American Psychologist

ISSN: 0003-066X

2021, Vol. 76, No. 2, 314–325
https://doi.org/10.1037/amp0000767

Adverse Childhood Experiences in African Americans: Framework, Practice, and Policy

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Adverse childhood experiences (ACEs) disproportionately impact African Americans because of profound subjection to historical-systemic oppression in addition to personal and intergenerational trauma exposure. This article utilizes a biopsychosocial-cultural framework to understand the correlates of ACE exposure in African Americans and attends to the cultural factors that contribute to resilience. We review the evidence base for culturally informed, preventive-interventions, as well as strategies for bolstering this work by capitalizing on cultural strengths that are salient in the African American community. We also highlight pertinent policy initiatives guided by recent strategic outlines by the Centers for Disease Control and Prevention. These policies provide the backdrop for the recommendations offered to facilitate the healthy biopsychosocial development of individuals and families. These recommendations can contribute to the expansion and creation of new policies that aim to strengthen individual coping in the face of adversity, enhance family bonds and resilience, and promote community capacity to reduce ACE exposure in African Americans.

Public Significance Statement
Adverse childhood experiences (ACEs) disproportionately impact African Americans. It is imperative that we develop and test culturally relevant programs to prevent ACEs, as well as design interventions to reduce the negative impact of exposure. We need evidence-informed policies to support these efforts.

Keywords: adversity, African American, biopsychosocial-cultural, treatment, policy

Editor's note. This article is part of a special issue, "Adverse Childhood Experiences: Translating Research to Action," published in the February–March 2021 issue of *American Psychologist*. Sharon G. Portwood, Michael J. Lawler, and Michael C. Roberts served as editors of the special issue.

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Dorian A. Lamis is a paid consultant for Bristol Myers Squibb. Charles F. Gillespie is a paid consultant for Cohen Veterans Bioscience. No other authors have conflicts of interest to report.

The authors acknowledge the following support - Joya N. Hampton-Anderson, AIM Youth Mental Health Foundation Clinical Science Fellowship; Sierra Carter, National Cancer Institute (3R01CA220254-02S1) and National Institute of Mental Health (R25MH087217); Negar Fani, Emory Medical Care Foundation and Emory University Research Council; Dorian A. Lamis, NARSAD Young Investigator Grant awarded by the Brain & Behavior Research Foundation; Jessica L. Maples-Keller, Building Interdisciplinary Research Careers in Women's Health of the National Institutes of Health (K12HD085850) and funding from the Georgia Clinical and Translational Science Alliance (UL1TR002378) and COMPASS pathways; Abigail Powers, National Center for Complementary and Integrative Health (K23AT009713); and Nadine J. Kaslow, National Institute of Mental Health (1R01MH078002-01A2). Joya N. Hampton-Anderson and Nadine J. Kaslow assumed primary responsibility for manuscript preparation. The remaining authors are listed alphabetically, and all contributed equally.

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Adverse childhood experiences (ACEs) interfere with physiological, cognitive, and social-emotional development; cause emotional pain; undermine people's sense of safety and security; result in maladaptive coping; hinder quality of life; and are costly to society (Centers for Disease Control and Prevention, 2019). The original ACEs study revealed that exposure to childhood abuse (psychological, physical, or sexual) and household dysfunction (substance abuse, mental illness, mother treated violently, or criminal behavior in household) was related to increased morbidity and mortality among primarily European American, middle-class adults (Felitti et al., 1998). While individuals from all sociodemographic backgrounds can be exposed to and negatively impacted by ACEs (Felitti et al., 2019), there is compelling evidence that the experience of childhood adversity is not equal across racial/ethnic groups. African Americans report more ACEs than Latinx and European American, individuals, and when their income increases, their experience of ACEs does not decrease to the extent that it does in other racial/ethnic groups (Slopen et al., 2016).

Increased vulnerability to ACEs in African Americans reflects a complex interplay of contextual factors that negatively impacts physical and mental health over time. The combination of historical-systemic, community (e.g., racism, deep poverty, police brutality, or deficits in child protection), intergenerational, and personal trauma exposure may impact African Americans' stress-related biology and approach to coping and render them more vulnerable to the negative long-term effects of ACEs (Conching & Thayer, 2019; McCrea et al., 2019). Given these disparities, researchers and scholars must explore the prevalence, nature, and impacts of ACEs in this population. Additionally, we must develop and implement preventive-interventions and policies that have the potential to transform this landscape.

To lay the groundwork for this transformation, this article details the epidemiology of ACEs in the African American community. It offers a biopsychosocial-cultural conceptualization of the manifestations of ACEs and attends to the influence of cultural factors on these outcomes. It builds a case for culturally informed, evidence-based preventive-interventions that capitalize upon this population's resilience in the face of toxic stress. The article concludes by recommending policies to reduce the prevalence and impact of ACEs in this population and enhance African American's capacity to thrive in the face of adversity.

Epidemiology of ACEs in the African American Community

Epidemiological surveys reveal that exposure to ACEs is a major public health problem; close to two thirds (62%) and approximately one quarter (23–25%) of adults, respectively, endorse exposure to at least one ACE or to three or more ACEs (Merrick et al., 2018). The incidence of ACEs varies by race; most studies find that African Americans report ACEs at a higher rate than European Americans (Felitti et al., 1998; Slopen et al., 2016). African American, Latinx, and multiracial adults endorse higher rates of ACEs than do adults from other racial/ethnic groups (Merrick et al., 2018). Both African American and Latinx children report exposure to multiple ACEs more often than their European American peers (Slopen et al., 2016). When types of ACEs are considered separately, there is some evidence that African American children have greater exposure to the majority of ACE categories than European American or Latinx children; only parental drug use and mental illness do not follow this pattern (Maguire-Jack et al., 2020).

When understanding rates of ACEs across racial and ethnic groups, it is essential to consider other social identities, such as socioeconomic status (SES). Across racial/ethnic groups, youth from low-SES backgrounds endorse more ACEs than those from higher SES households (Slopen et al., 2016). However, race/ethnicity and income interact such that the racial/ethnic disparities in rates of ACEs is most significant within the highest-income category. This finding may reflect the fact that European American children receive more advantage from household income than minority children across the SES spectrum. Thus, it is important to focus ACE conceptualization, preventive-intervention, and policy in African American youth across the socioeconomic strata.

Biopsychosocial-Cultural Perspective

The biopsychosocial model addresses the multifaceted interactions among biological, psychological, and social processes related to illness and health (Engel, 1977), and for the purposes of this article, adjustment to ACEs. Within the original framework, biology refers to basic scientific processes; psychology pertains to cognitive and behavioral processes; and social is related to interpersonal and socioeconomic factors (Engel, 1980). Recently, cultural factors have been conceptualized as influential to biopsychosocial factors and afforded a more prominent place in the model (Hatala, 2012). This shift reflects concerns that the previous model assumed uniformity or homogeneity within groups. In this expanded biopsychosocial-cultural model, culture adds necessary nuance and encompasses race, ethnicity, spirituality, sexual preference, gender identity, geography, language, SES, and so forth (Hilty, 2015). This model allows for a broader appreciation of the impacts of ACEs on African Americans and the ways cultural factors may influence outcomes in response to exposure to childhood adversity. Below, we describe the biological, psychological, and social correlates of ACE exposure in the African American community and detail cultural processes that influence the impact of ACE exposure.

Biological Correlates of ACE Exposure

A large body of data reveal that ACEs have persisting effects on neurological, endocrine, immune, and metabolic function (Danese & Lewis, 2017; Nemeroff, 2016), likely as a consequence of the interaction of ACEs with genes through sequence variation and epigenetic effects (Jiang et al., 2019). The ACEs study provided the first evidence of a graded association between cumulative exposure to ACEs and a broad swath of adult physical health outcomes (e.g., ischemic heart disease, cancer, chronic lung disease, skeletal fractures, or liver disease autoimmune disorders; Anda et al., 2006; Felitti et al., 1998). Subsequent studies have supported these findings among individuals with histories of childhood abuse (Paras et al., 2009; Wegman & Stetler, 2009).

Several studies with low-income African Americans residing in urban environments have found that fear physiology, autonomic function, and elevated inflammation, as indexed by c-reactive protein (CRP), are associated with trauma exposure including in the form of ACEs (Michopoulos et al., 2015). Collectively, these data highlight the heterogeneity of alterations in peripheral stress physiology in trauma-exposed African Americans. These modifications may individually, or in combination, increase allostatic load as well as the shared risk of developing stress-related physical and psychological disorders.

Psychological Correlates of ACE Exposure

Psychological Symptoms and Disorders

Across all racial/ethnic groups of adults, ACEs demonstrate strong associations with psychological symptoms/disorders, most prominently depression, posttraumatic stress, substance misuse, and suicidal behavior. The same pattern is true among African American adults. For example, in a study comprised of low-income African Americans, childhood emotional abuse was correlated with depressive symptoms (Crow et al., 2014). In a sample of low-income African American women, five forms of childhood maltreatment (physical, sexual, and emotional abuse; emotional and physical neglect) were independently related to risk for suicide attempts (Thompson et al., 2000), and the more forms of childhood abuse endorsed, the greater the likelihood of a suicide attempt (Anderson et al., 2002).

Attention has also been paid to factors that mediate the association between various ACEs and psychological symptoms and disorders in African American adults. The link between childhood emotional abuse and depressive symptoms has been shown to be mediated by emotion dysregulation (Crow et al., 2014). In a low-income African American sample, symptoms of posttraumatic stress disorder (PTSD) mediated the relation between childhood trauma and problematic alcohol and substance use (Cross et al., 2015). Hopelessness has been found to partially mediate the childhood maltreatment—suicide attempt link among low-income African American women (Meadows & Kaslow, 2002), and the childhood emotional abuse—hopelessness link has been mediated by existential well-being and positive self-esteem (Lamis et al., 2014).

Psychological symptoms and disorders also have been examined in African American youth exposed to ACEs. Among African American children living in low SES environments, those who experienced child maltreatment and who witnessed physical intimate partner violence perpetrated against their mothers report high rates of psychological distress (internalizing, externalizing, and posttraumatic stress symptoms; Kaslow & Thompson, 2008). In a prospective sample of diverse high school seniors, increased ACE frequency was associated with elevated levels of depressive symptoms, drug use, and antisocial behavior. The mental health effects related to the number of ACEs experienced was stronger among European American youth than among African American or Latinx youth (Schilling et al., 2007). The authors propose that this finding may reflect a "steeling effect" in which youth from some racial/ethnic groups demonstrate apparent improved ability to cope with stress. However, while the effects of this high effort coping in response to adversity may not be reflected in the form of psychological symptoms and disorders, it may be manifested in faster epigenetic aging in the form of an increased discrepancy between biological and chronological age that makes people more vulnerable to physical health problems (Miller et al., 2015).

Cognitive-Affective Deficits

ACEs also have been linked to unfavorable cognitive outcomes that impact higher-order cognitive abilities related to selective and sustained attention, working memory, inhibitory control, and cognitive flexibility (Guinosso et al., 2016). These effects persist into adulthood for African Americans and European Americans. A prospective study with a large, mixed-race sample found that childhood neglect predicted executive functioning deficits in adulthood, even when accounting for demographics, general intellectual functioning, psychopathology, and alcohol use (Nikulina & Widom, 2013).

The timing of ACE exposure plays a role in the development of cognitive-affective deficits. ACEs that occur during sensitive periods in brain development, including pre- and peri-pubertal time periods, affect regions undergoing the steepest increase in growth during that time (e.g., amygdala, hippocampus, or prefrontal cortex). These regions, which are responsible for higher-order cognition and emotion regulation, are sensitive to the effects of stress. ACEs also adversely affect basic emotion processing, leading to biases in attention and in the accurate recognition of emotions in adulthood (Young & Widom, 2014). In African Americans,

childhood maltreatment has been linked to biases in attention to emotional cues (such as threat-related facial expressions; Lakshman et al., 2020).

Although these data suggest that ACEs may have long-lasting effects on cognition, possibly contributing to cognitive vulnerabilities and/or decline in older adulthood, there are mixed findings on the moderating effects of race. In one longitudinal study with a mixed-race sample, no relation among race, early life adversity and cognitive decline was observed (Everson-Rose et al., 2003). In a later large-scale longitudinal study of Alzheimer's disease, some types of early life adversity were linked to a slower rate of cognitive decline in African Americans, whereas no relations between early life adversity and cognitive decline were evident in European Americans (Barnes et al., 2012). These surprising findings may suggest a race-specific mechanism of resilience that merits further exploration.

Social Correlates of ACE Exposure

Among low-income African American children, those exposed to childhood abuse have more problems with social functioning than those without such exposure (Lamis et al., 2014). Notably, these interpersonal challenges make it difficult to seek out and maintain social support over a lifetime (Segrin et al., 2016). For example, among low-income African American women, a history of childhood abuse is associated with lowered levels of social support (Bradley et al., 2005). Social support also mediates the relation between childhood abuse (when all forms of abuse are considered together or separately) and later PTSD symptoms in these women (Bradley et al., 2005; Stevens et al., 2013). This lack of social support in the context of ACE exposure is concerning, as social support is a key protective factor against the development of biopsychosocial difficulties in African Americans (Brown, 2008).

Cultural Processes That Influence the Impact of ACE Exposure

Cultural factors can influence biological, psychological, and/or social functioning secondary to ACE exposure. This section addresses ways in which cultural processes may impact functioning in those exposed to ACEs, with a focus on social class and culture specific coping.

Social Class

Because of systemic policies designed to route resources away from communities in which minorities live, African Americans, along with individuals from other racial/ethnic minority groups, are more likely to reside in low-income neighborhoods. Under resourced social environments put individuals at greater risk for ACE exposure and its negative impacts than do middle or upper SES environments (Giovanelli et al., 2019). Individuals living in poverty often are stressed because of difficulty attaining resources and neighborhood disorder, which in turn can strain family systems and make the perpetration and mistreatment that falls under the ACEs criteria more likely (Bruner, 2017).

Culture Specific Coping

A small body of literature examines the ways in which African Americans cope with ACE exposure. For example, one qualitative study found that African American women who were abused as children use a range of culturally relevant coping strategies, including spirituality, community support, activism, and racial reframing/racial attribution (Bryant-Davis, 2005). In addition, African American women with a history of maltreatment during childhood are less likely to exhibit PTSD if they utilize spirituality as a coping strategy (Zhang et al., 2015). Indeed, spiritual coping is a component of Africultural coping (Utsey et al., 2000), a rubric that encompasses culture-specific coping strategies used in stressful situations that are grounded in an African-centered conceptual framework. Africultural coping also incorporates the constructs of ritual-centered coping, collective coping, and cognitive/emotional debriefing, which also may be relevant to coping with ACEs. For example, community support and activities may be forms of collecting coping.

Another pertinent form of culture specific coping is the Strong Black Woman/Superwoman schema (Donovan & West, 2015; Woods-Giscombé, 2010). This refers to a tendency to cope with stress by projecting one's self as strong, self-sacrificing, and free of emotion. A history of ACEs (i.e., abuse) has been associated with the propensity to adopt the superwoman role, which leads to a reduced willingness to express emotions or seek assistance (Woods-Giscombé, 2010). Adoption of the strong black women ideology is one mediator of the relation between trauma exposure, including to ACEs, and eating problems (Harrington et al., 2010). In addition, the superwomen role interacts with racial discrimination in a manner that renders African American women vulnerable to physical health problems (Allen et al., 2019). Recently, racial discrimination was added as an ACE under an expanded, culturally informed model (Cronholm et al., 2015) and its relevance as an ACE in the lives of African American youth has been highlighted (Bernard et al., 2020).

Approach to Preventive-Intervention

To prevent ACEs and ACE exposure, mitigate against their short and long-term biopsychosocial impacts, and reduce health disparities, we need an array of preventive-interventions. To be effective, these programs must be evidence-informed, developmentally sensitive, multifaceted, and culturally grounded. Culturally grounded programs are ones that capitalize on the strengths of, and

support within, the African American community by being resilience-focused, empowerment-based, and attentive to the multiple systems in which individuals are embedded. Using a public health framework, these efforts must include primary, secondary, and tertiary preventive-interventions. Primary prevention includes universal, selective, and indicated prevention programs that help prevent ACEs and reduce intergenerational risk for ACEs. Secondary prevention involves interventions that reduce the number of recurring ACEs and the severity of the biopsychosocial impacts of these stressors once ACEs have occurred. Tertiary prevention refers to interventions that reduce the long-term biopsychosocial consequences of ACEs (Oral et al., 2016).

Primary Prevention Strategies

The Centers for Disease Control and Prevention (CDC) recently put forth a strategic outline of evidence-based ACE prevention approaches (Centers for Disease Control and Prevention, 2019). In this sections that follow, we use this framework as a guide to highlight key preventive-intervention methods to address the cause and consequences of ACES for African Americans across the SES spectrum.

According to the CDC, preventing ACEs requires teaching youth to adaptively manage stress, resolve interpersonal difficulties, and regulate mood and behavior. This can be accomplished by implementing universal school-based programs that strengthen social-emotional skills (Centers for Disease Control and Prevention, 2019). Such skills must be promoted across the SES spectrum given that the impact of ACEs persists for African American communities regardless of income. Preventing ACEs also entails teaching parents how to effectively cultivate family environments that support children's age-appropriate and healthy development (Centers for Disease Control and Prevention, 2019). For example, the Nurse-Family Partnership (NFP) is a home visiting program for low-income, first-time mothers that provides up to 2-years of parental support, positive parenting advice, and assessments of home safety. This program also monitors children's attainment of developmental milestones and provides wrap-around support linking families to health providers when indicated. When compared with a control group, families in the NFP program had more significant reductions in childhood maltreatment, substance misuse, and juvenile arrests over a 15-year time period (Olds, 2006). In addition, there is evidence in support of parenting programs that provide caregivers with skills-based training to cultivate strong attachment with their children as well as to address and prevent problem behaviors (Centers for Disease Control and Prevention, 2019). However, for such programs to maximally benefit African Americans, we need ongoing evaluation and adaptation efforts to ensure their cultural relevance. These programs also must be destigmatized, affordable, and not only accessible to those involved with Child Protective Services.

Secondary Prevention Programs

To reduce the detrimental effects of ACEs, secondary preventive-interventions can be applied directly after an adverse event. For example, psychological first aid (PFA) provides information, education, comfort, and support by trained lay people or mental health personnel (Ruzek et al., 2007). It allows for early identification of psychological symptoms, which when attended to, can increase the speed of recovery from ACEs and enhance resilience in response to future ACE exposure. Interventions such as PFA may benefit underserved communities with economic barriers to accessing mental health services as they can be embedded within community and health services.

Another secondary preventive-intervention promoted on a larger scale is Trauma Informed Care (TIC), a comprehensive, multilevel approach that modifies the way groups view trauma so individuals who have experienced childhood and life span adversity are not pathologized (Leitch, 2017). It involves training people (e.g., teachers, health care staff) to understand the impact of stressful traumatic events on health-related indicators and behaviors. TIC has received support in hospitals, schools, juvenile justice departments, mental health programs, and youth development agencies. The working alliance forged in TIC results in patients feeling empowered to discuss ACEs with service providers who understand how ACEs influence health, functioning, and wellness. However, TIC may have unintended consequences; by emphasizing the negative experiences of childhood it often fails to attend to, and build upon, protective factors and strengths.

Tertiary Prevention Programs

Evidence-based psychotherapies that reduce the negative effects of ACEs on health outcomes in children include parent–child interaction therapy (PCIT), child parent psychotherapy (CPP), and trauma-focused cognitive–behavioral therapy (TF-CBT). What these interventions have in common that mitigates the negative effects of ACEs is a focus on enhancing supportive parenting. Some interventions also consider the unique needs of minority communities. The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed for inner-city school settings with ethnically diverse youth with posttraumatic stress symptoms. Celebrating the Strengths of Black Youth (CSBY) is a strengths-based, small-group program that builds positive racial identity, nurtures self-esteem, and attends to race-related stressors among African American children (Okeke-Adeyanju et al., 2014). Recently, researchers have proposed modifications to TF-CBT so the intervention addresses race-based traumas and discrimination using race socialization strategies (Metzger et al., 2020).

Recommendations for Culturally Informed Preventive-Interventions

While evidence supports the need for ACE-focused preventive-interventions, we call for more culturally relevant and resilience-focused preventive-interventions that address the unique needs of African Americans and their numerous strengths. Resiliency is a dynamic process that includes positive adaptation through physical, psychological, social, and cultural resources in the face of adversity (Ungar et al., 2013). Such processes can be identified and targeted in the context of interventions to promote enhanced resilience to future adversity.

At the individual level, self-efficacy and self-regulation influence resilience capacity and may be mechanisms targeted in treatments. African Americans exposed to ACEs with a sense of purpose have higher levels of both resilience and recovery. Further, both active coping and spirituality are associated with fewer psychological symptoms in this population (Alim et al., 2008). Using a strengths-based approach that enhances African Americans' self-esteem and self-perceptions, as well as promotes a positive racial/ethnic identity may reduce the likelihood of developing psychological symptoms and disorders and may improve biopsychosocial outcomes (Stevens-Watkins et al., 2014).

At the family level, initiatives such as the Strong African American Families Program, should be implemented more widely as they are associated with lower risk for the negative health outcomes associated with ACEs (Brody et al., 2017). The Strong African American Families Program is culturally informed as it includes components that focus on enhancing adaptive racial socialization strategies and recognizing effective strategies to use in the face of racism. Another family based race socialization intervention, Engaging, Managing, and Bonding through Race (EMBRace), has shown preliminary acceptability as well as improvements in coping (Anderson et al., 2018). It may be another useful program for reducing the risk of negative physical and mental health outcomes associated with racism and its related sequelae.

At the community level, resilience-focused preventive-interventions must be rooted in an ecological and multisystemic framework that focuses on environmental processes that influence social disadvantage and early life adversity. Such interventions must appreciate that throughout the United States, this community is disproportionately subjected to high levels of life course adversity and stress, including racial discrimination, poverty, and community violence, which reflect longstanding structural societal inequities. These interventions also must recognize that African Americans have survived adverse experiences, known as historical traumas (e.g., slavery), that have long-lasting dire intergenerational biopsychosocial effects that may be inherited across generations. Further, these interventions must be based on an understanding that experiences of historical trauma along with current multisystemic racism are a collective injustice experienced by entire African American communities that reduces people's chances to combat ACEs (French et al., 2020; Umberson et al., 2014). Hence, a key component in promoting resiliency within communities that have experienced these collective injustices is interventions that emphasize communal and collective healing (French et al., 2020). Thus, culturally informed resiliency-based interventions must move beyond traditional preventive-interventions that promote individual-level resilience to reduce the effects of ACEs toward an elevation of collective strengths and voices of African Americans. Doing so fosters individual growth and facilitates communal and societal change. Through community partnerships and collaborations, services can be designed and implemented that target individual and systemic changes in vulnerable communities and their effectiveness can be evaluated.

Policy

Policy is critical for facilitating community and population level efforts to prevent ACEs, mitigate their effects, and decrease retraumatization among individuals exposed. Although ACEs have garnered much attention since the seminal study over 20 years ago, pertinent U.S. policies remain fragmented and limited at best (Srivastav et al., 2020). Most prevailing policies are narrow in approach and focus solely on increasing awareness.

One approach that can facilitate the development of policies intended to prevent or address ACEs in African Americans through an equity lens is the Empower Action model (Srivastav et al., 2019). Building upon the socioecological model, the Empower Action model brings protective factors for children and families together with key concepts related to advancing race equity and inclusion to provide guidance on addressing root causes of childhood trauma at increasing scales of influence (i.e., individual, interpersonal, organizational, community, and public policy; Bowen & Murshid, 2016). The model maintains a life-course perspective, highlighting how many outcomes associated with ACEs manifest decades later, supporting the notion that the policy landscape need not be limited to children alone to address root causes of trauma. Indeed, as trauma is often cyclical and intergenerational, many effective policies may operate via a two-generation approach by providing support and services for both children (who may or may not have had ACEs) and their caregivers.

To reduce ACE exposure and impact in African Americans, implementing and enforcing comprehensive policies is key to success and sustainability. Most policies to address ACEs have focused on prevention. Although valuable, this approach neglects the millions of Americans living with the

downstream effects of prior exposure to ACEs. Guided by the CDC's strategic outline, this section discusses policies with the potential to prevent ACEs and mitigate against the biopsychosocial-cultural consequences of exposure and builds upon the growing and dynamic evidence base for these policies. If these policies are implemented with attention to the target population, they can facilitate the reduction of health disparities and advance equity.

Strengthen Economic Supports to Families

One strategy highlighted by the CDC is increasing economic supports to families (Centers for Disease Control and Prevention, 2019). This approach includes promoting household financial security and ensuring family friendly work policies.

Policies that support the earned income tax credit (EITC) are necessary (Centers for Disease Control and Prevention, 2019). EITC is assistance for working families with low to moderate income implemented by the federal government. In 2016, the EITC removed approximately 6 million people out of poverty, half of which were children. Beneficiaries of EITC pay their bills, build their assets, and reduce their debt with funds from the credit. Additionally, policies that increase minimum wages along with workforce readiness programs for single parents encourage workforce participation and increase income for parents, thereby reducing ACE exposure and impact (Srivastav et al., 2020). Several work friendly policies exist that are key to the prevention and amelioration of the negative impacts of ACEs, including flexible and consistent work schedules and paid maternity leave. The same is true for childcare subsidies, which not only allows for greater access to high quality childcare, but also can serve to reduce parental stress and maternal depression (Centers for Disease Control and Prevention, 2019).

To prevent ACEs and promote resilience among historically neglected communities, policy initiatives must address the social and environmental conditions that perpetuate or increase the risk of childhood maltreatment and other forms of ACEs. For example, it is well-established that poverty is associated with parental risk factors that increase the risk of child maltreatment, such as parental stress, mental health problems, and prior history of abuse and neglect (Mulder et al., 2018). Thus, addressing the problem of ACEs in low-income African American communities cannot be uncoupled from a concerted effort to lift families and communities out of poverty. Therefore, it is important to advocate for promising policies that can support the economic stability of low-income families of color including distributing a higher proportion of child support payments submitted through the Temporary Assistance to Needy Families (TANF) program directly to families without a concurrent reduction in TANF benefits; widespread implementation of the federal earned income tax credit (only half of the states in the United States have implemented this policy); providing a living wage; expanding paid parental leave; and facilitating easier access to the federal Supplemental Nutrition Assistance Program (SNAP).

Further, policies that respond to structural inequities in addition to alleviating the burden of poverty should be considered. One example is the Moving to Opportunity (MTO) initiative that is a multicity housing voucher program. Families who moved from a high-poverty neighborhood to a low-poverty neighborhood through this program had children who were more likely to attend college, earn 30% more than children who did not move to a low-poverty neighborhood, and were less likely to live in single parent households (Chetty et al., 2016). Thus, the MTO experiment potentially could confer an intergenerational impact through supporting economic and housing stability, as well as increased access to education and health-promoting resources, helping to break cycles of poverty.

In addition, within low-income communities, housing instability can be a cause and a consequence of ACEs. Cost burdens universally plague low-income households (earning under $15,000); 83% paid more than 30% of their incomes for housing in 2014. These low-income households included 72% of renters and 66% of homeowners. Examples of housing initiatives to mitigate ACEs include inclusionary zoning (IZ) and rent control policies. IZ is a mechanism whereby a certain percentage of new construction in an area must be designated as affordable housing. The developer usually receives a financial incentive to offset profits from those housing units. With support from the private sector, IZ policies transfer some of the burden for developing and managing affordable housing from the public to the private sector. IZ has been adopted in many municipalities in the United States including in some major cities (Bellazaire, 2018). Opponents suggest that IZ policies increase building costs and shift the costs to other consumers. Rent control policies have similar criticisms where rent-controlled buildings have demonstrated deterioration from neglect and lack of investment from landlords. Proponents, however, argue that rent control policies promote neighborhood diversity and stability. Affordable housing units promote socioeconomic mobility and racial integration. Thus, housing policies that increase the number of affordable housing units promote diversity, support neighborhood investments, and benefit employers and families.

Promote Social Norms That Protect Against Violence and Adversity

According to the CDC, changing social norms to ones that protect against violence and adversity can be accomplished via public education campaigns, legislative approaches to reduce corporal punishment, bystander pro-

grams, and efforts to engage men and boys as allies (Centers for Disease Control and Prevention, 2019). Policies that support widespread dissemination of public education campaigns can alter social norms and enhance the community's sense of responsibility for preventing ACEs. If these campaigns aim to strengthen interpersonal connectedness and reduce the stigma associated with help-seeking, they can improve parenting practices and parental self-efficacy around issues related to the cycle of abuse. Such programs also can engage males of all ages as allies in the prevention of ACEs. These programs may be optimized if they use peer networks to foster healthy norms related to gender and violence, empower youth to intervene when they witness violent behavior, and include all relevant constituencies in changing the social context to one that does not tolerate abuse or violence.

Programs exist that specifically target the promotion of adaptive social norms related to violence perpetration and victimization within the African American community. For example, the Building Resiliency and Vocational Excellence (BRAVE) program has been designed to redefine gender roles for African American males with the ultimate goal of reducing racial disparities in health outcomes. This program incorporates resiliency networking, which includes coaching and career planning and fosters strong links with mentors. BRAVE has promising effects in terms of reducing risk factors for violence, although not violent behavior per se (Griffin et al., 2009).

Ensure a Strong Start for Children

Because children's biopsychosocial development most likely proceeds in a developmentally normative fashion if they have positive relationships with family and nonfamily members, policies are needed to ensure children's access to programs that lay the groundwork for them to flourish (Centers for Disease Control and Prevention, 2019). For example, policies must be put in place to support wide dissemination of early childhood home visitation programs, such as NFP, and greater access to affordable and quality children care that can buffer children against both ACEs and their negative impacts when experienced. Moreover, policies are needed to ensure greater availability of quality early education programs and culturally relevant preschool enrichment programs that include a family engagement component. Such programs benefit economically disadvantaged and ethno-racially diverse children in terms of providing them with the requisite building blocks to be cognitively, emotionally, and socially well-prepared to enter school, and ultimately to succeed academically and vocationally. Further, some of these programs (e.g., Early Head Start, Child Parent Centers) are linked to lower levels of ACEs and their negative downstream effects. Finally, advocating for policies that better support childcare workers in these programs (i.e., increased pay, flexible work schedules) is essential to expanding access to low-income communities and ultimately reducing risks for ACEs in these contexts.

Policies would be most welcome if they encourage developing, implementing, and disseminating programs designed or tailored to provide African American youth with the most solid foundation possible. For example, adding an empowerment-based parenting intervention for African American fathers whose children are in Head Start shows promise for fathers' ability to parent in a manner that promotes their child's healthy development, as well as their own self-esteem and satisfaction with being a parent (Fagan & Stevenson, 2002). In addition, including home-based maternal involvement for children in Head Start can enhance the program's effectiveness in ensuring African American children's readiness for school (Jarrett & Coba-Rodriguez, 2019). Further, there is potential value in incorporating an evidence-based, strengths-focused parenting program, Child Parent Relationship Training (CPRT), for low-income African American families with a child in Head Start (Sheely-Moore & Ceballos, 2011).

Connect Youth to Caring Adults and Activities

As emphasized by the CDC, policies must provide opportunities for African American communities situated in contexts that place children at greater risk for ACEs. The efforts should allow for the formation of stable and caring relationships with adults who can serve as positive role models and promote engagement in age-appropriate activities (Centers for Disease Control and Prevention, 2019). Such connections can buffer children from experiencing ACEs and their negative effects. Examples of such programs that must be supported by policy efforts are mentoring and afterschool programs (e.g., Big Brothers, Big Sisters); they provide an environment that bolsters children's resilience in the face of adversity and enables them to excel socially, academically, and vocationally.

In African American communities, the presence of natural mentors often is associated with positive developmental transitions and lower levels of biopsychosocial difficulties (Hurd & Sellers, 2013; Hurd & Zimmerman, 2010). Formal mentoring programs may be optimized if they promote Afrocentric values (Watson et al., 2015). Thus, policy efforts may be best if they encourage the development and evaluation of novel and culturally specific strategies for connecting African American youth to adults and activities within their communities.

Call to Action

We issue a call to action to reduce African American's disproportionate risk for exposure to ACEs, mitigate the biopsychosocial impacts of exposure, and lessen the myriad

other social injustices encountered by this population. This call involves the following action steps:

- Utilize a biopsychosocial-cultural conceptualization to frame and strengthen the conceptual clarity of this public health problem, inform future interprofessional research endeavors, and guide and bolster multisectoral programming and policy initiatives
- Fund evidence-informed, culturally grounded, developmentally sensitive, empowerment-based, multifaceted, and multisystemic primary, secondary, and tertiary prevention efforts to reduce the prevalence and impacts of ACE exposure
- Design, implement, and evaluate these preventive-intervention programs in accord with community-based participatory research models so that key stakeholders can provide guidance and input
- Ensure programs support race equity, inclusion, and well-being across the life span by reflecting intersectional cultural awareness, capitalizing on cultural and community strengths and resilience, encouraging strong cultural identity, and addressing sociocultural contexts in which ACE exposure occurs and can be prevented (Garza et al., 2019; Srivastav et al., 2019)
- Design, implement, and evaluate the efficacy and effectiveness of culturally informed preventive-interventions in community, outpatient, and higher-level care settings that capitalize upon this population's resilience in the face of toxic stress
- Disseminate evidence-based and culturally grounded preventive-interventions
- Create, implement, and enforce sustainable, comprehensive local and federal policies that address the prevention and downstream effects of prior ACE exposure
- Ensure these policies reflect a commitment to equity and inclusion, promote well-being across the life span, increase access to, and use of, comprehensive services, and reduce the societal costs of ACEs
- Create a socially just paradigm shift that prioritizes the well-being of African Americans

In closing, it is through the aforementioned collective, interprofessional, and multisectoral efforts that we can identify, challenge, and alter the systemic and structural oppression that allows for the disproportionate prevalence and impacts of ACEs. Concerted efforts to embrace these action items will aid in the culturally relevant pursuit of ACE prevention, responsivity, and intervention, as well as promote equitable integrated health outcomes for African Americans. Such widespread attention will enable us to overcome historical policy resistance and make progress toward our goal of developing a comprehensive, culturally, contextually, and evidence-informed response to ACEs in African Americans.

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Received March 2, 2020
Revision received September 26, 2020
Accepted October 1, 2020 ■