



Adverse Childhood Experiences: Survey of Resident Practice, Knowledge, and Attitude

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BACKGROUND AND OBJECTIVES: Adverse childhood experiences (ACEs) affect 20%–50% of adults and are associated with considerable adult chronic disease, unhealthy behavior, and early mortality. Physicians seldom identify this history although identification can improve health. Low screening rates are attributed to poor physician knowledge of ACEs and barriers to screening, including a lack of confidence to screen and insufficient training. Female physicians and physicians with personal ACE histories report more confidence to screen and fewer time barriers. Our aims were to identify resident screening practices, ACE knowledge, attitudes, and personal ACE histories and to determine preferred ways to learn more, if required.

METHODS: Family medicine residents were surveyed, using a previously published survey. Items included ACE screening practices, ACE knowledge, attitudes, and personal ACE histories.

RESULTS: The response rate was 97% (112/115), and 58% were female. Two percent of residents screened females and males at the first visit, thereafter residents screened women (6.3%) more than men (0.9%). One third of residents identified the correct prevalence of ACE in women and one tenth male prevalence. Unhealthy behaviors or physical chronic disease were not associated with ACE histories. Sixty-five percent of residents were not confident to screen. Twenty-nine percent of residents reported a trauma history. Eighty percent believed it was their role to screen. Formal medical training to screen was received by 45.5%; only five residents recalled training during residency.

CONCLUSIONS: Resident ACE screening rates were extremely low. Physician educational initiatives are recommended to increase confidence to screen and actual screening prior to graduation.

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sexual, and emotional abuse experiences and growing up in households witnessing parental violence and living with alcohol or substance abusing, mentally ill, or incarcerated members.^{1,3} Studying childhood abuse and household dysfunction together, collectively known as adverse childhood experiences, this sentinel paper identified that adults with ACE histories are common, one ACE category predicts another, and greater ACE histories are associated with adult mental, physical, somatic, and behavioral health difficulties.^{1,3} Enduring altered stress and reward neurobiology in the developing brain exposed to more ACEs⁶ and compensatory unhealthy behaviors have been identified as plausible mechanisms of action linking adverse childhood experiences to adult health outcomes.^{1,3} Consistent with Felitti's ACE study,¹ population-based studies in Canada,² the United States,^{4,6} and internationally^{7,8} identify that 20% to 50% of adult males and females have ACE histories. This includes physicians.^{9,10}

Alcoholism, substance abuse, depression, and suicide are far more common in those with an ACE history than those without.^{1,5,6,11} Chronic

There is a strong and graded relationship between adverse childhood experiences, often identified as ACEs, and subsequent persistent unhealthy adult

behaviors, much intractable adult chronic disease, and early death.¹⁻⁵ Felitti¹ was the first to describe the association between adult health status and childhood personal physical,

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diseases, including obstructive airways disease, ischemic heart disease, cancer, hepatitis, and medically unexplained symptoms, are related to ACEs in a dose-dependent fashion.^{1-3,5} Patients with persistent unhealthy behaviors, including smoking, particularly early age smoking, over-eating, physical inactivity, multiple sexual partners, recurrent teenage pregnancy, and frequent sexually transmitted diseases,^{1,3,5} are more likely to have ACE histories than those without these behaviors. Similarly, patients avoiding mammograms¹² and pap tests¹³ are more likely to have ACE histories.

The association between ACEs as possible root causes of much unhealthy adult behavior and physical disease is not widely recognized in the general medical literature,^{1,5,12} knowledge translation into general medical practice is limited,⁹ communication skills to identify this history are not well developed,¹² and general medical physicians seldom ask about ACE histories.^{1,9,10,12,13} Physician educational modules on ACEs have been recommended for over a decade.^{1,5,10} Patients with greater ACE histories seek care more often, health utilization is high, and quality of life is poor.^{2,5,11,12,14} Identifying this history improves health outcomes,¹⁷⁻²⁰ although physician factors,⁹ communication and office practice factors,¹² and patient factors^{13,15,16} influence disclosure. Patients seldom volunteer an ACE history but may disclose if directly asked.^{13,15,16} The presence of sensitive and informed physicians, assurance of patient safety, and physicians caring for patients in partnership increases the likelihood of disclosure for women survivors of sexual abuse.¹⁷ Upon disclosure, a range of interventions, suitable within a family physician's office, can alter health burden after years of difficulty.¹⁷⁻²⁰

A study of community family physicians screening adult patients for childhood trauma showed that screening for childhood trauma was not routine.⁹ Just over one quarter of

physicians screened females on any visit, and 12.2% screened males, although 79% felt screening was within the family physician role, and 70% believed screening was beneficial to patients.⁹ Higher screening rates were associated with knowledge of child trauma prevalence, confidence to screen, and a perceived role to screen.⁹ Most family physicians underestimated childhood trauma prevalence; 68.2% underestimated female prevalence, and 92.6% underestimated male childhood trauma prevalence. Half were not confident to screen. This study identified 33.6% of family physicians (42.4% female and 24.5% male) had trauma histories.^{9,10} Female physicians and physicians reporting any personal childhood or adult trauma were more likely to feel confident to screen^{9,10} and less likely to perceive time as a barrier to screen.^{9,10} Major screening barriers identified were not enough time to counsel (91.9%), not enough time to ask (89.9%), and competing multiple primary care recommendations (65.7%). A major barrier for almost half (45.1%) of the physicians was the belief they could do little to help patients who revealed a history of childhood physical or sexual abuse. Concerns about offending patients and discomfort asking about psychosocial issues were not barriers to screening. Family physicians were not aware of the variety of patient presentations suggesting an ACE history. Depression, anxiety, other mental health conditions combined, and addictions were the top four common conditions seen in adult primary care triggering a suspicion of childhood trauma. Somatic and chronic pain conditions were much lower. Neither unhealthy behaviors nor physical conditions were associated with childhood trauma histories. No formal training to screen was reported by 40% of physicians. Some formal training for the remaining 60% of physicians had been received in medical school (39.5%), residency (71.6%), and continuing medical education (41.6%). This study was conducted in 2007

and we questioned if family medicine residents were being better prepared to care for adult patients with ACEs. Our aim was to identify family medicine resident screening practices, ACE knowledge, attitudes, personal ACE histories, and determine preferred ways to learn more about ACEs, if gaps were identified.

Methods

Context

The University of Calgary offers a 2-year postgraduate family medicine residency program. All residents are expected to attend weekly, formal teaching days, unless they are on vacation, ill, or on distant placements.

Participants

Surveys, including an information sheet explaining the study, were distributed to all first- and second-year residents attending two mutually exclusive formal teaching days, spring and summer 2013.

Survey

The survey "Screening for Childhood Trauma in Adult Primary Care Patients"⁹ was adapted for residents, with permission. Demographics included resident gender and year of study. The first screening question identified how often residents asked about an ACE history with female patients and male patients, each differentiated between first and subsequent visits. The second screening question identified how they responded to a positive ACE history. Answer options were rarely or never, sometimes, usually, and always. Knowledge questions identified (1) common adult presenting complaints suggesting an ACE history, (2) adult female ACE prevalence, (3) adult male ACE prevalence, and (4) knowledge of someone with an ACE history outside their professional role. Four attitude items identified perceptions of the family physician role to screen, belief screening is beneficial to the patient, confidence to screen, and confidence to respond to a positive ACE history. Questions on physician role, beliefs

about screening, and confidence to screen and follow-up, enquired specifically about physical abuse in female and male patients and sexual abuse in female and male patients. Answer options for family physician role to screen and belief screening is beneficial to the patient were not at all, small extent, moderate extent, and great extent. Answer options for confidence to screen and confidence to follow up were not at all, somewhat confident, moderately confident, and very confident. Residents were asked to determine if a defined list of barriers were a major barrier, minor barrier, or not a barrier. Resident histories of personal childhood physical or sexual abuse, witness to parental violence, and intimate partner violence were identified. Answer options were never, sometimes, often, and very often. The personal ACE history question was optional. Finally, we asked about prior formal training to screen and preferred learning formats. An open-ended question was included inviting resident comments.

This study received approval from the Conjoint Health Research Ethics Board (CHREB), University of Calgary.

Data Analysis

Univariate statistics were used to describe resident gender, year of study, knowledge, and preferred methods to learn more. Conditions leading residents to consider an ACE history were categorized as per the original survey. Comments were grouped into themes. As screening rates were so low, no correlations were calculated.

In keeping with the original study,⁹ dichotomous variables were created as follows:

(1) screening behavior, “rarely or never/sometimes” versus “usually/always.”

(2) perceived role to screen, “not at all/small extent” versus “moderate/great extent.”

(3) usefulness to screen, “not at all/small extent” versus “moderate/great.”

(4) confidence “not at all/somewhat confident” versus “moderately/very confident.”

(5) barriers to screening, “major” versus “minor or no barrier.”

(6) personal ACE history and intimate partner violence, “never” versus “sometimes, often, very often.”

Results

The response rate was 97.4% (112/115), and 58% of that was female, representative of the entire cohort and gender percentage within the range of Canadian family medicine residency programs as per the College of Family Physicians of Canada. Respondent and class characteristics are presented in Table 1.

Screening Practices, Response to a Positive History, and ACE Knowledge

Two residents (1.8%) usually/always screened female and male patients on the first visit. Female patients were more likely to be screened at subsequent visits (seven residents, 6.3%) than male patients (one resident, 0.9%). The top four conditions suggesting an ACE history were depression, anxiety, other mental

health conditions combined, and somatic health presentations (Table 2). Subsequent conditions suggesting an ACE history in order, were addictions 8.0% (n=31), behavioral health - abuse and relationship difficulties 5.6% (n=22), and physical conditions 3.4% (n=13) including physical injury, obesity, chronic disease, and frequent pregnancies. Smoking, overeating, and avoidance of pap tests and mammograms were not identified as presenting complaints suggesting a history of childhood physical or sexual abuse.

Thirty-seven (33%) residents correctly identified adult female childhood trauma prevalence. Twelve (10.7%) residents correctly identified adult male childhood trauma prevalence. Almost all other respondents underestimated prevalence rates.

Attitudes: Family Physician Role, Belief Screening Is Beneficial, Confidence to Screen, and Barriers to Screening

Almost 80% of residents felt screening was within the family physician role and was of benefit to the patient to be screened. One third were moderately or very confident to screen. Slightly more were moderately or very confident to respond to a positive screen (Table 3).

Not enough time to fully evaluate or counsel victims of childhood physical abuse or sexual abuse was the top major barrier to screening, followed closely by not enough time to ask about a history of childhood physical or sexual abuse (Table 4).

Table 1: Resident Respondent and Class Characteristics

Year	Class Size	Attended Teaching Day	Surveys Returned n (%)	Female Attendees n (%)	Male Attendees n (%)	Excused Absent n (%)	All Class Response Rate
1	92	75	75 (100)	42 (56)	33 (44)	17 (18.5)	81.5
2	61	40	37 (92.5)	23 (57.5)	14 (35)	21 (34.4)	60.1
Total	153	115	112 (97.4)	65 (58.0)	47 (40.1)	38 (24.8)	73.2

Table 2: Resident Knowledge of ACEs and Management of Positive Screening

Top four conditions commonly seen in adult primary care patients for whom a history of childhood or sexual abuse might be suspected	n (%)
Depression	76 (20.0)
Anxiety	65 (17.7)
Other mental health conditions combined	108 (28.4)
Chronic pain/somatic	48 (12.6)
Knowledge of someone outside of professional role with history of childhood trauma	74 (66.1)
Usually/always respond when patients disclose they have a history of childhood physical or sexual abuse	
Suggest referral to mental health specialist	67 (59.8)
Discuss the history and reactions	63 (56.2)
Discuss medication to relieve persisting symptoms	25 (22.3)
Bring up the abuse history subsequent visits	20 (17.9)

Table 3: Attitudes: Family Physician Role to Screen, Useful to Patients to Screen, Confidence to Screen and Follow-Up

	Female, n (%)	Male, n (%)
Believe to a moderate/great extent it is part of the family physician role to screen for a history of childhood physical or sexual abuse		
Physical abuse	88 (79.5)	87 (77.7)
Sexual abuse	93 (83.0)	90 (80.4)
Believe to a moderate/great extent it is useful to the patient for the family physician to screen for a history of childhood:		
Physical abuse	93 (83.0)	89 (79.5)
Sexual abuse	95 (84.8)	90 (80.4)
Moderately or greatly confident in your ability to screen for a history		
Physical abuse	39 (34.8)	31 (27.7)
Sexual abuse	38 (33.9)	28 (25.0)
Moderately or greatly confident in ability to follow up with information collected during screening for a history of childhood:		
Physical abuse	35 (31.3)	34 (30.4)
Sexual abuse	33 (29.5)	32 (28.6)

Self-Reported Histories of Personal Childhood Trauma and Intimate Partner Violence.

Over one third of female residents (n=21, 36.2%) and one quarter of male residents (n=11, 25.6%) reported any childhood or adult trauma. Four female residents and one male resident had experienced intimate partner abuse. Physical abuse was reported by 17.8% (n=18) of residents. Fifteen (14.9%) residents witnessed parental violence. Forced sexual touching was experienced by 4.9% (n=5) of resident physicians.

Forced sexual practice was experienced by 3.0% (n=3) of residents. Thirty percent of residents with childhood or adult trauma reported two or more trauma categories (Table 5).

Prior Training and Future Learning

Over half of residents (n=61, 54.5%) reported no formal training to screen. Of those reporting formal training, only 4.5% (n=5) of residents recalled training during residency. In-person lectures and small-group

workshops were preferred methods to learn more. Specific additional training ideas were learning by doing and use of standardized patients. End of survey comments identified four themes. These were (1) interest in learning more about an important topic, (2) desire to build skills and confidence in residency, (3) identify how and when to make enquiry relevant in the doctor-patient encounter, and (4) concern about insufficient doctor-patient rapport to enquire as a medical student or early resident.

Table 4: Major Barriers to Screening

	n (%)
Not enough time to fully evaluate or counsel victims of childhood physical abuse or sexual abuse	78 (69.6)
Not enough time to ask about a history of childhood physical or sexual abuse	52 (46.4)
Competing multiple primary care recommendations	25 (22.3)
Uncomfortable inquiring about psychosocial issues	25 (22.3)
Concern about offending my patients by asking about a possible history of childhood physical or sexual abuse	25 (22.3)
Concern about taking a history of childhood physical or sexual abuse may re-traumatize a patient	18 (16.1)
There is little I can do to help those patients who have revealed a history of childhood physical or sexual abuse	15 (13.4)
The men I see as patients are unlikely to have been victims of childhood physical or sexual abuse	5 (4.5)
Difficult to verify reports of histories of childhood physical or sexual abuse	5 (4.5)
A history of childhood physical or sexual abuse is not a medical problem	4 (3.6)
The women I see as patients are unlikely to have been victims of childhood physical or sexual abuse	3 (2.7)
No reimbursement to me for screening for childhood physical or sexual abuse	3 (2.7)

Table 5: Resident Personal Childhood Trauma and Adult Trauma

Resident Gender	Surveys Returned	Preferred Not to Answer	Answered Trauma Question n (%)	Reported Any Trauma n (%)	Reported Two or More Trauma Categories n (%)
Female	65	7	58 (89.2)	21 (36.2)	7 (33.3)
Male	47	4	43 (91.5)	11 (25.6)	3 (27.3)
Total	112	11	101 (90.2)	31 (31.7)	10 (31.2)

Childhood trauma categories are Hit/Bruise, Sexual Touch, Forced Sex, Witness Parental Violence, and Feared for Safety/Intimate Partner Violence

Discussion

To our knowledge, this study is the first to examine family medicine resident practices screening adult patients for childhood adverse experiences (ACEs), knowledge of ACEs, attitudes to screening, resident personal ACE histories, and determine preferred ways to learn more about ACEs, if gaps were identified. Using a previously published family physician survey modified for residents we discuss our findings in relation to those of practicing family physicians completing the original survey.⁹

Resident screening rates were extremely low and much lower than non-routinely screening practicing physicians. Both resident and practicing physicians screened females preferentially over males. This may be due to strikingly similar resident and practicing physician ACE prevalence knowledge gaps, most underestimating prevalence. Only one third of resident physicians and practicing physicians alike were aware of female ACE prevalence. Only 10% of resident physicians and fewer practicing physicians were aware of

male ACE prevalence. This is of concern as 20%–50% of adults of both genders have ACE histories. Lack of awareness of the variety of presenting complaints suggesting an ACE history, particularly unhealthy behaviors and chronic physical disease, may in part explain low screening for both groups. Knowledge of ACE prevalence and increasing awareness of the variety of presenting complaints suggesting an ACE history will be important educational module components.

It is not surprising that practicing physician top barriers to screening are related to time. Although fewer residents identify the same top barriers to screening, that is, time to counsel (69.6% versus 91.9%) and time to ask (46.4% versus 89.9%), these barriers will require specific attention to increase screening rates. Unlike practicing physicians, nearly a quarter of residents identified both concern about offending patients and discomfort inquiring about psychosocial issues as major barriers. Effective modules will address how to screen and counsel in time efficient ways as well as acknowledge and build skills and confidence to reduce resident personal discomfort, worry about a lack of established doctor-patient relationship, and fears of offending when screening patients.

Fifty percent and 30% of practicing physicians and resident physicians, respectively, report confidence to screen although screening is much lower for practicing physicians and almost nonexistent for resident physicians. Women physicians and physicians with ACE histories are more likely to report confidence to screen and actually screen,^{9,10} and the same authors have suggested physician personal ACE experiences and subsequent counselling may be factors closing the gap between confidence to screen and actual screening. As close to 50% of practicing physicians felt there was little they could do to help patients who had disclosed a positive history modules addressing this knowledge gap, or “what now?” may be very relevant to increase actual screening. Although personal childhood trauma histories may increase confidence to screen, we have no knowledge of the 9.8% of residents and 5.1% of practicing physicians who declined to answer the personal trauma question.

Fifty percent of resident physicians and 60% of practicing physicians received formal training to screen in medical school. Of the formal training respondents, only 4.5% of residents reported formal residency training compared to 71.6%

reported by practicing physicians. The low resident formal training to screen is only partially explained by one half of first-year residents within their first 2 months in the program. In-person lectures and small-group workshops were preferred methods to learn more.

Implications

Residents seldom screen adult patients for ACE histories. Residents have similar knowledge gaps, lower confidence to screen, and lower actual screening rates than practicing physicians, indicating a need for educational modules. Physician lack of enquiry and lack of awareness of presenting complaints suggesting an ACE history leaves patient ACE history undisclosed, utilization unaddressed, and opportunities to improve health missed. Family physicians see patients with persistent unhealthy behaviors, including smoking, over-eating, alcohol and substance abuse, avoidance of mammograms, avoidance of pap tests, recurrent teenage pregnancy, and frequent sexually transmitted disease regularly. Family physicians diagnose and care for patients with mental health problems, obstructive airways disease, ischemic heart disease, cancer, hepatitis, obesity, and medically unexplained symptoms routinely. All are identified as patient presenting conditions that are more common in those with multiple ACE histories than those without. Most physicians address a behavior, like smoking, or treat a disease and are less likely to consider an underlying cause. To teach our physicians for tomorrow and help improve patient health outcomes today the development and implementation of postgraduate educational modules for physicians is due. Educational modules can build on resident and physician attitude strengths that screening for ACE histories is within the family physician role and of benefit to patients. Application in postgraduate training with skilled preceptor guidance affords protected time to

see patients, hone skills, minimize barriers, and build confidence to screen and actually screen prior to graduation. It is likely at least 25% of male residents and preceptors and more than 35% of female residents and preceptors have personal ACE histories as demonstrated in resident and family physician surveys. Modules will need to be sensitive to needs of patients, residents, and practicing family physicians with personal ACE histories, disclosed or undisclosed. Fortunately, patient-centered medical homes with access to mental health clinicians and behaviorist teams are increasing primary care capacity to help patients and family physicians care for patients with newly identified ACE histories and improve patient quality of life.

Strengths and Weaknesses

There are limitations to our study. Our results are limited to a single institution, have relatively small numbers, and rely on self-report data, which may reflect neither actual practice nor personal experience. We anticipated relating screening practices to personal trauma history, knowledge of ACEs, and confidence to screen as predicted by previous authors;^{9,10} however, screening practices were too low to allow such comparisons. Nonetheless, a strength of our study lies in our ability to adopt a previously published survey instrument and our high response rate. Future research directions include surveying family medicine residents and faculty at other medical schools as well as developing and researching effectiveness of educational modules to increase resident family physician confidence to screen and clinical practice to screen.

Conclusions

Our study confirms the need for and identifies content for resident educational modules to close practice, knowledge, and attitude gaps to increase confidence to screen and actual targeted screening prior to graduation. Modules must address

anticipated gaps in preceptor and resident practice, knowledge, and attitudes as well as be sensitive to and anticipate 25%–35% of physicians will have personal trauma histories. Increasing chronic diseases and expanding medical home team members including psychologists and behaviorists make this an ideal time to develop and introduce this educational initiative.

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