# Building Safe Families Through Educating on Adverse Childhood Experiences

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Abstract

There is a strong correlation between families that work with child welfare agencies and the prevalence of maltreatment during childhood. Adverse childhood experiences (ACEs) have been linked to poor health outcomes but are much more negatively correlated when 3 or more ACEs have been experienced during a childhood (Hunt, Slack & Berger, 2017; Crouch, Strompolis, Bennett, Morse, & Radcliff, 2017). Teaching parents about the impacts of ACEs and how they may more safely parent, can reduce the recidivism of future maltreatment in at-risk families who work with child welfare agencies. Education can give parents the power and motivation to make better decisions for themselves and for their families.

*Keywords:* adverse childhood experiences, intergenerational trauma, positive parenting, child welfare agencies

## Building Safe Families Through Educating on Adverse Childhood Experiences

The majority of parents who have children in the custody of the office of children's services have experienced adverse childhood experiences (ACEs) throughout their childhood (Thornberry et al., 2013). The trauma experienced has negative impacts on these parents' ability to safely care for their children and to provide healthy and enriching environments for their children. These parents have been taught through generational experience that adversity is part of living. Many of these individuals never fully understand the impacts of their negative experiences on their adult functioning (Anda, Felitti, Bremner, Walker, Whitfield, Perry, & Giles, 2006; Finzi-Dottan & Harel, 2014).

ACEs are defined as extremely stressful or traumatic experiences that occur for children under the age of eighteen (Bethell, Narangerel, Solloway, & Wissow, 2016). They can range from negative emotional and psychological experiences to physical. Notably, children do not have to be the actual victim of the negative act in order for it to be considered an ACE and have lasting negative impacts for them (Bethell, Narangerel, Solloway, & Wissow, 2016). Witnessing domestic violence between parents in the home can impact children who experience it, well into their adulthood. ACEs are often chronic in nature, meaning that they continue to occur within a family, which can lead to serious issues for children (Tlapek et al., 2017) Substance abuse in the family is an example of adversity experienced by children. It is part of an ongoing chaotic lifestyle that children experience in the home through their parents' choices. There are many consequences of the substance abuse that occur for children which are included in the category of substance abuse.

Bartlett, Kotake, Fauth, and Easterbrooks (2017) stated that parents who experience repeated trauma as children develop an understanding of maladaptive ways of parenting. They

repeat the cycle of abuse and neglect they experienced, as it is what was normalized for them. Parents who have children in the custody of child welfare agencies often lack the understanding of what are safe parenting styles, and in what ways nurturing their children can positively impact their children's outcomes (Bartlett, Kotake, Fauth, & Easterbrooks, 2017).

Exposure to early adversity can negatively impact lifelong wellness and often times intergenerational health (Schofield, Lee, & Merrick, 2013). The relationship between childhood trauma and mental health is of particularly important to many professionals due to the magnitude of the impact. Doctors, public health worker, child protective services, teachers, mental health counselors, addictions counselors, probation officers, corrections officers, judges and more all commonly deal with people who struggle due to avoidable experiences during their childhoods (DiLorenzo, White, Morales, Paul, & Shaw, 2013).

## Introduction of Research Question

Parents who work with child welfare agencies and have children in custody are by best practice, connected with mental health providers who assess their need for individual counseling (Brown, 2014). According to Daley et al. (2016) children are at risk for maltreatment when they are part of a family where there is substance abuse, poverty, instability, and domestic violence commonly occurring. By understanding the cycle of continued maltreatment through generations, repeated maltreatment and the occurrence of ACEs can be predicted. Pufahl (2007) recommends in order to prevent future maltreatment past trauma of parents be addressed by mental health professionals to aid in making them safe and healthy parents. Pufahl also states that in a family, the effects of mental or emotional instability on a parent will also affect their children in the family system. Vygotsky (2004) states that children are a product of their environment and develop the understanding of right or wrong and good and bad from the

modeling of their parents. Children watch their parents closely and are aware of subtleties and nuances that occur within relationships, which influences their understanding of typical relationships (Vygotsky, 2004). If instability is occurring in the home children will learn the cycle of negative coping, acting out, and maladaptive behaviors. These ways of adapting will follow these children well into adulthood, if not through their lifespan (Anda et al., 2006).

The project seeks to answer the following research question: What strategies can be used to educate parents on the impacts of trauma within families intergenerationally?

This question focuses on the specific population of individuals who struggle to maintain safety within their families. This question also addresses the idea that ACEs are monumentally responsible for negative adult outcomes. It addresses the high number of children who are in child protective custody belonging to parents experienced ACEs and the rising correlation between the two.

For parents who struggle to maintain a safe home for their children, there is a grave need for them to fully understand the impact that ACEs have had on them as adults. This includes the need for them to learn how to parent safely and address their children's needs fluidly (Brown, 2014). Parents experience ACEs as children and often do not connect their maladaptive adult behaviors to their trauma history (Thornberry, et al., 2013). Merrick et al. (2017) discusses the need for parents to process the impact of ACEs so they can understand the gravity of these negative experiences. By processing feelings, emotions, and thoughts, these clients can then address the maladaptive behaviors they have developed overtime. Psychoeducation along with parenting skills can help parents become more stable and healthy by decreasing the likelihood of functional impairments in adulthood and to develop a more nurturing skill set to from which to parent. Thoughtful intervention and focusing on the issue of intergenerational trauma will help

empower parents to break the cycle of abuse and neglect (Bartlett, Kotake, Fauth, & Easterbrooks, 2017; Merrick et al., 2017).

## Literature Review

Altafim and Linhares (2016) explain that child maltreatment is a social problem that is pervasive in nature. It affects children of all socioeconomic backgrounds, culture, religion and continues to grow in occurrence (Altafim & Linhares, 2016). Eighty percent of child maltreatment occurs from parents to their children. The consequences of child abuse and neglect can range depending on severity of trauma, resilience of the child, and number of childhood adverse experiences the child endures. The consequences can be neurobiological, psychological, or physical (Altafim & Linhares, 2016). Violence within the family is the one of the least noticeable forms of violence, as children often do not report the maltreatment against them (Altafim & Linhares, 2016).

### Child Welfare Agency Intervention

According to Heyman & Slep (2002), child welfare agencies seek to help parents learn how to parent more safely so that they may end the cycle of maltreatment. These agencies also play a role in ensuring permanency and well-being of children by providing support to parents. Some agencies focus highly on prevention of maltreatment while others concentrate on resolving the conduct and conditions that caused the children to endure maltreatment (Landers et al., 2017). By the time child welfare agencies are alerted to the attention of struggling families, there has typically already been several occurrences of child maltreatment in the home (Landers et al., 2017).

According to Landers et al. (2017), children whose parents receive services early on in cases are less likely to be re-victimized throughout their lifetime. Children ages zero to five are

most likely to be involved with child welfare agencies and are the most vulnerable due to their inability to protect against harm (Fallon, Jenkins, Akbar, & Joh-Carnella, 2017). Researchers have found that very young children who experience continued trauma have the worst outcomes later in life (Landers et al., 2017). Ages zero to five are the most crucial time for brain development and therefore the development of alterations to occur. These children are the least likely age group to report neglect or abuse due to their lack of verbal communication skills (Landers et al., 2017).

Child welfare agencies provide parents with substance abuse referrals and treatment, referrals for individual and family counseling, safe housing referrals, alternatives to violence programs, battered women programs, and parenting programs to help mitigate future maltreatment for children. Parents are assessed after completing programs to ensure that they have made behavioral changes necessary to ensure safe homes (Finzi-Dottan & Harel, 2014; Akin, Brook, Lloyd, Bhattarai, Johnson-Motoyama, Moses, 2016).

**Ecological Systems Theory**

Urie Bronfenberenner helped to coin the Ecological Systems Theory. Every child is part of many different systems which impact their development. There are immediate, or micro systems which lives within. The influences in this system are the most important on a child as they are who the child has contact with the most, and relies on for support, modeling, and safety. the mesosystem is next comprised of school, teachers, family and peers. The exosystem is more indirect, including extended family neighbors and the parents' work. These people usually do not have contact directly with the child but do affect the child's development. The child welfare system and the legal system are part of the exosystem category. The macrosystem is comprised

of a person's culture and the ideologies that come with that culture (Parke & Gauvain, 2009). A child development can be altered drastically depending on their environment.

According to Bronfenbrenner (1994), children who have supportive parents and role models have better school performance, have less emotional concerns, and build healthier relationships. Bronfenbrenner worked to develop research regarding the two-way interactions that are the environment for an individual's developmental process. The longer amount of time an individual is exposed to a particular environment, the more effective the positive or negative influence (Bronfenbrenner, 1994).

**Parental Risk Factors for Child Abuse and Neglect**

There are a number of risk factors that have been identified as increasing likelihood for child abuse and neglect: Low educational achievement, substance abuse, mental health concerns, and parental history of child abuse and neglect (Sidebotham et al., 2001). Parents with low educational achievement can have low intellectual ability and lack the understanding of safe parenting practices (Feldman, 1994). They often are not able to retain and implement parenting skills and techniques to ensure their children's needs are being met (Feldman, 1994).

Substance abusing parents are more likely to abuse and neglect their children due to the negative behaviors and low inhibitions that occur while parents are under the influence of drugs and alcohol (Fallon, Jenkins, Akbari, & Joh-Carnella, 2016; Finzi-Dottan & Harel, 2014). Such behaviors as impulse control issues, short patience, irritability, exhaustion, and substance seeking behaviors lead to unintentional maltreatment of vulnerable children (Barth, 2009). Mental health issues can contribute to lack of self-control, impulsivity, depression, and irritability, which can lead to child abuse and neglect if not properly addressed (Barth, 2009). In a 1994 study by

Kelleher, Chaffin, Hollenberg and Fischer, participants with a drug or alcohol problem were 4 times more likely to have neglected their children.

According to Bartlett et al. (2016), another risk factor for child abuse and neglect is adolescent motherhood. Women who have children before they are adults are at higher risk for maltreating their children because they have not matured emotionally (Barlett et al., 2016). Young mothers correspondingly may have not yet learned parenting skills to guide them to through safe and nurturing parenting. These mothers often times may not understand the developmental stages of their children enough to meet their needs. Adolescent mothers may be more easily influenced by negative peers to engage in acts that are unsafe for themselves as well as their children (Bartlett et al, 2016).

Parental mental illness is another risk factor for child abuse and neglect. Mental illness according to Barth (2009), can lead to poverty due to inability to keep jobs. This can cause families to struggle in other areas, which can lead to child welfare involvement (Barlow & Underdown, 2018). Mental illness can lead to behavior concerns that can be harmful to children. In the Barth (2009) study it was found that 23 percent of mothers who are involved with child welfare agencies have self-reported major depression. Parental depression has been linked to emotional regulation issues among parents. This causes challenges for parents when they are interacting, disciplining, and caring for their children. It was found that as mental health symptoms lessoned, appropriate parenting ability increased (Barth, 2009). Barlow and Underdown (2018) noted that child maltreatment occurs for babies when the mother-child bond is not built during infancy. Mothers who suffer from mental illness can struggle during this key bonding period, which can be harmful to their bond with their child (Barlow & Underdown, 2018).

Domestic violence was named as another risk factor for parental child abuse and neglect in families who are involved with child welfare agencies. There was an astounding 44 percent of child welfare mothers reporting intimate partner violence occurring in their relationships. These reports were closely linked with reports of harsher parenting styles by parents experiencing violence in their personal relationships. Parents who had previous domestic violence but no longer had it occurring in their relationships had showed lower occurrences of physical discipline with their children than those who had current violent relationships (Barth, 2009). This link of violence in intimate partner relationships and violence with children suggests that being immersed in violence creates problems with an ability to safely parent.

Child conduct problems was a risk factor found for parents who neglect and abuse their children that indirectly influenced parents. It was found by Barth (2009) that when children have extensive behavioral issues parents have increased levels of stress. This stress affects their ability to parent safely. Child conduct problems have largely been found as the result of negative experiences in the home. In order for parents to more adequately address the behavioral problems parenting programs as well as family counseling have been established for at-risk families (Bartlett, 2009). These programs have been implemented for families that have child welfare involvement as well as families on the verge of intervention by child welfare agencies, noted in school settings or by other community providers (DiLorenzo, White, Morales, Paul, & Shaw, 2013).

**Intergenerational trauma**

Bartlett et al. (2016) noted in their study that the transmission of child maltreatment is prevalent among parents who experience trauma during their childhood. The findings proved that type-to-type associations were most prevalent. When parents experienced parental

substance abuse as children they were most likely to then have parental substance abuse with their own children (Fewell, 2016). One of the findings of this study was that a child whose mother experienced maltreatment as a child is 50 percent more likely to report experiences of maltreatment during their childhood compared to a child whose mother was not maltreated during her childhood (Bartlett et al., 2016). The researchers of this study also noted that 50 percent of the children whose mothers experienced child maltreatment reported who were under the age of five (Bartlett et al., 2016). This information supports reports from Heyman & Slep (2002) that young children are most vulnerable to experience maltreatment. When comparing type-to-type, neglect was the most frequently noted type of maltreatment that was past generation to generation. Often this maltreatment goes on for years before the children are able to communicate this maltreatment to protective people to initiate child welfare agency involvement (Heyman & Slep, 2002).

Bartlett et al. (2016) found when a parent had experienced multiple types of trauma as a child, there was a 300 percent increase in the likelihood that they would multiple-type maltreat their own children. It was noted that this increase in maltreatment occurrences may be due to the severity of maltreatment the parent had experienced (Bartlett et al., 2016). If there are several types of maltreatment occurring, this is indicative of severe maladaptive behaviors of parents, which lead to more severe cases of maltreatment (Stephens & Aparicio, 2016). It is important to note that this study was conducted on young mothers (i.e., women who became mothers at or before the age of 21). There were no findings about the likelihood of generational transmission of trauma for women who became mothers further into adulthood (Bartlett et al., 2016).

Stephens and Aparicio (2016) emphasized the stigma experienced by families who are involved with child welfare systems. This stigma along with negative consequences of

personally experienced trauma causes these parents to have insecurities and overall adversely impacts their ability to function. Many of these parents do not receive the services to help remedy their personal trauma so they may be healthy and secure parents.

Parental substance abuse has been found to be a significant factor in negative outcomes for the transmission of trauma through generations (Stephens & Aparicio, 2016). Results from the study completed by Stephens and Aparicio (2016) revealed several themes around intergenerational trauma and substance abuse within families. Insecurity was prevalent in people who experience ongoing trauma in their homes as children. This insecurity saturated different areas as the individuals' lives such as relationships, finding suitable housing, financial security, and their ability to parent their children safely and appropriately (Stephens & Aparicio, 2016). In relationships insecurity was present in those with complex trauma histories. Reported feelings of insecurity in regard to housing emerged from these participants having unsafe living environments due to violence in the home. Women reported that once they had an unstable living environment, other areas of their lives also became unstable (Stephens & Aparicio, 2016). Unstable housing was tied to financial insecurity, in that often times obtaining safe housing free from domestic violence left these mothers in a financial crisis due to the cost of housing (Davis, Costigan & Schubert, 2017).

**Adverse Childhood Experiences: The Original ACE study**

The Center for Disease Control and Felitti et al. (1998) conducted a study from 1995 to 1997 investigating the ACEs. This study was one of the largest research inquiries done regarding neglect and abuse and the outcomes of such experiences (Felitti et al.,1998). The study included physical examinations and surveys regarding the childhood experiences of health maintenance workers in California. There was research gathered about their current health

information and regular behaviors. These same participants were followed over time to assess their overall well-being in health and behaviors (Felitti et al., 1998).

The ACE study used an index, which combines child abuse and neglect with household challenges such as parental incarceration, or a domestic violence. The results of this study led to the development of the ACE questionnaire, comprised of seven-teen questions, later revised to the ten questions. Within the questionnaire it notes that the questions are to be answered in regards to the first 18 years of life. The person is instructed to answer yes on the question if the occurrence happened even one time. The score is then added to find the ACE score. The questions are intentionally broad, as to be applicable to many people and to not negate some experiences by being overly specific (Felitti et al., 1998). The questionnaire was developed to aid professionals in gauging the likelihood of negative outcomes by quantifying the experiences of adults when they were children (Felitti et al., 1998). Of the 10 questions on the questionnaire five are personally related: physical abuse, sexual abuse, verbal abuse, physical neglect, and emotional neglect. The second five are related to others in the home: an alcoholic or drug abusing parent, an incarcerated family member, a family member with a mental illness, a mother who is a domestic violence victim, parental divorce, abandonment or death of a parent (Sacks, Murphey, & Moore, 2014). Each category counts as one ACE even if a person has experienced many occurrences of that particular adverse experience topic (Sacks, Murphey, & Moore, 2014; Felitti et al., 1998).

**Questionnaire Design**

Felitti et al. (1998) developed the questionnaire using previously published surveys that addressed different topics of abuse and neglect. The question regarding sexual abuse was adapted from four questions from a study of sexual abuse on White and African American

women during childhood (Felitti et al., 1998). Questions regarding substance abuse exposure were adapted from a national health interview survey. Questions from regarding physical and psychological abuse were developed from the Conflicts Tactics Scale. Health-related behavior questions were taken from behavioral risk factor surveys and a health and nutrition examination survey through the CDC. Questions regarding depression were derived from the Diagnostic Interview Schedule published by the National Institute of Mental Health (NIMH) (Felitti et al., 1998).

Each question was intended to be read with the introduction to have the questions answered only as they pertained to growing up during the first 18 years of life (Felitti et al., 1998). This was done to ensure uniformity of questions and to ensure they could accurately understood and answered. Skewed results could have been more likely if participants answered questions based on experiences that occurred after they were adults. This wording made the questions more succinct and clear for people of varying cognitive abilities to understand (Felitti et al., 1998).

**Major Findings**

Almost two-thirds of adults that participated in the ACE study reported to have experienced one ACE (Felitti et al., 1998). One-Fifth of the participants reported three or more ACEs. Repeated ACEs leads to a dose-response for individuals. A dose-response indicates that the more a person is subjected to ACEs, the more negative mental and physical outcomes that person experiences (Felitti et al., 1998). When an individual experienced ACEs there were factors contributing to the mitigation of those negative experiences, such as close family bond, early intervention, and other supportive services

The data from the study was broken up into 7 categories to concisely quantify the information derived. The categories were: adverse childhood exposures, relationships between categories of childhood exposure, relationship between childhood exposure and health risk factors, childhood exposures and clustering of health risk factors, relationship between childhood exposures and disease conditions, significance of dose-response relationships, and assessment of the influence of exclusions (Felitti et al., 1998).

The adverse childhood exposures section consisted of positive answers for the 7 categories of exposure to adverse experiences. The most prevalent childhood exposure was substance abuse in the household at 25 percent and the least prevalent was criminal behavior in the home at 3 percent. More than half of the participants responded that they had experienced more that one ACE. Only 6 percent of respondents reported more than four exposures (Felitti et al., 1998).

Felitti et al. (1998) found the relationship between categories of childhood exposure was significant in that an average of 80 percent respondents who were exposed to one category were also exposed to at least 1 other category. The amount of exposures to more than 2 categories was approximately 50 percent. Regarding demographic characteristics it was found that there were significantly less exposures to categories for older individuals, white or Asian individuals, college graduates (Felitti et al., 1998).

It was found that heath risk factors were significantly elevated in those with more than one childhood exposure. The prevalence and risk of smoking, obesity, lack of physical exercise mood issues, suicide attempts increased drastically with increased exposures. In a comparison of those with 1 exposure to those with 4 there was found to be a large increase in negative health risks. Similarly, those with a greater number of exposures also experienced more prevalence and

risk of drug and alcohol abuse, more than 50 sexual partners, and a history of sexually transmitted diseases (Felitti et al., 1998). When taking into account parental risk factors including previously experienced ACEs, there is a greater risk for child maltreatment due to risk factors associated with previous trauma.

When comparing exposures to in the aforementioned health risk factors leading to death, it was found that people who had no childhood exposures over half had exhibited none of the risk factors that may lead to death. For the people who had more than four exposures had 4 or more of the 10 risk factors for early mortality. This was similarly true when comparing the relationship between childhood exposures and disease conditions. The researchers compared people who experienced four or more childhood adverse exposures to those who experienced 0. They found that those who were exposed experienced one to two times more disease conditions such as chronic bronchitis, emphysema, skeletal fractures, hepatitis, jaundice, and overall poor health (Felitti et al., 1998).

Researchers of the original ACE study found significance in dose-response relationships between the number of childhood exposures and the 10 risk factors for leading causes of death. They compared people who were similar in age, gender, race, and educational attainment in order to narrow down the data to better understand the impact of the negative exposure experiences by these individuals and to rule out other variables. There was a significant dose-response noted between childhood exposures and diseases such as ischemic heart disease, cancer, hepatitis, jaundice, and skeletal fractures. There was no significant link found regarding disease conditions such as stroke and diabetes (Felitti et al., 1998).

The researchers of this study noted they excluded the information of participants who did not answer the questions fully or who did not complete the survey. They noted that the data was

unaffected by the lack of that information. One important limitation of this study was that all information gathered was by self-report and can be inaccurate, as validity cannot be fully measured. Secondly, medical conditions can be over reported or under-reported by people and therefore potentially skewing results. In contrast, when followed up on years later the reports of childhood exposure and links to risk factors were reasonably accurate (Felitti et al., 1998).

The 1998 study was examined and followed up on by Gilbert et al. (2009). The researchers in this study noted continued negative outcomes associated with ACEs. They explained that critical information regarding negative health outcomes should inform future practice for professionals, in relationship to the continued maltreatment of children (Gilbert et al, 2009). The researchers noted that the magnitude of the maltreatment crises extends through several generations and throughout both high and low-income countries. It was suggested from this study that focusing more and promoting children's rights could mitigate this health crisis (Gilbert et al., 2009).

**Neurobiology**

Neurobiological changes occur when children experience continued trauma causing their brain function to become abnormal (Perry, 2000). Experiencing consistent trauma causes the brain to react to the perceived threat associated with toxic stress. Over time the brain changes to adapt to the stress (Perry, 2000). Bucci, Marques, Oh, and Hams (2016) explain this stress as causing a dysregulation of the physiologic response. The hypothalamic-pituitary-adrenal axis is overused during this time, which causes abnormalities and wears out this part of the brain. The hippocampus is responsible for memory, cognition, and arousal. Children in these situations can have consistent hyper-stimulation, which can inhibit memories from forming clearly (Bucci et al., 2016; Perry, 2000).

Perry (2000) states that in response to acute stress, the sympathetic nervous system is activated. The catecholoaminergic system, which consist of the dopaminergic and noradrenergic systems, become sensitized by repeated stressful experiences in a child enduring repeated trauma. These systems become altered when they are overused during the occurrence of toxic stress (Perry, 2000). Changes begin to occur in the areas of attention, sleep, fine motor control and impulse control. The catecholamine system is also responsible for some cognitive and motor functions, which can be negatively affected by continuous stress. Negative impacts that have been noted by researchers are motor hyperactivity, impulsivity, sleep issues, hypertension, and tachycardia (Perry, 2000).

Choi, DiNitto, Marti, & Segal (2017) proffer that these neurobiological changes also cause changes in psychological and personality traits, causation of mental health disorder, and a higher vulnerability to stress and stress related health conditions. Suicidal ideation and attempts have been more common among individuals who experience ACEs. Gene-environment interactions take place that can change entire genomes, which lead to possible diseases in adulthood or can be passed on to future generations (Choi, DiNitto, Marti, & Segal, 2017; (Bucci et al., 2016).

Bucci et al (2016) explained that controlled stress is a normal part of life and that humans were built with the ability tolerate stress as long as there are protective factors that can alleviate ongoing stress. On the continuum of stress response there is positive, tolerable and toxic stress. Positive stress includes the elevation of heart rate or blood pressure during such time as a basketball game. It was noted that body achieves homeostasis naturally and quickly. Tolerable stress was defined as stress which was acute but time-limited (Bucci et al., 2016). This type of stress activates internal system changes but can be repaired with nurturing and caring supports.

Natural disasters are an example of tolerable stress. Toxic stress, which is the stress experienced by children who are maltreated, is prolonged stress that disrupts the development of the brain and causes the chronic stress response. Child maltreatment, and chronic household dysfunction are responsible for chronic stress in a child (Bucci et al., 2016).

**Resiliency**

Resiliency is ability or capacity to recover quickly from difficulties or hardships. It is the ability to adapt through adversity and trauma. In order to combat the negative effects of ACEs on children and adults, building resiliency within individuals is vital. Building resiliency can develop differently and be comprised of various factors depending on what is preferred by each person (Soleimanpour, Geierstanger, & Brindis, 2017). Resilience can be built and can drastically change the outcome for an individual's future health and overall well-being (APA, 2017; Tlapek et al., 2016)

Many researchers have shown that supportive relationships with family members, mentors, friends, and professionals are some of the most contributing factors to resiliency. From these relationships can come positive factors that further resiliency such as trust, role modeling, encouragement, building of self-esteem, and nurturing (APA, 2017). Other ways to build resiliency include making connections, accepting change, moving toward goals, striving for self-growth, keeping perspective, maintaining hope, and engaging in self-care (Howell & Miller-Graff, 2014).

In a study completed by Tlapek et al. (2016), researchers learned that for those who experienced abuse and neglect negative outcomes were not always inevitable if those individuals were able to build resiliency. They noted that when individuals are able to become resilience as youth they are less likely to re-experience abuse in neglect as they age into adulthood (Tlapek et

al, 2016). Frequently abuse and neglect occur in some form before intervention strategies can be implemented for many people. Therefore, having appropriate subsequent interventions can mitigate the damage caused by maltreatment.

In the aforementioned study, resiliency was considered as a moderator for the child abuse and negative mental health and behavioral issues for girls who are involved in the child welfare system (Tlapek et al., 2016). There was a positive correlation found within this study for high resiliency in girls and healthier mental health and behavioral health. Those who experienced emotional abuse but built resiliency had less significant experiences of depression. Girls who experienced sexual abuse reported less severe symptoms of Posttraumatic Stress Disorder (Tlapek et al, 2016). Within these findings it is important to note the role of resiliency in cases of maltreatment in children who are involved in the child welfare system (Howell, & Miller-Graff, 2014).

**Community Resilience**

Researchers developed a model for addressing toxic stress and adverse childhood experiences through building community resilience (Ellis & Dietz, 2017). The Building Community Resilience (BCR) model was developed after researchers interviewed doctors, child welfare workers, and ACEs experts. It was found that the most effective way to build community resilience is to continuously improve programs, adapt to new scientific data about ACEs and lasting negative impacts, and testing strategies to screen for ACEs (Ellis & Dietz, 2017). This innovate approach allows professionals to work together, as there are many facets of community involvement that can help to build resilience by working in a collaborative process.

Ellis and Dietz (2017) concluded that in order to develop the BCR model they gained a comprehensive understanding of ACEs and the factors that lead to toxic stress occurring in the

family. The authors explained that a community approach could only be successful if the partners work to implement good delivery of services and work as partners. Throughout this process addressing barriers, restructuring integration of services, and transparent communication about the effectiveness of services would need to occur for this model to be successful (Ellis & Dietz, 2017).

The BCR model consists of building resiliency through connecting families with resources, using a deliberate and strategic approach to combat toxic stress, and merging diverse community professionals such as teachers, doctors, social workers, community members, and more broad government organizations (Ellis & Dietz, 2017). The BCR approach does not seek to teach people about what they know but to address gaps where needs are not being met (Ellis & Dietz, 2017; Biglan, Van Ryzin,& Hawkins, 2017). Continuous community improvement allows for accountability of agencies and programs to constantly reassess the effectiveness of the programs in place on familial dysfunction and child maltreatment.

Within the BCR model there were 4 components that were developed to be implemented on a continuous basis: shared understanding, state of readiness, cross-sector partners, and engaged community (Ellis & Dietz, 2017). Within the shared understanding category reliance, toxic stress and ACEs and experiences of the community must be understood. The state of readiness category consisted of the ideas of provider capability, system capability and policy supports (Ellis & Dietz, 2017). In order to implement this model, the community systems in place must be supportive of the innovation. Within the cross-sector partners category was ways to connect, distribution of resources, partnership within the community, and political organizations, and the collaboration process. Lastly, organization linkages, leadership, social supports and attachment to the community were categorized under engaged community (Ellis &

Dietz, 2017). With each of these categories in place through this model, ACEs can be recurrently addressed on familial and community levels by professionals.

**Prevention**

Parenting programs have been developed to help parents learns skills to parent safely without exposing their children to maltreatment. Parents who gain an understanding of the needs of their children, the lasting of effects of maltreatment, and the cycle of maltreatment, can learn skills to reduce the negative impact they have on their children due to their previous lack of knowledge and unhealthy upbringing (Altafim & Linhares, 2016; Browne, 2014).

Psychoeducation is important tool for parents who have a propensity to maltreat their children. It allows for education on how trauma affects emotions, cognitions, and behaviors. This therapeutic technique helps to prevent future maltreatment by allowing parents to gain more clear understanding of how maladaptive behaviors lead to unsafe life choices and unsafe parenting for people in general and to them particularly (DiLorenzo et al., 2013).

Many parents who work with child welfare agencies have cognitive, intellectual, or social disabilities, which can impair their ability to safely parent due to lack of obtainable parenting knowledge (Dawson & Berry, 2002). In a study review completed by McGaw, Scully, and Pritchard (2010), it was found that parents with intellectual disabilities can be at higher-risk for maltreating their children. These researchers also found that these parents were at more high-risk for maltreating their children if they experienced trauma during childhood (McGaw, Scully, & Pritchard, 2010). Crittenden (1993) asserts that often, neglectful parents who have cognitive issues may fail to understand cues from their children to have needs met. These parents' failure to respond to their children could be due to a lack of perception of the signal, lack of understanding that the signal warranted parent intervention, did not know how to respond to the

signal from their child, or failed to properly implement their intervention (Crittenden, 1993). Parent educators can teach parents through individualized concrete methods on how to appropriately respond to their children's cues for parental assistance.

Harris (2014) noted that many studies on ACEs have been conducted which have provided professionals extensive data regarding the causes of ACEs and the prevalence of this national health crisis (Harris, 2014). During research completed by Harris (2014) it was found that early screening for ACEs and risk for ACEs are some of the most effective ways to prevent future negative experiences and to proactively refer families for further prevention. Educating parents about the severity of negative consequences and teaching them easy and affordable ways to address familial dysfunction can improve family dynamic and address concerns before they become toxic. Harris explains that trauma occurring in families should be considered as important as health care concerns such as cancer, because of the health effects toxic stress and trauma have on the brain and body (Harris, 2014).

There has been stigma surrounding the engagement of parents in parenting programs that has existed for decades (Akin et al., 2016; Wooten, 2015). Much like the in the mental health field, if an individual seeks services they are often viewed as damaged or weak. Attending such programs has a negative connotation that the family is flawed and that the parents are "bad parents" (Biglan, Van Ryzin, & Hawkins, 2017, p. 155). This negative implication has caused families to ignore problems that are occurring in their homes until the problem gets to the point of crisis, which leads to child welfare services involvement.

According to Balistieri and Alvira-Hammond (2016), providing families with education can drastically improve the quality of the relationships within the family. Building parents' toolboxes for positively parenting their children helps them better address children's behaviors,

stressors, and conflicts within the family unit. Family units must be viewed individually to get an understanding about tools work within that family, as well as to fully understand where there is a breakdown in communication, what the maladaptive behaviors are, and the cultural context of the issues (Balistieri & Alvira-Hammond, 2016; Berzenski, Yates, & Egeland, 2013).

Access to services has been a barrier for families to gain the skills they need in order to be safe and healthy. Recent changes in health care have allowed doctors to provide services to families and they may bill insurance for encounters. Biglan, Van Ryzin, & Hawkins (2017) note The United States Preventative Services Task Force has developed particular preventive services that can be provided without out-of-pocket costs to the families. This was developed because researchers found that providing up-front services allow for less medical costs later for individuals as they are preventing the development of long-term health issues including diseases and mental health disorders (Merrick et al., 2017)

In a study conducted with inmates in a Tennessee prison, it was found that fathers make up 90 percent of the inmates (Wooten, 2015). The majority of these inmates had little understanding of what ACEs are, are how they impact children. After parenting education, these fathers were able to understand the current ACE score of their children and were able to learn parenting skills to reduce future ACE for their children (Wooten, 2015). The idea of this study done in the prison system was to break the cycle of abuse and neglect by educating at-risk parents and providing them an opportunity to change their lifestyles and parenting styles. Many of the participants of this study stated that they had never been taught about child developmental milestones, nurturing parent practices, positive parenting skills, emotional regulation and effective, safe discipline (Wooten, 2015).

**Triple P Parenting program**

Positive parenting skills programs have been proven to be successful in promoting childhood well-being. According to Sanders, Kirby, Tellegen, and Day (2014) through their meta-analysis of parenting programs, they supported the theoretical foundation of Social Learning Theory in order to explain successful ways to parent safely. The Triple P-Positive Parenting Program was developed from the idea that incorporating, behavioral, developmental, and cognitive concepts (Turner & Sanders, 2006). When parents learn positive parenting skills they are able to meet their children's needs and reduce the number of behavioral issues from their children.

The Triple P program was developed to prevent child emotional and behavioral issues by enhancing parent's confidence through education and skill building (Sanders et al., 2014). This parenting model involves 5 levels of intervention for parents. Level one is media and community strategies such as television and online resources. Level 2 consists of brief intervention sessions with a professional. This can include individual or group parenting work. Level 3 consists of more focused intervention strategies through face-to-face instruction or telephone interactions. Level 4 is specifically designed for individuals through workbooks or online. Level 5 is a more advanced intervention level for parents who have completed previous levels (Sanders et al, 2014).

The benefits to this model are not only observed in children, but parent mental health has improved (Sanders et al., 2014). Parental conflict is also reduced when good parenting leads to good behaviors in children. Reducing the amount of stress within the family system reduces the risk of maladaptive behaviors by parents. The disadvantages seen by researchers regarding programs such as these, is that they are often used as intervention programs instead of prevention

programs (Sanders, Kirby, Tellegen & Day, 2014). Once parenting styles are in place, it can be hard for parents to break bad habits and change their maladaptive practices.

**Dialectical Skills Training**

Many parents who work with child welfare agencies struggle with mental health concerns and regulating their emotions. This causes them to struggle when trying to parent children who also have issues regulating emotions due to their stages of development. In order to appropriately parent and meet their children's needs, dialectical behavior therapy (DBT) skills can be taught to struggling parents (Ben-Porath, 2010).

In a study conducted by Martin, Roos, Zalewsk, & Cummins (2017), it was found that mothers who participated in DBT skills groups reported significant changes in their ability to regulate emotions and therefore more positively parent their children. The participants in this study attended weekly 2.5 hour group sessions and then one hour team meetings with therapists for 22 weeks. During the group sessions 4 modules were completed using DBT based techniques. Mothers were taught about mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. Workbooks, group discussion, real-life examples, and individual needs discussions were used in order teach parents in a genuine, concrete way (Martin, Roos, Zalewsk, & Cummins, 2017). This allowed the mothers to be able to practice the skills and apply them to their unique situations.

Mindfulness skills such as honing attention, deep breathing, and body relaxing were taught to reduce negativity and increase happiness, to increase control of the mind and thoughts, and to better understand reality (Martin, Roos, Zalewsk, & Cummins, 2017; Bethell, Narangerel, Solloway, Wissow, 2016). Distress tolerance was taught to help the participants deal with crisis situations without escalating them, to help them self-soothe, and become free from negative

urges. Emotion regulation was taught to help the participants label their emotions, decrease the frequency of the negative emotions, and decrease emotional suffering. Interpersonal effectiveness was taught to help participants get their needs met by others, build positive relationships and to relationships that were negatively impacting them, and to build self-worth (Martin, Roos, Zalewsk, & Cummins, 2017).

According to Martin, Roos, Zalewsk, and Cummins (2017), an outcome of this study that benefited the participants in not only regulating emotions but in helping them advocate for themselves and for the needs of their children. The skills learned in the DBT groups improved the participants' ability to engage with their children's teachers and other providers who work with their children. The reason for this is that these mothers felt supported and developed self-confidence from their experiences. These women felt mentally healthier and were therefore more emotionally available to address their children's needs. Participants also reported the ability to more calmly discipline their children without role modeling negative behaviors (Martin, Roos, Zalewsk, & Cummins, 2017).

## Conclusion

ACEs have lasting health, social, and emotional impacts on individuals throughout adolescence into adulthood (Anda et al., 2006). People who work with child welfare agencies are likely to have negative outcomes that can affect their ability to make appropriate decisions and safely parent. With the help of child welfare agencies parents can learn skills to mitigate poor parenting practices and emotion regulation issues (Ellis & Dietz, 2017). Child welfare agencies can help parents learn about the negative impacts of ACEs to help them understand the ways their behaviors could impact their own children. Parents can build resiliency for themselves and for their children by learning nurturing ways of interacting with others.

Intergenerational trauma can be mitigated through education and the implementation of new ways of parenting (Horton, 2003). Parents would also need to eliminate unhealthy behaviors such substance use, domestic violence and may need to attend individual counseling (Heyman & Slep, 2002).

## Application

Approximately two million children are referred in some capacity to child welfare agencies due to maltreatment in their homes (Schofield, Lee & Merrick, 2013). To mitigate the recidivism of child maltreatment, child maltreatment prevention has become an important public health focus (Schofield, Lee & Merrick, 2013). Parents who are mandated to work with child welfare agencies can learn a lot about trauma and the lasting impacts it has on their own lives and on their children's lives (Stephens & Aparicio, 2017). It is important that the professionals who work with these parents provide them with information necessary to reduce the risk of harm to children and to empower parents to make lasting behavioral changes that can positively impact their children in the future (Hawkins, 2017).

The information provided to parents should be able to be easily understood by parents with varying levels of intellectual ability. Parents can benefit from educational materials they can take with them in the form of a brochure or handout (Wooten, 2015). The implementation of education and discussion-based curriculum can allow parents a safe, and open forum to discuss their past-trauma and their understanding of new safe-parenting information (Schofield, Lee & Merrick, 2013).

### Description of Need

The effects of ACEs are detrimental to people who experience them and can affect not just the individual, but every person with whom they have a relationship (Bartlett, Kotake, Fauth,

& Easterbrooks, 2017). There is a cycle that occurs when people who grow up with many ACEs have children. Many of these individuals do not understand what the negative impacts of ACEs cause for them as parents to their own children. Many victims of ACEs believe that experiencing domestic violence, substance abuse, neglect, parental separation, incarcerated parents and other negative life situations are normal aspects of growing up as that is all they have ever been exposed to. Due to repeated exposure and normalization during childhood, these parents do not consider the negative impacts experiences repeated trauma and dysfunction in the family (Dinehart, Manfra, & Ullery, 2012). Researchers have concluded that an understanding of ACEs by parents as well as a prevention of ACEs would be necessary in order to protect the health and well1-being of people throughout childhood and on into their adulthood (Hughes et al., 2017)

Thornberry et al. (2013) discuss that people who experience domestic violence, neglect and abuse as children commonly become perpetrators of these acts as adults. These researchers recommend that social services employees and other professionals work to prevent continued maltreatment by giving these families supports that can help them become safe and healthy in their parenting as well as their relationships that may impact their ability to parent safely. The Child Abuse Prevent and Treatment Act 2010, describes maltreatment as an act or a failure to act by that of the parent which results in harm or serious risk of harm to a child in their care (Department of Health and Human Services, 2011)

Intergenerational maltreatment occurs when victims of maltreatment continue practicing unsafe behaviors in their lives in their due to the effects of the maltreatment on their brain development (Bartlett, Kotake, Fauth, & Easterbrooks, 2017, Thornberry et al., 2013). Researchers note that safe, nurturing, and stable relationships can help break this

intergenerational cycle, by modeling healthy domestic relationships as well and safe parent-child relationships (Thornberry, et al., 2013).

Longitudinal studies have been conducted which have linked child maltreatment by parents to resulting psychological conditions, medical conditions, and negative physical outcomes for these children (Daley et al., 2016; Anda et al., 2006). Due to the high rate at which negative outcomes are occurring, this incurs substantial monetary costs. The total economic burden throughout a lifetime caused by ACEs is more than 124 billion dollars. This includes the cost of mental health services, medical bills, incarceration costs, drug and alcohol abuse treatment, loss of employment, and other superfluous expenditures (Anda et al., 2006).

According to the State of Alaska (2013), ACEs impact 35 percent of Alaskans. In 2013, a behavioral risk factor surveillance survey (BRFSS) was conducted with 4,000 Alaskans and Alaska was found to have higher ACE scores than other states (State of Alaska, 2013). Substance abuse was reported by participants at a rate of 33.8 percent (State of Alaska, 2013). Alaskans reported negative health outcomes such a sleep disturbances and mental health issues such as depression. For those with three or more, negative health outcomes rose significantly. These health problems translate into high monetary costs for Alaskans individually and for the state as a whole (State of Alaska, 2013).

**Intended Audience**

The target population for this project were parents who had children in the legal or physical custody of the Office of Children's Services or other child welfare agencies. The intended population were individuals who struggled to maintain safety in their homes. The safety concerns ranged from domestic violence, incarceration and police involvement, substance abuse, child abuse, mental health disorders, and neglect (Merrick et al., 2017). This project did

not address families before there had been child maltreatment, but served to address families who struggled with safety so they could prevent future maltreatment and allow their children to heal.

It would be important for social services staff to be aware and skilled in this curriculum so that they could present the information to their future clients and could continue to promote safety in homes and could point out potential risk factors for their clients. The professionals must be well trained in understanding ACEs in order to help client's gain a full understanding of the impacts associated with negative experiences during childhood and how to avoid exposing children to ACEs (Barth, 2009).

**Implementation**

Parents who work with the State of Alaska child welfare agency are required by their caseworkers and by the court system to remedy the unsafe patterns of behavior that put their children at risk for abuse and neglect (State of Alaska, 2013). There is not currently a curriculum implemented for parents who work within the Alaska child welfare system to help remedy the recidivism of continue exposure to ACEs for their children (State of Alaska, 2013). It has been the hope that parents will discuss their personal trauma through individual counseling, but ACEs are not currently addressed with parents by their caseworkers in a clear, concise, and psychoeducational manner.

This project is intended to develop a curriculum that can be delivered to parents during one meeting time, due to the likelihood that parents may not attend a second training session. Parents can leave the training with information about ACEs and how they can prevent future ACEs for their children. During this training there will be an open forum for parents to discuss

with the training facilitator and their peers their experiences of ACEs throughout their childhood and how these ACEs impacted them as parents.

The tangible piece of this project will be curriculum called *Breaking the Cycle of Trauma* (Appendix A). This curriculum will include: an overview of what ACEs are, how ACEs are transferred intergenerationally, a description of a video that will be shown in training, discussion questions for the group, and several brochures and handouts. Each parent will have the opportunity to complete an ACE questionnaire and discuss their results or keep them confidential.

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# Breaking the Cycle of Trauma: A Curriculum for Parents

By: Katie Dabney

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**Breaking the Cycle of Trauma** is a step-by-step curriculum for parents who have children in the custody of child welfare agencies. Adverse Childhood Experiences are defined as traumatic and unhealthy exposures during childhood (Soleimanpour, Geierstanger, & Brindis, 2017). The curriculum is meant to teach parents about the negative impacts of ACEs on their children by identifying ACEs they have experienced during their own childhood (Koss & Marks, 1998). This curriculum will address the transmission of trauma through generations. The steps in the curriculum consist of: A Ted Talk on the effects of trauma, a brochure on ACEs and resiliency, the ACE questionnaire, and Dialectical Behavioral Therapy skills to help aid parents in emotion regulation.

By providing parents with skills to help them become safe parents, the recidivism of child maltreatment reduces greatly (Marie-Mitchell, Studer, & O'Connor, 2016). Parents can take the handouts home with them as to refresh themselves when parenting becomes difficult. With the implementation of this program in child welfare agencies in Alaska, we may see a positive change in the progress parents have in remedying the safety issues that occur in their homes.

Education is the best way to support parents and decrease future abuse and neglect for families who have experienced trauma generationally.

Katie Dabney

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## Considerations for the Facilitator

The facilitator will take referrals from Protective Services Specialists for participants for this curriculum. The specialist will be instructed by the facilitator to refer individuals who may work well in a group setting and may be willing to share information about themselves. The specialist will be instructed to refer participants who are emotionally healthy enough to engage in personal reflection and what may possibly be emotionally strenuous topics.

The facilitator may present this curriculum to participants individually for those who prefer not to engage in the group process. The steps that require personal reflection and discussion will occur between the single participant and the curriculum facilitator. Some participants may prefer to learn the curriculum with only the facilitator so that they may be more vulnerable in their responses with only one person hearing their personal information.

## Step-by-Step Curriculum for Breaking the Cycle of Trauma

**Step 1:** Facilitator will introduce themselves to the parent group and explain that this is a training curriculum for parents about Adverse Childhood Experiences and the impacts of ACEs on adult functioning and the ability to safely parent (Kilger, 2017; Reiser, Mcmillan, Wright, & Asmundson, 2014). Facilitator will explain to participants that group it will be approximately 2.5 hours with a comfort break of approximately 15 minutes halfway through.

**Step 2:** Facilitator will share with the parents the Ted Talk video How Childhood Trauma Affects Health Across a Lifetime By: Dr. Nadine Burke Harris.

https://www.youtube.com/watch?time_continue=4&v=vw0TkwjjpZU

**Step 3:** Facilitator will discuss with the group their thoughts on the video and will ask them each to share "What is one thing you took away from this video?"

The facilitator will ask for experiences and try to engage the group so that it becomes conversational. Point out any similar themes you note from participants and bring that to the group for discussion. This section is to allow participants to reflect on what they have learned and to link it to their life experiences.

**Step 4:** Facilitator will discuss ACEs and resiliency by providing a parent brochure to help prevent future ACEs. Discussion regarding the brochure will be encouraged.

**BREAK**

**Step 5:** Facilitator will introduce the ACE Questionnaire and ask parents to complete it. Facilitator will give statistics on the prevalence of ACEs and what the scores mean. Discussion about ACE scores will occur in small groups. People will be encouraged to reflect on if they feel their experiences impacted them as adults, without sharing specifics if they choose not to (Berzenski, Yates, Egeland, 2013). Berzenski, S.R., Yates, T.M., Egeland, B. (2013).

Facilitator will ask participants to discuss how their children may be impacted by household dysfunction. They will be instructed that this is a growing opportunity and not one for judgement (Wooten, 2015).

**Step 7:** The facilitator will discuss Dialectical Behavioral Therapy parenting techniques from Parent Guide Dialectical Behavior Therapy (http://www.fourwindshospital.com/about_four_winds/westchester/parentguidedbt.htm)

Deep breathing – Take slow deep breaths and think only of the breath and how your body feels as you breathe in and out slowly.

Validation – Try to understand the other person's point of view and let them know that you get how they feel. This helps to calm the other person. Telling them to "calm down" does not help.

Opposite Action – Think about what you feel like doing because of your current emotion. What is your action urge? Now do the opposite (i.e, if you are angry and feel like shouting, smile instead; if you feel like isolating, get involved in an activity with others)

GIVE – If it matters to you what the other person thinks of you then: speak Gently, act Interested, Validate, and use an Easy manner.

Wise Mind – This is the combination of Emotion Mind and Reasonable Mind. Recognize how you are feeling, think of what seems reasonable and let your Wise Mind tell you what to do.

Radical Acceptance – Recognize what you cannot change at this moment and

turn your mind towards accepting it until a change can be made.

Staying in the moment – Bring your mind away from past pain and future worry to just this moment. Stay there by reminding yourself and using your five senses.

3-2-1 – This skill is about distraction. Focus on 3 things you see, 3 things you physically feel and 3 things you hear, then 2 things you see, hear and feel and then 1 thing you see, hear and feel. Give each thing your full attention.

The Color Game – This is another distraction skill. Look around and name everything that is green, then everything that is red, then yellow etc. Give each thing your full attention

Walk the Middle Path – Recognize that there are two sides to every issue and each side has some truth to it. Try to see the "kernel of truth" in the other person's position and validate that truth even if you do not agree. This opens up the ability to communicate without getting into an argument.

**Step 8:** Facilitator will open up the discussion for parents to ask any burning questions.

**Step 9**: Facilitator will encourage parents to talk with their caseworkers about their trauma and counseling services available to them (Pufahl, 2007)

## References

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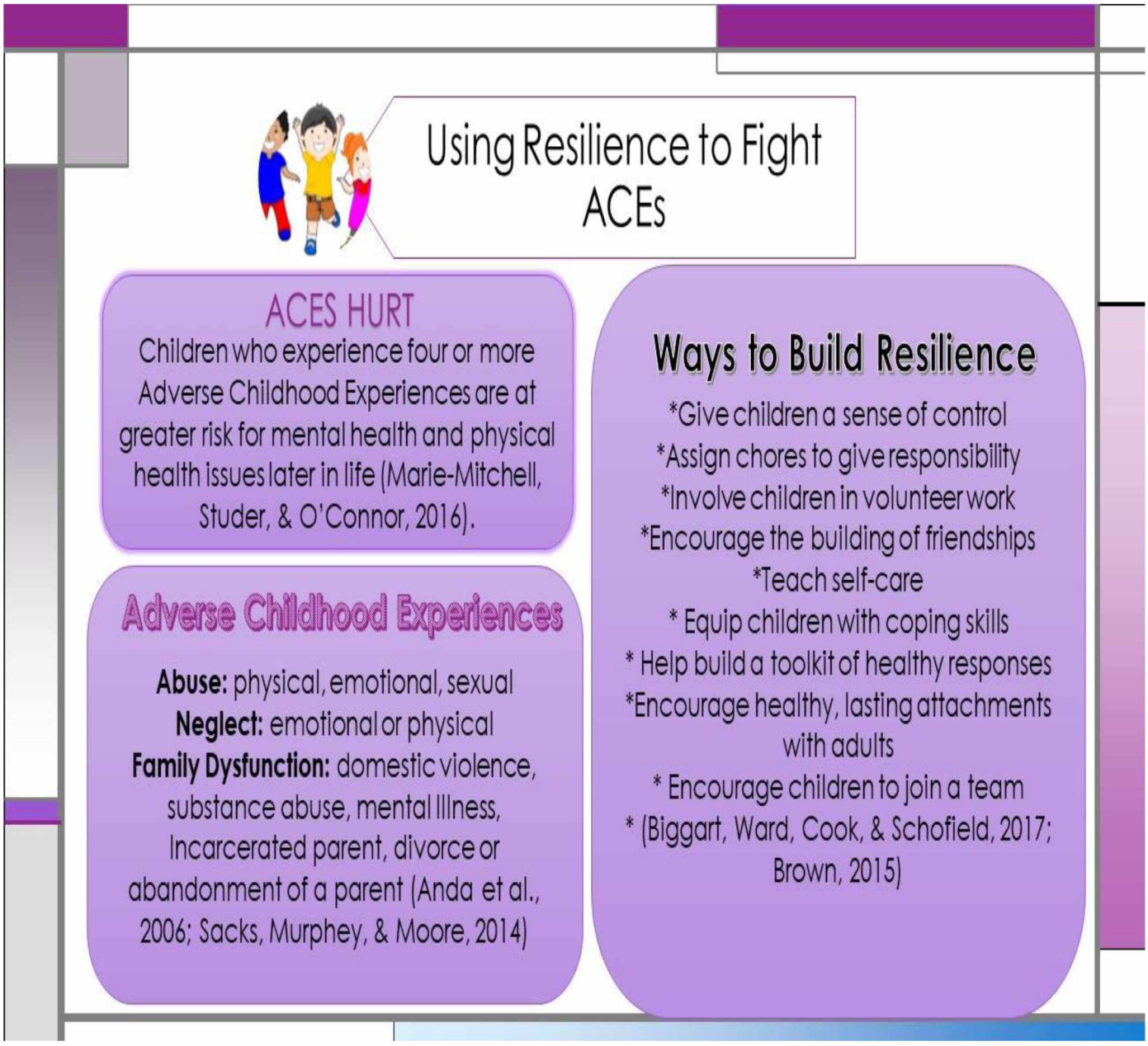
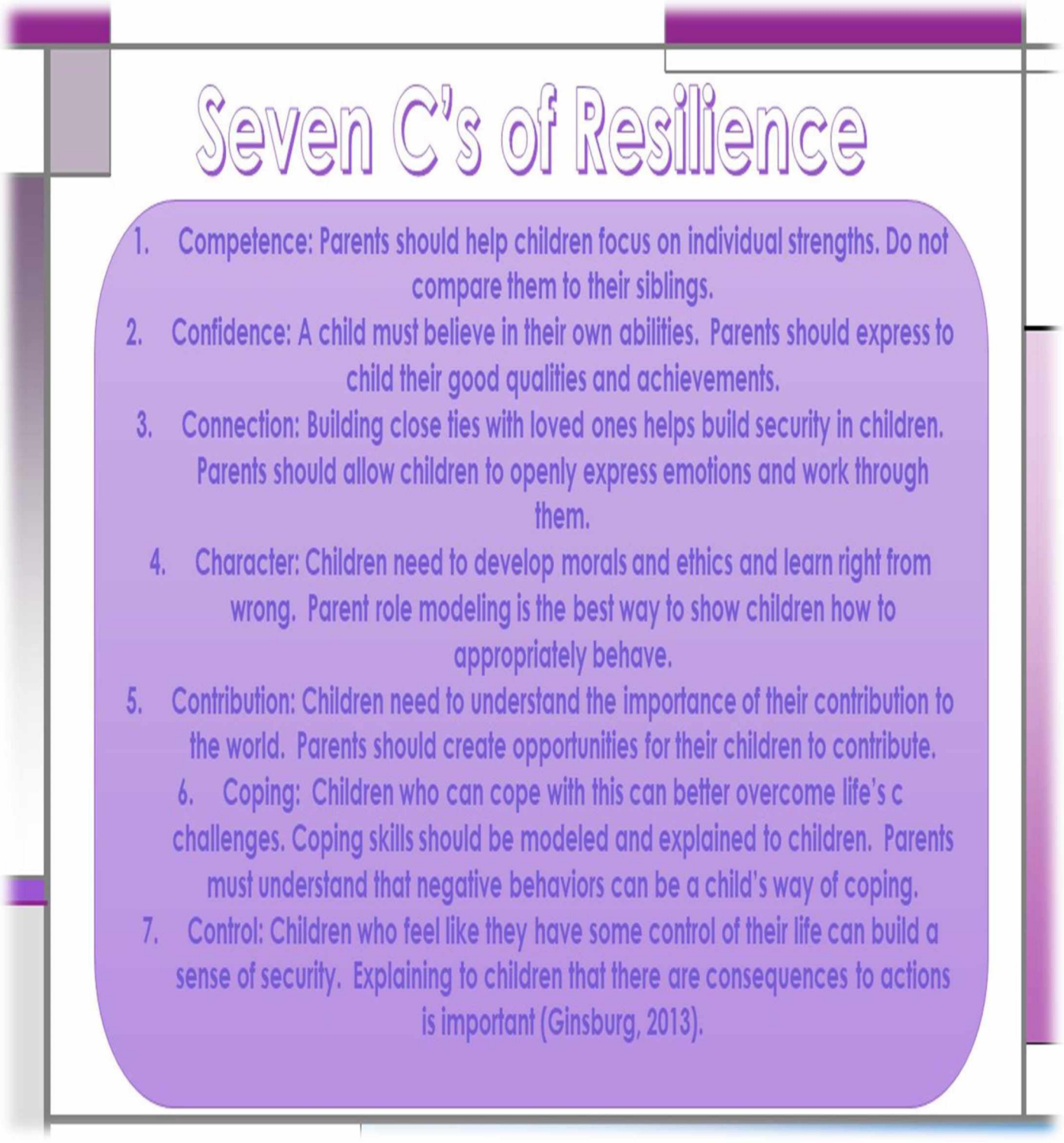

Using Resilience to Fight ACEs
ACES HURT
Children who experience four or more Adverse Childhood Experiences are at greater risk for mental health and physical health issues later in life (Marie-Mitchell, Studer, & O'Connor, 2016).
Adverse Childhood Experiences
Abuse: physical, emotional, sexual
Neglect: emotional or physical
Family Dysfunction: domestic violence, substance abuse, mental illness, incarcerated parent, divorce or abandonment of a parent (Anda et al., 2006; Sacks, Murphey, & Moore, 2014)
Ways to Build Resilience
*Give children a sense of control
*Assign chores to give responsibility
*Involve children in volunteer work
*Encourage the building of friendships
*Teach self-care
* Equip children with coping skills
* Help build a toolkit of healthy responses
*Encourage healthy, lasting attachments with adults
* Encourage children to join a team
* (Biggart, Ward, Cook, & Schofield, 2017; Brown, 2015)


Seven C's of Resilience
1. Competence: Parents should help children focus on individual strengths. Do not compare them to their siblings.
2. Confidence: A child must believe in their own abilities. Parents should express to child their good qualities and achievements.
3. Connection: Building close ties with loved ones helps build security in children. Parents should allow children to openly express emotions and work through them.
4. Character: Children need to develop morals and ethics and learn right from wrong. Parent role modeling is the best way to show children how to appropriately behave.
5. Contribution: Children need to understand the importance of their contribution to the world. Parents should create opportunities for their children to contribute.
6. Coping: Children who can cope with this can better overcome life's c challenges. Coping skills should be modeled and explained to children. Parents must understand that negative behaviors can be a child's way of coping.
7. Control: Children who feel like they have some control of their life can build a sense of security. Explaining to children that there are consequences to actions is important (Ginsburg, 2013).

## Adverse Childhood Experiences (ACEs) Questionnaire

http://www.cdc.gov/violenceprevention/acestudy/

**Prior to your 18th birthday did you experience:**

1. **Emotional Abuse** - Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

2. **Physical Abuse** - Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

3. **Sexual Abuse** - Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

4. **Emotional Neglect** - Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

5. **Physical Neglect** - Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Did it seem as though your parents or guardians didn't take care of you, ie. take you to the doctor if you needed it etc.?

6. **Loss of Parent** - Was a biological parent ever lost to you through divorce, abandonment, or other reason?

7. **Domestic Violence** - Was your parent or guardian: Often or very often pushed, grabbed, slapped, or had something thrown at them? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Repeatedly hit for at least a few minutes or threatened with a gun / knife?

8. **Family Member with Addiction** - Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9. **Family Member with Depression or Mental Illness** - Was a household member depressed or mentally ill, or did they attempt suicide?

10. **Family Member Incarcerated** - Did a household member go to prison?

Visit trf.net for courses and further information on the ACEs.