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ADVERSE CHILDHOOD EXPERIENCES (ACEs)

A SUMMARY OF PROMISING PRACTICES AND PROGRAM RECOMMENDATIONS

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This report is a summary of information about Adverse Childhood Experiences, what it is and how individuals and programs can modify their approaches and methods to be more responsive to their clients who have experienced trauma.

The report is intended for staff in the field, their supervisors and program directors. While we encourage everyone to read the summary, not all sections will be relevant to everyone. The following provides some guidance to selecting the sections most appropriate for your role.

The report is organized into sections, each section having a narrative portion and some call out boxes that represent the key actions or highlights discussed in that section. The first section, What do you need to know about the impact of ACES on development may be of interest to all readers.

The next two sections (Recommendations for Working with Families Impacted by trauma and Trauma Informed Care: What Can Organizations Do) are most relevant to field staff who are working directly with clients.

The section on Resources is most relevant to supervisors, managers or directors. The section on the Background of ACEs summarizes the basis for Adverse Childhood Experiences study, and is provided only for information and context.

Introduction

Increased public awareness has been focused on Adverse Childhood Experiences (ACE) and the ACE study in recent years. The ACE study has brought a new understanding about links between early adversity, mental health, physical health, and long-term consequences of childhood experiences. Talking about ACEs has helped raise awareness of child trauma across multiple disciplines, systems, and settings. These conversations about ACEs have the potential to open doors in discussions with children, families, and providers that may lead to actions to prevent childhood adversity and promote healing for those who have experienced trauma. ACE screenings may identify previously undisclosed trauma and adversity. However, rushing into action without understanding the impact of trauma or without sensitivity to developing trauma-informed systems and practices could increase rather than alleviate stress. Therefore this brief brings together resources and information from various sources to provide a context for understanding ACEs and providing best practices for trauma-informed care.

What Do You Need to Know About the Impact of ACEs on Development?

When working with families, we need to have a good understanding of the influence that development can have on children's reactions and responses to trauma or adverse childhood experiences. Preventing future childhood adversity is an important intervention, especially since victims of child maltreatment are 2 to 7 times more likely to be re-victimized compared with non-victims (Finkelhor et al., 2007). We know that a child's traumatic stress reactions vary by developmental stage, and it is important to remember that children who have been exposed to trauma use a great deal of energy responding to, coping with, and coming to terms with the adverse childhood experience. They may be trying to learn different developmental tasks but may also be thinking about what is happening at home or what has happened and worrying about whether or not they or someone they love at home will be safe. It takes a great deal of mental and emotional energy to contend with this type of stress, and children may have difficulty shifting their focus from these concerns rather than the task at hand, which could be, for example, their math test. The more they are struggling to come to terms with what happened to them, the less they can focus on just being a child and doing things that children at their age would normally do. Therefore, this can reduce their capacity to explore their environment and to master age-appropriate developmental tasks. The longer the traumatic stress goes untreated, the farther children can move away from appropriate developmental pathways. If a child is dealing with an ACE, it can have a profound impact on how they deal with other things in their world. It can affect how they see themselves and their future and how they relate to their environment and others around them.

What are the Effects of Trauma?

Traumatic events activate the body's alarm system. Typically, if the body detects something dangerous, it prepares itself to deal with that situation and then when the danger has passed, the body is supposed to be able to return to normal and get back to a calm state. Our bodies have regulating processes in place to help us calm down. However, for children who experience chronic stress or trauma, the body never gets a chance to settle down and the danger never feels like it passed, so they never get back to a more balanced and relaxed state. They have difficulty settling their bodies down. This increased arousal is a biological reaction, and it is difficult to unlearn or turn off. If the child is always on alert for danger, then they are constantly on edge and anxious. This can affect the way their bodies are developing and the way their stress hormones regulate, or their bodies don't learn that regulating process because it is never turned off. The brain development and stress hormones are impacted, which can affect their cognitive skills, language development and the way they react to challenges in the future. Some children react by withdrawing and becoming timid. Others act out with angry outbursts. They may try to cover their fear with bravado and a tough guy image, but underneath, their aggressive stance comes out of fear and attempts at self-protection.

When we experience a terrifying event, our body is equipped to respond quickly in order to protect us. If we think of this from an evolutionary standpoint it makes a lot of sense, as it has helped us survive as a species. When the tiger was chasing a human through the jungle, we

needed to be able to grab a spear and fight, run as fast as we could, or fall to the ground and pretend that we were dead. These strategies may have been very adaptive and automatic systems still operate today – the tigers just look a little different.

Fight, flight & freeze responses are normal responses to a frightening situation, including traumatic events. The response has to do with the way our brains and bodies respond to threat or danger in order to survive. In response to a threat, our brain releases a huge surge of stress hormones such as cortisol and adrenaline. Although these responses may have a survival function, continued states of stress can take a toll on our physical systems. Responses that may be adaptive in some contexts may be counterproductive and maladaptive in others, and physical and behavioral symptoms may develop as a result of traumatic stress. And this aroused and stressed state may be how children are arriving to school and responding to their environment.

Not all children respond to stress or traumatic experiences in the same way. Children's reactions to adverse experiences vary, in part because of their developmental stages when the event occurs. More information about trauma in early childhood can be found at <http://nctsn.org/trauma-types/early-childhood-trauma>.

Impact of ACEs on Parent Functioning and Parent-Child Relationships

We know that children learn about their world and how to manage their environment through their relationships with their caregivers (i.e., parents, child care providers, relatives, teachers, etc.). Children see how others react, and they learn to regulate their emotions through those reactions and their interactions with the adults in their life. Trauma and ACES can disrupt relationships and children's beliefs about relationships. We certainly would want children to believe that:

- Parents protect children
- Family members care for each other
- Community members do not hurt or endanger each other
- Systems (health, educational, judicial, etc.) help those in need.

What happens, however, when that person who is supposed to protect and look out for them can't or doesn't do that? What will the child do? Who do they now turn to? That parent/caregiver may no longer be their secure base or safe haven for support and protection. So, many of these beliefs can be shaken up when trauma is experienced. There can be a loss of their parents or caregivers as reliable protectors and a distorted view of who is safe and who is dangerous. Thus, in the face of trauma, attachment relationships can become more insecure.

Parents with a history of trauma or who are under stress may have more difficulty tuning into the needs of their children. Parent-child relationships may become strained and have more

conflict. Communication within the family may break down. ACEs in the parent's history may impact their parenting in many ways, including the following:

- Compromising parents' choices about their own and their children's safety and their ability to assess danger.
- Making it more difficult for parents to establish and maintain positive and trusting relationships.
- Impairing parents' ability to maintain control of their emotions.
- Compromising parents' self-esteem and mental health functioning.
- Undermining parents' healthy coping strategies, resulting in more risky behaviors, such as substance abuse, risky sexual behaviors, unhealthy eating, and antisocial behavior.
- Reacting strongly to reminders of trauma in ways that others may perceive as overreacting to minor challenges. Children may remind parents of traumatic events, as parents struggle with children's emotions, dependency needs, helplessness, or vulnerability that can remind them of their own childhoods.
- Disengaging or numbing as a coping style that may be perceived as being unmotivated or uncaring.
- Compromising planning and decision-making.
- Making parent more vulnerable to other stressors and life challenges.

Additional information about birth parents reactions may be found at

http://nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf

HOW CAN YOU PROMOTE RESILIENCE?

- Supporting families to develop positive relationships;
- Encouraging peer support and building natural social networks;
- Building perceptions of competence and nurturing talents and skills;
- Helping children and families see themselves positively and encouraging positive self-esteem;
- Offering choices and building ways in which they can feel successful and competent;
- Connecting families with faith communities, schools, and other places where they can feel connected and a sense of belonging and community;
- Supporting individuals to find causes outside of themselves in which they can find meaning and value.

Protective Factors and Resilience

ACEs and other traumas in childhood, however, do not dictate the future of the child. Some children survive and even thrive despite the trauma in their lives. For these children, adverse experiences are offset by protective and promotive factors that support them. Adverse events and protective factors experienced together have the potential to foster resilience. Our knowledge about what contributes to resilience in children is evolving, but we know that several factors are positively related to such protection, including cognitive capacity, healthy attachment relationships, the motivation and ability to learn and engage with the environment, the ability to regulate emotions and behavior, and supportive environmental systems, including education, cultural beliefs, and faith-based communities.

Recommendations for Working with Families Impacted by Trauma

Home Visitors Role

As home visitors, we can be in a unique position to support families and help them respond to traumatic events and responses they may be experiencing. There are ways to show care and concern for the family and provide some information and education around trauma and the effects it can have on individuals, which can certainly help families cope more effectively. A sense of safety is critical for functioning as well as physical and emotional growth. This sense of safety is compromised when one experiences an adverse event; however, responding in a kind, compassionate and empathic way allows the family to begin to understand, manage and tolerate what they are feeling. Creating an environment where they feel safe to express themselves and showing that we accept them as they are can be especially important in helping families heal from their traumatic experiences.

Parents and guardians must be nurtured and supported so they, in turn, can foster safety and well-being. Parents and relatives serving as resource families may themselves be dealing with trauma related to a crisis situation. We want, therefore, to be able to assist parents and caregivers who have traumatic experiences of their own. One way to do this is to identify and build on parent and caregiver protective factors. We can also try to define what has happened to them and normalize and respect their experience. As a supportive person in their life, home visitors can work hard to:

- Integrate cultural practices and culturally responsive services,
- Understand the effects of trauma so that we can educate our families, and
- Recognize that children’s “bad” behavior is sometimes an adaptation to trauma.

These are all factors that home visitors can provide for their families!

The Substance Abuse and Mental Health Services Administration (SAMHSA) principles for trauma-informed care are:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Sensitivity to Cultural, Historical, and Gender Issues

INCREASE RESILIENCE IN CLIENTS

- A strong relationship with at least one competent, caring adult (a good listener!)
- Feeling connected to a positive role model/mentor
- Having talents/abilities nurtured and appreciated
- Feeling some control over one’s own life
- Having a sense of belonging to a community, group, or cause larger than oneself.

What can we do as a Service Provider?	
Assessment:	<ul style="list-style-type: none"> • Ask “What happened to this person?” not “What’s wrong with him/her?” • Assess family histories to inform current functioning and parenting. • Behaviors may stem from past traumatic events and interactions • Be aware and understand the cumulative effect of trauma on families • Be mindful of systems interactions that may be trauma reminders or pose additional stress.
Approach:	<ul style="list-style-type: none"> • Integrate culturally-sensitive practices and responsive services. • Achieve trust through listening, validating and encouragement. • Create emotional and physical safety. • Use a non-judgmental manner that minimizes blame and criticism.
Methods:	<ul style="list-style-type: none"> • Be honest and clear about our services. • Avoid making professional promises. • Build on parents’ desires to do their best for their children. • Help parents better understand the impact of their past experiences. • Recognize that “bad” behavior is sometimes an adaptation of the trauma. • Use opportunities for parents and children to use their strengths and develop skills. • Create opportunities for families to have choices and engage in active planning.
Program:	<ul style="list-style-type: none"> • Ask whether or not our program is a good fit for this family. • Promote trauma screening. • Be informed about available evidence-supported trauma interventions.

Secondary Traumatic Stress (STS) for Staff

Working with individuals who have experienced trauma can be stressful for staff members. Hearing stories about terrifying experiences and seeing the impact that stress can have on children and families can take a toll on those who are trying to help. Awareness of the potential for compassion fatigue, secondary traumatic stress, vicarious traumatization, and burnout can improve health and wellness for helping professionals. Secondary traumatic stress is the distress that can occur when someone hears about another person’s traumatic experiences. At the individual level, staff members can experience symptoms similar to those associated with posttraumatic stress disorder (PTSD), such as experiencing images or memories that come into their minds when they don’t want them to, feeling tense or on edge, becoming irritable, having difficulty sleeping, avoiding clients or reminders of their stories, feeling numb or detached, overreacting to minor challenges, or becoming overly sensitive to danger. If you are experiencing these symptoms, it can be difficult for you to continue to provide high-quality

care to the people you serve. Sometimes people reach such a level of emotional exhaustion and discouragement that they leave the field altogether, or experience burnout (although the term “burnout” can be more generally applied to work-related stress that is not necessarily related to vicarious trauma). Organizations can also be impacted by secondary traumatic stress, as evidenced by communication systems breaking down, decreases in morale, becoming reactive or avoidant in dealing with challenges, encouraging staff not to express emotions, increasing rates of staff turnover, and reducing quality of care for children and families.

The first step in addressing STS is identifying the signs and signals that compassion fatigue is occurring. There are many strategies for identifying STS, including both informal self-assessments and formal assessments with questionnaires or organizational evaluations. Supervision approaches, especially a reflective supervision model, can bring attention to staff members’ reactions to the emotional challenges of engaging with clients who have experienced ACES and other traumatic experiences. Reflective supervision is a relationship-based form of supervision that addresses that impact of the work on the provider. Through a supportive supervisory approach, responses to staff members’ stress levels and to promoting positive staff-client interactions can be facilitated and the needs of all participants can be addressed.

Proactively, individual and organizational approaches can be adopted that prevent STS. Through a combination of training, awareness, wellness practices, organizational procedures, screening, and support services, stress can be reduced and compassion satisfaction can be enhanced. Prevention strategies at the individual level can include attention to getting adequate rest, exercise, nutrition, and balance of personal and professional activities, as well as participating in yoga, meditation, mindfulness, sports, or other stress-reduction or self-care activities. At an organizational level, prevention practices can include reflective supervision, reasonable caseloads and job responsibilities, flextime scheduling, sensitive personal and family leave policies, self-care strategies in the workplace, space and time allocations for wellness activities, safe and secure environments, preservation of off-work time, and positive communication practices.

When STS is identified, organizational intervention approaches should be in place to support affected staff members. Intervention can include supports through Employee Assistance Programs or connections with therapists who can assist with mindfulness-based or cognitive-behavioral treatment methods. Additional strategies, such as peer or group supports, reflective supervision, additional training, workload expectation modifications, or organizational consultation may reduce the impact of STS on the staff member and the overall workforce.

Tips for Self-Care:

Notice the Signs:

- Increased irritability or impatience
- Difficulty concentrating or planning
- Intense feelings and intrusive thoughts about clients' traumas that continue over time
- Nightmares about clients' experiences or sleeplessness
- Denying that childhood experiences can impact families, minimizing, or feeling numb or detached
- Hopelessness
- Being on edge, fearful, and on alert for danger
- Avoidance of clients or inability to listen to their stories
- Anger and pessimism
- Chronic fatigue
- Guilt
- Physical complaints (e.g., headaches, stomachaches) and susceptibility to illness

- **Get support from others.** You don't have to go it alone. Everyone needs a support system. Identify resources through supervisors, peers, teammates, and others in your organization. Individual or group supervision is essential to training and professional development. Reflective supervision may be especially helpful in managing STS.
- **Recognize that compassion fatigue is an occupational hazard.** You may have gotten into the field because of your compassion, empathy, and caring heart. Compassion fatigue can be a cost of caring. Make sure you balance what you give to others with maintaining care for yourself. Practice relaxing. Find meaning in the work you do.
- **Promote resilience.** Look for positive experiences and notice what is working well. Notice the strengths and positive attributes of other people and of yourself. Foster positive relationships and effective communication. Practice positive self-talk and complimenting others. Show kindness. End each day with acknowledging at least three good things that have happened during the day.

SELF-CARE

- Get Support
- Recognize that compassion fatigue is an occupational hazard
- Promote Resilience
- Seek help with your own history of ACEs
- Attend to consistent self-care
- Seek balance
- If you see warning signs, seek help

- **Seek help with your own history of ACEs.** Given the frequency of ACEs, you may have your own experiences that impact your work. Adults with unresolved traumatic experiences are at greater risk for STS. Find supports that can help you address issues that may be impacting you.
- **Attend to consistent self-care.** Find what strategies are most helpful in reducing your stress. Lead by example. The recommendations you give to your clients about rest, exercise, and proper nutrition apply to you too. Although there may be a temptation to neglect taking a break or relaxing when your workload is high, finding time for relaxation will make you more productive and prevent burnout.
- **Seek balance.** The more exposure to traumatic material you face, the more likely you are to experience STS. Work within your organization to divide responsibilities and try to have an optimal caseload and varied tasks so that you manage exposure. Establish routines that allow you to meet work expectations and have time to yourself to relax and attend to personal needs.
- **If you see warning signs, seek help.** If you see warning signs of compassion fatigue, don't wait until the problems are large before taking action. If problems continue for more than a couple weeks, seek professional counseling with a professional who has experience in trauma.

Trauma-Informed Care: What Can Organizations Do?

Many organizations are now using the term “trauma-informed care” to describe approaches that infuse sensitivity to people’s experiences with traumatic events into agency policies and practices and ways of interacting with clients and staff members. Trauma-informed care is not a specific model of intervention, but is a way of being that permeates client and staff interactions with an understanding of the impact of trauma and compassion for people’s responses and needs. According to excerpts from the Administration for Children and Families (ACF) *Resource Guide to Trauma-Informed Human Services* at https://www.acf.hhs.gov/trauma-toolkit?utm_source=blog&utm_medium=blog#chapter-6, here is some information about Trauma-Informed Care:

What do we mean by trauma-informed services and why is such an approach important?

The practice of trauma informed service is less about “what” you’re doing, and more about “how” you’re doing it. It requires being mindful of ways in which your interactions with clients might unintentionally make them feel unsafe, either physically or emotionally.

According to [SAMHSA’s concept of a trauma-informed approach](#), a program, organization, or system that is trauma-informed:

- *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively prevent *re-traumatization*.

The SAMHSA-funded [National Technical Assistance Center for Children’s Mental Health](#) has put together a [series of videos](#) by practitioners and state administrators that describe what trauma-informed means as an organizational approach, particularly in agencies that serve children and families. Being trauma-informed is described by the director of an agency as:

Taking the principles about being sensitive to someone’s background and history and weaving those principles into everything you do organizationally. Not just a set-aside training program, but to really see it at the culture level, that it is worked into everything you do [in an organization] from the policies and procedures to the practice and training; how you recruit, how you promote. Trauma-informed care sensitizes us.

Additional Resources:

- This **National Center on Domestic Violence, Trauma & Mental Health** guidance on [Action Steps to support emotional safety](#) may be useful to many programs interested in strengthening and deepening an existing trauma-informed practice.
- The **National Child Traumatic Stress Network** has developed [resources](#) on building partnerships between your organization and the families and youth served. They believe such partnerships are essential in order to maximize youths’ opportunities for choice and control, a key element of overcoming trauma.
- The **National Center for Families and Youth** features a [short slide show](#) on five collaborations to ensure trauma-informed services for youth and families.”

For organizations that want to examine their approaches and ensure sensitivity to trauma within their agency, the same website provides the following information:

“My agency has decided it wants to be more trauma-informed. Where do I start?”

A trauma-informed approach involves being aware of how clients who are affected by traumatic experiences may perceive and respond to your organization’s practices and services. Because implementing these approaches in some cases may involve considerable change in practice, for it to be successful leadership must commit to the change and actively engage in the process. Many organizations that have undertaken trauma-informed approaches have engaged in self-study that could involve [self-assessment](#) and/or small workgroups or task forces.

Trauma-informed practices [articulated](#) by the National Technical Assistance Center for Children’s Mental Health include:

- Creating safe, supportive, welcoming, and respectful environments
- Educating all staff about the impact of trauma—particularly those that provide direct care or are support staff
- Training any clinical staff in trauma-specific interventions
- Awareness by all staff about their own cultural attitudes and beliefs and education about culturally relevant approaches
- Training for all staff in avoiding re-traumatization

Additional Resources:

- ACF has produced [this presentation on five collaborations to ensure trauma-informed care for youth and families](#). Some youth who have gone through traumatic experiences have a range of needs that may be best served by a group of service providers working in tandem. When each organization of the partnership comes into contact with youth, that's one more chance to assess the youth's experience with trauma and to help them heal and build resilience.
- [Trauma-Informed Care: Perspectives and Resources](#). This is a free online tool created by the National Technical Assistance Center for Children's Mental Health and partners. It includes many resources, actions, and lessons learned from entities that have become trauma-informed, and is intended to support leaders and decision makers at all levels (national, state, tribal, territorial, and local) in taking steps on their journey.
- The **National Center on Family Homelessness** has produced a [Trauma-Informed Organizational Toolkit](#). The toolkit's *Agency Self-Assessment for Readiness for Trauma-Informed Approaches* which may provide a good starting place to gauge your agency's existing strengths for trauma-informed work, as well as identify additional training or plans you may need to get started. Although designed for agencies serving families experiencing homelessness, the agency self-assessment tool is applicable to other community organizations as well.
- The **National Clearinghouse on Families and Youth** offers a [free online course on trauma exposure in youth](#), which staff can take to learn more about how trauma affects youth and how to interact with youth to mitigate the effects of traumatic exposures.
- The **National Center on Domestic Violence, Trauma and Mental Health** has developed a [practice tip sheet on how to manage communication problems between clients and staff caused by clients' experiences of trauma](#). This tip sheet may be useful to share with front-line staff. Although originally developed for domestic violence services providers, the tips are applicable to work with youth who have been traumatized as a result of experiences in the home or on the street.

How do trauma-informed services differ from what I'm already doing?

[SAMHSA](#) has developed [six principles](#) that are meant to be generalized across multiple types of settings, which your organization can use to determine whether your approach is trauma-informed:

1. **Safety** - throughout an organization, the staff and people they serve feel physically and psychologically safe; the physical setting must be safe and interactions should promote a sense of safety.
2. **Trustworthiness and Transparency** - Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, families and staff.
3. **Peer Support** - Other individuals who have experienced trauma can serve as key partners in recovery from trauma.
4. **Collaboration and Mutuality** - Partnering and leveling of power differences between staff and clients and among staff.
5. **Empowerment, Voice and Choice** - Individual strengths are recognized, built on, and validated and new skills are developed as needed.
6. **Cultural, Historical, and Gender Issues** - the organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; there is a responsiveness to gender and consideration for historical trauma.

SIX PRINCIPLES OF TRAUMA-INFORMED CARE

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice and Choice
- Cultural, Historical, and Gender Issues

What are the key issues in making sure my agency does not re-traumatize our clients?

Public human services agencies are charged with providing services and supports to individuals, children and families. However, for some clients who have experienced trauma, certain approaches, particularly aggressive or confrontational methods, may cause additional harm. A number of coercive practices that were once common but are no longer widely used have been of particular concern. These include [seclusion and restraints](#) or other harsh disciplinary practices in the behavioral health or school system, or intimidating practices used in the criminal justice system. Where they continue to exist, these and similar policies, practices, and procedures can severely undermine efforts to achieve desired outcomes for clients in service systems.

In the past, human service agencies were not as focused on how to understand the impact of traumatic experiences on client functioning and mitigate the re-traumatizing effect of our service systems. In recent years, a range of human service providing agencies in different sectors have focused on how to [help] clients work through their reactions to traumatic events and reduce the chances of exacerbating existing problems through re-traumatization. The population-specific resource lists offer resources and suggestions that may be appropriate to the clients your organization or agency serves. A useful starting point is this [article providing tips for service providers on ways to avoid re-traumatizing clients](#), prepared by a Canadian organization focusing on homelessness. Also the Department of Justice's [Office on Victims of Crime has developed a module](#) which, while focused on trafficking issues, includes good [tips] on how to avoid re-traumatization.

What does my agency's physical space have to do with being trauma-informed?

The physical environment of your organization communicates your beliefs about the people you serve. It is important that your organization's physical setting be perceived as safe and welcoming and interpersonal interactions with staff and other clients promote a sense of safety. Your physical space sets the tone for your interactions with clients. For clients who have experienced trauma, reactions to perceived insecurity may be heightened and could inadvertently sabotage the ability of staff to engage families.

Additional Resources:

- A good general [resource](#) was created by the [National Center on Domestic Violence, Trauma, & Mental Health](#). This tip sheet provides guidance on how to arrange a physical environment to accommodate a wide range of feelings, interactions, and behaviors. Specific tips include:
- Communicating that a broad range of people are wanted and welcome in your programs
- Arranging for quiet spaces or places where people can move around more
- Reducing noise and clutter that can be unsettling
- Areas stocked with art supplies for people who want to express themselves in other ways
- While this [resource paper](#) was designed for health care audiences, the section on creating a safe environment has straightforward suggestions for making sure both your physical space and the social and emotional environment of your agency feel non-threatening to clients with trauma histories."

Summary Key Points

Adverse Childhood Experiences (ACEs), including child abuse and neglect as well as household dysfunction in the first 18 years of life, have been linked with a wide range of long-term consequences in mental and physical health and social dysfunction. These ACEs are prevalent, and as the number of ACEs increases, risks of poor outcomes increase. However, recognition of the importance of early childhood experiences and addressing the impact of trauma provides many opportunities. ACEs are the most preventable causes of serious mental illness, substance abuse, and high-risk sexual behavior and significant contributors to leading causes of death (including cardiovascular disease, diabetes, cancer, and suicide). Therefore, addressing ACEs not only can reduce suffering in children and families, but also reduce long-term economic and societal costs and break the cycle of childhood adversity that too often is repeated across generations. Fortunately, proven prevention and therapeutic interventions for trauma already exist, and we can link children and parents to effective trauma screening, assessment, and treatments that have been shown to reduce symptoms and improve outcomes. Home visitation can be a cost-effective strategy for supporting families and promoting health. Promoting positive relationships can offset the impact of negative experiences. Those who work with families can improve their skills at recognizing the impact of childhood adversity and providing high-quality trauma-informed care.

Resources

ACE resources

There are numerous websites that provide summaries and resources related to the ACE studies. Below is a list of a sampling of resources from national organizations:

- CDC: <https://www.cdc.gov/violenceprevention/acestudy/index.html>
- ACE Study: <http://acestudy.org/the-ace-score.html>
- SAMHSA: <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences>
- Administration on Children and Families <https://www.acf.hhs.gov/trauma-toolkit#chapter-4>
- NPR: <http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean>
- Child Trends: http://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf
- Robert Wood Johnson: <http://www.rwjf.org/en/library/collections/aces.html>
- American Academy of Pediatrics: https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf
- World Health Organization: http://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/
- Kid Central: <https://kidcentraltn.com/article/adverse-childhood-experiences-aces-protecting-your-child-and-building-resiliency>
- Center for the Developing Child, Harvard: <http://developingchild.harvard.edu/resources/inbrief-the-impact-of-early-adversity-on-childrens-development/>
- <http://developingchild.harvard.edu/wp-content/uploads/2010/05/Foundations-of-Lifelong-Health.pdf>
- TED Talk: http://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_a_cross_a_lifetime

- <https://acestoohigh.com/got-your-ace-score/>

Resources for identifying and addressing secondary traumatic stress include the following:

National Child Traumatic Stress Network tipsheets: <http://nctsn.org/products/secondary-traumatic-stress-fact-sheet-child-serving-professionals%20>, <http://nctsn.org/products/self-care-educators-dealing-secondary-traumatic-stress>, <http://nctsn.org/products/secondary-traumatic-stress-fact-sheet-community-violence-workers%20>

Child Welfare League of America: <http://www.cwla.org/addressing-secondary-traumatic-stress/>

Resilience Alliance: [http://www.nrcpfc.org/teleconferences/2011-11-16/Resilience Alliance Training Manual - September 2011.pdf](http://www.nrcpfc.org/teleconferences/2011-11-16/Resilience%20Alliance%20Training%20Manual%20-%20September%202011.pdf)

Critical Incident debriefing: [http://www.wchsa.org/vertical/sites/%7BB5D9E240-2100-4AE1-B9FD-C91DC7DBA2A5%7D/uploads/WI Conference Breakout Session The RRR Model - May 2012.pdf](http://www.wchsa.org/vertical/sites/%7BB5D9E240-2100-4AE1-B9FD-C91DC7DBA2A5%7D/uploads/WI%20Conference%20Breakout%20Session%20The%20RRR%20Model%20-%20May%202012.pdf)

New York Society for the Prevention of Cruelty to Children Restoring Resiliency Response Model: <http://www.nyspcc.org/training-institute/crisis-debriefing-services-restoring-resiliency-response-model/>

National Center on Family Homelessness What About You workbook: http://www.ncswtraumaed.org/wp-content/uploads/2011/07/NCFH_WhatAboutYou.pdf

Chadwick Trauma-Informed Systems Secondary Traumatic Stress Guidelines: <https://ctisp.files.wordpress.com/2015/09/stsinchildwelfarepractice-trauma-informedguidelinesfororganizations.pdf>

Additional resources on the prevention of interpersonal violence and addressing the impact of trauma:

Academy on Violence and Abuse: <http://www.avahealth.org/>

Center on the Developing Child at Harvard University: <http://developingchild.harvard.edu/>

Child Witness to Violence Project: <http://www.childwitnessstoviolence.org/>

Children's Bureau: <http://www.acf.hhs.gov/programs/cb>

Futures Without Violence: <http://www.futureswithoutviolence.org/>

National Child Traumatic Stress Network: www.nctsn.org

National Domestic Violence Hotline: 800.799.7233, TTY 800.787.3224, <http://www.thehotline.org/>

National Sexual Assault Hotline: 800.656.4673, <https://www.rainn.org/>

National Teen Dating Abuse Helpline: 866.331.9474, TTY 866.331.8453,
<http://www.loveisrespect.org/>

New York Office of Mental Health:

<https://www.omh.ny.gov/omhweb/facilities/bupc/page/info2.html>

Prevent Child Abuse New York: <http://www.preventchildabuse.ny.org/>

**Substance Abuse and Mental Health Services Administration (SAMHSA) guide to
Evidence-Based Practices:** <http://www.acf.hhs.gov/programs/cb>

Zero to Three: <https://www.zerotothree.org/>

Background of Adverse Childhood Experiences (ACE) study

Population: The original study of Adverse Childhood Experiences (Felitti et al., 1998) was conducted with over 17,000 people who received medical care through the Kaiser Permanente Health Maintenance Organization (HMO) in the 1990s. Approximately 75% of the people who responded to questionnaires about their early experiences were white, and the other 11% was Hispanic/Latino, 7% Asian/Pacific Islander, 5% African-American, and 2% other. 54% were female and 46% were male. 75% had completed at least some college. Overall, the population was predominantly white, educated, and relatively middle-class.

Method: A questionnaire was mailed to HMO members who had completed standardized medical examinations. The questionnaire included questions about the following experiences in the first 18 years of life: physical abuse, sexual abuse, psychological abuse, physical neglect, emotional neglect, living with someone who was a substance abuser, violence toward mother, living with someone with mental health problems or who attempted suicide, or having a household member who was imprisoned. The questionnaire was scored according to how many of these experiences were endorsed and scored on a 0-10 scale of number of types of adverse experiences. These scores were linked to health outcome data.

Findings:

- ACEs were very common. Almost 64% had experienced at least 1 adverse childhood experience. Nearly 38% reported 2 or more ACEs. 12.5% reported 4 or more.
- ACEs were strongly linked to health outcomes. The more ACEs that were reported, the greater the risk for health problems and other poor outcomes.
- These risks increased with a dose-response relationship such that as the number of ACEs increased, the negative health risk increased in a stepwise fashion.
- ACEs are related to risk factors for disease and can result in earlier mortality by 20 years (Brown, Anda, et al., 2009).
- People who experience one ACE are more likely to experience two or more ACEs. The combination of ACEs interacts so that risks are multiplied (Putnam, Harris, & Putnam, 2013).

The American Academy of Pediatrics (2014) https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf summarizes the ACE study in this way:

“Many people can identify a person in their life who struggles with a chronic illness like heart disease, diabetes, or hypertension. Most people also know someone who struggles with mental illness, substance abuse, or relationships in general. Traditionally, the health care system would point to high-risk behaviors such as poor diet, drug use, or a sedentary lifestyle as the primary

causal factors. Questions for patients have focused on “What’s wrong with you?” rather than “What happened to you? A 1998 study from the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente is leading to a paradigm shift in the medical community’s approach to disease. This study of more than 17,000 middle-class Americans documented quite clearly that adverse childhood experiences (ACEs) can contribute significantly to negative adult physical and mental health outcomes and affect more than 60% of adults” (p. 1).

“Never before in the history of medicine have we had better insight into the factors that determine the health of an individual from infancy to adulthood, which is part of the life course perspective—a way of looking at life not as disconnected stages but as integrated across time.

What happens in different stages of life is influenced by the events and experiences that precede it and can influence health over the life span. An expanding body of convergent knowledge generated from distinct disciplines (neuroscience, behavioral science, sociology, medicine) provides child health care professionals the opportunity to reevaluate what care is needed to maximize the effect on a child’s lifelong health. Importantly, an extensive body of research now exists demonstrating the effect of traumatic stress on brain development. Healthy brain development can be disrupted or impaired by prolonged, pathologic stress response with significant and lifelong implications for learning, behavior, health, and adult functioning.” (p. 2)

Research has demonstrated a strong relationship between ACEs, substance use disorders, and behavioral problems. When children are exposed to chronic stressful events, their brain development can be disrupted. As a result, the child’s cognitive functioning or ability to cope with negative emotions may be impaired. Over time, and often during adolescence, the child may adopt negative coping mechanisms, such as substance use or self-harm. Eventually, these unhealthy coping mechanisms can contribute to disease, disability, and social problems, as well as earlier death.

“Adults who have experienced ACEs in their early years can exhibit reduced parenting capacity or maladaptive responses to their children. The physiological changes that have occurred to the adult’s stress response system as a result of earlier trauma can result in diminished capacity to respond to additional stressors in a healthy way” (p. 4).

Study Limitations

Although the ACE study provided considerable public awareness about the frequency of early traumatic experiences and their later impact on health and development, there are a number of limitations in the ACE study that we need to keep in mind as we think about ACEs. These limitations include:

- a. Other traumas and adversities that impact families were not included in the ACE questionnaire, such as exposure to community violence, parental death, natural disasters, poverty, serious accidents, medical trauma, and other stressors.

- b. Resources and supports that help people cope with challenging experiences were not included in the assessments.
- c. Risks associated with high ACE scores are based on probabilities for large groups and do not reflect risk of disease for an individual.
- d. ACE questionnaires are readily available on the internet and elsewhere, but knowing a 0-10 score does not fully capture risk and protective factors. Knowing a numerical score without a context for understanding the score or what supports are in place to address challenges may increase stress and worries about the implications of the score. When people are calculating their ACE score, they should be connected with services to address their histories and current challenges.
- e. The frequency score (0-10) does not include severity, chronicity, resources, and other dimensions that impact how an individual was affected by their experiences.
- f. ACE scores do not take into account traumatic events that occur in adulthood.
- g. The original population in the study was not representative of the overall US population.

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