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Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships☆

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ABSTRACT

Although Adverse Childhood Experiences (ACEs) are linked to increased health problems and risk behaviors in adulthood, there are no studies on the association between ACEs and adults' states of mind regarding their early childhood attachments, loss, and trauma experiences. To validate the ACEs questions, we analyzed the association between ACEs and emotional support indicators and Adult Attachment Interview (AAI) classifications in terms of unresolved mourning regarding past loss or trauma and discordant states of mind in cannot classify (U/CC) interviews. Seventy-five urban women (41 clinical and 34 community) completed a questionnaire on ACEs, which included 10 categories of abuse, neglect, and household dysfunction, in addition to emotional support. Internal psychological processes or states of mind concerning attachment were assessed using the AAI. ACE responses were internally consistent (Cronbach's $\alpha = .88$). In the clinical sample, 84% reported ≥ 4 ACEs compared to 27% among the community sample. AAIs judged U/CC occurred in 76% of the clinical sample compared to 9% in the community sample. When ACEs were ≥ 4, 65% of AAIs were classified U/CC. Absence of emotional support in the ACEs questionnaire was associated with 72% of AAIs being classified U/CC. As the number of ACEs and the lack of emotional support increases so too does the probability of AAIs being classified as U/CC. Findings provide rationale for including ACEs questions in pediatric screening protocols to identify and offer treatment reducing the intergenerational transmission of risk associated with problematic parenting.

Introduction

Exposure to Adverse Childhood Experiences (ACEs) including abuse, neglect, and household dysfunction is associated with multiple long-term physical and mental health problems, which include depression (Chapman et al., 2004), suicide

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(Dube et al., 2001), risk of illicit drug use, HIV and sexual risk behavior (Dube et al., 2003; Leibling, 1986; Meade, Kershaw, Hansen, & Sikkema, 2009), alcohol abuse (Dube et al., 2002), heart disease, skeletal fractures, cancer, diabetes, and overall poor health (Felitti et al., 1998). Findings from the ACE Study indicate that childhood trauma exposure was commonly reported and categories of ACEs were highly correlated with one another (Dube et al., 2003; Felitti et al., 1998). Moreover, the ACE score, which is a total count of the number of ACE categories reported, can provide a measure of cumulative stress experienced during childhood. Using the ACE score, the seminal series of ACE studies demonstrated strong and graded relationships between the total number of ACEs and physical and mental health problems across the lifespan, as summarized above.

It is plausible that the established association between ACEs and negative health outcomes in adulthood is expected among adults who have not (yet) achieved a coherent state of mind tantamount to coming to terms with one's childhood history of adversity, which may in turn affect parenting the next generation. In fact, pronounced difficulties in making sense of a history of ACEs is an outcome of internal psychological processes that are identified by the Adult Attachment Interview (AAI; Main, Goldwyn, & Hesse, 2003; Main, Hesse, & Goldwyn, 2008). Such difficulties are clear from AAI responses that refer to loss and abuse experiences in an unresolved (U) or cannot classify (CC) manner (Main et al., 2008; Steele, Steele, & Murphy, 2009).

Through probes about early loss or abuse, the AAI can elicit the psychological manifestations in the adult of not having adapted to early adversities. Specifically, with respect to interviews that include mention of past physical or sexual abuse during childhood, the failure of reality testing or a failure to monitor what is reasonable are hallmarks of unresolved responses. Interviews classified as U with regard to trauma also typically take the form of attributing responsibility for the abuse to the self (e.g., "I deserved it," or "it was my fault," or "I was bad"), or by an attempt to diminish the significance by denying (unsuccessfully) the occurrence of abuse (e.g., "It was not really abuse" and/or "It taught me a lesson").

Unresolved responses to loss are indicated by AAI narratives that include lapses in the monitoring of speech or reason evident in several ways: (a) speaking in run-on sentences with excessive attention to detail in response to a single specific query about a significant loss; (b) replacing the name of a dead loved one with the self as in "I died when I was 14 years old," without a self-monitoring correction; and (c) referring to a dead loved one as having animate living characteristics in the present, such as "she can run faster than I can" in reference to a mother who has been dead for 10 years. This pattern of speech can also be seen as a failure of reality testing (Main et al., 2003). Although psychologically understandable, and perhaps inevitable in the immediate aftermath of trauma/loss experiences, speech patterns judged U have been validated against independent psychological measures of absorption and dissociation (Hesse & van IJzendoorn, 1999).

AAIs judged CC, which often include U features, are indicated by a speaker who presents highly disparate states of mind. For example, an interviewee may be highly idealizing regarding one parent while preoccupied with anger toward the other; or devaluing and derogatory toward one parent and passive child-like and fearful regarding the other parent. Interviews that are either U and/or CC share certain patterns of thought including the failures in reality testing mentioned above, dissociation, absorption, rapid shifts in one's emotional stance, and numbing or passivity. Past work with the AAI, involving 10,000 administrations of the interview (Bakermans-Kranenburg & van IJzendoorn, 2009), reveals the utility of collapsing U and CC responses to the AAI into one group, most typical in adult respondents with a history of complex trauma. AAIs classified U/CC are also a predictor of the most troubling infant-parent relationships, in which fear and disorganization predominate (Lyons-Ruth & Jacobvitz, 2008; Steele, Steele & Fonagy, 1996; van IJzendoorn, 1995).

Attachment disorganization is the most clinically relevant form of infant-parent attachment, itself predictive of externalizing disorders in later childhood (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010), post-traumatic stress disorder in middle childhood (Macdonald et al., 2008), dissociation across the teenage years evident from peer, teacher and self-ratings (Carlson, 1998), and borderline symptoms in early adulthood (Lyons-Ruth & Jacobvitz, 2008). These troubling childhood trajectories are linked not only to AAIs judged U, but also to AAIs judged CC.

Attachment theory and maltreatment research provide some clues and strategies as to how the cycle of abuse can be broken and how survivors of childhood adversity can move toward health (Dube, Felitti, & Rishi, 2013; Egeland, Jacobvitz, & Sroufe, 1988). Coherence and security in the AAI has been linked to optimal parenting in multiple longitudinal studies (Grossmann, Grossmann, & Waters, 2005). This can typically occur through establishing new relationships with a spouse or a therapist and through achieving psychological coherence and/or balance among emotional regulation, attentional processes and history of adversity (Main et al., 2008). Persons who have experienced childhood adversity, even those with exposure to multiple types of ACEs, can move toward health through the establishment of social ties that are supportive (Dube et al., 2013). In fact among adults with one or more ACEs (adult trauma survivors), Dube et al. (2013) found that those who reported having three or more family members or friends that they could talk to about their emotional problems or feelings were less likely to report depressed affect and more likely to self-report good or excellent health. Although the current report does not include measures of emotionally supportive relationships in adulthood or current life, it does include specific questions about the availability of supportive emotional relationships during the first 18 years of life, the same time period covered by the specific questions about exposure to ACEs. In this way, the benefits of such emotionally supportive experiences during childhood may be explored in connection with the likelihood of ACEs, and the likelihood of U/CC AAI responses.