



Do Pediatricians Ask About Adverse Childhood Experiences in Pediatric Primary Care?

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ABSTRACT

OBJECTIVE: The stress associated with adverse childhood experiences (ACEs) has immediate and long-lasting effects. The objectives of this study were to examine 1) how often pediatricians ask patients' families about ACEs, 2) how familiar pediatricians are with the original ACE study, and 3) physician/practice characteristics, physicians' mental health training, and physicians' attitudes/beliefs that are associated with asking about ACEs.

METHODS: Data were collected from 302 nontrainee pediatricians exclusively practicing general pediatrics who completed the 2013 American Academy of Pediatrics Periodic Survey. Pediatricians indicated whether they usually, sometimes, or never inquired about or screened for 7 ACEs. Sample weights were used to reduce nonresponse bias. Weighted descriptive and logistic regression analyses were conducted.

RESULTS: Only 4% of pediatricians usually asked about all 7 ACEs; 32% did not usually ask about any. Less than 11% of pediatricians reported being very or somewhat familiar with the

ACE study. Pediatricians who screened/inquired about ACEs usually asked about maternal depression (46%) and parental separation/divorce (42%). Multivariable analyses showed that pediatricians had more than twice the odds of usually asking about ACEs if they disagreed that they have little effect on influencing positive parenting skills, disagreed that screening for social emotional risk factors within the family is beyond the scope of pediatricians, or were very interested in receiving further education on managing/treating mental health problems in children and adolescents.

CONCLUSIONS: Few pediatricians ask about all ACEs. Pediatric training that emphasizes the importance of social/emotional risk factors may increase the identification of ACEs in pediatric primary care.

KEYWORDS: ACE; adverse childhood experiences; pediatric primary care; screening

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WHAT'S NEW

Few pediatricians usually ask patients about all adverse childhood experiences (ACEs). Pediatricians' attitudes and beliefs about ACEs are related to asking about them; physician/practice/training factors are not. Pediatric training that emphasizes the importance of social/emotional risk factors may increase identification in pediatric practices.

health and mental health (MH) problems.¹ Adverse experiences in early childhood have been linked to developmental delays and injuries in 4- and 5-year-olds, learning and behavioral disorders and high body mass index among children and adolescents, and poor MH in young children.^{2–4} The Adverse Childhood Experiences (ACEs) study retrospectively examined the long-term impact of adverse experiences, such as childhood abuse, neglect, and household dysfunction, and demonstrated that greater numbers of stressors experienced early in life were associated with later-in-life risk taking and unhealthy lifestyles, as well as with disease.⁵

Identifying ACEs in young children who are not yet in school can be difficult. However, most infants do receive well-child visits,⁶ and the American Academy of Pediatrics

THE STRESS ASSOCIATED with cumulative adverse experiences in early childhood has immediate and long-lasting effects, as it can disrupt developing brain circuits and increase levels of stress hormones, leading to adult

(AAP) recommends 7 well-child visits for children during the first year of life as well as frequent visits throughout early childhood.⁷ Given the frequency of contact with pediatricians and the impact that ACEs can have on children's health, pediatric offices may be a promising venue for identifying and managing adverse experiences in early childhood.

The AAP recognizes that early life experiences can impact long-term health outcomes and has consequently made significant efforts to raise the awareness of ACEs and their effects on early brain and child development among pediatricians.^{8,9} For example, to identify children at risk, it has encouraged pediatricians to implement routine screening to identify family- or community-level factors that may adversely affect children.^{9,10} However, we know little about which pediatricians do and do not regularly identify ACEs among their patients.

In 2013, the AAP included questions about identifying adverse experiences among children in its Periodic Survey (PS). Given these unique data, the goals of this study were to: 1) examine how often pediatricians ask patients' families about ACEs, 2) examine pediatricians' familiarity with the original ACEs study, 3) assess pediatricians' attitudes and beliefs about the impact of stress/adversity on child development, and the role that parents and pediatricians have in mitigating the effects of ACE, and 4) examine the associations of physician and practice characteristics, MH training, and physician attitudes and beliefs with asking about ACEs.

METHODS

PS 85 SURVEY ADMINISTRATION

The AAP has conducted a PS of pediatricians 3 or 4 times each year since 1987 to inform policy, to develop new initiatives, and/or to evaluate current projects. Data collection for the PS 85 occurred between July and December 2013. The survey contained largely closed-ended questions asking about sociodemographic and practice characteristics, and it included questions about attitudes, training, and behaviors about child/adolescent and maternal MH. The questionnaire was pretested and approved by the AAP institutional review board before the mailings. Information about the survey is available online (<http://www.aap.org/en-us/professional-resources/Research/pediatrician-surveys/Pages/Periodic-Survey-of-Fellows.aspx/>).

Of the 54,491 US nonretired AAP members, 1617 were randomly selected and asked to complete the PS 85. Although the sample represents the AAP membership on age, sex, and region (data not shown), the response rate was suboptimal ($n = 594$, 37%). Comparisons of responders and nonresponders showed that the former group was significantly older (46.6 vs 43.7 years, $P < .001$). Additional analyses examined differences between early and late responders, using late responders as a proxy for nonresponders. The groups were similar with respect to how often pediatricians ask patients' families about ACEs, familiarity with the original ACEs study, and pedi-

atricians' attitudes and beliefs about the impact of stress/adversity on child development (results not shown). Nonetheless, sample weights were created to reduce potential nonresponse bias and ensure that the respondents were representative of the AAP membership. Logistic regression was used to estimate response propensity scores. The final model included the 3-way interaction of age, sex, and region, as well as their 2-way interactions and main effects. Ten groups were created using deciles of the response propensity score distribution. The sample weights were the inverse of the average propensity score for each group. The sample weights were rescaled such that the mean was unity and the sum was equal to the analytic sample size.

EXPOSURE AND OUTCOME VARIABLES

Sociodemographic factors included physician characteristics (eg, race/ethnicity, sex, age) and practice characteristics (eg, years in practice, type of practice, patient insurance). Physicians were asked about their past child MH-related residency and fellowship training (in developmental/behavioral pediatrics, child psychiatry, adolescent medicine, and behavioral sciences), and their interest in future MH-related education, which was rated on a 3-point ordinal scale (very, somewhat, not at all). Physicians were also asked how familiar they were with the original ACEs study (very, somewhat, vaguely, not at all familiar). Their beliefs and attitudes about adverse experiences, the impact of ACEs on children, and the role that parents and providers play in mitigating the effects of ACEs were assessed using a 5-point Likert scale, ranging from strongly agree to strongly disagree. Responses were dichotomized such that strongly agree and agree were compared to the other 3 categories for positively worded questions, and strongly disagree and disagree were compared to the other 3 categories for negatively worded questions.

Using a 3-point ordinal scale (usually, sometimes, never), pediatricians were asked how often they inquired about or routinely screened for 7 ACEs: maternal depression, parental separation/divorce, physical or sexual abuse, hostile/rejecting parenting by mothers, domestic violence exposure, parental alcohol/drug use, and incarcerated relative. Although hostile/rejecting parenting by mothers was not included in the original ACEs study, it is conceptually similar to emotional abuse, which was in the original study; emotional abuse was not included in the PS 85. Pediatricians who reported usually inquiring about or routinely screening for 1 or more ACEs (asking about any ACEs) were compared to those who reported sometimes or never asking about any ACEs.

STATISTICAL ANALYSIS

Univariate and bivariate analyses were summarized using weighted percentages for categorical measures and weighted means and standard errors for continuous measures. Bivariate comparisons were assessed by the Rao-Scott chi-square test and weighted linear regression. Weighted multivariable logistic regression was used to

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