Some Important Definitions

(adapted from an article in Child Trends, April 2019, Bartlett & Sacks; additional content from ACEs Connection GLOSSARY TERMS FOR AND FROM THE FIELD)

Childhood adversity is a broad term that refers to a wide range of circumstances or events that pose a serious threat to a child's physical or psychological well-being. Common examples of childhood adversity include child abuse and neglect, domestic violence, bullying, serious accidents or injuries, discrimination, extreme poverty, and community violence. Research shows that such experiences can have serious consequences, especially when they occur early in life, are chronic and/or severe, or accumulate over time. However, adversity does not predestine children to poor outcomes, and most children are able to recover when they have the right supports—particularly the consistent presence of a warm, sensitive caregiver.

Adverse Childhood Experiences (ACEs)—a term coined by researchers Vincent Felitti, Robert Anda, and their colleagues in their seminal study conducted from 1995 to 1997—are a subset of childhood adversities. The researchers asked adults about childhood adversities in seven categories: physical, sexual, and emotional abuse; having a mother who was treated violently; living with someone who was mentally ill; living with someone who abused alcohol or drugs; and incarceration of a member of the household. The term ACEs has since been adopted to describe varying lists of adversities. The current ACEs study funded by the Centers for Disease Control and Prevention, for example, includes parental divorce or separation and emotional and physical neglect; other studies have added experiences of social disadvantage (e.g., economic hardship, homelessness, community violence, discrimination, historical trauma).

No ACEs lists or screening tools identify all childhood adversities, but those that do not include adversity related to social disadvantage are likely to overlook children in specific racial or ethnic groups, who are disproportionately affected. It is equally important to assess each child's well-being to inform the type(s) of services that would most benefit that child. Gaining a full picture of a child can avoid overtreatment of children who have been exposed to ACEs but are functioning well.

Toxic stress can occur when a child experiences adversity that is extreme, long-lasting, and severe (e.g., chronic neglect, domestic violence, severe economic hardship) without adequate support from a caregiving adult. Specifically, childhood adversities, including ACEs, can over-activate the child's stress response system, wearing down the body and brain over time. This

over-activation is referred to as toxic stress and is the primary way in which adversity damages a child's development and well-being. The extent to which a child's stress response to adversity becomes toxic and leads to serious health and mental health problems in adulthood also depends on the child's biological makeup (e.g., genetic vulnerabilities, prior experiences that have damaged the stress response system or limited healthy gene expression) and the characteristics of the adverse events or conditions (e.g., intensity, duration, whether a caregiver caused the child harm).

Trauma is one possible outcome of exposure to adversity. Trauma occurs when a person perceives an event or set of circumstances as extremely frightening, harmful, or threatening—either emotionally, physically, or both. With trauma, a child's experience of strong negative emotions (e.g., terror or helplessness) and physiological symptoms (e.g., rapid heartbeat, bedwetting, stomach aches) may develop soon afterward and continue well beyond their initial exposure. Certain types of childhood adversity are especially likely to cause trauma reactions in children, such as the sudden loss of a family member, a natural disaster, a serious car accident, or a school shooting. Other childhood adversities (e.g., parental separation or divorce) tend to be associated with more variability in children's reactions and may or may not be experienced by a child as trauma. Childhood trauma is associated with problems across multiple domains of development. However, trauma affects each child differently, depending on his or her individual, family, and environmental risk and protective factors. For example, two children who experience the same type of adversity may respond in distinct ways: One may recover quickly without significant distress, whereas another may develop posttraumatic stress disorder (PTSD) and benefit from professional help (for example, the services and supports that comprise trauma-informed care).

Secondary or Vicarious Trauma refers to the suffering and stress that comes from witnessing, helping, or trying to help a person who has ACEs and exhibits signs of trauma. Those who may experience secondary or vicarious trauma include nurses, teachers, therapists, hospice workers, family advocates, foster parents, child welfare workers, physicians, law enforcement, judges and emergency responders, among others. Symptoms of secondary trauma can include sadness, anger, poor concentration, emotional and physical exhaustion, and shame.

ACEs Screening, Trauma Screening, and Resilience Screening all have distinct purposes. When considering whether to begin a new screening protocol, think about what information will be gained and how it will be used enhance individualized interventions. Current screening and assessment, combined with trauma-informed approaches that are specific to each discipline, may be sufficient for addressing the symptoms of ACEs without adding an additional ACEs screening tool.

The Adverse Childhood Experiences (ACE)s Survey is meant to screen for events potentially experienced before the age of eighteen that have been shown to influence health and well-being (e.g., abuse, sexual assault, neglect, poverty, parental divorce, community violence, family history of alcohol abuse, incarceration, and mental abuse). ACEs screening is designed to identify potential risk for trauma but is not explicitly a traumatic-stress screener and should not be used interchangeably when referring to trauma (Finkelhor, 2017).

ACEs Surveys typically emphasize the total ACE score rather than identifying the specific trauma events that may be causing traumatic stress for the person. Trauma screeners are designed to specifically detect exposure to a variety of traumatic events, the severity of traumatic-stress symptoms, and the need for further assessment. Trauma-focused assessments can determine strengths as well as clinical symptoms of traumatic stress, and can help inform a treatment plan (Finkelhor, 2017). ACEs surveys can be completed by a broad array of professionals, whereas screening for trauma should only be done by trained mental health professionals.

ACEs scores do not evaluate how positive experiences or social supports can be protective against traumatic stress. A variety of Resilience Surveys are available to help practitioners assess and consider resilience as a key factor in selecting appropriate interventions. There are many versions that are specific to children, adolescents, adults and communities.

ACEs Science refers to research on the prevalence and consequences of adverse childhood experiences, and what to do to prevent them. It includes the original CDC-Kaiser Permanente ACE Study and subsequent surveys (epidemiology); brain science (neurobiology of toxic stress); health consequences (long and short-term effects); historical and generational trauma (epigenetic consequences of toxic stress); and resilience research & practice.

ACEs-informed individuals and organizations are those who understand the five areas of ACEs science and are committed to deepening their understanding through engaged learning.

Trauma-informed individuals and organizations have knowledge of the key assumptions and principles of a trauma-informed approach as outlined by the Substance Abuse & Mental Health Services Administration (SAMHSA). They use their understanding of trauma to shape policies, practices and interventions, using trauma-informed approaches to service delivery, and weaving trauma-informed practices into the ten domains of organizational culture.

Trauma-responsive individuals and organizations use their knowledge of trauma to change the way they interact and respond in professional and personal settings. Being trauma-responsive requires self-awareness and self-regulation in conjunction with trauma-informed approaches.

Resiliency-focused individuals and organizations balance knowledge of adversity, trauma, and toxic stress with hopeful strategies for building resilience. They focus on hope and healing as well as prevention of ACEs, promoting multiple pathways to resilience that include sleep, nutrition, exercise, mindfulness, healthy relationships, and behavioral health interventions as well as safe environments and connected communities.

The Five Protective Factors are the foundation of the Strengthening Families Approach: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children. If this resilience-building approach is paired with an understanding of ACEs science, parents with high ACEs may have a better understanding of how their own history affects their parenting and what to do about it. With knowledge of ACEs and protective factors, empathy for children increases and parents are more inclined to seek new skills that will prevent them from passing ACEs on to their children.