Let’s Face Adverse Childhood Experiences (FACE) It: Parent Education and Empowerment

Chia Thao¹*, Irán Barrera², Uyen (Sophie) Nguyen²

Authors’ affiliations:
¹ California State University, Fresno, USA
² Fresno State Department of Social Work, USA

*Corresponding author: Chia Thao
California State University, Fresno, USA
Email: chiat@mail.fresnostate.edu

ABSTRACT

Adverse childhood experiences (ACEs) are a major public health concern in the United States as childhood trauma can lead to long-term health and mental health consequences. They disproportionally affect low-income children of diverse backgrounds; however, parent education can potentially reduce ACEs among low-income young children. This study aims to examine whether parents’ perceptions toward ACEs changed after exposure to ACEs-related infographic education. In this study, we identified three main themes across the focus group interviews that highlight the importance of ACEs-related educational intervention. Following the ACEs-related education, our study found that the vast majority of participants’ attitudes toward and perceptions of ACEs changed from normalizing ACEs to acknowledging and accepting the consequences of ACEs; the participants also reported feeling empowered to prevent the cycle of ACEs. More importantly, the participants recognized that ACEs could cause long-term traumatic damage to the exposed child’s health outcomes, and they felt empowered to seek resources for ACEs-related interventions. These findings shed positive light on the significance of educating parents on ACEs, which should be considered for policy implications and program interventions to prevent child maltreatment in the United States. We propose an intervention model using the health literacy and educational empowerment frameworks along with other policy recommendations that highlight the importance of culturally and linguistically appropriate services for diverse families living in low-income housing communities.

Keywords: educational intervention; empowerment; Latino; African American; Hmong; low-income housing; Fresno
1. INTRODUCTION

Adverse childhood experiences (ACEs) are a major public health problem in the United States, as short-term and long-term childhood trauma can have a detrimental impact on one’s mental health (Dube et al., 2001; Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998; Jonson-Reid, Drake, & Kohl, 2009; Burke et al., 2011). The consensus of the body of literature highlights that children who experience maltreatment such as physical, emotional, and/or sexual abuse are more likely to have increased risks for several mental health problems, including substance use disorder, depression, suicide attempts, and risky sexual behavior (Hunt, Slack, & Berger, 2017; Liming & Grube, 2018; Navalta, McGee, & Underwood, 2018). For instance, Hunt et al. (2017) suggested that children exposed to ACEs are at a higher risk of suffering from health issues and behavioral problems later in life. In addition, children from disadvantaged communities, including African-American children, children from lower-income families, and children from single-parent households, are more likely to experience ACEs at an early age than their wealthy peers (Hunt et al., 2017; Liming & Grube, 2018). Most importantly, ACEs can influence children’s behavioral and academic outcomes (Jimenez et al., 2016; Keiley et al., 2001; Trzesniewski et al., 2006), leading to delinquency in adulthood (Bitsko, 2016; Kerker et al., 2015; Shin, McDonald, & Conley, 2018).

However, not all hope is lost. Studies have shown that early prevention and recognition of ACEs is critical for preventing depressive disorders later in life (Putnam, 2006). Some parenting education programs have shown success in reducing child abuse. One of the most evidential findings is from the Supporting Kids And Their Environment (SKATE) program in Australia, which was a child-focused intervention designed by an interdisciplinary team to address ACEs. The study found that educational intervention improves family relationships, thereby improving children’s behaviors (Lewis, Holmes, Watkins, & Mathers, 2014). Similar studies have echoed the importance of educational intervention and implementation as ways to prevent ACEs (Bethell, Newacheck, Hawes, & Halfon, 2014; Bitsko, 2016; Lindert et al., 2014; Putnam, 2006). However, existing literature lacks clarity on the intervention of ACEs-related educational interventions among low-income disadvantaged communities.

As a result, the goal of the current study was to assess the impact of a 15-minute ACEs education to residents of diverse racial/ethnic backgrounds living in low-income housing communities in the San Joaquin Valley of California. The study aimed to identify changes in parents’ perceptions and attitudes about ACEs after the educational intervention. This paper reports on the focus group conversations on ACEs that followed the educational intervention.

1.1 Prevalence of ACEs in the Central Valley, California

According to the U.S. Department of Health and Human Services (2018), an estimated of 3.5 million children were the subject of a child protective services
investigation in 2016, a 10% increase from 2012. Among those children, 17% were investigations for child maltreatment (U.S. Department of Health and Human Services, 2018). Similarly, child maltreatment was reported in California (Webster et al., 2018). Among such investigations, 223.2 involved Native Americans, 166.3 African Americans, 51 Latinos, 44 Whites, and 13.9 Asians (Webster et al., 2018).

The Lucile Packard Foundation for Children’s Health (2019) reported a higher rate of child maltreatment in Fresno County. Among such allegations, 71.9 per 1,000 children under 18 years of age were classified as cases of child abuse and neglect—a much higher rate than California’s state average of 54.6 per 1,000. According to the 2016 U.S. Census, Fresno County’s population was approximately 980,000; 53% were Hispanic/Latino, 30% White, 11% Asian, 6% African American, and 3% mixed races. The largest city in the county is Fresno, with an estimated population of 522,000.

Fresno was known to have one of the highest concentrations of poverty in the nation (Jiang, Ekono, & Skinner, 2014; U.S. Census Bureau, 2015), with 87% of the population living in a neighborhood identified as falling below the federal poverty guideline (Kneebone & Holmes, 2016). As a result, nearly 39% of children in Fresno live in poverty, compared to 23% in the state of California and 21% nationwide (Jiang et al., 2014; U.S. Census Bureau, 2015). Studies have shown that children living in poverty are more likely to experience frequent and intense childhood adversities that can lead to early death (Anda, Butchart, Felitti, & Brown, 2010). Social economic status is strongly associated with poor parental mental health and parenting behaviors (Conger et al., 1992, 1993; Linver, Brooks-Gunn, & Kohen, 2002).

The Fresno community is diverse in terms of racial and ethnic backgrounds. Income disparities also exist among minority communities in Fresno (Aratani, Barrera, & Kelley 2017). According to the U.S. Census Bureau (2015), 45% of Latino children and 44% of children with at least one foreign-born parent live in poverty; meanwhile, it 41% for African Americans and 50% for Hmong. Only 19% of White children live in poverty (U.S. Census Bureau, 2015). Such statistics are consistent with previous findings that children from diverse backgrounds are more likely to live in poverty than White children in the United States (Jiang et al., 2014). A higher prevalence of child maltreatment has also been among racial/ethnic minority groups. For instance, the Lucile Packard Foundation for Children’s Health (2019) used data from the California Child Welfare Indicators Project to identify 185 cases of child abuse and neglect per 1,000 children among African-American/Black children, followed by 71 among Latino children, 55 among White children, and 32 among Asian/Pacific-Islander children.

The high prevalence of child maltreatment among the racially diverse Fresno County community warrants a thorough investigation to better understand the complexities of this issue in the Central Valley. An interdisciplinary approach using the Health Literacy Model may be a
potential solution to address the overwhelming concern about child maltreatment in Fresno County.

1.2 Health Literacy Model to Address Child Maltreatment

Health literacy is defined as knowledge that is:

- linked to literacy and entails people’s knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course. (Sørensen et al., 2012, p. 3).

Studies have shown that limited literacy is prevalent among those of lower socioeconomic status and literacy (Nutbeam, 2008; Porr, Drummond, & Richter, 2006; Sørensen et al., 2012). Utilizing the health literacy model to address child maltreatment through efforts such as ACEs-related education can improve the current limitation and prevalence of ACEs among low-income, low-literacy communities.

Healthcare professionals play a crucial role in encouraging the effectiveness of ACEs-related education (i.e., education about child maltreatment). ACEs-related education is a powerful tool for individuals—both victims and perpetrators—to comprehend the importance of poor ACE implications. The health literacy model can foster empowerment for impoverised and illiterate individuals (Freire, 2005; Nutbeam, 2000; Wallerstein, 2006) and serve as an asset for improving people’s empowerment through ACEs-related knowledge (Sørensen et al., 2012). Empowerment improves individuals’ actions and health outcomes (Wallerstein & Bernstein, 1988; Wallerstein & Sanchez-Merki, 1994; Crondahl & Eklund Karlsson, 2016). As such, the purpose of this paper is to examine how an ACEs-focused educational intervention affects the perceptions of and attitudes toward child maltreatment among families of culturally diverse backgrounds living in low-income housing communities in Fresno.

1.3 Empowerment Education Component of the Intervention Model

Like health literacy, empowerment education is an equally important element of the ACEs intervention used in this study and merits distinction from its conjoined twin. Rappaport (1987, p. 121) defined empowerment as a process by which people gain control over their life circumstances. Hence, empowerment education seeks to cultivate the power in others through an interactive process of sharing knowledge, expertise, and resources (Funnell et al., 1991). Brazilian educator Paulo Freire (1973) developed a theoretical framework for empowerment education that asks the population-to-be-educated to identify their own issues and underlying causes as the first steps and then set goals and formulate strategies to overcome their challenges and attain these goals. In this way, Freire’s empowerment education process enables others to develop new beliefs in their ability...
to impact their personal and social spheres (Bergsma, 2004). Not only do empowered individuals have resource mobilization skills and perceived control over their own lives (Perkins & Zimmerman, 1995), but they also can affect group and systemic changes (Bergsma, 2004).

In the realm of health, empowerment education engenders a psychological shift in patients, thereby changing the relationship dynamics between patients and health professionals. Empowerment-oriented interventions focus on understanding socio-environmental causes of health conditions, instead of victimizing patients, and on providing opportunities for patients to build the knowledge and skills necessary to improve their well-being (Bergsma, 2004; Wallerstein, 2002). An empowerment orientation identifies patients’ assets and community capacity to foster protective factors, going beyond the commonly used “powerlessness” discourse centered around risk factors in patients’ lives (Wallerstein, 2002). The patients are no longer recipients of services; rather, they become active participants in their care, with health professionals serving more as collaborators than as authoritative experts (Funnell et al., 1991).

Therefore, empowerment education, together with health literacy promotion, has been widely regarded as an effective health education and prevention model and evaluated in different types of programs (Funnell et al., 1991; Wallerstein, 2002; Wallerstein & Bernstein, 1988). A meaningful intervention would integrate both empowerment education and health literacy promotion, as the effects of the two are intertwined. A high level of empowerment without a corresponding level of health literacy can lead to potentially harmful health choices by patients, whereas a low level of empowerment coupled with high health literacy can prompt patients to develop excessive dependence on health professionals (Schulz & Nakamoto, 2013).

The ACEs-related educational intervention of this study was built upon both components. By showing parents the ACEs infographic, the research team aimed to increase parents’ health literacy related to ACEs, thereby giving parents some sense of control and empowerment to address the issues.

2. METHODS

The researchers used a vignette approach to examine the perceptions of child maltreatment, as Lapatin and colleagues (2012) found that “vignettes provide a valuable approach that is acceptable to participants, elicits important insight on participant experience and services” (p. 1345). As noted in the original study (Barrera, Kelley, & Aratani, 2019), we believe utilizing a vignette style model to examine child maltreatment is an appropriate approach for people of color. As a result, three types of child maltreatment scenarios were presented to the participants to explore how parents perceived each scenario. We used convenience sampling of families of diverse backgrounds who receive federal housing subsidies from a local housing authority in Fresno, California. Because we focused on
developing prevention services utilizing mental health literacy and empowerment that are culturally sensitive, we first needed to know the beliefs or attitudes of the groups in this study (i.e., Latino, Hmong, and African American).

Our research question was: How do parents’ education about ACEs influence low-income housing residents’ attitudes?

2.1 Data Collection and Analysis

The researchers recruited a total of 24 participants for five focus group interviews. Three focus groups were conducted in Spanish, one was in English, and one was in Hmong. Eligibility criteria to participate in the focus groups were (1) having children and (2) receiving federal housing subsidies. Nine participants were recruited through parenting groups at locations managed by a local housing authority, which were in the city of Fresno as well as outside the city. The remaining 15 were recruited through convenience snowball sampling, where residents invited other residents to participate in the focus group. Ultimately, participants included six African Americans, seven Hispanics (including four participants who self-identified as Mexican and three as Hispanic), eight Hmong, one White, and two who did not specify their race or ethnicity. The majority of participants were female (n=25, 88%), although three males participated in the Hmong focus group (12%). The purpose of the focus group interviews was to understand the diverse perspectives of parents in low-income housing regarding child maltreatment, which were measured before and after a brief 15-minute educational intervention about the implications of ACEs. In this study, we focused only on the post results as the results for the pre intervention were published already (Barrera et al., 2019). The advantages of conducting focus group interviews over individual interviews include the ability to promote more discussions on a difficult topic such as child maltreatment. In addition, in consultation with the housing staff, it was decided that gathering participants would be easier via focus groups than individual interviews because of their unpredictable work schedules. Finally, although we recognized the sensitive nature of the research topic, we prioritized the feasibility and completion of this study, so we encouraged all members to actively participate.

Focus groups were held in July, August, and September 2017 at community centers that are part of subsidized housing complexes managed by the local housing authority. In general, focus groups should occur in non-threatening environments with a group of individuals who share certain characteristics to allow for a good group dynamic and greater self-disclosure (Krueger & Casey, 2000). All five focus group interviews were conducted at locations most geographically convenient for the participants. Focus groups were conducted in private rooms, where participants sat around a table and were able to see one another. The focus groups were conducted in the language that the participants preferred (English, Spanish, or Hmong). [Institution blinded for review] Institutional Review Board approved the focus group procedures. Focus group
discussions lasted an average of 60 minutes, ranged from 30 to 90 minutes, and were recorded for transcription purposes (Krueger & Casey, 2000).

Interviewers read vignettes that described the maltreatment of three children, Jose, Eve, and Justin (see Appendix A), and then followed with a list of semi-structured guiding questions. The participants were probed for examples, clarification, and/or details in their responses. The focus group questions centered on their perceptions about how the children in the vignettes are treated (see Appendix B).

After the vignette discussion, the interviewers implemented a 15-minute infographic information session about the significance of ACEs-related implications (see Appendix C). The interviewers presented thorough information on ACEs, followed by post-discussion questions related to ACEs (see Appendix D). The questions were developed to assist participants in engaging in a dialogue about ACEs after the educational intervention, with the hopes of capturing rich data around potential changes in their personal attitudes toward and beliefs about child maltreatment. Interviews questions were transcribed and translated into English. Member-checking was conducted during focus group discussions to confirm the credibility of narrative accounts. In addition, peer debriefing was conducted to assess focus group discussions along with a careful review of focus group notes. Coding consistency between coders was obtained by engaging in prior practice coding. Three coders independently analyzed the data to identify subcategories, categories, subthemes, and themes using MAXQDA software. Codes were compared, and any discrepancies were discussed among coders in detail and then finalized to increase the reliability and validity of our study.

3. RESULTS

“There’s no real definite answer for [ACEs]. I think that what doesn’t break you is gonna make you stronger.” –A Latino parent

A total of 21 interviewees captured the three main themes of the post ACE-related education discussions. Among the individuals who initially rationalized punitive parenting practices as part of growing up or had mixed views about ACEs, 77% changed their perceptions after learning about the negative implications of ACEs through the infographic, acknowledging ACEs as a potential problem. Table 1 highlights the breakdown of individuals’ perceptions following the ACEs-related education. Of the three individuals who still had views and did not change their perspective about ACEs, two acknowledged that the infographic education was helpful and true. Overall, the vast majority of the participants (71%) found the infographic to be informative and useful; it confirmed the poor impacts that the participants had observed after experiencing ACEs firsthand.
Table 1: Parents’ Views Post ACEs-related Education

<table>
<thead>
<tr>
<th>Summary</th>
<th>Percentage of interviewees (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seemed to have some changes in viewpoints</td>
<td>48% (10)</td>
</tr>
<tr>
<td>From only rationalizing physical punishment/neglect to acknowledging it as a problem</td>
<td>19% (4)</td>
</tr>
<tr>
<td>From mixed views (seeing that physical punishment/neglect is bad, but rationalizing it) to acknowledging the negative impact of ACEs</td>
<td>29% (6)</td>
</tr>
<tr>
<td>Did not change viewpoints</td>
<td>33% (7)</td>
</tr>
<tr>
<td>Acknowledged ACEs as a problem</td>
<td>19% (4)</td>
</tr>
<tr>
<td>Mixed views</td>
<td>14% (3)</td>
</tr>
<tr>
<td>Mentioned that infographics were true or helpful</td>
<td>71% (15)</td>
</tr>
<tr>
<td>Talked about self-empowerment</td>
<td>52% (11)</td>
</tr>
<tr>
<td>Expressed viewpoints either pre or post ACEs-related education</td>
<td>19% (4)</td>
</tr>
<tr>
<td>Acknowledged ACEs as a problem (pre or post)</td>
<td>10% (2)</td>
</tr>
<tr>
<td>Mixed views (pre)</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Rationalized ACEs (pre)</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Total number of interviewees who talked about this topic</td>
<td>100% (21)</td>
</tr>
</tbody>
</table>

Through an ethnographic analysis of post focus group transcripts, we identified three main themes across all focus group interviews that characterize participants’ perceptions of child maltreatment after exposure to the infographic education. It is important to note that we used findings from the initial study to come up with these themes (Barrera et al., 2019): (1) changing perceptions from normalizing or justifying punitive parenting practices as part of growing up (“it is not so bad”) to viewing those practices as a problem and recognizing their negative consequences, (2) affirming the usefulness of the infographic information, and (3) feeling empowered to seek resources to overcome ACEs-related consequences. Parents were
also asked to identify what types of resources they needed to prevent child maltreatment.

### 3.1 Changing perceptions of ACEs

“[ACEs education is] like an alert for people or so that they can also understand what we go through sometimes, [...] that we insult each other in the family and think that maybe it doesn’t have any effect, but it’s—sometimes it’s even greater than we think.” – A Latino parent

By comparing participants’ discussions before and after they learned about ACEs through an infographic, we found that most participants’ perceptions of ACEs shifted toward acknowledging the negative impacts of ACEs. Prior to seeing the ACEs infographic, only five participants (24%) stated that experiencing ACEs would have harmful effects on children; nearly three-quarters of the participants (n=15; 71%) either rationalized ACEs or expressed mixed views toward ACEs. Four participants talked about how parents who beat children mean well and that beating or hitting a child is a disciplinary method: “Kids, when they grow up, some are naughtier and must be disciplined by hitting.” In responding to Justin’s vignette scenario, one said that, “if she [Justin’s mother] isn’t a drug addict, then her beatings may be disciplinary matters, which means that her beatings are with good intentions and she will love [her children] after she teach[es] them the lesson.” Another participant suggested that enduring a rough childhood could teach a child early on how to “deal with” others: “I think that even if they have a rough childhood, as you get older—because you’re gonna be dealing with different people, even in relationships—eventually, you should learn how to work against that.” The third rationalization of ACEs was that bad experiences would help children know what to avoid, and these children could grow up into strong and healthy adults. Six participants discussed this view before they saw the ACEs infographic. In particular, one recalled: “Well my mom and my dad, they used to discipline us, they used to get the belt [...] or whatever, and I feel like I turned out okay. I don’t smack my kids. I do tell them to behave and calm down, but I’ve never smacked them, so I think I turned out okay.” Another participant stated that, “if [Jose’s] father is already an alcoholic and display[s] bad behavior [...] the boy might learn from those bad examples and will not turn out to be like his father. He will have kept all the bad memories in his heart and will learn that these bad parenting skills are unhealthy and will avoid being like this father in the future.” Although some participants recognized that ACEs could adversely influence a child’s well-being, including mental health, the majority justified those experiences.

However, after the participants were introduced to the formal concept of ACEs through an infographic and had a chance to ask questions about ACEs research, we saw a notable shift in their perceptions of ACEs. By asking participants all the same questions about the vignettes after a 15-minute ACEs-related information session, we were able to compare each participant’s views about ACEs and identify possible
changes. Overall, almost three-quarters of the participants (n=15; 71%) acknowledged negative consequences of ACEs, and approximately 5% (n=3) maintained mixed views afterwards. No participants purely rationalized ACEs as some had done before seeing the ACEs infographic. Of the five participants who started out by justifying ACEs, four began to discuss the negative effects of ACEs after learning about the research findings (the remaining participant did not express any views after the infographic). Similarly, among the 10 participants who had mixed views, six no longer mentioned their justifications for ACEs and instead talked about ACEs consequences. One shared that “[ACEs education] is very informative and it’s also like an alert for people or so that they can also understand what we go through sometimes, [...] that we insult each other in the family and think that maybe it doesn’t have any effect, but it’s—sometimes it’s even greater than we think.” The comparison between each participant’s views pre and post the ACEs education reveals that the majority of the participants who rationalized or had mixed views about ACEs initially started to acknowledge detrimental outcomes of those experiences for children. The following section discusses participants’ thoughts about the information session on ACEs during the focus group.

3.2 Validating the importance of ACEs educational intervention

“I believe that the findings from ACE are true. We are living proof that ACE exemplified our childhood experience and current mental health challenge in the United States.” –A Hmong parent

The vast majority of the participants indicated that the ACEs-related education was informative and useful, providing important validation for their own perspective and/or experience of ACEs. After the brief 15-minute educational intervention, the post discussion revealed that 71% of the participants acknowledged that child maltreatment affects people’s physical, social, and emotional well-being. Many participants validated that, due to their similar childhood experiences to those of Jose, Eve, and Justin in the vignettes, they are now suffering from the poor implications of ACEs. As one participant in an African-American focus group stated, “From my experience, yes. I’ve known a lot of people with ACEs, like a whole large group.” Another participant from the same cohort said, “I’m an adult. I have some ACEs, and according to this study that I’ve obtained—so, what I’m saying is that it lines up pretty well. What I’m saying also is that it’s not really fair to have an umbrella statement. However, I do agree that this has a lot of truth to it.” The validation was further supported by the Hmong participants, as the vast majority in this group stated, “Okay, well that means that all of us here are sick because we faced hardships in Laos (referring to their wartime experiences, struggles, and deprivation). Growing up, we did not have enough luxury to eat, nor did we receive the emotional support from our parents.” One Hmong parent shared that “the findings were very impressive. The results validated our thoughts and feelings. We now realize
that not just us, but people (children) with similar physical and emotional issues have the same health outcomes.” Ominously, a Latino parent agreed on the poor implications of exposure to ACEs during childhood and poor health outcomes into adulthood: “I definitely do feel it’s the truth, all that, it does affect, abuse, neglect, all that, very true. So, yes, I do believe it is the truth.” Based on these discussions, most participants express overwhelming support for efforts to prevent ACEs because the implications of ACEs reflect their own experiences and health.

3.3 Self-empowerment to prevent ACEs

“So in order to get out of that, we have to want it. And then when we want it, we gotta be consistent and do something about it while we’re still struggling with all the other stuff.” –A Latino parent

A dose of education about the adversities of ACEs goes a long way. Our discussions about ACEs after the educational intervention session provided evidence that education changes individual perceptions about ACEs; most importantly, education empowered many individuals in our study to want to break the cycle of ACEs and seek resources to prevent ACEs. The data indicated that, after the educational session, participants acknowledged ACEs as a problem. During the post discussion, one parent stated, “It (ACES) makes sense, yeah. It’s just disturbing, that’s all.” This point was supported by a Hmong parent: “I agree with the findings from ACEs.” The session was also informative for a Latino parent, who concluded, “I feel educated.” Most important of all, the education empowered many participants to want to change the situation of ACEs in their own family and community, as indicated by one Latino parent’s statement: “You’re gonna have to take some steps to make changes. You can’t just do what you’re doing because what you’re doing is just evading us. Moreover, that’s what I did the entire time. I mean, not everyone’s like me, but I just felt like if kids got more education—I know things are changing a lot. I mean, the fact that you’re here—[...] Education is very important.” Another Latino parent said, “I turned it around, and now my kids are in college.” Furthermore, an African-American parent stated, “you know, if they’re willing to say, ‘I am not going to live what I lived when I was young,’ they will actually...[change/prevent ACEs].” One Latino parent underscored the importance of preventing ACEs: “I think they’re gonna be in that statistic still...that same statistic is gonna carry over to their adult life, in some cases, not all...I think that’s gonna carry over into their adult life if it (ACES program intervention) can’t be addressed and avoided.” Other parents stressed the importance of ACEs-related education as follows:

It’s also, like you said, a little disturbing that it’s—where we now have to try to prevent and help the children that we’re raising and try to make sure that they don’t pick up any of these adversities so that they can have a better outcome. Moreover, if they do, be okay with saying, “How can I get the help that you need or get
the services to make sure that you know you’re okay with whatever you’re going through or how you tackle some of these issues that you feel about yourself?” So, I like that you guys have the program, I like that you guys are doing the research, because without it, there would be no services. I do like the fact that you are doing research on other ethnicities because it’s not just a black or white or Asian thing. It is about the children and about adults.

Many individuals were motivated to seek services after being informed about the unfortunate implications of ACEs. One Latino parent asked, “How can I get the help that you need or get the services to make sure that you know you’re okay with whatever you’re going through or how you tackle some of these issues that you feel about yourself?” Another parent from the same group said, “Now I have a child, so let me make sure that doesn’t happen to her….I don’t want that same thing to happen to her.”

Self-empowerment was best summarized by a Latino parent: “You’re showing up. That’s the first step. However, you gotta take it another step further yourself.” One Hmong parent clearly stated, “You need to go find these assistance programs. The government has already provided them, but you have to go find them. The correct way is for you to go find them, not for them to find you.” It is noteworthy that parents voiced concerns surrounding problems with current programs due to the lack of resources for ACEs intervention. About 30% of the parents also expressed the challenge of the limited existing programs. One parent explained:

What if you need behavioral health? What if you need mental health? A lot of the times, it’s six months to a year out. A lot of the times, by the time you get an appointment, the service is no longer available because it’s got chopped in funding. So, beware of the false promises. Yes, this is okay for people who can pay for the service, but now, we’re a targeted group where we don’t have a lot of money and we don’t have a lot of resources, and I don’t want my child being labeled a statistics.

In short, we learned through the post discussion that the parents’ behavior and attitudes about the punitive impacts of ACEs have severe consequences. After the educational intervention, parents felt empowered to make a more informed decision about ACEs. Many emphasized the importance of seeking services for ACEs intervention. On the other hand, there are barriers for some parents seeking ACEs-related services, as one parent reported the lack of resources. Therefore, future studies should focus on the type of intervention services that can close the gap in services.

4. CONCLUSIONS

There are limited education intervention programs targeting low-income parents of racial minority groups in particular. Parent education and awareness are a potential strategy for informing a
behavior change around childbearing and building nurturing parent–child relationships that can prevent ACEs or buffer the negative consequences of ACEs (Altafim & Linhares, 2016; Cowen, 2001; McCarthy et al., 2002; Prinz, 2016). Our study has shown that, after a brief ACEs-related education session, parents were more aware of the negative effects of ACEs on their children. As a result of being informed about the adverse impact of ACEs, parents’ knowledge of ACEs’ implications increased, and most parents became more accepting of the related consequences. Parents felt empowered by the information and discussed ways to stop the cycle of ACEs in their own families and communities. These findings shed a positive light on the importance of educating parents on ACEs, which should be considered for policy implications and program interventions to prevent child maltreatment in the United States.

The results from our study add to the small body of literature on the importance of an ACEs intervention program. Despite the limitations of the small sample size and no control group is present, our finding suggests some positive effects of educational interventions, which could be used for a future study involving a larger sample size.

### 4.1 Policy Implication

Studies have shown a strong association between ACEs and chronic health problems, mental health problems, and poor economic outcomes in adults (Felitti et al., 1998). This study has shown that information on ACEs could help buffer the experiences surrounding toxic stress, especially in communities with limited literacy surrounding trauma. This finding is significant as many low-income communities, including housing, do not have access to information that could help people make decisions about their own well-being. For these reasons, we propose a three-step process utilizing health literacy and empowerment to assist in alleviating issues surrounding ACEs for parents/family members (see Table 1). Utilizing Sørensen et al.’s (2012) definition of health literacy presented earlier and Wallerstein and Bernstein’s (1988) definition of empowerment “as a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society” (p. 380), the first step is to create culturally and linguistically information on ACEs utilizing words/symbols and other meaningful knowledge geared for specific populations (e.g., Latino, African American, and Hmong). Next, create culturally and linguistically competent parenting programs to promote healthy parenting practices. Finally, refer parents/family members to organizations addressing issues surrounding ACEs/trauma in a culturally and linguistically sensitive manner. We believe that this three-step process will result in parents/family members having adequate levels of health literacy surrounding ACEs and adequate levels of health literacy surrounding positive parenting to ultimately buffer toxic stress. We believe that the curriculum design for ACEs in this study is an exemplar for other entities to follow, especially those serving low-income people.
of color. However, we recognize that the curriculum was a short-term intervention, and further research is needed to investigate the long-term effect. In addition, this study did not include a comparison group that did not receive the intervention; as such, we cannot make any causal inference. Our small sample size is also a limitation to be addressed in future studies.

Table 2: Health literacy and Empowerment Three-Step Model for ACEs

<table>
<thead>
<tr>
<th>Targets</th>
<th>For</th>
<th>Recommended Programs</th>
<th>Intended Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Health Literacy</td>
<td>Parent/family members</td>
<td>Based on the theme we identified of “affirming the usefulness of the infographic information,” create culturally and linguistically sensitive information on ACEs utilizing words/symbols and other meaningful knowledge geared for specific populations (e.g., Latino, African American, and Hmong)</td>
<td>Adequate level of health literacy surrounding ACEs</td>
</tr>
<tr>
<td>(2) Health Literacy</td>
<td>Parent/family members</td>
<td>Based on the theme we identified as “viewing those practices as a problem and recognizing their negative consequences,” create culturally and linguistically competent parenting programs to promote healthy parenting practices</td>
<td>Adequate level of health literacy surrounding positive parenting</td>
</tr>
<tr>
<td>(3) Empowerment</td>
<td>Parent/family members</td>
<td>Based on the theme of “feeling empowered to seek resources to overcome ACEs consequences,” refer them to organizations addressing issues surrounding ACEs/trauma</td>
<td>Adequate level of health literacy surrounding ACEs to buffer toxic stress</td>
</tr>
</tbody>
</table>

5. ACKNOWLEDGMENT

Support for this study was provided by a grant from the Robert Wood Johnson Foundation Interdisciplinary Research Leaders program. Special thanks to Dr. Yumiko Aratani for the input, revisions, and guidance.
Appendix A

Jose is a 10-year-old boy who likes playing basketball with his friends. However, lately Jose has been feeling as if no one loves him. Jose’s father often drinks beer and yells at Jose when he is drunk. Jose’s mother has tried to stop her husband from yelling at Jose, but she often ends up in their fighting, and Jose feels as if he has no one to protect him.

Eve is a seven-year-old girl who enjoys drawing. She has a mother who cries and feels sad all the time. Eve’s mother feels fatigue almost every day and does not give much attention to Eve. Eve feels physically and emotionally neglected by her mother.

Justin is a third grader who likes playing with his young brother. His mother often gets angry at him and slaps him hard every time he misbehaves. Justin is usually scared of getting punishment when his mother is around.

Appendix B

1. How do you think children like Eve, Justin, and Jose will be when they are adults? Emotionally or physically?

2. Do you think they will be different from other children whose father did not drink and/or slap them or whose mother did not neglect or treat them violently?

3. Do you think Justin, Jose, and Eve can benefit from any type of help? If yes, what kind(s) of help? Probes used: help in their homes, in their housing community, or at school.

Appendix C

Educate parents on ACEs (15 minutes). We will show the ACEs infographics and explain the long-term health and mental health impact of ACEs.

Appendix D

1. How do you feel about ACEs now that you know about them?

2. How do you think Eve, Jose, and Justin will be emotionally or physically when they are adults?

3. Do you think Justin, Jose, and Eve can benefit from any type of help? What kind(s) of help?

4. What kinds of services do you think can help children or families with ACEs?
References:


