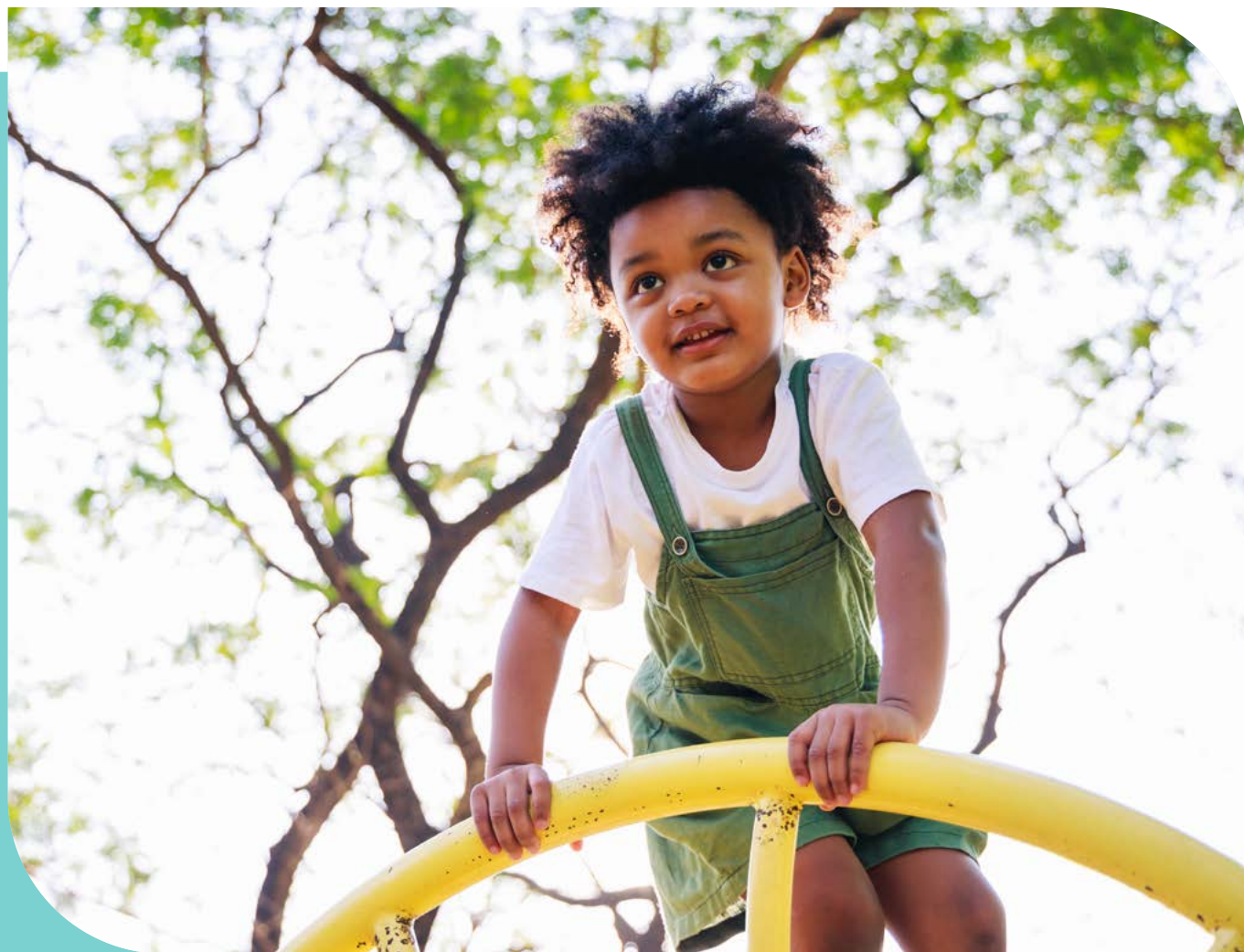


FACTSHEET 

ADVERSE CHILDHOOD EXPERIENCES



Childhood is a time of building blocks—foundational years that set people up for successes and challenges in adulthood. Children raised in safe, supportive, and resource-rich environments are more likely to grow up to be happy and healthy adults. Children who experience Adverse Childhood Experiences (ACEs) tend to face challenges and encounter negative social, behavioral, and health outcomes later in life.¹ Preventing and acting on ACEs is critical to improving health. Through family, community, and societal solutions, we can prevent ACEs and support infants, children, and adolescents who have experienced ACEs.

ACEs are a National Outcome Measure established for the Title V Maternal and Child Health (MCH) Services Block Grant program. The Children’s Safety Network works with Title V agencies to strengthen their infrastructure and create safe and healthy environments for infants, children, and adolescents.

This fact sheet provides:

Information on ACEs, including the types of and consequences of ACEs.

The most recent data from the 2021–2022 National Survey of Children’s Health (NSCH) on ACEs prevalence and disparities.

Recommended best practices from various leading organizations, such as the Centers for Disease Control and Prevention (CDC), and published studies to highlight programs and strategies to prevent and reduce ACEs.

WHAT ARE ADVERSE CHILDHOOD EXPERIENCES?

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur during childhood (ages 0-17). The CDC categorizes ACEs into three main types: abuse, neglect, and household challenges.^{2,3}

Abuse	Neglect	Household Challenges
<ul style="list-style-type: none"> » Physical (e.g., being hit by a parent or other adult) » Emotional (e.g., being insulted by a parent or other adult) » Sexual (e.g., being touched sexually by a parent or other adult) 	<ul style="list-style-type: none"> » Physical (e.g., not having an adult who regularly makes sure basic needs [food, clothing] are met) » Emotional (e.g., rarely feeling safe and protected) 	<ul style="list-style-type: none"> » Mental illness in the household (e.g., a household member having depression or attempting suicide) » Intimate partner violence (one or more adults in the household experiencing physical or sexual violence) » Divorce (parents/guardians being separated or divorced) » Incarcerated relative (a family member spending time in prison) » Substance misuse in the household (e.g., a household member having alcohol use disorder)

This list is not exhaustive. Examples of other types of adversity include (but are not limited to): experiencing economic hardship, death of parent or guardian, bullying, community/neighborhood violence, experiencing discrimination (e.g., based on race or ethnicity, disability, health condition, sexual orientation, or gender identity), natural disasters, refugee or wartime experiences, and witnessing or experiencing acts of terrorism.^{3,4,5}

ACES CONSEQUENCES

ACEs affect children's emotional, cognitive, and physical development, which can have an impact across the person's lifespan. Adversity causes stress, and depending on the amount, frequency, and seriousness of ACEs, can cause a chronic, prolonged activation of the stress-response system.^{6,7} Not only can stress affect the immune system, but especially in childhood, it can have a lasting effect on neurodevelopment and decision-making.⁸ ACEs are associated with unhealthy behaviors, such as substance use and risky sex,⁹ as well as fewer opportunities for education, employment, and financial security.¹⁰ ACEs can also significantly raise the risk of mental health issues such as depression and anxiety.¹¹ Ultimately, ACEs can contribute to early death through chronic diseases and health conditions, such as cancer, heart disease, kidney disease, stroke, asthma and diabetes,^{11,12} overdose, or suicide.¹³ The annual costs of ACE-associated physical and mental health illnesses and loss of healthy life years have been estimated to be \$14 trillion.¹¹

Unfortunately, ACEs can be intergenerational: individuals who have ACEs and face hardship in adulthood are more likely to have children who experience ACEs.¹⁴

HOW COMMON ARE ACES: UNDERSTANDING THE DATA

Data from the 2021-2022 National Survey of Children's Health (NSCH) indicate that 21.3% of children ages 0-17 had experienced one ACE during their lifetime, and another 17.4% had experienced two or more ACEs.⁵ The NSCH assesses ACEs based on responses to 11 items: 1) hard to cover basics on family's income; 2) parent or guardian divorced or separated; 3) parent or guardian died; 4) parent or guardian served time in jail; 5) saw or heard parents or adults slap, hit, kick punch one another in the home; 6) was a victim of violence or witnessed violence in their neighborhood; 7) lived with anyone who was mentally ill, suicidal, or severely depressed; 8) lived with anyone who had a problem with alcohol or drugs; 9) treated or judged unfairly due to race/ethnicity; 10) treated or judged unfairly due to sexual orientation or gender identity; and 11) treated unfairly because of a health condition or disability.*

* To note, ACEs data are available through other surveillance systems, such as the Behavioral Risk Factor Surveillance System (BRFSS), that have varying methodologies. For example, 2011-2020 BRFSS data shows higher rates of ACEs (63.9% experienced at least one ACE as a child and 17.3% experienced four or more ACEs).^{3,15} The BRFSS is self-reported by adults (18+) who retrospectively report on cumulative ACEs throughout their childhood while the NSCH is completed by caregivers of children (0-17) who report on ACEs to date rather than the entirety of childhood. The items assessed in BRFSS versus NSCH also differ (i.e., BRFSS includes abuse and neglect while NSCH includes economic hardship and experiences of discrimination). Due to differing survey methodologies and items, a comparison cannot be made between the data sets. Additional data sources that measure ACEs may be leveraged to guide prevention work in the states and communities.

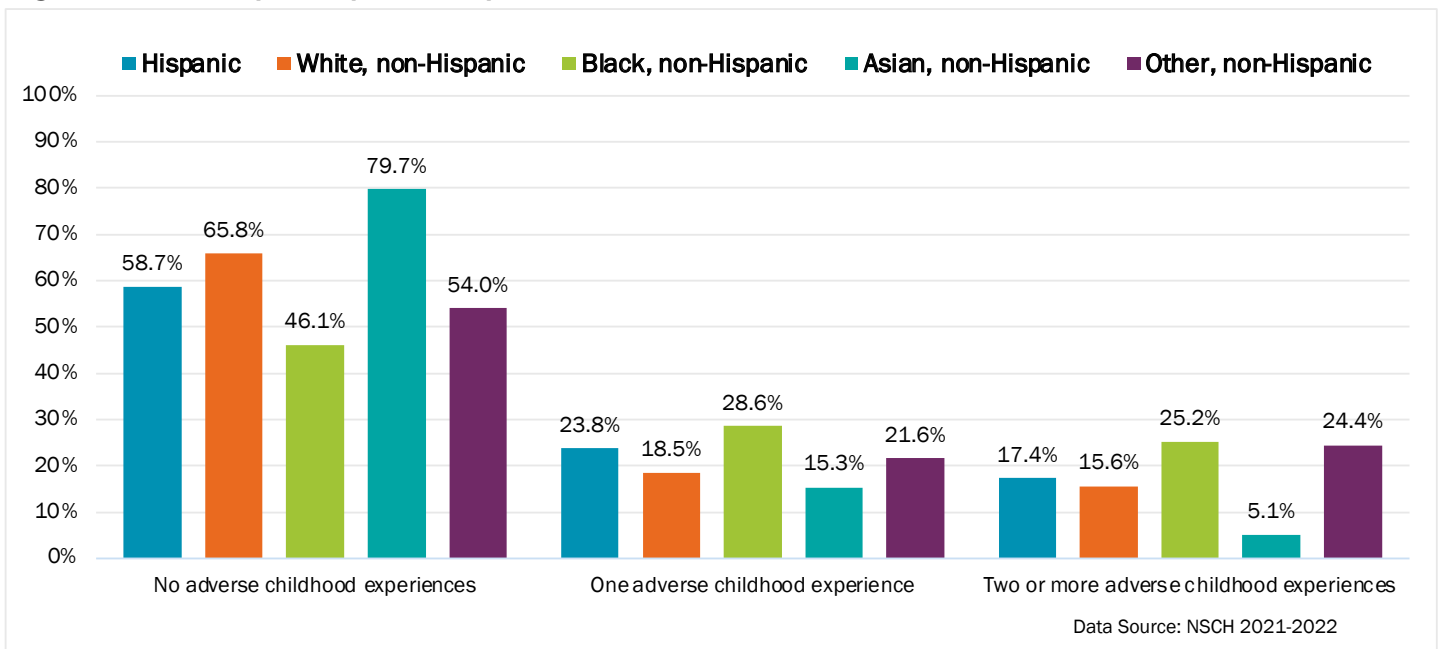
DISPARITIES IN ACES

ACEs are not experienced at uniform rates; rather, there are significant disparities between certain sociodemographic categories, such as race/ethnicity, family income, and the presence of special health care needs. The disparities information presented in this fact sheet are based on data retrieved from the 2021-2022 NSCH.⁵

Race/Ethnicity

According to 2021-2022 NSCH data, Black children are more likely to experience ACEs than their White, Asian and Hispanic peers. The prevalence of ACEs among this data source’s “Other” group may be driven in part by members of Indigenous groups, who are reported to be at high risk for ACEs.¹⁶

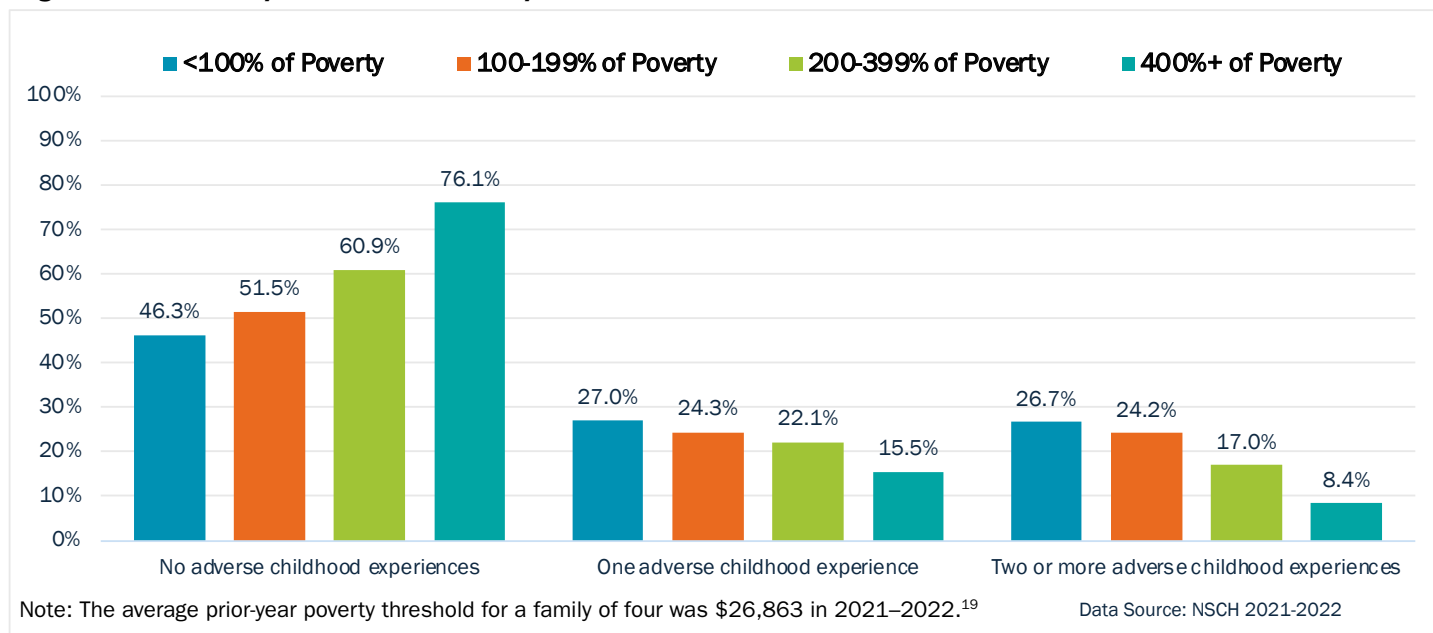
Figure 1. ACEs by Race/Ethnicity



Family Income

In general, the 2021-2022 NSCH shows that family income is negatively correlated with ACEs. Possible explanations are that lower income households are more likely to reside in more violence-prone neighborhoods and lack access to healthcare.¹⁷ Households with higher incomes are more able to provide resources for the children, including basic needs such as food and clothing, as well as access to quality childcare and after-school activities.¹ Also, economic hardship is correlated with parental stress, harsh parenting, and child problem behavior.¹⁸

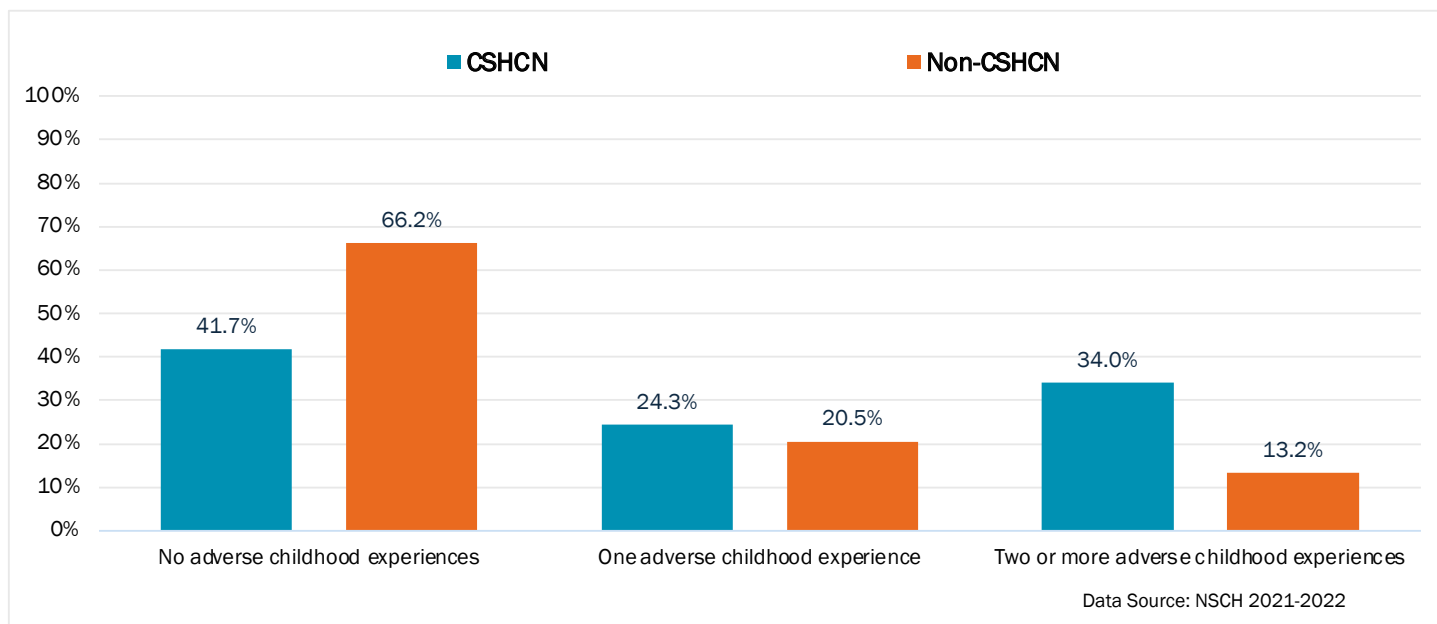
Figure 2. ACEs by Past Year Family Income



Children With Special Health Care Needs (CSHCN)

According to 2021-2022 NSCH data, CSHCN are significantly more likely to have experienced ACEs, compared to children without special health care needs. CSHCN status was determined by the CSHCN Screener, a validated instrument that was designed to reflect the federal Maternal and Child Health Bureau’s definition of CSHCN.²⁰ Children were identified as having special health care needs if they had a service need or functional limitation due to a medical, behavioral, or other health condition that had lasted, or was expected to last, at least 12 months. The relationship between ACEs and CSHCN status is complex and could be bidirectional. ACEs can put children at higher risk for special healthcare needs,⁷ and having special health care needs can also put a child at higher risk of experiencing ACEs.²¹

Figure 3. ACEs by CSHCN Status



RISK AND PROTECTIVE FACTORS

Risk and protective factors at the individual, relationship, community, and societal levels of the social-ecological model are associated with experiencing or preventing ACEs.^{1,2,4,22,23}

Social-ecological Level	Sample Risk Factors	Sample Protective Factors
Individual	<ul style="list-style-type: none"> » Poor school engagement » Behavioral problems 	<ul style="list-style-type: none"> » Academic achievement » Coping and emotional regulation skills
Relationship	<ul style="list-style-type: none"> » Social isolation » Early dating/sexual activity » Lack of positive relationships with adults » Parents with lower incomes and education levels » Younger caregivers or single parents » Parents with history of ACEs » Caregivers with weak communication skills 	<ul style="list-style-type: none"> » Positive peer networks » Supportive and caring relationships with caregivers or other adults » Parents with higher income and education level » Parental monitoring and supervision » Caregivers with strong communication skills

Social-ecological Level	Sample Risk Factors	Sample Protective Factors
Community	<ul style="list-style-type: none"> » High crime rates » High poverty rates » High unemployment rates » Unstable housing » Food insecurity » Easy access to drugs and alcohol » Few community activities for children 	<ul style="list-style-type: none"> » Community connectedness » Increased economic and job opportunities » Community norms supporting shared responsibility for well-being of children » Access to mental and physical healthcare
Societal	<ul style="list-style-type: none"> » Acceptance of negative masculine gender roles (e.g., aggression, violence) » Stigma towards help-seeking behaviors » Acceptance of corporal punishment » High cost of quality healthcare and childcare » Income inequality » Systemic racism 	<ul style="list-style-type: none"> » Laws against corporal punishment » Policies making quality childcare affordable » Family-friendly work policies

GUIDANCE FOR PREVENTION

ACEs are widespread and have lasting emotional, behavioral, and physical consequences. However, ACEs can be prevented by promoting protective factors, ranging across all the social-ecological levels. CDC has identified the six strategies below to prevent ACEs and mitigate long-term consequences of ACEs already experienced. They are also meant to disrupt intergenerational transmission of ACEs.¹

Strategies	Approaches	Examples
<p>Strengthen economic supports to families</p> <p>Children with parents facing financial hardship are more likely to experience ACEs because of a lack of resources, as well as the stress caused by financial insecurity. Economic support can reduce those factors and have been shown to increase access to quality childcare, reduce rates of child neglect, and youth perpetrated violence.</p>	Strengthening household financial security	Tax credits, childcare subsidies
	Family-friendly work policies	Paid parental leave, flexible work schedules, regular hours
<p>Promote social norms that protect against violence and adversity</p> <p>Individual, community, and societal-level programs and policies can reduce violent behaviors, encourage a communal sense of responsibility for others' well-being, and shift gender norms, all of which can help prevent ACE's.</p>	Public education campaigns	Shift harmful beliefs (e.g., that masculinity is tied to violence and aggression, stigma against help-seeking behaviors), encourage communities to share a sense of responsibility for children's well-being
	Legislative approaches to reduce corporal punishment	Reduce the use of physical punishment, especially effective when paired with education campaigns
	Bystander approaches, men and boys as allies in prevention	Programs such as Green Dot ²⁴ and Coaching Boys into Men ²⁵ that encourage bystanders to speak up when they see violent behavior, or sense that it could arise

Strategies	Approaches	Examples
<p>Ensure a strong start for children</p> <p>These tactics provide children and new parents with the care and educational opportunities that they might not have access to. They are shown to reduce rates of child abuse and neglect and are associated with higher academic achievement and lower substance abuse later in life.</p>	Early childhood home visitation	Community health programs, such as the <u>Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program</u> , ²⁶ that support home visiting for expectant and new parents living in disadvantaged communities
	High-quality (affordable) childcare	Licensing and accreditation for improving childcare quality
	Preschool enrichment with family engagement	Head Start programs, like <u>Child-Parent Centers</u> , ²⁷ that offer comprehensive early childhood education
<p>Teach skills</p> <p>Educational programs that are delivered to both youth and their caregivers help youth form healthy relationships with their parents and peers.</p>	Social-emotional learning	School-based programs that teach coping skills, emotional awareness, and regulation
	Safe dating and healthy relationship skill programs	Programs that reduce teen dating violence, like <u>Dating Matters</u> ²⁸
	Parenting skills and family relationship approaches	Programs such as <u>The Incredible Years</u> ²⁹ promote children’s academic, social, and emotional skills by fostering caregivers’ engagement in their child’s school experiences
<p>Connect youth to caring adults and activities</p> <p>Not only do after-school programs provide supervision during a time when violence peaks, but they, and mentoring programs, provide youth with positive role-models, educational opportunities, and healthy relationship development.</p>	Mentoring programs	Programs like <u>Big Brothers, Big Sisters</u> ³⁰ that provide supportive relationships between adults and children
	After-school programs	Programs such as <u>After School Matters</u> ³¹ that provide youth with structured, supportive environments

Strategies	Approaches	Examples
<p>Intervene to lessen immediate and long-term harms</p> <p>When ACEs are not prevented, these approaches can lessen the negative consequences of exposure. Interventions administered to children and adults help stop the progression from ACEs to behavioral and physical health problems, to transmission to future generations.</p>	Enhanced primary care	Clinician-administered brief screening assessments to identify the best interventional route
	Victim-centered services	Programs that provide social support to victims of partner violence
	Treatment to lessen the harms of ACEs, prevent problem behavior and future involvement in violence	Trauma-focused Cognitive Behavioral Therapy and Multisystemic Therapy
	Family-centered treatment for substance use disorders	Pairing substance use treatments and parenting interventions

ACES PREVENTION RESOURCES

- » [Information Hub: Adverse Childhood Experiences \(ACEs\) in Indian County | National Indian Health Board](#)
- » [Child Abuse and Neglect Prevention Resource for Action | CDC](#)
- » [Community Violence Prevention Resource for Action | CDC](#)
- » [Becoming Trauma Informed: Adverse Childhood Experiences \(ACEs\) and Trauma: Implications for Schools | The National Comprehensive Center](#)
- » [VetoViolence Preventing ACEs Trainings | CDC](#)
- » [The National Child Traumatic Stress Network](#)
- » [Healthcare Strategies for Preventing and Addressing ACEs and Toxic Stress | Salud America!](#)
- » [State Actions to Prevent and Mitigate Adverse Childhood Experiences | National Governors Association](#)
- » [Adverse Childhood Experiences \(ACEs\) Prevention | Prevent Child Abuse America](#)

REFERENCES

1. Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence. Centers for Disease Control and Prevention. 2019. Accessed September 16, 2024. https://www.cdc.gov/violenceprevention/pdf/aces-prevention-resource_508.pdf
2. Adverse Childhood Experiences Prevention Strategy. Centers for Disease Control and Prevention. 2021. Accessed September 16, 2024. https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf
3. Behavioral Risk Surveillance System ACE Data. Centers for Disease Control and Prevention. Updated June 29, 2023. Accessed September 16, 2024. <https://www.cdc.gov/violenceprevention/aces/ace-brfss.html>
4. About Adverse Childhood Experiences. Centers for Disease Control and Prevention. Updated May 16, 2024. Accessed September 16, 2024. <https://www.cdc.gov/aces/about/index.html>
5. Child and Adolescent Health Measurement Initiative. 2021-2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Accessed May 5, 2024. <https://www.childhealthdata.org>
6. Shonkoff JP, Garner AS, Siegel BS, Dobbins M, Earls MF, Garner AS, Mcguinn L, Pascoe J, Wood DL. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232-e246. doi: [10.1542/peds.2011-2663](https://doi.org/10.1542/peds.2011-2663)
7. Webster EM. The impact of adverse childhood experiences on health and development in young children. *Glob Pediatr Health*. 2022;9: 2333794X2210787. doi: [10.1177/2333794x221078708](https://doi.org/10.1177/2333794x221078708)
8. Smith KE, Pollak SD. Early life stress and development: Potential mechanisms for adverse outcomes. *J Neurodev Disord*. 2020;12(1):34. doi: [10.1186/s11689-020-09337-y](https://doi.org/10.1186/s11689-020-09337-y)
9. Substance Use and Sexual Risk Behaviors Among Youth. Centers for Disease Control and Prevention. Updated July 11, 2018. Accessed September 16, 2024. https://www.cdc.gov/healthyouth/factsheets/substance_use_fact_sheet-detailed.htm
10. Metzler M, Merrick MT, Klevens J, Ports K, Ford DC. Adverse childhood experiences and life opportunities: Shifting the narrative. *Child Youth Serv Rev*. 2017;72:141-149. doi: [10.1016/j.chilgyouth.2016.10.021](https://doi.org/10.1016/j.chilgyouth.2016.10.021)
11. Peterson C, Aslam MV, Niolon PH, Baco S, Bellis M, Mercy JA, Florence C. Economic burden of health conditions associated with adverse childhood experiences among US adults. *JAMA Netw Open*. 2023;6(12):e2346323-e2346323. doi: [10.1001/jamanetworkopen.2023.46323](https://doi.org/10.1001/jamanetworkopen.2023.46323)
12. Sanderson M, Mouton C, Cook M, Liu J, Blot WJ, Hargreaves MK. Adverse childhood experiences and chronic disease risk in the southern community cohort study. *JHCPU*. 2021;32(3):1384-1402. doi: [10.1353/hpu.2021.0139](https://doi.org/10.1353/hpu.2021.0139)
13. Injury Center Priorities. Centers for Disease Control and Prevention. Updated August 15, 2024. Accessed September 16, 2024. https://www.cdc.gov/injury/priorities/?CDC_AAref_Val=https://www.cdc.gov/injury/priority/index.html#cdc_generic_section_4-aces-suicide-and-overdose-are-related
14. Schickedanz A, Escarce JJ, Halfon N, Sastry N, Chung PJ. Intergenerational associations between parents' and children's adverse childhood experience scores. *Children*. 2021;8(9):747. doi: [10.3390/children8090747](https://doi.org/10.3390/children8090747)
15. Swedo EA, Aslam MV, Dahlberg LL, Niolon PH, Guinn AS, Simon TR, Mercy JA. Prevalence of adverse childhood experiences among U.S. adults — Behavioral Risk Factor Surveillance System, 2011–2020. *MMWR*. 2023;72:707–715. doi: [10.15585/mmwr.mm7226a2](https://doi.org/10.15585/mmwr.mm7226a2)
16. Waterman EA, Edwards KM, Mullet N, Herrington R, Hopfauf S, Trujillo P, Even-Aberle N, Wheeler L. Rates of recent adverse childhood experiences among indigenous children. *J Child Adolesc Trauma*. 2024;17:295-205 doi: [10.1007/s40653-023-00587-1](https://doi.org/10.1007/s40653-023-00587-1)
17. Goldstein E, Topitzes J, Miller-Cribbs J, Brown RL. Influence of race/ethnicity and income on the link between adverse childhood experiences and child flourishing. *Pediatr Res*. 2021;89:1861–1869. doi: [10.1038/s41390-020-01188-6](https://doi.org/10.1038/s41390-020-01188-6)
18. Neppi TK, Senia JM, Donnellan MB. Effects of economic hardship: Testing the family stress model over time. *J Fam Psychol*. 2016;30(1): 12–21. doi: [10.1037/fam0000168](https://doi.org/10.1037/fam0000168)
19. Poverty Thresholds. U.S. Census Bureau. Updated September 5, 2024. Accessed September 16, 2024. <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html>
20. Bethell CD, Read D, Stein REK, Blumberg SJ, Wells N, Newacheck PW. Identifying children with special health care needs: Development and evaluation of a short screening instrument. *Ambul Pediatr*. 2002;2(1): 38-48. doi: [10.1367/1539-4409\(2002\)002%3C0038:ICWSHC%3E2.0.CO;2](https://doi.org/10.1367/1539-4409(2002)002%3C0038:ICWSHC%3E2.0.CO;2)

21. Hoover DW, Kaufman J. Adverse childhood experiences in children with autism spectrum disorder. *Curr Opin Psychiatry*. 2018;31(2):128–132. doi: [10.1097/YCO.0000000000000390](https://doi.org/10.1097/YCO.0000000000000390)
22. Jones MS & Pierce H. Early exposure to adverse childhood experiences and youth delinquent behavior in fragile families. *Youth Soc*. 2020;53(5). doi: [10.1177/0044118X20908759](https://doi.org/10.1177/0044118X20908759)
23. Webb NJ, Miller TL, Stockbridge EL. Potential effects of adverse childhood experiences on school engagement in youth: A dominance analysis. *BMC Public Health*. 2022;22(1):2096. doi: [10.1186/s12889-022-14524-8](https://doi.org/10.1186/s12889-022-14524-8)
24. Coker AL, Bush HM, Cook-Craig PG, DeGue SA, Clear ER, Brancato CJ, Fisher BS, Recktenwald EA. RCT testing bystander effectiveness to reduce violence. *Am J Prev Med*. 2017;52(5): 566-578. doi: [10.1016%2Fj.amepre.2017.01.020](https://doi.org/10.1016%2Fj.amepre.2017.01.020)
25. Jaime MC, McCauley HL, Tancredi DJ, Nettiksimmons J, Decker MR, Silverman JG, O'Connor B, Stetkevich N, Miller E. Athletic coaches as violence prevention advocates. *J Interpers Violence*. 2015;30(7):1090-1111. doi: [10.1177/0886260514539847](https://doi.org/10.1177/0886260514539847)
26. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Health Resources and Services Administration. Updated August 2024. Accessed September 16, 2024. <https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program>
27. Reynolds AJ & Ou SR. Paths of effects from preschool to adult well-being: A confirmatory analysis of the Child-Parent Center Program. *Child Dev*. 2011;82(2):555-582. doi: [10.1111/j.1467-8624.2010.01562.x](https://doi.org/10.1111/j.1467-8624.2010.01562.x)
28. Niolon PH, Vivolo-Kantor AM, Tracy AJ, Latzman NE, Little TD, DeGue S, Lang KM, Estefan LF, Ghazarian SR, McIntosh WLK, Taylor B, Johnson LL, Kuoh H, Burton T, Fortson B, Mumford EA, Nelson SC, Joseph H, Valle LA, Tharp AT. An RCT of Dating Matters: Effects on teen dating violence and relationship behaviors. *Am J Prev Med*. 2019;57(1):13-23. doi: [10.1016/j.amepre.2019.02.022](https://doi.org/10.1016/j.amepre.2019.02.022)
29. Menting ATA, Orobio de Castro B, Matthys W. Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review. *Clin Psychol Rev*. 2013;33(8):901-913. doi: [10.1016/j.cpr.2013.07.006](https://doi.org/10.1016/j.cpr.2013.07.006)
30. Herrera C, DuBois DL, Heubach J, Grossman JB. Effects of the Big Brothers Big Sisters of America Community-Based Mentoring Program on social-emotional, behavioral, and academic outcomes of participating youth: A randomized controlled trial. *Child Youth Serv Rev*. 2023;144:106742. doi: [10.1016/j.childyouth.2022.106742](https://doi.org/10.1016/j.childyouth.2022.106742)
31. Hirsch BJ, Hedges LV, Stawicki JA, Mekinda A. After-school programs for high school students: an evaluation of After School Matters. Technical report. Northwestern University. 2011. Accessed September 16, 2024. <https://wallacefoundation.org/sites/default/files/2023-09/After-School-Programs-for-High-School-Students-An-Evaluation-of-After-School-Matters.pdf>

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