence (NICE) has also recently published guidelines for services working with adults and children who may be affected by violence and abuse (NICE, 2014). These guidelines state that frontline staff working with such client groups should be trained to recognise ACEs, to sensitively and appropriately ask about ACEs, and that training should ensure confidence in the ability to ask questions, how to respond appropriately to disclosure, and to ensure knowledge of referral pathways. The guidelines state that those frontline staff should receive regular training and supervision in which good practice is monitored and maintained and in which staff have the opportunity talk about their own experiences of violence and abuse, as well as those difficulties that arise as a result of working with such clients.

Based on the evidence cited at the outset of this paper along with the recommendations provided by leading researchers in the field and the professional guidelines provided by NICE, clinicians within an NHS Trust have 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 (REACh: Routine Enquire about Adversity

in Childhood: Larkin & Banner, *unpublished*). The present study was conducted within the REACh project, which will be described in more detail in the following section.

The Routine Enquiry into Adversity in Childhood (REACh) Project

The REACh project team developed Adverse Childhood Experiences (ACE) Awareness training based on Read and colleagues' (2007) and Toner and colleagues' (2013) research, and delivered it to four pilot sites across public and charitable sectors. The ACE 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 & Banner, *unpublished*). Following training, practitioners began to embed routine enquiry into their practice and were provided with regular follow-up sessions with the REACh trainer to allow space for reflection and skill development. Following this, services were expected to continue to offer regular supervision to ensure that routine enquiry remained an essential part of practitioners' roles.

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.

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 overarching aim of the present study was to explore the experiences of practitioners from within each of these services who embedded routine enquiry about adversity into their daily practice. It was hoped that insights into their experiences would further our understanding of what better facilitates, and hinders, routine enquiry, allowing for recommendations to made with regard to the future of embedding routine enquiry in to practice.

Method

Design

Qualitative methods of data collection and analysis were chosen since they are particularly suited to understanding subjective experiences (Smith, 2003). Furthermore, qualitative methods were chosen in order to gather detailed, rich accounts of participants' experiences, thoughts and emotions, which are difficult to obtain through quantitative methods (Braun & Clarke, 2006). Individual, semi-structured interviews were chosen as the method of data collection, which allowed the exploration of areas of research interest, whilst allowing flexibility to explore avenues that emerged as pertinent to the participant. A form of

thematic analysis was chosen to analyse the data since this allowed for themes to be identified describing common experiences among participants (Braun & Clarke, 2006).

Braun and Clarke's (2006) conceptualisation of thematic analysis, argues that thematic analysis, unlike other forms of qualitative analysis, is not bound within any one theoretical framework or within a particular epistemological position, and, therefore, can accommodate a range of positions. Within the present study, this allowed the researcher to derive themes from within the dataset using a realist, phenomenological perspective. That is, an epistemological position was adopted assuming that there is a close relationship between the ways in which people think and behave and that the language people use to describe their thoughts and experiences also reflect the meaning that they derive from them (Braun & Clarke, 2013). Furthermore, thematic analysis allowed the researcher to acknowledge their personal subjectivity in the research process allowing for interpretation within the analysis (Braun & Clarke, 2013).

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 ACE 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.

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 ACE training, Health Visitors used the Health Needs Assessment (Wright, Williams & Wilkinson, 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 ACE 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.

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

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 ACE 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.

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, Williams & Wilkinson, 1998) as part of their screening prior to the ACE 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).

Data Collection

Initial contact was made via e-mail to the managers of each of the four sites. The researcher then met with the managers and with practitioners from within the service who were available at that time. During these meetings, the researcher presented the rationale for the study and gave all those in attendance a copy of the Participant Information Sheet (Appendix G). Extra information sheets were left with the managers to give to those who could not attend. The information sheet provided details of the study, the commitment required, and provided the researchers contact details if they wished to participate.

The researcher met with those practitioners who wished to take part individually at their places of work. Prior to commencement of the interviews, the researcher explained the

limitations of confidentiality and gained informed consent with the use of a consent form (see Appendix H). The researcher also ensured each participant had the opportunity to ask questions before and after the interviews.

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 (see Appendix B). 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.

Analysis

Thematic analysis is an approach that can be used flexibly when analysing data qualitatively (Smith, 2003). The researcher used the stages recommended by Braun and Clarke (2006), 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 & Clarke, 2006). The researcher then proceeded to make initial notations on the transcripts (for an example, see Appendix C). These notations

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 (see Appendix D) 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.

In order to ensure 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. Within

qualitative research, aspects such as transparency and methodological rigour are important to

ensure the quality and reliability of analysis (Yardley, 2008), which the researcher took steps

to achieve through regular supervision with the research supervisor and with the use of

participant quotes throughout the results section. Furthermore, it is acknowledged that the

researcher is a Trainee Clinical Psychologist and, therefore, has developed their own

understanding of ACEs and has similar professional experiences to the participants taking

part in this study in terms of eliciting information about ACEs to inform formulations about

clients' experiences. Consequently, the researchers 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.

Ethical Considerations

The researcher gained ethical approval from Lancaster University's Faculty of Health

and Medicine Ethics Committee (see Appendix K), along with approval from the relevant

research and development department within the National Health Service (see Appendix L).

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. Within the Participant Information Sheet (see Appendix G) that was initially given

to participants, 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 (for full application form see Appendix I; for excerpt regarding responding to distress see Appendix E).

It is important to note that during data collection, one participant expressed some distress during the interview and asked for the interview to be paused. Following pausing the audio recording, the participant and researcher discussed the distressing material. When the participant indicated they were no longer distressed the researcher suggested continuing the recording since all of the information he had to talk about would be important for the analysis; the participant agreed for the interview to be reconvened and recorded. Following the end of the interview the researcher and participant discussed the distressing content further. However, due to time restrictions for the participant, this was brief; the researcher therefore telephoned the participant at the end of the working day to ensure his wellbeing and suggested further support if he felt it was needed. The participant assured the researcher that distress had not continued following the conclusion of the interview but the researcher ensured the participant had contact details for further support should the need arise. The research supervisor was also informed of this event, with the participant's knowledge.

It should be noted that 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.

Results

The following section reports the five themes that the analysis elicited: (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. All names reported in this section are pseudonyms to protect the anonymity of participants.

Theme 1: Change in Knowledge, Perception and Practice

This theme represents the varying degrees of impact that the ACE training had for participants' knowledge and awareness of early life experiences 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: some feeling little impact, "it was a nice informal session and kind of refreshed things…but yeah, nothing new" [Sam]; and some considerable impact, "prior to training we had never actually looked at adverse childhood experiences so it was really useful" [Pete].

This varying degree of impact seemed to be predicted by participants' prior experience of considering ACEs within their 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: "It's just about…trying to seek out if they had any traumas or difficulties in their childhood that then affect how they parent their children, so we already did that, and we also had routine questioning which, again, is routine for our service" [Zoe].

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]

Furthermore, participants identified how this increase in awareness then 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 with families and young

people, helping them 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 also 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].

In summary, the extent to which the ACE training impacted on participants varied.

This variation seemed to be related to the level of experience and awareness of ACEs

participants had prior to training. The training seemed to facilitate more ACE-informed

formulations of their clients' difficulties, which led to increased referrals to external services, including counselling, and allowed for more reflective and therapeutic conversations with clients.

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 felt no emotional impact since their practice had not significantly changed: "I don't think there's anything that's made anything more difficult, because, you know, we were having the levels of conversation that we are used to anyway" [Sarah]. Others described feeling "nervous" [Sam] at first and expecting routine enquiry to be a difficult experience, but in practice, clients rarely reported experiencing difficulties:

I've not had any negative experiences with doing the ACEs yet, yeah I have to say I was expecting to be going and looking at it and some people saying, well what the heck has that got to do with you, but I've not had any experience of that, I always find that people have been very open to talk about it. [Sam]

Participants did acknowledge 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 its 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:

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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 a significant level of 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]

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. The present theme reflects the varying degrees of confidence felt among the participants and the factors that seemed to impact on confidence.

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 participants this was an initial concern that did not materialise: "for me that was a worry but that hasn't happened" [Breda].

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 find 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].

Furthermore, this participant felt that, although they listened to clients' disclosures, that "that's not going to help the person" [Pete], and there was a sense of feeling betrayal by referring the client on: "I have just told you something and now you're telling me to go there and tell that complete stranger who I don't know" [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]

Interestingly, the participant who felt a significant lack of confidence in responding appropriately to disclosure described feeling conflict between seeking support from a manager and dealing with disclosure independently:

I mean, we can go to our managers, you know, whenever there is a problem, and they are available all the time and you can discuss stuff with them all the time, so again, it's my choice maybe whether I go to a manager or should I just deal with it myself first time, then I can deal with it rather than run straight to my manager, you know, venting out or whatever. [Pete]

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.

In summary, it seems that the more regular support participants received immediately following training was key to ensuring confidence in routine enquiry, and that following the appropriate reduction of this, that continuing clinical and peer supervision was important:

We had monthly supervision with the trainer and our manager and we shared, as a full team, our experiences and we backed each other up, we had all that and I think that's what has made us so confident in asking now. [Tara]

The participant who felt less confident felt that "the training was more about how to ask somebody about the childhood experiences rather than what to do next" [Pete]. This participant identified further requirements they felt they needed through training:

Definitely more training. How to close a session when something like that has been disclosed, something specifically on that and how to leave the person in a comfortable state so that when they come back in you can revisit it...and then for me myself it's, wow that's happened, now I have got someone else in five minutes, how do I detach? That's training again for staff. [Pete]

Theme 4: Making Sense of the Impact of Disclosure for Clients

Following the ACE 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 young people and families about adverse experiences, 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: "so you can have some really deep conversations, and how do you think, when you get mad like that, does that make your child feel" [Zoe]. 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 more subtle 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].

 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. However, other participants felt that clients were more likely to disclose to them because "they see us as health professionals and we probably get a lot more information than what we expect" [Zoe]. This may, however, reflect the different client groups that participants work with ranging from help-seeking clients to all new families from within the general population.

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]

Discussion

The aim of this research was to construct an understanding of the experiences of practitioners who were trained in adverse childhood experiences, and who were routinely

enquiring about these as part of their practice. 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 ACE training, participants described more in-depth, empathic understanding of their clients' difficulties based on an increased awareness that early adversity predicts poor 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 ACE training, and highlighted the positive impact it has had on their clinical practice. This is reflective of previous research in which Toner and colleagues (2013) 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 led 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 that participants had with their clients, through an increase in collaborative working, and through more empathic, ACE-informed understanding of clients' difficulties.

Within the therapeutic conversations participants reported as a result of routine enquiry, participants described helping 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 & Davis, 1994; Larkin & 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 & Symonds, 1991; Lambert & 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 finding is in contrast with previous research in which Agar and Read (2002) found that clinicians tended not to respond to disclosure with increased referrals. This discrepancy may reflect the impact that the ACE training had in facilitating fundamental changes in participants' understanding of the aetiology of their clients' difficulties, and thus commitment to change in practice. 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 & 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 is 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, 2001; 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 and colleagues' (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 and colleagues' (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 and colleagues' (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 ACE 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 ACE 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.

Limitations

One limitation of the present 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 ranged from participants who worked help-seeking young people experiencing significant difficulties, to participants who worked with all new families from within the general population. 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 routinely enquiring.

A final limitation that is important to note is that the researchers position within the research paradigm may have impacted upon participants' responses. That is, since participants were aware that the researcher was conducting research based on the REACh project and was receiving supervision from the leads of the project, they may have felt a need to demonstrate good practice and commitment to routine enquiry. Every effort was made, however, to reduce this possibility, and the researcher stressed at the beginning of the interviews that this research was independent of the project and that all responses would be entirely confidential.

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. Therefore, the researcher suggests that this should be a fundamental 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 researcher recommends 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 also 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 clients 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 clients 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 researcher also recommends 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 recommend 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 ACE 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.

Recommendations for Future Research

Due to the potential discrepancies identified within this study between the experiences of practitioners working with different client groups, it may be important to consider the specific needs of different services working with different client groups in terms of the level and content of ACE training that they require. In particular, research could explore the experiences of staff working specifically with children and young people to determine if their experiences and needs of training 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.

It may also be helpful to conduct quantitative research to determine if the differences in standardised versus conversational styles of asking the ACE questions leads to any difference in terms of rates of disclosure. This would further our understanding of the more helpful practicalities within routine enquiry, which would aid the development of the practice as it develops nationally.

Clinical audits could be conducted within individual services that are embedding routine enquiry to determine the extent to which referral patterns are changing. This would allow for insight into the extent to which practice changes as a result of routine enquiry. Alongside this, research could explore the impact that counselling has for those referred in terms of improvements to quality of life and psychological difficulties. This would allow for empirical exploration into the extent to which changes in referral patterns are impacting outcomes for clients.

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, psychological difficulties and health and social outcomes. This would allow

for empirical evidence that routine enquiry is essential for all those working directly or

indirectly with children and young people.

Dissemination Strategy

This research will be submitted for publication to the Journal of Psychological

Trauma: Theory, Research, Practice and Policy. The researcher chose this journal because of

its published content with the aim of highlighting the impact that psychological trauma,

including childhood trauma, has on psychological, social and health outcomes. Furthermore,

the journal publishes research that explores the practical and service-related issues relating to

psychological trauma. The editor, Dr Kathleen Kendall-Tackett, has a particular interest in

the impact of psychological trauma, and the impact factor for the journal is 2.097. The

journal is a publication from the American Psychological Association within the Division of

Psychological Trauma. Guidelines for authors published by the journal are included in the

Appendices (Appendix V).

In addition to submitting this study to an academic journal for publication, the

researcher intends to disseminate the findings to the leads of the REACh project and to the

services and participants who took part.

The researcher intends to write a concise report and executive summary suitable for

the leads of the REACh project which will include a summary of the findings, a brief

discussion regarding interpretation of these findings based on previous research, and the

researchers recommendations for future implementation of routine enquiry. This report will

be also be given to the services and participants that took part in the research.

Finally, the lead of the REACh project has requested that the researcher produce a

poster presentation of the findings of the research, and to orally present this at a research

conference, in coordination with other REACh project presentations. This extended

dissemination strategy aims to further promote routine enquiry across services and

researchers nationally.

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Appendices

Section 1

Appendix A: SRP suitability form

Appendix B: Interview schedule

Appendix C: Example of transcript with initial notations

Appendix D: Example of initial coding and narrative development for Pete

Appendix E: Section from ethics application form detailing plan of responding to distress

during interviews

Appendix F: Journal of Psychological Trauma: Theory, Research, Practice and Policy –

Instructions for Submission

Section 2

Appendix G: Participant Information Sheet

Appendix H: Consent form

Appendix I: Ethics application form

Appendix J: Research protocol

Appendix K: Approval letter from university ethics

Appendix L: Approval letter from research and development department

Appendix A: SRP suitability form

This form is for you to describe briefly (no more than one side of A4 in 12 point text) the topic of your proposed service-related project. This form must be submitted to the programme assistant (academic) who will forward it to the Chair of the Exam Board for scrutiny. Forms longer than one page long will not be accepted.

Name of trainee	
Title of proposed SRP	Childhood adversity and trauma: Experiences of professionals trained to routinely enquire about childhood adversity
Brief explanation of study content	This study aims to explore the experiences of staff who have received Adverse Childhood Experience (ACE) training and who are using routine enquiry in their everyday practice with children and young people. As part of a larger NHS funded project (REACh: Routine Enquiry About Adversity in Childhood) which is currently in a pilot phase, 3 staff members from each of the four pilot sites will be recruited. Semi-structured interviews will be used and analysed using a form of thematic analysis.
Rationale for proposed SRP	Literature suggests strong causal links between childhood adversity and trauma and poor health, social and psychological outcomes in later life, particularly experiences of psychosis.
Relevance to clinical psychology theory, practice or services	The REACh project has been developed by clinical psychologists. Clinical psychology theory takes in to account early experiences and this project is linking this theory and developing innovative practice based on this. The following paper aims to assist evaluation and aid development from the pilot phase.

Appendix B: Interview schedule

The following are a list of topics and subtopics that will be brought in to discussion by the researcher during the semi-structured interviews.

1. The impact of training
- Knowledge & Awareness of the consequences of childhood adversity
  - Could you tell me when you had the training and what you thought of it at the time?
  - Could you describe to me any ways in which you felt the training impacted on your knowledge or awareness?
- Confidence in routinely enquiring
  - Can you describe how you felt about asking the ACE questions following the training?
  - Could you tell me about anything that made you feel more confident / made it difficult asking the ACE questions?
  - What are your main thoughts or feelings about embedding routine enquiry into your everyday practice?
- Ability to respond appropriately to disclosure
  - Could you describe how routine enquiry has impacted on the way you work with clients?
  - Could you describe any ways that hearing disclosure may impact on you?
  - Can you describe any positive / negative experiences you have had as a result of routine enquiry?

2. Changes in practice
- How has your practice changed since training?
- What has helped/hindered routine enquiry?
- How has routine enquiry impacted on the work that you do with clients?
- In what ways do you feel that routine enquiry impacts on your clients?
- Could you describe any ways you feel your service has changed as a result of the training?

3. Practicalities
- How has support been provided from your service/organisation?
- How/when to ask:
  - Do you tend to ask the questions at a specific time?
  - Can you describe how you ask the questions?
  - Can you describe anything that you think helps when asking the questions?
  - Can you describe things you feel that cause barriers to asking the questions?

Don't forget:
- That's pretty much everything I wanted to talk to you about, is there anything you'd like to add that I've not asked you?

Appendix C: Example of transcript with initial notes

J – So it sound like it's distressing for you. Is it the response for you when someone discloses something to you? Is the difficulty how you deal with that?

P – When someone says something like that obviously you're going to get really emotional about it.

J – Yeah, definitely.

P – And looking at how young that person is and what they have had to deal with, can like, becomes your burden as well when they've shared it. And its hard because we get an hours slot with each client and quite often with our capacity we don't have a lot of room for manoeuvre, but its hard when someone has disclosed something so intimidate to move on from that, after you've closed the session, to move on from that to somebody else and then not think about that, its so difficult to do that, and as a professional quite often you're forced to do that, but then it depends on the individual, that person might then decide well, I am going to call that person again this week, or tomorrow, or even later on in the day, and spend more time with that person to try and resolve what ever issues there are or give them the best, rather than making a referral and that's the job done, it wouldn't, that wouldn't be the job done, cause that person is coming back to and coming back with the same issues, and by making a referral its not really dealt with, and they've disclosed it to you so you feel obliged to, you have to do something about it and quite often you cant devote as much time as you need to devote to it, because of the other caseloads that you have

J – Yeah, you've got limits haven't you.

P – Yeah, yeah

[Handwritten margin notes:]

Hearing difficult disclosures can become a burden

Difficult to emotionally detach from a person who has disclosed and move on to the next person.

Time limitations feel difficult when someone has disclosed.

Sometimes feel need to give the person more time following disclosure

Feeling obliged to deal with the disclosure

Time limitations are difficult as feel the need to spend more time with person following disclosure