

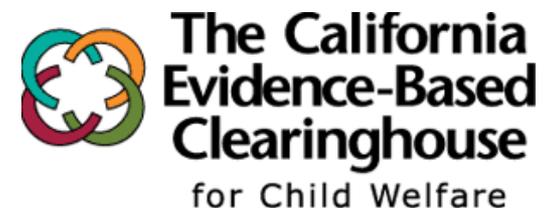
Trauma-Aware Foster Care

John Stirling, MD

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SCV Medical Center

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Overview

- Traumatic stress
- ...and foster care
- Consequences of untreated trauma
- The toolbox for resilience
- The community response

What would foster care medicine look like if we were all truly aware of traumatic stress and its consequences?



First Question:

Why aren't we using what we know?

Conclusions (in advance)

- Abused and neglected kids
- Suffer a wide variety of effects arising from
- Chronic activation of the threat response, and
- Lack of parental support to provide
- Coping tools (self-regulation) that enable
- Cognitive and interpersonal learning

Trauma: Long-term consequences

- problems with interpersonal functioning
- cognitive functioning
- mental health disorders, including PTSD
- substance abuse disorders
- affective / conduct disorders
- anxiety disorders
- eating disorders

Briere, 1997; Nader, 1997; Saigh et al., 1999



The Relationship Between Adverse Childhood Experiences and Adult Health: Turning Gold Into Lead

Vincent J. Felitti, MD

“Health Alert”, Vol. 8, No. 1

Family Violence Prevention Fund

Categories of Adverse Childhood Experiences

**Category
Prevalence (%)**

Abuse, by Category

Psychological (by parents)	11%
Physical (by parents)	11%
Sexual (anyone)	22%

Household Dysfunction, by Category

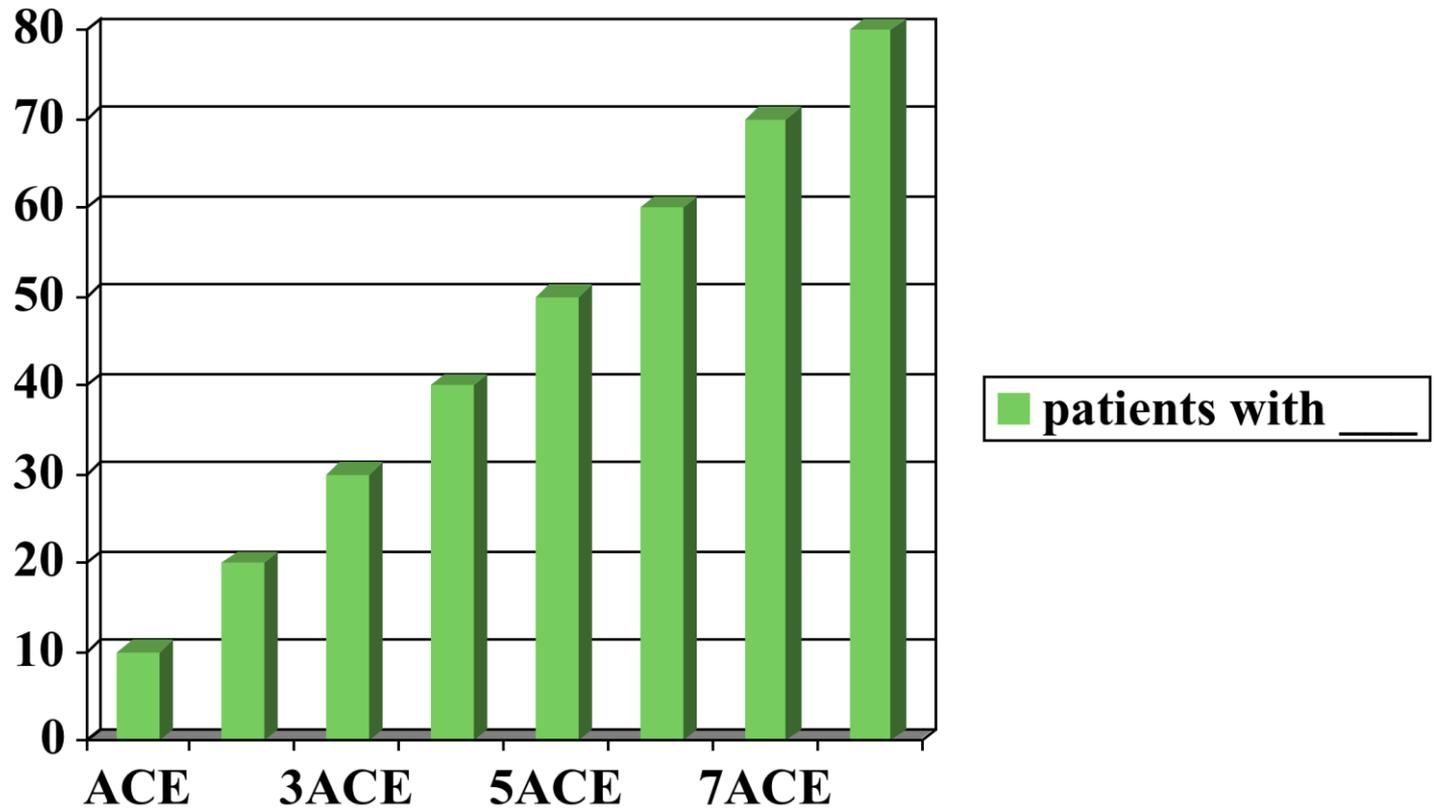
Substance Abuse	26%
Mental Illness	19%
Mother Treated Violently	13%
Imprisoned Household Member	3%

Adverse Childhood Experiences Score

<i>ACE score</i>	<i>Prevalence</i>
0	48%
1	25%
2	13%
3	7%
4 or more	7%

- **More than *half* have at least one ACE**
- **If one ACE is present, the ACE Score is likely to range from 2.4 to 4**

ACE Studies - results



Adverse Childhood Experiences

Consequences:

- obesity
- depression
- drug / alcohol abuse
- teen pregnancy
- incarceration

Adverse Childhood Experiences

But also:

- diabetes
- hypertension
- fractures
- job performance / satisfaction
- cigarette smoking...



Adverse Childhood Experiences determine the likelihood of the ten most common causes of death in the United States

- **Smoking**
- **Severe obesity**
- **Physical inactivity**
- **Depression, suicide attempt**
- **Alcoholism, illicit drug use**
- **50+ sexual partners, h/o STI**

The ecology of traumatic stress

Child factors

- Developmental stage
- Temperament
- Life skills
 - Cognitive
 - Interpersonal
- Social capital

The ecology of traumatic stress

Trauma factors

- Severity (as *perceived* by the victim)
- Chronicity

What Is Child Traumatic Stress?

- Child traumatic stress refers to the *physical and emotional responses* of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (such as a parent or sibling).
- Traumatic events overwhelm a child's capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.

Types of Traumatic Stress

- **Acute trauma** is a single traumatic event that is limited in time. Examples include:
 - Serious accidents
 - Community violence
 - Natural disasters (earthquakes, wildfires, floods)
 - Sudden or violent loss of a loved one
 - Physical or sexual assault

Types of Traumatic Stress

- **Chronic trauma** refers to the experience of multiple traumatic events.
- These may be multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse, neglect, or war.
- The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.

Types of Traumatic Stress

- **Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child’s care—and the impact of such exposure on the child.
- Children who experienced complex trauma have endured multiple interpersonal traumatic events from a very young age.
- Complex trauma has profound effects on nearly every aspect of a child’s development and functioning.

Source: Cook et al. (2005). *Psychiatr Ann*,35(5):390-398.

Trauma: U.S. Prevalence

- Each year in the United States, more than 1,400 children—nearly 2 children per 100,000—die of abuse or neglect.
- In 2005, 899,000 children were victims of child maltreatment
 - 62.8% experienced neglect
 - 16.6% were physically abused
 - 9.3% were sexually abused
 - 7.1% endured emotional or psychological abuse
 - 14.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)

Source: USDHHS. (2007) *Child Maltreatment 2005*; Washington, DC: US Gov't Printing Office.

Trauma: California

- Between July 1, 2006 and June 30, 2007, alone, 41,875 children entered California's child welfare-supervised foster care system.
- The most common reasons why children were removed and entered child welfare-supervised foster care were:
 - Neglect: 79.6%
 - Physical abuse: 11.7%
 - Sexual abuse: 3.7%
 - “Other”: 5.9%

Source: Needell et al. (2007). *Child Welfare Services Reports for California*. Retrieved January 29, 2008, UC-Berkeley Center for Social Services Research (http://cssr.berkeley.edu/ucb_childwelfare).

Trauma: U.S. Prevalence

- One in four children/adolescents experience at least one potentially traumatic event before the age of 16.¹
- In a 1995 study, 41% of middle school students in urban school systems reported witnessing a stabbing or shooting in the previous year.²
- Four out of 10 U.S. children report witnessing violence;
8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted.³

1. Costello et al. (2002). *J Traum Stress*;5(2):99-112.

2. Schwab-Stone et al. (1995). *J Am Acad Child Adolesc Psychiatry*;34(10):1343-1352.

3. Kilpatrick et al. (2003). US Dept. Of Justice.
<http://www.ncjrs.gov/pdffiles1/nij/194972.pdf>.

Trauma and foster care

Remember:

- The foster care system was *conceived* to help children who had suffered severe trauma.

Prevalence in Child Welfare Population

- A national study of adult “foster care alumni” found higher rates of PTSD (21%) compared with the general population (4.5%). This was higher than rates of PTSD in American war veterans.¹
- Nearly 80% of abused children face at least one mental health challenge by age 21.²

1. Pecora, et al. (December 10, 2003). *Early Results from the Casey National Alumni Study*. Available at: http://www.casey.org/NR/rdonlyres/CEFBB1B6-7ED1-440D-925A-E5BAF602294D/302/casey_alumni_studies_report.pdf.

2. ASTHO. (April 2005). *Child Maltreatment, Abuse, and Neglect*. Available at: <http://www.astho.org/pubs/Childmaltreatmentfactsheet4-05.pdf>.

Prevalence in Child Welfare Population

- A study of children in foster care revealed that PTSD was diagnosed in 60% of sexually abused children and in 42% of the physically abused children.¹
- The study also found that 18% of foster children who had not experienced either type of abuse had PTSD,¹ possibly as a result of exposure to domestic or community violence.²

1. Dubner et al. (1999). *JCCPsych*;67(3): 367-373.

2. Marsenich (March 2002). *Evidence-Based Practices in Mental Health Services for Foster Youth*. Available at:
<http://www.cimh.org/downloads/Fostercaremanual.pdf>.

Prevalence in Child Welfare Population

- > 1/2 of children in dependent care report depression, PTSD, anxiety/panic, drug dep.

Congressional Briefing on Mental Health Services and Former Foster Youth, 2005

- 54% of children in public sectors in San Diego dx'd with ADHD/disruptive disorders, anxiety disorders

Garland et al., 2001

Trauma and foster care

National Goals for foster placement:

- **75%** reunified with family within 12mo.
- **65%** with one or two placements
(= **35%** with three or more)

Dept of HHS, 2004

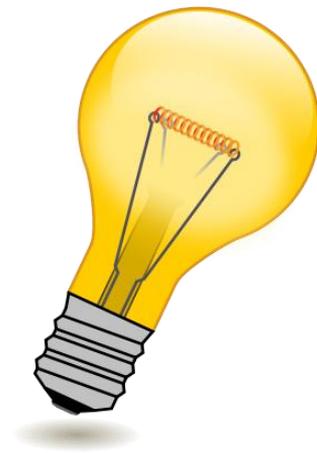
Separation from siblings (Santa Clara Co.):

- **50%** separated from some sibs
- **30%** separated from all sibs

Santa Clara Co. DFCS, 2008

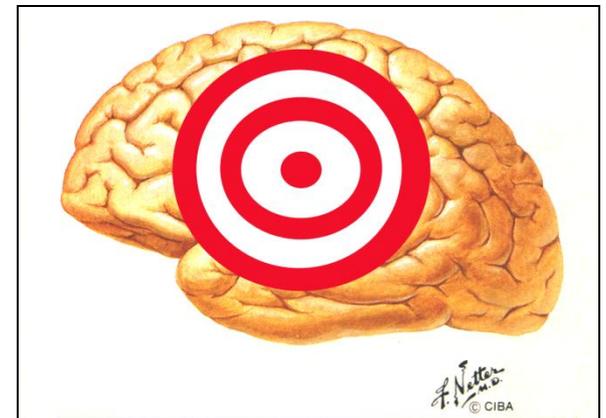
Stirling's First Law:

Most conditions will get better
if you don't make them worse!



Neuroscience: what we've learned

- The brain is not mature at birth
- Experience determines its architecture
- Timing can be critical
- Relationships are critical for social and emotional development
- Effects of adversity



Fight, Flight, or Freeze?



Neuroendocrinology

STRESS



Hypothalamic / pituitary stimulation



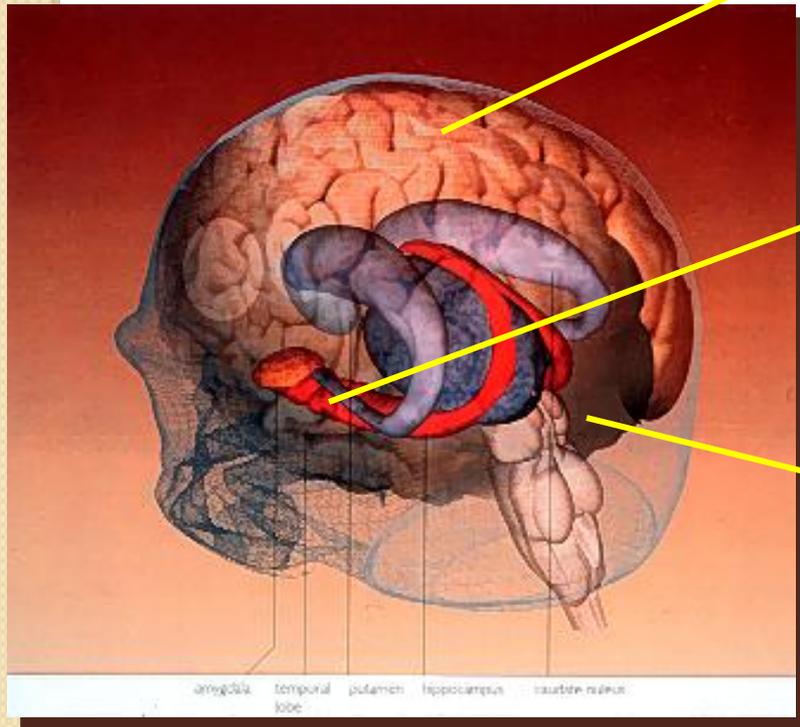
Adrenal cortisol release

Neuroendocrinology

Studies show abuse victims have:

- **Enhanced pituitary sensitivity**
- *Duval, 2004*
- **Cortisol spikes w/ trauma reminders**
- *Elzinga, 2003*
- **Higher cortisol levels, abnl variation**
- *Cicchetti, 2001*
- **Cortisol spikes, higher baseline**
- *Bugenthal, 2003*
- **Heightened inflammatory response**
- *Altemus, 2003*

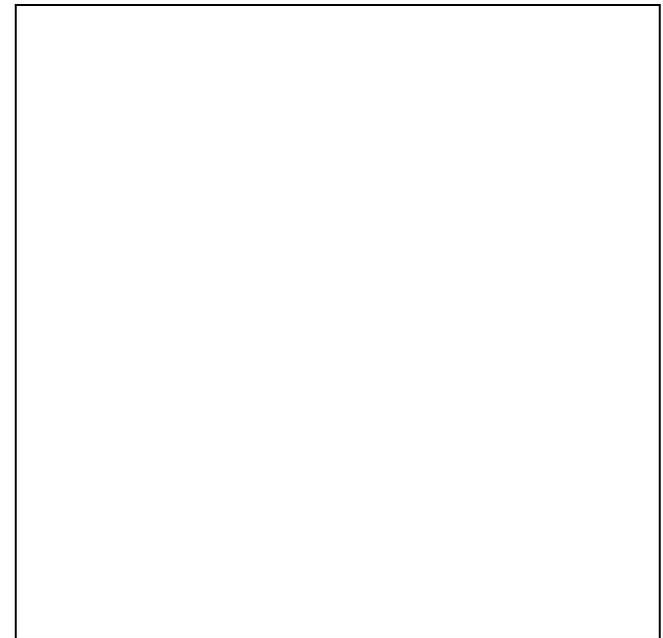
The Brain: Targets of Stress



- Cerebral cortex
 - EEG changes
 - smaller callosum
- Limbic system
 - neuronal changes
 - decreased size
- Brainstem/
Cerebellum
 - altered transmitters

It takes a whole brain to learn:

- Cognitive (*left brain*)
 - Vocabulary
 - Logical reasoning
- Experiential (*right brain*)
 - Emotional awareness
 - Self-regulation



Neuroendocrinology

Symptoms of “stress response”:

- Irritability
- Hyperarousal
- Dysregulation of affect

AKA: “Behavior problems”

Post Traumatic Stress Disorder (PTSD)

Criteria include:

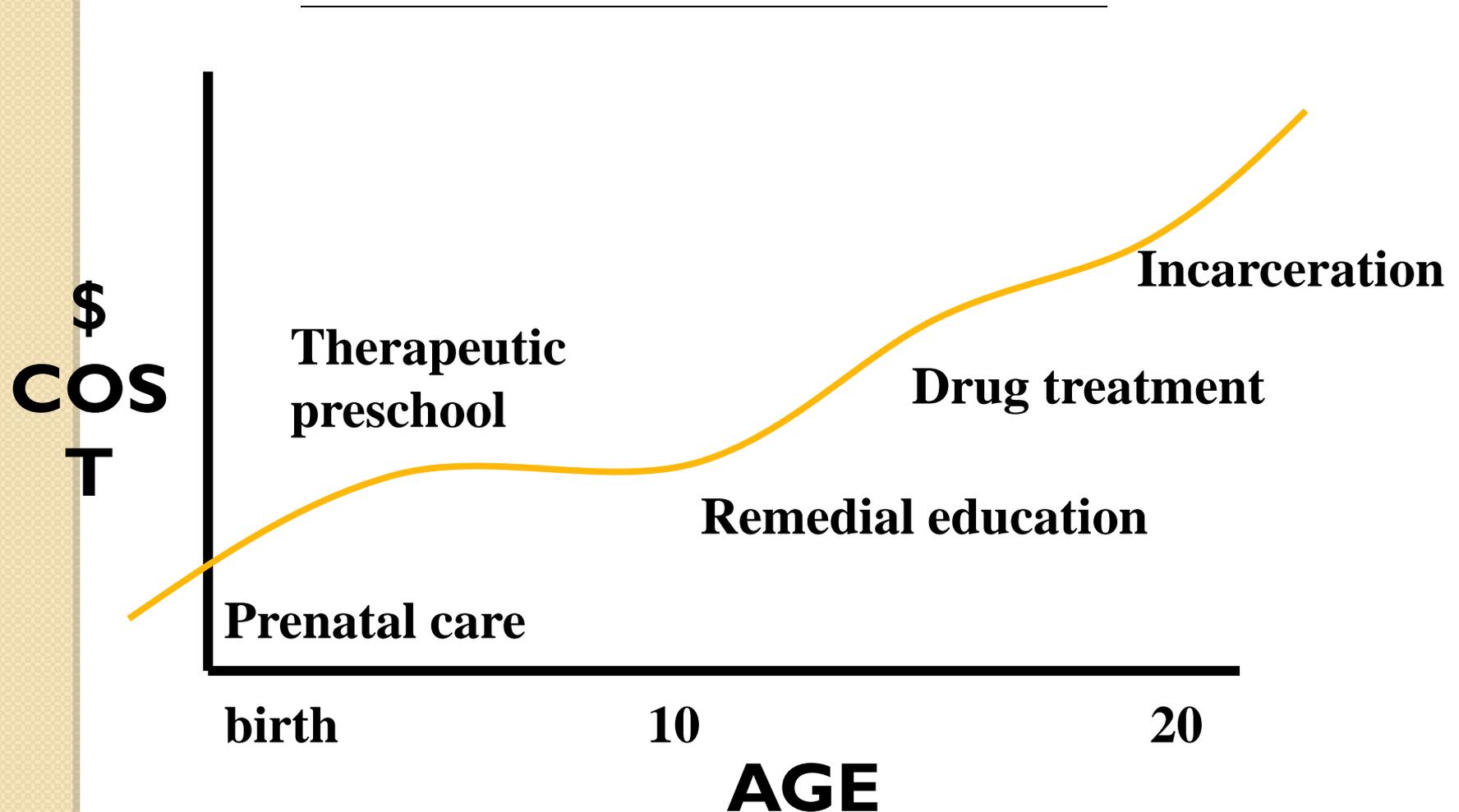
- Numbing of affect
- Intrusive memories
- Persistent arousal
- Avoidance of “trigger” events

Maltreated kids may have...

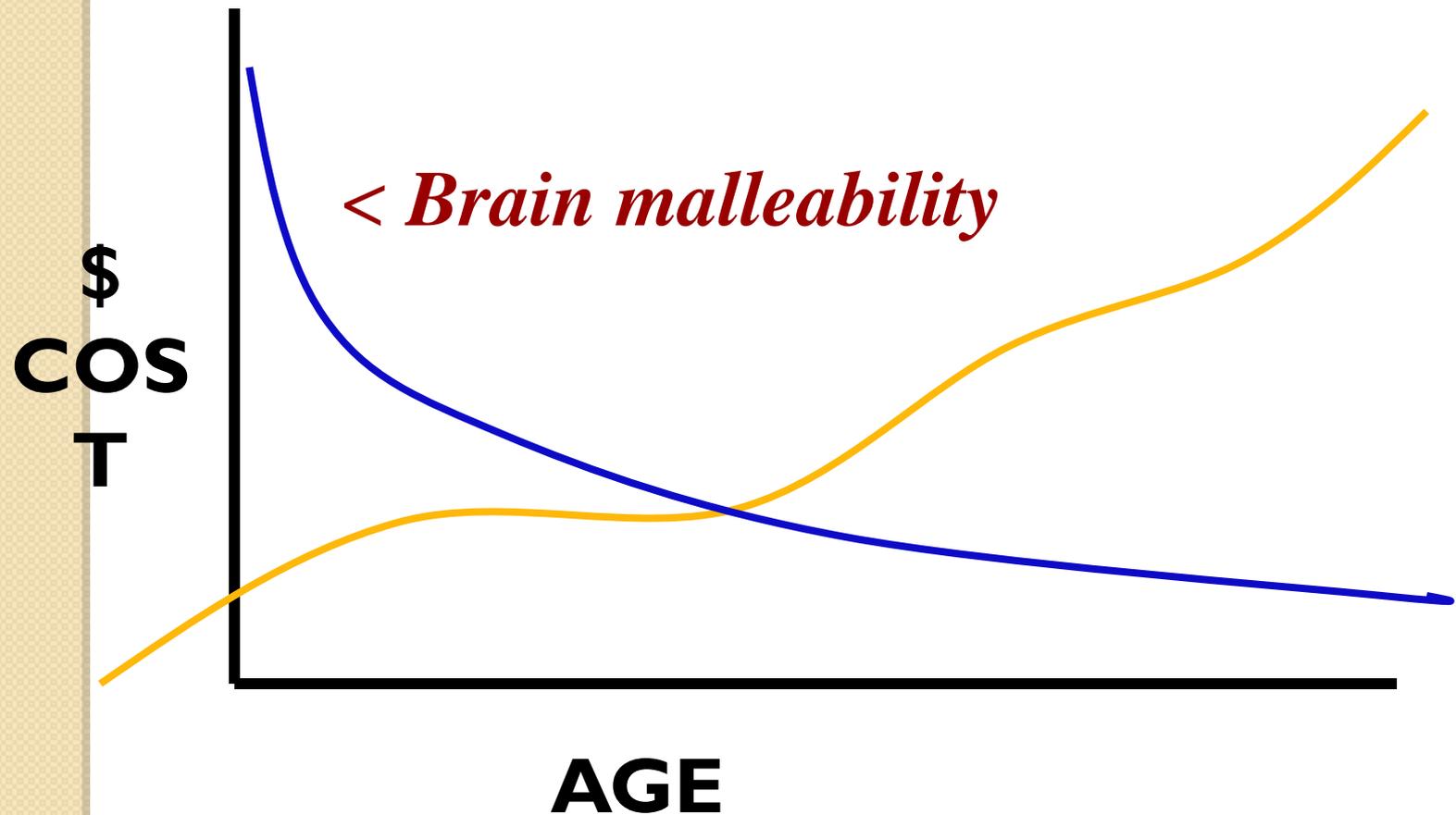
- Persistent fear/alert state
- Poor differentiation of affect
- Dysregulation of affect

...and thus may avoid intimacy

Costs of Intervention



Costs of Intervention



Resilience?

“Recovery” can depend on:

- Neuronal growth
- Behavioral compensation
- Minimizing secondary trauma

Genes for Resilience?

- Epigenetics = study of gene x environment
- Binder et al., *JAMA* 2008
 - Gene polymorphism + child abuse = PTSD
 - Changes in cortisol receptors
- Szyf & Meany, *Pub Lib of Science* 2008
 - Suicides shared DNA methylation
 - All were child abuse survivors
 - Affects protein synthesis

Development

Stress can be:

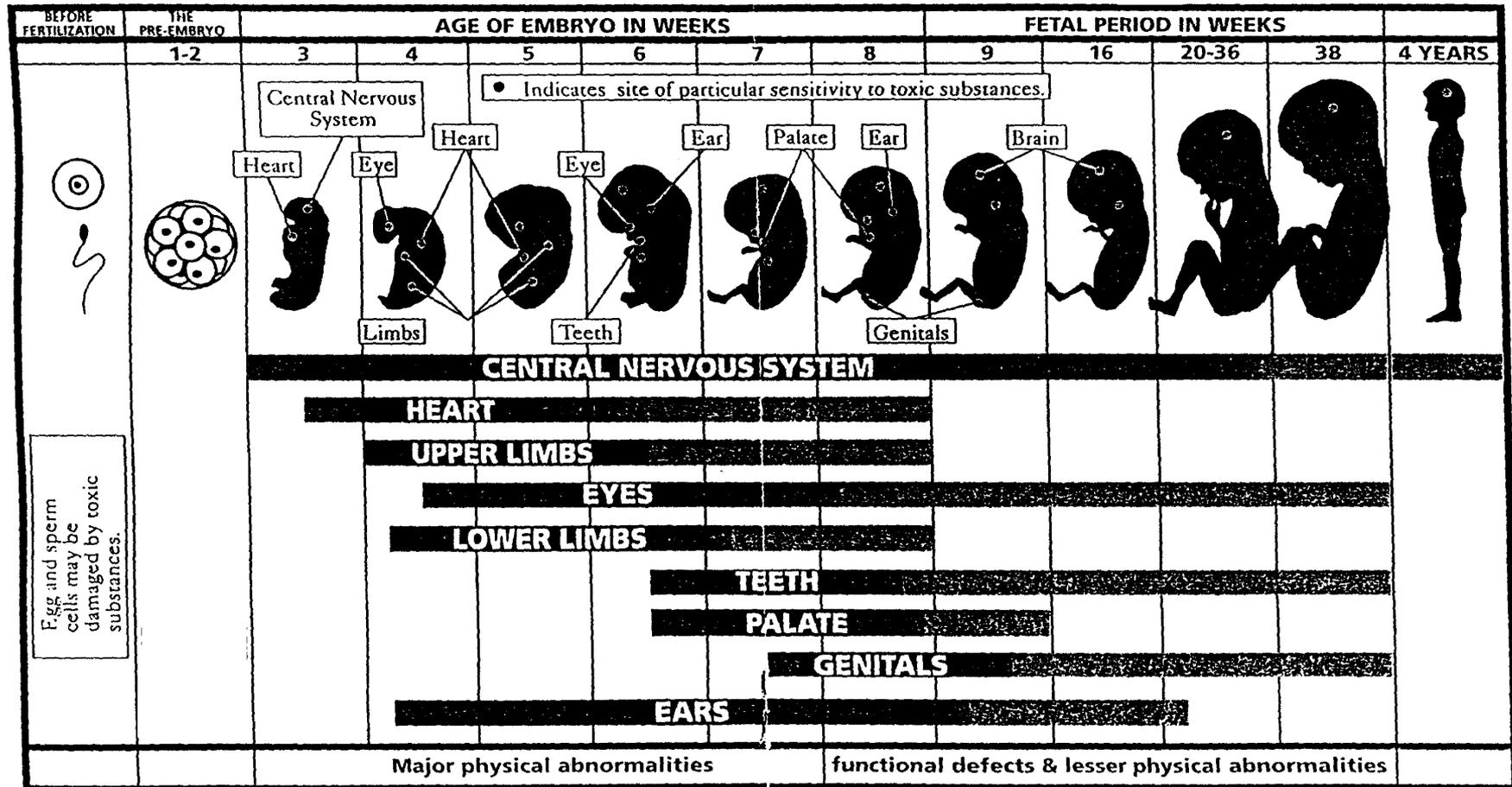
- **Prenatal**
 - Malnutrition
 - Toxins
- **Perinatal**
 - Birth trauma
- **Postnatal**
 - Physical or emotional trauma
 - Grief and loss
 - Malnutrition

Development

Deficits can be:

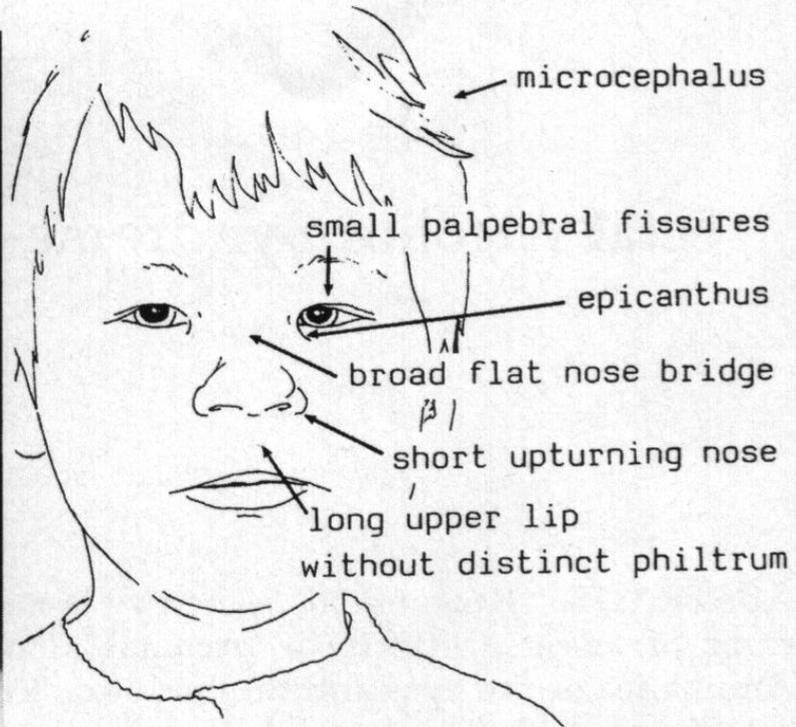
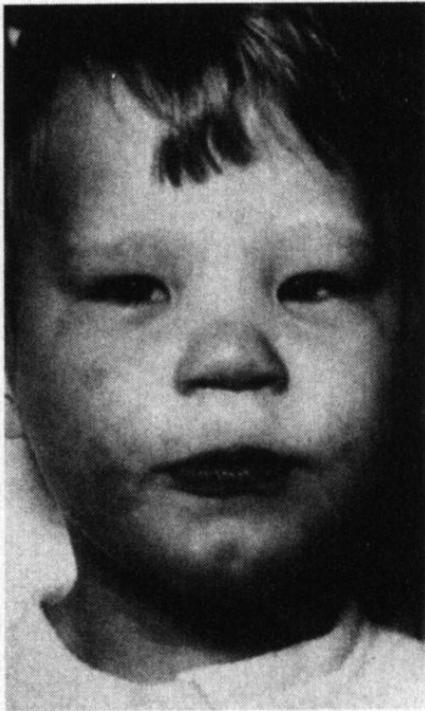
- **Physical**
 - Somatic
 - Neurologic
- **Cognitive**
 - Language / speech
 - Analytical processing
- **Emotional / behavioral**
 - Attachment / trust issues
 - Self-regulation

Effects of Toxic Exposures



Note: Adapted from: Moore, Keith L., 'The Developing Human, 4th Ed. (W.B. Saunders, Philadelphia, 1988)

FAS: Facial Characteristics



FAS: Characteristics

- Craniofacial abnormalities
- Pre- and/or postnatal growth deficiency
- CNS dysfunction

But...

Expression is variable

FAS/FAE: Cognitive dysfunction

- Low IQ
- Poor judgement (“social IQ”)
- Hyperactivity / attentional deficits
- Visual/spatial skills, learning and memory
- Slow processing

No consistent/specific pattern

FAS/FAE: Communication

- High prevalence
- Wide variety of deficits
- Poor social-communicative *function*, even with good *skills*

No consistent/specific pattern

FAS/FAE: Sensorimotor deficits

- Sensory processing / integration problems
 - feeding, sleeping
 - touch, movement, visual/auditory, taste/smell
- Hearing disorders
- Poor visual acuity, nearsightedness

Goals of Development

(after Von Horn)

- Attachment
- Regulation
- Cognition

Types of attachment

- *Secure*
 - expectations rewarded, comfort available
- *Avoidant*
 - rejects caregiver
- *Anxious*
 - clings, fearful of separation
- *Disordered*
 - approach/avoidance

Types of attachment

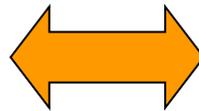
- Secure (56-65%)
- Insecure
 - Avoidant (20-25%)
 - Ambivalent (10-20%)
 - Disorganized (5-10%)

In a normal population!

Types of Attachment

Child

- Secure
- Avoidant
- Ambivalent
- Disorganized



Parent

- Nurturing
- Dismissive
- Preoccupied
- Disorganized

Take home points

Foster children are a unique group of kids

- Trauma-altered physiology
- Often lack resilience; “empty toolbox”
- “Fish out of water” – We (providers and parents) can’t expect simple and quick adaptation



Process

- Screening
- Assessment
- Referral
- Treatment
- Encouraging resilience

Chasnoff, ntiupstream.com

Medical evaluation

- Clearance exam
- Initial medical evaluation
- Follow up evaluation(s)

AAP, Fostering Health, 2000

Common initial medical findings

- Nutritional deficiencies
- Acute infectious diseases
- Deficient immunizations
- Growth retardation
- Developmental delays
- Congenital conditions
- Behavioral concerns

Maltreated kids may have...

- Persistent fear/alert state
- Poor differentiation of affect
- Dysregulation of affect

...and thus may be hard to parent!

Initial office visit

- Review medical history and records
- Assess growth and development
- Perform complete physical exam
- Address foster parent concerns
- Provide:
 - Necessary screening tests
 - Immunizations
 - Parent education

Initial developmental evaluation

- Careful assessment of all developmental domains, hearing, and vision
- Review of sleep and feeding
- Review of attachment behaviors and parenting to promote attachment
- Future developmental screens
 - PEDS, PSC, ASQ

Early Intervention services

Any child

- Not showing significant progress within weeks/months of adoption
- With known adverse history (prematurity, VLBW, cerebral palsy)
- With known diagnosis (cleft palate, FAS, sensory deficit)
- With anxious foster parents

Presentations of Trauma...

- Complex PTSD
- Attention-Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Major Depression or Bipolar Disorder
- Autism Spectrum Disorders
- Reactive Attachment Disorder

...Or Comorbidity?

Therapeutic implications

Diagnosis

- Must take into account early stresses
- Looks for maladaptive adaptations

Therapeutic implications

Therapy

- Remember that early trauma affects not only perception, but ability to learn
- Should involve both hemispheres
- Cannot involve *only* the child!

Tools

Child Welfare Trauma Training Toolkit (2008)

- The *Child Welfare Trauma Training Toolkit* is designed to teach professionals about the values about the child welfare system, how to use the toolkit, safety, permanency, analysis and care for them and families.



Evidence basis

Programs with a Scientific Rating of 1 - Well-Supported by Research Evidence

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Programs with a Scientific Rating of 2 - Supported by Research Evidence

- **Child Parent Psychotherapy for Family Violence (CPP-FV)**

Evidence basis

Programs with a Scientific Rating of 3 - Promising Research Evidence

- **Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)**
- **Eye Movement Desensitization and Reprocessing (EMDR)**
- **Sanctuary Model SITCAP-ART**

Evidence basis

Programs with a Scientific Rating of 6 - Not Rated

- **Forensically Sensitive Therapy (FST)**
- **Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)**
- **Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET)**
- **Trauma-Focused Play Therapy**

Conclusions: kids

- Abused and neglected kids
- Suffer a wide variety of effects arising from
- Chronic activation of the threat response, and
- Lack of parental support to provide
- Coping tools (self-regulation) that enable
- Cognitive and interpersonal learning

Conclusions: team

Whether in

- Screening,
- Assessment,
- Referral,
- or Treatment,
- Everyone has a role, and
- Success depends on working together!

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NCTSN.net.org

CAevidencebasedclearinghouse.org



A Free Research Publication Dealing with the Effects of Adverse Childhood Experiences on Adult Health and Well Being



Co-Principal Investigators

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Dr. Anda earned his MD from Chicago's Rush Medical College in 1979, and is Board Certified in Internal Medicine. After earning an MS in Epidemiology from the University of Wisconsin School of Medicine in 1984, he served for 2 years as an Epidemic Intelligence Service Officer for the Centers for Disease Control and Prevention (CDC). At the CDC, Dr. Anda has served as an Epidemiologist in the Nutrition Division, the Behavioral Risk Factor Surveillance Branch, the Cardiovascular Health Studies Branch, and on the Task Force on Genetics in Public Health. From 1992 to 1994, he was the Chief of Epidemiology and the Surveillance Section in Cardiovascular Health. Since 1993, Dr. Anda has been a Co-Principal Investigator of the ACE Study. He has authored and co-authored numerous publications on the health and social implications of adverse childhood experiences.



Origins and Essence of the Study

The Adverse Childhood Experiences (ACE) Study is a decade-long and ongoing collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC). However, some of the concepts for the ACE Study had their beginnings in 1985 when, as a specialist in Preventive Medicine, Dr. Felitti initially set out to help obese people lose weight through the Positive Choice programs. To his amazement, those people most likely to drop out of the weight loss program were those who were successfully losing weight!

On digging more deeply, in a careful study of 286 such patients, Dr. Felitti learned that many had been unconsciously using obesity as a shield against unwanted sexual attention, or as a form of defense against physical attack, and that many of them had been sexually and/or physically abused as children. That is to say, although obesity was conventionally viewed as the problem, it was often found to be the unconscious solution to other, far more concealed, problems. The prevalence and severity of these problems was totally unexpected. Many, like childhood sexual abuse or suicidality, were shielded by social taboos against freely discussing these topics, even in medical settings.
(Continued on page 2.)

Dr. Felitti, is a graduate of Johns Hopkins Medical School (1962), and a Physician in the Department of Preventive Medicine, Southern California Permanente Medical Group. He founded the Department of Preventive Medicine for Kaiser Permanente in San Diego, California, 28 years ago, and served as Chief of Preventive Medicine until March 2001. Under Dr. Felitti's leadership, the Health Appraisal Division of the Department of Preventive Medicine provided Comprehensive Medical Evaluation to 1.1 million people; and during his career, the health risk abatement programs expanded from three (weight loss, smoking cessation and stress management) to a wide range of cutting-edge risk abatement programs offered to over 1,000 patients per month at one facility. Dr. Felitti is also Clinical Professor of Medicine at University of California, San Diego, and a Fellow of The American College of Physicians, licensed to practice medicine in Maryland, California, and Arizona.



HIGHLIGHTS Among the Initial ACE Study Findings:

ACEs Are Common

Two-thirds of participants reported at least one ACE (see page two for the prevalence of individual ACEs).

ACEs Tend to Occur in Groups

Of persons who reported at least one ACE, 87% reported at least one other ACE.

70% reported 2 or more others, and more than half had 3 or more others!

Inside This Issue:

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Origins and Essence of the Study, continued

It also became evident that many obese patients had previously used tobacco, alcohol, and street drugs to moderate stress and feelings of despair before turning to food. ***In many instances, obesity – although the most noticeable finding – was less important than other concurrent problems that were less obvious.*** Simultaneously with the work that Dr. Felitti was doing, Dr. Robert Anda, of the CDC, was studying multiple medical and public health problems including smoking, alcohol abuse, obesity, and numerous chronic diseases. His interest in, and study of, the psychosocial origins of health-related behaviors and diseases dovetailed with the clinical observations of Dr. Felitti. Moreover, the CDC has programs that deal with obesity, alcohol related problems, and the use of illicit street drugs, and high-risk sexual behaviors are well known to play an important role in the spread of the Human Immunodeficiency Virus (HIV) which causes AIDs. Therefore, Dr. Felitti’s observations and the research priorities of the CDC came together. The CDC teamed up with Kaiser Permanente to develop a large-scale epidemiologic study of the influence of stressful and traumatic childhood experiences on the origins of behaviors that underlie the leading causes of disability, social problems, health-related behaviors, and causes of death in the United States. Unlike most prior studies in this area which had tended to focus on single types of childhood abuse (especially

sexual abuse) and specific health problems (usually mental health issues), the ACE Study was designed to simultaneously assess childhood exposure to multiple types of abuse, neglect, domestic violence, and types of serious household dysfunction such as substance abuse. Moreover, the ACE Study included assessment of a wide array of high priority health and social problems ranging from adolescence to adulthood. Thus, the ACE Study is the largest study of its kind ever conducted (more than 17,000 study participants) and the range of adverse childhood experiences and health related outcomes studied was unprecedented. The Study determined that an unexpectedly high number of these people – adults who came to the Department of Preventive Medicine for comprehensive medical screening – had experienced significant abuse or household dysfunction during their childhoods. For the purposes of the ACE Study, adverse childhood experiences were defined as emotional, physical, or sexual abuse, emotional or physical neglect, and growing up in a household where someone was an alcoholic, a drug user, mentally ill, suicidal, where the mother was treated violently, or where a household member had been imprisoned during the patient’s childhood. Additionally, they included contact sexual abuse and serious physical and emotional abuse. The Study found the following burden of individual ACEs:

<u>Abuse:</u>	
Emotional	10%
Physical	26%
Sexual	21%
<u>Neglect:</u>	
Emotional	15%
Physical	10%

Household Dysfunction

Mother treated violently	13%
Mental illness	20%
Substance abuse	28%
Parental separation or divorce	24%
Household member imprisoned	6%

Because the ACE Study research team found that ***in most cases, not just one, but several, of these ACEs existed in the child’s home,*** a simple scoring system was used (called the ACE score), in which each participant was attributed one point for each category of adverse childhood experience occurring prior to age 18. The percentage of Kaiser members with each ACE score is shown below. Note that ***only 1/3 of persons reported no ACEs.***

ACE score:	
0	33%
1	26%
2	16%
3	10%
4	6%
5	5%
6	6%

Using the ACE score as a measure of the burden of traumatic childhood exposures, the ACE Study team found that as the ACE score increased the chances of being a user of street drugs, tobacco or having problems with alcohol abuse increased in a stepwise fashion. Thus, ***ACEs were not only unexpectedly common, but their effects were found to be cumulative.*** The first publication from

the ACE Study examined the relationship of the ACE Score to many of the leading causes of death in the United States. Major risk factors for these causes of death – such as smoking, alcohol abuse, obesity, physical inactivity, use of illicit drugs, promiscuity, and suicide attempts – were all increased by ACEs. Among the more notable findings were that ***compared to persons with an ACE score of 0, those with an ACE score of 4 or more were twice as likely to be smokers, 12 times more likely to have attempted suicide, 7 times more likely to be alcoholic, and 10 times more likely to have injected street drugs.***

The behaviors such as alcohol or drug abuse, smoking, or sexual promiscuity are likely the result of the effects of ACEs on childhood development, which we now know to be neurodevelopment. In many, if not most, cases the behaviors may act to alleviate the emotional or social distress that results from ACEs. Thus, these behaviors, typically considered to be *problems*, continue because they function as short-term solutions, even though they have detrimental, long-term effects. The findings from the ACE Study suggest that problems such as addiction frequently have their origins in the traumatic experiences of childhood (Continued on Page 3.) ***Origins and Essence of the Study, continued***

The True Nature of Preventive Medicine



Mechanisms By Which Adverse Childhood Experiences Influence Adult Health Status

—and that the molecular structure of various chemicals or the physiologic effects of certain behaviors (e.g. overeating, sexual behaviors) — while ultimately leading to disease and disability, may be particularly effective in ameliorating their effects.

The ACE Study also showed that as the ACE score increased the number of risk factors for the leading causes of death increased. Thus, persons with high ACE scores are later at much higher risk for health and medical conditions resulting from their choice of remedies for their pain. While these approaches are effective in the short term, they often have dire long-term consequences such as serious chronic health and social problems.

In addition, the underlying causes of these problems — *adverse childhood experiences* — would typically go undetected because of shame, secrecy and social taboo, which prevent people from talking about such things. These same social taboos prevent physicians and other health care providers — those best poised to help victims of child abuse — from asking the very questions that would help identify these underlying causes of major impediments to Americans' health and well being.

In combination, the fallout from various forms of child abuse and household dysfunction is monumental, costing Americans untold sums of money because of the health risks such as the use of street

drugs, tobacco, alcohol, overeating and sexual promiscuity. Not the least of these high-ticket medical costs is due to: cardiovascular disease, cancer, AIDS and other sexually transmitted diseases, unwanted often-high-risk pregnancies, chronic obstructive pulmonary disease, and a legacy of self-perpetuating child abuse.



ACE Study to AMA Committee on Family Violence.

May 17, Vallejo, CA; Keynote address at Children's Network of Solana County.

Jun 7, San Diego, CA; ACE Study presentation at Wexler Conference on the Family.

Jun 27, San Diego, CA; ACE presentation at San Diego Academy of Family Practice Annual Conference.

Presentations by Dr. Anda:

Apr 3, Portland ME; University of New England. Symposium on Domestic Violence. "The Wide Ranging Effects of Adverse Childhood Experiences."

Apr 6, Bethesda, MD; Walter Reed Army Medical Center. Plenary Speaker. Forensics Symposium: Families, Violence and Trauma. "The Role of Domestic Violence and Related Adverse Childhood Experiences on Health."

Apr 17; Seattle, WA; Ft. Lewis Army Center. Keynote Speaker. "The Wide Ranging Health and Social Impact of Adverse Childhood Experiences."

May 10. Columbus, OH; Ohio Community Forum on Child Abuse. Plenary Speaker. "The Numerous Effects of Childhood Abuse and Related Adverse Childhood Experiences."

Jun 9. Washington, DC; Annual Leadership Conference of the National Children's Alliance. Plenary Speaker. "The Wide-Ranging Health and Social Impact of Adverse Childhood Experiences".



Speaking of ACEs -- 2003

Presentations by Dr. Felitti:

Jan 7, San Diego, CA; State Health Dept Conference on Adolescent Obesity.

"Adverse Childhood Experiences and Adolescent Obesity."

Feb 5, San Diego, CA; San Diego Children's Hospital International Conference.

"Adverse Childhood Experiences and Adult Health."

Feb 15, Denver, CO; National Meeting of American Association for the Advancement of Science (AAAS),

"Adverse Childhood Experiences and their Relationship to Adult Health."

Feb 15, Denver, CO; Interview about ACE Study with German Public Radio.

Mar 3, San Diego, CA; Fox Television Network Interview on ACE Study and its Implications for Adolescent Health.

Mar 10, San Diego, CA; Presentation of ACE Study at San Diego State University School of Public Health.

Mar 25, San Diego, CA; Presentation of ACE Study results at Cities of the Future Conference.

Apr 2, St. Louis, MO; Keynote address National Conference on Child Abuse.

Apr 4, Boston, MA; Interviews with press & TV

Apr 5, Boston, MA; Keynote address, Massachusetts Citizens for Children Conference.

Apr 11, Chico, CA; Keynote at Butte County Health Dept Annual Meeting.

Apr 13-17, Germany; Daily Workshop on Relationship of ACEs to Obesity.

Apr 15, Germany; Plenary Presentation of ACE Study to Annual Lindau Psychotherapy Conference.

Apr 29, San Diego, CA; Presentation of ACE Study at Positive Choice.

May 16, San Francisco, CA; Presentation of



SPECIAL THANKS

TO

Stephen M. Rose, Ph.D.

Prof., College of Health Professions
University of New England -

Westbrook Campus
Portland, Maine

FOR

Single-handedly increasing the ACE Reporter list of Subscribers by at least 200, thereby helping countless others benefit from important lessons learned from the ACE Study.

For a Closer Look: ACE Publications

Data quoted in this issue came from one or more of the following publications:

First ACE Publication

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, et al JS. The relationship of adult health status to childhood abuse and household dysfunction. American Journal of Preventive Medicine. 1998;14:245-258.

ACEs and Alcohol Abuse

Dube SR, Anda RF, Felitti VJ, Edwards VJ, Croft JB. (2002). Adverse Childhood Experiences and personal alcohol abuse as an adult. Addictive Behaviors. 2002. 27(5), 713-725.

ACEs and Illicit Drug Use

Dube SR, Anda RF, Felitti VJ, Chapman DP, Giles WH. Childhood Abuse, Neglect and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experience Study. Pediatrics 2003; 111(3): 564-572.

ACEs - Prevalence and ACE Score Statistics

Dong M, Anda RF, Felitti VJ, Dube SR, Giles WH. The Relationship of Exposure to Childhood Sexual Abuse to Other Forms of Abuse, Neglect and Household Dysfunction during Childhood. (In press, Child Abuse and Neglect).

ACEs and Smoking

Anda RF, Croft JB, Felitti VJ, Nordenberg D, Giles WH, Williamson DF, Giovino GA. Adverse childhood experiences and smoking during adolescence and adulthood. Journal of the American Medical Association. 1999;282:1652-1658.

ACEs and STDs

Hillis SD, Anda RF, Felitti VJ, Nordenberg D, Marchbanks PA. Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. Pediatrics 2000 106(1):E11.

ACEs and Suicide

Dube SR, Anda RF, Felitti VJ, Chapman D, Williamson DF, Giles WH. Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from Adverse Childhood Experiences Study. Journal of the American Medical Association. 2001: 286, 3089-3096.

ACEs and Teen and Unintended Pregnancy

Dietz PM, Spitz AM, Anda RF, Williamson DF, McMahon PM, Santelli JS, Nordenberg DF, Felitti VJ, Kendrick JS. Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood. Journal of the American Medical Association. 1999;282:1359-1364.

Anda RF, Felitti VJ, Chapman DP, Croft JB, et al. Abused boys, battered mothers, and male involvement in teen pregnancy: New insights for pediatricians. Pediatrics 2001: 107(2), e19.

ACEs and Violence, Self-perpetuating Cycle of Violence

Whitfield CL, Anda RF, Dube SR, Felitti VJ. Violent Childhood Experiences and the Risk of Intimate Partner Violence in Adults: Assessment in a Large Health Maintenance Organization. Journal of Interpersonal Violence 2003; 18(2):166-185.

Anda RF, Whitfield CL, Felitti VJ, Chapman D, Edwards VJ, Dube SR, Williamson DF. Alcohol-impaired parents and adverse childhood experiences: the risk of depression and alcoholism during adulthood. Journal of Psychiatric Services 2002; 53(8):1001-1009.



The Editor's Corner

This is the first of what I hope will be many editions of the *ACE Reporter*, created in response to increasing demand, from people of all walks of life, who hunger for a deeper understanding of events in their own lives and those of people near them. In short, this publication is created for *you*. I therefore encourage you to make it *yours* by telling me how the content can be improved to suit your needs.

This first edition was dedicated to the general nature of the ACE Study; subsequent issues will take a deeper look into each aspect of the Study's findings.

Wishing you peace,

Carol A. Redding
caredding@cox.net



The *ACE Reporter* is a privately-funded, independent, volunteer publication. Every reasonable effort has been made to ensure the accuracy of the information contained herein. Readers and contributors to this free publication agree to hold the Editor, and all parties in any way associated with this publication, free from every form of harm that might result from errors or omissions. Any subscriber and/or contributor who does not agree to this condition should unsubscribe by email to: caredding@cox.net or by standard mail to:
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Melissa Pierce

Melissa Pierce works with the Health Education Division of the Butte County Department of Public Health. She has a Master's degree in Counseling and provides direct client services, in addition to writing family violence prevention policy.

Initially my work with the county's public health department had been more about others and how issues of violence affect all people and our world at large. I soon recognized that my work also held significant *personal* meaning. While aware that my family of origin had been dysfunctional, I had not focused specifically on how several aspects of my early life—including having witnessed violence against my mother—may have had a significant impact on my development.

Learning about the ACE Study not only validated many of my life's experiences and those of others close to me, but it has given new richness and meaning to my work with clients. After connecting with the ACE Study through the articles in the Summer 2001 issue of the Family Violence Prevention Fund's "Health Alert" Newsletter, especially Dr. Felitti's cover article, "Reverse Alchemy in Childhood: Turning Gold Into Lead", meeting Dr. Felitti at the 8th International Conference on Family Violence Prevention in San Diego was truly a highlight of my year.

Throughout the policy writing that went on for over a year, as well as the direct client services I provide in the course of counseling and testing people for the HIV virus, the ACE Study has been in my heart and mind. Its relevance feels profound. As I speak with people about their HIV risk factors, they share about their lives. Lives with pain and histories of pain. *I wonder if they have made the connections between current and past pain*, and if they were to do this, if it might give them a sense of clarity and even perhaps restore a sense of sanity to their lives.

Melissa Pierce

