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**Parents, Adverse Childhood Experiences and Psychological Distress**

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**Research Paper**

Exploring the Impact of Enquiring About the Adverse Childhood Experiences of Parents

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**Abstract**

Due to identified public health risks, there have been calls to develop methods of early detection in child and family services to interrupt the widespread impacts and intergenerational continuity of Adverse Childhood Experiences (ACE). Routine Enquiry about Adversity in Childhood (REACH) is a model that supports health professionals to consistently and appropriately ask service-users about ACEs in clinical practice. This study aimed to understand how parents, who had experienced at least one ACE, experienced being asked about their own ACEs and what, if any, subsequent impact occurred. Eleven semi-structured interviews were conducted across seven participants, analysed using thematic analysis. Three themes were developed. The first relates to a five-stage chronological model of ACE enquiry. The second raises issues of disproportionate social power in the enquirer-discloser relationship. The final themes illustrate a process of post-disclosure behaviour change, seemingly initiated by ACE enquiry. These findings provide a theoretical contribution to disclosure literature and provide clinical recommendations to support engagement of parents in discussions regarding the impact of trauma histories.

**Keywords:** Routine enquiry; adverse childhood experiences; trauma; parents; children

Although ‘trauma’ and ‘traumatic impact’ are terms in common academic and clinical usage, they remain difficult to adequately define. Efforts to clarify what is meant by these terms have focussed on providing or critiquing clinical definitions for the diagnostic criteria of post-traumatic stress disorder (PTSD) (American Psychiatric Association; APA, 2013; Division of Clinical Psychology; DCP, 2013; World Health Organisation; WHO 1990). These definitions have been widely criticised for their narrow focus, which excludes many experiences that may invoke a trauma response, but do not adequately meet the objective diagnostic criterion (Scott & Stradling, 1994). Diagnostic definitions also do not sufficiently acknowledge the subjective nature of traumatic experiences and response (see Bovin & Marx, 2011; May & Wisco, 2016; Weathers & Keane, 2007). Conversely, it has been suggested that it is the subjective cognitive appraisal of events, rather than an objective measure of stressor severity that determines the psycho-biological stress response (Allen, 2005; Olf, Langeland, & Gersons, 2005). Therefore, one’s internal processing of any event may determine whether it is deemed traumatic. For this study, psychological trauma is defined as the psycho-biological consequence of “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (Substance Abuse and Mental Health Services Administration, 2012, p. 2).

There is general unanimity of opinion regarding the traumatic nature of particular types of events, such as sexual assault and involvement in or being witness to natural disaster (Saunders & Adams, 2014). Consequently, much of the literature, including childhood trauma, has focused on such experiences (Rossiter et al., 2015). However, between the 1980’s and the turn of the century, there was an increased deliberation regarding the subjective interpretation of experiences deemed traumatic (Copeland, Keeler, Angold, & Costello,

2007). For instance, research identified that the incarceration of a child's parent or a parent disclosing a historic suicide attempt was as likely as sexual assault to result in that child experiencing diagnostic classifications of post-traumatic stress (Giaconia et al., 1995). Other childhood experiences have subsequently been recognised as having a potentially traumatic impact, and have been frequently associated with increased risk of experiencing mental health difficulties and reduced health-related quality of life in adulthood (Benjet, Borges, Méndez, Fleiz, & Medina-Mora, 2011; Draper et al., 2008; Huang, Schwandt, Ramchandani, George, & Heilig, 2012).

An important development over recent years in exploring the link between childhood trauma and detrimental adult outcomes, is research on Adverse Childhood Experiences (ACEs) (Centers for Disease Control and Prevention; CDC, 2013; Felitti et al., 1998). The original ACE study evolved as a method of assessing, amongst adults, the prevalence of exposure to different types of adverse events experienced during the first 18 years of life (Felitti et al., 1998). Numerous ACE studies have consistently demonstrated associations between ten categories of experiences with increased risk of health and social difficulties, increased health care costs, and reduced life expectancy (Felitti & Anda, 2014).

The ten categories of ACE have been separated into three theoretical subsets. The first, household dysfunction, consists of living with a parent who experiences mental health difficulties, living with a parent who misuses alcohol or drugs, separation from a parent or carer via divorce or imprisonment, and witnessing domestic violence. The second relates to personal experience of abuse; physical, sexual and emotional. The final subset incorporates personal experiences of both physical and emotional neglect (Felitti et al., 1998). These categories provide an ACE score, giving a measure of cumulative stress experienced during childhood. This is achieved by assigning a score of one to each ACE category, totalling ten (Murphy et al., 2014).

Some have questioned the reliability and validity of self-report methods of assessing the impact of childhood trauma, such as ACEs. For instance, although Dube, Williamson, Thompson, Felitti and Anda, (2004) reported high test-retest consistency for ACEs, this has been criticised. Widom, Raphael and DuMont (2004) highlighted potential influence of variables such as the age and physical or psychological health status of participants in the Dube et al. (2004) study; referring to the likelihood of greater negative bias or false negatives for older participants and those in poorer health. However, a number of international studies have indicated reliable and valid internal consistency of the ACE questionnaire (Bruskas & Tessin, 2013; Kazeem, 2015; Pinto, Correia, & Maia, 2014). In a review of literature regarding validity, Hardt and Rutter (2004) concluded that retrospective assessment of ACEs can be considered “sufficiently valid...to warrant its use in case-control studies even though there is significant under-reporting and probably some bias” (p.270). Others have highlighted cultural issues in defining ACE categories and have begun to research additional ACEs, such as peer rejection, peer victimisation and exposure to community violence (Finkelhor, Shattuck, Turner, & Hamby, 2013). However, these currently require further validation and therefore, when discussing ACEs within this study, we refer only to the validated ten.

Despite difficulties in establishing accurate international prevalence rates, estimates from American (Dube et al., 2003a; Felitti et al., 1998), UK (Bellis et al., 2013; Bellis et al., 2014b), cross-European (Bellis et al., 2014a) and cross-continental studies (Kessler et al., 2010) have suggested that around half to two-thirds of the population report experiencing at least one ACE. Of particular relevance to these prevalence findings is the dose-response relationship; higher ACE scores equate to greater numbers and severity of the aforementioned health and social outcomes in adulthood (Dube et al., 2003b; Edwards, Holden, Felitti, & Anda, 2003). However, the temporal relationship between ACE exposure and health outcomes could not be accurately verified, so it is not possible to know with certainty

whether onset of health or social difficulties occurred pre or post-ACE exposure (Dube et al., 2003).

Of particular interest to the current study is the intergenerational continuity of ACEs; children of parents that experienced ACEs are at greater risk of experiencing ACEs themselves (Narayan et al., 2016; University College London (UCL) Institute of Health Equity, 2015). Rates of maltreatment continuity have been shown to vary (Berlin, Appleyard, & Dodge, 2011) and Ertem, Leventhal and Dobbs (2000) outlined the methodological shortcomings of research that claims evidence of continuity. However, numerous studies have indicated a greater risk of abuse among children of parents that experienced abuse (Dixon, Hamilton-Giachritsis, & Browne, 2005; Egeland, Bosquet, & Chung, 2002; Ertem et al., 2000; Kaufman & Zigler, 1993; Pears & Capaldi, 2001), of which Egeland, Jacobvitz, and Sroufe (1988) has been described as providing strong, methodologically sound evidence (Ertem et al., 2000). Mediation analyses have highlighted the multifactorial nature of continuity (Dixon, Hamilton-Giachritsis, & Browne, 2005) and, given the high prevalence rates of ACEs, it is therefore important to consider what may constitute such risks.

Attachment theory (Bowlby, 1951; 1982; 1988) provides one psychological framework for understanding intergenerational continuity of ACEs. Attachment theory posits that the parent-child relationship shapes the development of internal working models of the self and others. One internalises, via experience of a parent or carer, a model of oneself as a parent or carer, encompassing one's assumptions and expectations of parental and child behaviour (George, 1996; Morton & Browne 1998; Steele et al., 2016). These internal working models of the self as a parent, particularly when experiencing high levels of stress, may determine one's choice of parenting behaviour (Bowlby, 1982; Busch & Lieberman, 2010).

Higher numbers of ACEs have also been found to predict higher levels of parenting distress, which has been linked to problematic parenting (Steele et al., 2016). Parents who experience childhood maltreatment have demonstrated difficulties in displaying particular beneficial parenting behaviours and attitudes, such as sensitivity, responsiveness and parental reflective functioning (Slade, 2005; van IJzendoorn, 1995) and greater levels of unhelpful behaviours, like hostility, intrusiveness and aggression (Conger, Schofield, Neppl, & Merrick, 2013; Lyons-Ruth & Jacobvitz, 2008; Newcomb & Locke, 2001).

There has long been debate regarding what constitutes “good enough” vs. “not good enough” parenting, yet clarity has been hampered by attempts to account for prevailing economic, social and political contexts in which family systems function (see Taylor, Spencer & Baldwin, 2000). However, unhelpful parenting behaviours, such as those listed, have, in particular contexts, demonstrated negative associations with elements of child development (Gershoff, 2002; Newman, Harrison, Dashiff, & Davies, 2008). Such behaviours, attitudes and stressful conditions have also been found to increase the risk of child maltreatment (Montes, de Paúl, & Milner, 2001). Social learning models suggest that children who experience ACEs are more likely to display intergenerational continuity of harmful parenting behaviours, such as physical punishment, by modelling the parenting they experienced as children (Muller, Hunter, & Stollak, 1995; UCL Institute of Health Equity, 2015).

Given the repeatedly demonstrated impacts and intergenerational continuity of ACEs, there is a widespread public health need to interrupt this cycle of adversity (Murphy et al., 2014; Shonkoff, Richter, van der Gaag, & Bhutta, 2012). There have been requests to develop methods of early detection in child and family services to support the identification of clinical need, develop and provide targeted support, and to prevent poor outcomes (Munro, 2011; Read, Hammersley & Rudegeair, 2007; Steele et al., 2016). However, one difficulty in attempts to develop such methods has been that survivors of childhood trauma can often be

reluctant to voluntarily disclose (Anderson, Martin, Mullen, Romans and Herbison, 1993; Frenken & Van Stolk, 1990; Read, McGregor, Coggan & Thomas, 2006).

Survivors have described shame and guilt in relation to their experience, and anxiety about sharing their story as primary barriers to disclosure (Alaggia, 2004; Dohary & Clearwater, 2012). Some have described avoiding disclosure due to uncertainty about the legitimacy (Dohary & Clearwater, 2012) or the severity of their experiences (Crowley & Seery, 2001). Others have expressed concern about potential consequences (Sorsoli et al., 2008), such as their story being shared further without their permission (Del Castillo & Wright, 2009; Tener & Murphy, 2015). Difficulties in predicting the impact of a disclosure has been suggested to result in increased distress, which can be further exacerbated by negative responses from the listener (Glover et al., 2010).

Little is known about the decision to disclose childhood trauma in adulthood, or the process of disclosure (Tener & Murphy, 2015). Draucker and Martsolf (2008) proposed a series of stages for adult disclosure of childhood trauma. These stages involve initial consideration of the method and completeness of their potential disclosure, including evaluations of the listener and assessment of potential consequences. This is followed by the purposeful decision to begin disclosure, during which the listener's response is evaluated and, if appraised as positive, will lead to sharing in greater detail. However, as with much of the literature on disclosure, this model refers specifically to disclosure of sexual abuse and it is unclear whether this staged model would be applicable to disclosure of other or multiple forms of childhood trauma, such as ACEs.

Whether elicited by enquiry or voluntarily shared, disclosures involve deliberation and calculated decisions about how, what and with whom to share (Del Castillo & Wright, 2009). The quality of relationship between discloser and listener, particularly concerning trust

(Draucker & Martsof, 2008; Hunter, 2011; Sorsoli et al., 2008) is important to ensure the survivor feels comfortable (Del Castillo & Wright, 2009) and that the listener is able to provide a positive, unconditional and non-judgmental response (McGregor, Glover, Gautam, & Ju'lich, 2010; Sorsoli et al., 2008). However, practitioners have historically cited discomfort with, and an apparent reluctance to enquire about trauma (Read et al., 2006; Read et al., 2007; Read & Fraser, 1998). Young, Read, Barker-Collo, and Harrison (2001) investigated the motives underlying professionals' enquiry-avoidance. They discovered that professionals experienced anxiety about distressing the service-user or themselves and feared encouraging false memories. However, disclosure has been repeatedly demonstrated as having positive influences on recovery and psychological healing, resulting in greater resilience, more positive perceptions of self and reduced experience of distress (Frattaroli, 2006; Hemenover, 2003; Marriott, Lewis, & Gobin, 2016).

Research has also found that disclosure can encourage post-traumatic growth (Slavin-Spenny, Cohen, Oberleitner, & Lumley, 2011; Smyth, Hockemeyer, & Tulloch, 2008); a phenomenon in which people experience cognitive benefits following trauma, including; meaning making; re-evaluation of personal priorities; increased self-awareness; increased reflection; and appreciation of life (Tedeschi & Calhoun, 2004). However, whilst disclosure has been found to provide short-term relief, others have found no long-term positive impact on emotional functioning (Zech & Rime, 2005). Furthermore, research has shown that the effects of disclosure depend, in part, on the response of the listener, with negatively appraised responses resulting in negative impacts (Tener & Murphy, 2015). Consequently, principles and guidance on 'why, when and how to ask about childhood abuse' have been proposed (Read et al., 2007). Encouraging safe disclosure, with an appropriately trained listener, may offer one method of detecting, providing support for and preventing ACEs.

Routine enquiry has been applied as an effective method of assessing other health-related societal issues, such as domestic violence, with clinicians describing it as an important clinical duty (Price, Baird, & Salmon, 2007). Service-users also expressed an expectation to be asked and that by asking, cultural discourses around the appropriateness of disclosure are altered and public awareness is increased (Salmon, Baird, & White, 2015). In 2013, Lancashire Care Foundation Trust (LCFT) developed a model for Routine Enquiry about Adversity in Childhood (REACH); a programme designed to assist health professionals in developing the skills and confidence to detect ACEs in a clinical population, and to formulate targeted support. However, little is known about how people disclose childhood trauma and less is known about how people experience being asked about ACEs. Formal evidence does not currently exist regarding parents' experiences of ACE enquiry and "whether asking about ACEs makes a difference in their healing processes or in their parenting decisions" (R. J. Gillespie, personal communication, May 17, 2016). This has been described as "a gap" in the disclosure and ACE literature (H. Larkin, personal communication, May 3, 2016). Due to limited documented knowledge, the primary research questions were intentionally broad; 'How do parents experience being asked about their own ACEs?' and 'What is the impact on parents who are asked about their ACEs?'

## **Method**

### **Participants**

The criteria for participation attempted to be as inclusive as possible, as prior to investigation, little was known regarding which factors may influence a parent's response to routine enquiry about adversity. All participants had parental responsibility for at least one child and must have identified at least one ACE during REACH. Participants were required to be competent in English, due to resource restrictions, but no restrictions were placed on any

demographic information for either participants or their children. Participants were excluded if they were currently receiving support for post-traumatic stress, to preclude risk of eliciting trauma-responses.

Recruitment services were third sector and local authority family support services. Professionals were family support workers or family wellbeing practitioners trained in REACh and working with parents. These services accept referrals via professionals in education, housing, health, social care or police and youth justice services or self-referral. The services provide advice and guidance on a range of childcare, learning and family support needs. All parents accessing these services are offered REACh at the initial assessment stage, as per guidance from Read et al. (2007). Consent is obtained from parents to complete REACh and parents are advised that they may decline to answer any questions during assessment (see McGee et al., 2013).

The author attended service meetings to introduce and discuss the project with professionals. Professionals were asked to identify parents on their caseload that met the inclusion criteria and share with them a participant information sheet (PIS) (Appendix A). Participants were asked to contact the author or to provide verbal consent for the author to contact them.

Seven participants were recruited in total. All participants were invited to be re-interviewed for the purpose of checking the accuracy of and further developing the interpretation of parents' individual and collective accounts. Four agreed to be re-interviewed; data was analysed across eleven interviews from seven participants. Six participants were female and all identified as white British. ACE scores ranged from two to eight, with an average of 4.3.

### **The Author's Perspective**

To support the reader's interpretation of qualitative findings, it is important to clarify the author's affiliation with the topic and their epistemological and ontological stance (Elliott, Fischer & Rennie, 1999; Braun & Clarke, 2006; Braun & Clarke, 2013). It is acknowledged that the author is a trainee clinical psychologist, with prior clinical experience as an assistant clinical psychologist and psychological play and parenting specialist, working directly with parents, children and families in mental health services. The author also spent their final year placement of clinical psychology doctoral training working on the development of REACH and other methods of routine enquiry. However, the author had no involvement in the training of services that supported recruitment, which occurred prior to their association with REACH.

Due to the interpretive nature of qualitative analysis, incorporating and demonstrating methodological trustworthiness and rigour is valuable and, as such, a number of steps were taken in attempt to exhibit procedural credibility (Kidd, et al., 2016; Shenton, 2004; Yardley, 2008). Firstly, reflections on the research process were logged and shared with research supervisors. Coding and theme development were also submitted to multiple rounds of review by supervisors to identify and challenge bias. Finally, participants were invited to comment on the analysis to encourage the trustworthiness of conceptual interpretations of participant accounts (Kidd, et al., 2016).

The author believes that, from an objectivist ontological stance, a reality exists independent of the author's knowledge, in that an experience occurs and a response is actioned by parents following REACH. However, a subjective epistemological view is taken to this, in that it is held only possible to know about any reality via social interactionism; developing meaning through interpretive processes by engaging critically in social interaction with, for this study, parents (Handberg, Thorne, Midtgaard, Nielsen, & Lomborg, 2014). From this position, the intention of this research is thus to pragmatically construct knowledge that provides a useful understanding for, for instance, services working with parents. It is

hoped that this pragmatic conceptualisation can influence an understanding of and engagement with parents' experiences in relation to REACh and encourage further discussion.

### **Data Collection**

Data were gathered via individual, face-to-face and telephone interviews and followed a semi-structured format, consisting primarily of open-ended questions. Initial interviews lasted an average of 49 minutes, ranging from 30 to 69 minutes. Follow-up interviews lasted an average of 29 minutes, ranging from 21 to 45 minutes. The aim was to facilitate exploratory conversations and rich accounts of participant's views regarding their experience of being asked about ACEs during REACh. An interview topic guide was used to scaffold the questions included in the interviews, whilst allowing for exploration of each participant's individual experiences (see Appendix C). The topic guide continually evolved during collection to include additional questions relating to concepts or emerging issues. This was done to ensure that the research questions were sufficiently addressed and to permit consideration of participants' experiences and understanding.

The approach to follow-up interviews allowed clarification of the meaning of participants' experiences and permitted investigation of additional content stimulated by the initial interview (Knox & Burkard, 2009). Participants were read a narrative description of their individual account, on which they were asked open-ended questions regarding the accuracy of the description. This process was repeated with a narrative description of the collective accounts, alongside further meta-discussion regarding their experience of the interview.

An electronic dictation device was used to record qualitative data provided during interviews. All audio data were transcribed by the author. Participants were given pseudonyms to protect anonymity.

### **Data Analysis**

As this study attempted to address a gap in the literature, it was felt the research design should enable the identification of themes across participant accounts and should subsequently highlight recommendations for future empirical direction (Fielden & Sillence, 2011). Consequently, data were analysed using inductive thematic analysis at both the semantic and latent level, following the phased approach outlined by Braun and Clarke (2006). This approach encouraged procedural replicability, whilst maintaining epistemological flexibility (Fielden & Sillence, 2011). The aim of analysis was to distinguish patterns of meaning across participant accounts embedded within the data (Braun & Clarke, 2013).

Audio recordings were listened to individually, prior to transcription, to commence a process of immersion with the data, making note of reflections on both the content and manner of delivery in participant accounts (Braun & Clarke, 2006; Braun & Clarke, 2013; Hammersley, 2010). To establish meaning within the data set, a critical frame was applied to encouraging analytic reading of data (Braun & Clarke, 2013). Codes were generated using the comments function in Microsoft Word to create semantic and conceptual notations on lines of data (Appendix D). Coded lines of text were transferred into a spreadsheet using Microsoft Excel, along with their corresponding code and any notations. This enabled side-by-side examination for similarities between codes, in terms of content or hypothesised meaning.

Initial candidate themes were developed by grouping and giving similar codes provisional descriptive titles, based on quotes that captured the central organising concept. Groups of candidate themes were then arranged within discrete sheets within the spreadsheet to begin identification of overarching concepts. Codes and scarcely populated candidate themes not grouped thematically were categorised as miscellaneous and stored in a separate sheet. This allowed continual reference with new developing themes until the completion of the analysis, upon which miscellaneous themes were discarded.

To encourage an inductive approach, the conceptual meaning of themes were appraised against the content and context of participant accounts by re-reading them against original transcripts. This approach aimed to ensure themes adequately represented the experiences portrayed. The analysis was then organised into a coherent structure, comprising final overarching themes and subthemes, with individual, descriptive narratives that depicted the conceptual meaning of, and associations between each theme (Table 1). All follow-up interviews indicated that final themes and their narrative descriptions accurately reflected participant experiences. A thematic map was produced to present the proposed structure of the final analysis (Figure 1).

### **Ethical Considerations**

The study was reviewed by Lancaster University's Faculty of Health and Medicine Research Ethics Committee and approved by the University Research Ethics Committee prior to commencement. To manage potential distress following interviews, risk management plans were devised. The PIS provided information regarding confidentiality, withdrawal procedures, and details of organisations offering support (Appendix A). Participants provided informed written consent prior to participation (Appendix B). Please refer to the Ethics section for more details.

## Findings

Three themes were developed from participant accounts. The first represents a proposed five-stage chronological model of ACE enquiry. The second and third themes illustrate a number of psychological processes functioning within this model, pertaining to issues associated with power in the enquirer-discloser relationship and the process of post-disclosure behaviour change, respectively.

### **A Chronological Staged Model of Parents' Responses to ACE Enquiry**

Analysis revealed a chronological pattern to parents' responses to REACH, the order of which was confirmed as accurate by the four re-interviewed participants. This theme comprises five subthemes, each describing a separate stage.

**Stage 1 - Deciding how much to disclose: "I might say something to you that you might use against us, so I better not"**. The first stage of enquiry relates to the process of decision-making upon being asked permission to talk about ACEs; the pre-enquiry phase. The decisions concern, primarily, how to and how much to disclose about their childhood, following an almost unanimous feeling of discomfort regarding the enquiry.

Over two thirds of parents reported experiencing initial negative cognitive or emotional responses when asked permission to discuss ACEs. For example, parents described feeling "awkward" (P6), "weird" (P3) and "a bit nervous" (P4). One parent described feeling so overwhelmed that they seemingly experienced a flight-freeze style response: "I just wanted to walk out, erm, but I didn't. I sat there, kept quiet" (P2). This supports Alaggia (2004) and Dohary and Clearwater (2012), who described anxiety as a key barrier to disclosure. The rationale for such responses primarily related to fear of judgement and potential consequences, also supporting previous findings on barriers to disclosure (Alaggia, 2004; Del Castillo & Wright, 2009; Dorahy & Clearwater, 2012; Draucker & Martsof, 2008).

Parents described concern about possible ulterior motives behind REACh. For instance, P4 described considering whether the professional was secretly judging her as a parent: “I was thinking, well, what does she want to know about my childhood for, you know. Is it, am I a bad mum? Is that why she’s asking these questions?”. P3 also described a general distrust of professionals as a concern for disclosure, “at the start it was like, ‘she’s a professional, be careful what you say’”.

There were also clear factors that helped parents to feel more comfortable discussing their childhood. For instance, concerns were partially settled when professionals explained clearly the rationale and process of REACh, including available support: “she told me why she was asking, she explained it all first and I think that helped” (P1). Informing parents that they do not have to answer the questions was similarly supportive, “I had the choice, so I thought, no I don’t mind” (P4). The skills or personal qualities of the professional was also cited as a relief to discomfort: “You know, she doesn’t push, she doesn’t direct me or anything” (P6). In fact, the most frequently referenced factor that supported parents to feel comfortable disclosing more detailed information was the relationship with the professional, particularly concerning trust. This substantiates previous findings that cite a trusting, accepting, non-judgemental relationship and response as supportive of decisions to disclose (Del Castillo & Wright, 2009; Draucker & Martsof, 2008; Hunter, 2011; McGregor et al., 2010; Sorsoli et al., 2008).

Prior to responding, it appeared that parents rapidly weighed up factors that made them feel more or less comfortable, before making a decision regarding the legitimacy and comprehensiveness of their impending disclosure. This appears to marry with the considerable internal debate cited in Draucker and Martsof’s model (2008). However, despite overwhelming discomfort, all chose to disclose something, with over half explicitly describing a sense of acquiescence; parents felt the need to provide some form of answer.

For instance, P4 illustrated a lack of protest, despite feeling uncomfortable: “I just felt a bit took aback, a bit, but I said, yeh”.

**Stage 2 - Disclosure is an Emotional Rollercoaster: “I was practically crying inside”.** The second stage entails numerous emotional responses during the process of disclosure. Over two thirds of participants described a range of emotions experienced between starting and finishing their disclosure.

Chiefly, emotions felt on commencing disclosure were associated with discomfort. For example, P1 described experiencing numerous negative emotions, stating “it made me feel a little angry and a little resentful” and “it made me feel guilty as well, because of some of the things that I’ve done similar to my parents that I didn’t want to do”. Whereas P2 described a more constant state of distress, “I was practically crying inside”. Draucker and Martsof (2008) also described how the telling process can be highly emotive for some.

Such strong emotions appeared to be in relation to a process of remembering: “it made me think about some things I hadn’t thought about for a long time” (P1). Conversely, P5 described the process of disclosure as less emotional than others, stating, “it felt alright...it was just normal” (P5). However, she qualified this statement by saying “it was alright, cos I had a good childhood”. This may suggest that emotionality during disclosure may be somewhat determined by the way one cognitively appraises one’s childhood, despite ACEs, which supports theories that stipulate the role of subjective interpretation in determining trauma responses (Allen, 2005; Olf et al., 2005).

All but two described a sense of relief following disclosure, regardless of distress experienced, which supports the short-term relief found by Zech and Rime (2005). For instance, P6 described the act of disclosure as “getting it all out of my system! So, I’m not gonna lie, I did feel better after getting it off my chest!”. P7 described a sense of relieving

pressure, “it was like a weight off my shoulders!... I felt happier that I’d told somebody the truth! Instead of...bottling it all up!”

**Stage 3 – The cognitive aftermath: “I went over the conversation in my head, over and over and over again all night!”**. The third stage observed what appeared to be a cognitive and emotional aftermath of disclosure for all parents following the end of the appointment, primarily involving rumination and paranoia.

All but one parent described experiencing incessant rumination once they left the appointment, lasting from “a few days” (P1) to “months” (P7). A couple of parents described ruminating about memories of their own childhood. However, parents more frequently described ruminating on the act of disclosure. For example, P3 described how the conversation kept “coming back all night long”. P6 illustrated how these thoughts penetrated multiple areas of her life: “I could be out having a walk; it would be on my mind. On my mind at work...thinking about my mum”.

Parents went on to experience persistent paranoid thoughts about the possible consequences of their disclosure. It was inferred by the author that many quotes appeared to depict how, following brief relief immediately post-disclosure, parents experienced anxiety and paranoia relating to relinquished control over whether or how the information would be shared: “anything could happen now, they could say anything, do anything and twist anything” (P3). These distressing thoughts and loss of control after revealing their story supports Glover et al., (2010), who concluded that an inability to predict the consequences of disclosures can invoke psychological distress (Tener & Murphy, 2015). Perhaps this is one reason for the erosion of relief observed by Zech and Rime (2005), who found that post-disclosure relief was time-limited.

**Stage 4 – Reflection results in heightened awareness, which leads to**

**(re)evaluations of self and others: "I think it opened my eyes a bit more"**. The fourth stage portrays how the experience of persistent rumination and paranoia appeared to encourage increased reflection about their own childhood, their parents and their current situation. For instance, P6 described reflecting on and beginning to re-story the way she remembered feeling as a child: "I've never thought about it before and I know it was always there, but I realised that I was unloved!". Parents described reflecting on the way they were parented and beginning to make connections to their own parenting choices: "I've just thought more about how my mum was with me growing up, really, and linking that to my parenting" (P3). This may support social learning models of ACE continuity; parenting choices are developed via parent modelling (Muller, Hunter, & Stollak, 1995).

Reflection guided (re)evaluation. For instance, P7 described cognitively re-appraising her childhood, "after I'd told her everything I thought, yeh, I must have had a bad childhood!". P6 described re-evaluating her parents, "I worshiped the ground my dad walked on, and then I stopped seeing my dad for a while, erm, and if I'm honest I actually felt a bit...angry towards my dad!". Whilst others re-evaluated their sense of self as a parent, "it made me think, really, that I hadn't been as good a parent as what I thought!" (P6).

However, not all (re)evaluations were negative. P5 reported that, "it made me feel grateful", and "when I realised that I'd done what my mum used to do, it made me feel like I was doing something right!". Increased reflection also appeared to help some parents to feel empathic towards their own parents: "it's sort of helped me to understand her a bit more...put myself in her shoes" (P3). This process of (re)evaluation may indicate a process of post-traumatic growth, resulting in (re)evaluation of personal priorities and increased self-awareness (Tedeschi & Calhoun, 2004).

**Stage 5 - Motivation to be a better parent: “it actually did make me stop and think, I want her brought up better!”.** The final stage depicts what appeared to be an either transitory or enduring surge in motivation towards newly pledged parenting goals and subsequent attempts to initiate parenting-based behavioural changes, driven by (re)evaluations.

All described experiencing an increased desire to be a “better parent” (P7), particularly motivated by providing a better upbringing for their child than they experienced. For instance, P7 stated, “It made me think...I don’t want (child)...being brought up the same way. It actually did make me stop and think, I want her brought up better!”. Parents described experiencing this as a sudden realisation, “I think it was a wakeup call...I thought, you’re gonna have to change your life around!... I kept thinking to myself ‘no, you’re not gonna be like my mum’” (P4). They seemingly held these motivating thoughts in mind, “I thought about it for so long after we had that conversation, thinking, ‘I’m gonna change this!’” (P1). Such thinking also appeared to drive modification of parenting goals and the re-conceptualisation of their role as a parent:

it did make me look at it a little bit more and just want to make sure that he’s got everything that I didn’t feel. And it’s not just about what you do, as a parent, it’s about time, predominately time! And how you make a person feel is very, very important. I see that now.

Consequently, many of the parents described experiencing an increased motivation to engage in, what they considered to be, positive parenting activities, “I just wanted to do more with them, do more reading, play more games with them...to create more good memories for them” (P3). P1 also described this increased desire to act out their understanding of positive

parenting: “I felt I just needed to do more. So I doubled the amount of housework that I normally do, erm, you know, bought the kids some new clothes”.

Acting on this increased drive to parent, all described conscious attempts to alter their behaviour during the weeks following enquiry. Some of these attempts involved noticeable behaviour changes, such as “spending all my time with her, “Me and my kids have like a movie day or a movie night now” (P5), and “I started reading more books with them, playing more games with them, trying to focus my mind on them” (P3). For some parents, this occasionally involved overcompensation: “For those few days where I was feeling unsettled, if they asked me for something they got a yes. I was very much a push over for those few days” (P1). However, other changes were more discrete and cognisant, described as parenting “maybe a bit more mindful really” (P6). For instance, P1 clarified how, during a discussion with her daughter, she responding more reflectively than she typically would have: “My initial gut reaction was ‘NO’, but I didn’t say it...I said...in my head, ‘that’s what your dad would have done’ ...instead of going with my gut reaction...I’m thinking about it more”. Increased reflection following elicited disclosure seemingly improved parental reflective functioning, a quality associated with ‘beneficial’ parenting (Slade, 2005).

### **Power in the Enquirer-Discloser Relationship: “I Felt Like, If I Didn’t Work with Her, That Would Go Against Me”**

This theme describes issues associated with inherent power imbalances in the clinical encounter that permeated all stages. Here, power refers to an act of influence between professionals and service-users during the enquiry process, which originates from the dominant social status of professionals (Carter, Swank & Brown, 2014; Zur, 2009). Through the operation of their socially defined statuses, service-users are often positioned within a submissive role in relation to professionals, unbalancing the relationship. Service-users can

consequently experience undue pressure to conform to the perceived wishes of professionals, often in fear of perceived consequences or of upsetting the professional (Frosch, May, Rendle, Tietbohl, & Elwyn, 2012; Joseph-Williams, Edwards, & Elwyn, 2014; Kettunen, Poskiparta, & Gerlander, 2002).

Disproportionate power appeared to influence parents' decision to disclose, particularly those who acquiesced. For instance, rationales underpinning acquiescence included feeling obliged to answer, "I felt like I should" (P2) and fearing possible unspoken consequences of declining, "I felt like, if I didn't work with her, that would go against me" (P2). Parents seemingly recognised professionals' power to judge and, more importantly, act on such judgements, such as referring to social services, "They could do something or say something, you know, that could trigger social care" (P4). They consequently experienced an implicit pressure to conform.

Trust in the professional and the quality of their interpersonal relationship appeared to partially eliminate fear of consequences and therefore lessened professionals' power to apply such consequences: "I...got to know her and knew that she wouldn't tell anybody, unless I was at risk or my daughter was at risk" (P7). However, for some, there appeared to be an active or implicit attempt to contest power imbalances by acting to increase their own power. Although all answered, some withheld detailed information: "I didn't go into detail" (P3). P7 described fabricating parts of the story to avoid talking about genuine experiences, "I just didn't want to answer them, so I made up a lie". A person gains a power advantage when they acquire knowledge of another's personal information and therefore knowledge-power lies with those holding information (Zur, 2014). Withholding information or fabrication may, thus, be seen as a method of avoiding vulnerability, or maintaining or acquiring power. Power also appeared to be redistributed somewhat when professionals informed parents of

their choice over engagement: “she told me I didn’t have to answer them...so if I didn’t want to...I knew it wasn’t going to be a problem” (P1).

### **The Post-Enquiry Behaviour Change Process: “Seeing Changes...It Was Making the Kids Happier”**

The final theme relates to an apparent process of change observed across the chronological model, particularly concerning parenting. This process appears to map onto the readiness stages outlined in the stages of change (SOC) model; pre-contemplation, contemplation, preparation, action and maintenance (Heimlich and Ardoin 2008; Prochaska & DiClemente, 1983).

In stage one, invitation to discuss ACEs appeared to move a person from pre-contemplation, where the person was unaware of any issues or where intention to change was low, “I’ve never thought about it before” (P6), to contemplation, where awareness of issues increased and change was considered, “it’s just made me more aware of myself and how I parent [pause] I want it to be different now” (P1). These could be described ‘cues to action’ (Janz, Champion, & Strecher, 2002), provided externally, by the enquiry in stage one, and internally, via the remembering and reflective processes in stage two, three and four; all of which seemingly construct the contemplation phase.

Contemplation was dominated by a fear of consequences and increased awareness of subjective norms, resulting in reflections about the perceptions of others regarding their parenting: “I even said to (husband), ‘she’s going to think we can’t cope...and probably try and take our three kids” (P3). Reflections also highlighted elements of their parenting that participants disapproved of, altering their attitude towards these behaviours, “I was so determined not to be a parent like mine, but in some ways I still am...I hate that” (P1). The theory of planned behaviour (TPB) (Ajzen 1985, 1991; Ajzen & Madden 1986) suggests that

intentions, based on attitudes towards a behaviour, the propensity to abide by subjective norms, and perceived efficacy over successful performance, predict behaviours. Post-enquiry reflection appeared to alter parents' intentions regarding their parenting choices.

Parents also seemed to evaluate risks to their own, but more notably their child's wellbeing as a result of their parenting choices. Based on their own childhood experiences, parents appeared to view the susceptibility and severity of intergenerational risk as high. Consequently, it appeared that parents considered changing their behaviour to avoid risking their child experiencing a similarly negative childhood. According to the health belief model (HBM) (Becker, 1974), motivation to change depends on threats to wellbeing, which require appraisals of the susceptibility and severity of risk, and a perception that "taking action is likely to either prevent or reduce the risk at an acceptable cost with few barriers" (Nisbet & Gick, 2008, p.297). Parents can engage in this process on behalf of their children (Redmond, Spoth, Shin, & Hill, 2004), such as by taking preventive action when they perceive elevated risk to their child (Spoth, Redmond, Kahn, & Shin, 1997), influenced by internal and external cues to action (Janz, Champion, & Strecher, 2002). P3 described preventative motivations, portraying a desire "to create more good memories for them, so...they can say they had a good childhood". Consequently, parents experienced an upsurge in motivation to parent differently by stage five, which can be seen as movement towards preparation, where self-efficacy improves and they commit to action.

Maintenance also seems to occur in stage five. Some described success in maintaining changes, reinforced primarily by noticeable positive impacts on their child and themselves, "It was making the kids happier. We're happier. So we want to keep things going and moving forward" (P3). However, not all changes were maintained. P1 explained that she fell "back into our old routines, I think it was more like it tapered off". P2 also suggested that more support and continued conversation on this topic would have been beneficial.

## Conclusions

In response to the limited documented knowledge concerning parents' experience of ACE enquiry, the present study aimed to explore these experiences and establish any subsequent impact. Thematic analysis established three themes. The first represents a proposed five-stage chronological model of ACE enquiry. Following an almost unanimous negative perception of ACE enquiry, driven primarily by anxiety about disclosing their story and a fear of judgement and consequences, all parents chose to disclose information, with many describing a sense of acquiescence. The process of disclosure was highly emotive. Post-enquiry impacts involved initial rumination, leading to paranoia, increased reflection on self and others and eventually a process of (re)evaluating one's parental goals, roles and priorities. Evaluations appeared to drive the final stage. All parents experienced increased motivation and ensuing attempts to parent differently, propelled by the desire to give their child a better start in life.

The second theme illustrated the complex influence of and occasional struggle for power in the enquirer-discloser relationship, which appeared to impact the process from pre- to post-enquiry. The final theme demonstrated the process of post-disclosure behaviour change occurring across the chronological staged model, which seemingly maps onto the SOC model (Prochaska & DiClemente, 1983). These themes and the points at which they relate to the chronological staged model are depicted in Figure 1.

## Clinical Implications

Trust appeared to be highly influential in supporting decisions to disclose and in limiting distress during and post-enquiry. Guidance on enquiry about childhood adversity suggests that enquiries should be conducted early to reduce the risk of professional avoidance (Read et al., 2007). However, all parents believed that developing trust over time is essential to encourage engagement and reduce anxiety. The therapeutic relationship is a widely

accepted predictor of outcomes in clinical encounters (Roth & Fonagy, 2013), and therefore current guidance may require review regarding the most appropriate enquiry-point in care pathways.

The preamble also appeared valuable in improving engagement and comfort with enquiry, whilst a lack of transparency about intentions to share information following the clinical encounter had detrimental effects on these factors. More detailed information pre-enquiry, alongside a clear statement of intentions of whether information will or will not be shared immediately post-enquiry, may improve engagement and reduce negative post-enquiry effects. Furthermore, Draucker and Martsof (2008) described decisions to disclose as purposeful and carefully planned. Such deliberation does seemingly occur prior to REACH. However, the author considers whether there is sufficient time available for service-users to fully consider their options directly following the request for permission to enquire. Another clinical implication would be to consider introducing REACH during an appointment prior to the one in which enquiry is planned. This may enable service-users to make a more considered and informed choice about disclosure.

However, any attempts to address these difficulties may need to be evaluated alongside careful consideration of power. Service-users' pre-existing interpretations of professionals' social status produces imbalanced power that appears to influence disclosure. Professionals' power may implicitly coerce engagement, which raises questions about service-users' ability to provide genuine consent. The influence of professionals' power also seemingly continues beyond the end of the appointment, due to continued fear of consequences concerning their disclosure. "In so many ways, the power differential and...vulnerability persist, regardless of the termination of...sessions." (Gabbard, 1989, p. 122). This mental representation and the continued influence of professional power and judgement may unintentionally contribute to behaviour change seen in stage five, indicating

implicit ethical issues of such assessments. Research has suggested that professionals should acknowledge the imbalance of power in clinical encounters and seek instead to maintain a neutral position and pursue egalitarian collaboration with service-users to reduce inherent influence over choice (Marecek, J., & Kravetz, 1998; Zur, 2009). Collaboration and empowered involvement in decision-making can stimulate motivation to wilfully engage and promote emotional well-being (Fitzsimons & Fuller, 2002). However, engagement is sometimes defined in relation to compliance (Dawson & Berry, 2002) and it is therefore important for professionals to consider not only their power, but their intentions when attempting to 'engage' service-users. Moreover, parents did not specify factors that contributed to issues of power. Further research may assist exploration of power dynamics surrounding enquiry and disclosure.

A final area of implication involves the apparent fit between the stages of ACE enquiry proposed and the SOC model. Parents seemingly progressed through each stage without professional assistance; none informed the professional of the experiences they described across all stages. This finding highlights an opportunity for professionals to support parents' transitions through stages.

Transitions are typically motivated by two factors; self-efficacy and the outcomes of decisions based on factors associated with HBM and TPB (Armitage & Conner, 2000; Ajzen & Madden, 1986; Becker, 1974). Randolph, Fincham and Radey (2009) suggest that professionals should provide external and promote internal cues to action at various points throughout parent engagement. For instance, professionals could provide detailed information about the risks of intergenerational continuity of ACEs, allowing parents to assess the severity of child-related risk, and help parents to identify benefits and barriers, perhaps through motivational interviewing (Miller & Rollnick, 2012). This may improve engagement

and provide a means of preventing continuity of ACEs. Further research is required to establish the chronological staged model and to evaluate the impact of intervention.

### **Limitations**

Firstly, participation was limited to those proficient in English, which limits the generalisability of findings, beyond that by which qualitative research is typically criticised (Myers, 2000). Although no further restrictions were placed on participant demographics, lack of participant gender and ethnic diversity should be taken into account when interpreting these findings.

In terms of information about ACEs, only the score was collected. It was not possible to determine whether specific ACE categories or combination had any impact on parents' experience of enquiry, or their subsequent response. Additionally, although all professionals were trained in REACH, which provides guidance on questions and appropriate methods of disclosure-response, it is not known exactly what questions participants were asked during ACE enquiry, and whether or not this experience was therefore equally comparable across participants.

Finally, data collection relied entirely on retrospective narratives. It could be argued that these results rely, therefore, on the accuracy of accounts, which cannot be guaranteed. However, in alignment with the author's epistemological position, reality is understood subjectively. Analysis relies on the author's subjective interpretation of the participants' subjective interpretations of their experience, and thus does not claim to provide an objective account of participants' experiences. However, re-interviewing participants was intended to regulate the impact of this limitation.

Nonetheless, these findings contribute to our understanding of ACE enquiry and highlight implications for service delivery, provision and development. It is hoped that these

findings begin plugging the previously indicated gap in the literature and provide the first of many attempts to understand service-user experiences and the impact of being routinely asked about ACEs in clinical practice.

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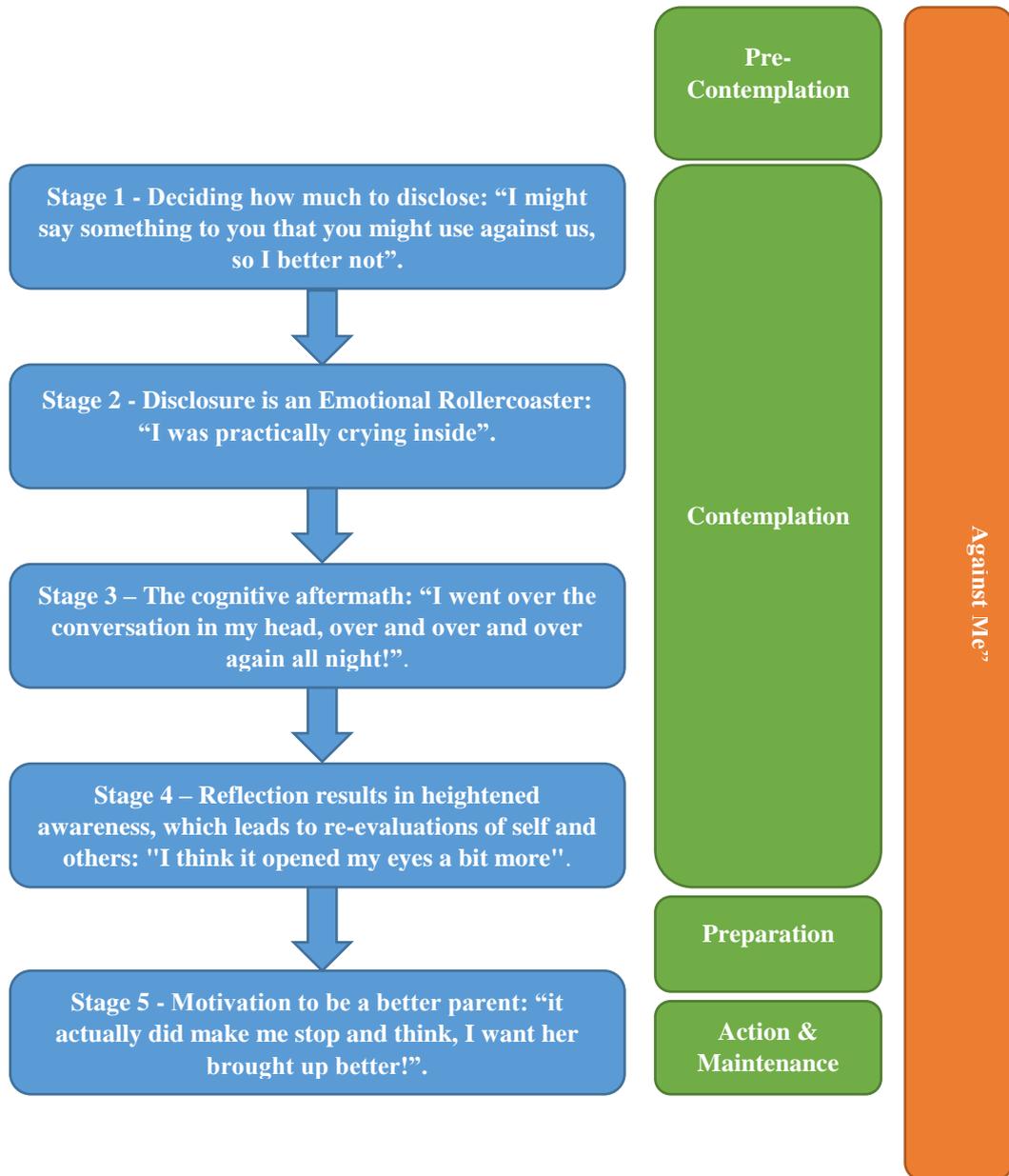
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Tables and Figures

Figure 1: Thematic Map



**Table 1: Example of Codes and Themes**

<b>Theme</b>	<b>Subtheme</b>	<b>Narrative descriptions</b>	<b>Example codes</b>
A Chronological Staged Model of Parents' Responses to ACE Enquiry	Stage 3 – The cognitive aftermath: “I went over the conversation in my head, over and over and over again all night!”.	Parents experienced incessant rumination post-enquiry	as soon as I went to bed I, the conversation would go around in my head again. It was like “should I have said that like that” and replay the entire conversation again “should I have said that, should I have said that” and then “oh maybe I should have said that instead” or then I would remember something that I didn't say (P1)
			it was on my mind quite strongly. Even, whatever I was doing, making tea, I could be out having a walk, it would be on my mind. On my mind at work, on my mind, thinking about my mum (P6)
		Parents experience paranoid thoughts, primarily concerned with a fear of possible consequences post-enquiry	I might have been in the shower and I would think “she's spying on me her!”, but I were thinking “no, I'm getting paranoid” (P4)
			I was thinking about it, what had been said, thinking, how is she going to twist that and turn it against us, sort of thing. I even said to (husband) “she's going to think we can't cope, we can't cope with (children), we wouldn't cope with (child) and probably try and take our three kids, put them up for adoption” and everything like that. Some horrible things were going through my mind (P3)
			I was just expecting to get the phone call off social workers, you know, more than anything (P7)