Evolving a More Nurturing Society to Prevent Adverse Childhood Experiences

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Abstract

This article presents a framework for evolving a society that nurtures the health and well-being of its population. We review evidence that adverse social conditions, including poverty, conflict, discrimination, and other forms of social rejection, contribute immensely to our most ubiquitous psychological, behavioral, and health problems. We then enumerate the ways that effective family and school prevention programs could ameliorate much of the social adversity leading to these problems. The widespread and effective implementation of these programs—in primary care, social services, and education—must be a high priority. Beyond the implementation of specific programs, however, we must also make a more concerted effort to promote prosocial values that support nurturing families and schools. Our society's priorities must be to generate specific policies that reduce poverty and discrimination and, in so doing, reduce the risk for negative health-related outcomes.

Keywords: adverse childhood experiences; family; health; peer groups; prevention

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HERE WE PUT forward the changes our society needs if we are to significantly reduce the incidence of adverse childhood experiences (ACEs). Research has converged in showing that such experiences are a primary reason children and adolescents develop psychological, behavioral, and health problems, which often undermine their well-being throughout life.[1] We articulate a public health framework that can help us understand the social conditions that contribute to these experiences and the programs and policies that can reduce their occurrence in entire populations.

Adverse Childhood Experiences

Growing evidence indicates that we cannot achieve significant improvements in Americans' health until we learn to prevent the ACEs that play such a large role in the development of society's most prevalent health problems. Anda et al[2] discovered that adults who had faced multiple adverse experiences in childhood had significantly higher rates of a wide variety of physical illnesses. The adverse experiences included psychological, physical, or sexual abuse; emotional or physical neglect; family dysfunctions including alcohol or drug abuse in the home; divorce or loss of biological parent; depression or mental illness in the home; the mother being treated violently; or a household member being in prison. They also found that a wide variety of health behaviors and disease outcomes were more likely to occur as a function of the number of adverse experiences a person had been exposed to as a child. These negative outcomes included tobacco, alcohol, and other drug use; chronic depression; suicide attempts; anxiety disorders; hallucinations; problems staying employed; sexual promiscuity; and multiple marriages.

Exposure to ACEs has also shown a significantly greater likelihood of premature death due to physical illness, and research has discovered the physiologic pathways that undergird this relationship. Stressful family experiences are known to lead to lifelong changes in inflammatory processes associated with increased levels of heart disease, stroke, and tumor growth.[3–6] Research also finds, however, that maternal nurturance can attenuate the link between early childhood disadvantage and later metabolic syndrome,[7] which includes high blood pressure, impaired glucose control, abdominal adiposity, and lipid dysregulation, and is a precursor and contributor to many chronic diseases, including diabetes, heart disease, and stroke. In the same study, researchers found that simply escaping poverty during the life course did not attenuate this link, suggesting that early adverse social experiences, rather than poverty per se, lead to negative long-term health effects; and that a more nurturing social environment is the key to reducing risk for these negative effects. Clearly, reducing children's exposure to these adverse experiences must be a high priority for society.

Societal Conditions That Contribute to ACEs

The problem of ACEs needs to be analyzed within the context of the deterioration of our communities

over the last 50 years. Putnam[8] provides a thorough and carefully researched account of what has happened. The proportion of people living on middle-class incomes has declined by about 18% since 1971.[9] One in 5 children is living in poverty,[10] and nearly 50% are poor or near poor.[11] Twenty-two million Americans need drug abuse treatment, but only 2.5 million are receiving it,[12] and drug overdose deaths have increased dramatically in the past 15 years.[13] Additionally, family stability has declined. In 1971, 20% of children under age 7 lived with a single parent who lacked a high school diploma; now 60% of such children do.[8] In addition, lower income neighborhoods all over the country have lost the social cohesion and collective efficacy so important for successfully raising children.[14] Many of these conditions, such as drug abuse and single parenting, are among previously identified adverse experiences. Other conditions, such as poverty, contribute to child abuse, neglect, drug abuse, and mental illness.

In addition, a significant proportion of the population experiences discrimination, which is also a significant stressor for families. Landrine and Klonoff[15] found that 96% of a representative sample of African Americans in California had experienced discrimination in the past year, and 95% of them reported that it was stressful. Pascoe and Richman's[16] meta-analysis of 134 studies of the impact of discrimination showed that it was associated with higher rates of depression, anxiety, and schizophrenia, as well as poorer physical health and a greater number of unhealthful behaviors such as smoking and excessive drinking. These experiences are one reason why the life expectancy of African Americans is 3.7 years less than it is for white Americans.

Discrimination is not only an experience of minority group members. White people living in poverty are significantly more likely than affluent people to be seen as lazy, unpleasant, immoral, violent, mentally ill, abusive, alcoholic, unkind, inconsiderate, stupid, and dirty.[17]

All of these conditions make adverse experiences more likely. Nationwide, awareness of the problem of adverse experiences has increased, and treatment providers are increasingly being encouraged to screen for trauma and to provide treatment that will ameliorate the effects of past trauma.[2]

These steps are undoubtedly important. In addition to them, however, we believe that much more can be done to prevent adverse experiences from occurring in the first place. Prevention scientists have not only developed family, school, and community interventions that can prevent ACEs but they have also identified policies that can reverse the trends that have brought about the adverse social conditions that contribute to ACEs.

Social Processes Underpinning Adverse Social Experiences

Understanding the social conditions that contribute to adverse experiences and their physiologic effects shows us that we must prevent these experiences or ameliorate their impact, but it does not explain the social processes that underpin so many of the adverse experiences. To generate a population-level impact on public health, we must identify and address the social processes involved in adverse experiences. We describe 2 key sources here.

Family Coercion in Childhood

Patterson and colleagues[18–20] compared interactions in families with aggressive children to families without. They found that those with aggressive children had more interactions in which family members used coercive (ie, hostile, aggressive) measures to negotiate conflicts or disagreements. In families with aggressive children, family members frequently engaged in such social exchanges, which often continued until one person escalated the conflict by yelling, threatening, or hitting, which would effectively end the argument and bring a brief respite from the other's aversive behavior. Such families also demonstrated significantly fewer warm and reinforcing interactions that would promote or reward prosocial behavior. Longitudinal studies of children with this risk profile showed that coercive processes contribute to development of antisocial behavior,[21] substance use,[6] violence,[22] and depression,[23] all of which can contribute to later health problems. Additional research has shown that coercive processes are involved in most forms of social conflict.[24]

Peer Rejection in Adolescence

Peer rejection can be highly stressful, with negative implications for both mental and physical health; it is particularly likely among children exposed to adverse experiences at home.[25,26] For a number of reasons, adolescents are particularly susceptible to the effects of peer rejection. First, peers become increasingly important as a source of influence and affiliation during this developmental period. Adolescents tend to rely less often on their parents for social support, reducing parents' ability to serve as buffers against stress.[27–29] Additionally, brain development during this period makes social reward increasingly salient,[30,31] resulting in an elevated desire for peer group acceptance and making youth increasingly vigilant for signs of rejection. Finally, early adolescents may be particularly vulnerable to social stressors due to a developmental lag in self-regulatory capability.[32] Thus, early adolescence represents a developmental period of high risk for negative stress-related outcomes related to peer rejection. At the same time, early adolescents tend to experience more peer rejection, as a surge in aggressive and exclusionary behavior often accompanies the transition to middle school, a time when youth are renegotiating social structures.[33,34]

We have ample evidence that adverse social conditions in childhood contribute to the burden of ill health, not only through their impact on the development of psychological and behavioral problems that compromise health but also through direct impact on physiologic functioning. To achieve a population-level improvement in public health, we should provide services to remediate