The origins of the adverse childhood experiences movement and child sexual abuse: a brief history

Simon Partridge

Abstract: This short history explains the advent of the now rapidly growing adverse childhood experiences movement as grounded in Dr Felitti's recognition of the link between childhood sexual abuse and obesity. It draws attention to Bowlby's prior use of the term "adverse childhood experiences" (1981), and his own struggle to recognise how significant and widespread childhood sexual abuse was in defiance of orthodox Freudian/Kleinian oedipal explanations of "infantile sexuality". It suggests that if Bowlby had lived a little longer he would not have been surprised by Felitti's discovery and would have welcomed it.

Keywords: child sexual abuse, obesity, adverse childhood experiences (ACEs), Bowlby, Felitti, ACEs Study, ACEs Score.

In his revealing final interview with Virginia Hunter (1994) in early 1990, John Bowlby honestly admits and regrets his ignorance of child abuse: "I was totally unaware of physical abuse until 1960. I was really unaware of sexual abuse until about 10 or 15 years ago" (p. 123). Had Bowlby lived a few years longer he would have been able to see that the novel Adverse Childhood Experiences (a term Bowlby was the first to coin in 1981[1]) Movement was founded on the recognition of the link between childhood sexual abuse and the tendency to obesity. I don't think he would have been surprised.

The adverse childhood experiences movement (now known in the Anglophone world as ACEs) grew from the acute observation the medical doctor Vincent Felitti made in 1985. Dr Felitti was running a highly successful obesity programme at Kaiser Permanente, a non-profit, but insurance-financed, health organisation in San Diego, California. Felitti began to notice that some of his most successful patients started to rapidly put weight back on as they approached an optimal goal. He was a frustrated but curious physician and he was determined to find out what was at the bottom of this regression. To start on this he conducted an in-depth follow-up consultation with a fifty-three-year-old woman who had debilitating diabetes connected to her weight problem, and who was gaining weight again.

He asked the usual preliminary questions one of which was: How old were you when you first became sexually active? But on this occasion he misspoke and asked, "How much did you weigh when you first became sexually active?"

"Forty pounds," said the patient. The answer stopped Felitti short and he thought he'd misheard her. Something made him repeat the question the same way.

She repeated, "I was forty pounds. It was when I was four years old, with my father." Felitti was deeply shocked by the response because in twenty-three years of medical work he had never heard of someone telling a story of sexual abuse during a check-up. When Nadine Burke Harris (see Acknowledgement) inquired of Felitti why he had never asked a patient if they had been sexually abused, he replied, "I probably never asked, I was a doctor not a therapist." Bowlby's response to Hunter to a similar "how could that be" question is instructive:

> You [Hunter was a social worker] are well alerted to these things and some of us weren't. What you are alerted to you notice, what you aren't alerted to you probably don't, especially if you have been taught not to. [Bowlby's appropriate dig at Freudian/Kleinian dismissal of environmental factors] (Hunter, 1994, p. 123)

It's doubtful being a psychotherapist at that time would have been much help to Felitti!

This case made a deep impression on Felitti, but it was possibly a one-off. A few weeks later he interviewed another woman patient who was putting on weight again after some spectacular losses. Having checked the patient for any medical abnormality which might explain the gain, emboldened by his previous experience, he asked what she thought was going on. It turned out she was sleep-walking (something she'd done in her childhood) at night to her kitchen where in the morning she'd find dirty pots and dishes and opened cans of food. Felitti pressed the matter and said, "Your sleep-eating explains the weight gain, but why are you doing it now?"

It turned out that the woman worked in a convalescent home and was looking after an older male patient who remarked how attractive she looked now she'd lost weight, and started propositioning her. The sexual connection had risen again. After further probing Felitti discovered that the woman had a lengthy history of incest with her grandfather, from age ten, when she first started to put on weight.

In these situations weight gain seemed to be a protective factor; for the patient it was a defensive solution rather than as he had assumed a "problem". It occurred to Felitti that he might have found a hidden relationship between histories of abuse and obesity. To check his speculation he started to ask in normal check-ups and interviews for his obesity programme whether potential participants had a history of childhood sexual abuse. Out of 186 patients it seemed every other person had. To confirm matters further he enlisted the help of five colleagues to screen their next twenty-eight patients for a history of abuse—the same result was confirmed, about half of a total of 286. Felitti was pretty sure he was onto something big, and he started to publicise his findings to a wider audience.

In 1990 he presented his findings to a National Obesity Conference in Atlanta, where he was roundly criticised. One member of the audience insisted the patients' stories were fabrications. A response which Bowlby had also had to battle against from orthodox analysts.

However, a significant person at the conference did believe Felitti's patients. This was an epidemiologist from the Centers for Disease Control and Prevention (CDC), the USA's federal public health authority. He was David Williamson, a senior research scientist at CDC who happened to be sitting next to Felitti at dinner that night. Williamson thought that the connection Felitti had spotted between obesity and childhood sexual abuse could be very important, but that no policy maker was going to believe a case founded on a sample of only 286—a much bigger, epidemiologically sound evidence base was needed.

In the aftermath of their meeting, Williamson introduced Felitti to Dr Robert Anda, a physician epidemiologist at CDC. From 1990 to 1992, Felitti and Anda would review the literature on the connection between abuse and obesity, and figure out the best way to create a robust study. The aim was to identify:

1. The relationship between exposure to abuse and/or household dysfunction in childhood and adult health risk behaviour (alcoholism, smoking, drug addiction, overeating), and
2. The relationship between exposure to abuse and/or household dysfunction in childhood and disease.

To do that convincingly they needed comprehensive medical evaluations and health data from a large number of adults. Fortunately a lot of such data was readily available from the medical organisation for which Felitti worked, Kaiser Permanente in San Diego. In 1994, after several months of negotiation over the research protocols between CDC and Kaiser, the go-ahead for the comprehensive "ACE study" was finally given. Between 1995 and 1997, Felitti and Anda would ask 26,000 members of Kaiser whether they would be prepared to take part—17,421 said they would, enough to convince anyone if properly conducted.

A week after the first of two visits to initiate this process, each participant was sent an ACE score questionnaire asking about childhood abuse and exposure to household dysfunction, as well as about current health risk factors, such as alcohol, smoking, and drugs.

The questions collected crucial information about what Felitti and Anda termed "adverse childhood experiences" (neither seemed aware of Bowlby's prior use of the term). The questions were empirically derived from the prevalence of adversities they had encountered in the Kaiser obesity programme. They sorted their definitions of abuse, neglect, and household dysfunction into ten specific categories:

- emotional abuse (recurrent)
- physical abuse (recurrent)
- sexual abuse (contact)
- physical neglect

- emotional neglect
- substance abuse in the household
- mental illness in the household
- mother treated violently
- divorce or parental separation
- criminal behaviour/incarceration in the household.

Each category experienced counted as one point, giving a maximum score of ten. Using the data from the medical evaluations and the questionnaires Felitti and Anda correlated the ACE scores with health risk behaviours and health outcomes, providing two broad findings:

Firstly, ACEs were very common: 67% of the San Diego sample (a largely middle-class one since Kaiser is insurance-funded) had one ACE and nearly 13% had four.

Secondly, there was a "dose-response" relationship between the number of ACEs experienced and illness/disease. For example, a person with four or more ACEs was twice as likely to develop heart disease and cancer.

In May 1998 the detailed findings of the study were published as "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults," in the *American Journal of Preventive Medicine* (Felitti et al., 1998). This has become the founding document of the ACEs movement.

Acknowledgement

This piece draws heavily on paediatrician Nadine Burke Harris's book *The Deepest Well: Healing the Long-term Effects of Childhood Adversity*. See the Book Reviews section in this issue (p. 117) for more information.

Note

1. "Thus *adverse childhood experiences* have effects of at least two kinds. First they make the individual more vulnerable to later adverse experiences. Secondly they make it more likely that he or she will meet with further such experiences. Whereas the earlier adverse experiences are likely to be wholly independent of the agency of the individual concerned, the later ones are likely to be the consequences of his or her own actions, actions that spring from those disturbances of personality to which the earlier experiences have given rise." (Bowlby, 1988, pp. 36–37, my emphasis)

References

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