Adverse Childhood Experiences (ACEs) Routine Enquiry as a Way of Working with Women's Trauma: Narratives of Practitioner and Organisational Change

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Abstract: Long-term impacts of Adverse Childhood Experiences (ACEs) are widely evidenced and attention has more recently focused on implementing ACEs routine enquiry within social service interventions. As a group of researchers and practitioners, we were all involved in a study to assess the level of ACEs for women accessing a domestic violence service and explore trauma-informed responses to women's childhood experiences and inter-generational patterns of trauma. Our narratives describe working with an ACEs routine enquiry questionnaire and we explore our practice concerns, practice interactions, and client responses. We emphasise the importance of feedback and transformation for women when embedding new practices, the intersection of the personal and professional when working with trauma, and reflective spaces for practitioners. Our narratives illustrate the depth of work necessary to introduce a new tool or practice, a critical consideration for incorporating ACEs routine enquiry into health and social service agencies.

***Keywords*:** domestic violence, trauma, innovation, adverse childhood experiences, practice development

Introduction and Background

Practitioners, social service organisations, and researchers are increasingly interested in links between Adverse Childhood Experiences (ACEs) and domestic violence, poverty, and substance use which imply the need for appropriate health and social care responses (Bellis et al., 2013). The impacts of ACEs also stretch well beyond the individual who immediately experiences them. In addition to increasing the likelihood of significant personal struggle, ACEs are linked to intergenerational effects—as those who encounter ACEs are more likely to engage in behaviour that creates potential ACEs for their own children (Bellis et al., 2015; Renner & Slack, 2006). Drug and alcohol misuse, violence, and incarceration affect communities as a whole, not just individuals and families, which in turn has implications for both prevention and intervention (Burstow et al., 2018). For instance, Bellis et al. (2019) found that reducing the prevalence of ACEs by just 10 percent in the population—through the use of programmes to moderate the effects of ACEs or prevent them altogether for children—could produce an annual savings of 96 billion EUR in the area of healthcare alone.

How organisations can incorporate understanding and interventions in relation to ACEs has received some attention. Numerous blocks and challenges to implementation of ACEs routine enquiry have been identified (Quigg et al., 2018). This article provides a range of narratives from six practitioners within an Irish domestic violence agency that implemented a pilot of ACEs routine enquiry. The conclusion of the pilot saw a subsequent request from the research funding

agency for follow up ACEs training for 14 community and state agencies; a new project is also underway to implement trauma-informed interventions for women and children using the domestic violence service and follow up with women who completed the original ACEs routine enquiry. The narratives here focus on the practitioners involved in the pilot and their experiences of asking women about trauma experienced in childhood, and their own learning and practice development that occurred as a result. In this way we hope to contribute to the debates about considering and incorporating ACEs routine enquiry into social service responses, as well as share practice lessons and viewpoints.

ACEs Routine Enquiry and Domestic Violence

Felitti et al. (1998) found a strong interrelationship between ACEs and severe chronic disease and premature death in adulthood, effectively launching what is now a growing body of research and evidence-based practice. The current ACEs categories of focus include child maltreatment (sexual abuse, physical abuse, verbal abuse) and children's environment (domestic violence, parental separation, mental illness, alcohol abuse, drug abuse, incarceration) (Bellis et al., 2015). Although ideas about ACEs are at times contested (Kelly-Irving & Delpierre, 2019), a score of four issues or more is seen to significantly increase the likelihood of a person engaging in future risky behaviour, which may lead to a range of poor health outcomes in adulthood (Bellis et al., 2015; Felitti et al., 1998). ACEs also impact on wider society; for example, there may be intergenerational effects and pressures on health and social care agencies, particularly in terms of complex social problems such as substance use and domestic violence (Bellis et al., 2015; Gutierres & Van Puymbroeck, 2006; Ørke et al., 2018).

To date there has been limited focus on ACEs and gender implications, although experiencing childhood abuse increases the likelihood of experiencing intimate partner violence as an adult (Ørke et al., 2018) and substance use is often used to cope with the repeated trauma. Domestic violence and substance use are often intertwined, but ACEs can be a pivotal factor influencing later life experiences (Brown et al., 2015). It is important to note that there is a gender difference in how this plays out, with a resulting impact on the services operating at the intersection of these two areas. Women are significantly more likely to experience domestic violence as both children and as adults than are men (Bellis et al., 2015). Women are also more likely to use substances as a means of coping with this. Gutierres and Van Puymbroeck (2006) report that 90 percent of women in substance misuse treatment have a history of traumatic violence; there is also evidence of a "lifespan victimization among women who misuse substances" (p. 502), as the combination of ACEs and substance use puts these women at further risk for future domestic violence and sexual abuse.

Routine enquiry can be defined as the implementation of standard queries or questions to all service users within a health setting and is often considered in order to explore unexpressed needs such as those emanating from experiences of domestic violence, childhood abuse, and trauma (Brooker et al., 2019; Eustace et al., 2016). Routine enquiry for ACEs is in its relative infancy within social and health services, though it is claimed that it can assist practitioners in moving beyond spontaneous disclosure of historical abuse; instead, a pro-active and sensitive enquiry process can allow for adequate supports to be provided (Ford et al., 2019). There has

been some work to utilise ACEs routine enquiry within certain health and social service organisations, with a view to exploring the most appropriate interventions for individuals and to mitigate any intergenerational effects (McGee et al., 2015). ACEs routine enquiry tools and methods are usually conducted through either face-to-face meetings or self-completed questionnaires. Some organisations target only those individuals who present to specific parts of the service (e.g., in cases of domestic violence cases, those seeking refuge), while others adopt a universal approach, regardless of specialist or intensive need. The timing of routine enquiry can vary—sometimes it is at the point of first contact, others only after establishing a relationship with the service user (McGee et al., 2015). Within domestic violence organisations, McGee et al. (2015) found that crisis mitigation often takes precedence, with the result that ACEs routine enquiry is contingent on the skills of the practitioner at that moment. Despite, or perhaps because of, the volume of the literature on this topic, ACEs routine enquiry remains challenging. For instance, a review of pilot ACEs routine enquiry programmes across a range of sectors in the U.K. found limitations in delivery caused by lack of practitioner and organisational expertise, capacity, and commitment (Hardcastle et al., 2020; Quigg et al., 2018).

Trauma informed responses have been broadly identified as important to disclosures of childhood maltreatment, harm, and risk (Bellis et al., 2015), though again the consideration of trauma informed responses in the wake of ACEs routine enquiry is relatively new (Gilliver, 2018). While connections between trauma histories and presenting issues are being noted and responded to in the areas of domestic violence (Pill et al., 2017) and substance use (Fuller-Thomson et al., 2016; Scheidell et al., 2017), to date there has not been as much of a focus on the potential for incorporating an ACEs-informed approach into services in these areas, for both women and their children who present to them. It was within this context that the authors initially came together as part of a research project to pilot ACEs routine enquiry within an Irish domestic violence service.

The Research Project

Let us first describe the research study that led to us subsequently coming together to write the narratives that form the central part of this paper. The study took place in an organisation that delivers services to women and children who experience domestic violence. Established 25 years ago, it is located in a large town in Ireland with a range of staff involved in providing emergency accommodation, key worker support, counselling, helpline support, children's interventions, court accompaniment, and creative interventions such as art and play therapy. The study aimed to a) identify the level of ACEs for women accessing a domestic violence service and b) consider and explore trauma-informed responses to women's childhood experiences and the intergenerational transmission of trauma. To meet these aims, an action research approach (Hart & Bond, 1995), involving three phases, was taken over a nine-month period. The first phase involved the implementation of ACEs routine enquiry for women accessing all aspects of the organisation's services (n=60 service user participants) using a 10-question ACEs questionnaire adapted from the U.S. Centers for Disease Control and Prevention short ACEs tool (Hardcastle & Bellis, 2019). The second phase, undertaken concurrently, was a series of co-operative inquiry groups facilitated with domestic violence service staff and designed to support their implementation of the ACEs routine enquiry with service users and their development of

responses to women who completed the routine enquiry.

The study found that high numbers of women who were subject to domestic violence had experienced ACEs earlier in their lives. Of the 60 women who completed the ACEs routine enquiry in the study, over one-half (58 percent) reported experiencing at least two ACEs in their childhood; one-third of all respondents reported experiencing four or more (Morton & Curran, 2019). Service users reported significant levels of overlap between direct child maltreatment and adverse home environments. These findings offered early indications of both ACEs' prevalence as well as the types of ACEs that most define the experiences of the women presenting to the domestic violence service and have been reported on elsewhere (see Morton & Curran, 2019). The study concluded that this form of ACEs routine enquiry, while not an end in itself, was a useful tool to engage women in conversations about trauma and intergenerational patterns and a basis for developing trauma-informed interventions. In the aftermath of this study, the lead researcher and lead practitioner reconvened a year later to discuss what we had learned from the pilot study and made the decision to write about the experiences of engaging in practice and organisational change.

Narrative Development

In line with the collaborative nature of the research and practice development project, we sought to undertake something similar for the writing of the narratives in this article. We invited all of the practitioners within the domestic violence service (n=14) to consider writing a narrative on their experience of enacting ACEs routine enquiry and of subsequently working with women. Five staff decided to proceed, as well as both researchers and the lead practitioner (n=8). Over a six-week period we met weekly via an online meeting platform to discuss and review all of the emerging narratives. The focus of the narratives—concerns, practice interactions, and client responses to explorations of childhood trauma—were agreed collaboratively. As writing commenced, mutual support and feedback were offered until everyone was satisfied with their narrative. Each narrative was initially drafted by an individual. As we progressed through a number of drafts and co-writing, each narrative began to feel like it was as much a group narrative as an individual one, though we have retained the first-person presentation in each. One practitioner, an art therapist, decided to also complete a visual piece that represented her experience of incorporating understandings of ACEs into her art therapy practice within the organisation. This art piece concludes the written narrative section. Her work drew on many conversations with colleagues and reflects many of the themes present in each practitioner reflection that precedes it and was felt to be an appropriate reflection of the value of presentational knowledge (Reason, 1999). The discussion and conclusion were written by the two researchers and lead practitioner, reviewed by all co-authors, and feature points agreed by all those participating. This collective writing process was important to all those involved. It embodied and reflected the collaborative and empathic way the organisation seeks to undertake client work, while also valuing the lived experience of the practitioners (Reason & Bradbury, 2008). The narratives are presented in a sequenced way, concluding with the visual art piece, followed by a discussion of implications for practice and policy.

Practitioner Narratives

The Third Generation: Geraldine

In recent years I found myself wondering whether I was really making a difference. Bearing witness to the intergenerational patterns of domestic violence presenting at our service weighed on me heavily, a constant leaden worry. Throughout my years in a leadership role, I have continued client work and have dwelled on the fact that many women experiencing abuse spend a long time (sometimes years) asking the question, "What did I do wrong?" Repeat admissions to the service were prevalent, sometimes with children and many times without. I often wondered what damage the children may experience by remaining with the perpetrator, as well as with other family members or friends or, at times, in temporary state care. It became a regular occurrence for second-generation daughters to come to the agency for support. I always felt guilt and disappointment when this happened, that we had failed this woman when she was a child. In recent years we have even supported a third-generation daughter; she was slipping through the cracks but thankfully this time maybe we had intervened before the implications of her childhood got too embedded in her life.

Understanding ACEs as traumatic events that occur in childhood and seeing the link between ACEs and long-term impacts, I became energised and felt that this fitted with my experiences of working with women through repeated generations. Thinking about these cases from an ACEs perspective made such sense. One of the key elements of the ACEs training for me was the profound statement of asking a service user, "What has happened to you?" as opposed to "What's wrong with you?" The other important element for me was hearing the impact that experiencing trauma can have on one's physical health and the emerging evidence of ACEs and future health implications. Many of the women I worked with over the years jumped back into my mind—those who had health scares or developed medical conditions, most especially cancer, but also high anxiety, depression and other trauma-related illnesses—women who stayed in abusive relationships for their children, coming to us in their 60s to begin to enjoy their later life, only to soon be diagnosed with life-threatening cancers that quickly stole their independence again.

Our methods were important; we gently asked women about the ACEs they ticked on the questionnaire and if they wanted to talk about them. I felt the energy change from initial practice concerns around the fear of re-traumatizing the woman to trusting the process for the betterment of the woman and her family. I gained a huge insight into how working with the ACEs tools can facilitate women who find themselves "stuck" in their recovery journey, opening up important conversations, and allowing the support worker to offer therapeutic intervention as a healing process.

One such experience has stayed with me. In chatting with one woman about her ACEs journey, she explained that, while she didn't experience any of the ACEs mentioned in the questionnaire, she had been bullied by a teacher in her primary school. She described the fear that permeated her daily life as an eight- and nine-year old girl: the dread of going into school, the stomach-churning fear, and the awful moments when her mind would blank and she couldn't

answer the teacher's question. The bullying and abuse affected her self-esteem, her self-confidence, and her whole life journey. She never believed in herself and her own abilities and this left her open to be taken advantage of in all aspects of her life, including her intimate relationships. I wonder often if she ever would have spoken about this or explored its impact had we not implemented ACEs routine enquiry. This approach to working with historical trauma was new to me, but I no longer feel the sense of helplessness and guilt when I think of second- or third-generation women accessing our service. We are now working hard to understand their trauma, to help them understand their experiences, and to respond in ways that will protect the next generation.

Leadership and Dealing with Doubt: Mary

Three years ago, my working life took an unexpected turn when I found myself having to temporarily step into the shoes of the Project Leader as the year came to a close. There is a lot of pressure on this leadership role at year-end, with funding and reporting deadlines to ensure all is in order financially. With these responsibilities looming, I was then approached by a colleague with an opportunity (ACEs research) that might further enhance our practice. I worried that if I struggled to manage this new initiative it would negatively impact the organisation and the women we support. Staff look to their manager for direction, and what if I didn't have the answers for them? Worry niggled at the edges of me each morning heading into work.

My niggly fear slowly turned to confidence. Over the next two years, I led the implementation of the research and subsequent practice changes internally. The initial training brought our organisational team and invited community and statutory partners together. The families we work with liaise with many local agencies, and so a collaborative approach is key. Unfortunately, not all staff from our own organisation could attend the initial training. I was concerned about this on two levels. Practice development is pivotal across the team; service users need to experience a similar level of support and expertise from anyone working in our organisation. Resistance to organisational change emerged as another dynamic. I understand and respect that practice changes can create ambivalence for people, and we provided a supportive space where staff who did not attend the initial training could discuss their concerns. This worked well, and subsequently nearly all staff members ultimately engaged in the training.

Holding the leading role carries accountability—to the service users, staff, and funders. Deadlines certainly guided me and kept me—and staff who kept pace with the momentum of the work and the research time frame—on track. But I valued the chances I had to put the new tools into practice. Shortly after the training, I carried out an ACEs routine enquiry with a shelter resident, and it really struck me how a tool that looks so simple could evoke such rich conversations. We had an in-depth conversation about her relationship with her mother growing up, and it enabled her to connect her childhood experiences to how she now relates to her own children. She didn't want a cycle of rejection to continue, and we had many more conversations on engaging meaningfully with her child. Her shift from acknowledging her lack of physical comforting with her child, to attempting to hug and touch, to welcoming the feel of her child's light body in her arms was so emotive for me as a practitioner. Would work have happened in the absence of this tool? Possibly, but maybe not for some time. The ACEs routine enquiry

definitely opened up doors for this woman, and for other women I worked with, much sooner. This became a theme in our staff reflections upon the ACEs routine enquiry and a motivator to continue enacting new work practices.

A key support was the process of the action research inquiry group which was facilitated by the researcher. This group provided me with a sense of emotional containment and direction throughout the process; it was an essential aspect to the success of the pilot. Staff reflections, reactions, and challenges were able to be raised in these group settings, which allowed the team to reflect and respond appropriately. The added structure has also been a positive development for the organisation as a whole and the direction of our future work. While our service always operated from a trauma-informed response, we had no framework that gave our work such incredible weight as the ACEs framework has done. As a manager, it allows us to approach funders and advocate for the added interventions and supports for service users as part of this evidence-informed approach, which thus far has been well received. We have since been successful in securing further funding to continue to provide the interventions of art therapy, play therapy, and psychotherapy which provide spaces for the varying needs of service users. We are also at the initial stages of planning and building a dedicated therapeutic space for the agency, which will be an integral part of the service in providing better outcomes for women, children, and families.

Trauma and Health Impacts: Breeda

After the initial meetings about the ACEs routine enquiry, I found myself despondent. The women using our services were being failed by systems that did not hold perpetrators of abuse to account. After 20 years working in the shelter, it is always the woman who has to do the running and the hard work—whether it is trying to move with her children to a safe place, applying for a court order to keep herself and children protected, or managing the overwhelming emotional and physical impacts of abuse. During this time period, the perpetrator is often snug at home, not a bother on him. And now we were discussing having the woman also reflect on her childhood experiences of abuse.

Surprisingly, I eventually became a little captured by the possibilities of ACEs routine enquiry—primarily because of the simplicity of the process for both our staff and our service users. What became most important to me though was that staff and service users would be both physically and psychologically safe if we introduced it. Why was I so concerned about safety? I was struck by the long-term health impacts of ACEs shown in the research. Yet, little did I know that I would, myself, live out an experience of trauma and abuse impacts on my health during the course of our ACEs project, providing me with a stark, visceral reminder of the importance of understanding these connections.

I became immersed in an extended family situation in my own life, the features of which included mental health issues, substance use, abusive behaviour, repeated adult suicide attempts, and two children whom I cared deeply about. Not only did I find myself bearing witness to the impact of abusive and manipulative behaviours on the children, I also felt compelled to try and sort the situation out by providing some level of care and mediation for them. The personal

result was the manifestation of a moderately serious health condition—a swift, immediate, and crushing reminder of physical vulnerability in times of extreme stress. I have thankfully taken time to reflect, heal, and recover, but the lesson has stayed firmly with me. Trauma can manifest its impacts in our bodies, and our health can be the price.

The irony of the situation I bore witness to was that—as can be common in situations where mental health and abuse co-exist—the abusive person was hospitalised and cared for, while those impacted by his behaviours were left with little or no support to deal with the vicious situation and its aftermath. During this period, I had severe daily headaches and a lack of sleep. My fear and anxiety levels were through the roof. Bursts of adrenaline left me with sweaty hands, rapid heartbeat, and increased blood pressure. I felt like an elastic band being pulled further and further apart as I tried to ensure the children were safe. I thought of the mothers who could often be at the centre of such experiences, with minimal support or no way out. While working in an organisation that was implementing ACEs routine enquiry, I was trying to protect children in my own life who, perhaps one day, would be able to tick so many boxes on an ACEs questionnaire.

So where did this leave me in regard to ACEs and its usefulness? I had a temporary leave of absence from the organisation for one year. When I left, I had many reservations about how we would implement it. When I returned, I was astounded by how absorbed and integrated the understanding and responses to ACEs had become. Asking direct questions to the women about previous experience of abuse through the medium of 10 set questions such as "What has happened to you?" was a game changer for me, and I realised that, as an organisation, we were now providing a safe space for the service users to break their silence on long-held traumas.

By the time I returned to work, 60 women had completed the ACEs routine enquiry. I observed that the normal fear that comes with change within our organisation was not present, and I wondered how this had been achieved. I think it was ultimately a result of the tedious, continuous, and honest collaboration between the staff and the researchers. Considering the evidence base of ACEs and my own experience, I have really started to consider more deeply the number of women that we work with who experience physical illness and health issues. It has become my ongoing query, my route perhaps, into asking about, and understanding, her trauma.

Dealing with Disclosure: Martina

How to deal with disclosures of traumatic experiences was something I was really worried about when we started working with ACEs routine enquiry, and, ironically, my most vivid experience was a situation responding to exactly that. I had been working with a woman over a number of support sessions and felt I had a good understanding of all she had experienced and was dealing with. There seemed to be a comfortable ease between us. It did not occur to me there could be anything else happening beyond what we had discussed already. She agreed to complete the ACEs questionnaire willingly, and I ensured that there was time to discuss anything that may have come up. When she finished, I asked if she was OK and if there was anything in the questionnaire she would like to talk about. I observed her slouching and condensing herself into the chair as she disclosed a childhood trauma she had never spoken about. I could see the

emotion flooding her face as if the memory became a raw reality again, and the pain in her voice was nearly unbearable to hear. I encouraged some deep breaths, and when she eventually spoke again, her voice seemed stronger and she said she felt somewhat relieved at this disclosure. Further work together revealed there was ongoing abuse and trauma in her current life we had not yet discussed; prior to us talking about her childhood experiences, she had felt it could not be named. My belief is that the day she completed the ACEs routine enquiry, she began her healing journey.

Over the course of the ACEs project, at times I found bearing witness to emotional vulnerability deeply saddening. Often, I found women had experienced multiple ACEs. The emotional pain expressed was very difficult to hear, and I would sometimes feel overwhelmed by the ongoing intensely traumatic lives some of the women revealed after their questionnaires. At the same time, I was gaining increased confidence in my own practice. I was shocked by the revelations of the woman described above, as I thought I knew her story prior to using the ACEs routine enquiry, but it was because I had no idea that this earlier, unnamed trauma was deeply embedded in her physical and emotional body. I felt a new sense of freedom in my work with the realisation I had an effective way of potentially positively impacting women's life patterns.

My feeling was that this was just the tip of the iceberg for some women—their journeys can be longer and more challenging—but the introduction of this simple tool gives them motivation to dig deep within. If the right supports are put in place, they can move from where there was no escape to a life of peace and freedom after ACEs routine enquiry. Each time I worked with women and the ACEs questionnaire, conversations opened up about experiences I did not know about, and I often gained a new understanding or deeper sense of the women and their lives. Some women found it easy to talk of their childhood, while others definitely did not, and I learned quickly to read when it was not the right time for some to engage with the process. I feel that the women who engaged in the ACEs routine enquiry gained and grew from the process and from the interventions that were offered subsequently, such as art therapy and counselling. For the woman described above, this was a life-changing experience.

One of the things I have learned in this process is that I have the skills to "hold" a woman during her journey of disclosure and healing. Allowing a woman to reflect in a safe environment has huge benefits in increasing her self-awareness and opening the possibility of developing a better understanding of herself and others, especially the behaviours of the person abusing or manipulating her. What I am left with as we reflect on this process is that keeping women connected in a trusting relationship is one of the most important things to do in helping them understand and process their childhood traumas.

From Ambivalence to Embedded Practice: Erika

As a mature woman, I have many years of lifelong learning, self-development, and personal experience of the often-challenging road of past trauma recovery to draw on in my one-to-one work with women experiencing domestic violence. I am privileged to work in an organisation progressive in both practice and policy development, with an ongoing focus on developing practitioner skills, and as part of a team willing to push the boundaries of client provision where

both growth and personal/professional development is encouraged. This does not mean I blindly adopt new practices without question, as my journey with ACEs proved.

My initial attraction to ACEs was two-fold. First, I was aware clients may repeat the abuse they themselves experienced or witnessed as children in their adult relationships; I often hear things like, "I hated what my father did to my mother and now I'm with X who does the same to me." I recognised ACEs routine enquiry could afford opportunities for positive change. Second, ACEs offered an established research base for reference, with accessible facts and figures to form the basis for further practice development, rather than relying on unsubstantiated or subjective individual beliefs in the influence and impact of past experiences on later life choices. My curiosity was engaged.

It was with a largely enthusiastic attitude and enquiring mind that I attended the initial training. I felt assured by the straightforward simplicity of the 10 ACEs questions that would not exclude clients with poor literacy skills or for whom English is not their first language. I also agreed with the idea that clients would only be asked to complete ACEs after at least three meetings so as to first allow for trust to be built. I was, however, also concerned about the impact on clients and if I would be skilled enough to manage any fall-out if, for example, clients who already feel excessively guilty about their children would feel even more so when connecting their past experiences to those of their children now. I felt ambivalent about the benefit of completing ACEs with older clients: How would they view their roles as older mothers whose adult children are now facing complex life problems? And I questioned if clients might become more sympathetic towards their abusers, many of whom also had ACEs and already trade on these to draw women back into relationships.

I worked with over 35 women as they completed ACEs routine enquiry. Though an initially shaky ACEs routine enquiry practitioner (the experience resulted in a few new grey hairs for me), my concerns were ultimately allayed by a combination of the clients themselves and an ongoing organisational supervision.

A number of clients spoke about their abusers' traumatic childhoods. While I had worried that sympathy for this trauma would result in some women getting reeled back into a relationship that had taken them years to end, quite the opposite proved true. Following the ACEs routine enquiry and support, clients—even those just recently out of an abusive relationship—found their resolve not to return to the abuser was copper-fastened. Clients often identified and explored the different responses of themselves and their abusers to these shared childhood experiences. We also explored their normalised view of minimising and accepting (at times almost expecting) violence in their adult relationships. Relationships often started in late teenage years when the client was particularly vulnerable and easily exploited—the abuser would, for example, express his hurt at his experiences and the client would aim to heal him. Asking the client now, "So who was hurting?" often proved a pivotal moment as this offered the opportunity to explore how their own hurt was disregarded by both the abuser and by the client themselves. Without the ACEs routine enquiry, this wonderful opportunity for insight, growth, and a focus on the client's own needs could easily have been missed.

With the group of older clients (aged 60+), whose own children were now adults, I questioned if ACEs would add to their existing insecurities and trauma while offering little positive growth. Once again, I was privileged to witness the opposite. A number of clients had "lightbulb" moments with insight that their ACEs were not their fault. Inviting clients to compare themselves to children they know at present, who are of a similar age to when they had their own adverse experiences, resulted in the inevitable conclusion that they themselves "were just children" at the time. This allowed some clients to connect their legacy to their later life choices, and there was healing for others when discussing anger towards their mothers (also in abusive relationships) for not protecting them or for having to parent younger siblings while they were still children themselves. In thinking through why their own mothers did not leave, we reflected upon the greater opportunities for women to leave abusive relationships in the current day, in light of improved opportunities for economic and societal advancement. For some, this insight then initiated conversations with their adult children about experiences growing up with abuse. Clients named that they had more compassion for their children/grandchildren who may have some behaviour difficulties and that they could, after ACEs routine enquiry, now connect current challenges to abuse witnessed or experienced in their formative years.

Follow-up sessions allowed for exploration of clients' resilience, strength, and courage to not only survive their abusive childhood, but also their abusive adult relationships; answers were often insightful for both the client—as they found it supportive to hear that a high ACEs score does not define who they are today—and myself as a practitioner, as I gained new appreciation for their strengths. Combining ACEs knowledge with the wisdom of their years gave this group of clients a framework to view themselves in a more positive light, with newfound energy and confidence. They could view their lives through clear, rather than smudged, windows.

Presentational Knowing: Lisa

As an art therapist working with women and their children in the shelter, I instinctively wanted to compose an image representing some aspect of what it was like for me to participate in the ACEs project. This image reflects how often my first impression of someone is how they present themselves to the world; it takes time to really understand what is going on underneath. The ACEs questionnaire became a tool to help carefully peel back that top layer and really acknowledge the journey, and often the trauma, that women have gone through. The image was inspired by an amazing woman whom I worked with throughout the ACEs project. She spent almost 40 years with a man who tormented her heart and soul every day. She stayed for the sake of her children but, after retiring from her job, she had to spend each day in a house where every glance, word, and move was scrutinized. After years of contemplating change, she left this life in search of freedom and independence. I was so struck by the courage and strength that lay within this woman's fragile body. Shortly after leaving the abusive relationship, she was diagnosed with a life-threatening illness and needed to be cared for by family. This woman has had such a profound effect on me, and I still think of her. When I first meet a woman, her face is drawn, pained, avoiding eye contact. The image here has a pale complexion and presents well enough to the world, but the ACEs routine inquiry has allowed us the opportunity to ask and bear witness to our clients' childhood journeys. The dark colours and the twists in her hair represent the childhood legacies ever-present for our women. But intertwined with these are leaves, foliage,

and flowers that mark our clients' growth, new awareness, and confidence. For me, ACEs routine enquiry has provided a mechanism to slip past the façade towards greater authenticity and understanding in our therapeutic work.

Figure 1: *The masks that people wear* (original piece by Lisa Dundon)

Discussion and Conclusions

Some important themes emerged for us as a result of writing the narratives, including the importance of feedback and transformation for women when considering and embedding new practices; the intersection of our personal and professional lives when working with the traumatic experiences of others; and the importance of creating spaces to reflect, write, or even produce art, especially in the context of high pressure and stress such as during the COVID-19 pandemic.

What became most apparent from the narratives is that the reactions and transformations experienced by women as a result of the ACEs routine enquiry were key in developing our practitioner responses, and in informing our ongoing practice development. While we wanted to avoid telling the stories of individual women in our narratives, and instead highlight our own

practice responses and challenges, we were all impacted by individual women we worked with. A common theme was that often we had worked with a woman extensively or thought we knew her story, only to discover that there were key experiences or elements she had never disclosed or that she had not viewed as relevant to her current life struggles. As practitioners that seek to build empathetic, collaborative, and trusting relationships with the women we work with, this was challenging. We had assumed our traditional approach was enough to ensure everything that needed to be named could be named. The ACEs questions, although they remain debated (Kelly-Irving & Delpierre, 2019), helped us open conversations about things that might not have been talked about otherwise, but that proved relevant to the women's journey and current challenges. It was humbling to realise that sometimes trust, empathy, and a good knowledge base are not enough—that sometimes you aren't asking the right questions or asking in the right way to allow all the relevant experiences to emerge. We do not assume that ACEs routine enquiry is the right tool for every setting or every organisation. Rather, we realise there is always a need to keep expanding our skills and approaches, especially when we see even a percentage of our service users having poor or mediocre outcomes despite our interventions and support.

This raises important questions about the long-term impact of ACEs on the trajectory of women's lives and the possibility that ACEs experiences may increase their risk or vulnerability to abusive relationships in later life (Pill et al., 2017). ACEs prevention strategies are in their relative infancy, and there has been little focus to date on the possible gendered implications of ACEs, particularly in regard to domestic violence (Bellis et al., 2019). As we develop this work within our organisation, we realise we will need to continually consider, implement, and evaluate trauma-informed responses, as well as advocate for prevention strategies (Burstow et al., 2018). We feel we need to be supported in this intervention work with research that further considers the links between ACEs and domestic violence experiences in later life, as well as further research on the effectiveness of interventions and provider responses.

Not surprisingly, working with ACEs routine enquiry highlighted tensions between our personal and professional lives, particularly in relation to the health impacts of ACEs. Realising and working with the health implications of childhood trauma for women brought a lens to our own health, our own experiences of trauma, and to how these are discussed, understood, or known amongst a group of colleagues. While the collaborative writing process was helpful in developing a shared understanding of these issues, it also raises questions about how such dynamics would be managed in other organisations working with ACEs or other trauma-informed approaches. As a group, we had over many years of practice, skills training, and knowledge that helped us develop a good understanding of the potential traumatic impact of our work (Morton & Hohman, 2016; Pearlman & Saakvitne, 1995), yet it was still a surprise to consider the health impacts in such sharp relief. We would suggest that any agency or practitioner team needs to consider specific structures to address or respond to the potential impacts on staff of adding or expanding their work on trauma.

For those of us writing the narratives, this became an important process and experience in and of itself. We came together during a time of tight restrictions due to the COVID-19 pandemic, when we were not able to meet each other in person and our lives and interactions were heavily prescribed by public health guidelines. The writing process helped develop further understanding

and learning among the authors and led to a deepening of respect for each other's skills. It is hard to quantify the positive impact of working on something like this during one of the most challenging years the agency had ever experienced. Writing the narratives was generative for the organisation and resulted not only in important reflections on practice, but also a striking piece of art. We realised we had seen different aspects of each other. Although the process challenged us and brought us outside of our comfort zones, it solidified our practice and our commitment to innovative practices. In hindsight, it was interesting that during a time when public health advice recommended only the provision of essential services, we deemed this work important enough to concentrate on, even though not essential. Perhaps this is a vital learning point, that at times when it seems appropriate to pull back and retract interventions and innovation, it can be both sustaining and generative to seek connection and learning through writing and engaging in creative processes (Vass et al., 2008).

For us, this process of developing these narratives has been transformative, increasing our care and respect for each other and for the women we work with. Our narratives illustrate the depth of work that must go into introducing a new tool or practice—something that has perhaps been overlooked in the move to incorporate ACEs routine enquiry into health and social service agencies (Quigg et al., 2018) but is critical to future work in this area. We now also have a piece of art that we feel honours both our process and narratives and the experiences of the women we worked with.

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