

A decorative graphic consisting of a grid of blue squares of varying shades, arranged in a pattern that tapers to the left.

# When adversity turns into trauma Understanding the long term effects of adverse childhood experience

**Peter Fonagy**, OBE FMedSci FBA FAcSS

Director, Division of Psychology & Language Sciences

Chief Executive, Anna Freud Centre

Senior Clinical Advisor Child Mental Health, NHS England

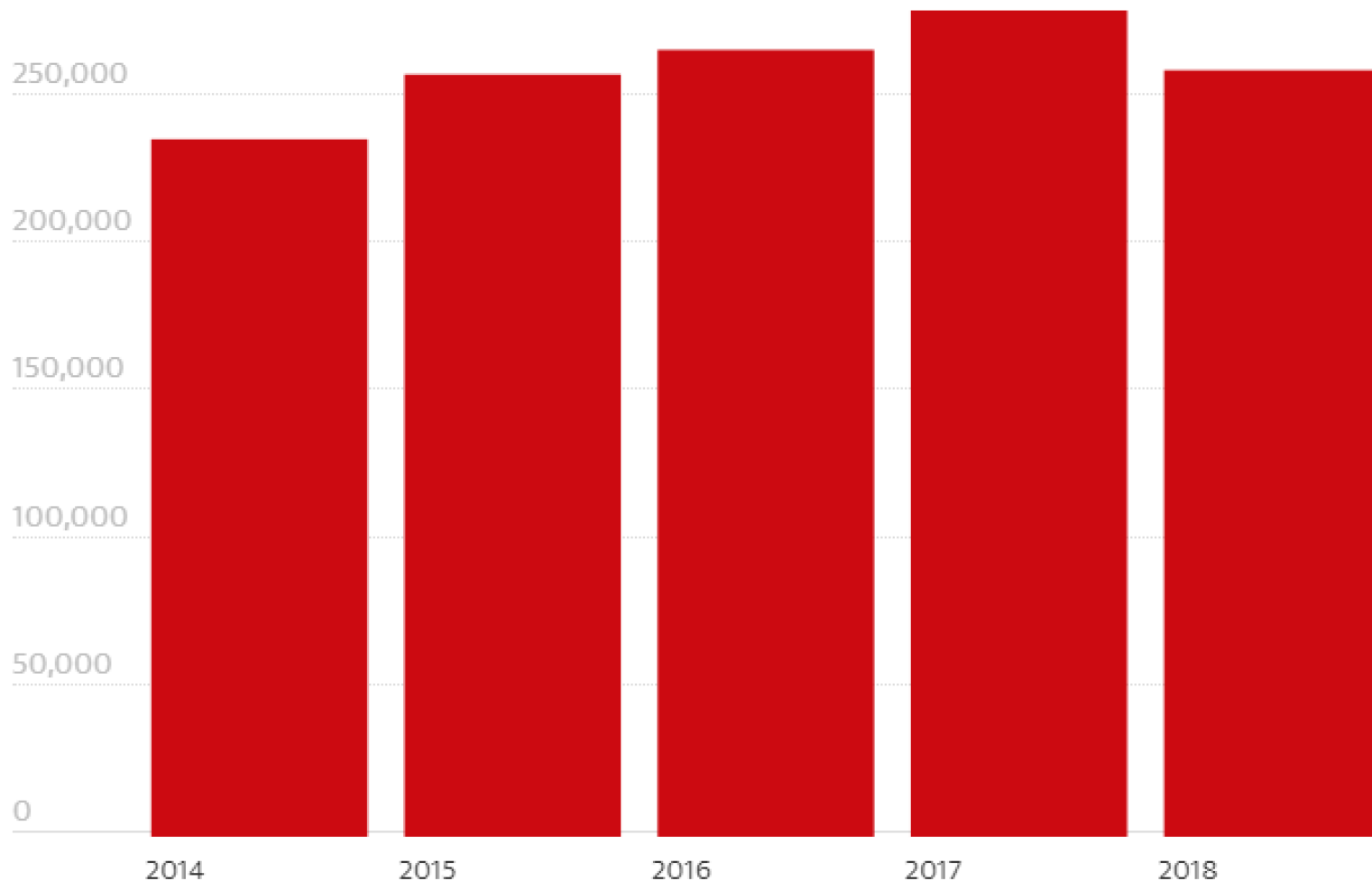
Slides from: [P.Fonagy@ucl.ac.uk](mailto:P.Fonagy@ucl.ac.uk)

# What is the right of a child?

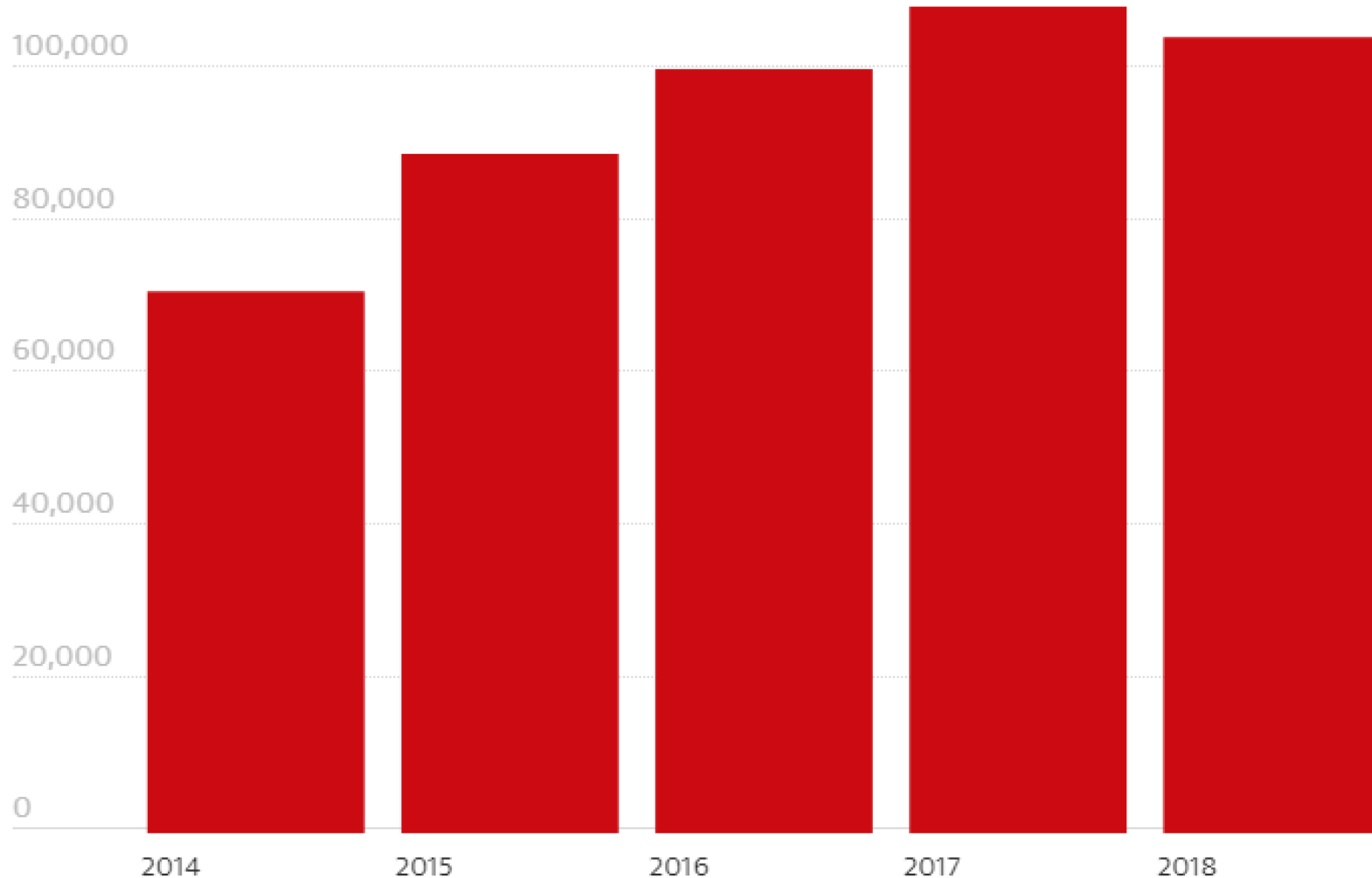
National Child Traumatic Stress Network (NCTSN)

- Being safe
- Being seen
- Being wanted
- Being competent
- Being a contributor

**Since 2014 nearly 1.3m records have been put on the Merlin database of vulnerable individuals notified to social services by Metropolitan Police (Guardian FoI, 6/7/2019)**



**The highest number of records (nearly half a million) relate to 'child care/welfare' notified to social services by Metropolitan Police (Guardian Fol, 6/7/2019)**



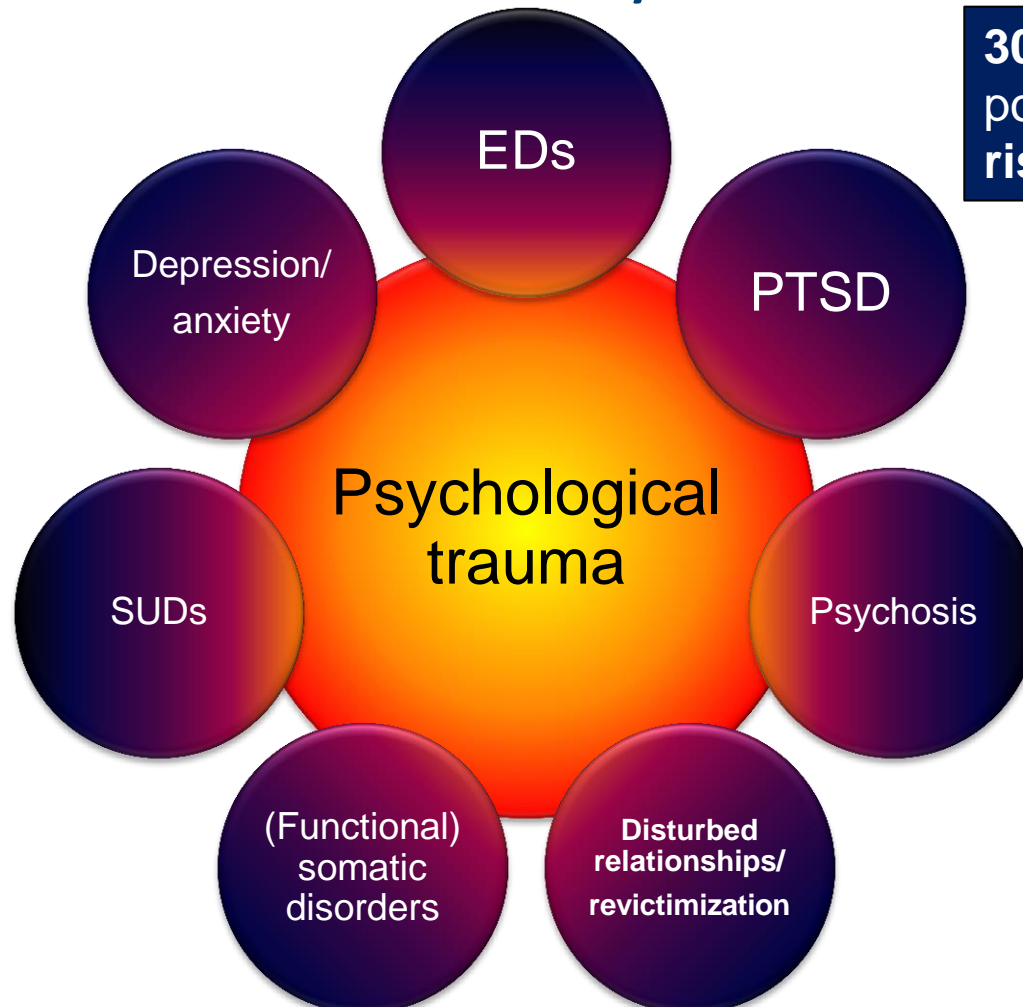
# ACEs – prevalence and impact

More than **half of young people** are exposed to potentially traumatic events

Trauma exposure has a substantial **direct impact on the mental health** of young people (e.g. PTSD, depression, anxiety, attachment disorders)

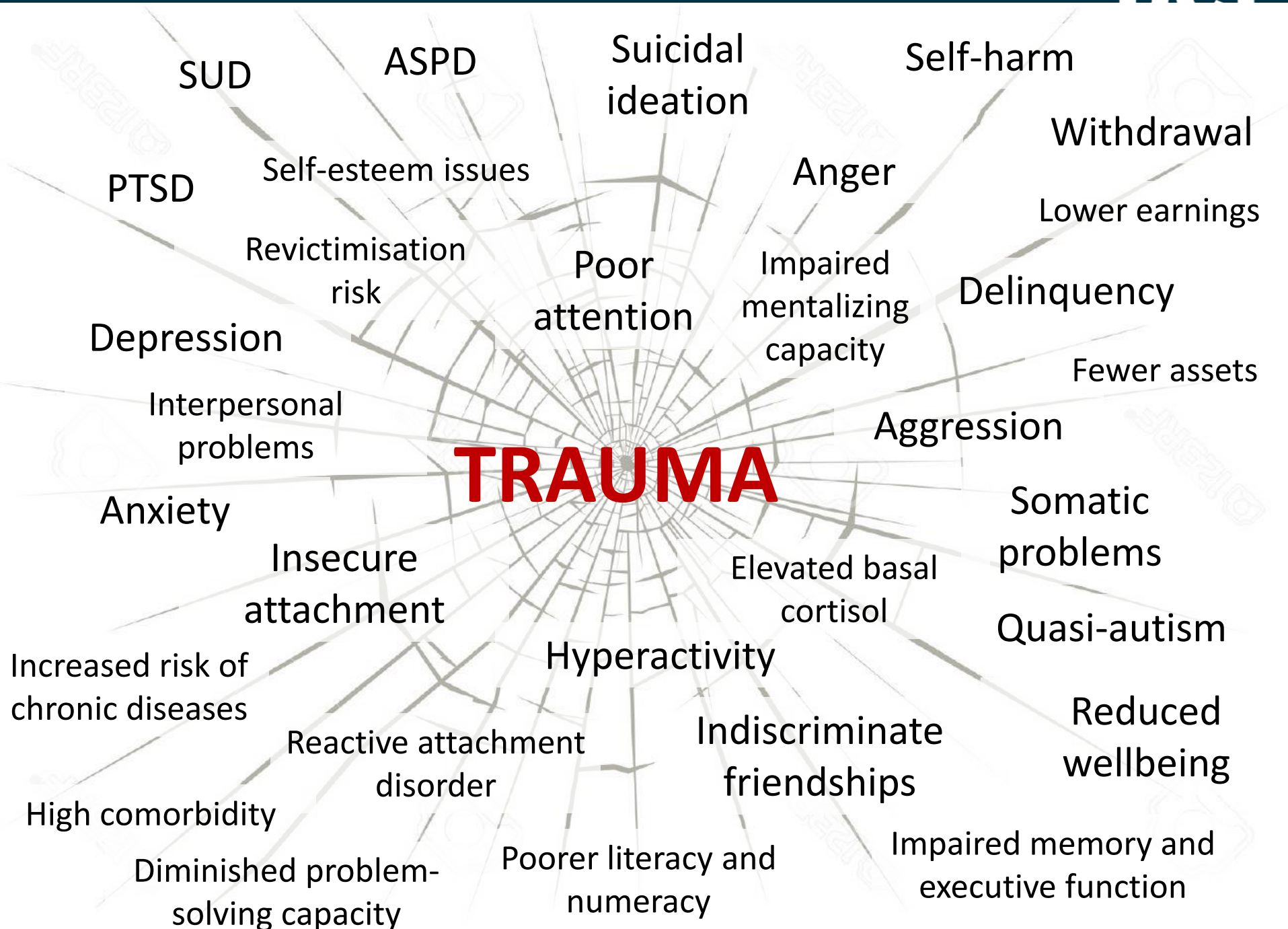
Many mental health disorders **in adults** are **associated with childhood trauma**

# Psychological trauma is a **transdiagnostic** vulnerability factor

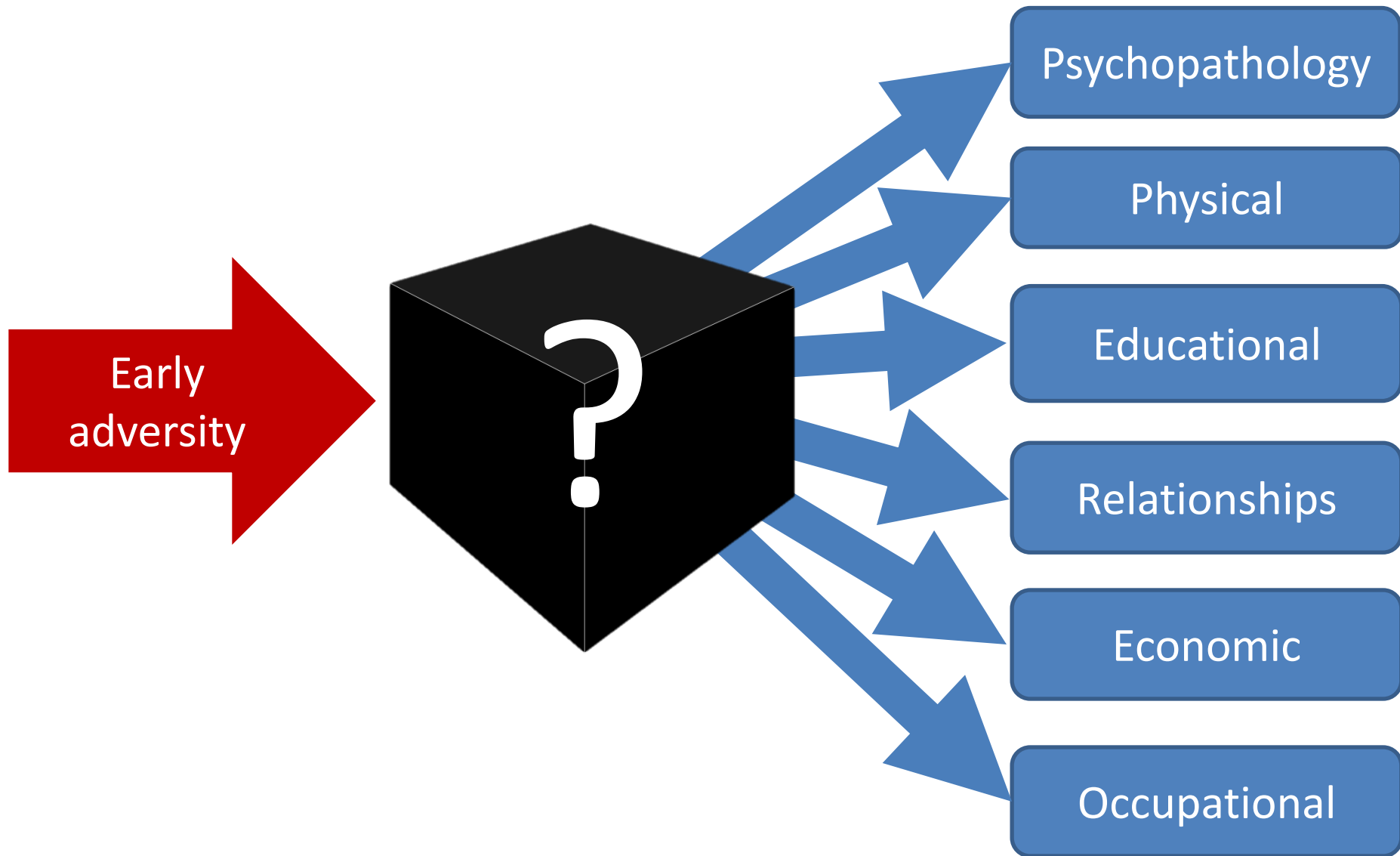


**30–70%** of the population-**attributable risk**

**Multifinality**: one specific developmental factor may lead to different developmental outcomes, depending on its interaction with other factors



What could mediate such a bewildering range of outcomes across multiple domains?





# Early adversity as an *ecophenotype*



- **Earlier** age at **onset** of psychopathology
- Greater symptom **severity**
- Higher levels of **comorbidity** (also with somatic)
- Greater risk for **self harm** and **suicide**
- High risk of **re-victimisation** and other **interpersonal problems**
- Poorer **response to treatment**

**Equifinality**: patients with the same diagnostic label differ considerably in the extent to which they experienced early adversity but those with a history show similarities

# Trauma and transdiagnostics

More difficult to identify a disorder to which childhood **maltreatment is not linked** than to identify a disorder to which it is linked with specificity (Vachon et al., 2015)

Childhood maltreatment **influences broad, general factors** (e.g., internalizing, externalizing) common to multiple different types of disorders **rather than specific disorders** or clusters of symptoms (Conway et al., 2018)

## Stress embedding:

- neural **changes in threat systems** lay down a **vulnerability** to later disorders.

## Stress generation:

- maltreated individuals **behave in ways** that **contribute to the occurrence** of other negative events in their lives

Involves an etiological chain with **at least four stress related processes.**

## Stress sensitization:

- exposure to early maltreatment generates more **vulnerability to later proximal stressors**

## Stress sensitivity:

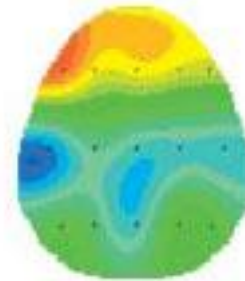
- some individuals are **genetically more or less sensitive to environmental influence** (Belsky, 2015)

# Stress Embedding: EEG responses for Angry faces

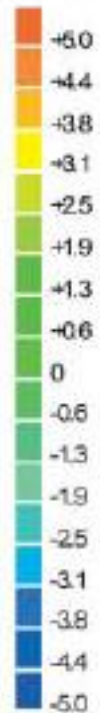
Maltreated group



Comparison group



Scale (microvolts)



310 ms

(Source: Cicchetti & Curtis, 2005, *Dev. & Psychopath.*)

## Threat processing

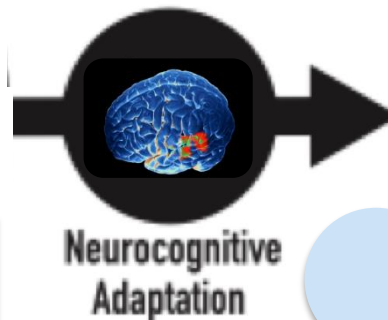
- how individual **perceives**, processes, **responds** to and shapes their social ecology
- Increase risk of **exposure to stressor events**
- **Degraded social support**

## Social Cognition

- Misunderstanding **intentions**
- **Symbolic thinking** deficits
- Social **hypervigilance**

## Emotion Regulation

- Failure to **monitor, evaluate, and modify** emotional **reactions**
- Disorganized **attachment**

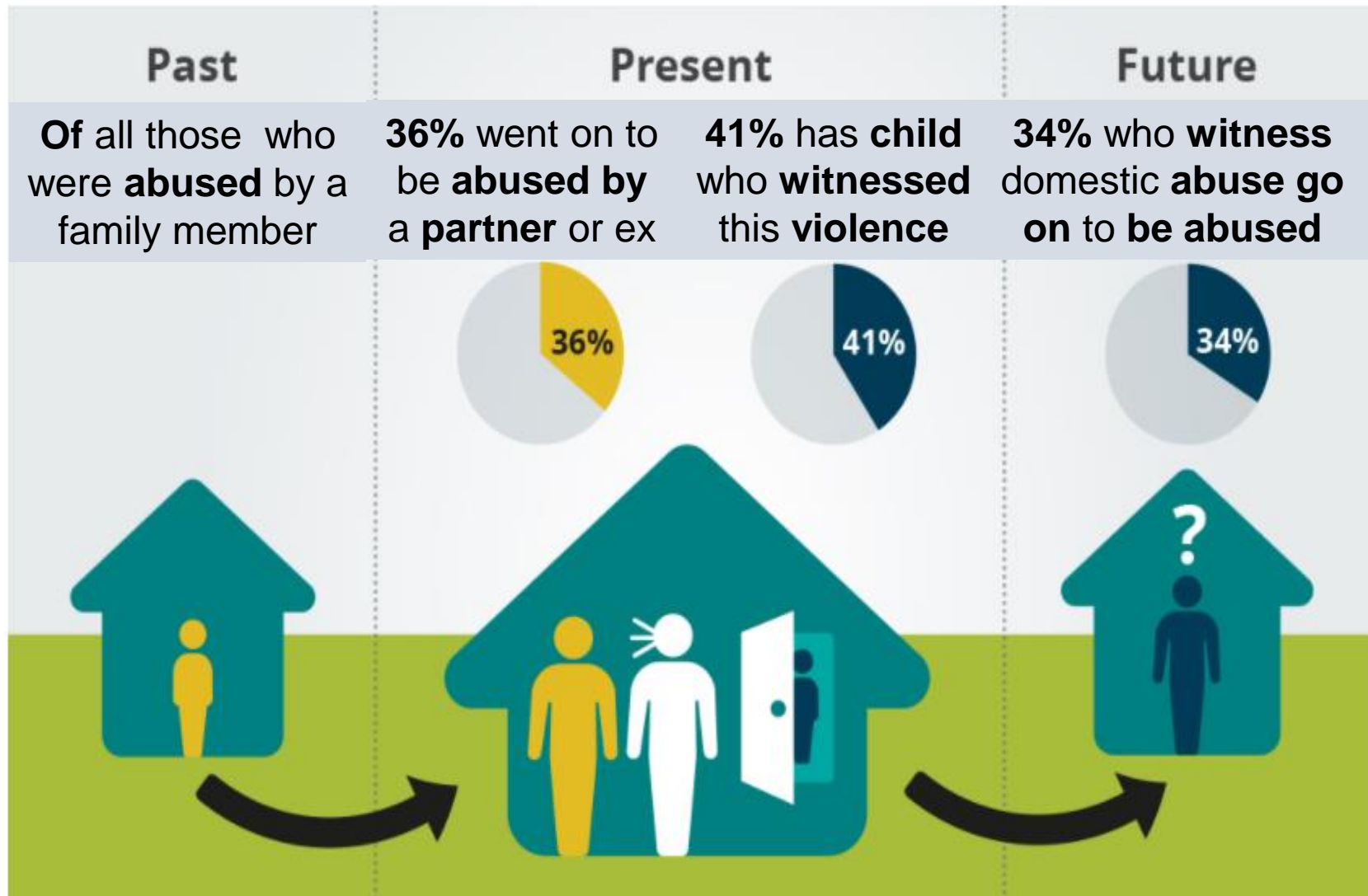


## Memory Processing

- Inadequate processing of **trauma experience**
- Privileging **negative memories** relative to positive memories

- McCrory et al., 2011, 2013; Majeu et al., 2010; Tottenham et al., 2011, 2017; White et al., 2012; Dannlowski et al., 2012
- Mehta et al., 2010; Goff et al., 2013; Hanson et al., 2015; Dennison et al., 2016; Tottenham et al., 2017
- Gee et al., 2013; Marusak et al., 2010, 2015; Puetz et al., 2014, 2016; McLoughlin et al., 2015

# The intergenerational impact of child abuse



# Summary points from available evidence



The importance of individual or *personalised* understanding of children exposed to early maltreatment and neglect



Not to let headline issues from their past or from diagnoses OR “quasi-diagnoses” cast a shadow over individual needs



Neurobiological research emphasises that:  
*Adversity breeds Diversity*



Avoid thinking of these children solely in terms of “attachment & trauma” [cf ASF] to get the right support, in the right families, at the right time

# Overshadowing & Masking

**Diagnostic overshadowing** is when a person's additional comorbid symptoms ***are identified...***

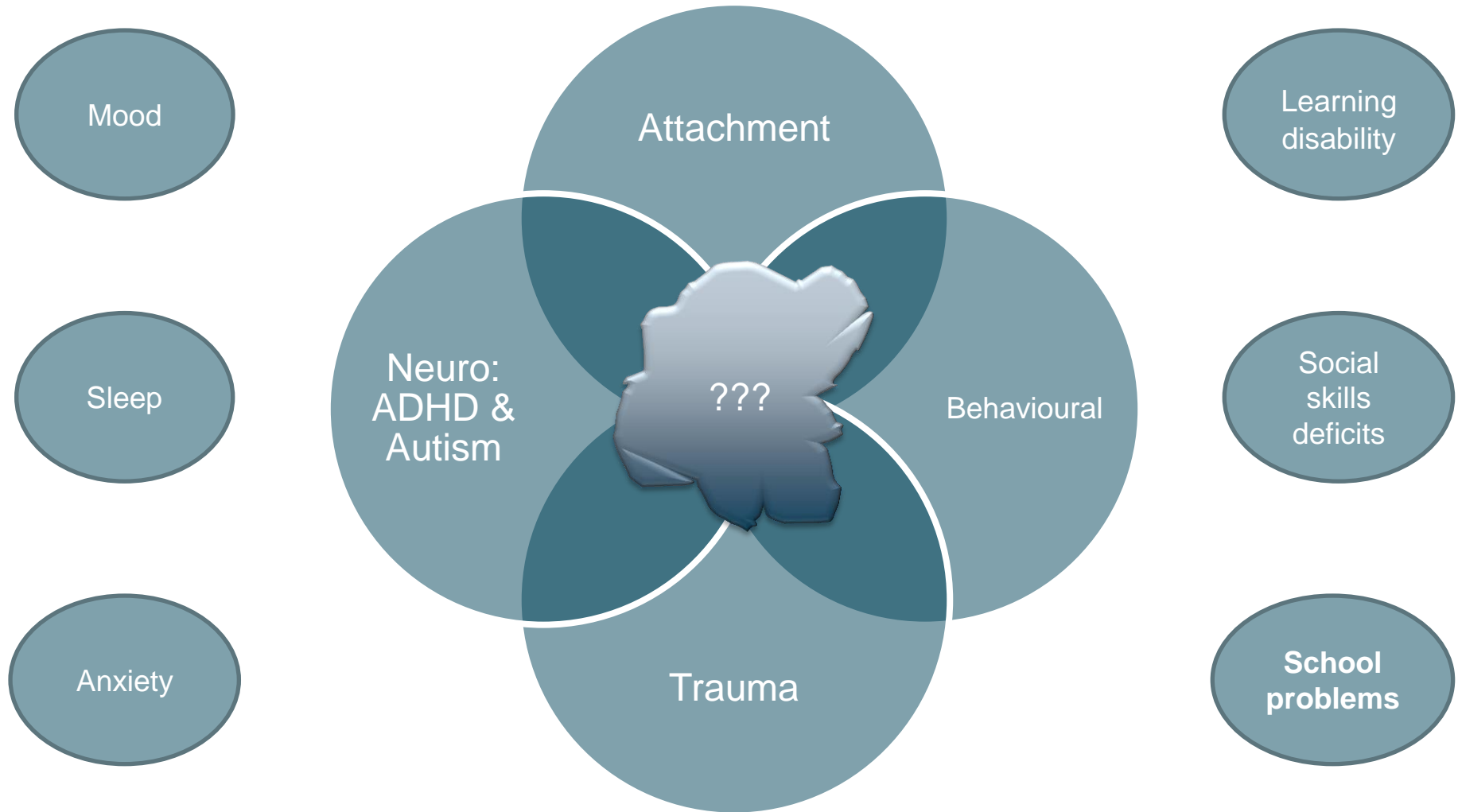
- but mistakenly subsumed under their primary condition or status
- e.g. LAC

**Diagnostic masking** is when comorbid symptoms ***are not identified...***

- due to focusing solely on the existing condition / status
- e.g. trauma

# Unusual & unique phenotypes

(in which common disorders still identifiable)





# Models of covariation of symptoms/diagnoses

## A. Correlated-Factors Model

MDD

GAD

Fears

CD

SUD

ADHD

Schz

BPD

OCD

# Models of covariation of symptoms/diagnoses

C. Bifactor Model

Factor 1

MDD

GAD

Fears

CD

SUD

ADHD

Schz

BPD

OCD

# A general psychopathology factor in early adolescence

Praveetha Patalay, Peter Fonagy, Jessica Deighton, Jay Belsky, Panos Vostanis and Miranda Wolpert

## Background

Recently, a general psychopathology dimension reflecting common aspects among disorders has been identified in adults. This has not yet been considered in children and adolescents, where the focus has been on externalising and internalising dimensions.

## Aims

Examine the existence, correlates and predictive value of a general psychopathology dimension in young people.

## Method

Alternative factor models were estimated using self-reports of symptoms in a large community-based sample aged 11–13.5 years ( $N=23\,477$ ), and resulting dimensions were assessed in terms of associations with external correlates and future functioning.

## Results

Both a traditional two-factor model and a bi-factor model with a general psychopathology bi-factor fitted the data well. The general psychopathology bi-factor best predicted future psychopathology and academic attainment. Associations with correlates and factor loadings are discussed.

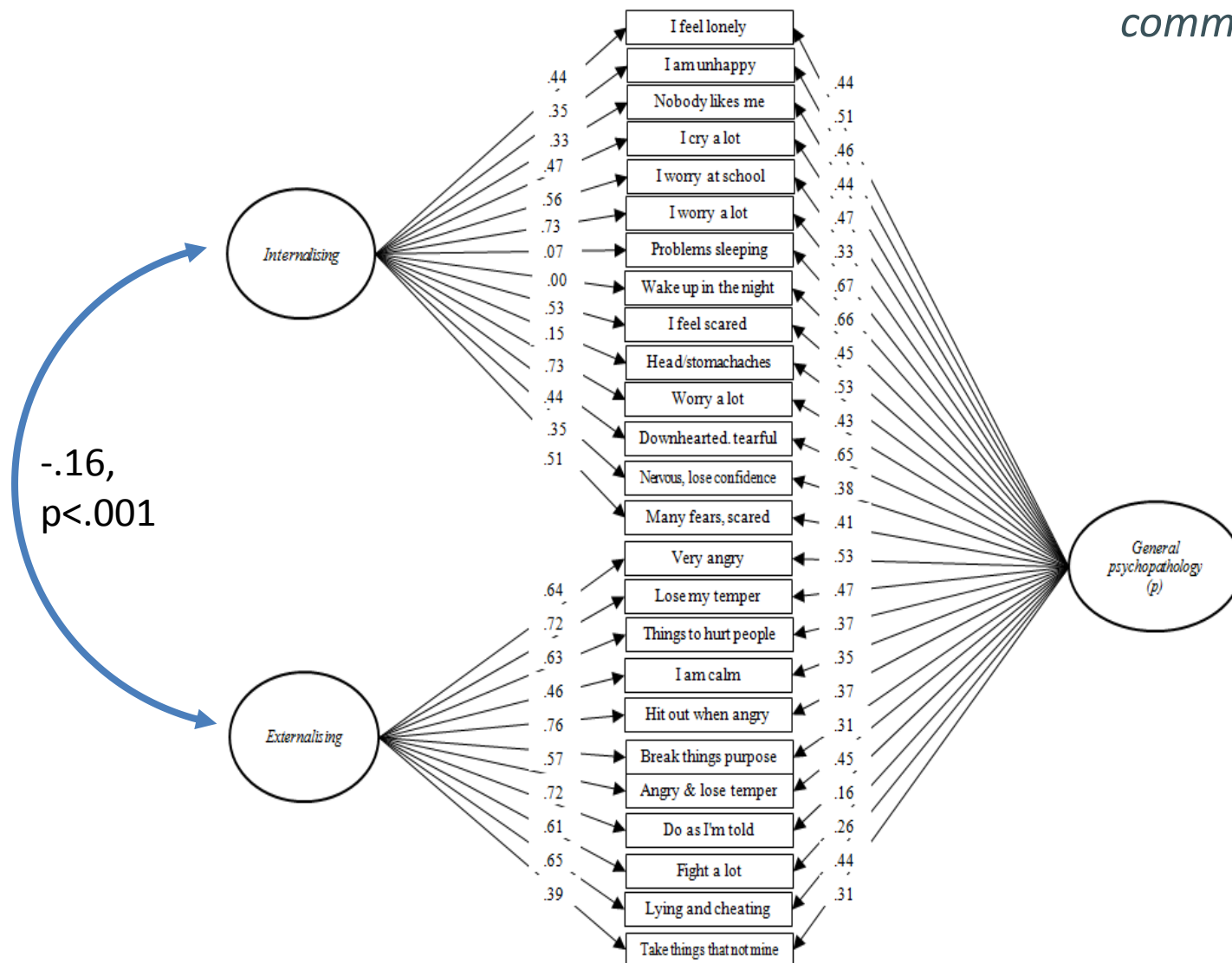
## Conclusions

A general psychopathology factor, which is equal across genders, can be identified in young people. Its associations with correlates and future functioning indicate that investigating this factor can increase our understanding of the aetiology, risk and correlates of psychopathology.

## Declaration of interest

None.

# Bi-factor model with the item-loadings

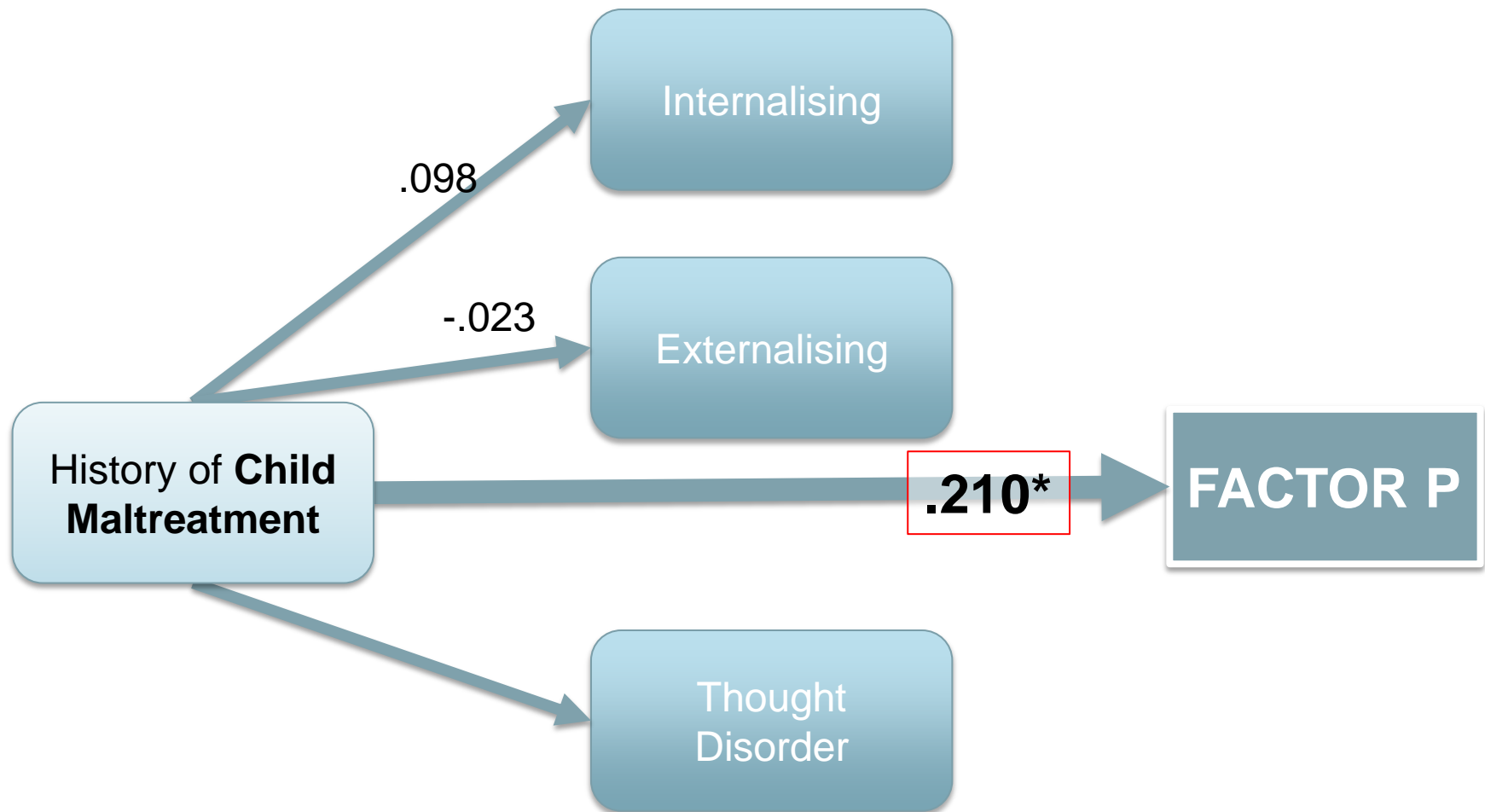


community-based sample  
aged 11-14 years  
(N= 23, 477)

# Logistic regression predicting future caseness

Predictor N=10,270	B	Wald Chi-square	Odds-ratio
<b>2-factor model</b>			
Internalising	.49***	76.4	1.80
Externalising	1.41***	689.64	4.11
<b>Bi-factor model</b>			
Internalising	.22	4.43	1.25
Externalising	1.43***	413.74	4.16
P-Factor	2.33***	479.01	10.30

# Child Maltreatment and psychopathology: Comparing structural models



2. Bifactor Model: P Factor ( $*p < 0.01$ ) Factors ( $*p < 0.01$ )

*When does  
adversity become  
traumatic?*

*Attachment, social  
isolation and  
trauma.*

# Mentalization based definition of trauma links social context and individual experience

Adversity becomes traumatic when it is compounded by a sense that **one's mind is alone**: normally an accessible **other mind** provides the **social referencing** that enables us to frame a frightening and otherwise overwhelming experience.





# Trauma as non-shared experience of adversity

- Adversity is **ubiquitous**
- **Trauma is** not the event but the **experience** associated with the **event**
- Experience of **adversity** is likely to **entail** a failure of **mentalizing** → **disconnection** from others
- The **rate** at which **mentalizing** is **recovered** to process the event will determine the extent to which it has **traumatic impact**
- The **social context** (social referencing) in which the **experience** of the event **is processed** can **mitigate** the traumatic consequence
- **Isolation**, the absence of sharing of mental states, is the **hallmark of adversity** becoming traumatic

# What is it that does not happen in caregiving environments characterised by adversity?



Where the social context gives **insufficient resources** to devote attention to the child

- It signals physical **aggression** is more **likely to be needed** to ensure survival



This is the **mechanism for the transgenerational transmission** of aggressive interpersonal strategies

- Increase likelihood of not desisting .



The child's **mind and body** needs to be **prepared for violent competition** for resources


- Alternative but **incompatible strategies** for ways of relating to others (intra-species **collaboration**) are **sacrificed**.



What is sacrificed?

- Namely, the **uniquely human capacity to envision mental states** in our fellow humans in order to understand their actions.

# What does not happen: Curiosity about minds



How must it **feel to be you** right now, boss?

I know that I **don't KNOW** what you must think, boss, but I can *wonder* what that is...

Why do I keep getting into trouble over **my rabbit habit**...?

Is there **something about me and rabbits** that stems from my childhood, I wonder...?

# What does not happen: Capacity to Trust

