Encouraging Strengths in Parents and Youth to Promote Positive Childhood Experiences

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Twenty-five years ago, Felitti et al[1] published the landmark study on adverse childhood experiences (ACEs) and their significant negative effects on adult physical and mental health. ACE scoring has been adapted for families and children with modification of the criteria,[2] including items to assess exposure to neighborhood violence, bullying, and discrimination. However, this is a deficit-based model that does not consider protective factors.

Positive childhood experiences (PCEs) can mitigate the effects of ACEs and have positive effects on mental health and relationships.[3,4] Sege et al[5,6] introduced the Health Outcomes of Positive Experiences framework (HOPE), which organizes PCEs into 4 broad categories: stable and supportive relationships; safe, equitable environments in which to live, learn, and play; civic and social engagement that promotes children's sense that they matter to others; and opportunities for social and emotional development.

In this issue of *Pediatrics*, Huang et al[7] present a study of a nationally representative population demonstrating that, after adjusting for ACEs, PCEs are independently associated with lower risks of fair or poor adult health, fewer adult mental health problems, and later age of onset of any physical or mental health condition. Their PCE survey items, similar to published scales[8,9] associated with improved mental health outcomes, include able to confide in parents, parents understood their problems, positive relationship with their parents, happy at school, comfortable with a group of friends, and neighborhood support. This study demonstrates that PCEs have an important role in enhancing health resilience by promoting healthy outcomes, while also protecting adults from poor mental and physical health conditions.

What can be done to foster more PCEs and fewer ACEs? Policies and community efforts that increase positive social determinants of health (SDoH), promote equity, and decrease racism will help,[10,11] but these take time and political will. Pediatricians can commit to building strengths in parents of children and in their adolescent patients. Strong families are better equipped to provide protective factors for their children. Youth strengths can be thought of as developmental tasks that must be achieved to become healthy, happy, productive adults and parents. Strong youth can find and build on PCEs to help buffer the effects of ACEs and negative SDoH. To start this work, choose a strengths-based framework.

The Strengthening Families Approach and Protective Factors Framework[12] is an initiative developed for preventing child abuse and neglect of children aged birth to 5 years, focusing on supporting those families to build 5 strengths or protective factors[13]:

- Parental resilience
- Social connections
- Knowledge of parenting and child development

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- Social and emotional competence of children
- Concrete support in times of need

Many maternal child health programs encourage the use of this framework in agencies serving young families. Pediatricians already focus on many of these strengths when interacting with families. Be intentional and point out how strengths that mitigate ACEs and negative SDoH can help young children become happier and healthier. This information can be a powerful motivator for families. Vow to never ask about ACEs without also identifying family strengths.

Pediatricians have an opportunity to identify and encourage strengths in their adolescent patients.[14] The late Dr Paula Duncan, my colleague, mentor, and friend, set out on a strengths-based journey after an encounter with an adolescent who told her, "Do you realize that I can be alone on a Friday night, not drinking, not using drugs, not having sex, and be perfectly miserable? You need to tell me what I can say yes to!" Duncan et al[15] researched frameworks used to conceptualize adolescent strengths. These included Pittman's[16] 5 C's (contribution, confidence, competence, connection, character). To these, Ginsburg[17,18] added coping and control. Other frameworks and measures have been identified.[19] However, it was Brendtro's[20] simple but powerful Circle of Courage[21,22] that has spoken to so many pediatricians as an image conceptualizing youth strengths:

- Belonging (connection)
- Mastery (competence, confidence, coping)
- Independence (control, confidence)
- Generosity (contribution, character)

Can we actually implement a strengths-based framework in our approach to all our patients, no matter what their ACEs are? Duncan et al[23] demonstrated in a quality-improvement project that primary care pediatricians were able to significantly improve their ability to screen for strengths, as well as risks. Notably, these pediatricians were already asking about some strengths a third of the time with their patients at baseline; learning to use a strengths framework made them more intentional about it. Many commented that discussing strengths improved engagement with youth, as well as their own satisfaction with the encounter. In a recent study, Coble et al[24] found that medical students who were taught a strengths-based interviewing technique (SSHADESS[25] [Strengths, School, Home, Activities, Drugs, Emotions, Sexuality, Safety] rather than the HEADSS[26] [Home, Education, Drugs, Sexuality, Safety] framework) used more effective communication skills without compromising the ability to complete the entire psychosocial assessment. Sandra Hassink, MD, past president of the American Academy of Pediatrics, pointed out that these conversations are the core of who we are.[27]

Dr Duncan, along with her coeditors Drs Joseph Hagan and Judith Shaw, made sure that *Bright Futures*[28] uses a strengths-based approach. The goal is not just to ask about strengths in an intake questionnaire or interview, but to make parents and youth aware of them; many do not feel they have any strengths until someone points them out. Parents can be shown how to build strengths in their children. Youth usually have no control over their ACEs and negative SDoH. Explaining the protective role of strengths and resilience, along with the health and mental health benefits, can foster hope and motivation.

Excellent recommendations[29–33] have been made for pediatricians; they can seem overwhelming, yet do not have to be. Think about a strengths framework that makes sense to you. Practice pointing out 1 strength you observe in each of your clinical encounters. Educate a family or youth experiencing difficulties about the protective effects of strengths and resilience. What could you say about strengths to the mother of a 4-year-old who is going through a divorce, a 12-year-old entering foster care, a 17-year-old who just became a father? Strengths can promote PCEs and counteract ACEs and should be a part of every health encounter we have with our patients and their families.

ABBREVIATIONS

ACE: adverse childhood experience
PCE: positive childhood experience
SDoH: social determinants of health

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