How understanding ACEs can change the way you practice

Marisa Adair:

With the onset of the COVID-19 pandemic and the added stressors on children, youth and families, more attention has been focused on the impact of adverse childhood experiences (ACEs) on the mental health and wellness of British Columbians. Research that started in the 1990s has shown a co-relation between the number of ACEs in a young person's life, such as abuse, neglect, and family dysfunction, and an increased risk of mental health and substance use disorders and other chronic diseases. Research shows a physiological and neuroscientific link between trauma experienced as a child and the health and wellbeing of adults. The good news is there are ways that physicians can help to mitigate and address these challenges. I'm Marisa Adair and today on our Doctors of BC podcast, we welcome Dr Linda Uyeda, a BC family physician, whose personal journey of self-discovery led to her interest in the mind body connection and the impact of adverse childhood experiences. Linda has incorporated her learnings on ACEs into her medical practice, and today we're going to discuss the long-term impact of ACEs and what physicians can do to address and mitigate the impact on their patients. Welcome to the show, Linda.

Dr Linda Uyeda:

Thank you so much, Marisa. I'm really happy to be here, and I'm excited that we're talking about this topic today.

Marisa Adair:

Can you start by explaining to us what exactly are adverse childhood experiences?

Dr Linda Uyeda:

There was a study published in 1998 by Doctors Felitti and Anda, and it was a study that looked at multiple events that would happen in a child's life before the age of 18. Essentially what it showed was that there was a direct dose response relationship between the amount of adversity and the decades later effects on mental health and physical health. It was remarkable information, and very eye-opening. And so I only learned about this several years ago, but my journey into this information started really with my family and with having my own children. I started to learn this information really in an effort to help me decide how I was going to parent. I

still feel like I'm really at the beginning of my understanding and my learning. Understanding all of these things now that we have scientific evidence pointing us in the direction where we once felt were airy-fairy, fluffy stuff really does have a bearing on the outcomes for our patients and ourselves.

Marisa Adair:

So from a physiological, neuroscience perspective, exactly how do these adverse childhood experiences translate into chronic disease or mental health issues?

Dr Linda Uyeda:

I think the biggest learning point for me didn't happen in my medical school training, it came about when I was going to parenting courses, and when I was learning about the neuroscience of development. Our nervous systems are really under-formed when we're first born. This gives us an opportunity to then match our nervous system to the environment in which we are raised. As we grow up we're learning about what we need to do in order to survive in the environment in which we find ourselves. I think probably the most profound understanding came about when I more fully understood the autonomic nervous system, which is below our consciousness.

And so when stressful things happen to us, our reactions are very reflexive. This cascade of things happening in our body when we mount a stress response happen almost instantaneously, like a reflex. The way I teach this is if you can imagine yourself walking down the hallway and all of a sudden someone jumps out of a doorway and yells "boo" at you. You feel that adrenaline rush and your heart rate speeds up, your blood pressure rises, the sugar in your blood increases, your muscles tense and tighten. It's your body's way of giving you that extra instantaneous energy that you need to either fight or run. Our body realizes we can't do everything at once, and other systems are shut down. Our digestive system is shut down. Our sexual response system changes, all to activate what is most likely going to be a lifesaving event. But the real kicker for me was that this system, because it's developed so early on and it is primitive, there's not a lot of understanding going on. And so whether it's a physical threat or an emotional threat, that system doesn't know the difference. If we are under an emotional threat like I don't have enough food to eat, I'm not getting protected in instances where there's trauma around me, those emotional threats also set off that system. If you can imagine if a child

is being raised in an environment where they constantly feel unsafe, unsupported, or unloved, their systems are going to be going off all of the time.

And so in essence, what happens is our nervous system becomes sensitized, going into that stress response more often, and that can be lifesaving in situations where I do need to fight, I do need to run. But over time, if I put my heart rate up, we call that tachycardia. If I put my blood pressure up, we call that hypertension. If I leave my sugar on for too long, it translates to diabetes. So these effects that are learned in our earliest years are carried forward into our life. And unless we learn new skills and new ways of being in the world and those new skills and those new ways of being, almost require that we learn them in concert with another human being. And that's where my understanding really shifted as a physician.

Marisa Adair:

You gave me a simple, yet powerful example earlier about a young patient you had who was having challenges around breathing. And can you share that with us?

Dr Linda Uyeda:

When we talk about trauma, we often talk about the fact that it's really important to have this longitudinal relationship with our patients. But I also work in a youth clinic setting. And so there are times when I don't have that longitudinal relationship with the youth who are just coming in for birth control for example. And for this particular patient, that's what happened. She came in to refill her birth control prescription and in the midst of that, we were just talking about her life and talking about how things were going with COVID. And she was saying, "I'm doing fairly well, but I struggle sometimes with my breathing." And I said, "Oh, tell me a little bit more about that." And she said, "Well, it's really frustrating because I've discussed this with my GP, my GP sent me to a respirologist. I've had breathing tests done, and everybody's telling me that it's normal. I'm fine. There's nothing wrong." So with that, I spent a few minutes with her just educating her about that stress response. When we become stressed, we breathe more quickly and sometimes when we have stressful things that have gone on in our childhoods, we're more likely to experience the sense of fight or flight. And with this, our breathing can be affected. And

she just looked at me with this expression of relief and said, "This makes total sense to me." She disclosed to me that she was raised in the foster system. That is more how I use ACEs in my practice. I don't screen for them on a regular basis, but I'm aware of them. We don't need to do a deep dive into our patient's past history in order to help them, if we sense that this is what's going on with our patient, that gives us an opening to start discussing these things over and over again. I have had that experience where I explain the physiology of stress and trauma, and you can palpably feel the relief in the patient because they feel validated that these are experiences that they are truly having in their body. And that they're real, that they come from somewhere.

Marisa Adair:

It sounds like what I'm hearing is that it's really important to ask questions and listen, and get to know your patients. Is that the advice you would give to doctors who want to start thinking about ACEs and perhaps to start to integrate it into their practice?

Dr Linda Uyeda:

Yeah, absolutely. The ACEs study to me is a very small part of addressing trauma informed practice. So I have had patients that have an ACE score of zero and yet they're still struggling. And so I'm trying to help physicians and teachers and community members understand more about attachment theory as well, because you can have zero ACEs, but have attachment insecurity and it can show up in many of the same ways. Essentially the science is the same, but you can have microtraumas inside a relationship with your primary caregivers that also lead to these changes. The beautiful thing about all of this information is it also gives us an opportunity to heal. I don't know, a single person who isn't impacted by trauma and attachment. It is so widespread. The attachment literature shows that in North America, 45 to 50% of us are insecurely attached.

Marisa Adair:

Is there a fear that in taking this approach, some physicians may be triggered themselves with respect to their own childhood?

Dr Linda Uyeda:

I have definitely talked to some physicians who have that concern, but I would say that if we don't recognize what is going on, we are actually probably being triggered on a regular basis without having that explicit knowledge. So if I have somebody in my office who is we would call "difficult" and they're acting out, they're raising their voices. If I, myself, have a traumatic history or have experience with somebody coming at me in that manner, I'm going to be triggered. And I'm not likely going to be able to respond in a way that is helpful to that person. So, like I said, this is a long journey, but in my personal life and in my practice life,, the things that I have learned, the counseling that I have done has been profoundly helpful in all areas of my life.

Marisa Adair:

Canadians are really reeling from the discovery of the remains of Aboriginal children at the residential school site in Kamloops. What happens when it is an entire generation or generations of people who are impacted by a common adverse childhood experience?

Dr Linda Uyeda:

I was born and raised in Kamloops and I could see the residential school across the river from where I grew up. So when I learned about this, it felt like a gut punch, like somebody hit me in my body. I can only imagine how our Indigenous people have felt to have that wound reopened. I need to bear witness to all of that and not insert what I think needs to happen and what I think that community needs to heal. We need to listen to them right now. Again, it comes down to that attachment dynamic. I need to liste and hear the truth. So just saying again, I don't need to open up all of those old wounds with patients who've experienced that trauma. I need to recognize that it is there. I need to understand the physiological changes, and the risks that come with experiencing those kinds of traumatic events, and then bring some compassion to the problems that I see in front of me. I don't need to have them explain to me their whole story. So within my own family both sets of my grandparents went through the Japanese Canadian internment, and I'm still as a granddaughter of those people trying to understand what that means to me, how that shaped me, with parents who were raised during that time. What I want people to understand is that it happened, it happened to people that I care about, that people that I loved and I still see effects of it within my own family.

Marisa Adair:

How can doctors begin to establish trust and rapport, with their patients to really work through these challenges?

Dr Linda Uyeda:

Just listening and hearing what's important to our patient. As physicians, we learn all of these algorithms, we have all of these things that we want for our patients: the hemoglobin A1C, the blood pressure targets, etc. But if you understand attachment theory, you have to understand that the trust and mutual respect has to go both ways I often try to find out what's important to them in their life right now, so asking that young girl about how COVID has affected her. Then you're allowing them to lead the conversation, to lead their care, because maybe their goal isn't to have a perfect hemoglobin A1C. So I need to listen to that as a physician.

Marisa Adair:

It's great to hear that there are ways for physicians and others to help patients mitigate the impact of ACEs, but what can we do to prevent adverse childhood experiences?

Dr Linda Uyeda:

It's interesting for me, as I've learned this information, I constantly have to keep taking a step back. And so what I mean by that is, early in my learning, I was thought it's about the parents then, right? If the parents were there to support their child and buffer them from these things, then the issue would be solved. But what if that parent doesn't have the skills? What if they don't have the resources? What if they don't have the money or the food to support their child? Then we need to back up some more say, what are the community resources for this? What is the culture willing to do to support this? And then we need to back up even more into what is the government willing to do? I belong to the Child and Youth Mental Health and Substance Use Community of Practice. We are working with the Ministry of Health and trying to change policy. We are trying to educate people even in the family justice system to understand trauma and the impacts of all of these decisions that are made so high up. But there are things that we can all do on an individual basis to try to shift this at a grassroots level as well: one interaction at a time. Even having an interaction with a mother, with a young child having a temper tantrum in

the grocery store, I can show her compassion and say, I've been there and it's hard. Once you understand this information, you cannot go back. This information will only help us grow in empathy and understanding for all of us.

Marisa Adair:

Ultimately understanding ACEs and incorporating it into a physician's practice is good for the physician too, in terms of their own health and wellbeing?

Dr Linda Uyeda:

I believe it's protective. The more I am able to see that I have a positive effect on my patient, the more enjoyable my work is. But if I'm just on that hamster wheel and I'm seeing patient after patient, and I'm trying to make my goals be heard, and it feels futile, I'm at much higher risk for feeling like I'm not making a difference. So, like I said, as I have brought this into my own practice, my sense of feeling like I can do something to actually help people heal, not just to patch up their blood pressure or improve their diabetes, I'm actually helping them heal. So that is where my bucket gets filled up.

Marisa Adair:

Is this taught in medical schools? Are today's young doctors gaining an understanding of this?

Dr Linda Uyeda:

I just had a teaching session with medical students, but it doesn't seem to be across the whole school. It's really sporadic. These were medical students who came to our Community of Practice and said, we want this information. We want to offer it to other students and in my humble opinion, this is foundational to what we do as physicians. And if we want to be healers, we have to understand this information. So our goal is that it becomes, you know, a big part of the curriculum for all physicians across BC,

Marisa Adair:

In the meantime, what can doctors do and where can they turn to get more information about ACEs?

Dr Linda Uyeda:

The CYMHSU community of practice is a great place to start. We're hoping to increase the number of people that we have involved in that collaborative. We're hoping to increase education around ACEs and attachment theory. There are so many ways that physicians can learn about this and my way isn't going to be everyone else's way, but there is so much information it's out there. We just really need to keep sharing. At this point as a physician, you kind of need to look for it. You need to actually focus on it and make it a priority.

Marisa Adair:

Thank you, Linda, for this really informative and powerful discussion. I hope that it will prompt physicians out there who are listening and others to look into this further and all the very best you. Thank you for joining us.

Dr Linda Uyeda:

Thank you so much for having me.