A Community-Engaged Exploration of Childhood Adversity and Resilience to Inform Mental Health Intervention

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Abstract

This study investigated a link between adverse community environments and adverse childhood experiences (ACEs) using the *pair of ACEs* (POA) framework to better understand community members' perspectives on how they were impacted across the lifespan by their childhood experiences. In addition, we identified mitigating factors that played a role for participants in building individual and community resilience. Researchers used a community-based participatory research approach with qualitative methodology to explore the experiences of 15 community members. Nine themes emerged related to both adversity and protective factors across family, community, institutional, and structural levels. Findings have implications for the counseling profession in terms of practice, advocacy, and future research.

Keywords: adverse childhood experiences, adverse community environments, pair of aces, community-based participatory research, mental health intervention

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Within the United States, childhood trauma has been identified as a public health emergency, with growing evidence tracing the impact of adverse childhood experiences (ACEs) to adult disease and health disparity throughout the lifespan (Bartolomé-Valenzuela et al., 2024; Danielsdottir et al., 2024; Dube, 2018; Shankoff et al., 2012). ACEs are potentially traumatic events experienced from birth to the age of 17. Of the more than 300 million people in the United States, 60% of adults reported experiencing at least one ACE before age 17 (Centers for Disease Control and Prevention, 2019). The Centers for Disease Control and Prevention (CDC) found that one in six adults reported experiencing four or more ACEs during their childhood, with women and communities of color at higher risk. When the toxic stress related to experiences of ACEs is not properly mitigated, evidence suggests deleterious outcomes can persist into adulthood including higher risk of suicide, incarceration, homelessness, school drop-out, and the development of health problems such as heart and lung disease, an increased likelihood of substance use and addiction, and potentially higher rates of depression (Bartolomé-Valenzuela et al., 2024; Carbonneau et al., 2016; Chapman et al., 2004; Danielsdottir et al., 2024; Dube et al., 2001; Dube et al., 2002; Dube et al., 2006; O'Neal et al., 2016). Evidence also suggests that ACEs and their consequences can be prevented when certain protective and resilience factors are developed in communities (Dube, 2018).

The *pair of ACEs framework* (POA) was developed as part of the *building community resilience model* (BCR), a community-integrated framework aimed at addressing the root causes of ACEs (Ellis, 2019). This framework asserts that ACEs do not develop in isolation but are often compounded by another type of ACE - adverse community environments. Taken together, adverse childhood experiences combined with adverse community environments create a pair of ACEs that contribute to trauma experiences at the individual, family, and community levels. Within the POA framework, these adverse community environments create fertile soil to produce adverse childhood experiences. Therefore, to effectively address the prevalence of adverse childhood experiences within a given community, mental health practitioners alongside community stakeholders must address the POA in tandem (Ellis et al., 2017; Ellis et al., 2022).

The POA framework aligns with the social justice standards of the counseling profession and recent calls for practitioners to focus efforts upstream to community-level prevention and intervention. Since their adoption, the *multicultural and social justice counseling competencies* (MSJCC; Ratts et al., 2016) have established social action as a standard component of practice for counselors. Ratts and colleagues recognized that awareness, knowledge, and skills related to multicultural competency was not sufficient. In response, they added the action of social justice work to the standards of multicultural practice. As a result, counseling practitioners have been challenged to expand their conceptualization of counseling interventions from that of work solely at the individual and family level, to also include prevention, intervention, and advocacy work at the community level. Therefore, counseling practitioners are relying on models such as Bronfenbrenner's *ecological model* (1977) and the *social determinants of mental health* model (SDMH, Compton & Shim, 2015; Johnson et al., 2023; Lenz & Lemberger-Truelove, 2023; Lenz & Litam, 2023; Neal Keith et al., 2023; Pester et al., 2023) to structure and implement social justice and equity-focused mental health intervention. We submit that the POA framework also be considered alongside these models as a justifiable approach to social justice-informed counseling intervention specifically within the context of childhood adversity.

Scholars have long discussed expanding the conventional ACEs framework to include community-level adversity. Neighborhood effects and perceived neighborhood cohesion can affect the development of children and adolescents (Fleckman et al., 2022; Minh et al., 2017; Niwa & Shane, 2021), with adverse community experiences having a substantial effect on adolescents (Cohen-Cline et al., 2019). Considering the role that community events play in human development, the idea of ACEs expansion is reflected in recent literature (Finkelhor, 2020; Fleckman et al., 2022; Giovanelli, 2021). Researchers have identified exposure to community violence, racism,

peer victimization, discrimination, socioeconomic inequality, community dysfunction and immigration-related mistreatment as adverse experiences that can occur at the community level (Baras-Gonzalez et al., 2021; Cohen-Cline et al., 2019; Duncan et al., 2023; Fleckman et al., 2022; Hamby et al., 2021; Karatekin & Hill, 2019; Lee et al., 2020; McEwen & Gregerson, 2018), noting that these adverse community experiences are more prevalent in low-income communities and communities of color (Calthorpe & Pantell, 2021; Cohen-Cline et al., 2019; Duncan et al., 2023; Hampton-Anderson et al., 2021; McEwen & Gregerson, 2018).

Purpose of the Study

The purpose of this study, therefore, was to operationalize the link between *adverse community environments* and *adverse childhood experiences* in a large urban city in the southern United States using the POA framework to inform resilience-building community-engaged coalition work. As a research team led by counseling professionals, we had an interest in examining the role and integration of mental health providers within this coalition. We aimed to understand community members' perspectives on their experiences with adverse community environments and the impact of those experiences on adverse childhood experiences, as well as to identify mitigating factors that played a role in building individual and community resilience. We used the following research questions to guide our inquiry: (1) What connections do participants express between the POA? (2) What impact does the POA have on participants? and (3) How did participants endure their experience of the POA?

Method

Research Design and Rationale

The guiding principle of our study was Community-Based Participatory Research (CBPR), a framework for research where community participation is centered throughout the research process (Burke et al., 2013; Dari et al., 2019). CBPR supports a shared leadership model engaging a community advisory board (CAB) to guide research activities from project development to completion. For this study, we collaborated with a 10-person community advisory board (CAB) of community members with expertise ranging from law, mental health, education, community activism, and organizing. We partnered with a local community organizer to recruit CAB members. He provided a list of fifteen individuals who either lived or directly worked in our community of interest. We contacted these individuals and ten agreed to take part in the CAB. Throughout the process of the study, the CAB provided critical guidance and accountability to maintain alignment with our target community's priorities (Burke et al, 2013; Fassinger & Morrow, 2013; Lyons et al., 2013). We provided each CAB member with a $50 payment per CAB meeting for their contribution.

Participants

Upon receiving institutional review board approval, we applied purposive sampling to ensure various perspectives on the interplay between adverse community environments and childhood experiences. We employed multiple recruitment methods including community outreach, social media campaigns, and collaborations with local organizations that serve as trusted entities and gatekeepers within the community. Our inclusion criteria for participation focused on individuals who had 1) experienced at least one conventional ACE and 2) experienced housing insecurity representing community-level adversity. Participant experiences of ACEs were screened using the Adverse Childhood Experiences (ACE) Study Questionnaire (ACE-Q; Felitti et al., 1998) and self-reports of having experienced housing insecurity (i.e., eviction experiences, time in public housing, loss of property, difficulty paying rent/taxes/mortgage). Sixteen individuals volunteered for the study and 15 people participated in the study. Recruited participants were informed about how the study's results would be used to train mental health clinicians and other service providers about the needs, values, lived experiences, and preferences for resources of members within their community. We provided each participant with a $50 gift card per focus group meeting/interview as an incentive for their involvement.

Participants varied in their age (M = 48.07 years, SD = 16.47) and predominantly identified as Black/African American (n = 14, 93.3%), with one person identifying as White (6.7%). Most respondents identified as cisgender women (n = 11, 73.3%), with the remaining identifying as cisgender men (n = 3, 20%) and one identifying as a transgender woman (6.7%). Participants reported that their total household income during the past 12 months ranged from $1,000 to $145,000, with an average of $63,720.86. One respondent (6.7%) did not respond to this item. Participants predominantly identified as heterosexual (n = 10, 66.6%), followed by lesbian (n = 3, 20%), gay (n = 1, 6.7%). One person (6.7%) did not respond to this item. Most respondents identified as not living with a physical or mental disability (n = 10, 66.7%), with three individuals reporting having a physical disability only (20%) and two people reporting having a mental disability only (13.3%). All 15 participants identified their religious affiliation as Christian (100%). Finally, most respondents reported their highest level of education as completing a graduate degree (n = 5, 33.3%), followed by earning a bachelor's degree (n = 4, 26.7%), earning a diploma or GED (n = 4, 26.7%), and an associate degree or certification (n = 2, 13.3%).

Researcher-Participant Relationship

Our research team was composed of two white women, a Black woman, and a Black man with expertise in professional counseling, CBPR, and black studies in teacher education. All three women had backgrounds as professional counselors and pursued this study because they believed it was important to understand how to better provide contextual clinical services in the study's community of interest using a framework like the POA. Additionally, all three women were cultural outsiders. The two white women were outsiders based on both their racial identity and as transplants to the community of interest. The Black female team member lived outside the community of interest. The male research team member had a background in educational studies in diverse populations, was a cultural insider who grew up in the community of interest, began participation as a CAB member, and later joined the research team. He was initially appointed by the CAB to lead participant interviews and remained on the research team to participate in data analysis and dissemination. The diverse academic, professional, and insider/outsider identities of the research team enabled us to approach our research with a critical lens. Together, we actively worked to mitigate our biases by continuously reflecting on our positionalities and integrating both our insider and outsider perspectives into the research process. One example of a bias was the anticipation of stories of more struggle from the focus group members. This was explored in conversation with the research team so that the stories of struggle were not privileged in the analysis and data presentation as opposed to the stories of joy and endurance. Our discussions took place in team meetings throughout the research process where we addressed data collection logistics, the coding and analysis of data, and cultivated ongoing interactions with our CAB.

In addition, we intentionally addressed power dynamics between our research team and the study participants through a commitment to ethical integrity and mutual respect, principles central to CBPR and social justice-focused research (Fassinger & Morrow, 2013; Lyons et al., 2013). Throughout the study, we maintained transparency about the research goals and processes with both the CAB and study participants, which helped build trust and foster shared ownership of the research outcomes. Regular team reflection sessions allowed us to discuss and address dynamic-related issues with participants, ensuring our interactions remained respectful and productive. This included discussing potential ethical dilemmas within the research team and with external ethics advisors from our CAB to ensure that our decisions aligned with ethical guidelines and the best interests of the community members involved in our study.

Data Collection

Our data collection process involved two focus groups and one individual interview all led by a Black male research team member whose role was determined by the CAB. This research team member had training in Black and disruptive qualitative methodologies and held insider status with our community of interest. The first focus group was comprised of eight participants who met four times in person at a local community center. These

in-person meetings ranged in length from 93 to 99 minutes (M = 94.75; SD = 2.87). The second focus group was composed of six participants who met virtually over Zoom three times with meetings ranging in length from 53 to 74 minutes (M = 65.67; SD = 11.15). We planned each individual focus group meeting to last 90 minutes and for the meetings to terminate once all questions from the interview protocol were answered. The variation in duration and number of meetings between the two groups was primarily influenced by the differences in the number of participants in each group. Additionally, we provided a meal for the in-person focus group which extended the duration of that group. One participant who was not able to join a focus group participated in an individual interview that was held virtually over Zoom. This interview covered the full interview protocol and lasted 72 minutes. There were no identifiable differences between the data collected in the focus group format compared to the individual interview. Each session (focus group; interview) was audio-recorded with the participants' consent, and comprehensive notes were taken to capture non-verbal cues and contextual details. Recordings were de-identified, transcribed verbatim through an electronic transcription service provided by Landmark Associates (2009), and evaluated for accuracy and consistency by the research team. We found no significant discrepancies between the transcriptions and the audio recordings.

We employed the same 11-prompt, semi-structured interview protocol for both the focus groups and the interview. This protocol was developed in collaboration with our CAB, ensuring that the questions were relevant and sensitive to the community's context (Lyons et al., 2013). Sample protocol questions were: (a) How do you see that your childhood experiences have affected you throughout your life if at all?; (b) What influence do you think your neighborhood had on the experiences you had as a child if at all?; (c) Describe a traumatic event that your community experienced during your childhood. How did your community adapt and cope with that experience?; (d) If you could create your ideal neighborhood, what would it be like?; and (e) Now that we have had this conversation, what would you like for us to do with this information?

Data Analysis

All members of the research team participated in data analysis. All four team members had graduate-level qualitative methodology training as part of their completed doctoral programs and had previous experience conducting various qualitative studies. One research team member also worked as a research and evaluation consultant for mental health equity research. Together, we implemented a thematic analysis approach (Braun & Clark, 2006) beginning with a detailed reading of the transcripts to familiarize the research team with the data. Initially, team members independently coded the transcripts to generate initial themes, using inductive and deductive coding strategies to capture anticipated and emergent themes. This initial coding process involved identifying, analyzing, and reporting themes within the data. Throughout this phase, the research team met five times to compare and refine coding schemes, ensuring consistency and comprehensiveness in theme development. After establishing a preliminary set of themes, the research team engaged in an additional round of discussion to refine these themes and ensure they accurately represented the data.

To further validate our findings, selected excerpts of the data and our interpretations were presented back to a subset of participants (n = 10) during an 83-minute Zoom meeting in a process known as member checking. In addition, we also presented our findings to our CAB during a 50-minute Zoom meeting for further feedback and contextualization. This step was crucial for verifying the authenticity and accuracy of our analysis, allowing participants and community members to confirm or challenge our interpretations, thereby enhancing the credibility and depth of our findings (Fassinger & Morrow, 2013; Lyons et al., 2013; Morrow, 2005). The CAB and focus group members provided feedback on our themes and sub-themes and we integrated this feedback into our final results.

Results

The thematic analysis of participants' responses revealed 9 recurring themes and 37 sub-themes (italicized for emphasis). Respondent quotes appear in Table 1. We organized the themes relying on the ecological model (Bronfenbrenner, 1994) to align the results with this commonly adopted approach by counseling practitioners to conceptualize and structure systemic interventions. The following are descriptions and discussion of these themes starting with the immediate environment of the microsystem and expanding outward to the chronosystem capturing the impact of participant experiences over time.

Narratives of Themes

Family-level Themes

Family-level Adversity. Participants shared their experiences of family-level adversity, encompassing various challenges encountered within their immediate family units. These adversity factors included: 1) *disruption of the family unit*, wherein several individuals reported their experiences of growing up in households affected by divorce, single parenting, or being raised by other adults; 2) *criminal justice system involvement,* wherein several people had personal experience with the criminal justice system or experienced family members' involvement; 3) *financial challenges*, wherein several respondents discussed the impact of limited financial resources on their access to basic needs, educational opportunities, and overall quality of life; 4) *death*, wherein several persons revealed how the loss of a family member was a significant source of adversity. Participants expressed the challenges of navigating life without their loved one's presence, the lack of support for coping with the loss, and the impact it had on their family dynamics and overall well-being.; 5) *violence*, wherein several individuals discussed exposure to interfamily violence and experiences of personal physical abuse. Respondents highlighted the impact of violence on their sense of safety, trust, and overall family dynamics; 6) *mental health issues/stigma*, wherein several people described the impact of mental health issues within their families, such as depression, anxiety, substance abuse, or other psychological challenges. They discussed the stigma some family members had surrounding mental health, which often exacerbated the difficulties that impacted their family; and 7) *disconnection*, wherein several participants shared experiences characterized by strained relationships, a lack of emotional support, or a sense of alienation. They described feelings of isolation, abandonment, or being emotionally distant from family members.

Family-level Protective Factors. Respondents highlighted several protective factors within the family context that contributed to their ability to endure adversity. These protective factors included: 1) *familial sacrifices*, wherein several individuals shared stories of the sacrifices made by family members to provide them with opportunities and support. They spoke of parents working multiple jobs, foregoing personal needs, or making difficult choices to ensure their children's well-being and success. Participants reflected on how these sacrifices often preserved their childhood innocence and shielded them from some of the adverse realities facing their families; 2) *family/parental support*, wherein several persons emphasized the importance of supportive family environments and parental guidance. They highlighted the presence of caring and involved parents who provided emotional support, nurtured their talents, and advocated for their well-being; 3) *the presence of extended family*, wherein several individuals discussed the benefits of having a network of supportive relatives who provided guidance, love, and stability during challenging times; 4) *communal parenting*, wherein several respondents revealed the support their caregivers received from community members and neighbors in helping them raise and nurture the children in their neighborhoods. They described the collective responsibility of caring for, supporting, and protecting children in the community, emphasizing the support and guidance families received from neighbors and community members; and 5) *feelings of protection*, wherein several people spoke of instances where their collective network of caregivers provided protection from adverse circumstances or environments- shielding them from violence, advocating for their rights, or creating safe spaces within their homes. They described how these experiences increased their perceptions of safety during their childhood.

Table 1

Key Themes Identified

Theme	Example quote[1]
Family-level adversity	AT: "As we got older, he would get high or whatever—or when he didn't get his way or somebody wouldn't give him money or a car to get drugs, he would snap. I remember, one day—it was a Sunday mornin'. I will never forget it. He hit me, and I snapped. I snapped so much to the point that I slammed my door. He kicked my door, and my response was to kick the door out so far it came off the door hinges. I just remember I got down the hallway physically fighting. I'm fighting. Everybody's yellin'… 'cause I was like, 'You're not gonna hit me.'"
Family-level protective factor	Tea: "We knew what we had to do, and we knew that our parents would watch us go from one house to the other. We couldn't just get out and go up the street to the other family's house. A parent would watch us to make sure we made it. It was not in a formal neighborhood watch. The parents just decided we made this choice to move in this place and we got to keep these children safe."
Community adversity	Dee: "Then, of course, crack showed its ugly face there, and the same things were happening. We're walking from school, people getting in shoot-outs. Walking from school, you could hear the bullets ricocheting off the buildings, and we were running for our lives, literally."
Community protective factors	Bea: "My neighborhood was encouraging, supporting, and we knew and respected each other. My earliest memories were of [neighborhood name] and spending time with our grandparents, cousins, and church members. The neighborhood consisted primarily of double tenant houses. We would hear the roaring of trains and the smell of the nearby factories, and steel companies. The areas were clean, and the neighbors were proud of their homes. We later moved to [neighborhood name] which was an area that had teachers, laborers, musicians, and a mix. Neighbors looked out for each other, and the youth respected the elders here as well. There was a rich heritage in this area and people took pride in the neighborhood."
Institutional adversity	Lee Lee: "I guess back then, they used to tell us we couldn't put weave in our hair, but now that's okay. You know what I'm saying? If your name was [male name], you couldn't come to school with no skirt on and say, 'This is me.' You know what I'm saying? Nowadays, in the school system, it's accepted. I guess that's another memory because I hid who I was for a long time, but now…I look back and I'll be like, only if I was born in a different era…I could have been more content instead of trying to hide who I really was."
Institutional protective factors	Karla: "The school I went to in middle school, we had a counselor on site. We would go in her trailer and have counseling sessions. That was important for me because I needed those sessions. I wouldn't be where I am without it. I wonder if all schools have that same privilege."
Structural adversity	Trina: "I used to worry about are we gonna have enough food to eat or am I gonna have enough money to keep the lights on."

Theme	Example quote[1]
Structural protective factors	Thelma: "You cannot change the soul and throw in an old, used-up soul, a soul that has no nutrients, and expect somethin' meaningful to bloom. That's what we have done. [Redacted name] talked about the behaviors. We change the soul for these children. That's on us. The question is, how can we change the soul so they can thrive? As we were talkin' I thought about, it's more than just education. We need a community. We need that soul where the parents are making a living wage. We need the soul—if the parents are not thriving, we can't expect the generation behind us to thrive, so it goes beyond—to me, we can't separate what we want for the children without sayin' what the parents need to teach the children the values. To provide those things that they need. We change the soul on these kids, on the next generation, and so we cannot expect them to thrive until we replenish the soul…That's systemic, so that's gonna take more than of the parents. We need some system changes to change that soul. We need government to step in. 'Cause we can do our part all we want to, but if we don't have the resources from our government to me it's all for naught."
Generational change	Jessica: "I realized in myself that I had a short trigger myself and that I had an anger issue, and before children even came into the picture, I was terrified. At first, I thought it was just me. I'll defend myself, and nobody's gonna talk to me crazy…Then it's like, no, Jessica. That's not what you're doing. You are continuing a cycle of something that you grew up in. Then just thinking of having children and doing that to them terrified me—so I almost bolted through the therapy doors. [Laughter] It was like, help me please. I think it has helped me and given me things to use when I'm feeling myself going back into those old habits and stuff like that."

[1]*Note.* Participant names have been changed to the alias of their choice.

Community-Level Themes

Community-Level Adversity. The experiences of community-level adversity shared by participants revealed the challenges they faced within their immediate surroundings. Adversities within this theme included: 1) *violence/crime*, wherein several individuals reported their experiences of living in neighborhoods dealing with high violence and crime rates. They highlighted incidents of drug-related violence and gun violence that created a pervasive sense of insecurity and negatively affected their well-being.; 2) *neighborhood blight*, wherein several respondents described the presence of dilapidated buildings, abandoned homes, and neglected public spaces within their communities. Participants expressed how the physical decay and lack of maintenance contributed to a sense of despair, diminished community pride, and further economic decline.; and 3) *fear/feelings of danger*, wherein several persons discussed the fear and feelings of danger that characterized their neighborhoods. They spoke of being afraid to walk through the neighborhood due to the perceived crime risk. The constant need to be vigilant and hyper-aware of their surroundings was identified as a significant source of stress and impacted their sense of security and community cohesion.

Community Protective Factors. Participants also identified protective factors present within their neighborhoods and communities. These protective factors encompassed: 1) *a village mindset*, wherein several people described neighbors looking out for one another, offering support, and fostering a collective responsibility for the community's well-being. These supportive community relationships provided emotional support, a sense

of belonging, and resources that contributed to their ability to cope with adversity; 2) *neighborhood pride*, wherein several individuals spoke of robust communities with leaders and business owners by whom they felt represented and in whom they could see themselves. They described a rich heritage of civil rights accomplishments and leaders in their neighborhoods and their connection to that history. This pride served as a protective factor, instilling a sense of connection, ownership, and collective responsibility within their neighborhoods; and 3) *supportive structures*, wherein several respondents mentioned the existence of community centers, local organizations, and programs that offered resources and support. These structures played a vital role in fostering resilience, providing opportunities for growth, and addressing the needs of community members.

Institutional-Level Themes

Institutional-Level Adversity. Institutional adversities were significant challenges faced by participants within various systems and organizations, such as schools and churches, in which the participants were involved. These adversities included experiences of 1) *racial violence*, wherein several people described incidents of racial profiling, physical assaults, and acts of violence perpetrated based on race. Individuals highlighted the distressing and traumatic nature of these experiences, which had a profound impact on their psychological well-being and sense of safety within educational and religious settings.; 2) *interpersonal racism*, wherein several persons discussed instances of explicit or implicit racial bias, microaggressions, and discriminatory practices directed towards them by peers, teachers, or administrators, specifically within educational settings. These experiences undermined respondents' sense of self-worth, contributed to feelings of marginalization, and hindered their academic and social experiences within the educational system; and 3) *discrimination*, wherein several participants reported being treated unfairly or experiencing biased treatment based on their race, gender, or other protected characteristics. Additionally, they highlighted instances of discrimination related to their gender identity, such as transphobia, which further exacerbated the challenges they encountered. The pervasiveness of discrimination negatively impacted their access to resources, opportunities, and overall well-being within institutional settings.

Institutional Protective Factors. Within the institutional context, respondents highlighted protective factors that mitigated the impact of institutional adversities. These protective factors included the support and sense of community derived from: 1) *church/religion*, wherein several people identified the role of religious institutions in providing support, community engagement, and resilience. They shared stories of finding solace, guidance, and a sense of belonging within their religious communities; 2) *the positive influence of sports*, wherein several individuals highlighted the opportunities for skill development, teamwork, and mentorship that sports provided. Sports offered an avenue for personal growth, a sense of achievement, and positive social interactions; 3) *the guidance provided by mentor programs*, wherein several persons described the support and positive role modeling they received from mentors. Mentorship programs played a critical role in providing opportunities for personal and professional development while fostering resilience; and 4) *access to educational resources*, wherein several participants reported experiences of quality education, academic support programs, school-based mental health resources, and opportunities for exploring extramural activities. These resources provided respondents with tools for empowerment, resilience, and upward mobility.

Structural-Level Themes

Structural Adversity. Structural adversities represented broader challenges rooted in public policy and societal systems and structures. Three sub-themes emerged, including: 1) *resource insecurity*, wherein several participants described limited access to essential resources such as food, healthcare, transportation, and quality education. The lack of sufficient resources exacerbated existing disparities and created barriers to upward mobility; 2) *discrimination*, wherein several individuals shared experiences of discrimination based on race, gender, socioeconomic status, or other factors. They reported experiences of systemic biases, unequal treatment, and limited opportunities within various structural systems such as housing, retail spaces, public spaces, employment, and social services; and 3) *community disruption*, wherein several persons discussed the disruption caused by

various community-level factors, including gentrification, urban development, or displacement. They revealed stories of losing their homes, having infrastructure create physical divides in their communities, neighborhood displacement, and the erosion of community cohesion due to these structural changes. Community disruption created challenges in maintaining social support networks and undermined a sense of belonging. Overall, these adversity factors created by unsupportive public policy initiatives and structures perpetuated inequalities for the respondents and were often accompanied with a sense of loss within their communities.

Structural Protective Factors. Despite structural adversity, participants identified protective factors within the structural domain that provided support. These protective factors included: 1) *housing access*, wherein several people highlighted the importance of affordable and safe housing as a protective factor; 2) *human resources*, wherein several persons expressed how individuals, such as social workers, pastors, community organizers, and advocates, played a protective role within the structural context. These resources provided support, guidance, and assistance to individuals facing structural adversity. They offered resources to navigate systems, access services, and advocated for individuals' rights within various settings; 3) *service resources*, wherein several respondents emphasized the importance of access to healthcare facilities, community centers, and mental and social service programs. These resources provided essential support, including medical care, counseling, and educational programs; 4) *environmental resources*, wherein several participants shared the importance of access to parks, green spaces, and clean environments. These resources promoted physical and mental well-being, provided opportunities for recreation and relaxation, and contributed to a sense of community and connection; and 5) *financial resources*, wherein several people highlighted the importance of economic resources in overcoming structural adversity, fostering economic stability, and providing opportunities for upward mobility and financial security. They discussed resources, including access to banking services, financial literacy programs, and economic development initiatives.

Chronosystem-Level Theme

Generational Change. Participants reflected on the transformative impact of generational change. Our initial conceptualization of this theme was focused primarily on ways that participants had *gained perspective* over time and desired to *do things differently* than the previous generations. When we shared this theme with the focus group members, they expressed that we missed what they did not want to change about their childhoods. This feedback initiated another round of data analysis resulting in a new sub-theme focused on *passing along the good parts of the past*. The finalized sub-themes included: 1) *gained perspective*, wherein several individuals discussed the transformative effect of gaining perspective as they transitioned into adulthood or parenthood. Gaining perspective allowed respondents to develop a deeper understanding of the challenges they faced and motivated them to break the cycle of adversity for future generations; 2) *doing things differently,* wherein several persons discussed their commitment to provide a nurturing and supportive environment, breaking negative patterns, and creating positive change. Participants emphasized the importance of learning from past experiences to guide their decisions and actions, striving to create a better future for themselves and future generations; and 3) *passing along the good parts of the past,* wherein several individuals discussed joyful, fun, happy, and connected memories from their childhood in their neighborhoods and communities and expressed a commitment to preserving and transmitting positive aspects of their heritage and community from one generation to the next. They shared an intentional effort to ensure that valuable traditions, values, and cultural elements endured, providing a sense of continuity and connection to the past and continually working toward self-determination.

Discussion

If mental health providers want to effectively address the POA in a community, they must first strive to better operationalize their framework. This study worked to further define how the POA impacted the lives of people in a large urban city in the southern United States. From the results, it appeared that the participants were

impacted not only by the conventional set of ACEs at the family level but also by adversity at the community, institutional, structural, and intergenerational levels. Individuals reported adversity factors at each level and protective factors at each level that helped them endure their experiences of adversity.

Adversity Factors

Our findings of adversity at the family level were consistent with the outcomes of the foundational ACE study conducted by the CDC and Kaiser Permanente (Felitti et al., 1998). Despite these similarities, our study also yielded unique categories of adversity at the family level. These included financial challenges and disconnection within the family. Participants reported the feelings of insecurity they experienced as children when they were unsure if they would have access to adequate food and housing. Additionally, they shared experiences of disconnection within their families when adult family members were unable to meet their emotional needs for connection, understanding, and security. During the member-checking process, respondents reflected on the theme of disconnection and recognized that their parents were often doing the best they could. They reflected that their parents were often unable to provide emotional support because of their own limitations connected to a lack of knowledge and example, their own experiences of trauma, and their desire to avoid difficult experiences. Participants connected this reflection to the theme of generational change and their own desires to do things differently with their children while also having compassion for the limitations of their own caregivers.

Our results also were similar to previous studies that identified childhood adversity factors experienced outside of the home or family unit, such as exposure to community violence, racism, peer victimization, discrimination, socioeconomic inequality, community dysfunction and immigration-related mistreatment (Baras-Gonzalez et al., 2021; Cohen-Cline et al., 2019; Duncan et al., 2023; Fleckman et al., 2022; Hamby et al., 2021; Karatekin & Hill, 2019; Lee et al., 2020; McEwen & Gregerson, 2018; Nadal et al., 2019). These results further reinforce the need to expand the ACEs framework to include community-level adversity factors. Additionally, we found novel adversity factors at the community, institutional, and structural levels including feelings of danger/fear in the community, neighborhood blight, and community disruption. These factors offer a new contribution to the ACE literature because they illuminate the impact of a child's perceptions of safety within their community and the impact of the built environment on the well-being of children. Research has established that ongoing experiences of stressors such as fear and worry about safety contribute to higher degrees of stress on the body's allostatic load, creating difficulty regulating systems such as the cardiovascular, lipidic, and metabolic systems (Brody et al., 2013; Gruenewald et al., 2012). Therefore, perceptions of lack of safety and not just experiences of violence should be considered when assessing childhood adversity factors.

Additionally, the impact of the built environment on the well-being of children should be considered. Participants expressed the impact of seeing their neighborhoods decline as businesses and neighbors moved out of the community, resulting in abandoned buildings and homes and fewer community resources. They also shared stories of having to leave communities or having communities separated due to infrastructure changes. These experiences of community disruption disconnected our respondents from their neighbors and support systems and created a disconnection between them and the neighborhood heritage and pride they once knew.

Protective Factors

When creating the themes and sub-themes, we went back and forth between using the terms *protective factor*s and *endurance* because we did not want to dismiss the struggle experienced by our participants due to the various adversity factors they encountered, many of which were a result of marginalization across multiple systems. We did not want to place the onus of resilience on the individual respondents when oppressive systems disproportionately disadvantage certain groups. We did not want to perpetuate or reinforce the Black strength stereotype or put the responsibility on individuals to develop resilience when oppressive systems need to be dismantled rather than endured. When we shared the themes related to *protective factors* to the CAB, they expressed concern about the use of this term and encouraged us to explore the idea of *endurance factors* rather

than protective factors. When we shared this feedback with the focus group members for member-checking, they decided the term protective factor did accurately convey their experiences. They believed that protective factors included the endurance of adversity but acknowledged that its meaning went beyond simple endurance to highlight systemic change factors.

Previous research also has looked at protective factors that help prevent the deleterious effects of ACEs using constructs such as *benevolent childhood experiences* (Narayan et al., 2019), *positive childhood experiences* (Sege & Browne, 2017), *counter-ACEs* (Crandall et al., 2019), *protective and compensatory experiences* (Morris et al., 2021), and neighborhood effects on childhood development (Minh et al., 2017). In addition to these existing factors, our study found familial sacrifice and feelings of protection as protective factors at the family-level. Participants reported that through their families' sacrifices and the actions of caregivers keeping adult concerns amongst themselves, parts of their childhood innocence were protected, allowing them to play, dream, and have access to resources with little awareness of the burden that their families were struggling financially. Respondents shared that they gained perspective and awareness of these sacrifices as they entered adulthood and as many became parents themselves. This factor was one that participants discussed when they expressed wanting to pass along the good parts of their childhood to their own children.

Additionally, feelings of protection by caregivers and care-giving adults also were a protective factor for our respondents. Just as perceptions of lack of safety led to adverse experiences for our participants, perceptions of protection from caregivers also led to resilience. Respondents reported that when caregivers shielded them from violence, advocated for their rights, listened to them, or created safe spaces within their families, it created trust between them and their caregivers, creating a sense of protection from adversity inside and outside their home.

At the community-level, the sub-theme of neighborhood pride discovered in this study is a unique contribution to the neighborhood-level protective factors and helps to expand the existing protective factors focused on a sense of connectedness and collective socialization (Crandall et al., 2021; Crandall et al., 2019). Participants expressed a deep sense of pride in the intergenerational heritage and history of their communities. They shared stories of community leaders who were mentors/models and many who became civil rights leaders. They expressed the community pride that developed from their collective sense of purpose, generational storytelling, and connection to generational history. This sense of neighborhood pride helped respondents develop an intergenerational connection beyond their current neighborhood/community to a connection with the protective features and narratives of their communities' history. It allowed them to connect to legacies of human rights, self-determination, collective strength, and communal protection, aiding in racial/cultural identity development (Sue & Sue, 1999) and a connection to community cultural wealth (Yosso, 2005) as protective factors.

At the institutional level, our findings were consistent with previous literature identifying involvement in extracurricular activities, community-based programs, and access to educational resources as protective factors. Specifically, our findings identified involvement in activities with church/faith institutions, sports programs, and mentor programs as protective. In addition, we found that robust educational resources also provided participants with opportunities for development, career exploration, and upward economic mobility, which mirrors previous studies that identified a sense of belonging at the institutional level as an indicator for positive health outcomes (Bethell et al., 2019; Bunting et al., 2023; Crouch et al., 2021).

Finally, our findings expanded this understanding of protective factors discovered at the structural level to include access to environmental resources. Resources such as access to parks, community gardens, green spaces, and clean environments provided participants opportunities for leisure, relaxation, and physical activity that contributed to their sense of community and connection and helped their physical and mental well-being. This is in alignment with established wellness models such as Sweeney and Myers's (2004) indivisible self-model of wellness that highlights the importance of physical activity, social connection, and leisure as primary components of overall well-being. Additionally, recent research has established the efficacy of outdoor nature-based interventions on preventing and treating mental health problems (Coventry et al., 2021). Coventry and colleagues found that

activities such as gardening and green exercise had positive impacts on symptom reduction related to depression, anxiety, negative affect, and stress. This underpins the necessity of both developing and utilizing green spaces as a component of community wellness at the structural level (Lozada et al., 2024).

Taken together, our results suggest that mental health providers should understand childhood adversity from a broader vantage point that not only prioritizes the family-level but also considers the community, institutional, and structural-level factors of adversity that impact their clients. In doing so, mental health providers can develop preventative measures and interventions targeting each level.

Implications for Mental Health Intervention

Our findings have important implications for mental health intervention. At the individual and family level, there are implications for both assessment and intervention. For assessment, counseling practitioners should consider using expanded ACE measures that include community-level adversity when assessing clients for ACEs such as the Revised ACE Questionnaire (Finkelhor et al., 2015) and the PHL ACE Survey (Cronholm et al., 2015). They also might consider utilizing other measures that include community-level adversity in conjunction with standard ACE screeners such as the Juvenile Victimization Questionnaire (Hamby et al., 2004) and the Childhood Experiences Survey (Choi et al., 2020). Additionally, counseling practitioners should screen for the social determinants of mental health (SDMH; Compton & Shim, 2015; Lund et al., 2018) to better understand the upstream factors contributing to the adversity and stress of their clients with screeners such as the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Assessment (PRAPARE, 2022), the WE CARE Survey (Garg et al., 2007), and the Cultural Context Index (Beauchamp et al., 2024).

For interventions, mental health providers should take direct action when working with individuals or families experiencing financial insecurity to help them gain access to local resources that can meet their basic needs. To do so, counseling practitioners should proactively develop a network of resource referrals and community connections that can be utilized as clients' needs emerge to directly connect them with appropriate resources. Additionally, counseling practitioners should spend time in sessions to coordinate these resources with clients or provide support for clients as they pursue the provided referrals.

Mental health providers also should consider interventions focused on helping parents understand appropriate parent/child boundaries, strategies to talk to their children about challenging circumstances, and skills for effective emotional support for their children. By offering support in these ways, counseling practitioners can help caregivers develop the necessary skills to create familial connection and feelings of protection in their homes knowing these offer important protective factors for their children.

At the community level, mental health providers should develop community-based and community-informed approaches to mental health care. Populations who have been historically marginalized from access to counseling services need contextualized mental health care (e.g., sewing circles, barbershop conversations). To accomplish this, counselors should develop feedback mechanisms to better comprehend the context of their community and their mental health needs with a more informed understanding of the existing cultural community wealth as well as community adversity factors (e.g., feelings of danger, blight, disruption). This community-informed approach can help providers develop contextualized services and activities that meet those specific community needs and fit within existing community structures. Effective feedback mechanisms such as CABs that utilize a shared leadership model with members of the community can help counselors better plan and implement contextualized community prevention and intervention programming. CABs have been successful in many healthcare settings and should become an adopted practice of community-based counseling interventions (Ali et al., 2023; Burke et al., 2013; Heck et al., 2023; Lozada et al., 2024; So, 2022).

Additionally, counseling practitioners should prioritize place-based counseling models that address the larger systems and social determinants influencing a client's mental health. Models such as the ecologically informed transdisciplinary prevention model for family health and well-being (EITPM; Lozada et al., 2024) and

the social justice counseling model (SJCM; Crethar et al., 2008) both account for these larger societal contexts. These approaches appropriately situate the client within their larger societal context and address individual concerns and the upstream social determinants impacting those concerns.

At the institutional level, counseling practitioners should intentionally develop and work within resilience-building coalitions comprised of community institutions (e.g., healthcare systems, schools, religious institutions, city/community programs) to promote individual and community wellness. Because children's involvement in extracurricular activities, community-based programs, church/faith institutions, sports programs, mentor programs, and educational development programs are protective factors, these should be prioritized in prevention and intervention programs. Counseling practitioners can consider how to infuse mental health content and social-emotional learning into institutional programming. As trusted entities in the community, these types of institutions and programs can provide safe places for mental health intervention that might otherwise be stigmatized. Counseling practitioners also should consider how to work within these institutions to create greater levels of safety and wellness, directly addressing and combating issues of oppression and discrimination within institutions through psychoeducation and professional development.

At the structural level, counselors should take an active role in legislative advocacy to influence policy change at the local, state, and federal levels (Farrell & Barrio-Minton, 2019; Toporek & Daniels, 2018). Counselors should actively advocate for increased funding for both mental health services and needed social services to help ease the burden of adversity for children and families. Given our results, services and resources such as safe and affordable childcare, affordable housing, access to healthy food, career exploration, community center programming, access to green space, mentoring programs, community recreation, extracurricular activities, and community-based mental health services should be prioritized.

Limitations and Future Research

Although we used several strategies to attend to our positionality throughout the study (e.g., discussions of our biases and personal observations in research team and CAB meetings, member-checking), we did not utilize journaling as a strategy to track these biases in a systematic way. The absence of this practice from our methodology poses a potential limitation to the interpretation of our data. Additionally, this study offered a place-based understanding of the experiences of adversity and the corresponding mental health needs of community members in a large urban city in the southern United States. Our findings, however, may not be transferable beyond the setting of our study. Future research should continue to develop the science of place-based mental health research to help mental health professionals better contextualize their approaches to meet the mental health needs of their communities. Additionally, future research should examine the expansion of the conventional ACE framework to improve the identification of adversity factors that should be included in an expanded ACE framework, the impact of those factors, and the salience of those factors on mental health throughout the lifespan. Finally, more robust outcome research on community- and population-level mental health intervention is needed to help mental health professionals enhance their prevention approaches.

Conclusion

To better address the public health crisis of childhood trauma, mental health practitioners must understand the impact of the POAs on their community and implement prevention and intervention practices to address them in tandem. This study expanded on the conventional ACE framework to operationalize adversity and protective factors at the family, community, institutional, and structural levels. Our findings can inform an expansion of counseling practice to include interventions that integrate the POA framework into standard clinical services thus supporting and further operationalizing social justice action in the counseling professions.

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Declaration of Interest Statement

The authors declare no conflicts of interest in relation to this work.

References

Ali, S. S., Mahoui, I., Hassoun, R., Mojaddidi, H., & Awaad, R. (2023). The Bay Area Muslim mental health community advisory board: Evaluation of a community based participatory approach. *Epidemiology and Psychiatric Sciences, 32*, e7. https://doi.org/10.1017/S2045796022000786

Bartolomé-Valenzuela, M., Pereda, N., & Guilera, G. (2024). Patterns of adverse childhood experiences and associations with lower mental well-being among university students. *Child Abuse and Neglect, 152*, 106770. https://doi.org/10.1016/j.chiabu.2024.106770

Beauchamp, A. M., Shen, G. C., Hussain, S. H., Adam, A., Highfield, L., & Zhang, K. (2024). Cultural context index: A geospatial measure of social determinants of health in the United States. *SSM - Population Health*, *25*, 101591. https://doi.org/10.1016/j.ssmph.2023.101591

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive childhood experiences and adult mental and relational health in a statewide sample: Associations across adverse childhood experiences levels. *JAMA Pediatrics, 173*(1), e193007. https://doi.org/10.1001/jamapediatrics.2019.3007

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101, DOI: 10.1191/1478088706qp063oa

Brody, G. H., Yu, T., Chen, Y. F., Kogan, S. M., Beach, S. R. H., Simons, R. L., Gibbons, F. X., Evans, G. W., Windle, M., Gerrard, M., & Philibert, R. A. (2013). Cumulative socioeconomic status risk, allostatic load, and adjustment: A prospective latent profile analysis with contextual and genetic protective factors. *Developmental Psychology*, *49*(5), 913–927. https://doi-org.spot.lib.auburn.edu/10.1037/a0028847

Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husen & T. Postlethwaite (Eds.). *The International Encyclopedia of Education 2nd Edition*, Volume 3 (p. 1643-1647). Pergamon.

Bunting, L., McCartan, C., Davidson, G., Grant, A., Mulholland, C., Schubotz, D., Hamill, R., McBride, O., Murphy, J., Nolan, E., & Shevlin, M. (2023). The influence of adverse and positive childhood experiences on young people's mental health and experience of self-harm and suicidal ideation. *Child Abuse and Neglect*, *140*, 106159. https://doi.org/10.1016/j.chiabu.2023.106159

Burke, J. G., Hess, S., Hoffmann, K., Guizzetti, L., Loy, E., Gielen, A., Bailey, M., Walnoha, A., Barbee, G., & Yonas, M. (2013). Translating community-based participatory research principles into practice. *Progress in Community Health Partnerships: Research, Education, and Action, 7*(2), 115-122. https://doi.org/10.1353/cpr.2013.0025

Calthorpe, L. M. & Pantell, M. S. (2021). Differences in the prevalence of childhood adversity by geography in the 2017-18 National Survey of Children's Health. *Child Abuse and Neglect*, *111*. 104804. https://doi.org/10.1016/j.chiabu.2020.104804

Carbonneau, R., Boivin, M., Brendgen, M., Nagin, D., & Tremblay, R. E. (2016). Comorbid development of disruptive behaviors from 1½ to 5 years in a population birth-cohort and association with school adjustment in first grade. *Journal of Abnormal Child Psychology, 44*, 677-690. doi: 10.1007/s10801-015-0072-1

Centers for Disease Control and Prevention (2019, November 5). *CDC vital signs: Adverse childhood experiences (ACEs): Preventing early trauma to improve adult health*. https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

Chapman D. P., Anda R. F., Felitti V. J., Dube S. R., Edwards V. J., & Whitfield C. L. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*, 217–225.

Choi, C., Mersky, J. P., Janczewski, C. E., Plummer Lee, C., Hobart Davies, W., & Lang, A. C. (2020). Validity of an expanded assessment of adverse childhood experiences: A replication study. *Children and Youth Services Review*, *117*, 105216. https://doi.org/10.1016/j.childyouth.2020.105216

Cohen-Cline, H., Jones, K. G., Kulkarni-Rajasekhara, S., Polonsky, H. M., & Vartanian, K. B. (2019). Identifying underlying constructs of childhood adversity in a low-income population. *Child Abuse and Neglect*, *91*, 1–11. https://doi.org/10.1016/j.chiabu.2019.02.005

Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus, 13*(4), 419-425. https://doi.org/10.1176/appi.focus.20150017

Coventry, P. A., Brown, J. E., Pervin, J., Brabyn, S., Pateman, R., Breedvelt, J., Gilbody, S., Stancliffe, R., McEachan, R., & White, P. L. (2021). Nature-based outdoor activities for mental and physical health: Systematic review and meta-analysis. *SSM- Population Health*, *16*, 100934. https://doi-org.spot.lib.auburn.edu/10.1016/j.ssmph.2021.100934

Crandall, A., Magnusson, B. M., Hanso, C. L., & Leavitt, B. (2021). The effects of adverse and advantageous childhood experiences on adult health in a low-income sample. *Acta Psychologica, 220*, 103430. https://doi.org/10.1016/j.actpsy.2021.103430

Crandall, A., Miller, J. R., Cheung, A., Novilla, L. K., Glade, R., Novilla, M. L. B., Magnusson, B. M., Leavitt, B. L., Barnes, M. D., & Hanson, C. L. (2019). ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health. *Child Abuse and Neglect, 96*, 104089. https://10.1016/j.chiabu.2019.104089

Crethar, H. C., Rivera, E. T., & Nash, S. (2008). In search of common threads: Linking multicultural, feminist, and social justice counseling paradigms. *Journal of Counseling and Development, 86*(3), 269-278.

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M., & Fein, J. A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventive Medicine, 4*9(3), 354-361. http://dx.doi.org/10.1016/j.amepre.2015.02.001

Crouch, E., Radcliff, E., & Probst, J. (2023). Changes in positive childhood experiences during the COVID-19 pandemic. *Academic Pediatrics*. Advance online publication. https://doi.org/10.1016/j.acap.2023.06.020

Crouch, E., Radcliff, E., Merrell, M. A., Brown, M. J., Ingram, L. A., & Probst, J. (2021). Racial/ethnic differences in positive childhood experiences across a national sample. *Child Abuse and Neglect, 115*, 105012. https://doi.org/10.1016/j.chiabu.2021.105012

Daníelsdóttir, H. B., Aspelund, T., Shen, Q., Halldorsdottir, T., Jakobsdóttir, J., Song, H., Donghao, L., Kuja-Halkola, R., Larsson, H., Fall, K., Magnusson, P. K. E., Fang, F., Bergstedt, J., & Valdimarsdóttir, U. A. (2024). Adverse Childhood Experiences and Adult Mental Health Outcomes. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2024.0039

Dari, T., Laux, J. M., Liu, Y., & Reynolds, J. (2019). Development of community-based participatory research competencies: A Delphi study identifying best practices in the collaborative process. *Professional Counselor, 9*(1), 1-19.

Dube S. R. (2018). Continuing conversations about adverse childhood experiences (ACEs) screening: A public health perspective. *Child Abuse and Neglect, 85*, 180-184. https://doi.org/10.1016/j.chiabu.2018.03.007

Dube S. R., Anda R. F., Felitti V. J., Chapman D., Williamson D. F., & Giles W. H. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from adverse childhood experiences study. *JAMA, 286*, 3089–3096.

Dube S. R., Anda R. F., Felitti V. J., Edwards V. J., & Croft J. B. (2002). Adverse Childhood Experiences and personal alcohol abuse as an adult. *Addictive Behaviors, 27*, 713–725.

Dube S. R., Miller J. W., Brown D. W., Giles W. H., Felitti V. J., Dong M., & Anda R. F. (2006). Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *Journal of Adolescent Health, 38*, 444.e1-444.e10.

Duncan, S., Horton, H., Smith, R., Purnell, B., Good, L., & Larkin, H. (2023). The restorative integral support (RIS) model: Community-based integration of trauma-informed approaches to advance equity and resilience for boys and men of color. *Behavioral Sciences, 13*, 299. https://doi.org/10.3390/bs13040299

Ellis, W. R. (2019). *Community resilience: A dynamic model for public health*. [Doctoral dissertation, The George Washington University]. ProQuest Dissertations Publishing.

Ellis, W. R. & Dietz W. H. (2017). A new framework for addressing adverse childhood and community experiences: The building community resilience model. *Academic Pediatrics, 17*, s86-s93.

Farrell, I. C., & Barrio Minton, C. (2019). Advocacy among counselor leaders: The three-tiered legislative professional advocacy model. *Journal of Counselor Leadership and Advocacy, 6*, 144–159. https://doi.org/10.1080/2326716X.2019.1644254

Fassinger, R., & Morrow, S. L. (2013). Toward best practices in quantitative, qualitative, and mixed-method research: A social justice perspective. *Journal for Social Action in Counseling and Psychology*, *5*(2), 69–83. https://doi.org/10.33043/JSACP.5.2.69-83

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2013). Improving the adverse childhood experiences study scale. *JAMA Pediatrics, 167*(1), 70-75. https://doi.org/10.1016/j.amepre.2015.02.001

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Adverse Childhood Experiences Study Questionnaire [Database record]. *PsycTESTS*.

Finkelhor, D. (2018). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse and Neglect, 85*, 174-179. http://dx.doi.org/10.1016/j.chiabu.2017.07.016

Finkelhor, D. (2020). Trends in adverse childhood experiences (ACEs) in the United States. *Child Abuse and Neglect, 108*, 104641. https://doi.org/10.1016/j.chiabu.2020.104641

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2015). A revised inventory of adverse childhood experiences. *Child Abuse and Neglect, 48*, 13-21. http://dx.doi.org/10.1016/j.chiabu.2015.07.011

Garg, A., Butz, A. M., Dworkin, P. H., Lewis, R. A., Thompson, R. E., & Serwint, J. R. (2007). Improving the management of family psychosocial problems at low-income children's well-child care visits: The WE CARE Project. *Pediatrics, 120*(3), 547-558. https://doi.org/10.1542/peds.2007-0398

Giovanelli, A. & Reynolds, A. J. (2021). Adverse childhood experiences in a low-income black cohort: The importance of context. *Preventive Medicine, 148*, 106557. https://doi.org/10.1016/j.ypmed.2021.106557

Gruenewald, T. L., Karlamangla, A. S., Hu, P., Stein-Merkin, S., Crandall, C., Koretz, B., & Seeman, T. E. (2012). History of socioeconomic disadvantage and allostatic load in later life. *Social Science and Medicine*, *74*(1), 75-83. https://doi.org/10.1016/j.socscimed.2011.09.037

Hamby, S., Elm, J. H. L, Howell, K. H., & Merrick, M. T. (2021). Recognizing the cumulative burden of childhood adversities transforms science and practice for trauma and resilience. *American Psychologist, 76*(2), 230-242. https://doi.org/10.1037/amp0000763

Hamby, S. L., Finkelhor, D., Ormrod, R., & Turner, H. (2004). *The Juvenile Victimization Questionnaire (JVQ): Administration and scoring manual*. Durham, NH: Crimes Against Children Research Center. Retrieved from https://www.unh.edu/ccrc/sites/default/files/media/2022-02/the-juvenile-victimization-questionnaire-jvq-administration-scoring-manual.pdf

Hampton-Anderson, J. N., Carter, S., Fani, N., Gillespie, C. F., Henry, T. L., Holmes, E., Lamis, D. A., LoParo, D., Maples-Keller, J. L., Powers, A., Sonu, S., & Kaslow, N. J. (2021). Adverse childhood experiences in African Americans: Framework, practice, and policy. *American Psychologist, 76*(2), 314-325. https://doi.org/10.1037/amp0000767

Heck, J. L., Jones, E. J., & Goforth Parker, J. (2023). Establishment of a community advisory board to address postpartum depression among Indigenous women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 52*(4), 320–327. https://doi-org.spot.lib.auburn.edu/10.1016/j.jogn.2023.04.007

Johnson, K. F., Kim, H., Molina, C. E., Thompson, K. A., Henry, S., & Zyromski, B. (2023). School counseling prevention programming to address social determinants of mental health. *Journal of Counseling and Development*, *101*, 402–415. https://doi.org/10.1002/jcad.12471

Karatekin, C. & Hill, M. (2019). Expanding the original definition of adverse childhood experiences (ACEs). *Journal of Child and Adolescent Trauma, 12*, 289-306. https://doi.org/10.1007/s40653-018-0237-5

Landmark Associates (2009). Landmark Associates [Online computer software]. www.thelai.com

Lee, H., Kim, Y., & Terry, J. (2020). Adverse childhood experiences (ACEs) on mental disorders in young adulthood: Latent classes and community violence exposure. *Preventive Medicine, 134*, 106039. https://doi.org/10.1016/j.ypmed.2020.106039

Lenz, A. S., & Lemberger-Truelove, M. E. (2023). The social determinants of mental health and professional counseling: A call to action. *Journal of Counseling and Development*, *101*, 375–380. https://doi.org/10.1002/jcad.12489

Lenz, A. S., & Litam, S. D. A. (2023). Integrating the social determinants of mental health into case conceptualization and treatment planning. *Journal of Counseling and Development*, *101*, 416–428. https://doi.org/10.1002/jcad.12487

Lozada, F. T., Wheeler, N. J., Green, M. K. N., Castro, A. J., Gómez, R. F., & Gutierrez, D. (2024). An ecologically informed transdisciplinary prevention model for Black and Latine family wellbeing. *Journal of Counseling and Development*, *102,* 1–16. https://doi.org/10.1002/jcad.12506

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E. C., Breuer, E., Chandra, P., ... & Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *The Lancet Psychiatry, 5*(4), 357-369. https://doi.org/10.1016/S2215-0366(18)30060-9

Lyons, H. Z., Bike, D. H., Ojeda, L., Johnson, A., Rosales, R., & Flores, L. Y. (2013). Qualitative research as social justice practice with culturally diverse populations. *Journal for Social Action in Counseling and Psychology*, *5*(2), 10–25. https://doi.org/10.33043/JSACP.5.2.10-25

Lyons, K., Tibbits, M., Schmid, K. K., Ratnapradipa, K. L., & Watanabe-Galloway, S. (2023). Prevalence and measurement of adverse childhood experiences (ACE) among children and adolescents in the U.S.: A scoping review. *Children and Youth Services Review, 153*, 107108. https://doi.org/10.1016/j.childyouth.2023.107108

McEwen, C. A. & Gregerson, S. F. (2018). A critical assessment of the adverse childhood experiences study at 20 years. *American Journal of Preventive Medicine, 56*(6), 790-794. https://doi.org/10.1016/j.amepre.2018.10.016

Minh, A., Muhajarine, N., Janus, M., Brownell, M., & Guhn, M. (2017). A review of neighborhood effects and early child development: How, where, and for whom, do neighborhoods matter? *Health and Place, 46*, 155-174. https://doi.org/10.1016/j.healthplace.2017.04.012

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250.

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology, 60*, 234-244. http://libres.uncg.edu/ir/uncg/f/J_Myers_Indivisible_2004.pdf

Nadal, K. L., Erazo, T., & King, R. (2019). Challenging definitions of psychological trauma: Connecting racial microaggressions and traumatic stress. *Journal for Social Action in Counseling and Psychology, 11*(2), 2–16. https://doi.org/10.33043/JSACP.11.2.2-16

Neal Keith, S., Coleman, M. L., Hicks Becton, L. Y., & Springfield, J. (2023). Assessing the social determinants of mental health in counseling practice. *Journal of Counseling and Development*, *101*, 381–391. https://doi.org/10.1002/jcad.12470

Niwa, E. Y. & Shane, J. (2021). The spaces between: Parents' perceptions of neighborhood cohesion and child well-being. *Journal of Applied Developmental Psychology, 75*, 101293. https://doi.org/10.1016/j.appdev.2021.101293

Novilla, L. K., Broadbent, E., Leavitt, B., & Crandall, A. (2022). Examining relationships between positive and adverse childhood experiences with physical and mental health indicators in a low-income adult sample. *Child Abuse and Neglect, 134*, 105902. https://doi.org/10.1016/j.chiabu.2022.105902

Oh, D. L., Jerman, P., Purewal Boparai, S. K., Koita, K., Briner, S., Bucci, M., & Harris, N. B. (2018). Review of tools for measuring exposure to adversity in children and adolescents. *Journal of Pediatric Health Care, 32*(6), 564–583. https://doi.org/10.1016/j.pedhc.2018.04.021

O'Neal, L. J. & Cotton, S. R. (2016). Promotive factors and psychosocial adjustment among urban youth. *Child Youth Care Forum, 45*, 947–961. doi:10.1007/s10566-016-9364-z

Pester, D. A., Jones, L. K., & Talib, Z. (2023). Social determinants of mental health: Informing counseling practice and professional identity. *Journal of Counseling and Development*, *101*(4), 392–401. https://doi.org/10.1002/jcad.12473

PRAPARE. (2022). *Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences*. https://prapare.org/wp-content/uploads/2022/09/Full-Toolkit_June-2022_Final.pdf

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28-48. https://doi.org/10.1002/jmcd.12035

Rog, D. J., Reidy, M. C., Manian, N., Daley, T. C., & Lieberman, L. (2021). Opportunities for psychologists to enact community change through adverse childhood experiences, trauma, and resilience networks. *American Psychologist, 76*(2), 379–390. https://doi.org/10/1037/amp0000778

Shonkoff, J. P. & Garner, A. S. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232-e246. https://doi.org/10.1542/peds.2011-2663

Struck, S., Stewart-Tufescu, A., Asmundson, A. J. N., Asmundson, G. G. J., & Afifi, T. O. (2021). Adverse childhood experiences (ACEs) research: A bibliometric analysis of publication trends over the first 20 years. *Child Abuse and Neglect, 112*, 104895. https://doi.org/10.1016/j.chiabu.2020.104895

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice.* John Wiley and Sons Inc.

Toporek, R., & Daniels, J. (2018). *American Counseling Association Advocacy Competencies*. https://www.counseling.org/docs/default-source/competencies/aca-advocacy-competencies-updated-may-2020.pdf?sfvrsn=f410212c_6

Warner, T., Leban, L., Pester, D., & Walker, J. (2022). Contextualizing adverse childhood experiences: The intersections of individual and community adversity. *Journal of Youth and Adolescence, 52*(3), 570-584. https://doi.org/10.1007/s10964-022-01713-2

Yosso, T. J. (2005). Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race Ethnicity and Education, 8*(1), 69–91. https://doi.org/10.1080/1361332052000341006