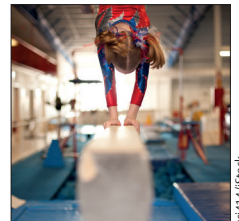


Leveraging the adverse childhood experiences (ACEs) framework to strengthen safeguarding in youth sport



shg44/istock

“My sexual abuse was 100 percent preventable”

Debra Grodensky

Childhood trauma and adversity exposure are well studied risk factors for a range of deleterious medical and psychiatric outcomes.¹ Interpersonal trauma is one of the strongest predictors of poor outcomes in paediatric populations. Paediatricians in primary care and emergency settings are therefore apt to screen patients for interpersonal violence that might occur at home and in intimate relationships.¹ However, sport is also a common—but understudied—setting for interpersonal trauma.² Reports of systemic physical, psychological, and sexual abuse are emerging from youth sporting environments with increasing frequency, and across numerous sports. Intentional violence (eg, abuse) is entrenched and prevalent in youth sport, but the extent is unknown.

There is a dearth of reliable, empirical data on the incidence and prevalence of abuse (physical, psychological, and sexual), neglect, peer aggression, undue stress, harassment, hazing, bullying, and other forms of intentional violence in sport.³ Moreover, methods of data collection are inconsistent across studies, definitions of abuse vary widely, and study protocols are often neither athlete centred nor trauma informed. Best available data estimate the prevalence of all forms of abuse in sport ranges from 2% to 92%.^{4,5} Due to ethical and methodological challenges, few quantitative studies have examined abuse in sport; those studies that have examined these themes have commonly relied on small samples of elite athletes within a single sport.

Sport drop out is a known consequence of athlete abuse.⁵ Yet, almost all recorded studies have queried youth athletes who are currently competing. In this way, the cohort of children and adolescents who have dropped out of sport (often silently) due to abuse are excluded from the sample. This overt sampling error might dilute prevalence estimates and incite other inaccuracies. Standardised data collection in a safety-net setting, such as a paediatric primary care environment, could capture a larger, more complete dataset and offer additional insight into the broad range of young people’s experiences in sport. This approach would

yield more accurate estimates of problem scope, while providing paediatricians with an opportunity to refer children and adolescents with sport-related emotional distress and traumatic symptoms to appropriate mental health services.

Current approaches for epidemiological data collection in abuse in youth sport frequently rely on direct questioning, via surveys distributed during competition or training. For example, at the Youth Olympic Games, athletes visiting the International Olympic Committee Safe Sport desk were asked to voluntarily answer a survey about their understanding of abuse in sport, including knowledge of where to report abuse.⁶ Similarly, a team of scientists developed a nine-item Violence Toward Athletes Questionnaire for a group of athletes, aged between 14 years and 17 years, who were actively participating in organised sports, and who answered the questionnaire voluntarily.⁷

Assessing sensitive topics, such as abuse prevalence, using direct questionnaires in convenience samples is a good start, but not ideal. First, these previously used methods can inadvertently reactivate trauma without a clear referral mechanism for mental health services when needed.⁸ Second, they open the door to selection bias (eg, fundamental differences between those who volunteer to participate and those who do not). Finally, they ignore the forces in sport that actively promote under reporting—namely, pressure to conform to dominant sport values (eg, an overemphasis on performance rather than development outcomes, and the belief that suffering is a natural part of sport), the presence of entrenched power imbalances, the belief that intentional violence has instrumental effects, a winner-takes-all rewards system, and an organisational tolerance of abuse.⁹

Paediatricians routinely ask a host of difficult questions, and can do so, in part, due to trust built over time with their patients. Structured instruments, such as the Adverse Childhood Experiences (ACEs) questionnaire, provide a scaffolding to cover a range of stressors in a systematic and consistent way.¹⁰ Paediatricians have an opportunity to positively inform the science of safeguarding in youth sport by repurposing the ACEs questionnaire and framework

to include an additional query about abuse in sport settings. In doing so, ACEs might offer sport more accurate prevalence estimates of athlete abuse, using methods that are trauma informed, evidence based, and practical. Early identification of athlete abuse offers an important intervention point to promote more positive trajectories in young people who have associated traumatic symptoms.

As injury prevention strategies rest on established incidence and severity data, accurately determining the scope of intentional violence in youth sport is an urgent matter. Having clear, empirical data justifies the scale and scope of solutions-oriented prevention programming, and enables more sophisticated root-cause analyses. Where current approaches fall methodologically and ethically short, the vetted approach that paediatricians have used over time can step in, provide support, and potentially yield consensus epidemiological data on which this emerging field can stand firm.

We declare no competing interests.

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