A Presentation for Mental Health Professionals:
Understanding Adverse Childhood Experiences and Self-Esteem
A Research Paper
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Abstract

The purpose of this project and subsequent paper is to educate mental health professionals to have a better understanding of how adverse childhood experiences (ACEs) impact individuals later in life. ACEs are common, affecting people from all walks of life. According to the Centers for Disease Control and Prevention (CDC), 26% of the population has one ACE, while 12% has four or more ACEs (2017). Due to the pervasiveness of ACEs, it is important that mental health professionals understand how ACEs affect individuals. This body of work aims to educate mental health professionals on the ACE study and testing, as well as which events constitute an ACE. Additionally, this body of work will focus on how physical and mental health, brain development, and self-esteem are affected. In regards to mental health, the area of self-esteem will be examined specifically, as several research studies have shown that individuals who experience ACEs are more apt to suffer from low self-esteem (Ekinci & Kandemir, 2015; Oates, 1984; Oberst & Stewart, 2003). Based on findings, recommendations will be made for interventions mental health professionals can use with their clients to help increase client self-esteem. These interventions include the Adlerian concept of social interest, as well as journaling, and mindfulness.
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Adverse Childhood Experiences (ACEs) which include childhood trauma, impact the mental and physical health and functioning of people, regardless of age, gender, race, and socioeconomic background. According to the Centers for Disease Control and Prevention (CDC), ACEs are common, with 26% of the population having at least one ACE, while 12.5% of the population have experienced 4 or more ACEs (CDC, 2017). Due to the pervasiveness and the impact ACEs have on the general population, it is important for mental health professionals to understand ACEs and their effect on individuals. This literature review examines the ACE study and testing, discussing what types of traumatic events constitute ACEs, and how ACEs can impact an individual’s physical health and brain development, and mental health. In regards to mental health, the area of self-esteem will be examined specifically, as several research studies have shown that individuals who experience ACEs are more apt to suffer from low self-esteem (Ekinci & Kandemir, 2015; Oates, 1984; Oberst & Stewart, 2003). Additionally, this literature review will explore a few interventions, including the Adlerian concept of social interest, as well as behavioral stress management, such as mindfulness, meditation and, journaling, all of which mental health professionals can use to help increase self-esteem in those affected by ACEs.

**ACEs Study**

According to the Centers for Disease Control (CDC) (2017), The CDC-Kaiser Permanente Adverse Childhood Experience (ACE) Study is one of the largest investigations analyzing childhood abuse and neglect and how it impacts health and well-being later in life. Prior to this study, “the relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household
ACEs AND SELF-ESTEEM

dysfunction during childhood had not previously been described” (Felitti et al., 1998, p. 245).
The study took place at Kaiser Permanente, in San Diego, California. The study was started by
Dr. Vincent Felitti, along with Dr. Robert Anda of the CDC, after Felitti was baffled when
patients in a weight loss program who were successful at losing weight were dropping out of the
program. After surveying the patients, it was found that weight loss made the patients feel
vulnerable, with a large portion of the patients disclosing that they were victims of childhood
sexual abuse (Monnat & Chandler, 2015). Thus, the ACEs study was conceived.

The study began with one round of data collection in 1995 and a second round in 1997
(Felitti et al., 1998). The questionnaire, which was mailed to participants, contained 60
questions and took individuals about 45 minutes to complete (Hillis, Anda, Felitti, &
Marchbanks, 2001). Among some of the findings of the study was that the more ACEs an
individual had experienced, the more likely the individual is to have multiple risk factors later in
life. Additionally, the ACEs study proves that childhood trauma is prevalent among all groups,
even affecting highly educated white adults with access to health care (Anda et al., 2006); and
according to Monnat and Chandler (2015), having “health insurance does not contribute to the
mediation of any ACEs” (p. 736).

ACE’s Testing and Categories of Childhood Abuse

To define the adverse childhood exposures, the study consisted of three categories of
childhood abuse: psychological abuse, physical abuse, and contact sexual abuse. Additionally,
there were “four categories of exposure to household dysfunction during childhood: exposure to
substance abuse, mental illness, violent treatment of mother or stepmother, and criminal
behavior” (Felitti et al., 1998, p. 248). According to Felitti et al., the questions asked on the
questionnaire are as follows:
(Did a parent or other adult in the household) … Often or very often swear at, insult, or put you down? Often or very often act in a way that made you afraid that you would be physically hurt? Often or very often push, grab, shove, or slap you? Often or very often hit you so hard that you had marks or were injured? (Did an adult or person at least 5 years older ever) … Touch or fondle you in a sexual way? Have you touch their body in a sexual way? Attempt oral, anal, or vaginal intercourse with you? (Did you) … Live with anyone who was a problem drinker or alcoholic? Live with anyone who used street drugs? Was a household member depressed or mentally ill? Did a household member attempt suicide? (Was your mother or stepmother) … Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her? Sometimes, often, or very often kicked, bitten, or hit with a fist, or hit with something hard? Ever repeatedly hit over at least a few minutes? Ever threatened with, or hurt by a knife or gun? Did a household member ever go to prison? (p. 248)

Participants in the survey were “defined as exposed to a category if they responded “yes” to 1 or more of the questions in that category” (Felitti et al., 1998, p. 248). All 7 categories of childhood exposure to abuse and household dysfunction were used in the analysis. Thus, the possible number of exposures ranged from 0 (no exposure) to 7 (exposed to all categories). The most common of the 7 categories of childhood exposure was substance abuse, affecting 25.6% of respondents. The least common category of childhood exposure was evidence of criminal behavior in the household, affecting 3.4% of respondents. Additionally, the study showed that 52% of respondents experienced more than 1 category of adverse childhood exposure and 6.2% of respondents experienced more than 4 adverse childhood exposures (Felitti et al., 1998).

Another study maintained, according to Dong et al. (2004), that if an individual “had one ACE,
the likelihood of their having another was 2 to 18 times higher than those reporting no ACEs” (p. 778).

**Impacts of ACEs**

The experiences, positive or negative, an individual has in childhood shape their entire lives. “Childhood is a particularly salient stage of development, and thus, adverse events during childhood have the potential to influence developmental pathways and shape the character and content of later life” (Monnat & Chandler, 2015, p. 725). ACEs are associated with ill effects for the individual in both physical health, including brain development, and mental health, not to mention social consequences. According to Iniguez and Stankowski (2016), ACEs increase rates of the following in adulthood:

- unemployment, use of public assistance for medical care, lack of emotional support,
- dissatisfaction with life, poor general and physical health, occurrence of frequent mental distress, limitations cause by mental or physical health issues, smoking, heavy drinking,
- increased body mass index, and diagnoses of depression, anxiety, and asthma. (p. 130)

In addition, experiencing ACEs in childhood can lead individuals to increased rates of sexually transmitted diseases, unintentional pregnancies, and intimate partner violence (Hughes, Lowey, Quigg, & Bellis, 2016).

Not only have the number of categories of adverse childhood experiences been shown to have a positive relationship to the presence of adult disease, but “the seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life” (Felitti et al., 1998, p. 245). Even those individuals who report just one ACE are more likely to have disorders. “Adults who experienced even one ACE reported worse health, were more likely to
report a functional limitation, and were significantly more likely to report a diagnosis of diabetes or heart attack” than those who reported no ACEs (Monnat & Chandler, 2015, p. 733).

**Physical Health Impacts of ACEs**

In addition to some of the physical ailments mentioned previously, Teicher and Samson (2016) assert adult survivors of childhood trauma also have higher rates of inflammation, metabolic syndrome, arthritis, ischemic heart disease, cancer, and “shortened telomeres associated with reduced life expectancy” of up to 20 years less than the average person (p. 241). There is even causal evidence linking different categories of childhood trauma to specific physical diseases. For example, according to Goodwin and Stein (2004), from data drawn by the National Comorbidity Survey (N=877), there are associations between childhood physical abuse and an increased risk of lung disease, peptic ulcer, and arthritic disorders. “Childhood sexual abuse was associated with increased risk of cardiac disease and childhood neglect was associated with increased risk of diabetes and autoimmune disorders” (Goodwin & Stein, 2004, p. 519). Additionally, there is emerging evidence that some ACEs are associated with certain physical outcomes, but not others. For example, in a study by Monnat and Chandler (2015), “verbal abuse was associated with only self-rated and functional limitations and witnessing parental domestic violence was associated only with odds of a diabetes diagnosis” (p. 745) while experiencing physical abuse in childhood was associated with all four health outcomes in the study: self-rated health, the presence of a functional limitation, diabetes, and experiencing a heart attack.

To further complicate matters, Monnat and Chandler (2015) assert that individuals who have experienced ACEs many times attempt to manage their psychological problems, for example, increased perceived stress and anxiety, through “avoidance-focused coping
mechanisms” (Monnat & Chandler, p. 727). Even though these are adaptive means of coping with trauma, they may be damaging to health in the long term. “Coping strategies like smoking, alcohol consumption, overeating, and engaging in risky behaviors can temporarily alleviate distress, shame, and helplessness, but can lead to health problems over time” (Monnat & Chandler, p. 727). Furthermore, individuals who experienced childhood trauma are more likely to underutilize healthy coping mechanisms, such as exercise, as an adaptive strategy to deal with residual effects of the trauma (Monnat & Chandler, 2015). This underutilization of healthy coping mechanisms to combat the effects of childhood trauma can also contribute to physical health problems.

**The Effect of ACEs on Brain Development and Functioning**

Experiencing childhood trauma affects brain development, changing how the brain functions, making the individual more susceptible to many afflictions later in life. Presently, a clearer, but complex picture is starting to emerge on the relationship between ACEs and alterations in function and structure of regions in the brain that are susceptible to stress, as well as the long-term effects the changes in the brain can cause in the many areas of the individual’s life. According to Heim and Nemeroff (2001) “emerging evidence from clinical studies suggests that exposure to early life stress is associated with neurobiological changes in children and adults, which may underlie the increased risk of psychopathology” (p. 1023).

The brain development of children is particularly vulnerable to trauma due to the rapid rate at which the brain develops in children, and also, the way in which the child’s brain is receptive to environmental input, also known as brain plasticity (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). “The process of early brain development is constantly modified by environmental influences” (Glaser, 2000, p. 99). Childhood trauma constitutes one aspect of
these environmental influences, “which present the maturing child’s brain with experiences that will crucially---and potentially adversely---affect the child’s future development and functioning” (Glaser, p. 99).

In early brain development in humans, there are sensitive periods during which certain experiences affect brain maturation. “Although certain experiences are essential for orderly brain development to proceed, the occurrence of some noxious experiences will cause harm to the developing organism” (Glaser, 2000, p. 100). It is during traumatic events that the child’s brain is at a heightened state of stress and it releases fear related hormones. Perry et al. (1995) assert that when a child experiences trauma, such as abuse, the brain remains in a heightened pattern “reactivated when the child is exposed to a specific reminder of the traumatic event (e.g. gunshots, the presence of a past perpetrator) (Perry et al., 1995, p. 278). Additionally, according to Perry et al., these parts of the brain may be reactivated anytime the child thinks or dreams about the event. This prolonged heightened state frequently changes the emotional, behavioral, and cognitive function in the individual by overworking and reducing the volume of the hippocampus area of the brain (Perry, 2000). The hippocampus is an area of the brain responsible for cognition, memory, and arousal. It has been shown that this reduced hippocampal volume in brains of individuals who experienced childhood trauma is also a common thread in individuals with a vast array of psychiatric disorders (Teicher & Samson, 2016). Additionally, Heim and Nemeroff (2001) assert that when the central nervous system, which is “integrally involved in the regulation of stress and emotion”, is persistently sensitized as a consequence of trauma experienced in childhood it may represent the underlying biological substrate of an increased vulnerability to subsequent stress as well as to the development of depression and anxiety. A number of
preclinical studies suggest that early life stress induces long-lived hyper(re)activity of corticotropin-releasing factor (CRF) systems as well as alterations in other neurotransmitter systems, resulting in increased stress responsiveness. (p. 1023)

Furthermore, Glaser asserts that in infants, “new stimuli are expected to be presented in a way which is safe, nurturing, predictable, repetitive, gradual, and attuned to the infant’s developmental state” (2000, p. 100). The absence of certain interactions with infants, such as handling of the infant, responsive gaze, and talking to the infant contribute to the elimination of synaptic connections. The elimination of synaptic connections can lead to “permanent deficits in cognitive abilities” (Glaser, p. 100). Healthy brain development during the sensitive period in infants is also dependent on appropriate input and sensitive interaction with the primary caregiver. Often individuals who experienced ACEs had primary caregivers as infants that were not engaged or were withdrawn, or could also have been insensitive, intrusive, and angry. In the absence of appropriate input and sensitive interaction with the primary caregiver, “the infant brain is unable to learn self-regulation of affect”, becoming apparent later in life manifesting as aggression or hypervigilance (Glaser, p. 101). In addition, it also effects cognitive abilities and other areas, according to Cook et al. (2005):

- exposure to traumatic events may alter the child’s brain causing long-term effects with:
  - attachment, including trouble with relationships, boundaries, empathy, and social isolation;
  - dissociation, including altered states of consciousness and impaired memory;
  - emotional regulation, including difficulty identifying emotions and communicating needs;
  - self-concept, including lack of sense of self, body image issues, low self-esteem, shame, and guilt;
  - and finally, behavioral control, including, difficulty controlling
impulses, oppositional behavior, disrupted sleep and eating patterns, and trauma re-enactment (p. 396)

**Impact of ACEs on Mental Health**

Research consistently shows that there is a link between ACEs and mental illness. This is especially true for those individuals who suffered multiple ACEs, making it more likely that they will develop mental illness (Schilling, Aseltine, & Gore, 2007). As previously discussed, much of the current research is beginning to connect childhood trauma and the effect of the trauma on the child’s developing brain, making those individuals who experienced childhood trauma more likely to develop a vast array of psychiatric disorders in their lifetime. Additionally, experiencing trauma in childhood can “lead to negative beliefs about the self, world, and others. These kinds of beliefs make potentially distressing interpretations of ambiguous everyday events more likely and have been shown to be associated with psychosis” (Larkin & Read, 2008, p. 291). Furthermore, “survivors of childhood maltreatment show higher prevalence of depression, anxiety, substance abuse, eating disorders, suicidal symptomatology, psychosis and personality disorder as well as diminished cognitive functioning and poorer treatment response” (Teicher & Samson, 2016, p. 241).

Research is able to predict which ACEs are the strongest contribution to developing mental disorders, as well as linking certain ACEs to specific mental illnesses. According to Kessler, Davis, and Kendler (1997) “childhood adversities associated with maladaptive family functioning (e.g. parental mental illness, child abuse, neglect) were the strongest predictors of disorders” (p. 1111). Cancel et al. (2015) maintain that individuals who endured child abuse or neglect make it more likely for them to develop schizophrenia. Mauritz, Goossens, Draijer, and van Achterberg (2013), link “interpersonal trauma such as emotional, physical and sexual abuse
to PTSD” and dissociative disorders (p. 2). Mood disorders in general are shown to be more prevalent in individuals who experienced sexual abuse. According to Larrson et al., bipolar disorder specifically is proven to be more prevalent in individuals who suffered sexual abuse (2013).

**Impact of ACEs on Self-Esteem**

Self-esteem is defined by Brodski and Hutz (2012) as, “people’s representations of their typical, or general, global feelings of self-worth” (p. 259). Thus, self-esteem reflects people’s “representations of how they typically feel about themselves through time and context” (Brodski & Hutz, p. 259).

Individuals who experience childhood trauma report lower self-esteem than those individuals who did not experience childhood trauma (Nelson-Goff, Crow, Reisbig, & Hamilton, 2007; Valerio & Lepper, 2009). Survivors of ACEs often feel ashamed about and stigmatized for their childhood adversity, many times making it difficult to recognize and disclose that these events occurred, possibly affecting treatment outcomes later. Additionally, Emler (2002) asserts that low self-esteem is a risk factor for many other problems including: suicide, suicide attempts, depression, teen pregnancy, victimization by others, eating disorders, low earnings from employment, and continuity of employment. Thus, it is important for mental health professionals to consider the relationship between ACEs and self-esteem.

Due to the fact that children learn their self-worth from the adults around them and the adult’s reaction to them, it is imperative that caregivers provide a loving and safe environment from the beginning, as self-esteem begins to develop early. According to Cook et al.:

by age 18 months, maltreated toddlers already are more likely to respond to self-recognition with neutral or negative affect than non-traumatized children. Over time,
children normally consolidate a stable and integrated sense of identity. Responsive, sensitive caretaking and positive early life experiences allow children to develop a model of self as generally worthy and competent (2005, p. 395)

Conversely, Cook et al. (2005) maintain that when the child experiences maltreatment by significant people in their lives, they not only fail to develop age-appropriate competencies, but are also likely to have feelings of the self as “flawed, helpless, deficient, and unlovable” (p. 396). These children who view themselves as powerless or incompetent and who expect others to reject and dislike them are more likely to blame themselves for negative experiences and have problems eliciting and responding to social support (Cook et al., 2005). Additionally, children surrounded by violence in their homes and communities around them learn from early on that they cannot trust, the world is not safe, and that they are powerless to change their situations. It is these beliefs about themselves, others, and the world that reduce their sense of competency. Traumatized children may view themselves as “powerless, damaged, and may perceive the world as a meaningless place in which planning and positive action is futile” (Cook et al., p. 396).

**Recommendations for Interventions to Build Self-Esteem**

At the core of Adlerian theory is the belief that individuals all have one basic desire, which is the need to feel significant and belong (Adler Graduate School, n.d.). Undoubtedly, individuals who endured ACEs have diminished self-esteem, feel discouraged and inferior. According to Alfred Adler, discouraged individuals act in unhealthy ways, sometimes withdrawing or giving up (Adler Graduate School, n.d.). Conversely, encouraged individuals feel capable, appreciative, and for the most part are cooperative and connected. According to Cook et al. (2005) “to plan for the future with a sense of hope and purpose, a child needs to value
him or herself” (p. 395). Mental health professionals need to utilize interventions that assist individuals who endured ACEs in acquiring a sense of hope, control, and the ability to see one’s own actions as having meaning and value. Or in Adlerian terms, mental health professionals can help individuals with low self-esteem due to ACEs by using interventions which allow the individual to express and accept encouragement, respect, and social interest to help the individual feel fulfilled and optimistic (Adler Graduate School, n.d.). Such interventions will be discussed below.

**Mindfulness**

Mindfulness plays a core role in the Buddhist practice and philosophy, however, can be used by anyone to increase their self-esteem, as well as many other mental and physical health benefits. Mindfulness is defined by Jianfeng, Pouchan, Nie, and Chengjing (2016) as “an individual’s awareness of, and conscious attention to, present-moment experiences” (p. 1298). Mindfulness practices, for example, meditation, can be used as a preventative intervention to enhance self-esteem (Jianfeng et al., 2016). Through mindfulness, individuals “learn to accept their thoughts, feelings, and situations, thereby enhancing their well-being” (Jianfeng et al., 2016, p. 1299). Additionally, “researchers using mindfulness-based therapy have indicated that training in mindfulness promotes people’s self-acceptance, resulting in higher self-esteem” (Jianfeng et al., p. 1299). Mindfulness works by helping people focus instead of thinking or worrying about the past.

There are many variations of mindfulness-related interventions. Individuals can participate in relaxation and body scan exercises. In these exercise, participants are “prompted to notice changes in their bodies and locate where the warm feelings were” and other body sensations (Yildiran & Holt, 2015, p. 50). Deep breathing while concentrating on the breath is
another method to use. With this exercise, participants can be prompted to “focus on the tip of their nose, noticing the sound of the breath and the air on the face” (Yildiran & Holt, p. 50).

Olfactory experiences can be used to promote mindfulness as well. For example, incense sticks and candles can be used to focus on scents, prompting participants to “focus their attention on the scents of fruits and flowers”, helping the participants to focus and calm their minds (Yildiran & Holt, p. 50). There are many apps for cellphones and computers that are useful for practicing mindfulness and meditation. For example, Headspace and YouTube are both valuable tools for practicing mindfulness and meditation.

**Journaling**

Journaling is also an effective tool for boosting self-esteem. Through journaling, the individual is possibly able to boost self-esteem and confidence by recognizing personal goals and intentions. According to Fritson (2008) “journaling is often used to promote self-introspection, reflection, and change in the client’s perceptions, behaviors and cognitions” (p. 75).

Journaling can take many forms in therapy and have many positive results, other than just increasing self-esteem. For example, “clients may be required to identify specific thoughts, their resultant feelings and behaviors, and journal about the impact of altering their thoughts” (Fritson, 2008, p. 76). This enables individuals to “actively alter their behavior in an attempt to improve their personal perspectives, mood, and daily functioning. Significant research supports cognitive strategies, such as journaling improve mood and functioning of depressed and anxious individuals” (Fritson, p. 76). Additionally, journaling has been “shown to improve clients’ self-awareness, promote active reflection on clients’ selves and make changes in clients’ thoughts, perceptions, behaviors, and mood”, all of which are instrumental in increasing self-esteem (Fritson, p. 76).
Social Interest

Humans have an innate need for social interest to help them offset their feelings of inferiority and foster healthy self-esteem. Adlerian theory asserts that “social interest is the true and inevitable compensation for all natural weaknesses of individual human beings” (Ansbacher & Ansbacher, 1956, p. 154). This need for human need for social connectedness is innate, however, it must be consciously developed (Adler Graduate School, n.d.).

Adlerian Psychology maintains that individuals can foster encouragement through social interest activities (Adler Graduate School, n.d.). In other words, individuals can promote self-esteem by helping others. Research shows that people who participate in volunteer activities “report higher self-esteem, self-efficacy, and social connectedness than non-volunteers” (Brown, Hoye, & Nicholson, 2012, p. 468). Increased social connectedness and a sense of belonging are associated with volunteering and was found to be the strongest first step in increasing self-esteem. Additionally, volunteering increases self-esteem as it gives the individual a sense of purpose by helping in the community and making a difference, and by taking the focus off of one’s self, providing individuals with the opportunities to feel a sense of achievement and empowering the individual through the new experiences and increased skillset (Brown et al., 2012).

Presentation

The material was delivered through a power point presentation at Alliance Health Care’s staff of in-home adult rehabilitative mental health services (ARMHS) workers and in-home therapists. This writer is currently on staff at Alliance Health Care as an ARMHS worker and in-home therapist. Alliance Health Care is a for profit organization located in Eagan, Minnesota. In addition to employing ARMHS workers and in-home therapist, the company also provides
personal care assistance (PCA) services. The company operates on the premise that health care is a basic human right, and must be coordinated with other human services when necessary in a comprehensive manner that enhances quality of life and promotes independence. The company’s mission is to maintain a progressive, nurturing environment with a team dedicated to fulfilling the highest standards of quality care while encouraging consumer independence. (Alliance Health Care, n.d.). The clients at Alliance Health are very diverse and are all severely and persistently mentally ill (SPMI).

The information in the presentation and this paper allowed the staff at Alliance Health Care a broader awareness of how ACEs affect the clientele they serve. Additionally, it allows them to gain a better understanding of the client’s behavior and reasons behind their behaviors as related to ACE exposure, and to provide interventions to assist the clients in facilitating change. This presentation opened up a conversation at the organization on how the ARMHS workers and in-home therapist can better serve their clients who experienced ACEs, engaging the clients to affect change. The interventions of mindfulness, journaling, and social interest that were presented will be implemented in the future when working with the clients. Lastly, the organization is thinking about adding an ACE questionnaire to their intake packet.

According to the feedback by the staff at Alliance Health Care, the staff felt the presentation and information presented was interesting and relevant to their clients. One staff member reported she would have like to have statistics on how ACEs affect different racial groups. Additionally, the staff reported that they will be interested to see what future research proves about ACEs and how they impact clients, since it is a relatively new area of study.
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