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Link Between Adverse Childhood Experiences and Incarceration

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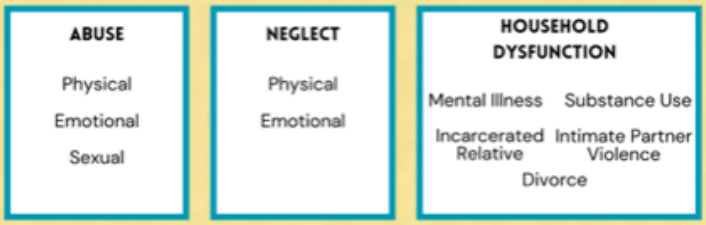
With 1.8 million people in prisons and jails, the U.S. is the world leader in incarceration, housing about 5% of the world's population, but 20% of the world's prison population (Vera Institute of Justice, 2022; Walmsley, 2014). Incarceration impacts not only those inside but also communities. In total, the U.S. government spends over $80.7 billion annually on public prisons and jails (Prison Policy Initiative, 2023). These funds detract from other public services, such as education. For example, Texas has the largest state prison population (Carson, 2022) and its funding grew nearly eight times the rate of school spending (Ingraham, 2016). Incarceration also impacts families financially, and its effects can be intergenerational emotionally, and socially (DeHart et al., 2018). Children with an incarcerated parent are twice as likely to become incarcerated themselves in comparison to children without an incarcerated parent (Burgess-Proctor et al., 2016).

A major pathway into incarceration involves abuse and subsequent trauma. Research estimates that over half of incarcerated people have histories of victimization and abuse (Browne et al., 1999), but incidences are likely underreported due to difficulty accessing incarcerated populations and stigma surrounding victimization histories. Other research has found a direct link between adverse childhood experiences (ACEs) and incarceration. This technical report provides a summary of research and scholarship demonstrating the childhood adversity to prison pipeline, including gender differences.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are stressful or traumatic events that occurred during one's childhood. As depicted in Figure 1, ACEs are comprised of ten main types that fall under abuse, neglect, and familial dysfunction (Felitti et al., 1998). A foundational ACE Study using the original 10 items was conducted by the Centers for Disease Control and Kaiser Permanente in the mid-1990s with a sample of 17,337 patients and focused on how traumatic childhood events may negatively affect adult health (Felitti et al., 1998). Thirty-six percent had no exposure to ACEs and the majority (64%) had exposure to at least one ACE. Thirteen percent of participants experienced four or more ACEs.

Figure 1. Types of ACEs



Since the foundational ACE study, others have argued that community-level factors, including economic hardship and racial discrimination, should also be considered (e.g., Mendez et al., 2022). The Philadelphia ACE Project (Merritt et al., 2013) expanded the original 10-item ACE scale to include additional items measuring childhood exposure to bullying, community violence, neighborhood safety, racism, and living in foster care (see Figure 2). The expanded ACEs study conducted by the Philadelphia ACE Project with 1,784 adults from Philadelphia found a larger percentage of ACE exposure than the original 10-item study: 83% experienced at least one ACE and 37% experienced four or more ACEs.

Figure 2. Expanded ACEs

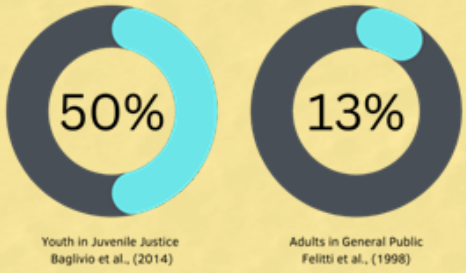
Both the original ACE study and the Philadelphia ACE project represented retrospective self-reports of ACEs with adult participants. Sacks and Murphey (2018) used data from the 2016 National Survey of Children's Health (NSCH) to describe the prevalence of one or more ACEs reported by a parent or guardian among children from birth through age 17 using nine measures including community-level ACEs. They found that 45 percent of children in the U.S. have experienced at least one ACE. In Texas, 49% of children had exposure to at least one ACE, which is higher than the national average. Importantly, their findings indicate national disparities in exposure to ACEs across race and ethnicity: Black (61%) and Hispanic (51%) children were more likely to experience ACEs than white (40%) and Asian (23%) youth.

ACEs are highly correlated to one another due to their interrelated nature. Thus, exposure to a single ACE exponentially increases the odds of being exposed to other ACEs (Baglivio & Epps, 2016). Felitti at al. (1998) discovered that people who had encountered four or more types of childhood exposure faced significantly higher health risks compared to those who had experienced none. These risks included a 4 to 12-fold increase in the likelihood of developing alcoholism, drug abuse, depression, and attempting suicide. Additionally, there was a 2-4 fold increase in the likelihood of smoking, reporting poor self-rated health, engaging in sexual intercourse with more than 50 partners, and contracting sexually transmitted diseases. Furthermore, there was a 1.4 to 1.6-fold increase in the likelihood of being physically inactive and suffering from severe obesity.

The Link Between ACEs and System-Involvement

Research has found a direct link between childhood trauma and incarceration. The link can begin during adolescence through juvenile justice-involvement. Youth with ACEs are at increased risk for juvenile justice system involvement and re-offense (Baglivio et al., 2014). Using a sample of 64,329 youth under juvenile justice supervision in Florida, Baglivio and colleagues (2014) examined the prevelance of ACEs in comparison to adults in the general public from the foundational ACE study. Their analyses indicate youth report disturbingly high rates of ACEs and have higher composite scores than adults in the general public : youth were 13 times less likely to report zero ACEs (2.8% compared to 36%) and four times more likely to report four or more ACEs (50% compared to 22 %) in comparison to the original ACE study of mostly college-educated adults (Baglivio et al., 2014; see Figure 3).

Figure 3. Prevalence of Four or More ACEs Across Populations

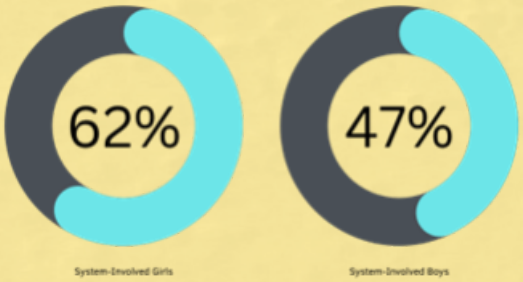


The majority of research on ACEs and system-involvement has focused on youth populations (Graf et al., 2021). Other research has confirmed the link between ACEs and incarceration into adulthood as well. For example, Roos et al. (2016) found that after controlling for sociodemographic variables and substance use, childhood maltreatment significantly increased the risk of incarceration in adulthood.

Gender Differences

Prior research indicates exposure and responses to ACEs are not equal across gender (Widom et al., 2018). Girls are typically more susceptible to sexual abuse, have higher rates of exposure to ACEs, and are more likely to experience multiple forms of ACEs as well as repeated exposure than boys (Baglivio & Epps, 2016; Baglivio et al., 2015; Cloitre et al., 2009). In Baglivio and colleagues' (2015) study on system-involved youth, girls were 4.4 times more likely to have been sexually abused than boys. Furthermore, Baglivio and Epps (2016) found that 62% of system-involved girls had experienced over four ACEs compared to 47% of boys (see Figure 4). In Dube and colleagues' study (2003) on adults in the general public, ACEs were more prevalent among women on all indicators except for physical abuse and neglect. However, victimization, especially sexual, is likely underreported among boys/men due to increased stigmatization surrounding masculinity and victimization (Reed & Boppre, 2020).

Figure 4. Comparison of Four or More ACEs Across Gender

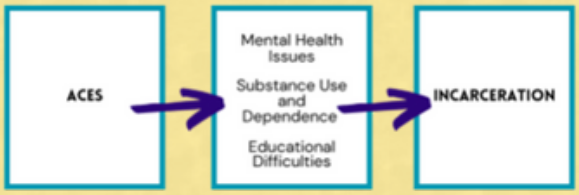


Data Source: Baglivio & Epps (2016)

Intermediate Factors

The link between ACEs and system-involvement is often more complex. Higher ACE scores have been linked to notable negative behavioral, health, and social outcomes. These outcomes, if untreated, can eventually contribute to the likelihood of system-involvement later in life. Most related to incarceration later in life are mental health issues, substance use and dependence, and educational difficulties (see Figure 5).

Figure 5. ACEs and Intermediate Factors Leading to Incarceration



Mental Health

Exposure to four or more ACEs significantly increases the risk of developing mental health disorders (Boullier & Blair, 2018). As described by Sheffler et al. (2020), ACEs interfere with the formation of healthy ways to manage emotions by causing alterations in interpretations and beliefs, affecting the structure and function of important brain regions, and leading to the adoption of harmful coping mechanisms. Each of these factors, both individually and in combination, contributes to a higher likelihood of mental health issues. ACEs are linked to an elevated risk of various conditions, including mood disorders (e.g., depression), anxiety disorders, trauma-related disorders (e.g., Post-Traumatic Stress Disorder [PTSD]), psychotic disorders, and personality disorders. Cumulative childhood trauma can lead to complex PTSD with additional symptoms reflecting disturbances in emotional and interpersonal self-regulatory capacities, including aggressive or socially avoidant behaviors (Cloitre et al., 2009).

As summarized by the Center for Substance Abuse Treatment (2014), initial reactions to trauma can manifest in various ways such as fatigue, confusion, sadness, anxiety, restlessness, emotional detachment, disorientation, heightened arousal, and a diminished emotional response. These responses are typically experienced by most survivors, are socially acceptable, have a psychological purpose, and tend to fade over time. However, there are signs that indicate more severe reactions, such as persistent distress without periods of calm, severe dissociation symptoms, and intrusive memories that persist even in safe environments.

Delayed responses to trauma can include ongoing tiredness, sleep disturbances, nightmares, fear of the traumatic event recurring, anxiety related to flashbacks, depression, and avoidance of activities remotely connected to the traumatic experience. Trauma can manifest differently across gender. For example, girls tend to respond to ACEs, particularly sexual abuse, through internalization and are more likely to experience PTSD symptoms (McLaughlin et al., 2013).

When untreated, mental health issues can lead to system-involvement. Forty-three percent of people incarcerated in state prisons have been diagnosed with a mental health disorder (Bureau of Justice Statistics, 2016). People with mental health disorders are overrepresented in prisons and jails relative to the general public (Prins, 2014). Belcher (1988) argued that jails have become the default housing for homeless people with mental health issues due to decreased access to mental health treatment in the community and criminalization of homelessness (e.g., vagrancy) without shelter and resources.

Incarcerated women report a higher prevalence of PTSD and depression than incarcerated men and women in the community. Cabeldue and colleagues (2019) found high rates of reported childhood and adult victimization among a large sample of women incarcerated in a Southern state, which were significantly related to PTSD and depression symptoms. Results demonstrate the link between incarcerated women's ACEs and mental health issues later in life.

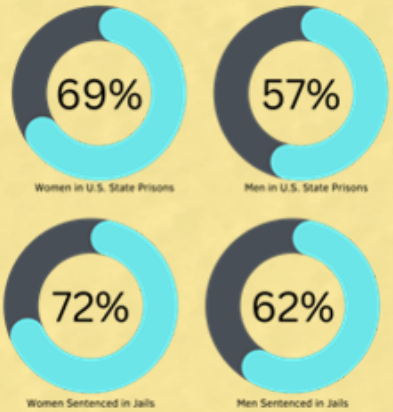
Substance Use and Dependence

Exposure to ACEs increases the likelihood of illicit drug use by 2-4 times (Dube et al., 2003). Substance use can become problematic if a person becomes physically or emotionally dependent or if using despite negative consequences[1]. People who have experienced childhood trauma are 1.2 to 1.5 times more likely to meet the substance dependence criteria defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; Wu et al., 2010). There is a positive association between ACEs and substance use disorder diagnosis later in life (Leza et al., 2021; Wolff & Shi, 2018). As ACEs affect emotion regulation, causing an inability to manage distressing emotions, people may use substances to cope with unwanted feelings or emotions (Cloitre et al., 2009).

[1]For more information, please visit the America Psychiatric Association website: https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder

More than half (58%) of people incarcerated in state prisons and two-thirds (63%) of people sentenced to serve time in jail[2] met the DSM IV criteria for drug dependence or abuse (Bronson et al., 2017). In comparison, approximately 5% of the total general adult population met the criteria for drug dependence or abuse (Bronson et al., 2017). Women in state prisons and jails were more likely to meet the DSM IV criteria for drug dependence or abuse in comparison to men (see Figure 6).

Figure 6. Comparison of Prevalence of Drug Dependence Across Gender



Mullings and colleagues (2004) conducted a secondary data analysis on interviews with 1,198 women during their intake into the Texas prison system. The results indicated that women with alcohol dependency were more likely to have grown up in disorganized family situations, including parental drug and alcohol use-related problems, childhood neglect, and childhood physical and sexual abuse. Further, childhood neglect was a significant predictor of alcohol dependency. The findings indicate a strong connection between childhood adversity and alcohol dependency among incarcerated women.

Research suggests that girls and women are likely to respond to childhood trauma, especially sexual abuse, through substance use (Jones et al., 2013). Boppre and Boyer (2021) conducted interviews and focus groups with women under community supervision to further understand how ACEs lead to system-involvement. Of the 19 women interviewed, 17 reported issues related to substance use and/or dependency. Among the 17 women who had substance abuse, 12 had trajectories directly linked to their ACEs. Women indicated certain ACEs were particularly impactful for their onset and continued substance use: childhood emotional and sexual abuse, neglect, educational difficulties, witnessing domestic violence, the death of a loved one, and familial substance use.

Women in their study reported using to self-medicate underlying trauma or to escape their homes. For example, one participant stated,

"*When I was about six or seven, my mom remarried. He abused us girls in every sense of the word for a couple years. He really committed the worst abuse when any of us were left alone. [I use because of] my childhood... I don't like feeling lows in my emotions. I use not to feel... I wanted to be numb... I would say that my childhood, out of everything we talked about, had the most impact on [my system-involvement].*"

Educational Difficulties

Experiencing multiple ACEs also heightens the risk for lower educational attainment (Baglivio & Epps, 2016; Centers for Disease Control and Prevention, 2015). Research has shown that youth with higher ACE scores have issues in school, including disciplinary infractions and academic outcomes (Baglivio & Epps, 2016; Perez & Widom, 1994). Scholarship has well-documented the school to prison pipeline through which exclusionary discipline policies, school-police partnerships, surveillance technologies and disproportionality in sanctioning across race and ethnicity leads youth into the juvenile justice system (Muñiz, 2021; Snapp et al., 2015). Black, Latiné, and Indigenous students as well as LGBTQ2S+ students face increased likelihood for discretionary offenses (i.e., disrespectful, defiant, or loitering), and disciplinary infractions leading to subsequent suspension or arrest (Muñiz, 2021).

Such pathways are important to consider in the abuse to prison pipeline as untreated trauma can lead to perceived "disruptive" behaviors. Trauma can prevent effective learning due to symptoms that interfere with the ability to pay attention in class (Hardaway et al., 2014). Symptoms of trauma can impact emotional regulation and reactions, especially among youth (Copeland et al., 2007). Educational attainment has a direct link to access to employment later in life, as well. The unemployment rate was significantly higher among those who reported having had any ACE than among those who reported no ACEs (Lui et al., 2013) and more so among women (Currie & Widom, 2010).

[2] People can either await trial in jail (75%) or be sentenced after conviction to serve time in jail (Herring, 2020). This figure refers to those sentenced to serve time in jail.

Discussion and Conclusion

This report has several important takeaways. First and foremost, the link between ACEs and incarceration later in life is well-documented. However, exposure to ACEs is not deterministic, meaning that if a child experiences high adversity, they are not destined to become incarcerated later in life. Service providers, practitioners, and the public must be aware that the likelihood of incarceration does increase with exposure to ACEs, therefore, it is crucial to 1) prevent ACEs and 2) support youth who have experienced ACEs to disrupt the abuse to prison pipeline. Research indicates resiliency factors and counter-ACEs that can prevent the negative impacts of ACEs following exposure (Crandall et al., 2019).

Researchers and practitioners must exercise caution when using the ACEs framework. While the ACE literature is useful for understanding exposure among populations, there are issues when applying the framework to individuals. Most prior research on treating mental health for people exposed to ACEs focuses on cognitive behavioral treatment finding positive results (Lorenc et al., 2020). The findings for other approaches, such as psychological therapies, parent training, and broader support interventions, are inconclusive, although there are some positive results. Nonetheless, scholars warn that these approaches do not account for the social pathways leading to ACE exposure (Lorenc et al., 2020). Kelly-Irving and Delpierre (2019) argue that applying the ACE framework to individuals could exacerbate inequalities as screening could lead to stigmatization, pathologizing, and unnecessary intrusion. The ACEs framework should be used at societal and community levels to prevent harm and ACE exposure.

As most ACEs emerge within familial systems and communities, prevention efforts must target social and structural roots of adversity, such as poverty and structural racism. The Centers for Disease Control and Prevention (CDC) provides a framework for ACE prevention strategies (see Table 1). The CDC's strategies move beyond the individual-level and provide recommendations for communities to support families. Efforts to prevent exposure to ACEs can ultimately reduce the likelihood of incarceration.

Table 1. CDC Prevention Strategies

Preventing ACEs	
Strategy	**Approach**
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality childcare • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

Given the high prevalence of ACEs, universal trauma-informed care (TIC) is essential to support youth and adults who have experienced ACEs. As defined by Substance Abuse and Mental Health Services Administration (SAMHSA, 2023), a trauma-informed approach broadly incorporates awareness of trauma and its impact into all aspects of organizational functioning and is reflected in certain general principles, which is distinct from trauma-specific clinical interventions. Additionally, the Missouri Department of Mental Health created a guidebook to help implement trauma-informed schools[3]. Becoming trauma-informed requires several phases, including trauma-awareness among staff and leadership as well as trauma-responsive disciplinary approaches and instruction. Trauma-informed schools are achieved when 1) all staff respond to students and one another in a way that reflects the science of trauma, 2) Staff members routinely share new information and innovative ideas to meet the changing needs of students, and 3) Trauma-informed responses are embedded within the organization.

Trauma-informed care must extend to correctional settings. The environment and procedures in prisons and jails can exacerbate trauma (Goldsmith et al., 2014). For example, restraints and searches can trigger stress responses stemming from underlying trauma (Benedict, 2014). Trauma-informed care can improve staff interactions with incarcerated people and even reduce assaults and self-injury, making facilities safer and more humane (Benedict, 2014).

[3] https://dmh.mo.gov/media/pdf/missouri-model-trauma-informed-schools

Future Research

The majority of studies examining the link between ACEs and system-involvement focused on youth with a short follow-up period (Graf et al., 2021). There is a significant lack of longitudinal research to examine the outcomes of ACEs into adulthood. Matched samples of people in the community and incarcerated would be helpful to examine differences in ACE exposure outcomes. Much of the prior research used the original 10-item ACE scale. More research should be conducted using the expanded version of ACEs to assess community factors.

Few studies have examined how demographic factors beyond gender may shape exposure, responses to ACEs, and subsequent incarceration. Studies focusing on gender typically focus on girls/women, yet boys/men also experience gendered realities related to ACE exposure and seeking help (Reed & Boppre, 2020). Emerging research suggests LGBTQ2S+ people face increased risk of victimization, neglect, homelessness, and subsequent incarceration (Avalos & Boppre, in press). Future research should assess potential increased exposure among additional populations and accessibility to inclusive culturally-responsive services.

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