



Research article

A revised inventory of Adverse Childhood Experiences

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ABSTRACT

This study examines whether the items from the original Adverse Childhood Experiences (ACE) scale can be improved in their prediction of health outcomes by adding some additional widely recognized childhood adversities. The analyses come from the National Survey of Children's Exposure to Violence 2014, a telephone survey conducted from August 2013 through April 2014 with a nationally representative sample of 1,949 children and adolescents aged 10–17 and their caregivers who were asked about adversities, physical health conditions and mental health symptoms. The addition of measures of peer victimization, peer isolation/rejection, and community violence exposure added significantly to the prediction of mental health symptoms, and the addition of a measure of low socioeconomic status (SES) added significantly to the prediction of physical health problems. A revised version of the ACES scale is proposed.

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Introduction

The Adverse Childhood Experiences (ACE) Scale has become a very popular tool among researchers and advocates concerned about long-term effects of childhood trauma. The ACE scale, which assesses early experiences like physical abuse, neglect and sexual abuse, has been found to predict negative physical health and mental health outcomes, such as heart disease (Dong, Giles, et al., 2004), liver disease (Dong, Dube, Giles, Felitti, & Anda, 2004), substance abuse (Dube et al., 2003), depression (Edwards, Holden, Felitti, & Anda, 2003) and suicide (Dube et al., 2001).

Despite its predictive ability, the scale and its component items were not formulated by any systematic process, and there is much reason to believe it could be improved. The current scale is made up of 10 items. Five of them concern aspects of child maltreatment: physical abuse, psychological abuse, sexual abuse, physical neglect and emotional neglect. Five additional items concern parental or family incapacities: parental loss through divorce, death or abandonment, parental imprisonment, parental mental illness, parental substance abuse, and violence against the mother.

However, there is strong evidence that other common childhood adversities missing from this list also have negative long term developmental effects. Among these are childhood bullying and peer victimization, isolation and peer rejection, poverty and deprivation, and exposure to community violence, as discussed below. At the same time, some of the adversities on the original ACE list may NOT be strong predictors of problems. For example, parental divorce may at one time have subjected a child to particular stigma and deprivation. The original ACE scale sample consisted of adults most of whom grew up in the 1950s and 1960s. But the negative impact of divorce has abated as it has become more widespread (Amato & Keith, 1991). Moreover, divorcing parents have learned and are instructed to pay more attention to ways to attenuate its impact on

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children, and professionals help them do so. Research on divorce suggests that the toxic element is exposure to protracted parental conflict more than divorce itself (Buehler et al., 1998; Kitzmann, Gaylord, Holt, & Kenny, 2003; Kline, Johnston, & Tschann, 1991; Vandewater & Lansford, 1998).

There is considerable evidence about the negative developmental effects of other childhood adversities not included in the original ACE scale. Children growing up in violent communities have serious mental health and behavioral problems (Gorman-Smith & Tolan, 1998) and these are independent of family factors (Linares et al., 2001). Bullying and peer victimization have been shown in longitudinal studies to have consequences on psychiatric disorder (Copeland, Wolke, Angold, & Costello, 2013), with effects in some instances exceeding those of parental maltreatment (Price-Robertson, Higgins, & Vassallo, 2013). In addition to bullying victimization, isolation and social rejection by peers may make an independent contribution to problems and later adjustment (Boivin, Hymel, & Hodges, 2001; Juvonen & Gross, 2005; Kupersmidt, Coie, & Dodge, 1990). Finally poverty has been shown to have multiple effects on child development leading to physical and mental health consequences in adulthood (Aber, Bennett, Conley, & Li, 1997; Duncan & Brooks-Gunn, 2000). Among the separate pathways from poverty to adult problems are things like poorer prenatal care, greater exposure to disease and environmental toxins, more accidents and lack of quality medical care. The uncertainty of life conditions under poverty may also lead to generalized stress dysregulation associated with later physical and mental health problems (Evans & Kim, 2007).

The hypothesis of the present study is that these additional childhood adversities add to the ability to predict health problems and distress over and above the original ACE items using the comprehensive background information available in a national sample of youth. The current analysis parallels a previous study but adds an additional dimension of physical health as an outcome to the earlier which only assessed psychological distress (Finkelhor, Shattuck, Turner, & Hamby, 2012). The present study also makes an important contribution to the ACE literature since most of that current literature is based on adult retrospective assessment of childhood adversities, some of it quite remote, as in the original ACE sample whose average age was 55–57 (Felitti et al., 1998).

Methodology

Participants

The National Survey of Children's Exposure to Violence 2014 was designed to obtain up-to-date incidence and prevalence estimates of a wide range of childhood victimizations. This particular study focuses on the 1,949 children and adolescents from the survey whose ages were 10–17 at the time of the survey (hereinafter referred to as "youth"). Interviews were conducted over the phone from August 2013 through April 2014 by the employees of an experienced survey research firm.

Sample

A nationwide sample was obtained using four sources: (1) an address-based sample (ABS) of households from which cell and residential numbers could be dialed; (2) a pre-screened sample of households with children from recent national random-digit dialed (RDD) surveys; (3) a listed landline sample (targeted on indication of a child in the household based on commercial lists); and (4) cell phone numbers drawn from a targeted RDD sample frame. This combination of sample frames was an effort to increase nationwide coverage of households including those served only by cell phone while efficiently reaching households with children to obtain the desired number of completed interviews. The details of the study are described in more detail in (Finkelhor, Turner, Shattuck, & Hamby, 2015).

Procedure

A short interview was conducted with an adult caregiver (usually a parent) to obtain family demographic information before asking to interview the youth. Information on youth health status was also obtained in the caregiver interview. Respondents were promised complete confidentiality, and were paid \$20 for their participation. Respondents who disclosed a situation of serious threat or ongoing victimization were re-contacted by a clinical member of the research team, trained in telephone crisis counseling, whose responsibility was to stay in contact with the respondent until the situation was appropriately addressed locally. All procedures were authorized by the Institutional Review Board of the University of New Hampshire.

Response Rates

The response rates varied from 67% for the ABS sample [AAPOR RR4] to 22.9% for the matched telephone numbers on file, 30.6% for the pre-screened sample, 21.7% from the listed landline sample, and 14.2% for the cell phone RDD sample. Some of these response rates are low by historical standards, but they are as good as or better than what is typical at the current time in national survey research.

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