Asia-Pacific Chiropractic Journal

Channeling Healing Energy: Awareness of Adverse Childhood Events in the Chiropractic clinical encounter

Charles Blum and Jeffrey Blum

Narrative: Chiropractic is a low-tech hi-touch discipline. We recommend that Chiropractors approach all patients with the assumption that ACEs may be present, whether consciously or unconsciously recognised. The most challenging situations often involve patients who are unaware of their trauma and lack effective coping mechanisms. Even so, heightened sensitivity is warranted whenever patients exhibit bracing, hyper-reactivity, or disproportionate responses to seemingly benign stimuli.

Indexing terms: Chiropractic; touch; Adverse Childhood Events.

Introduction

> *... Equally important is careful attention to language, tone, and nuance, with continuous monitoring of the patient's verbal and non-verbal cues ...'*

In the late 1970s, while I was attending Chiropractic college, our curriculum included a psychology course focused on its relevance to Chiropractic clinical practice. One statement from the instructor made a lasting impression: he suggested that at least one in ten patients would likely have experienced an adverse childhood event (ACE). (1, 2) At the time, this estimate struck me as surprisingly high.

However, within my first year of practice, my clinical impressions suggested that the prevalence was closer to one in five patients. By 1990, this estimate had increased to approximately two in five, by 2000 to three in five, by 2010 to four in five, and by 2020 I had come to believe that nearly all patients have experienced some degree of ACEs. This observation aligns closely with findings by Gerber and Adger Antonikowski, who reported that 'experiencing trauma is commonplace: up to 90% of adults and 72% of children have experienced some form of lifetime trauma'. (3)

ACEs vary widely in severity and type, encompassing physical, emotional, sexual, and other forms of abuse or neglect. At this point, however, it appears unlikely that anyone escapes childhood entirely unscathed. Shah et al, in their 2025 systematic review, reported that among approximately 2,000 annual deaths related to child maltreatment, more than 40% resulted from physical abuse, with half of those children being younger than one year of age. Notably, many of these children had unidentified abusive injuries prior to the fatal event. (4)

Baca and Salsbury (5) emphasise that within Chiropractic, trauma is often understood as an acute physical injury, sometimes severe. However, trauma in a psychological context may be equally

damaging and is defined as an emotional response to a distressing event, such as abuse, assault, or neglect, that challenges an individual's sense of safety, justice, and environmental predictability.(6)

The purpose of this article is not to focus on the assessment of ACEs in children, although this remains crucial for all healthcare providers, but rather to address how ACEs exert insidious and often unrecognised effects on adult healthcare presentations and behaviours.

Adverse Childhood Events

ACEs represent a complex phenomenon, and a child's risk may be closely linked to the early child-rearing experiences of their parents, which can be transmitted across generations. 7, 8) Additionally, parents with multiple ACEs may experience post-traumatic stress disorder (PTSD) symptoms, an under-recognised mediator in the intergenerational transmission of ACEs. (9)

The '4Rs Model of Trauma-Informed Care: Realise, Recognise, Respond, and Resist Re-Traumatisation; encourages chiropractors to understand the prevalence and effects of ACEs, identify health conditions and behaviours associated with trauma, and foster safe and positive therapeutic experiences for patients. Creating and maintaining an environment of safety, trust, and transparency is a central component of trauma-informed care'. (5)

Baca and Salsbury (5) also describe a ten-question ACE survey (Table 1), adapted from AcesAware.org. A score of four or more affirmative responses is considered significantly associated with ACE exposure, with higher scores correlating to increased morbidity and reduced longevity in adulthood.

Table 1: Trauma-Informed Adverse Childhood Experiences (ACEs) Screening Tool

Item No.	ACE Category	Screening Question*
1	Neglect	During your childhood, did you ever feel that you did not have enough to eat, had to wear dirty clothes, or lacked someone to protect or care for you?
2	Parental Loss or Divorce	Did you experience the loss of a parent due to divorce, abandonment, death, or another reason?
3	Household Mental Illness	Did you live with anyone who was depressed, had a mental illness, or attempted suicide?
4	Household Substance Abuse	Did you live with anyone who had problems with alcohol or drug use, including misuse of prescription medications?
5	Domestic Violence	Did your parents or other adults in your household ever hit, punch, beat, or threaten to harm one another?
6	Household Incarceration	Did you live with anyone who was incarcerated (jail or prison)?
7	Verbal Abuse	Did a parent or adult in your household ever swear at you, insult you, or demean you?
8	Physical Abuse	Did a parent or adult in your household ever hit, beat, kick, or otherwise physically harm you?
9	Emotional Abuse	Did you feel that no one in your family loved you or believed you were special?
10	Sexual Abuse	Did you experience unwanted sexual contact, including fondling or oral, anal, or vaginal intercourse or penetration?

It is crucial for Chiropractors to recognise that many patients, at some level, may be responding to ACEs in unconscious ways. The Compassion Prison Project (10) has demonstrated that the vast majority of incarcerated individuals have experienced profound ACEs. Fritzi Hortzman's presentation, Step Inside the Circle, further illustrates how powerful it can be for individuals to become aware of the influence of ACEs on their life choices and decision-making processes. (11)

My clinical experience has led me to believe that most, if not all, patients are carrying some degree of unresolved ACE-related imprinting within their psyche and body. Beyond formal assessment tools, one particularly telling indicator is incongruity between a patient's verbal narrative and their observed behaviour. While some patients present with conscious awareness of ACE-related challenges, many remain unaware that childhood trauma may be influencing their current physical or emotional state.

For patients who are unaware of possible ACEs, it is essential that the clinician proceeds cautiously and allows the patient to guide the conversation. ACEs may involve profound disruptions to psycho-emotional development, and some trauma may be preverbal, limiting the patient's ability to articulate their experience. In such cases, the body often communicates through unconscious myofascial armouring, bracing, or guarding in response to touch.

When working with patients who may be affected by unconscious ACEs, the Chiropractor's touch must be gentle and attuned to the patient's responses. (12) Equally important is careful attention to language, tone, and nuance, with continuous monitoring of the patient's verbal and non-verbal cues. (13) Statements that appear innocuous to the clinician may inadvertently trigger distress. Rather than personalising or internalising these reactions, the clinician should remain focused on the patient, offering space for the patient to express preferences and boundaries without judgment, thereby reinforcing safety and respect.

For patients who openly acknowledge the physical and emotional effects of their ACEs, heightened sensitivity and responsiveness from the clinician are warranted. These patients can often help guide the pace and nature of care. Gentle touch, reduced adjustive force, and allowing additional time for integration of bodily changes may be essential. Some patients may wish to share memories or emotions that arise when certain areas are touched or allowed to relax; providing space for this process can facilitate the release of protective patterns that were once adaptive in childhood but are no longer necessary in a safe adult environment.

In contrast, for patients exhibiting incongruent physical and psychological presentations suggestive of unconscious ACEs, it is critical to not pressure them to acknowledge past trauma. As care progresses and safety is established, such patients may spontaneously share bodily sensations or emotional experiences. In many cases, communication occurs primarily through safe, respectful touch rather than words. Non-verbal clinician–patient communication may be sufficient, provided the clinician maintains awareness that ACEs, possibly occurring at a preverbal developmental stage, may be influencing the presentation.

When patients appear physically safe yet remain concerned about their bodily responses, carefully framed questions may be appropriate. Examples include:

- ✓ 'Many people have experienced childhood trauma that can become embedded in the body. When I touch this area, I notice increased tension. Are you aware of any emotional response when I touch your neck, back, or low back'?
- ✓ 'How long have you noticed sensitivity in this area, and do you recall a time when it felt different'?
- ✓ 'When you focus your attention on this tension or pain, does a particular feeling arise'?
- ✓ 'When I touch your neck, I feel your body bracing, as if it is feeling unsafe. Would you be willing to share what you are experiencing'?

Special care is warranted when working with regions that may be particularly sensitive for patients with trauma histories, such as the pubic bone, inguinal ligament, sternum, adductor muscles, and solar plexus. Language that seems neutral to the clinician may unexpectedly provoke reactivity. Rather than challenging or defending one's words, it is often more therapeutic to acknowledge the response and offer calm reassurance.

> We recommend that Chiropractors approach all patients with the assumption that ACEs may be present, whether consciously or unconsciously recognised. The most challenging situations often involve patients who are unaware of their trauma and lack effective coping mechanisms. Even so, heightened sensitivity is warranted whenever patients exhibit bracing, hyper-reactivity, or disproportionate responses to seemingly benign stimuli.

For some patients, simply maintaining awareness and acting with sensitivity is sufficient. For others who are open to exploring the origins of persistent tension or pain, there may be an opportunity to consider how past trauma is held within the musculoskeletal system. (14) Clinicians should also recognise that visceral and autonomic nervous system dysfunction may be associated with ACEs. (15)

An emerging subset of patients includes those presenting with benign joint hypermobility syndrome (BJHS). (16) BJHS is increasingly recognised as involving more than ligamentous laxity, with comorbidities affecting the peripheral nervous system and autonomic regulation. (17, 18) In my clinical experience, BJHS often overlaps with sensory processing sensitivity (SPS), or the 'highly sensitive person' trait. (19) Among patients with BJHS (20, 21) and SPS, (23, 24) I have frequently observed a history of ACEs. Additionally, individuals with a lifelong tendency toward vasovagal syncope may have symptoms precipitated by childhood trauma. (25) Thus, ACEs, BJHS, and SPS may represent a constellation of interrelated clinical presentations.

Patients with a conscious or unconscious history of adverse childhood experiences (ACEs) may present for Chiropractic care in a somatically guarded or protective state. As the somatic patterns used to protect or 'armour' the patient begin to relax or resolve through care, the patient may be left in an emotionally vulnerable state. In such cases, referral to a psychotherapist can be crucial in helping the patient successfully integrate these therapeutic changes. While referral to any competent therapist may be beneficial, when emotional and somatic aspects of trauma are closely interwoven, referral to a psychotherapist trained in somatic-based approaches (e.g., body psychotherapy, somato-emotional psychotherapy, eye movement desensitisation and reprocessing [EMDR]) may be a more effective option.

In general, Chiropractic care may facilitate the un-peeling of somato-emotional layers from the outside inward, whereas psychotherapy can assist in un-peeling emotional–somatic layers from the inside outward. For patients presenting with a history of ACEs, an interdisciplinary approach is important. If a patient initially responds to Chiropractic care but their somatic condition repeatedly returns, referral for psychotherapy may be indicated. Likewise, collaborative interdisciplinary relationships are valuable so that psychotherapists working with patients whose somatic presentations may be limiting therapeutic progress can consider referral for chiropractic care.

Conclusion

It is reasonable to assume that many patients have experienced some degree of ACEs during childhood. Investigating whether such experiences contribute to a patient's somatic presentation may be warranted, particularly in cases characterised by an incongruent response to Chiropractic

care, for example, when symptoms improve temporarily but recur despite appropriate ergonomic or lifestyle modifications.

Additionally, incongruent emotional responses to care may suggest unresolved trauma related to ACEs and indicate the need for a respectful referral for psychotherapy. When making such referrals, it is essential that the chiropractor does not minimise the patient's somatic discomfort or imply that the pain is imaginary.

Jeffrey D Blum
BAnthropol, MA, LPCC
Licensed Professional Counsellor
Boulder, CO

Charles L Blum
DC
Director of Research
Sacro Occipital Technique Organization - USA
Private practice of Chiropractic
Santa Monica, CA
drcblum@aol.com

Cite: Blum CL, Blum JD. Channeling Healing Energy: Awareness of Adverse Childhood Events in the Chiropractic clinical encounter. Asia-Pac Chiropr J. 2026;6.4 apcj.net/Papers-Issue-6-4/#BlumBlumACE

References

1. Pfefer M, Stephan R. Cooper SR, et al.The Role of Chiropractors in Identifying and Reporting Intentional Injuries in Children. Journal of Clinical Chiropractic Pediatrics. 2009;10(2):661-74.
2. Pfefer MT, Globe G, Terre L. The role of chiropractors in the detection of family violence: Epidemiology, training, and interdisciplinary collaboration [poster presentation; the Association of Chiropractic Colleges' Thirteenth Annual Conference, 2006]. J Chiropr Educ. 2006 Spring;20(1):104-5.
3. Gerber MR, Adger Antonikowski A. Trauma-Informed Care. JAMA. 2025 Jul 8;334(2):173-4.
4. Shah SN, Fong HF, Haney SB, et al. Has This Child Experienced Physical Abuse?: The Rational Clinical Examination Systematic Review. JAMA. 2025 Jul 8;334(2):160-70.
5. Baca KJ, Salsbury SA. Adverse childhood experiences and trauma informed care for chiropractors: a call to awareness and action. Chiropr Man Therap. 2023 Aug 14;31(1):30.
6. American Psychological Association. APA Dictionary of Psychology. 'Trauma'" https://dictionary.apa.org/ Last Accessed January 9 2025.
7. Ylitervo L, Veijola J, Anu-Helmi Halt AH. Emotional neglect and parents' adverse childhood events. Eur Psychiatry. 2023 Jun 9;66(1):e47.
8. Schickedanz A, Escarce JJ, Halfon N, et al. Intergenerational Associations between Parents' and Children's Adverse Childhood Experience Scores. Children (Basel). 2021 Aug 29;8(9):747.
9. Narayan AJ, Lieberman AF, Masten AS. Intergenerational transmission and prevention of adverse childhood experiences (ACEs). Clin Psychol Rev. 2021 Apr;85:101997.
10. 'Compassion Prison Project' https://compassionprisonproject.org/ Last Accessed January 9 2025.
11. Fritzi Hortzman. Step Inside the Circle.https://www.youtube.com/watch?v=FVxjuTkWQiE Last Accessed January 9 2025.
12. Blum C. Channeling healing energy: The power of touch in the chiropractic clinical encounter, Part three. Asia-Pac Chiropr J. 2023;3.3

13. Blum C. Channeling healing energy: The power of words in the chiropractic clinical encounter, Part two. Asia-Pac Chiropr J. 2023;3.3

14. Wickramasekera I. The High-Risk Model of Threat Perception Modulates Learning of Placebo and Nocebo Effects and Functional Somatic Disorders. Brain Sci. 2025 Sep 2;15(9):955.https://pubmed.ncbi.nlm.nih.gov/41008315/

15. Santoro G, Sideli L, Musetti A, et al. The Relationship Between Childhood Trauma and Shame: The Mediating Role of Dissociation. Eur J Investig Health Psychol Educ. 2025 Aug 7;15(8):151. https://www.mdpi.com/resolver?pii=ejihpe15080151

16. Simpson MR. Benign joint hypermobility syndrome: evaluation, diagnosis, and management. J Am Osteopath Assoc. 2006 Sep;106(9):531-6.

17. Gazit Y, Nahir AM, Grahame R, Jacob G. Dysautonomia in the joint hypermobility syndrome. Am J Med. 2003 Jul;115(1):33-40.

18. Bohora S. Joint hypermobility syndrome and dysautonomia: expanding spectrum of disease presentation and manifestation. Indian Pacing Electrophysiol J. 2010 Apr 1;10(4):158-61.

19. Blum CL. Benign joint hypermobility (BJHS) and sensory processing sensitivity syndromes (SPSS): A survey of patients over 5 years: A case report [Abstract]. Asia-Pac Chiropr J. 2022;3.1

20. Ercolani M, Galvani M, Franchini C, et al. Benign joint hypermobility syndrome: psychological features and psychopathological symptoms in a sample pain-free at evaluation1. Percept Mot Skills. 2008 Aug;107(1):246-56.

21. Smith TO, Easton V, Bacon H, et al. The relationship between benign joint hypermobility syndrome and psychological distress: a systematic review and meta-analysis. Rheumatology (Oxford). 2014 Jan;53(1):114-22.

22. Sharp HEC, Critchley HD, Eccles JA. Connecting brain and body: Transdiagnostic relevance of connective tissue variants to neuropsychiatric symptom expression. World J Psychiatry. 2021 Oct 19;11(10):805-20.

23. Wei X, Lü W. Childhood abuse and depressive symptoms in adolescents: Affective inhibitory control as a mediator and sensory processing sensitivity as a moderator. Child Abuse Negl. 2024;154:106957.

24. Buchtova M, Malinakova K, Benitan MC, et al. Sensory processing sensitivity and its associations with guilt, shame, self-esteem, and neuroticism. BMC Psychol. 2025 Oct 30;13(1):1203.

25. O'Hare C, McCrory C, O'Leary N, et al. Childhood trauma and lifetime syncope burden among older adults. J Psychosom Res. 2017 Jun;97:63-69. dDOI 10.1016/j.jpsychores.2017.03.019. https://pubmed.ncbi.nlm.nih.gov/28606501/