research. When this research was initially proposed, a number of faculty expressed concern that it would be inappropriate to ask older women about a history of sexual abuse. However, participants were very interested in volunteering to take part in the research, reporting that it was validating to talk about their histories, including CSA. The women indicated that they had not been able to talk about the abuse earlier in their lives because it was not acceptable to discuss it.

Society has again discovered evidence for the reality and extent of CSA. We need to be careful that we do not cycle into a phase of suppression. What we teach our students is critical—in the classroom, clinic, and research lab. We support the systematic consideration of abuse and applaud Becker-Blease and Freyd (2006) for imploring psychologists to reflect on their scientific and personal reasons for not inquiring about abuse.

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It's OK to Ask About Past Abuse

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Becker-Blease and Freyd (April 2006) made a compelling case for the importance of asking about a history of child abuse. In their article, they systematically reviewed often-voiced concerns about and objections to asking questions about child maltreatment in survey research. They concluded that by failing to ask about a history of child maltreatment, an important predictor of later-life problems may be overlooked. The Adverse Childhood Experiences (ACE) study provides strong evidence of the association between early traumatic experiences and some of the major public health problems facing our nation. In fact, the experience of conducting the ACE study serves as an important case study of the acceptability of asking about childhood abuse.

The ACE study was carried out among adult members of a large metropolitan health maintenance organization (HMO) who were about to undergo a comprehensive physical examination (Felitti et al., 1998). More than 30,000 members were mailed questionnaires covering a wide range of health behaviors and conditions and that included, more crucially, detailed questions about whether they had experienced childhood abuse (physical, sexual, or emotional) or had been exposed to various forms of family dysfunction, including alcoholism, drug abuse, criminal behavior, interparental violence, and mental illness. Members were assured that their responses would be anonymous and that the information they provided would not become part of their medical record. In addition, and as required by the institutional review board responsible for the study, they were given a 24-hour hotline number to call if they experienced distress from receiving or completing the survey. However, over a 24-month period of data collection, the hotline did not receive a single call. Although we cannot conclude that the receipt of the questionnaire did not result in distress, we feel confident that the level of distress was not of sufficient severity to lead to increased mental health service use.

The overall response rate to the survey (68%) is indicative of the acceptability of asking people about their possible childhood abuse experiences. Those who reported child abuse more generally in response to a separate medical questionnaire completed as part of the physical examination were slightly more likely to be respondents to the ACE questionnaire (Edwards et al., 2001). However, the strength of the association between maltreatment and health problems in the responder and nonresponder groups was remarkably similar. In a recent review of studies published in the previous 20 years, Hardt and Rutter (2004) found that retrospective research results are more likely to underestimate rather than overestimate the prevalence of childhood abuse.

The nonresponse rates to individual questions on the ACE study questionnaire among survey respondents were also low (1.3% to 6.9%), indicating that more than 90% of survey respondents found direct, behaviorally oriented questions about their childhood history of maltreatment and household dysfunction to be acceptable. Furthermore, Dube, Williamson, Thompson, Felitti, and Anda (2004) calculated test–retest reliability on a subsample of ACE study participants who completed the ACE questionnaire at two different times approximately 1 year apart. These findings suggest that scientists can be confident that retrospective responses to questions about child maltreatment are stable over time. Cohen's kappas for individual maltreatment categories were in the good range, between .6 and .7.

Results from the ACE study have shown an association between traumatic childhood experiences and a broad range of health outcomes, including liver disease, ischemic heart disease, reproductive health, and mental illness, as well as a variety of health risks such as obesity, smoking, and alcoholism (see Felitti et al., 1998, and Edwards et al., 2005, for a summary of ACE study results). The associations that these studies showed demonstrate that researchers studying health outcomes who do *not* ask study subjects about traumatic childhood experiences are overlooking an important risk factor for many of the major health issues of our day. Moreover, we would argue that these associations illustrate the added importance of asking survey participants

about a *range* of traumatic childhood experiences, because our research has shown that multiple forms of maltreatment are commonly experienced by one individual. As we recently reported, of all participants in the ACE study who reported having had at least one type of adverse childhood experience, 59.3% reported experiencing at least one additional category of maltreatment or family dysfunction (Edwards et al., 2005). Similar results were reported by Finkelhor, Hamby, Ormrod, and Turner (2005) in a study involving a nationally representative sample of children and adolescents.

Finally, we would argue that where health matters are concerned, open and honest communication between medical practitioners and patients is paramount. Training doctors and nurses to be aware of the relationship between child maltreatment and health in adulthood may improve the practice of medicine. Because a history of adverse childhood experiences may have implications for adult patients' adherence to medical regimens, as well as for their health outcomes in general, asking patients whether they have had any such experiences may result in better health care for those who have had traumatic childhoods.

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The findings and conclusions in this comment are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

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A Public Health Perspective on "The Ethics of Asking and Not Asking About Abuse"

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Becker-Blease and Freyd's (April 2006) article provides a thought-provoking and important perspective regarding the ethics of researchers asking or not asking adults about abuse they experienced as children. Many of these authors' concerns with research on abuse during childhood apply equally to abuse and violence experienced at all life stages. Focusing on intimate partner violence (IPV), we wish to amplify upon and respond to their observations from the perspective of public health scientists involved in large-scale telephone survey research on violence (including family violence, IPV, sexual violence, and suicide; Black, Kresnow, Arias, Simon, & Shelley, 2006).

Over 25 million U.S. women have experienced IPV during their lifetime (National Center for Injury Prevention and Control [NCIPC], 2003). IPV is a significant public health problem associated with both short- and long-term negative health consequences; the yearly costs of medical and mental health care services and lost productivity as a result of IPV against women in the United States alone exceed $5.8 billion (NCIPC, 2003). Accurate prevalence estimates, measurement of time trends, and an improved understanding of risk and protective factors associated with IPV are essential to assist health officials and policy planners in designing effective prevention and intervention programs (Saltzman, Green, Marks, & Thacker, 2000). Respondent reports are the best way to estimate IPV prevalence; information retrieved directly from the respondent is likely to be more accurate and complete than information retrieved from existing records. However, as Becker-Blease and Freyd (2006) pointed out, concerns are often raised regarding the appropriateness of asking about violence victimization and whether asking such questions increases respondents' distress or risk for harm.

As Becker-Blease and Freyd (2006) described, most discussions of the ethics of self-report research on abuse and violence focus on the risks of asking participants about experiences with violence and assume participants receive no direct benefits. This focus is based on commonly held beliefs and assumptions that asking about abuse is upsetting, harmful, and stigmatizing. Further embedded in these beliefs are implicit assumptions that survivors are not emotionally stable enough to assess risk or seek help and that researchers (and others concerned with human subjects' protection) have an obligation to protect survivors from questions about their experiences.

Becker-Blease and Freyd (2006) suggested that concern about the vulnerability of abuse survivors to harm from questions about their experiences is based largely on the personal beliefs of researchers. We would add that these beliefs are not supported by the findings of studies in which adult victims of violence and abuse have been asked about reactions to such questions. As the title of Becker-Blease and Freyd's article implies, many adults with a history of sexual or physical abuse will trust researchers with the truth about their experiences as victims, if asked; indeed, respondents are grateful to know that others care about these issues. Our research supports these assertions. For example, in the NCIPC's Second Injury Control and Risk Survey (ICARIS-2), respondents were told they were free to skip any question they wished and to end the interview at any time; 0.25% of respondents chose to skip IPV-related questions. In contrast, 15.1% chose to skip the income questions (Black et al., 2006). Furthermore, very few participants reported feeling upset or fearful as a result of being asked about violence and abuse. And it should be noted that the vast majority of the few respondents who did