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ACE Reporter

Findings of the Adverse Childhood Experiences Study

The ACE Study is an on-going, study on the long-term effects of childhood trauma on long-term health. It is a collaborative effort by Co-principal Investigators Robert F. Anda, MD, MS of the Centers for Disease Control and Prevention, Division of Adult Health and Disease Prevention, and Vincent J. Felitti, MD of Kaiser Permanente, San Diego.

The risk of depression increases with:

- **childhood emotional abuse.**
- **growing up with someone who is mentally ill.**
- **the number of categories of abuse experienced.**

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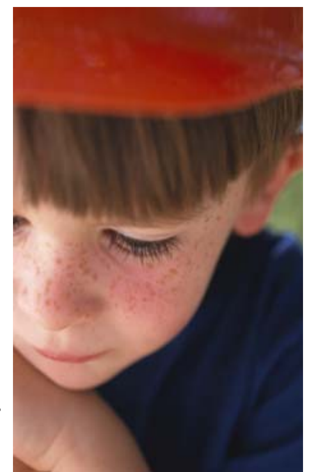
Our Next Issue: ACEs and Stress: Paying the Piper

The ACE Study: Depression and Suicide

One of the core lessons learned from the Adverse Childhood Experiences Study is that "…childhood stressors such as abuse, witnessing domestic violence, and other forms of household dysfunction are highly interrelated [1-2] and have a graded relationship to numerous health and social problems."[1-6] Depression and suicide loom large among them.

Not only does the ACE Study demonstrate a strong, graded relationship between the number of categories of ACEs and participants' lifetime history of depression, but it also demonstrates that "The likelihood of childhood/adolescent and adult suicide attempts increased as ACE Score increased. An ACE Score of at least 7 [categories, not incidents] increased the likelihood of childhood/adolescent suicide attempts 51-fold and adult suicide attempts 30-fold (P<.001)."[7]



According to the National Institutes of Mental Health, "Depressive disorders affect approximately 19 million American adults."[8] The World Health Organization illustrates the global view of depression as follows: "Depression is the leading cause of disability as measured by YLDs [Years Lived with Disabilities] and the 4th leading contributor to the global burden of disease [based on Disability Adjusted Life Years, which are the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability (DALYs)]. By the year 2020, depression is projected to reach 2nd place of the ranking of DALYs calculated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined. Depression occurs in persons of all genders, ages, and backgrounds, …is common, affecting about 121 million people worldwide,…among the leading causes of disability worldwide…[and] fewer than 25 % of those affected have access to effective treatments."[9]

Compare this information with ACE Study findings, which clearly demonstrate that the higher the participant's ACE Score, the greater the lifetime history of depression, and one might reasonably conclude that adverse childhood experiences are the underlying cause of a significant percentage of the depression reported at national and international levels. [10]

While the term "depression" encompasses a wide range of disorders, for the purposes of The ACE Study, depressed affect was determined as present if a study participant responded "yes" to the question, "Have you had two or more weeks of depressed mood in the past year?" Attempted suicide was defined as a "yes" response to the question, "Have you ever attempted to commit suicide?" [7]

Like many other common medical problems, depression does not exist in a vacuum; it is often related to other conditions. *(Continued on Page 2.)*

The ACE Study: Depression and Suicide

(Continued from Page 1)

For example, ACE Study data "strongly suggest that prevention and treatment of alcohol abuse and depression, especially among adult children of alcoholics, will depend on clinicians' inquiring about parental alcohol abuse and the long-term effects of adverse childhood experiences, with which both alcohol abuse and depression are strongly associated." [10] This necessity is not limited to the treatment of alcoholism or depression. It is equally true of issues such as obesity and closely-related diabetes, to use of tobacco and to chronic obstructive pulmonary disease, to intravenous use of street drugs and AIDS, and to behaviors such as sexual promiscuity and related conditions such as STDs and unwanted/ unplanned pregnancies[3].

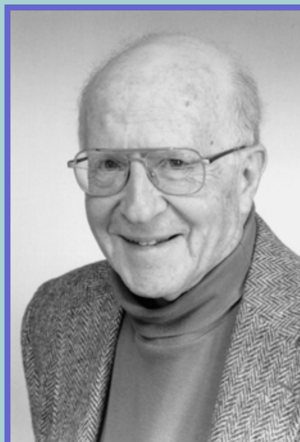
"Of all the individual ACEs, emotional abuse exhibited the strongest relationship...to depressive symptoms among both men and women…[suggesting] that emotional abuse is characteristically combined with other forms of abuse, thereby potentiating its impact. Succinctly stated, 'names do hurt' and assessment for childhood emotional abuse may provide an important benchmark for other forms of abuse and a heightened risk for depressive symptoms in childhood…Moreover, ACEs are common and account for a considerable proportion of depressive disorders—as evidenced by the estimates of the population attributable risk. Prevention of ACEs and early treatment of persons affected by them will likely substantially decrease the serious burden of depressive disorders."[11]

George Engel on the Biopsychosocial Practice of Medicine

Given the clear relationship between ACEs and disease, the ACE Study findings would certainly seem to support arguments in favor of the practice of biopsychosocial medicine, espoused by early proponent George L. Engel, MD, who in 1977 said, "The proposed biopsychosocial model provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care." [12] To effectively address any individual's health status requires evaluating one's whole state of being—biological, psychological, and social. Failure to do so results in a myopic focus on symptoms, rather than root causes, the natural outcome of which is a patient who walks away with all of the reasons he is ill still intact, regardless of how well his symptoms have been treated.

Those interested in learning more about Engel's approach to health care should read: George L. Engel, *The Need for a New Medical Model: A Challenge for Biomedicine,* Science, 196 (1977): 129-135; and George L. Engel, *The Clinical Application of the Biopsychosocial Model*, American Journal of Psychiatry, 137 (1980): 535-543.

While Engel's research might appear "dated" because of its year of publication, his message is timeless. See Page 4 for more information on Dr. Engel and his profound legacy.



George L. Engel, MD
1913—1999

***The ACE Study: Depression and Suicide* and *Engel* References**

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[7] Dube SR, Anda RF, Felitti VJ, Chapman DP, et al. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. JAMA. 2001;286:3089-3096.

[8] http://www.nimh.nih.gov/publicat/depresfact.cfm

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[11] Chapman, DP, Whitfield, CL, Felitti, VJ, et al. Adverse childhood experiences and the risk of depressive disorders in adults. Journal of Affective Disorders. 2004;82:217-225.

[12] Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977; 196:129-136. P 135.

"Wisdom begins in wonder."

Socrates (470-399 BCE)

Living in Shades of Gray

By Katherine Otto

Katherine Otto currently writes and manages grants and research for Project Open Hand/Atlanta, a non-profit organization helping people with chronic disease or disabilities overcome barriers to improved health through nutrition services. As a survivor of several adverse childhood experiences and their aftereffects, she is well acquainted with the significant ways in which emotions interact with physical health. She offers an intimate example of what it is like to live with chronic depression, and her personal discovery of its underlying causes.

I enjoy watching travel programs on PBS showing various sights, the best places to stay, the easiest way to get around. The shows provide a window on a world still out there to explore. But experiencing the world this way is less satisfying than seeing it in person, for I only get a view as small and two-dimensional as my television screen. Someone else controls what is filmed and shown. The sights and sounds are edited. I can't stop and visit longer, decide to go down another street or into a different museum or shop. The smells and ambience are missing. *I'm not living the experience; I'm outside looking at someone else living it.*

As a survivor of several traumas throughout childhood, I had felt this way as long as I could remember. Then I was diagnosed with dysthymia--chronic depression--and learned the effects those experiences had on my neurochemistry and how my brain was built.

When we are born, our hearts and other organs are fully functioning. But our brains continue development as they build innumerable connections throughout the critical period of our first few years [(1)]. When a small child experiences abuse, domestic violence, parental unavailability, and other traumas, the brain's hormones and neurotransmitters act in ways much different than they do in a child without extreme stressors[(2)]. Under repeated stress, the hormone cortisol bathes the brain in a continual cycle, upsetting the balance and/or uptake of norepinephrine and other neurotransmitters, raising blood glucose levels, changing the ability of some chemical substances to cross the blood-brain barrier, depressing brain cell activity, and much more[(3)].

Neurochemical changes are intermediary mechanisms necessary for depression to manifest. Causes for such changes, such as, trauma and stress, result from life experiences. Genetics may play a role in depression to the extent that genetic variations between individuals can modulate the intensity of depression, when it occurs. People can become depressed either in response to disease or disability (e.g. receiving the bad news that one has cancer, loss of independence due to accident or advanced age), or because of disease (e.g. cerebral iron overload resulting from the disease Hemochromatosis changing normal brain function).

It is important to recognize that people can become diseased as a result of the life events that cause depression. Traumatic life experiences can be the cause of both the disease and the depression. Disease can result from coping mechanisms used to relieve depression (e.g. smoking to enjoy the calming effects of nicotine leads to emphysema)[(4)]. Disease can also result from chronic stress, due to high levels of circulating stress hormones) [(5)]. Patients with heart disease, diabetes, and other illnesses should be screened not only for depression, but for underlying causes that could have occurred decades earlier)[(4)].

Side effects of some medications can also cause depression. And people with problems such as anxiety, eating disorders, and substance abuse often experience depression[(6)], which is likely related to life experiences that have caused their disorders, resulting in depression.

Depression comes in several forms: major depressive episodes (lasting at least 7 days), dysthymia (milder but longer lasting), postpartum depression, and bipolar disorder (cycles of mania and depression). Women are twice as likely as men to experience depression, with the increased risk commonly said to be related to hormonal changes, but with no regard to the fact that women experience higher rates of adverse life experiences. Men are more likely to mask depression with substance abuse, anger and violence, and less likely to seek treatment[(6)].

> **IT IS IMPORTANT TO RECOGNIZE THAT PEOPLE CAN BECOME DISEASED AS A RESULT OF THE LIFE EVENTS THAT CAUSE DEPRESSION.**
>
> **TRAUMATIC LIFE EXPERIENCES CAN BE THE CAUSE OF BOTH THE DISEASE AND THE DEPRESSION.**

I found my path to recovery from depression upon beginning treatment for an eating disorder. I had self-medicated my feelings with food, overeating my way to uncontrolled type II diabetes, sleep apnea, morbid obesity, asthma, and edema. I worried I was going to go blind, and I had little energy left after a day's work. In treatment, I learned that certain foods craved by the body signal the need for certain neurotransmitters which are in short supply[(7)]. Since taking a selective serotonin reuptake inhibitor, my food cravings and depression are gone. I now eat and enjoy healthy foods, and I walk daily. For the first time in my life, I don't feel deprived of the foods I am not eating. I've lost 180 pounds. I no longer feel I am outside a window, looking in at others living. For the first time, I am inside, actually living.

[1] Robert R. McCormick Tribune Foundation (1997) *Ten Things Every Child Needs* (video), WTTW, Chicago.

[2] Shonkoff, J. P. (2000) *From Neurons to Neighborhoods: The Science of Early Childhood Development.* National Research Council and Institute of Medicine, National Academy Press, Washington, D.C., pp. 212-215.

[3] http://www.fi.edu/brain/stress.htm

[4] Felitti VJ, Anda RF, Nordenberg D, et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. Am Journal Prev Med. 14:245-258

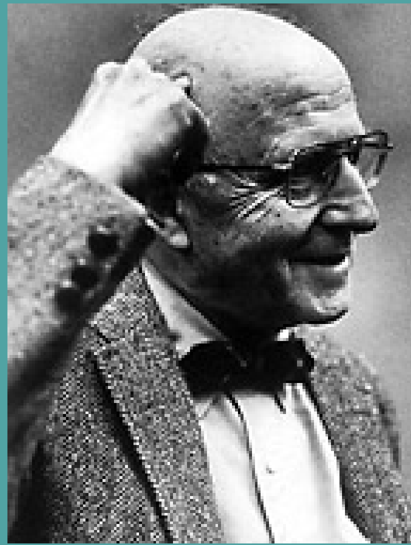
[5] Chapman, DP, Whitfield, CL, Felitti, VJ, et al. (2004) Adverse childhood experiences and the risk of depressive disorders in adults. Journal of Affective Disorders. 82:217-225.

[6] http://www.nimh.nih.gov/publicat/depression.cfm#readNow

[7] Wurtman, J. (1989) *Carbohydrate Craving, Mood Changes, and Obesity*. Journal of Clinical Psychiatry 49 (Suppl.) 37–39.

George L. Engel, MD

1913-1999



Few of us in medicine have the creativity, vision, or persuasiveness to have a transforming influence on the fundamental ways in which we think about health and illness and frame our approach to the care of patients. George Libman Engel was such a person, and our profession is poorer for his passing, which we mourn. Engel's early life experience undoubtedly influenced his professional career interests significantly. He, his parents, and his brothers grew up in the home of his uncle, Emanuel Libman (of Libman-Sacks endocarditis), distinguished pathologist and internist at Mount Sinai Hospital in New York City. A superb clinician and keen observer of patients ("he could *smell* typhoid fever on a ward"—George Engel's words), Uncle Manny, of whom Engel spoke and wrote often, surely had a profound effect on George, his twin brother Frank, and their older brother Lewis. Frank went on to become a distinguished internist/endocrinologist at Duke and Lewis a distinguished biochemist at Harvard.

George Engel attended Dartmouth College and graduated from the Johns Hopkins Medical School in 1938. He then served a 2-year rotating internship at Mount Sinai before going on to the then Peter Bent Brigham Hospital in Boston for fellowship training.

Engel's first article, published in 1935, dealt with organic phosphorous compounds in muscle. Many of his other early articles also were principally biomedical in their orientation. One suspects, however, that the early influence of Libman and Engel's own growing interest in the science of clinical observation, led him quite naturally to come under the influence in his later training years of several clinical masters and patient-centered mentors who had a broad view of human biology. Special among these were Soma Weiss and John Romano, with whom Engel worked when he was a postresidency fellow at the Brigham. Both were important to Engel's growing concern with the interaction of psychological and biological forces in health and illness.

Engel accompanied Romano when the latter was recruited to become chair of psychiatry at Cincinnati. In 1946, Romano was recruited to the chair of psychiatry at Rochester and he asked Engel to accompany him so that they could pursue together their common cross-disciplinary objectives for medical education and patient care. They chose Rochester because of the collegiality of the faculty and because they perceived it to be a school with "freely permeable" departmental barriers—as Romano put it. Both characteristics, they felt, would make the institution hospitable to their interdisciplinary way of thinking. The support of Dean Whipple, Wallace Fenn (chair of physiology), and William McCann (chair of medicine) was key to their decision to come to Rochester and their ultimate success in achieving their goals.

Rather than educating psychiatrists, they focused on the education of medical students, introducing them to what Engel later called the "biopsychosocial model," described in his seminal article in *Science* in 1977. The objective was to give students and ultimately others an appreciation of the interaction among biological, psychological/behavioral, and social forces in maintaining health and influencing the onset and course of illness. Engel also emphasized the influence of the physician himself/herself, as a person, in helping the patient remain well, and in the healing process. He also stressed to other faculty that the manner in which we treated our students would influence how they treated their patients. It took time, but ultimately belief in the validity of the model became accepted at Rochester and then widely in the United States and abroad.

Engel was increasingly given a national and international platform to talk about his ideas, as an invited speaker and visiting professor at many institutions. His more than 300 publications embraced the fields of psychosomatic medicine, internal medicine, neurology, and psychiatry, an expression of his capacity to bridge multiple disciplines. Engel has had an enormous impact worldwide on our understanding of human disease, on the education of health professionals, and on humane patient care.

Engel's leadership role in professional societies and the many awards and honors he received are too numerous to mention here, but one that he especially treasured was his selection in 1997 by the Association of American Medical Colleges for the AOA Distinguished Teacher Award.

Dr Engel died suddenly of cardiac failure on November 26, 1999, at his home in Rochester, NY. He was predeceased by his beloved wife of more than 60 years, Evelyn, who died in 1998. He is survived by his son Peter (Albany, NY), his wife Anna, and their children Julie and Eric; and by his daughter Betty (San Diego, Calif) and her husband Michael.

Jules Cohen, MD
University of Rochester School of Medicine and Dentistry
Rochester, NY
JAMA Vol. 283 No. 21, June 7, 2000
(Printed with Author's Permission)

Suicide Prevention Hotline
1.800.SUICIDE

Robert F. Anda, MD, MS Receives the Margaret Cork and APTR Awards

Rob Anda, MD, MS, was recently presented with the Association for Prevention Teaching and Research Special Recognition Award. This award "...is given periodically to an individual, agency, or organization which has provided outstanding service to the Association, its members, or to the field of prevention and public health education" [*APTR Quarterly*, Vol 53, No.3, Summer 2006].

Dr. Anda has been a Co-Principal Investigator for the Adverse Childhood Experiences (ACE) Study for 12 years and has been the lead designer of the study, led analysis of the data, and preparation of its now more than 35 peer-reviewed publications.

On October 19, 2006, in Washington, D.C., Dr. Anda was presented the Margaret Cork Award, created to honor pioneers in the field of children of alcoholics. The award was presented by the National Association for Children of Alcoholics, in recognition of scientific breakthroughs resulting from the Adverse Childhood Experiences Study.

For more information on NACoA, see: www.nacoa.net

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Authentic Voices International

Authentic Voices International is a grassroots group of adult survivors of child abuse. AVI members come from all walks of life. What we have in common is a history of childhood trauma and a present desire to put an end to child abuse and neglect. We do this by applying whatever skills and talents we have to dispel the secrecy and shame that allow child abuse to flourish.

If you would like to become part of this growing movement of advocates for a healthier, happier world for all children—and the adults we have become—then contact: Carol Redding at redding@acestudy.org to be directed to the AVI contact and programs in your area.

Daniel P. Chapman, PhD, M.Sc.

Dan Chapman is a Psychiatric Epidemiologist at the Centers for Disease Control and Prevention (CDC). After finishing graduate training in experimental psychology, Dr. Chapman completed fellowships in Psychiatry and Preventive Medicine at the University of Iowa College of Medicine. He has authored more than 30 publications, and made more than 60 presentations before scientific and medical organizations, as well as invited addresses on topics ranging from the public health implications of sleep disorders, to the use of electroconvulsive therapy in the treatment of depression in older adults.

In addition to adverse childhood experiences, Dr. Chapman's research interests include psychopharmacology, mixed anxiety and depressive disorders, and medical comorbidities* of psychiatric disorders. In his spare time, Dr. Chapman enjoys traveling, movies, exercise, and is an avid hockey fan.

* "Comorbidity" means two or more health problems exist in the same patient at the same time.

The ACE Study: Moving Forward

According to the CDC, "The ACE Study ...prospective phase is currently underway. In this ongoing stage of the study, data are being gathered from various sources including outpatient medical records, pharmacy utilization records, and hospital discharge records to track the subsequent health outcomes and health care use of ACE Study participants. In addition, an examination of National Death Index records will be conducted to establish the relationship between ACE and mortality among the ACE Study population.

Several replications of the ACE Study in different settings are also underway. In China, medical students are the subjects of an ACE investigation. In Puerto Rico, the link between women's cardiovascular health risks and ACE are under study."

http://www.cdc.gov/NCCDPHP/ACE/future.htm

In loving memory of
LARRY E. CHATHAM
1951-2004

Larry Chatham in 1984 at 658 lbs.

The ACE Study reveals that, "Obesity risk increased with number and severity of each type of abuse [experienced in childhood]...Abuse in childhood is associated with adult obesity."

Williamson DF, Thompson, TJ, Anda, RF,. Dietz, WH, Felitti VJ. Body Weight, Obesity, and Self-Reported Abuse in Childhood. International Journal of Obesity, 2002;26:1075–1082.

Photo Courtesy of Betty Davis, Kaiser Permanente

Christmas of 2003 was a surreal time in San Diego County. The October firestorms, some patches of which still burned, left a lingering pall of emotional and atmospheric darkness. While such heaviness of heart was new to many San Diegans, it was not new to Larry E. Chatham. Born December 18, 1951, into a dysfunctional family who made it clear to him that he was unwanted and unloved, Larry knew what it was to carry a heavy heart.

I met Larry only once. While working with the ACE Study, I had heard stories of him, of his battle to escape morbid obesity, of his being so big that he literally could not enter or leave his own apartment except through the double-wide window. I had heard a lot about his body, but not much about his spirit. Christmas Eve, 2003, Dr. Felitti--who had worked with Larry when he was part of Kaiser Permanente's weight loss program--asked me to locate Larry. The quest took me to his last known address, a nice apartment complex where there were neighbors who remembered Larry fondly.

One of them, Sue, related to me the story of one of Larry's suicide attempts. He had called and asked her if she still had the name and phone number of his cousin. Sue said she did; she became suspicious that Larry intended to harm himself--something he often spoke of doing. Before she could act on her suspicions, Larry called again to say, "I can't pull the trigger". Sue told him that he should just sit tight and wait for her to get there. She got the Apartment Manager to go with her to Larry's place, not because she was afraid that he would harm her, "Larry would never hurt me or anyone else," but because she is physically disabled and thought she or Larry might need someone able-bodied to assist.

Sue and the Manager arrived at Larry's apartment, where he gave the gun to Sue and his suicide letter to the Apartment Manager. That night, Larry checked himself into the hospital. He had reached the absolute depths of despair and was ready to begin the slow, painful assent into the life he really wanted--healthy, productive, happy.

Sue told me that he had reduced to 299 lbs, was very committed to achieving his goals, and that he was scheduled for knee replacement surgery. She said, "He's done all this on his own because he wants to. No one is helping him. He has plans for his future." She told me that "his cats are gone; he finally had to let go of them. They were like his kids, but they were keeping him tied to this place, when he needed to move on." When I told Sue that I was planning to visit Larry immediately after talking with her, she said, "Larry is a very negative person. You have to be ready for that."

With all of this in mind, I drove to the convalescent home where Larry was staying. I realized that--other than his size--I had no idea what he looked like. He wasn't in his room. One of the staff told me, "Larry likes to spend as much time as he can outdoors. Look out back." That's where I found him. Larry offered me his hand. From there we had a conversation that lasted about 35 minutes, during which he confirmed the information that Sue had given me. He said he'd had a hellish 13 years, that the most recent year-and-a-half had been very bad, as he grappled with his struggle to lose weight, sepsis resulting from infection of pressure sores on his bottom, and a constant administrative battle on all fronts, as people in the facilities where he stayed resisted his efforts to become increasingly active and energetic about his pursuit of a normal life. He told me that he had earned a Bachelor of Science degree in Computer Science "while sitting in a wheelchair" and that he had once worked as a mechanic. Larry spoke of his constant battle with negative thoughts about himself, doubting his own intelligence and abilities. He said food was the only comfort that he had.

"Fat people don't want to be fat. There's nothing anyone can do to change a fat person. He has to want to do that himself...It's not until the fat person takes responsibility for being fat, and forgives himself, then decides to make a change that he will recover."

Larry said, "Fat people don't want to be fat. There's nothing anyone can do to change a fat person. He has to want to do that himself...It's not until the fat person takes responsibility for being fat, and forgives himself, then decides to make a change that he will recover." Larry said that "being fat is like being in a rut. Every year you're in it, it gets deeper and deeper. When you

finally decide to crawl out of it, it's hard, and you're going to fall back into it sometimes. When that happens, you have to forgive yourself and keep moving forward." He expressed enormous guilt over being obese and told me that getting over the guilt is tremendously difficult. Larry said, "I'm a Christian, but there are some days when it's still hard. I almost killed myself four times." He also said, "I just have to believe that God has a purpose for me and believe."

That pre-Christmas day, Larry viewed himself as "Christopher Columbus sitting on the Coast of Spain or Portugal or wherever, just looking off at all that water as far as the horizon. He didn't know what was beyond it; he just knew he had to find out. So do I." It didn't take much imagination to see Christopher Columbus in the determination on Larry's face.

Larry viewed himself as "Christopher Columbus sitting on the Coast of Spain or Portugal or wherever, just looking off at all that water as far as the horizon. He didn't know what was beyond it; he just knew he had to find out. So do I."

Larry looked to me to be in pretty good physical condition. His clothes were clean. His hair and beard were clean and neatly trimmed. He was in a wheelchair but moved around a lot while we talked. He was both elated and frightened by his impending knee surgery, which was scheduled for mid-January. He had fought very hard to win the right to have that surgery. I found nothing negative about him. He was full of life, self-knowledge, and determination. He was gracious, intelligent, and it was a pleasure to be in his company. As we made our parting comments, I asked Larry to keep in touch. I looked forward to hearing from him. I drove away feeling as if I had just played a part in an odd version of Dickens' *A Christmas Carol.*

Weeks passed, and I called the contact numbers I had for Larry. I learned that he was no longer living in the convalescent home where I had visited him, and that he had had his surgery; but no one could tell me where he was. I waited to hear from him.

On June 14, 2004, I received a message from Larry's friend Judy Sheard. She said that Larry had died the day before. "He had struggled for months after his knee replacements and never fully recovered from the infections and massive trauma to his body. He knew his knee replacement surgery was his last chance for a normal life. He was scared to death, but willing to die for the chance to live normally. He was a very grumpy guy and made life hell for the nurses and therapists who took care of him after his surgery. Emily and I made him posters and visited as much as possible. It was hard to visit. He was quite impatient and demanding. I bought him a cell phone, but he quickly abused it. He was trying desperately to escape in any way possible. I suspected that he acted in the knowledge that this was his last chance and he did not have a great shot at it."

Judy said, "Larry appreciated the work that you are doing with the ACE Study and related activities. He so much wanted to 'get his story out there' and encourage other fat people to not give up. I met him 20+ years ago in the basement of the La Mesa Kaiser building in 1980. He was the life of our class; everyone loved him. He worked at Buck Knives at the time, was married, and was struggling to have as much of a normal life as possible. Shortly after, his wife left him and the temporary weight loss he achieved was gone. He weighed 657 when I met him. We stayed in touch. It was hard to visit him. We talked a lot on the phone. My daughter was born in 1990, while Larry was in the hospital with congestive heart failure. They were able to weigh him at just over 1,000 pounds. He lay on a table almost upside down because of the pressure of his weight on his heart. I brought Emily to visit him and he held her in the crook of his arm. He looked so peaceful holding her; I had so wished that he had someone to care for like her. He sewed her bibs and blankets and painted pictures of birds of paradise. Emily and I visited him in his apartment over the years. It smelled awful. She didn't seem to mind going. She somehow knew that he was very special."

Judy's message continued, "Larry remained a friend, an inspiration and guiding light to me. He had a dedicated, wonderful doctor. I'm sorry that I can't remember his name. Even on the last day--when it was evident that the infection was taking over--he still struggled to do something. to help his patient. It was decided that Larry's body was done. His doctor was so regretful that he hadn't been able to help Larry achieve his dreams. It was clear that Larry had touched him as he did the rest of us. I felt a tremendous sense of relief the second that he died--pain free at last."

As I read Judy's message, I felt an inexplicable sense of personal loss and profound sadness. Larry E. Chatham, the little boy whose own mother refused to love and nurture him, had managed to grow into a person who could inspire--even in a stranger--the will to cherish him. I do not know where the human spirit finds that kind of inner strength, but Larry had it; and it was his wish that his story be known.

Larry's story goes beyond Larry himself, beyond his important messages about "fat people", dreams, and the tenacity of human spirit. He also teaches us how important the Judys, Emilys, Sues, generous apartment managers, and caring physicians of the world are to helping us see not just the fat, but the person within. The importance of being connected to people who value us highly—and the damage that can be caused by their rejection—is clear in Dr. Felitti's recent comment, "In 1984, Larry weighed 658 lbs. Later, after his wife left him [when he had reduced to] 408 lbs, he got to 1,087 lbs."

Today, Judy says of Larry, "He was a demanding, needy, unreasonable guy. And I learned so much from him. I wish I had been a better friend. We did fight and I called him ungrateful at times. But to live as long as he did with the strength and will that he did--he attributed it to God. I believe the world can learn so much from a man like Larry, from his determination and persistence. I miss him terribly."

Carol Redding

Speaking of ACEs: Upcoming Presentations by City

City, State	Anda	Felitti	Redding	Sponsor	Contact
Chicago, IL			12/14/06	Chicago Dept Public Health	Pam Geer at 312.745.0381
Colombia, Bolivia		Early April, 2007—TBD		(pending)	(redding@acestudy.org)
Daytona Beach, FL	5/17-18/07			Florida Department of Health, Child and Adolescent Health Unit	Anne_Knox@doh.state.fl.us
Deerfield, MA	Apr or May, 2007			Franklin County and Greenfield Community College	greenk@frsu38.deerfield.ma.us
Eugene, OR	3/22-24,/07			Substance Use and Brain Development Conference	(redding@acestudy.org)
Louisville, KY	5/22-25/07 (TBD)			Div of Mental Health and Substance Abuse	Justina.Keathley@EKU.EDU
Norfolk, VA	2/9/077			Old Dominion University—TBD	(redding@acestudy.org)
Oklahoma City, OK		1/24-26/07		Oklahoma Institute for Child Advocacy	aroberts@oica.org
Portland, OR		4/17-21/07		(pending)	(redding@acestudy.org)
San Antonio, TX			4/2/07	Healthy Families San Antonio	nchicks@hfsatx.org
San Diego, CA		01/22/07		Children's Hospital	jnelson@chsd.org
San Francisco, CA	Oct, 2007 TBD	Oct, 2007 TBD		American Academy of Pediatrics	*Only members may attend.*
Santa Rosa, CA		March, 2007		Santa Rosa County Health	rmunger@sonoma-county.org
Seattle, WA		3/26-27/07		Children's Justice Program	jamt300@dshs.wa.gov
Seattle, WA		4/19 - 5/8/07		Childhaven	robinb@childhaven.org
So San Francisco, CA			2/15/07	Kaiser Permanente	Nina.Raff@kp.org
Tulsa, OK		1/24-26/07		Oklahoma Institute Child Advocacy	aroberts@oica.org

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Health Presentations is home to information about the Adverse Childhood Experiences Study, and to Authentic Voices International, adult survivors of child abuse, who are active in peer-support and child abuse prevention. Because we are a charitable organization, we rely upon your contributions to support our work, including production of *ACE Reporter* and the acestudy.org web site. If you benefit from our work, we ask that you:

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Happy Holidays from all of us volunteers at ACE Reporter

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Editor's Corner

I am happy to report that ***ACE Reporter*** is back on track! This issue focuses on Depression and Suicide. Our Spring, 2007, issue will focus on the connections between childhood trauma, stress, and damaged health. Here's how we can help you...

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To view the CDC's ACE Study web site, download ACE Study Questionnaires and Articles:	http://www.cdc.gov/NCCDPHP/ACE/
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Here's how you can help us...Donate! Even the smallest contribution means a lot to us. Because Health Presentations is 100% volunteer-operated, your tax-deductible contributions go straight into programs, not salaries. I look forward to hearing from you! Wishing you peace, *Carol*

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