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Adverse Childhood Experiences: Piloting a Group Therapy Program Using Psychoeducation, Music Therapy, and the Creative Arts for Adults with Complex Concurrent Disorders in an Inpatient Setting

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Abstract

Research shows a significant correlation between adverse childhood experiences (ACEs) and later adult mental health and addiction issues. There is currently no literature on therapeutic interventions to begin to redress their complex issues. Mental health, psychiatric, and addiction treatment centers often avoid tackling the manifold roots of dysfunction in clients' lives. We present the implementation of group therapy for clients with significant ACE histories, inspired by an initial in-service for clients on the subject of ACEs in mental health and addictions. Establishing group therapy for a broad spectrum of adverse childhood events proved to be an ambitious yet rewarding task. We discuss developing a comprehensive curriculum with a psychoeducational focus, a trauma-informed lens to support symptom management and resilience, and expressive elements by incorporating music therapy and the creative arts because of emerging evidence of the need for trauma recovery to engage in expressive and embodied outlets. Group observations and anecdotal evidence from clients' evaluations of the group support the urgent need for moving from research findings on ACEs to the implementation of group therapy.

Keywords: Adverse Childhood Experiences, Psychoeducation, Music Therapy, Creative Arts, Trauma, Recovery, Complex Concurrent Disorders, Substance use, Addiction, Group Therapy

Introduction

One key message learned from Felitti et al. [1] is that adverse childhood experiences often lead to adverse adult experiences. In our concurrent disorders setting, many clients continued to experience adverse experiences well beyond the age of 18. Many correlations exist between ACEs and later problems in life [2-8]. There remains, however, a dismaying gap in the literature on the remediation of ACEs for clients with substance use and mental health issues. This article explores the current literature on ACEs for persons with concurrent disorders, the use of music therapy and the creative arts as applied to ACEs, then presents the implementation and development of inpatient group therapy for adverse childhood experiences. The group includes elements of support groups, verbal counseling, creative arts therapies, and psychoeducation. We aim to advocate for ACE groups in similar settings to support clients in their quest toward optimal health.

ACEs include stressful, potentially traumatic events occurring before the age of 18 [1]. ACEs include physical, sexual, and emotional abuse, neglect, domestic violence, familial substance use and mental health issues, family separation or divorce, or an incarcerated household member [1,9,10]. These experiences can impact the child's social, emotional, and cognitive development and increase the potential for lifelong mental health and substance use issues, suicide attempts, sleep disturbances, and high-risk sexual behaviors [11,12] (p. 2). Childhood exposure to chronic stress can disrupt neurodevelopment and lead to deficits in cognitive function and emotion regulation. This can then lead to the acquisition of substance use, self-harm, and other unhealthy coping mechanisms [13]. Higher ACE exposures correlate to the increased likelihood of experiencing various mental health disorders, including mood disorders, substance use disorders, anxiety disorders, and impulse control disorders.

We asked ourselves many questions about formulating a group that would support clients toward understanding how their ACEs affect their mental health and addictions issues and what coping skills could be learned and practiced within the group. Given the complexity of numerous ACEs combined with active concurrent disorders, we realized the daunting task of offering a meaningful group would require a careful balance of process work with resilience building. Our initial plan was to explore each ACE topic sequentially, combining the topics with insight-oriented discussions and adjunctive PowerPoint materials from trauma literature, quotes, and creative arts approaches. We surveyed the medical records of the clients in combination with group discussions to better understand their needs. We soon realized that a range of topics could serve as anchors for each session, a discovery informed by client's feelings and thoughts about themselves. Psychoeducational sessions on attachment, ACOA, trauma, and recovery [14], childhood neglect, effects of sexual abuse, and short film segments such as Gabor Maté's TEDx Talk on "The Power of Addiction and the Addiction of Power" [15] proved to be vital and engaging topics for the group. Clients repeatedly say that this group fills a gap in their recovery and augments messaging from other programs. The vast majority of clients say that this is the first time they have self-disclosed about past painful experiences.This group supports and intersects with other programs offered at the facility, such as Women Seeking Safety, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy for

Anxiety, Men Seeking Safety, Matrix Model program, and Drug Awareness.

The Setting

The clients described in this article are in a Canadian inpatient tertiary-care facility receiving treatment for severe and complex concurrent substance addictions and mental health disorders. This means all clients have an addiction to at least one substance disorder with co-occurring significant mental health disorders. The program is based on recovery and care planning for each client and offers a wide range of interdisciplinary professional services. Emphasis is placed on group-based programming, though brief individual therapy is available to clients on a referral basis. Clients stay for up to nine months to support skills development and a trajectory to long-term sobriety and optimal mental health. There is an average of 90 clients; about 80% are male, likely due to treatment facilities in the city for women only; we often have a few clients who identify as non-binary or transgender. Clients range in age from 19-65. The ethnic demographic is broad, always necessitating cultural competence and humility. We also serve several clients of indigenous heritage. When considering all of our group's clients to date, the average ACE score is 7.4 out of 10. The higher a person's ACE score, the greater the risk of chronic disease and mental illness. In comparison, the ground-breaking study of over 17,000 individuals who were primarily white, colleague-educated, with jobs and good health care benefits had 1 in 8 who scored four or more ACEs [1]. Within clients who have attended our group, 85% score four or more. Note that score results are referenced here with consent.

Sometimes also called dual diagnosis or co-occurring disorders, complex concurrent disorders are defined by the Centre for Addiction and Mental Health [16] as substance use disorders in conjunction with one or more Axis I diagnosis. What adds to our clients' complexities are the often co-occurring diagnoses of Major Depressive Disorder, Bipolar Disorder, Panic disorder, PTSD, Unspecified Psychotic Disorders, Schizophrenia, Social Anxiety Disorder, Attention Deficit Hyperactive Disorder, and Substance Use Disorders. Other comorbid conditions can include hypertension, Chronic Obstructive Pulmonary Disease, developmental delay, concussion/acquired brain injury, asthma, cognitive impairment, Hepatitis C, adrenal insufficiency, chronic pain, fibromyalgia, and diabetes. Addictions are almost always to multiple substances.

Literature Review

With the impact of ACEs being well documented, this literature review will focus on the effects of ACEs on persons in addictions recovery or psychiatric care settings. Frewen et al. [17] conclude that lifetime traumatic stressors and a history of ACEs uniquely predicted concurrent PTSD and complex PTSD and each ACE increased the likelihood for early initiation into substance use 2- to 4-fold. Rytila-Manninen et al. [18] infer a parallel for ACEs' risk factors and serious mental disorders and inpatient hospitalization among adolescents. Similarly, Felitti & Anda [19] indicate relationships between childhood adversity and later sexual behaviors, psychiatric disorders, and medical diseases. Anda et al. [20] identified a correlation between ACEs and later risk of alcoholism and depression. In Canadian prisons for women, Brown et al. [21] report 90% of those in treatment for alcoholism had abuse-related trauma as a child or adult, and Chaim & Henderson [22] also report 90% of incarcerated women and 62% of men indicated a history of traumatic distress. Allen and Lauterbach [23] identified several studies wherein persons who have experienced childhood trauma are more likely to be diagnosed with a personality disorder in adulthood (our site has an average of 25% of clients with a personality disorder). We find further evidence for ACEs in developing mental health issues in Zarse et al. [24], where a score above five is associated with an increased likelihood of being prescribed antidepressant, anxiolytic, antipsychotic, or mood-stabilizing medications. Higher ACE scores are also associated with less specific indicators of poor health, including measures of mobility, homelessness, and unemployment [2,25-28]. Guarnaccia et al. [29] similarly report that 32 male subjects with substance addiction experienced a more significant number of ACEs than their nonclinical controls ($p < 0.05$). Compounding the effects of ACEs for some of our clients are the added effects of intergenerational trauma. This applies to many clients from assorted backgrounds, especially for our Indigenous clients where intergenerational trauma is prevalent due to the effects of colonization, the Indian Reservation System, and residential schooling [30,31].

Music Therapy and the Creative Arts in Trauma Recovery

What does music therapy have to do with this group? The first author has a history of childhood abuse and spent many years working through many ramifications. This informed his doctoral work on childhood sexual abuse and the creative arts within curriculum, instruction, and anti-oppressive pedagogy. Current practices in childhood trauma recovery are more and more infused with expressive domains to engage the whole being in externalizing experiences, using metaphor, and discovering creativity within adversity. Multiple modalities may be beneficial because of the effects of childhood trauma on the brain and body [32,33,34,35,36]. Forgeard [37] and her team found in an extensive qualitative study that when subjects who had experienced traumatic events perceived greater creativity, they had a marked increase in posttraumatic growth. Ascribed benefits studies of creative arts and trauma show better results than brain-based or psych-based studies [38]. Benefits include improved sleep, relaxation, resilience and empowerment, social benefits, self-worth, emotional outcomes like emotional balance, mood stabilization, fewer affective and cognitive disturbances, increasing expression of non-traumatic feelings. Van Der Kolk [39] asserts that taking action is vital. By this, he means engaging the body through expressive outlets, breathwork, and meditation, arguing that words alone cannot substitute for action.

Gold et al. [40] define music therapy as a form of therapy that uses music experiences and client-therapist relationships for therapeutic change. Music therapy studies have demonstrated positive effects for persons with severe mental health issues regarding negative symptoms and social functioning [40,41,42,43,44]. Several writers cite music as an effective means for reducing stress and anxiety levels, findings supported by brain research [45,46,47,48]. Johnson [49] proposed that "music therapy might function as a sensorial approach to traumatic memories that detours linguistic and logical mediation" (p. 223), a finding supported by Bensimon et al. [50] in their study on group music therapy with post-traumatized soldiers.

To date, only two music therapy articles make mention of adverse childhood experiences. In a critical interpretive synthesis of research literature by McFerran et al. [38], they highlight how connections between the brain and trauma have led to the establishment of music-based programs for those with ACEs. Benefits include stabilizing, entrainment, and expression. Other positive outcomes identified were resilience, empowerment, improved self-worth, and improved relaxation. Fletcher [11] writes about the use of rap in music therapy with Appalachian youth with ACEs, where clients identify with certain rap songs because they resonate with the lyrics about substance use, depression, poverty, disempowerment, and even hopelessness.

There are indications for creative arts therapies as they involve multiple senses, allow for alternate communication channels between the brain's hemispheres [51]. Whereas speech and language functions are typically in the left hemisphere, the right hemisphere is viewed as the centre for attention, emotions, and implied meanings. It is the more creative and artistic side of the brain. Early childhood trauma [52] "…can lead to enduring right-hemisphere inefficient function, and most alarming is the effect on the right brain's stress coping systems" and that "severe relational trauma, especially neglect and/or abuse, disrupts the development of, specifically, the right brain (p. 22)." Perry [53] advocates for the use of arts-based interventions

in the context of the neurosequential model of therapeutics. Recent theory about the connection between the brain and trauma [53-56] has led to a burgeoning interest in providing music-based programs with people who have had adverse experiences [38].

A Curriculum for an ACE Group

Client referrals come in several ways: 1) a group tracker on the intranet is where staff can refer clients to specific core groups. This tracker records those who are referred, attending, completed, and who declined; 2) the facilitators review upcoming admission profiles for histories of childhood adversity and trauma, adding these potential group members to the referral spreadsheet tracker; 3) lists of daily groups are available on weekly calendars, and each unit's whiteboards, so clients sometimes self-refer when they see "Adverse Childhood Experiences" listed. We feel it is valuable that clients can attend the group based on their self-directed desire to attend. Once the group size reaches eight or more clients, we then post the group as being "Closed," which clients understand to mean it is by referral only and can be added to the waitlist for the next round or the commencement of a second ACE group. Clients are often socioeconomically disadvantaged. They cannot afford individual therapy. Multiple treatment stays can foster institutionalization, which can cause apathy. Many clients have never received individual or group therapy for their adverse childhood experiences. Instead, treating their symptoms is often the only approach. It is dismaying that clients have rarely had counseling for any of the numerous adversities they have faced. Historically, facilities have argued that they do not possess the resources to open up childhood trauma topics with clients, and therefore it would be unethical to do so. What the writers encounter, then, are clients who--even in their fifties and early sixties--have never told anyone that their mother beat them, that their father was an alcoholic, that their grandfather sexually abused them, that they felt unloved in the foster system, that their Indigenous grandmother was residential schooled, and so on. On the other hand, staff often enjoy access to employee assistance counseling, individual psychology sessions, and the will to advocate for themselves to optimize health. Without careful attention to the complexities of addiction, we otherwise risk treating substance use disorders as solely cognitive events.

The group meets once per week. To increase a sense of safety, we hold the group in the auditorium, though rather than using standard auditorium seating, we gather in a circle. We prefer it when group members can see each other and converse with each other. It can also shift the typical group session away from being solely lectured to rather than being a more active participant. This spacious setting allows for the least disruption by other staff or clients moving throughout the building. Gentle music plays from an iPod onto a Bluetooth speaker as clients enter and often for the initial portion of the group. We cover group guidelines each time, including confidentiality, arriving on time, expecting the facilitators to be reliable and organized, and for the clients to practice self-regulation when feeling stressed or triggered. We ask clients to reach out to the co-facilitators during or after the group should they feel flooded or upset.

Regarding self-regulation, advice to clients is that telling lengthy trauma narratives can be harmful to both themselves and others in the group. We convey that it is okay to talk about their experiences but to be understanding if one of the group facilitators invites them to pause and practice a self-regulation strategy before continuing. We review what this can look like, such as three deep breaths, eye contact, noticing muscle tension in one's body, and consciously relaxing. Each group session includes a brief music-based grounding experience at the beginning or end and also consists of a closing song such as “I can see clearly now” with its lyrics of “I can see all obstacles in my way, gone are the dark clouds that had blind, it’s gonna be a bright, bright sunshiny day” [57]. We find that sharing experiences, insight, and engagement in the creative arts has produced a sense of group cohesion. Between groups, we observe clients being supportive of each other.

We observed that many clients struggle to manage their weekly calendars, which affected attendance initially. A significant amount of time investment fostered regular participation and group cohesion. Only a selection of core groups is considered mandatory for clients, so clients need a level of motivation to attend groups. We achieved this through invitations (reminders) handed to clients in person or taped on the door to their rooms the day prior. With the first session typically done 1-1, this also builds trust and rapport. When clients miss the group, we check in on how they are doing. In the days following the group, we also connect with attendees to see how they managed with the topic covered that day. A list of both global and local resources for ACE is available to clients at the end of each session. Resources include community and online support groups, legal advice, education, and how to report child abuse.

We are presently developing this group to have a 12-week curriculum. This includes the following topics (not in a set sequence): Introduction to ACEs, self-destructive behaviors and coping mechanisms, genogram, developing resilience, verbal/emotional abuse, childhood neglect, attachment, timeline, anger, self-worth, and lessons from adult children of alcoholics. We do not expect clients to wrap up their entire childhood adversity in roughly three months, childhood sexual abuse, but believe it provides the groundwork for continued personal growth. It is feasible that a client who wants to repeat the course could certainly do so. After session one, the general structure for sessions is a two-minute grounding exercise (often client-led with live musical accompaniment) followed by a period of discussion and psychoeducation on the day's topic, ending with a relevant creative arts intervention. Weekly topics include verbal abuse, attachment theory, Judith Herman’s [14] stages of recovery, self-disclosure related to ACEs, childhood neglect, anger management, negative self-image, dissociation, resilience, childhood sexual abuse, and shame. Creative arts interventions include drumming for embodiment, collective songwriting for empowerment, lyric interpretation for insight, art in the form of a personal coat of arms or a timeline of life events both positive and not, dance/movement for physical expression, and awareness of others.

The facility employs a trauma-informed practice (TIP) approach, an essential component of this group [58]. TIP principles support creating an environment of safety, collaboration, and equalizing power imbalances. ACE group members then discuss the psychoeducational material presented by the group facilitators. This begins with an open discussion about the ACE-Q and any areas that might be missing. With this approach, the facilitators seek to be seen as people sharing information rather than experts simply regurgitating academic knowledge. Psychoeducation carried out with humility decreases the perceived or actual knowledge gap between clients and the group facilitators. Therapists running the group must do some thorough exploration of their ACEs to be effective.

Remaining flexible with weekly outlines allows us to stay mindful of the group’s presenting issues in our plans. When new clients join the group in subsequent weeks, they first meet with one of the group facilitators to go over the material from session one before attending the group. When multiple new clients have joined the group in the same week, session one is rerun. The first session introduces the ACE study and reviews the long-term impacts of ACEs. It is also an opportunity for the client to complete the ACE-Q then discuss their score and significant life events related to their current challenges. This largely psychoeducational session is new material for clients, who report being largely unaware that childhood experiences are powerful determinants of who we become as adults. In graph form, we show clients the dose-effect of ACE scores related to alcoholism, COPD, smoking, injected drug use, substance use, anxiety disorders, mood disorders, impulse control disorders, and suicidal ideation [1]. This is routinely the first time clients understand that they have been dealing with more extraordinary challenges than others. From here, they can begin to move from self-admonition for their circumstances to a position of compassion and hope.

Our approach falls under more than one treatment model, starting with a psychodynamic lens, given the effects of childhood experiences on later life. When considering ACEs our clients have endured, it is also helpful to recognize how General Strain Theory (GST) applies here [59,60,61,]. GST acknowledges the cumulative effects that multiple experiences have on an individual. We use a humanistic approach, emphasizing elements such as the fulfillment of individual potential, a therapeutic relationship rooted in empathy, and the cultivation of healthy pursuit of a meaningful and purposeful life [62] (p. 109). We also draw upon Borczon's [63] recovery model, which focuses on hope, a healthy self-concept, empowerment, and meaning, among other benefits. Music therapist Michael Silverman inspires our psychoeducational approach through his research [64-69]. The Integrative Trauma and Attachment Model taught by psychologist Lori Gill [70] greatly influenced our approach and philosophy of care. For example, she notes how the left hemisphere comes "online" around age three (reading, writing, talking). Suppose the left hemisphere is "offline" with trauma recall. In that case, there can be challenges with connecting the affective and creative domains of the right hemispheres with the brain's verbal and rational thinking components [71]. She also cites Teicher et al. [72], who found that childhood neglect is associated with reduced corpus callosum area. What appears prevalent is that trauma disrupts brain hemisphere communication. She also advocates supporting clients to do trauma work in ways that support them in understanding what they have been through, framing it, expressing it in safe ways, and integrating new coping mechanisms.

Given the range of ACEs and other adverse and traumatic experiences our clients are admitted with, we needed to have goals for the group that would be common yet fundamental. Goals are informed by Crenshaw [52]: safety; promoting mastery experiences; affect regulation; stabilizing impulsive aggression against self and others; repairing sense of self by understanding trauma-related expectations; developing an awareness of who they are and what has happened to them; learning to be in the present by examining how the past affects them today; teaching coping mechanisms; finding meaning, developing perspective, and establishing a positive orientation towards the future (p. 22).

Contraindications include psychomotor agitation, psychotic symptoms that disrupt their thought processes, and clients with dysregulation, wherein they often cannot manage their emotional reactions or the reactions of others. Current approaches to adverse childhood treatment recommend beginning insight-oriented process work as soon as possible [70]. There are two locked assessment units in the facility for those who are flight risks or need a higher acuity of care. Clients from these units can obtain passes if qualified to participate in the group. Our perspective is that it is essential that clients, even shortly after admission if sufficiently stable, can access the group to benefit from it.

Sample Session

Topic: Childhood neglect.

Group guidelines: 1) keep what is shared confidential; 2) avoid long "horror stories" as you practice self-regulation and take care of each other; 3) make sure everyone in the group has a chance to be heard, be mindful of not dominating the conversation; 4) talk to each other, not just the group facilities – this is your group; 5) know that this is a safe space, kept optimally free from interruptions; 6) if you feel particularly upset or triggered stay and talk to one of us; 7) as much as possible, stay for the entire group—the summary, grounding, closure, takes place by staying for the duration of the group; . To end, we summarize the experience, practice a grounding technique, sing the closing song.

Video segment: we show a short clip of a dog being rescued off the street, looking sad and unkempt. Later, with care and love from the dog's rescuers, the dog is playful and happy. Many clients strongly identify with the dog's experience. The story can give them an understanding of the need to take care of themselves and to receive care from others. The story also gives a message of hope about what the future can look and feel like.

Slides: Neglect is the most prevalent form of child maltreatment. This is followed by seven signs you grew up with childhood neglect: 1) You were often the caretaker for your siblings, yourself, or even your parents; 2) You grew up to believe your needs do not matter because no one showed you that they did (and still do, matter); 3) You didn't develop compassion for yourself; 4) You struggle to receive love because it feels unfamiliar, even stressful; 5) You don't often share your feelings before you grew up squashing them down; 6) You feel an excessive responsibility for others' emotions; 7) You feel like who you are is flawed or insufficient. Group sharing takes place during some of the slides.

Activity: Write a letter to your childhood self, expressing compassion, kindness; let your childhood self know that you will strive to take care of your feelings, your health, your body, your boundaries, and your finances rather than neglect yourself. Clients are provided with a clipboard, paper, pens, and an envelope. They are invited to share what they wrote afterwards, though it is not a requirement.

Summary and Grounding: the session is summarized with an emphasis on self-care. A grounding experience is guided for 2-3 minutes to gentle recorded music or live piano music.
Closing song: "I can see clearly now."

Takeaway: Colour-printed poster with a positive statement about self-care.

Results & Discussion include more of a summary of the article

Once a cohort of clients had participated in the group for three months, we invited them to provide basic feedback in response to questions about the group. We used informed consent to make use of their statements anonymously. When asked, "Why did you come to the group?" clients responded, *I needed support; To share and learn from others' experiences in life; To open up and share common emotions and experiences with other people so I wouldn't feel so alone; To share with you all; Needing help to fight this nightmare; Because it sounded interesting and relevant to my struggle; I have childhood issues I want to resolve. When asked, "Has the group been helpful? If so, in what way?" clients responded, Yes, for talking it out; Yes, I get to share my childhood experiences with others; this helps release some stress; To be able to share with others helps me not to feel so alone. To vocalize and share deep trauma in a safe environment is healthy and leaves me feeling connected and safe; To get feedback and select a choice or route in my life to take; To learn that we're all together walking hand in hand; It brings up past experiences and shines a light on them.*

In our group observations, we were pleasantly surprised when clients who were relatively freshly admitted to the facility and who had earned treatment program passes for a program such as ACE were benefiting from the group and engaging in recovery early on. We have found that once a sense of group emerges, clients will continue to attend the session independently, missing only rarely. Given the work schedule of the authors, the group occurs on a Sunday morning before lunch. In this way, we miss the busy competition for programs during the week while at the same time offering a process-oriented group on the weekend, which clients have said they appreciate. We continue to see the powerful effects of breaking the silence. Many clients have not been afforded the opportunity to tell their story even once. Trauma-informed practice must sometimes include space for clients to name their trauma to understand and begin to remediate the symptoms they experience. We say "sometimes" because some clients where insight-oriented process work is not accessible to them, where naming their adverse or traumatic experiences can do more

harm than good. However, we must have a hidden bias wherein we regard clients as incapable of insight and growth.

Questions stemming from this pilot group include how to assess ways in which clients are experiencing the group. Is the group beneficial for them? Does it aid their recovery? Do they feel more confident about themselves and the roots of their mental health issues? What further resources can we provide that the clients can access to continue group or individual therapy in the community? What meaning do the creative arts experiences add for clients? Is it possible to develop a curriculum that could run for 90 days before repeating? How would other settings implement a similar group without the value of a six to nine-month stay? Is there a place for support groups that are ACE-informed in concurrent disorders treatment? We are now asking ourselves, where do we go from here with this group? When group members are keen to continue participating in the group, we encounter a conundrum: do clients stay for 6-9 months in the group, or do they earn a certificate and move on? Do we start a second ACE group since there is a waiting list? Indeed, there could be a few ACE groups on various units running each week. We are also continuing to seek ways to indigenize the session content. While we do acknowledge and openly discuss the impact of residential schooling, colonization, and systemic racism as well as naming our own settler status, we are very mindful of the need for further work in this area. We also plan to consult with a newly hired Indigenous Care Coordinator.

An area for further research on ACEs is revising the ACE-Q to be a more useful clinical tool. Further, verbal and physical abuse that takes place outside of the home is not a consideration. We intend to revise the ACE-Q to reflect the experiences of our clients better. The same issue arises when considering sexual abuse or sexual assault, which occurs outside the home and should not be limited to an age difference of 5 years or older. Another area left out of the initial questionnaire is about death within the family unit. Understandably, the original questionnaire was not intended as a standardized tool, though it is routinely applied this way. It does make for an informative beginning to screening for ACE experiences, and the authors recommend adjusting it according to the clients they serve. The next step is to run a small year-long quantitative practice-based study using pre and post-measures to assess what benefits the clients might be obtained from the group.

In summary, this article seeks to highlight the need for remediation between childhood exposure to abuse, neglect, violence, maltreatment, and other adverse experiences and the subsequent serious health problems that arise. Group therapy in mental health settings can support clients with histories of ACEs by integrating understanding how trauma and substance use intersect. By addressing distorted beliefs and negative self-concept related to adversity, abuse, or trauma, a reduction of negative emotions and behaviors may be possible. The group promotes safety and self-regulation and helps clients rebuild a sense of hope for the future.

Disclosure Statement

None of the authors has any financial or nonfinancial conflicts of interest to declare.

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