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Mental Health Problems in Adults Due to ACE- ACase Study

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Abstract--- This case study has been extracted from the Mental Health Centre at the University. The student seeks counselling for depression and inability to carry out his academic and personal responsibilities, accompanied by serious medical problems such as obesity, diabetes and high cholesterol issues. He had been on psychiatric treatment some years ago but did not complement it with therapy. This case study has been presented to highlight the need for detailed assessment of young adults, especially students and the fact that Adverse Childhood Experiences (ACEs) are a very predominant cause for their maladaptive behaviours during adulthood. Recommendations have been made for comprehensive assessments and counselling process. Through this paper, the author hopes to emphasize the urgent need to implement stringent assessment procedures during childhood to identify ACEs and put into place corrective and preventive measures through robust policies.

Keywords--- Adverse Childhood Experiences, Behaviour, Chronic Diseases, Counselling, Mental Health, Neurological Problems, Substance Abuse, Suicide.

I. Introduction

The Centre for Disease Control and Prevention conducted the first large-scale study CDC-Kaiser [1] between 1995 and 1997, on over 17,000 members of Health maintenance organizations, to describe 'Adverse Childhood Experiences or **ACEs'**and their health outcomes in adults. Since then, many studies have been conducted to understand the impact of ACEs on both mental and physical health and the long term implications on life outcomes, opportunities and financial stability in adults who have undergone ACEs[2]. Studies have further shown the value of recognizing ACEs as high risk factors for toxic stress, self-destructive behaviours including but not limited to suicidality and substance abuse, and serious, perhaps permanent damage to the endocrine, immune and neurological systems, predisposing the victims to chronic diseases and even untimely death. The volume of evidence accumulated to prove the negative consequences of ACEs on adulthood has been highlighted as a growing public health concern [3]. There is an urgent need to understand adult behaviours in terms of their adverse experiences and identify solutions (in medical, psychiatric and therapeutic setups) that can help to repair at least some of the damage. Health care providers especially at the microsystem levels (for example, schools, colleges and universities) need to now adapt to the growing evidence and respond in new ways to change the outcomes.

In this paper, a case study of an adult student at the University has been presented. The details show the extent of his symptoms and the debilitating effects of his illness. Several adverse experiences during his childhood appear to have resulted in his present condition; some portions of his narrativehave been mentioned verbatim in the case study. Along with the differential diagnosis and prognosis, a counselling model[4], previously designed by the author has been recommended as a course of action, while keeping in mind the barriers that need to be overcome during the course of counselling and therapy.

II. Review of Literature

Many studies show a high prevalence of behavioural, adjustment and emotional problems in young adults who have experienced trauma during their childhood; much of the data comes from the United States or European countries. Very few studied have been conducted on a large scale in India. In one study of young adults between ages 18 and 24, it was found that 57% of the youth had experienced more than three types of traumatic events during their early formative years; predominant among them were sexual abuse, neglect, antipathy and physical abuse [5].The risk of developing chronic physical as well as mental illness has been well established; but the likelihood of morbidity and risk-taking behaviours in adulthood also becomes higherwhen children are exposed to more ACEs [6]. Among mental illnesses depression seems to have very high occurrence in association with higher number of ACEs that children are exposed to [7].

It was also found that psychological well-being was negatively related to household challenges due to reduced resilience. The poor levels of resilience were found to have resulted due to abuse and neglect, the primary ACEs [8].

In research similar to global studies, depression in adults was found to be four times higher among the individuals who suffered trauma during their early years [9]. They also found that dysfunctional families experience twice the antipathy, sexual and psychological abuse, confirming that the impact of ACEs continuesinto the future

generations. Suicidality (ideation and attempts) and tendency towards violence were more prevalent in youth who reported multiple ACEs [10].

Although researchers and practitioners suggest the urgency and imperativeness of preventive measures and policy changes to ensure safety of children, the value of therapeutic interventions is also recognized and documented. Cognitive Behaviour Therapy along with carefully prescribed antidepressants have been found to be quite effective in the treatment of depression in adults who have suffered ACEs [11]. Anxiety and PTSD too have been successfully treated with CBT and trauma-narrative based approaches, which emerged superior to treatment using drugs.

As valuable as drugs and therapy are in the process of treatment, educating and counselling the patients as well as the families is absolutely essential to see any significant improvement. Multiple diverse screening methods should be put in place to identify the mental health risks that may occur in youth. This will enable health care professionals to plan and execute suitable counselling and therapeutic processes that address the individual's biological, socio-cultural, psychological and contextual ecology. Neurocounselling is an emerging field which can be used to work with youth experiencing physical, mental, physical, and behavioural difficulties or concerns [12]. Neurocounselling provides an empirical framework to make assessment and counselling of people with history of ACEs, more effective. Researchers[13] have elucidated the positive benefits of contemporary interventions like mindfulness during the counselling process along with inputs from neurocounselling.

III. Method

Demographic details, family and personal history and medical and psychiatric history were taken using questionnaires developed at the Mental Health Centre at the University.All the other information has been consolidated from the counselling sessions over a period of 5-6 weeks.

Case History

General Information

- **Name:SGK**
- **Age:** 26
- **Occupation:** Student
- **Referral Details:** Presenting difficulties in sleep, poor appetite, destructive behaviour due to uncontrolled rage- mostly self-directed, bouts of sadness
- **Central Problem:** Has had a traumatic childhood- death of father, separation from mother, bullying in hostel, alcohol and physical abuse- self and others, depression lasting for a week or two. Currently, unable to get out of bed, eat, or exercise- affecting health and blood sugar levels; has vivid nightmares and bouts of depression- cries continuously and is unable to carry out academic work.

History of Presenting Complaints

- **Common Psychiatric Symptoms:**Poor sleep, appetite, nightmares, depressed mood, intermittent episodes of rage, tends to take on others' emotional problems and becomes even more depressed, poor coping skills, poor understanding of his emotions or behaviours, unhealthy attachments.
- **Precipitating Event:**Break-up with girlfriend, mother's illness.
- **Impact of Illness on**
  - **Work:** Unable to attend classes regularly, unable to keep up with academic demands-tardy
  - **Social Relations:** Has no confidence to carry out social responsibilities (mother's hospitalization/ treatment); avoids people and doesn't share problems with anyone, but goes out of the way to help others in distress; has a good group of friends and hostel-mates.
  - **Self-care:**Very poor eating and sleeping habits, poor hygiene and lack of exercise; eats a lot of unhealthy foods instead of meals.

Psychiatric History

- **Details of Previous Episodes of Illness:**Had several episodes of depression over the past 4 years; not pervasive.
- **Previous Psychiatric Admissions/Treatment:**None.
- **OutpatientTreatment:**Medicated for depression and anxiety; discontinued after a short time.
- **Suicide Attempts:**Self-harming behaviours persistent; has requested others to beat him up.
- **Drug and Alcohol Abuse:**Consumed alcohol for a several months; has been clean for past 3 years; no smoking or drugs.
- **Interval Functioning (What is the Patient Like Between Episodes/When "Well'):**Friendly, sociable, does his work well, enthusiastic and well-loved by everyone, caring, proactive and well-adjusted.

Past Medical History

- **Details of Medical Conditions:**Surgery for removal of kidney stones, broken bones (during fights) and diabetic (latest HbA1c 7.3); quite overweight.
- **Effect of Medical Conditions on Psychiatric Symptoms:**Weight and diabetes maybe aggravating depression.
- **Can the client understand the complexity of medical problems that might be aggravated by psychiatric conditions?** Yes (but largely unable to carry out corrective measures consistently).

Family History

- **Parents and Siblings, Nature of the Relationships between Family Members:**Very poor relations with extended maternal family-resulting in a lot of aggression and destructive behaviours; father's brother is the primary caregiver; mother has some serious health problems and hence unable to support. Good strong relationship with uncle, cousins and mother. No siblings, father passed during patient's childhood.
- **Any Family Tensions and Stresses and Family Models of Coping**
  - Mother's illness and interference of extended family are triggers for stress.
  - paternal uncle supports the family financially and emotionally, mother is mostly independent and tries to be supportive of the student.
  - however, student tends to not share any of his problems with the mother.
- **Family history of psychiatric illness (including drug/alcohol abuse, suicide attempts):** none.

Personal History

- **Early Development:** Normal.
- **Childhood:** Relatively normal till death of father; father was very proactive in his school matters and expected high performance, but was also indulgent.
- **School:**Has changed many schools due to difficult behaviour; mostly in hostel; has been bullied and then became a bully.
- **Adolescence:**Disturbed, violent, self-harm, inconsistent social relationships due to movement.
- **Social Network:**Has a good set of friends at school and hostel, good relationships and communication during periods of normalcy.
- **Habits:**Inconsistent daily routine (others mentioned in earlier sections).
- **Leisure:**No specific activity; long-distance relationship through social networking site.
- **Problems Faced in Adjusting to Predictable Stages of Development:**Difficulties with schoolmates during high school years- bullied, got into physical fights, injured self and others.
- **Response to Stressful life Circumstances (Death/ Accident/ Illness:** Father's death: did not understand it at that time, still consumed with grief and has some guilt over it.
- **Mother's Grief and Illness:**Feels helpless and useless; complains about being a burden and wishes he could end it all.
- **Personality Traits Prior to Illness (Premorbid Condition):** Warm, affectionate, amiable, conscientious, strong superego, intelligent, assertive, very sensitive to others' needs, resourceful.
- **Personality Traits During Illness (Premorbid Condition):**Distant, asocial, angry and sometimes violent, poor decision making abilities.

Summary and Diagnosis

- **Diagnosis:**Depression and anxiety.
  Symptoms: Pervasive and persistent sadness for over 4-5 days, inability to carry out tasks of daily routine, inability to complete academic tasks, poor appetite, poor sleep, vivid and recurring nightmares, sudden bouts of rage and violent behaviour, self-harming behaviours.
- **Supporting Evidence:**Information from roommates and friends, history of trauma and violence, alcoholism, poor social relationships.

Differential Diagnosis

- **Death of Father:**Unresolved grief, loss and trauma leading to anxiety.
- **Separation from Mother:**Additional separation anxiety, sense of abandonment, compensatory behaviours in the form of aggression, weeping, unhealthy eating and sleeping habits.
- **Bullying at School:**Violent outburst, impulsivity, substance abuse, nightmares.
- **Ill-treatment by extended family/ community:**Mistrust, anger.
- **Cumulative effect of ACEs:**Anxiety, depression, self-harm, suicidal ideation, poor attention, poor physical and mental health, low confidence and self-esteem, low resilience, moodiness.

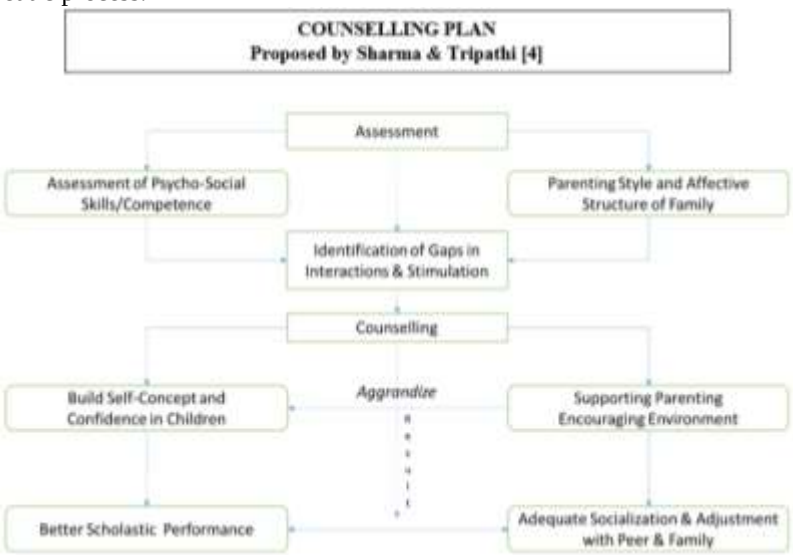
Recommendations for Treatment

SGK has been advised,

- To seek psychiatric help to stabilize and elevate his mood.
- To get tested for various physical aspects including diabetes, hypothyroidism, obesity, etc.
- To seek and continue medical support for maintain blood sugar and weight levels.
- To continue therapy with counsellor at University regularly.
- To follow a nutritious and regular diet, exercise regime and routine activities.

Prognosis

Student will benefit from consistent and extended psycho-education, therapy supported by anti-depressants. His own desire to make a good life for himself and his confidence in his academic/ professional life will go a long way in supporting the therapeutic process.



Course of Treatment based on the counselling plan mentioned above *(student is still undergoing counselling at the Mental Health Centre in the University and seeking psychiatric/ medical help at the local hospital):*

1. **Assessment:**
   - **Psycho-social Competence(Interpersonal and Intrapersonal Skills):** The student demonstrated limited interpersonal skills, resulting mostly due to severe bouts of depression, poor clarity of thought and disinterest in socializing. He is however very aware of the different feelings he experiences and is very introspective. The negative bias/ cognitive distortion is apparent in the way he describes himself, especially when depressed. But he is also very aware of his own strengths and understands that these will help him overcome his depression.
   - **Psychological Status(For Presence and Extent of Mental Disorder):**Preliminary assessment was made for presence of Depression; further psychiatric evaluation was made to confirm the same.
   - **Physical Health Status(For Presence of Any Medical Condition that May be Influencing his Mental Health Status):** Further assessment was conducted for any disturbances in thyroid levels, vitamin D levels and hyperglycaemia;
   - **Family Dynamics/ Affective Family Structure:** Details about the family structure and dynamics were gathered during the interview; details about the death of father and separation from mother, relationship between student and his grandparents, uncle and cousins, significant determinants of the psychological status of the student.
2. **Identification of Gaps (In Interaction and Stimulation):**The student's ability to interact with his environment is not diminished; however, he tends to isolate himself often for various reasons, which he is able to identify. Very few opportunities to motivate himself are used although he is aware of this too.
3. **Counselling:**
   - **Family:** Since student lives in the hostel, his family has not interacted with the counsellor.
     - The mother and uncle are both aware that the student is seeking help and are supportive of him.
     - Friends of the students have also been informed of his situation and they are seeking help regularly to understand the student's needs and are helping.

- **Student:** Several sessions of counselling have been conducted to motivate the student to take charge of his life and make necessary changes.
  - Feelings and thoughts surrounding his traumatic experiences have been addressed and resolved to some extent.
  - His fear of facing painful situations (his mother's illness/ hospitalization) was addressed and he was helped to overcome it. The student spent some time taking care of his mother during her treatment and is now reassured of his ability to deal with such things in the future.
  - He is still unable to accept himself during the depressive states; he blames himself for all the trouble he got into during the early years and is guilty about the pain caused to the family.
  - More counselling sessions are required to address the student's guilt, his poor confidence and self-esteem levels, and the consequent symptoms of sleeplessness, nightmares and fear.

IV. Discussion

Adverse, painful and traumatic experiences like loss of parent, abuse and loss of social/ personal opportunities can alter the course of normal development of a child. Many times, the consequences of these experiences become apparent only during adulthood in the form of personality problems, difficulties in adjustment and disturbances in daily functioning. In addition, any physical health problems exacerbate these mental conditions and coping or recovery become that much more difficult. Illnesses like Diabetes, Thyroid dysfunction and vitamin deficiencies are strong indicators of depression and anxiety [14].Physical illness in combination with ACEs can manifest as mental illnesses or chronic ill-health, resulting in serious detriment to life and career opportunities and relationships. Hence, it becomes necessary to make early assessments of any adverse experiences a child is likely to undergo and put in place preventive practices ensuring safety and security and the normal development of the child. When adults present problems in the form of depression, anxiety, maladaptive and self-destructive behaviours, poor health conditions and so on, it will be worth our while to check for a history of adverse/ traumatic experiences during childhood. Counselling, psychoeducation and therapy can be planned out for the individual as well as her/his family members to ensure holistic benefit that is also long-lasting.

V. Conclusion

In the present case, the student has been exposed for extended periods of time to multiple adverse experiences during his childhood. These were largely considered as 'bad' behaviours and additional punishment was meted out to the student. The current symptoms, especially the depression, poor health, disturbed sleep and poor resilience are a consequence of the ACEs. The student's ability to understand and analyse his problems could have been compromised during the formative years; in addition, since he did not receive adequate emotional support from his mother or other family members, his psychological state was further worsened. The student requires regular and consistent counselling, supported by nutritional coaching, medication for physical problems as well as for depression. Educating the student and his mother about the issue will help them to participate proactively in the healing process. The can be helped to build resilience and positivity using the support of his friends and room-mates.

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