



The Impact of Attachment-Disrupting Adverse Childhood Experiences on Child Behavioral Health

Kristen R. Choi, PhD, MS, RN¹, Tatum Stewart, LCSW², Eric Fein, MD, MS, MPP³, Michael McCreary, MPP⁴,
Kristen N. Kenan, MD, MPH⁵, Jewel D. Davies, MA, LCPC⁶, Sara Naureckas, MD⁷, and Bonnie T. Zima, MD, MP⁴

Objectives To describe patterns of overall, within-household, and community adverse childhood experiences (ACEs) among children in vulnerable neighborhoods and to identify which individual ACEs, over and above overall ACE level, predict need for behavioral health services.

Study design This was a cross-sectional study that used a sample of 257 children ages 3-16 years who were seeking primary care services with co-located mental healthcare services at 1 of 2 clinics in Chicago, Illinois. The outcome variable was need for behavioral health services (Pediatric Symptom Checklist score ≥ 28). The independent variables were ACEs, measured with an adapted, 28-item version of the Traumatic Events Screening Inventory.

Results Six ACE items were individually predictive of a clinical-range Pediatric Symptom Checklist score after adjusting for sociodemographic covariates: emotional abuse or neglect (OR 2.93, 95% CI 1.32-6.52, $P < .01$), natural disaster (OR 3.89, 95% CI 1.18-12.76, $P = .02$), forced separation from a parent or caregiver (OR 2.95, 95% CI 1.50-5.83, $P < .01$), incarceration of a family member (OR 2.43, 95% CI 1.20-4.93, $P = .01$), physical attack (OR 2.84, 95% CI 1.32-6.11, $P < .01$), and community violence (OR 2.35, 95% CI 1.18-4.65, $P = .01$). After adjusting for overall ACE level, only 1 item remained statistically significant: forced separation from a parent or caregiver (OR 2.44, 95% CI 1.19-5.01, $P = .02$).

Conclusions ACEs that disrupt attachment relationships between children and their caregivers are a significant predictor of risk for child emotional or behavioral problems. (*J Pediatr* 2020;221:224-9).

Traumatic events during childhood can have far-reaching, harmful effects on child development and health across the lifespan. As many as 60% of adults in the US experience at least 1 adverse childhood experience (ACE) before they reach the age of 18 years.^{1,2} The negative impact is supported by a well-established dose-response relationship between an ACE and poor health and social outcomes, such as depression, heart disease, lung disease, high risk behaviors, violence victimization, homelessness, involvement with the criminal justice system, and poor economic productivity.¹⁻³ Over time, ACEs can produce a sustained, toxic stress response in children that disrupts child development, emotional regulation, interpersonal relationships, and physiologic processes, and ultimately contributes to increased risk for poor outcomes.⁴

In addition, there is growing evidence that the specific kind of ACE and constellation of ACEs are necessary to understand a child's risk trajectory and develop appropriate interventions.⁵⁻⁷ Constellation of ACEs refers to groups of ACEs that occur together, interact, and exert harmful effects as a collective group of experiences.⁵ To assess a constellation, clinicians and researchers often rely on a simple count of ACEs (ACE score) as a risk assessment, which may obscure the contribution of specific ACEs or ACE constellations to certain health and social outcomes.^{2,8} In addition, ACE screeners traditionally capture maltreatment and within-household dysfunction but may miss the role of community adversity, such as firearm violence, bullying, overpolicing, and socioeconomic resource deprivation.^{9,10}

Although the total number of ACEs is a key indicator of risk, evidence also suggests that certain ACEs can have a differential effect on outcomes, which may be influenced by extent and quality of a child's sense of attachment. Secure and supportive caregiver relationships among other resilience and protective factors (eg, positive peer relationships, predictable home routines) can have a buffering effect against toxic stress and protect children from lasting developmental harm.^{3,11} Many children who experience ACEs have limited access to positive relationships and other protective factors, especially when the ACE originates with a child's parent, caregiver, or other family member. Attachment-based ACEs are

From the ¹School of Nursing, University of California, Los Angeles, CA; ²Erie Family Health Centers; ³Harbor-UCLA Medical Center, David Geffen School of Medicine at UCLA; ⁴Center for Health Services and Society, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles, CA; ⁵Department of Pediatrics, University of Illinois Hospital and Health Sciences System; ⁶Metropolitan Family Services; and ⁷Erie Family Health Centers, Northwestern University Feinberg School of Medicine

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ACE	Adverse childhood experience
PSC	Pediatric Symptom Checklist
TESI	Traumatic Events Screening Inventory

particularly harmful because they disrupt attachment relationships between a child and their caregiver. They remove or diminish the buffering effects that secure caregiver relationships have on ACE-related toxic stress.¹¹⁻¹³ Attachment-based ACEs usually are nonviolent and chronic.¹² They include psychological maltreatment, physical or emotional neglect, forced separation from a caregiver, caregiver impairment such as substance misuse or mental illness, and parenting that is frightening, unpredictable, or nonresponsive. Attachment-related ACEs of early childhood are, thus, often the foundation for further accumulation of ACEs across later childhood and adolescence that lead to poor outcomes over the lifespan.⁵

To examine the differential impact of attachment-related ACEs, we analyzed ACE screening data from a sample of low-income children and youth seeking care at 2 federally qualified health centers in Chicago.¹⁴ The objectives of this study are to describe patterns of overall, within-household, and community ACEs among children in vulnerable neighborhoods; and explore which individual ACEs, over and above ACE constellation, predict risk for emotional or behavioral problems. We hypothesized that attachment-related ACEs would be independently predictive of need for behavioral health services after adjusting for ACE constellation.

Methods

This cross-sectional analysis used the baseline data from a study of a co-located mental healthcare model at 2 Federally Qualified Health Centers located on the West and South sides of Chicago, Illinois. The study population was black and Hispanic youth from a range of zip codes in Chicago near the clinics. The clinics each serve an estimated 1500-1800 children (under age 18 years) annually.

Sample and Procedures

Children and their parents or caregivers, who were seeking primary care services at one of the Federally Qualified Health Centers from April 2016 to September 2017, were invited to participate in the study if they had a positive Pediatric Symptom Checklist (PSC) score indicating need for behavioral health services, or if they were referred by a provider for behavioral health or developmental disabilities services.¹⁵ To recruit participants in the study, clinicians introduced potentially eligible children to an on-site study coordinator. The study coordinator confirmed eligibility, obtained informed consent, and administered the baseline survey with a web-based data capture system.¹⁶

Inclusion criteria for the study were that the child was between 3 and 17 years of age, the child and their parent or caregiver were English- or Spanish-speaking, the child, caregiver, or both completed the study ACE screener, an adapted version of the Traumatic Events Screening Inventory (TESI), and the child had not received services at the site where they were seeking care in the past 3 months.^{14,17,18} There were 507 children who were eligible for enrollment in the study. Of the eligible sample, 340 children agreed to

enroll and 277 children went on to complete baseline measures. Fifteen children were excluded from the current study because they did not complete the TESI. Out of the 261 children with a completed TESI who qualified for inclusion in the analytic sample, there were only 4 children who identified as non-Hispanic White. Because this group was too small to make meaningful comparisons, they were excluded from the current analysis. The final sample was 257 child/caregiver dyads. Additional details about the sample selection are reported elsewhere.¹⁴ The parent study was approved by Institutional Review Boards from the University of California, Los Angeles and the University of Illinois at Chicago.

Study Variable Construction

Outcome Variable. Need for behavioral health services was measured with the PSC, with a cut-off score of 28 used to indicate a clinical-range behavioral problem.¹⁹ The PSC is a 35-item screening measure of emotional, cognitive, and behavioral problems in children.¹⁵ It is completed by parents and is commonly used to screen for behavioral problems in primary care.

Independent Variables. A 28-item, screening version of the TESI was used to measure ACEs.¹⁴ This measure uses yes/no, behaviorally specific items to identify household and community events that might be experienced as adverse or traumatic. All parents or caregivers completed the parent-report version and children older than 12 years of age completed the child-report version. ACE items were considered present if either the child or the parent or caregiver endorsed the item. The ACEs we considered to be potentially attachment-disrupting were emotional abuse or neglect, sexual trauma, physical violence, forced separation from a parent or caregiver, incarceration of a family member, and experiencing the death, illness, or actual or attempted suicide of someone close to the child. These items were selected based on a conceptual framework of complex trauma and attachment.²⁰ Because our study used a yes/no ACE screener, we could not account for whether or not a caregiver was involved in the ACE, but we anticipated that these experiences would have the most likely attachment-disrupting potential.

Other independent variables were ACE constellation (high ACE, moderate ACE, low ACE) identified in a separate analysis¹⁴; sociodemographic characteristics including child sex (boy/girl), child race or ethnicity (black, Hispanic), child age (years), child primary language as a proxy for acculturation (English/Spanish), parent marital status as a proxy for primary support (married/unmarried), and parent insurance status as a proxy for family socioeconomic status (insured [Medicaid or Private]/uninsured); parent depression measured with the 9-item version of the Patient Health Questionnaire-9.²¹

Statistical Analyses

This analysis was conducted using R v 3.2.2. Descriptive statistics, frequencies, and bivariate scatterplots were used to

summarize characteristics of the sample and explore relationships between variables. To explore the individual contribution of ACE items to a clinical-range PSC score, we first estimated a series of logistic regression models (model series 1) using each of the ACEs endorsed by study participants to predict clinical-range PSC scores while adjusting for sociodemographic characteristics. All ACEs that were individually predictive were carried forward to the next model series. Next (model series 2), we added the ACE constellation variable (high ACE, moderate ACE, or low ACE) to our models retaining the significant ACE items from model series 1 to adjust for multiple ACEs. Missing data were multiply imputed using chained equations; all analytic variables were missing at rates of less than 3%.²²

Results

There were 507 children who were eligible for enrollment in the study. Of the eligible sample, 340 children agreed to enroll and 277 children went on to complete baseline measures. Fifteen children were excluded from the current study because they did not complete the TESI. Out of the 261 children with a completed TESI who qualified for inclusion in the analytic sample, there were only 4 children who identified as non-Hispanic white. Because this group was too small to make meaningful comparisons, they were excluded from the current analysis. The final sample was 257 child/caregiver dyads. The sample was 46% (n = 118) girls and 27% (n = 70) children and youth who identified as black (Table I). On average, children were 8.6 years of age (SD = 4.5) with a mean of 4 (SD = 3.4) overall ACEs and 4 (SD = 4.53) PSC symptoms at the time of screening; 26% of the sample had a clinical-range PSC score. There were 14% of children in the sample who were primarily Spanish-speaking (n = 36). More than one-half (53%, n = 137) of parents/caregivers were unmarried, 77% (n = 198) of parents reported having no insurance, which was a proxy for family socioeconomic status. The most commonly reported ACEs for our sample

Table I. Sample demographic and clinical characteristics

Variables	Mean (SD) or % (n)
Sex	
Girls	45.9 (118)
Boys	54.1 (139)
Race	
Black	27.2 (70)
Hispanic	72.7 (187)
Language	
English	86.0 (221)
Spanish	14.0 (36)
Age	8.56 (4.45)
Overall ACE count	4.11 (3.40)
High ACE	18.0 (47)
Moderate ACE	52.1 (136)
Low ACE	29.9 (78)
PSC Overall ≥28	26.5 (68)

N = 257 children ages 3-16 years.

Table II. Frequencies of individual ACEs

ACEs	n (%)
Death/illness witness	120 (46.7)
Forced separation	58 (22.6)
Suicide exposure	29 (11.3)
Abusive physical punishment	8 (3.1)
Family violence (physical)	63 (24.5)
Family violence (verbal/emotional)	61 (23.7)
Incarceration of a family member	60 (23.3)
Sexual trauma experience	9 (3.5)
Emotional abuse or neglect	36 (14.0)
Accident experience	23 (8.9)
Accident witness	49 (19.1)
Medical trauma	78 (30.4)
Bullying	74 (28.8)
Physical attack	47 (18.3)
Mugging	6 (2.03)
Attack threat	22 (8.6)
Weapon attack	4 (1.6)
Kidnapping	5 (1.9)
Animal attack	17 (6.6)
Community violence	95 (37.0)
Other trauma	37 (14.4)
Natural disaster	15 (5.8)
War/terrorism exposure via media	130 (50.6)

N = 257 children ages 3-16 years.

were violent media exposure (50.6%), the death or serious illness of someone close to the child (46.7%), community violence (37.0%), medical trauma (30.4%), and bullying (28.8%) (Table II). No children in the sample reported witnessing rape or direct war or terrorism exposure, and kidnapping and weapon attacks were rarely endorsed (1.9% and 1.6% of the sample, respectively).

Of the 23 ACEs that were endorsed by study participants (model series 1), we found that 6 were individually predictive of a clinical-range PSC score after adjusting for sociodemographic covariates (Table III and Figure). These items were emotional abuse or neglect, natural disaster, forced separation from a parent or caregiver, incarceration of a family member, physical attack, and community violence. We carried these 6 items forward to the next series of models (model series 2), but also added the ACE constellation variable to adjust for co-occurring of ACEs. After this adjustment, only 1 ACE remained individually predictive of a clinical-range PSC score, over and above ACE constellation: forced separation from a parent or caregiver.

Discussion

This study examined the individual contribution of a wide range of household and community ACEs to need for behavioral health services after adjusting for ACE constellations. Youth in the study sample had very high levels of ACEs, averaging 4 ACEs at an average sample age of 8 years. National estimates suggest that a majority of adults report 1 ACEs by age 18 years.^{1,2} In this sample of high-ACE youth from vulnerable neighborhoods in Chicago, forced separation from a parent or caregiver was the only ACE that was

Table III. Logistic regression models predicting clinical-range PSC Scores (≥ 28) with ACEs

Predictor ACEs	Model series 1		Model series 2	
	OR (95% CI)	P	OR (95% CI)	P
Emotional abuse or neglect	2.93 (1.32-6.52)	<.01		
Natural disaster	3.89 (1.18-12.76)	.02		
Incarceration of a family member	2.43 (1.20-4.93)	.01		
Physical attack	2.84 (1.32-6.11)	<.01		
Community violence	2.35 (1.18-4.65)	.01		
Forced separation	2.95 (1.50-5.83)	<.01	2.44 (1.19-5.01)	.02

N = 257 children ages 3-16 years.

In model series 1, a series of logistic regression models were estimated using each of 23 individual ACEs to predict having a clinical-range PSC score (≥ 28). The models were adjusted for sociodemographic covariates including age, sex, race/ethnicity, primary language, parent marital status, and parent insurance status. The 6 ACEs that were individually predictive of the outcome (shown above, model series 1) were carried forward to model series 2. The same models were re-estimated, but another covariate was added for ACE constellation to adjust for total ACE burden. After this adjustment, only 1 ACE remained individually predictive of the outcome (shown above, model series 2).

independently predictive of a clinical-range PSC score, over and above ACE constellation. This finding is consistent with evidence of the profound harm of attachment-related ACEs on health and social outcomes.^{23,24} It also aligns with attachment theory and interpersonal neurobiology frameworks for understanding the role of caregivers in the

development of toxic stress.²⁵⁻²⁷ Although 5 other ACEs were also significant predictors of a positive PSC score—community violence, experiencing a natural disaster, emotional abuse or neglect, incarceration of a family member, and physical attack—these associations were not significant after accounting for ACE constellations. Our study suggests that attachment-related ACEs are of particular importance in the development of behavioral problems among children and youth.

Currently, there is widespread concern among child-serving professionals about the harmful effects of forced separation of children from their parents or caregivers, disruption of attachment bonds, and early childhood trauma, due in part to increased focus on immigration-related family disruption in the current political environment.^{28,29} This study adds to the existing literature on the harm of attachment-related ACEs and separation of children from caregivers, via immigration or other more common forms of separation such as child protective services and foster care involvement. Our study demonstrated that even after accounting for a wide range of household and community ACE constellations, children living in vulnerable neighborhoods who are separated from their parents or caregivers are at elevated risk for behavioral problems.

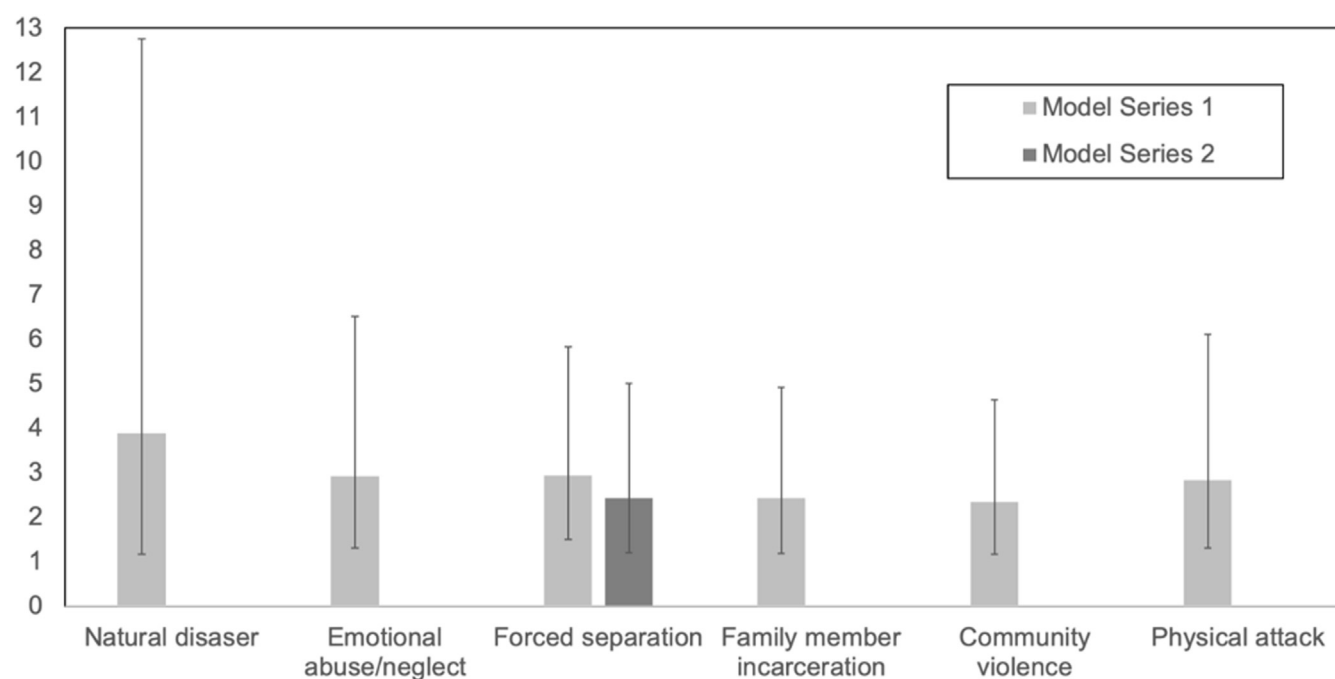


Figure. Models predicting clinical-range PSC scores by individual ACE items. In model series 1, each bar gives the odds of having a clinically significant PSC score (≥ 28) when the ACE item indicated was endorsed. A separate logistic regression model was estimated for each ACE item in this model series. The 6 ACEs shown above were statistically significant, individual predictors ($P < .05$) of the outcome. All estimates were adjusted for age, sex, race, parent marital status, parent depression, insurance status, and primary language spoken. In model series 2, the 6 significant models were adjusted for ACE cluster in addition to the covariates described above. After this adjustment, 1 ACE item remained a statistically significant, individual predictor of the outcome (forced separation). CIs (95%) are shown for all ORs.

For children living in vulnerable communities, it is important to consider community-specific mechanisms for attachment disruption. For example, studies suggest that paternal incarceration may increase behavioral problems among children.³⁰ Parental incarceration may be especially high in communities with longstanding, race-related structural inequities where mass incarceration often occurs.³¹ Children in other communities, such as rural communities, may experience attachment disruption via caregiver impairment related to opioid or other substance misuse.³² Generational trauma should also be a consideration; grandparents and parents of children with higher ACE exposure likely have their own trauma history that impacts their ability to parent and fully meet the child's emotional needs. Although our analysis did not capture generational trauma or parent ACEs, understanding the inter-generational nature of trauma and adversity is an important consideration for clinical care.^{33,34} Assessing generational trauma may allow for a more nuanced approach to high ACE exposure in children and the corresponding higher likelihood of depressive symptoms in their parents. Clinicians and other professionals who serve children should consider community partnerships to identify and address the various forms of adversity in the lives of children, youth, and families.

This study has strengths and limitations that should be considered when interpreting the results. The study used a comprehensive screener to assess ACEs that included both within-household and community ACEs as well as ACEs identified by community partners as relevant to youth in their community. We captured a broad range of ACEs that is not always assessed in research or clinical practice. It allowed for a more thorough analysis of the contribution of individual ACEs to behavioral health outcomes. A limitation of the study is that the data were cross-sectional and as such, the findings are only associative. The study used a simple ACE screener and so could not account for subjective appraisal, frequency, or duration of the ACE, or perpetrator characteristics. There may have been unmeasured confounding factors in the kinds of families who agreed to participate in this research for which the analysis could not account. For children under the age of 12 years, only parent-reported data were available for ACEs. Parents with more symptoms of depression may have been either more likely to perceive ambiguous stressors as traumatic or to be underinformed on their child's traumatic experiences. Children and youth in the sample had high ACE levels and were from racial and ethnic minority communities in vulnerable neighborhoods, limiting the generalizability of the findings to other populations.

Professionals who serve children currently are grappling with how best to screen for a number of psychosocial factors that impact health over the course of life, including ACEs. Adversity can be deeply entrenched in family and community history, and the quality of child-caregiver attachment relationships is central to both risk and resilience. Findings from this study indicate that attachment-related ACEs are more predictive than other household and community ACEs of behavioral health problems among children. Clinicians

who screen for ACEs should consider community-specific factors that might disrupt attachment security for children, including immigration raids or enforcement, adult opioid use disorders, mass incarceration, and natural disasters. Community organizations and providers with shared goals to improve child behavioral health outcomes may consider partnerships and cross-system collaboration with legal and social service organizations to minimize disruption of parent-child relationships. They may also consider recommending evidence-based parenting resources that could reduce the harm of attachment disruption.³⁵ ■

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Reprint requests: Kristen R. Choi, PhD, MS, RN, School of Nursing, University of California, 700 Tiverton, Factor Bldg Rm 3-238, Los Angeles CA 90095. E-mail: krchoi@ucla.edu

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