VIEWPOINT

Exploring Parents' Adversities in Pediatric Primary Care

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Recent attention focused on the effect of adverse childhood experiences (ACEs) provides important support for a life course perspective to health. However, the growing popularity of screening parents for ACEs requires consideration of its benefits and consequences. This Viewpoint explores potential issues associated with parental ACE screening. Although the focus of this Viewpoint is on parental ACE screening, similar and additional concerns (eg, possible need to involve child protective services) arise for child ACE screening. We also offer an alternative approach, grounded in evidence. Specifically, parents should be screened for current psychosocial issues like intimate partner violence, mental health problems, and substance use, all of which are common distal consequences of ACEs. Each has effective interventions. Education should be provided to all parents about how a prior adversity can affect their health, parenting behaviors, and relationships with their children. These discussions should occur in the context of trusting parent-clinician relationships; recognizing parents' strengths; and encouraging safe, stable, and nurturing relationships with their children.

Approximately 25 years ago, seminal research demonstrated the early childhood antecedents of adult disease by showing an association between birth weight and adult cardiovascular disease.[1] Similarly, the effect of poverty and cumulative stress on subsequent health has been well described and is now reinforced by neurobiological research documenting disruptions in the hypothalamic-pituitary-adrenal axis and changes in brain morphology.[2,3]

The childhood antecedents of adult disease is further supported by the ACE studies,[4] which enrolled more than 17 000 adults insured by Kaiser. Following a health assessment, adults were mailed a questionnaire about ACEs include experiencing emotional, physical, or sexual abuse and neglect; witnessing violence against one's mother; experiencing parental separation or divorce; and living with household members who were substance users, mentally ill, or suicidal or who had been imprisoned. It is important to emphasize that the ACE questionnaire was designed as a research instrument and not as a clinical questionnaire. Medical record and self-report data provided researchers with information on health and risk behaviors. More than half of the participants in the study reported experiencing at least 1 ACE. Furthermore, the study reported that a higher number of exposures had an increased odds of engaging in unhealthful behaviors and experiencing poor health, including substance use and depression, compared with participants who reported fewer adverse experiences. The authors acknowledge study limitations including possible recall bias secondary to the study's retrospective design.

A recent study[5] documents the importance of other common adversities, like community violence, socioeconomic status, and peer victimization, which were not assessed as part of the ACE studies. Additional limitations of ACE scores are that they do not distinguish between a single episode or recurrent episodes (eg, watching your mother get hit once vs assaulted on many occasions) and that all adversities are considered equivalent (eg, sexual abuse is equal to parents' divorce). Furthermore, the ACE score does not allow for counting the same adversity for both parents (eg, having a father and a mother who are incarcerated).[6] Finally, scores do not take into consideration individual physiological or temperamental differences or different life experiences, like social supports, religious or cultural traditions, or psychotherapy. Families are diverse in cultural background and are embedded in neighborhoods and communities, which may contribute to resilience and may mitigate the effect of ACEs. Although the effect of prior adversities should be recognized, individuals should not be defined by their past experiences. The primary purpose of identifying risk factors is to prevent a problem. The purpose of identifying a problem is to provide interventions that help the patient or parent. The United States Preventive Services Task Force (USPSTF) has established principles for recommending screening tests, which include the need for evidence of improved outcomes related to screening and a need for evidence that its benefits outweigh its risks.[8] Although we do not necessarily suggest that parental ACE screening meet USPSTF criteria, understanding efficacy, benefits, and risks of parental screening is critical. Currently, there is insufficient evidence supporting an effective response or meaningful intervention for parents who have high ACE scores. Including such scores in their child's medical record may have unexplored risks that could include stigmatizing parents or making them feel guilty, embarrassed, or hopeless. Another risk that bears exploration is whether assigning ACE scores could perpetuate discrimination for already marginalized individuals and communities.

Rather than obtaining a parental ACE score—given these limitations and concerns—we think clinicians should focus on discussing a child's social environment and on cultivating the parent-child relationship within the context of a trusting family-clinician relationship. Clinicians should sensitively and safely ask questions about current psychosocial issues such as depression, intimate partner violence, and alcohol or substance abuse. Asking about these as a part of the social or family history is considered a best practice in the American Academy of Pediatrics Bright Futures program. Each of these parental challenges has the potential to interfere with a

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child's safety, learning, and development; has empirical support for screening; and has evidence-based therapies. Pediatricians need training during and after residency to elicit and understand these issues and to work with families to find help, as needed. Current evidence-based models like the Safe Environment for Every Kid[7] offer clinician training, screening protocols, and recommended responses for these 3 key issues including inquiring about strengths.

Beyond identifying these issues, pediatric clinicians should provide information to all families about the potential effect of parents' prior adversities on their parenting practices and on their own health. This approach is consistent with core principles of trauma-informed care, which stresses the high prevalence of trauma and supports a universal approach to patients; thus, it is most consistent with a trauma-informed approach to provide information to all patients, rather than restricting these discussions to those who are comfortable disclosing as part of an ACE score. All parents also should be offered options such as parenting groups, mindfulness, exercise, psychotherapy, and discussions with friends and family to support their own well-being and to support their relationship with their child. Because much of what supports parenting and well-being occurs in the community and involves connecting with others, pediatricians, or staff must be aware of and collaborate with community-based agencies that serve children such as schools and early intervention programs. Clinicians may need to advocate for sufficient mental health services, either integrated with primary care or in the community.

Parents and children are best cared for in the context of a trusting longitudinal relationship with their pediatrician. This ensures a safe and nonjudgmental setting to identify potential problems, promote child health, and nurture resilience and hope. Incorporating parents' histories and experiences into well-child care is an idea whose time has arrived. However, until there are studies that assess benefits and risks of screening parents for ACEs, we suggest the time-honored approach involving a caring clinician asking, listening to, and supporting families' experiences.

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