EM Consulting

HOW TO BE HELPFUL:
PATIENT DISCLOSURES OF ADVERSE CHILDHOOD EXPERIENCES

Some of us may have conscious, or unconscious hesitations in asking about, or hearing about, adverse childhood experiences. We may have beliefs that talking about difficult events from childhood might make patients worse. We might think that if they cry when they disclose this, that it is causing more pain for them; and that we have harmed them by asking. We may have a belief that talking about difficult experiences in the past isn't helpful, that it keeps people in the past, instead of helping them "move on." We might feel it is too difficult to hear and that we might feel too much pain when the patient shares.

It is important to reflect on these beliefs—if we don't, we will likely convey that we do not want to hear this part of patients' lives. This can reinforce feelings of shame patients might already have about their past and even solidify the secrecy that often surrounds these experiences.

HELPFUL STRATEGIES:

Language Tips: Avoid using the word "Trauma" or "Traumatic" to describe incidents before the patient does. We listen to how a patient appraises events, and use their words.

Respond to indications, or clues about difficult childhood experiences. Patients often give us hints that they have experienced adverse childhood experiences. If we do not pick this up and ask directly, it can replicate an unhealthy family system that ignores or minimizes the event(s). It is important not to "miss" cues or clues about this. For example, patients might say:

- *"I just have trust issues" or "I don't trust anyone"*
- *"I don't know why this is bothering me so much" (when referring to a current situation)*
- *"I'm not close with my mom/dad/childhood caretaker"*
- *"I'm SUPER protective of my daughter/son"*

We can respond with a simple and powerful empathic reflection and open-ended question:

- *"You don't trust anyone…thank you for sharing that with me. Tell me more about that…."*
- *"You are super protective, as you said…..what has led you to that parenting decision?"*

Appreciation: *"thank you for sharing this with me"* is respectful, kind, and acknowledges that patient's do not have to tell us anything- it is a choice this patient made to share this.

Affirm Autonomy: Build in phrases to let patients know it is their decision what they share, for example, *"tell me more, if you'd like…"* as it gives the most autonomy and space to the patient, to share what they feel is important.

Empathic Reflection: Reflecting back a summary of what the patient shared with you. Empathic reflection is powerful, respectful, empathic. *"it sounds like things were pretty tough when you were a kid, that your mom had severe mental health struggles, and you never felt safe…'*

Normalize not telling an adult when they were young, and affirm their decision-making on this, as children. The majority of children who are sexually abused do not tell another adult. This may be because they were threatened by the person who was causing harm, it may be because they were shamed and blamed themselves; it may also be because they accurately assessed that they would not be believed by their caretaker or other parent.

Ask about meaning and healing (stay in the present) If patients disclose adverse childhood experiences, ask what meaning they make of it and how they think about healing, now. These examples demonstrate how to move the conversation to the present:

- *"I wonder how you feel this has impacted your life as an adult?"*
- *"How have you managed to survive (or thrive) thus far, given the challenges you have had to contend with?"*
- *"Tell me about how this has affected you in your adult life…."*
- *"Tell me about your healing process so far…"*
- *"What do you feel you need at this stage of the healing process?"*
- *"What are the special qualities about yourself that you've relied on?"*
- *"Who are the people in your life who are part of your healing?"*

Reflect back strengths: When we look for strengths, we will see them. Share back with patients what you see, for example *"I can hear how important it is to you, to be a different kind of father than you had"* or *"It sounds like you've done a lot of healing on your own".*

AVOID:

1. Asking details about the abuse or other trauma. It is not healing or helpful for most people to discuss details, such as who, how, frequency, age, who knew, etc. At worst, re-telling in detail can retraumatize; at best it is often unpleasant and unhelpful. Remember, it is not about the event(s), it is about the patient's experience of the events. We aren't reporters or investigators, and we don't need details.

2. Asking questions about who the patient told when they were children. Many, perhaps most, children who were abused, especially sexually abused, do not tell another adult. Many judge and blame themselves for this, and some have been blamed by others, as adults (it is not uncommon for a mother's first reaction to a child's adult disclosure about the abuse, to be ***"why didn't you tell me?"***). By asking who they told, or if they told, when they were a child, it gives the impression that they should have done this.

3. Suggest forgiveness: Telling people they need to forgive people who caused them harm is not helpful, and will often be interpreted as judging. Furthermore, people do not need to forgive to heal.

4. Minimize the difficult experience: Avoid 'explaining' why the person who did harm "yea, back then whipping your kids with a belt was normal' or "I'm sure she loved you, I'm sure she just had her own trauma."

5. Try to 'fix' the patient. When we jump in and try to 'fix' someone, it doesn't feel like empathy. It feels like we don't want to listen anymore. Avoid giving advice, or sharing platitudes that the patient might not agree with ('well, there is a reason for everything' or 'God never gives us more than we can handel'.

6. Assume they need therapy: Not everyone needs or wants therapy. Most people's healing paths don't involve professional help. We only inquire if people might want therapy, we don't assume or indicate they need to.

6. Distress empathy: If patients feel their disclosures have distressed us, it isn't helpful to them. They may feel they have to take care of us, that they overwhelmed us, or that they are 'too much'. If we feel distressed, we can use strategies to take care of our own feelings.