

Insights Into Intimate Partner Violence From the Adverse Childhood Experiences (ACE) Study

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HIGHLIGHTS

- Adverse childhood experiences, such as witnessing or experiencing family violence (including sexual abuse), have significant long-lasting impacts on an individual's health.
- Adverse childhood experiences are common and tend to occur in clusters.
- The cumulative impact of multiple exposures can be captured in an "ACE Score."
- The ACE Score likely captures the cumulative (neuro)biologic consequences of traumatic stress.
- The ACE Score has a strong, graded relationship to numerous health, social, and behavioral problems throughout the lifespan.

The Adverse Childhood Experiences (ACE) Study is an ongoing, decade-long collaboration between the Division of Adult and Community Health at the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Department of Preventive Medicine in San Diego. This study is the largest of its kind ever done to examine the health and social effects of adverse childhood experiences throughout the lifespan. It involves 17,337 middle-class members of the Kaiser Permanente Medical Care Program in San Diego, California, who agreed to participate during the course of a comprehensive medical evaluation.^{1,2,3,4}

The Study assessed 10 categories of stressful or traumatic childhood experiences.⁵ The experiences chosen for study were based upon prior research that has shown them to have significant adverse health or social implications, and for which there are substantial efforts being made in the public and private sector to reduce the frequency of their occurrence. A unique aspect of the ACE Study is that a broad range of adverse childhood experiences (ACEs) were chosen for study as follows:

- Childhood abuse (emotional, physical, and sexual).
- Neglect (emotional and physical).
- Growing up in a seriously dysfunctional household (having a battered mother, substance abuse or mental illness in the home; parental separation or divorce; or having incarcerated household members).

The relationship of these experiences to a wide range of health and social problems throughout the lifespan has been, and continues to be, described by the ACE Study team.^{6,7,8,9,10,11,12,13,14,15,16,17,18,19}

Prior research into the effects of childhood maltreatment and related experiences (including witnessing domestic violence) has tended to focus on only one or two categories of experience, such as physical or sexual abuse or domestic violence, and has generally focused on a limited range of outcomes. The data from the ACE Study provides the opportunity to assess a wide array of damaging experiences that children commonly experience and that lead to myriad consequences throughout the lifespan. In addition, the ACE Study assessed a wide variety of health and social issues of clinical and public health importance.

Study Population

The Study population was drawn from members of the Kaiser Health Plan in San Diego County who were undergoing a comprehensive biopsychosocial evaluation at the Department of Preventive Medicine's Health Appraisal Clinic. The data were collected in two survey "waves" (Wave I, N=8,708 and Wave II, N=8,629). Wave II included information on additional issues found to be important in the Wave I survey. The total study population included 9,367 women (54%) and 7,970 men (46%) (total sample=17,337). Their mean age was 56 years. Seventy-five percent were white, 39% were college graduates, 36% had some college education,

and 18% were high school graduates. Only 7% had not graduated from high school.²⁰

Battered Mothers

We used four questions from the Conflict Tactics Scale (CTS)²¹ to define childhood exposure to a battered mother, framed as follows: "Sometimes physical blows occur between parents. While you were growing up, in your first 18 years of life, how often did your father (or stepfather or mother's boyfriend) do any of these things to your mother (or stepmother):

- 1) Push, grab, slap, or throw something at her?
- 2) Kick, bite, hit her with a fist, or hit her with something hard?
- 3) Repeatedly hit her over at least a few minutes? or
- 4) Threaten her with a knife or gun, or use a knife or gun to hurt her?

A response of *sometimes*, *often*, or *very often* to either the first or second question, or any response other than *never* to either the third or the fourth question defined a respondent as having had a battered mother.

Physical Abuse

The definition of physical abuse also came from the CTS and was framed as follows:

"Sometimes parents or other adults hurt children. While you were growing up, that is, in your first 18 years of life, how often did a parent, stepparent, or adult living in your home 1) push, grab, slap, or throw something at you? or 2) hit you so hard that you had marks or were injured?"

A response of *often* or *very often* to the first question, or *sometimes*, *often*, or *very often* to the second defined childhood physical abuse.

Sexual Abuse

Sexual abuse was defined using questions adapted from Wyatt:²²

"Some people, while they are growing up in their first 18 years of life, had a sexual experience with an adult or someone at least five years older than themselves. These experiences may have involved a relative, family friend, or stranger. During the first 18 years of life, did an adult, relative, family friend, or stranger ever 1) touch or fondle

your body in a sexual way; 2) have you touch their body in a sexual way; 3) attempt to have any type of sexual intercourse with you (oral, anal, or vaginal); or 4) actually have any type of sexual intercourse with you (oral, anal, or vaginal)?"

A *yes* response to any of the four questions was defined as contact sexual abuse during childhood.

The definitions of each of the other ACEs have been published in detail elsewhere.^{23, 24}

Key Findings From the ACE Study

This section will focus on the following key findings from the ACE Study that have appeared in peer-reviewed scientific journals, with an emphasis on how having grown up with a battered mother (intimate partner violence) is highly interrelated with other types of ACEs and, therefore, is part of a spectrum of childhood experiences that have a wide array of health and social consequences.

- Adverse childhood experiences are common.
- ACEs tend to occur in groups rather than singly.
- The cumulative impact of multiple exposures can be captured in an ACE Score.
- The ACE Score likely captures the cumulative (neuro)biologic consequences of traumatic stress.
- The ACE Score has a strong, graded relationship to numerous health, social, and behavioral problems throughout the lifespan.

Adverse Childhood Experiences Are Common

Adverse childhood experiences are very common, even in this well-educated, predominantly middle-class study sample (Table 9-1).²⁵ Moreover, our estimates of the prevalence of childhood exposures to physical and sexual abuse are similar to population-based surveys. For example, a national telephone survey of adults conducted by Finkelhor et al.²⁶ used similar criteria for childhood sexual abuse and determined that 16% of men and 27% of women had been sexually abused; in the ACE Study cohort 16% of men and 25% of women in our sample had experienced contact childhood sexual abuse. In our study, 30% of the men had been physically abused as boys; this closely parallels the 31% prevalence recently found in a similarly structured population-based study of Canadian men.²⁷ The similarity of the estimates from the ACE Study to those of population-based studies suggests that our findings would be applicable in other settings.

ACEs Tend to Occur in Groups Rather Than Singly

At the time that the ACE Study was designed, relatively little was known about the co-occurrence of the 10 ACEs chosen for study, and even less was known about the cumulative impact of multiple different exposures. Initial analyses of the data showed that ACEs tended to be highly interrelated,^{28, 29} and other research corroborated their co-occurrence in detail.^{30, 31, 32} Table 9-2 illustrates how growing up with a battered mother is strongly related to the risk of experiencing other categories of ACEs.^{33, 34}

Overall, the presence of any one category of ACE significantly increased the risk of having any additional categories of ACEs two- to 18-fold (median: 2.8-fold).³⁵

Table 9-3 shows the probability (%) of experiencing additional ACEs based upon the occurrence of each in-

dividual category of ACE.³⁶ In the case of persons who had a battered mother, 95% reported at least one additional ACE, and the reporting of multiple others was common. In the entire study population, 81%-98% of respondents who had experienced one ACE reported at least one additional category of ACE (median: 87%).

The ACE Score

Because adverse childhood experiences are highly inter-related, we used the ACE Score as a measure of the cumulative exposure to abuse, neglect, domestic violence, and other forms of serious household dysfunction.^{37, 38, 39, 40} The ACE Score is a simple scoring system created to indicate the breadth of exposure to the 10 categories of adverse experience in childhood and adolescence. Exposure to any category counted as one "point" on the

TABLE 9-1. PREVALENCE OF EACH CATEGORY OF ADVERSE CHILDHOOD EXPERIENCE BY SEX.

ADVERSE CHILDHOOD EXPERIENCE BY CATEGORY	PREVALENCE (%)		
	WOMEN (N = 9,367)	MEN (N = 7,970)	TOTAL (N = 17,337)
ABUSE			
Emotional	13.1	7.6	10.6
Physical	27.0	29.9	28.3
Sexual (contact)	24.7	16.0	20.7
NEGLECT			
Emotional	16.7	12.4	14.8
Physical	9.2	10.7	9.9
HOUSEHOLD DYSFUNCTION			
Battered mother	13.7	11.5	12.7
Parental separation, divorce, or loss in childhood	24.5	21.8	23.3
Mental illness in household	23.3	14.8	19.4
Household alcoholism or drug abuse	29.5	23.8	26.9
Incarcerated household member	5.2	4.1	4.7

Data are for the Wave II survey only for the neglect estimates.

TABLE 9-2. GROWING UP WITH A BATTERED MOTHER AND THE RISK OF OTHER ACES

BATTERED MOTHER	EMOTIONAL ABUSE (%)	PHYSICAL ABUSE (%)	SEXUAL ABUSE (%)	EMOTIONAL NEGLECT (%)	PHYSICAL NEGLECT (%)	PARENTAL SEPARATION OR DIVORCE (%)	SUBSTANCE ABUSE (%)	MENTAL ILLNESS (%)	CRIME (%)
No	7.0	21.7	18.7	11.6	7.3	20.0	22.7	17.7	4.6
Yes	31.3	57.5	36.4	35.9	27.5	51.2	64.5	37.2	15.2

TABLE 9-3. PREVALENCE OF EACH CATEGORY OF ADVERSE CHILDHOOD EXPERIENCE AND REPORTING OF ADDITIONAL ACES GIVEN THE PRESENCE OF ANY ONE

ACE CATEGORY	PREVALENCE OF EACH CATEGORY ACE (%)	ADDITIONAL ACES (%)						
		0	≥ 1	≥ 2	≥ 3	≥ 4	≥ 5	≥ 6
Abuse								
Emotional	10.2	2	98	90	77	62	42	25
Physical	26.4	17	83	64	46	32	20	12
Sexual	21.0	22	78	58	42	29	19	12
Neglect								
Emotional	14.8	7	93	79	63	47	32	19
Physical	9.9	11	89	75	61	50	37	24
Household dysfunction								
Parental separation or divorce	24.1	18	82	61	43	30	19	12
Household substance abuse	28.2	19	81	60	41	29	18	11
Household mental illness	20.3	16	84	65	48	34	21	13
Battered Mother	13.0	5	95	82	64	48	32	20
Crime	6.0	10	90	74	56	43	30	23
Median		13.5	86.5	69.5	52.0	38.5	25.0	16.0
Range		2-22	78-98	58-90	41-77	29-62	18-42	11-25

Prevalence data vary slightly from Table 9-1 because data in this table are from the Wave II survey only.

TABLE 9-4. PREVALENCE OF THE ACE SCORE BY GENDER

ACE SCORE	PREVALENCE (%)		
	WOMEN	MEN	TOTAL
0	31.3	34.2	32.7
1	24.2	27.3	25.6
2	14.8	16.4	15.5
3	10.4	9.3	9.9
4	6.8	4.8	5.9
≥5	12.5	8.0	10.5

TABLE 9-5. PERCENTAGE INCREASE IN THE RISK OF BEING A VICTIM (WOMEN) OR PERPETRATOR (MEN) OF IPVA AS AN ADULT BY TYPES AND NUMBER OF ABUSIVE OR VIOLENT EXPOSURES

VIOLENT CHILDHOOD EXPERIENCE	INCREASED RISK OF BEING A FEMALE VICTIM OF IPVA (%)	INCREASED RISK OF BEING A MALE PERPETRATOR OF IPVA (%)
Physical Abuse	140%	120%
Sexual Abuse	80%	80%
Battered Mother	220%	200%
NUMBER OF CATEGORIES OF VIOLENT EXPERIENCES*		
None	reference group	reference group
1	90%	130%
2	230%	230%
All 3	280%	280%

* The trend for increasing risk of victimization and perpetration with increasing number of violent experiences was statistically significant (P<0.001).

Score; the number of categories of adverse experience were then summed. The ACE Score therefore ranged from 0 to 10. There was no further scoring within a category. Statistical analysis has confirmed the usefulness of this approach by demonstrating that the observed number of respondents with high ACE Scores was notably higher than the expected number under the assumption of independence of ACEs ($p < .0001$).⁴¹ The prevalence of the ACE Scores by gender are presented in Table 9-4.⁴² Two-thirds of participants reported at least one category of ACE. One in 10 people had an ACE Score of 5 or more; higher ACE Scores are somewhat more common in women.

THE ACE SCORE HAS A GRADED RELATIONSHIP TO NUMEROUS HEALTH AND SOCIAL OUTCOMES: CUMULATIVE STRESS AND BIOLOGIC PLAUSIBILITY

The summed ACE Score was then matched against that range of biomedical, emotional, and social findings that were determined by comprehensive medical evaluation and the ACE Study questionnaire.^{43,44,45} It is noteworthy that the use of the ACE Score as a measure of the cumulative exposure to traumatic stress during childhood is consistent with more recent understanding from the neurosciences⁴⁶ of the effects of traumatic stress. Neuroscientists have linked childhood maltreatment using experimental animal models as well as case-control studies in humans to long-term changes in brain structure and function involving several interconnected brain regions including the prefrontal cortex, hippocampus, amygdala, corpus callosum, and cerebellum.^{47,48,49,50,51,52,53}

Early stress is also associated with lasting alterations in stress-responsive neurobiological systems, including the hypothalamic-pituitary-adrenal axis and monoamine neurotransmitter systems; these lasting effects on the developing brain would be expected to affect numerous human functions into adulthood including (but not limited to) emotional regulation, somatic signal processing, substance abuse, sexuality, memory, arousal, and aggression.^{54,55,56,57,58,59,60}

For example, the ACE Score has a strong graded relationship to:

- Smoking, alcohol use and abuse, illicit drug use, and parenteral drug use.
- Teen and unintended pregnancy, stillbirths, and spontaneous abortion.
- Early (by age 14) initiation of sexual intercourse, promiscuity, and sexually transmitted diseases.
- Indicators of poor worker performance.

- Suicide attempts, depression, and poor health-related quality of life.
- Ischemic heart disease, liver disease, diabetes, obesity and other leading causes of death in the United States.

Thus, as part of a complex set of co-occurring ACEs, exposure to a battered mother contributes to many of the leading chronic health and social problems in the United States. The prevalence of this problem, the persistence of these effects, and the significant difficulty in treating them is a major clinical and social problem. The ACE Score appears to be a good measure of the cumulative, lifetime impact of traumatic stress on neurodevelopment in childhood. Childhood and adolescent experiences literally become hardwired; childhood and adolescent life experiences become "biology" in the form of brain structure and function, thus leading to persistent effects. These persistent effects are "hidden" from view, making recognition and treatment of the origins of these effects in traumatic experiences difficult.^{61,62}

Physical Abuse/Sexual Abuse/Having a Battered Mother and the Risk of Intimate Partner Violence as an Adult

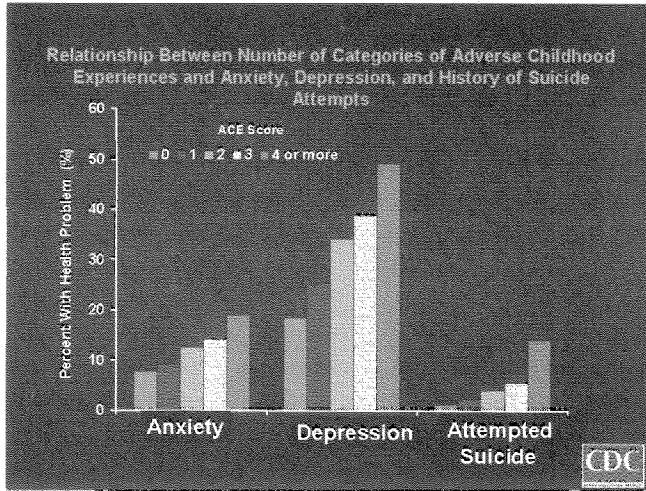
We studied the relationship of childhood physical or sexual abuse or growing up with a battered mother to the risk of being a victim (women) or perpetrator (men) of intimate partner violence and abuse (IPVA) as an adult.⁶³ Each of these three ACEs is associated with the risk of IPVA; as the number of these violent childhood experiences increased, the risk of IPVA also increased (Table 9-5). Thus, childhood exposure to abuse and domestic violence may lead to revictimization and perpetuation of a cycle of violence, and indicates that as part of any risk assessment for IPVA in adults, screening is needed for a past history of childhood abuse or exposure to domestic violence. Such a pattern of revictimization^{64,65} and ongoing violent exposures would expectedly contribute to the perpetuation of a wide array of risk factors for disease, social problems, and the leading causes of death in the generations that follow.

Selected Findings From the ACE Study: The Cumulative Impact of Multiple Categories of Adverse Childhood Experience

The ACE Score has repeatedly been shown to have cumulative impact (dose-response) on the risk of a wide range of health and social problems. The following section provides a graphic overview of selected findings.

Mental Health

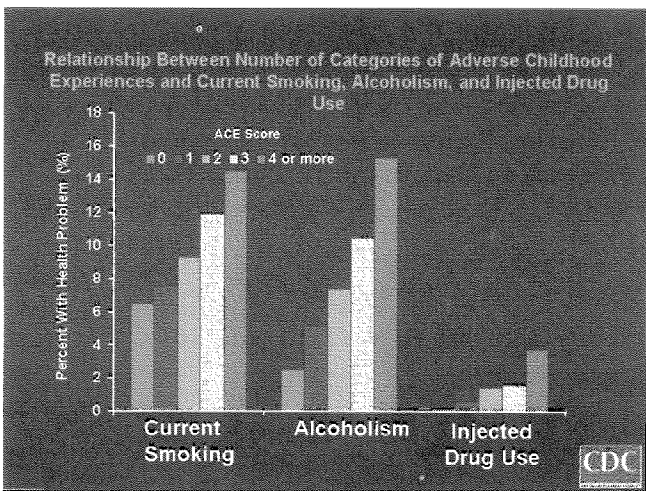
FIGURE 9-1. RELATIONSHIP BETWEEN NUMBER OF CATEGORIES OF ADVERSE CHILDHOOD EXPERIENCES AND ANXIETY, DEPRESSION, AND HISTORY OF SUICIDE ATTEMPTS



Current problems with anxiety, depression, or a history of a suicide attempt increased in a graded fashion as the ACE Score increased. Compared to persons with an ACE Score of 0, those with an ACE Score of ≥ 4 had the risks of these three problems increase 2.4-fold, 3.6-fold, and 10.2-fold, respectively.

Substance Abuse

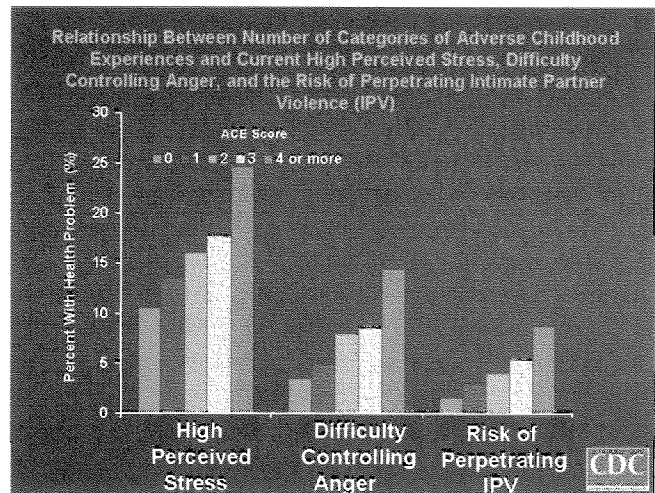
FIGURE 9-2. RELATIONSHIP BETWEEN NUMBER OF CATEGORIES OF ADVERSE CHILDHOOD EXPERIENCES AND CURRENT SMOKING, ALCOHOLISM, AND INJECTED DRUG USE



Compared to persons with an Ace Score of 0, those with an ACE Score of >4 had the risks of these three problems increase 1.8-fold, 7.2-fold, and 11.1-fold, respectively.

Risks for Violence/IPVA

FIGURE 9-3. RELATIONSHIP BETWEEN NUMBER OF CATEGORIES OF ADVERSE CHILDHOOD EXPERIENCES AND CURRENT HIGH PERCEIVED STRESS, DIFFICULTY CONTROLLING ANGER, AND THE RISK OF PERPETRATING IPVA



Current problems with high levels of perceived stress, difficulty controlling anger, and the risk of perpetrating IPVA increased in a graded fashion as the ACE Score increased. Compared to persons with an ACE Score of 0, those with an ACE Score of ≥ 4 had the risks of these three problems increase 2.2-fold, 4.0-fold, and 5.5-fold, respectively.

What the Study Shows in Broader Terms

Major categories of adverse childhood experience are far more common than we anticipated in this population of middle-class HMO patients. Moreover, the effects of ACEs are long-term, powerful, cumulative, and likely to be invisible to physicians and to society in general because the linkage between cause and effect is concealed by time, shame, secrecy, and a general reluctance of health care professionals to routinely inquire about certain taboo subjects like family alcoholism, incest, and intimate partner violence. Moreover, the effects of the original traumatic insults may be silent until much later in life⁶⁶ when they are likely to be overlooked by investigators

and clinicians who are understandably prone to focus on proximate and organic determinants of human well-being. This leads to treatment of *symptoms* without an understanding of their frequent origins in the disruptive effects of ACEs on childhood neurodevelopment.

To change this pattern of physician practice will be difficult, requiring distinctly more than increasing intellectual awareness; indeed, such change illustrates the difficulty of shifting from a biomedical to a biopsychosocial style of practice. Experience in such biopsychosocial evaluation of approximately 400,000 patients in one Kaiser Permanente setting indicates that population-based screening for intimate partner violence and related problems is possible, but not by using techniques of conventional history taking. Conventionally seeking such information is fraught with difficulties resulting from physician inexperience and discomfort with the thematic material, as well as from time pressures. Additionally, patient discomfort due to physician age, sex, and racial differences adds another layer of difficulty.

The experience at Kaiser Permanente suggests that problems may be circumvented by using a skillfully devised paper or Internet-based biopsychosocial questionnaire that is filled out at home before the visit. (Appendix H). Patients seem to attribute to such an inert mechanism whatever characteristics they might seek in the idealized interviewer. The Mrs B. responses in the standardized biopsychosocial questionnaire (Appendix I) illustrate how intimate and usually concealed information becomes far more freely available using this approach, which is what we used in the ACE Study. Of course, one ultimately must deal interpersonally with using such information in a traditional doctor-patient interview, but it is far easier to do so when one understands in advance where the problems lie. We have found we can respond comfortably to a *yes* answer on the questionnaire in this manner: "I see that you frequently were beaten as a child (molested as a child, are living in a violent household, etc). Tell me how that has affected you in your life." This statement is easy to make and, in our experience at Kaiser Permanente, indicates that it is not threatening for a patient to hear. It is usually productive of concise answers that help guide treatment plans. When it does not produce a helpful answer, it frequently plants in the patient's mind a useful seed that may later be harvested. In short, we have found it possible to create a mechanism for population-based screening that, when made operational, becomes part of the evolution of one's own practice experience.

Autobiographical writing is often used as the next therapeutic step at Kaiser Permanente. For example, "Before we meet again to discuss this further, I'd like

you to start sending me, by e-mail attachment, a detailed autobiography of your life in five-year segments." James Pennebaker at the University of Texas has studied this approach in depth.⁶⁸ We have found autobiographical writing acceptable to patients, useful, and affordable. The effect of this retelling of the story in detail is to allow the patient to start becoming desensitized, through repeated exposure in a supportive setting. It also allows patients to reanalyze the causal relationship of various life experiences to outcomes later in life, including medical problems.

Many patients will need pharmacologic treatment of depression or anxiety using standard approaches that most clinicians find relatively easy to implement. Recommending reading⁶⁹ and referral to nationwide support organizations^{70,71} are other steps that we have found helpful. In general, the role of the physician is not to be a psychotherapist but to elaborate the full extent and ramifications of the patient's problem, lay out a treatment plan, and periodically meet with the patient to encourage continuation of the process, provide support and understanding, and make any necessary revisions in what is being done. If psychotherapy is affordable and available, that too can be helpful, as has been Ericksonian hypnotherapy.^{72, 73} No one step is adequate; the more that can be put into place, the more likely is an improved outcome. Kafka understood when he wrote in his book, *A Country Doctor*, "Writing prescriptions is easy, but coming to an understanding with people is hard."⁷⁴ Nevertheless, we have found that it can be done by practicing physicians and other health professionals, and it can be applied, even on a population basis.

This approach has enabled us to engage usefully in the identification of intimate partner violence, which increasingly is referred to as "complex trauma" with resultant "trauma spectrum disorders."⁷⁵ We found in the ACE Study that children who grew up with intimate partner violence have a 95% probability of experiencing multiple forms of traumatic or potentially developmentally disabling life events. The ACE Study documents that these individuals are highly likely to manifest behavioral, health, and social problems, not only proximate to the exposures (Chapter 2) but also throughout adolescence and adult life. Given that most persons in the study who had battered mothers experienced two to three other categories of ACEs, it is important to understand that an increasing ACE Score has an increasing effect—a "cumulative stressor" effect. Thus, growing up with a battered mother is usually part of a *set of experiences* that leads to increased risk of a variety of health and social problems.

Resulting Effects on Health Care Treatment

These links between childhood experience and adult health and social function have significant implications for health professionals. We found that adults who reported any single category of adverse childhood experience were likely to have suffered multiple other categories during childhood. Therefore, assessment of exposure to other ACEs is important when working with persons identified as having had any single type of ACE. Children experiencing abuse, neglect, or household dysfunction should always be screened for other types of maltreatment and traumatic stressors. This information, if routinely gathered, will likely contribute to more meaningful diagnoses, improved treatment of affected persons, and better integration of prevention, social services, and legal venues. We have found that many clinicians feel a significant sense of personal fulfillment when they develop these skills in their practices. And from the patient's standpoint, being helped in telling another person the worst secret of one's life, and coming out of that feeling still accepted as a human being, is a crucial first step in recovery.

Information from the ACE Study suggests that traumatic stressors during childhood and adolescence represent a common pathway to a variety of important long-term behavioral, health, and social problems. Thus, an integrated rather than a separate or categorical perspective on the origins of health and social problems throughout the lifespan is needed. This approach to intimate partner violence and related ACEs, and to the consequences of exposure to them, may unify and improve our understanding of many seemingly unrelated health and social problems that tend to be identified and treated as categorically separate issues in Western medical practice.

The numerous health and social problems associated with increased ACE Scores suggests that traumatic stress has multiple effects on mind, brain, and body. Early abuse survivors tend to have multiple overlapping psychiatric disorders that have been described as "comorbidity."⁷⁶ However, the term comorbidity implies that these represent coincident disorders with distinct etiologies. An alternative explanation is that disorders (like depression, post-traumatic stress disorder, dissociation, substance abuse, and borderline personality disorder) often have a common etiology that is modulated by genetics⁷⁷ and repeated stressor exposure, such as childhood maltreatment. "Trauma spectrum disorders" is the term used to describe these overlapping conditions. Similarly, the artificial distinction between psychiatric and physical disorders has represented an impediment to the effective treatment of the numerous problems among survivors

of childhood maltreatment. Our findings from the ACE Study indicate a need to develop more broad-based approaches to addressing the effects of childhood maltreatment. Of necessity, this must involve programs to help physicians and other health professionals become more comfortable in discussing with patients topics never before discussed, and often personally disturbing.

Most adverse childhood experiences are never identified, nor are they incorporated into a child's or an adult's health history. The historical mind-body dichotomy in traditional medical training points clinicians away from full etiologic analysis of health issues that may have their origins in the exposure to traumatic stressors during childhood. This needs to be changed. We have found it possible to carry out this change on a population basis using effective approaches that are acceptable to patients and comfortable for physicians and other health professionals.

EDITOR'S NOTE

We are pleased to be able to present the ACE Study as a separate chapter in this book. Many IPV victims and survivors experienced one or more categories of adverse childhood experiences and today struggle with the long-term health care consequences of those experiences. These consequences are then compounded by the consequences of intimate partner violence and abuse in their adult life. The result: Patients who frequent our health care setting seeking relief for chronic health problems which may become lifelong if the previous abuse and adverse childhood experiences are not identified and addressed.

WRAPPING IT UP

The information presented in this chapter sets the stage for improving the care of such patients. In light of the information gained from The ACE Study, the editors recommend the following take-away points from this chapter:

1. Identify the adverse childhood experiences that your patient experienced. You can develop a questionnaire for your health care setting similar to the one in Appendix H of this book.
2. Create an overview of your patient's current health problems to insert into the patient's chart.
3. Ask your patient to create a detailed autobiography of his or her life in five-year segments. This can be sent by e-mail attachment

and might be kept in a computer file, separate from the patient's medical record. (The Pennebaker method mentioned in this chapter usually consists of 20-minute writing sessions three times a week.)

4. Discuss the autobiography with your patient at a visit set up to do this. What is missing? Why?
5. Assess your patient for depression and anxiety to see if you should recommend pharmacological intervention for this.
6. Refer your patient for psychotherapy and other treatment options such as Ericksonian hypnotherapy if that is possible in your practice setting.
7. Encourage your patients and set up quarterly appointments solely dedicated to monitoring and assessing their progress.

For more information regarding the Adverse Child Experience Study, please visit the Web site: www.acestudy.org.

Endnotes

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