Addressing Adverse Childhood Experiences: It’s Not What You Know but Who You Know

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In the article "Adverse Childhood Experiences and Protective Factors with School Engagement," Robles et al1 identify several key family and neighborhood protective factors that might help mitigate the effect of adverse childhood experiences (ACES) on school outcomes. Academic performance is 1 of the strongest and most consistent predictors of health, both during childhood2 and throughout the life course.3 There is also increasing evidence that ACEs are a key pathway through which disparities in academic and health outcomes may be transmitted across generations.4–6 Hence, identifying strategies that can support school function, particularly among those affected by ACEs, may be critical for reducing health disparities.

One particularly interesting finding noted by the authors was that the most powerful protective factor in their analysis was having a parent who can talk to the child about things that matter and share ideas. Many of the traditional ACEs (such as experiencing abuse or neglect and being separated from a parent because of death, incarceration, or divorce) disrupt the healthy development of social bonds within a family and may leave children without the consistency and support they need to thrive. Hence, it is not surprising that having positive supportive relationships with adults is a source of resilience.7 Strengthening a child’s existing family connections and improving family functioning by referring children and parents to mental health services, parenting programs, and social services may help address the effects of trauma and reduce additional family stressors for patients with a history of ACEs.8,9 Solely relying on such individual referral strategies, however, is likely insufficient to meet the needs of all children and families affected by ACEs.

One important source of healthy relationships not explored in this analysis are schools themselves. Both the World Health Organization10 and the Centers for Disease Control and Prevention11 recognize that school is not only a place to transmit academic knowledge but also a place for vulnerable children to connect with supportive adults and peers outside of their families. Supportive relationships with peers, teachers, and coaches as well as school connectedness and belonging have been shown to protect against depression, substance use, and other risky health behaviors.12–16 These positive connections also promote academic success.17,18 Policies that foster a supportive school environment (where students can bond with a caring, consistent adult and practice healthy interactions with their peers) might be especially effective for children affected by ACEs whose home environments may be less supportive. Such policies might include reducing class sizes,19 increasing professional development regarding trauma-informed practices,20 investing in nonclassroom support staff (such as school counselors, psychiatric social

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workers, and school nurses, and using restorative justice practices to resolve conflicts. In addition to building the capacity of schools to foster healthy connections, the school can be an important touch point for students and families to access primary care and mental health services. A number of evidence-based school interventions have been shown to successfully address trauma and build resilience. School-based health centers offer students who are at risk for poor academic outcomes access to health care in a confidential and convenient setting without missing school. Many school-based health centers offer robust primary care and mental health services that are particularly attuned to the needs of adolescents and vulnerable populations. Such school-based and school-linked mental health services are particularly effective at engaging at-risk students.

Although there has been an explosion in ACEs-related research, few practical, evidence-based clinical strategies to prevent or reduce the impact of ACEs on negative life outcomes have been tested or systematically implemented. Focusing on modifiable upstream protective factors can help us move from merely documenting associations to implementing solutions that operate before students ever need clinical interventions. As we look for solutions that can sustainably and effectively reach large numbers of children, we must go beyond individual referrals for patients and families and build supportive social systems. Schools are a key public institution and resource that might be supported in this fashion to promote healthy social interactions and build resilience for children exposed to ACEs. As pediatricians and child health advocates, ensuring that children from disadvantaged communities most affected by ACEs have access to supportive schools may be key to achieving both education and health equity.

**ABBREVIATION**

ACE: adverse childhood experience

**REFERENCES**


