JOINING FORCES Joining Families

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FEATURED INTERVIEW

Adverse Childhood Experiences: Promises, Risks, and Cautions

An interview with David Finkelhor, PhD

David Finkelhor, PhD

David Finkelhor, PhD, is the Director of the Crimes against Children Research Center, Co-Director of the Family Research Laboratory, and Professor of Sociology at the University of New Hampshire. He is well known internationally since 1977 for his work on child victimization, child maltreatment, and family violence. He has written extensively on child sexual abuse, child homicide, missing and abducted children, children exposed to domestic and peer violence, and other forms of family violence. Dr. Finkelhor is editor and author of 11 books and over 150 journal articles and book chapters. He has received grants from many institutions and received a variety of professional achievement awards. Dr. Finkelhor is also a singer and songwriter, largely about research and researchers.

Dr. McCarroll: This is the 20-year anniversary of the study of adverse childhood experiences (ACEs) (Felitti, et al., 1998). Has interest in ACEs increased?

Dr. Finkelhor: Enormously. It is a very big focus for a lot of people in research and policy. The fact that maltreatment and other childhood adversities have long-term effects has been widely accepted in the social sciences and policy areas for years. But, the ACEs study added an on-ramp to involving the medical and the public health communities because of the apparent evidence that child maltreatment was related to risk for certain important chronic health conditions such as heart disease, asthma, and so forth, and the related hope that we could save money on health care costs through child maltreatment and childhood adversity prevention.

Dr. McCarroll: People in many fields are writing about as well as attempting to screen for ACEs.

Dr. Finkelhor: Oh, yes. There are lots of screening efforts going on. Some pediatric practices have started to screen for ACEs: some screen the kids, some screen the parents. It is a very widespread initiative.

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In This Issue

This issue of *Joining Forces Joining Families* (*JFJF*) features an interview with David Finkelhor, PhD, on adverse childhood experiences (ACEs). We provide a brief summary of Dr. Finkelhor's recent article questioning the wisdom of screening for ACEs in healthcare settings. Other articles on ACE screening include a review of the concept of resilience as it relates to adversity in development. In our regular research methods article, we describe differences in screening methods. Websites of Interest features the Crimes Against Children Research Center, which Dr. Finkelhor directs, and two additional sources of information about ACEs: SAMHSA and the CDC. All of these contain online resources that educate about ACEs and childhood victimization.

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One alternative to ACE screening is symptom screening. Symptoms are known mediators in the causal chain between adversity in childhood and later health problems and they may be better predictors than the ACEs themselves.

It seems to me that the interest in ACEs went in two main directions. The first direction was a policy-advocacy argument, which was, "Look. If childhood adversities are associated with these health problems, there is really a great deal of benefit to try to prevent them from occurring. So, let's invest in adversity prevention programs: parent training, family and prenatal education and those types of things."

The second direction was, "Oh, these adversities seem to predict bad outcomes. Wouldn't it be helpful for us to know who are the high risk people in our patient population so let's start screening everyone for these risks?" That is where the screening initiative developed. I am more enthusiastic about the first initiative than I am about the second. My concern has developed from my review of the literature on universal screening in general and the prospects and perils of that kind of an effort. I am concerned that there is a certain amount of fuzzy thinking that has infused this screening mania right now.

Dr. McCarroll: How has screening been conducted and with what success?

Dr. Finkelhor: When people talk about ACE screening, it is not always about using the classic ACE inventory that Felitti and colleagues developed (Felitti, et al., 1998). A lot of the screening efforts have adapted it or developed their own inventories. There is a diversity of things that are being screened for and that is a reflection of one important problem, which is that there is no consensus based on scientific testing on exactly what to screen for. What kinds of adversities and other indicators are most likely to predict high risk? We haven't settled this question.

There is another problem you need to anticipate in any screening effort, even with fairly good general screening tests, is that they produce a lot of false positives. A lot of people may have this elevated score, but they are really doing fine. You can get a lot of people who are then sent for treatment who turn out not to actually have problems. That can overwhelm the treatment system with low priority cases. With childhood adversities, this can also possibly mean more referrals to child protection authorities and investigations of families who do not need it or benefit from it and, in fact, resent it.

Dr. McCarroll: That may suggest the need for good instruments. Do you find much psychometric data on the screening that is being conducted? Or is it based on people thinking this would be important to do?

Dr. Finkelhor: There is some psychometric data, but it is mostly just to show that the items that people are using are associated with disease or problem behavior and that the accumulation of these is associated with more problem behaviors. But, that tends to be a very easy test. You generally can show that the more items that are responded to, the more bad things are likely to be happening. There are dozens and dozens of things that we could screen for. You could start with a big universe of them and then narrow it down to the ones that are the best, a small number, but we really haven't done that. Also, that does not necessarily tell you very efficiently who needs referral and treatment.

Dr. McCarroll: Who should refer and who should treat often depends on the cutoff values. A lot of screening work ignores psychometric issues like cutoff points and false positives. It is never really conclusive; there is always error.

Dr. Finkelhor: Exactly.

Dr. McCarroll: You brought up important issues about the screening of children. Is that being done?

Dr. Finkelhor: It is being done, but one of the problems the field is wrestling with is the

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The best reason for screening for the symptoms rather than the ACEs, in my view, is that we actually have evidence-based treatments for most of these symptoms.

existence of mandatory reporting laws requiring the reporting of even a "suspicion" of maltreatment. In a pediatric practice or behavioral health practice, if you ask about the child being physically abused, sexually abused, neglected, or exposed to domestic violence, a "Yes" requires a report to a child protection system. A lot of the systems adopting these screens do not want to trigger those reports. This is a really big issue. They recognize that triggering those reports might be counterproductive in that they would create reports of low-level episodes that do little to help the family and might destroy the rapport between the family and the provider. One of the things that some people have done is to give the parent, or in some cases the youth, a list of adversities and say, "Don't tell me which adversities, just count up the number that have happened to you and write the number down." The idea is that the higher numbers will correlate with more risk, which they do. The problem there, as I see it, is if one of your goals is to provide help for high risk people, then any person trying to prescribe an intervention would have to get the history to find out for sure what specific adversities triggered the referral. They would need to answer the question, "What are the problems we are actually dealing with here?" So, you may be blind to reportable problems in the initial screening, but that blindness cannot be sustained throughout the referral process so reporting is still likely to be an outcome.

Dr. McCarroll: Is their idea that some treatment is effective for all the ACE conditions and you do not need to know the specifics? Is that the theory they are working on?

Dr. Finkelhor: That may be the theory, but that is not what research on practice says needs to happen. Various available interventions are geared to specific different kinds of family problems. Obviously, an intervention for a family where domestic violence is occurring would be different from the intervention where the child may have been sexually abused. So ultimately you need this differentiated information.

One of the key problems that has been found in universal screening in general is that there are negative effects to universal screening that need to be factored into any equation about whether it has overall system-level benefits. In the case of universal prostate screening, for example, the negative effects were that a lot of men get biopsied and most turn out not to have cancer, but the biopsy can sometimes result in serious complications. For every person you save from cancer, how many did you expose to this procedure and may have actually given them a bad outcome that they would not have otherwise had. The outcome studies on prostate screening have not shown that they are really saving lives.

Similarly, in the case of universal ACE screening there are people who may be subjected to investigations and other kinds of aversive events, who might not have needed it, might feel alienated as a result, and it might disturb the relationship they have with their provider. Those are all potentially negative outcomes that might result from this universal screening. We have to assess how often that occurs and weigh it against any benefit that we find to the screening. We just do not know what those parameters are right now and the people who are doing screening are not mostly doing it in the context where they can assess fully those potential negative outcomes.

Dr. McCarroll: What would a provider do with a child that comes up with an ACE score of six, for example.

Dr. Finkelhor: That is kind of a black box in my understanding. They basically make a referral to a behavioral health specialist. That could help if there is a rich supply of diverse family and youth services in the practice or the community to make referrals to, people with a lot of knowledge about evidence-based interventions. But in most places in the country, a referral to behavioral health may or may not send you to somebody who really knows a lot about how to treat the specific childhood adversities, like exposure to domestic violence. They may or may not have training in evidence-based treatments, and in some cases the wait lists for referral are very long. Until we know exactly what we need to do, with which kinds of families, and are confident that the services will be available, we cannot be confident that screening will be beneficial. There are no clear protocols for how to handle the referrals, or how to triage the referrals that we know will result in benefit. Also, in the case of disease screening, we know how the disease will progress. With an ACE score of six, we do not know if the person will get heart disease, COPD, or any other condition.

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Should There Be Screening for Adverse Childhood Experiences?

By James E. McCarroll, PhD, and Joshua C. Morganstein, MD

While the study of ACEs has produced significant advances in the study of their effects on health, much more research needs to be done before screening can be implemented on a large-scale basis.

Adverse childhood experiences (ACEs) can have significant effects on child and adult health. In addition to programs that attempt to prevent these events, issues of screening for those exposed are important. Felitti, et al. (1998) related ACEs to health outcomes. Seventeen questions were grouped in two categories: abuse (psychological, physical, and sexual) and household dysfunctions (mother treated violently, and anyone living in the household who was a substance abuser, was mentally ill or suicidal, or ever imprisoned). Adult respondents in a health maintenance organization were asked to respond to the 17 questions as part of a standardized medical evaluation. Over nine thousand responded to the questionnaire. The results showed that there was a graded relationship between the number of items endorsed and risk factors that contributed to major causes of illness and death in the U.S. An increase in the number of ACEs is associated with a greater likelihood of negative adult physical and mental health outcomes. Since this study was conducted there have been many hundreds more with similar results.

It has been suggested that primary care providers screen adolescents and emerging adults for ACEs, but clinically efficient tools for such screening are currently lacking (Pardee, Kuzma, Dahlem, Boucher, & Darling-Fisher, 2017). However, screening is a complex undertaking, both scientifically and clinically. For example, Finkelhor (2017) has suggested that screening for ACEs might be premature. He noted that high ACE scores (e.g., number of items endorsed) are non-specific and that this procedure does not meet the model for effective screening. To be effective as a medical procedure, screening requires the existence of a specific risk factor that can be treated. Likewise, there should be a specific intervention that would be done based on the results of the screening. Finkelhor raised other questions such as whether negative effects involved in screening (e.g., time, cost, training, stigma, and false positives) would outweigh the positive ones.

The items that are useful in ACE research for prediction of adverse outcomes are unclear. In an effort to test and improve on the classic ACE items, Finkelhor, Shattuck, Turner, and Hamby (2013) suggested deleting some items and adding new ones. The items recommended for removal included parental separation or divorce and incarceration of a household member. New suggested items included parents always arguing, having no good friends, having someone close with a bad illness or accident, below average grades, peer victimization, property victimization, exposure to community violence, and low socio-economic status. Other authors have also suggested additional items such as family financial problems, food insecurity, homelessness, parental absence, parent/sibling death, bullying, and violent crime (Mersky, Janczewski, & Topitzes, 2017).

While the study of ACEs has produced significant advances in our understanding of the effects of ACEs on health, much more research needs to be done before screening can be implemented on a large-scale basis. Finkelhor (2017) suggested that the most effective screening program would be for the conditions for which established and effective treatments exist.

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Adverse Childhood Experiences and Resilience

By James E. McCarroll, PhD, and Joshua C. Morganstein, MD

Resilience is the ability of the individual to continue a normal life trajectory in spite of adversity, not a fixed invulnerability or superior functioning.

Adverse childhood experiences (ACEs) have been associated with a wide variety of negative health and behavioral outcomes in adults (Felitti et al., 1998). This important insight has led to a wide body of research to understand how to prevent the effects of ACEs and to treat negative outcomes when they occur in both children and adults. However, an early assumption that ACEs are universally associated with negative outcomes is not accurate. Adversity is associated with wide variations in outcomes following exposure to different types of adverse events (Rutter, 2012).[1] This observation led to attempts to discover what accounts for positive changes in the face of adversity. Many concepts have been put forth to account for this fact such as competence, the capacity for adaptive behavior (Masten & Tellegen, 2012), and positive psychology, a concept that includes building valued subjective experiences and individual traits, and institutions to improve quality of life and prevent pathologies (Seligman, 2000).

More recently, the concept of resilience has drawn much research attention. While there is no consensus on a definition of resilience, Rutter (2006) described it as an interactive concept of relative resistance to environmental risk experiences, or the overcoming of adversity. The important point is that resilience is *interactive* [author's italics] in that it has to be *inferred* [author's italics] from individual variations in outcome among those who have experienced significant adversity (Rutter, 1987). This description emphasizes that resilience is a process, not the fixed invulnerability of an individual. Resilience also should not be thought of as superior functioning, but rather the ability of the individual to continue a normal life trajectory in spite of adversity (Rutter, 2013).

Rutter's (2013) review of resilience reveals that adversity is an environmentally as well as genetically mediated risk. Mediated means that "something" works differently in people between facing adversity and the outcome. This "something" that mediates is the subject of research. In other words, what factors interact between the exposure to risk and the outcome? Another route to reducing risk impact as well as promoting resilience is the alteration of environmental exposure (Rutter, 1987). For example, parental supervision and the regulation of children's activities can reduce exposure to high-risk community environments as well as promote pro-social activities. Exposure to adversity may result in sensitization, which increases vulnerability, or decreases vulnerability through a "steeling" (author's quotes) effect. Steeling can occur as a result of manageable challenges or small doses of stress. This means that risk factors may actually be strengthening if they occur in a way and at a time during development when the individual can cope with them, physically and psychologically (Rutter, 2013). Such experiences, although multi-determined through the interaction of biological factors, such as genetics, and environmental effects can result in increased self-efficacy and resilience to later stresses.

Research on risk and protective factors often seems to assume that they work the same way and that risks are the same in non-stressed groups as they are in those who are stressed. This is also not always the case because risk and protective factors are identified because of their effects, not their nature. Not all individuals respond to stress in the same way and outcomes cannot be understood as the balance between risk and protective factors (Rutter, 2013).

Two dynamic processes underlie resilience: (1) those that operate prior to adversity to promote resilience (e.g., maternal warmth, sibling warmth, and a positive atmosphere in the family) and (2) those that operate after adversity to restore good functioning (Rutter, 2013). Examples of the first are taking responsibility and successfully coping with challenges. The implication of this second mechanism underlying resilience is the possibility that early adverse experiences in childhood can be corrected in adults, that of turning point effects in adult life. Such turning points involve a "knifing off" [author's quotes] of the past and the opening of opportunities for the future. Positive adult experiences can provide a major discontinuity with past adversities and open up fresh opportunities for success. Examples are positive external

1. This review borrows heavily from the work of Michael Rutter, who has researched developmental psychopathology since the 1970s and has produced some of the most thoughtful papers on resilience.

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Resilience is an interactive process between the individual and the environment and has to be inferred in the outcome among those who have experienced significant adversity.

interventions such as mentorship by individuals who have overcome their own adversities such as substance abuse or crime and personal actions such as entering into a good marriage.

Prevention factors promoting resilience can be thought of as features that act differently depending on the presence or absence of environmental risk. An example is child adoption, which has no benefits to the child in the absence of adversity, but is protective when there is an environmental risk, such as remaining in a family when the child has been abused or neglected or there are serious family conflicts. It is important to keep in mind that resilience is multi-determined and depends on the context of experiences, biological factors, and environmental factors. Resilience as well as adversity should be seen as lifelong factors that can influence and be influenced by changes.

Assessment of the effects of adverse experiences, whether they occurred in childhood or later life, is more complex than screening. Much needs to be done to understand the interplay between adversities and outcomes. Biological effects on resilience require better understanding. The brain is largely the arbiter of the body's response to all life events. Stress upsets the body's homeostasis through a variety of genetic and environmental interactions, but the body adapts during these changes. How these functions occur has been the subject of an increasing volume of mind-body research allowing more understanding of adversity and resilience at all levels of the body, neurobehavioral and physiological (Karatoreos & McEwen, 2013). More needs to be learned about critical periods when stress occurs, the mediators that occur to protect the body against overload and disturbances to homeostasis, how negative changes can be mitigated, how the brain changes in response to stress and recovery, and how to address long-term negative effects such as severe child abuse and neglect.

There are also public policy implications to the increased use of the concepts of childhood adversity and resilience across disciplines such as health, education, and social welfare. There are many arenas of policy recommendations to improve resilience such as strengthened families, increased counseling and mental health services, supportive school environments, community programs, socioeconomic improvement, and a more comprehensive conception of resilience (Ager, 3013). The complexity of these challenges includes the need for more and better qualitative and quantitative research that engages a research-policy linkage, analysis at multiple levels, and engagement in knowledge transfer initiatives.

Adverse experiences and their effects upon development and outcome are complex, involving practices and policies that intend to better the lives of people. Both adversity and resilience have effects that are multi-determined, the outcome of which depend on the interplay of many factors. As is the case with many of the efforts to improve lives, particularly for children, one size does not fit all when it comes to understanding risk and protective factors in the context of adverse experiences and resilience.

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Social Support, Self-Esteem, and Peer Attachment in Adolescents Decrease Adverse Effects of Childhood Maltreatment

By James E. McCarroll, PhD, and Joshua C. Morganstein, MD

Social support can sometimes act as a means to decrease adverse psychological outcomes and enhance social and academic functioning of abused and neglected children.

Effects of adversity are often negative. However, and fortunately, such effects can be mitigated under some circumstances. Research on the effects of child abuse and neglect searches for such circumstances as interventions that can be applied in prevention as well as treatment. Among such circumstances are mediators, links between adverse experiences and outcomes. Mediators are opportunities for intervention. For example, in a study of adults with a history of child abuse and neglect, social support mediated the relationships between child maltreatment and adult anxiety and depression (Sperry & Widom, 2013). Higher levels of social support were associated with lower levels of anxiety and depression.

Research to improve the lives of maltreated children has often focused on families and friends as well as schools as sources of positive experiences that promote resilience. In a group of 101 adolescents, the effects of parental maltreatment and being the victim of peer bullying on severity of depression in adolescents were assessed (Seeds, Harkness, & Quilty, 2010). Parental maltreatment was defined as (a) antipathy, (b) indifference, and/or (c) physical abuse. Peer bullying was defined as verbal and/or physical harassment by a same-age peer. Mediators examined were *appraisal* (availability of others for support), *belonging* (availability of others for companionship), and *tangible* support (availability of material aid or instrumental support), and the number of close friends reported by participants. Father-perpetrated maltreatment and bullying were mediated by lower perceptions of both tangible support and belonging and thus resulting in greater depression severity. Contrary to expectations, severe mother-perpetrated abuse was mediated by higher perceptions of tangible support and lower depression severity. Severe maternal maltreatment was associated with more peer confidants. The authors suggested that mother-perpetrated abuse led some adolescents to seek out other sources of practical aid that somewhat protected them from depression.

Maltreatment has been found to have many complex effects on school achievement and adjustment of children and adolescents. (Lim & Lee, 2017) In a study of 2,351 Korean middle school students, parental neglect was negatively related to school adjustment. Self-esteem and peer attachment mediated the relationship between child neglect and school adjustment. In other words, higher self-esteem and peer attachment were associated with better school adjustment. Peer attachment and self-esteem were also significantly positively correlated.

The search for mediators is often the route to interventions for abused children. However, the complexity of human development requires that individual differences in experiences and reactions must be considered in such programs. Educators, social service workers, healthcare providers and policy makers should further efforts to reduce exposure of children to parental maltreatment and peer bullying as well as enhancing social support as a means to decrease adverse psychological outcomes and enhance social and academic functioning.

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BUILDING BRIDGES TO RESEARCH

What is Screening and How Does It Apply to Adverse Childhood Experiences?

By James E. McCarroll, PhD, and Joshua C. Morganstein, MD

Screening as a primary prevention approach to ACEs would involve administering a standard set of questions to everyone, regardless of their clinical presentation. It generally fails to meet the criteria established for screening in clinical practice.

In the medical field, screening is a method of detecting disease or adverse exposures associated with high risk for disease (lead poisoning in children, for example) in persons assumed to be healthy and, thereby, reduce morbidity and mortality. Screening is not diagnostic. That is done by additional tests and follow-up evaluation for those whose screening is positive. Many health conditions can be screened and preventive actions taken with the assurance that the benefit to society and the patient are substantial (see Grade A recommendations at *https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions*).

Some examples of routine screening are some cancers (coleorectal, lung, cervical), osteoporosis, abdominal aortic aneurism, and many more health-related conditions including behaviors such as alcohol misuse and tobacco.

Among the criteria for the effectiveness of a screening test are that (1) there must be an accurate screening test for the condition, and (2) evidence exists that screening can prevent adverse health outcomes (Cole, 2000), (3) that it is reasonably quick to perform, (4) it is safe and acceptable to the person being screened and to the person performing it, and (5) the statistical properties of the test (sensitivity, specificity, positive predictive value and others) are known and are acceptable (Jekel, Katz, & Elmore, 2001).

Research over decades has shown correlations between exposure to adverse childhood experiences (ACEs) and negative medical and behavioral outcomes for children and adults. A review of 35 studies found that ACEs were associated with asthma, infection, somatic complaints, sleep disruption, and delays in cognitive development (Oh, et al., 2018). Given this history, it is not surprising that many have suggested screening for ACEs in an attempt to prevent negative outcomes for children (McKelvey, Selig, & Whiteside-Mansell, 2017) and adults (Glowa, Olson, & Johnson, 2016).

Screening as a primary prevention approach to uncovering ACEs is less formal and generally fails to meet the criteria established for clinical practice. Universal screening would involve administering a standard set of questions to everyone, regardless of their clinical presentation. An example would be to use some or all of the 17 items from the Felitti, et al. (1998) study, asking these questions of all patients who come to see a provider. There are many other ways for a provider to consider how to work with individuals who have a history of ACEs, such as exposures to childhood traumas. Among these are an awareness of the correlation between ACEs and negative outcomes and sensitive history taking to determine if such an association exists.

The question of whether and how to screen for ACEs is the subject of debate. Arguments are made for and against it in terms of whether it should be performed and, if so, its effects on providers, children, adolescents, parents and patients. There are barriers to screening by providers and to methods of clinical inquiry. In a review of qualitative studies of the experiences of professionals who work with children and adolescents, many expressed discomfort in inquiring about childhood adversity (Albaek, Kinn, & Milde, 2017). Three themes were found: (1) feeling inadequate and unequipped to work with childhood adversity, (2) fear of making it worse for children due to their inability to predict consequences that may result from inquiry, and (3) facing the horrors of childhood abuse. The authors described this process as walking children through a minefield. Additional barriers are largely about provider time, lack of training and familiarity with the concepts of ACEs, and how these are related to health outcomes (Tink, Tink, Turin, & Kelly, 2017).

On the other hand, Glowa, Olson, & Johnson (2016) reported that ACE screening of adult patients by providers was feasible in that it did not interfere with the visit and, in the opinion of the provider, was acceptable to the patient. When parents of children six years or younger were asked about their perceptions of their ACEs screening, they accepted and appreciated the screening in the pediatric setting and believed it could lead to

Knowledge of ACEs can give medical and social service providers a better understanding of the relationship of trauma or other adversity to patients' health and risks of negative health and behavioral outcomes.

needed services (Conn, et al., 2017). They also viewed the screening as a motivating factor and that the provider could help them learn the necessary skills and obtain resources.

The American Academy of Pediatrics provided a document for pediatric providers to consider when addressing ACEs in their practice: Addressing Adverse Childhood Experiences and Other Types of Trauma in the Pediatric Setting (*https://www.aap.org/en-us/Documents/ttb_addressing_aces.pdf)*. This guide uses the medical home model for children and youth with special health care needs. The model provides coordinated care and a family-centered approach for children who have been exposed to ACEs. Children are identified through routine screening or surveillance. Suggestions are given on how to ask about ACEs and what to do once an exposure is found. This document provides a reasonable discussion of how to consider ACEs in a pediatric practice.

Given this brief description of screening, what can be done in addressing how to assess for ACEs? Dr. Finkelhor (2017) discusses three important issues on screening for ACEs: (1) What should be screened for? (2) What interventions should be in place for those who screen positive for a given ACE? and (3) What are the possible negative outcomes and costs of ACE screening? These should be considered prior to instituting informal screening or case finding.

Knowledge of ACEs can give medical and social service providers a better understanding of the relationship of trauma or other adversity to patients' health and risks of negative health and behavioral outcomes. However, the road to this goal is not well understood as it depends on many individual (patient and provider), family, institutional, community, and societal factors. Training of providers, costs incurred and anticipated, maintenance of the program, and dealing with unanticipated outcomes must all be considered in the implementation of programs that seek to identify and mitigate the impact of ACEs in order to improve health outcomes.

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An interview with David Finkelhor, PhD, *from page 3*

The most important thing, from my point of view, is to go back to the original insight from the ACEs, which is that we have lots of justification now to engage in primary prevention.

Dr. McCarroll: In the child maltreatment literature, people make the case that it is not necessarily the single type of maltreatment that is always harmful, but the combination of maltreatment.

Dr. Finkelhor: Poly-exposure does increase the likelihood of a negative outcome, but it depends. If you are just screening adults on that and you are not really trying to remedy the source of the problem that is one thing. But, if you are treating juveniles where the problems may be ongoing, there is a very different set of responsibilities.

One alternative to ACE screening is symptom screening. You might want to screen all adults and all children for certain types of current symptoms — depression, anxiety, substance usage — because we know these symptoms to be mediators between adversity in childhood and later health problems and they may be better predictors than the ACEs themselves. We do not know for sure that symptom screening is better than adversity screening, but it is a possibility. But, the best reason for screening for the symptoms rather than the ACEs, in my view, is that we actually have evidence-based treatments for most of these symptoms. If you are screening for post-traumatic stress symptoms or for depression or for hyperactivity or acting out behavioral problems, for drug abuse, these are all things for which we have treatments. They are also known mediators in the causal chain from ACEs to later health problems. And, to some extent they are less complicated. We know much more about how to screen for them and, to some extent, they are less complicated. A lot of medical practices already do ask about depression, and they ask about substance abuse. The question for me is not whether ACEs show who is at risk, but does it do a better job of predicting risk than some of the symptom screening measures that perhaps have clearer implications for referral and treatment? This is an important practice issue that needs to be settled. My hypothesis is that you might be able to do just as well or even be more successful by screening for symptoms alone. Screening for symptoms might be precise. Some of the stress response mechanisms may show up in biological mechanisms like cortisol levels. To the extent that we can measure those kinds of things in laboratory tests, they might be very good predictors of later health problems. They may be the exact things we want to be measuring that show whether somebody's childhood adversity is affecting them currently.

Dr. McCarroll: Who should be concerned about ACEs? Would that be anyone who deals with families and children? There is an argument for universal screening in places like schools and sports activities. Where would that go?

Dr. Finkelhor: I am increasingly nervous to take this universal adversity screening beyond the medical/public health sector. The potential for stigmatization is really pretty intense once you start doing this is other places like schools and day care. My basic point is that I just think we have to be cautious and not jump into practices without some evidence basis for them. Just the knowledge that ACEs predict outcomes does not necessarily mean that there is going to be benefit to asking everybody about it.

Dr. McCarroll: But, is it not also true that ACEs do not have to lead to a bad outcome?

Dr. Finkelhor: Many people are resilient. Although the number of ACEs is correlated with bad outcomes, the point is rarely made that you still can find people with high ACEs scores who do not seem to have any problems. That is very reassuring.

Dr. McCarroll: The topic of resilience is perhaps another facet of the ACE business. Is that something you have seen in the literature?

Dr. Finkelhor: There are people who have taken that insight and now they are trying not to just screen for ACEs, but for resilience factors as well. We should be interested in improving prediction as much as possible, and resilience factors may help prediction, but how we should use that in a clinical way is not yet clear. I am not sure that it is a solution to the ACEs screening dilemmas to say, "Oh, we are screening for ACEs, but we are also screening for resilience factors." If you do not yet know with some confidence what exactly to do with the results you get from screening because there is no kind of clear evidence-based model, then you have not changed the equation very much by just adding the resilience items as well.

I have a couple of bottom lines on this. One is that to the extent that people want to do screening, they should start with a very simple model and they should use the evidence base as guidance. We have, for example, interventions for abusive parenting. If you want to screen for parents that are using coercion and yelling to

manage their kids, you can then connect them to parent education programs that have been proven to reduce that kind of problem. That is a good place to start, it is pretty straightforward, and you can evaluate it. It is better not to throw the whole kitchen sink in at the beginning.

Another thing that can be less problematic is not to start with screening everybody, but to train the clinical staff to look for the kinds of families that might most benefit from having some additional questions asked about what is going on with them and then give them some information.

Moreover, to engage families in these programs, you don't have to necessarily screen for ACEs. It is often sufficient to appeal to people's desire to be good parents, to enjoy their children and family, to promote healthy development, and to help them overcome the frustrations they face.

The most important thing, from my point of view, is to go back to the original insight from the ACEs, which is that we have lots of justification now to engage in primary prevention. In the larger community, not just healthcare, we ought to be focusing on developing family enrichment, parenting programs, household safety programs, prenatal education, school safety programs, and anti-bullying programs, all of which are known to reduce the occurrence of these toxic childhood experiences. We are moving in that direction, and we have a lot of promising findings in this area, but there is where I would like to see us concentrate our efforts.

For example, home visitation programs have been greatly expanded over the last 20 years, and especially since the passage of the Affordable Care Act. We can build on that infrastructure to create and implement training modules that are maximally engaging for parents and convincingly effective for preventing adversities. How to manage inconsolable infants? How to select responsible caregivers? How to avoid blow-ups and domestic violence? How to prevent sibling abuse? We know a lot about the parenting skills that are protective. There are many good parenting programs. Much of the challenge is making the acquisition and deployment of these skills easy, enjoyable, and long-lasting. A similar strategy applies to the increasing use of family life specialists in primary care medical practices.

Moreover, to engage families in these programs, you don't have to necessarily screen for ACEs. It is often sufficient to appeal to people's desire to be good parents, to enjoy their children and family, to promote healthy development, and to help them overcome the frustrations they face. This is an exciting time for positive parenting, but we need to remember to use the tools of evaluation to build out our knowledge base and keep on improving.

Dr. McCarroll: Prevention rather than remediation.

Dr. Finkelhor: Not that we should abandon remediation, but I am just afraid that with the ACE screening, we are getting too far away from the original prevention orientation.

Dr. McCarroll: Looking at the ACE items and thinking about how you would prevent them is one way of thinking about it.

Dr. Finkelhor: Yes. Exactly.

Dr. McCarroll: Thanks again for your time and your thoughts.

Dr. Finkelhor: You are welcome. Good talking to you.

References

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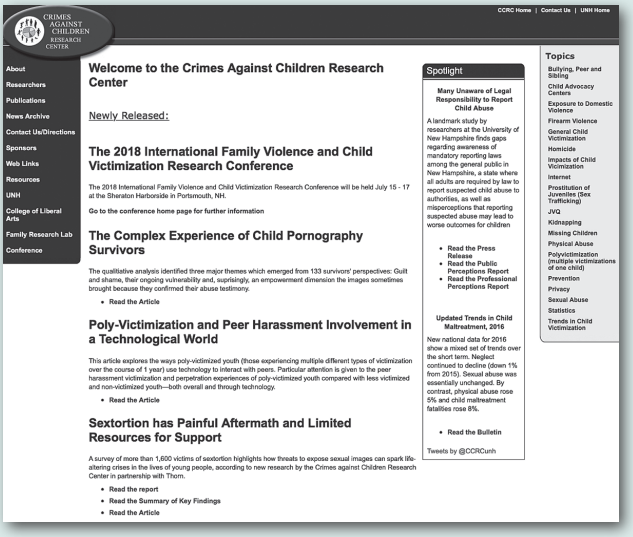
Until we know exactly what we need to do, with which kinds of families, and are confident that the services will be available, we cannot be confident that screening will be beneficial. There are no clear protocols for how to handle the referrals, or how to triage the referrals that we know will result in benefit

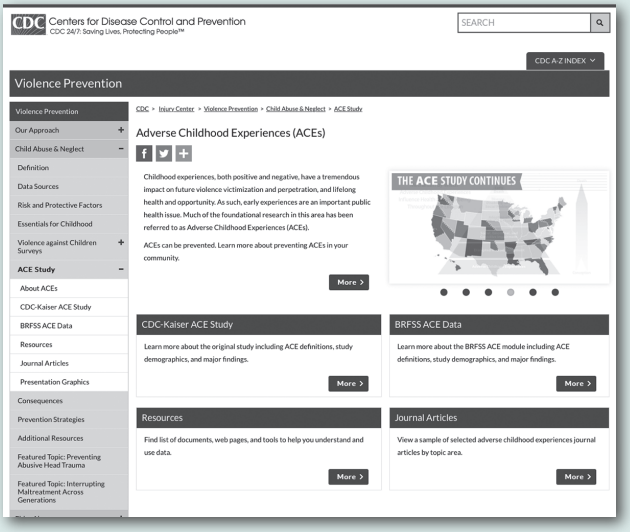
Websites of Interest

Three websites have important information about adverse childhood experiences (ACEs).



Crimes Against Children Research Center

— at the University of New Hampshire, directed by Dr. Finkelhor, has an extraordinary number of resources about children including adverse childhood experiences, bullying, technology in youth harassment victimization and many, many more. **(See: http://unh.edu/ccrc/).**



The Centers for Disease Control and Prevention (CDC)

also provides material on the nature of ACEs, prevention tips, and possible outcomes. It also provides an excellent video that can be used for educational purposes. **(See https://www.cdc.gov/violenceprevention/acestudy/index.html)**

The Substance Abuse and Mental Health Services Administration (SAMHSA)

also provides a tab for ACEs in addition to their many other programs such as suicide prevention, and other topics of trauma. Search **https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences** to find this specific information.