Adverse Childhood Experiences and Health and Wellness Outcomes among Black Men Who Have Sex with Men

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Abstract Black men who have sex with men (BMSM) are a population at the intersection of two minority statuses—racial minority and sexual minority. Membership in either group, compared to white or heterosexual group membership, may increase one’s risk of negative childhood and adult experiences. Baseline data from an HIV intervention efficacy trial (the Black Men Evolving Study) were used to explore the prevalence of adverse childhood experiences (ACEs) among 536 BMSM and associations between ACEs and adult mental and physical health outcomes. Overall, the prevalence of ACEs

was high among this sample of BMSM with almost 90% experiencing at least one ACE. Findings revealed that ACE score was significantly associated with adult mental health (AOR = 1.21, 95% CI [1.12, 1.30]), but not with adult physical health. All ACEs were significantly associated with mental health, but only physical neglect and household substance abuse were significantly associated with physical health (AOR = 1.69, 95% CI [1.02, 2.74] and AOR = 1.57, 95% CI [1.03, 2.40], respectively). The findings support the need for interventions targeting improved adult health outcomes, particularly for minority groups, to consider the impact of early adversity on health and wellness.

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Keywords Adverse childhood experiences · ACEs · Black men · Men who have sex with men

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While all people may be at risk of experiencing adversity in their lifetimes, some groups are at greater risk than others due to structural inequities. Minority group membership is often associated with increased social and economic challenges and health risks. When minority statuses intersect and individuals belong to multiple subgroups, challenges and health risks may be exacerbated. Black men who have sex with men (BMSM) are a population in which race and sexual orientation statuses intersect. Membership in either group, compared to white or heterosexual group membership, increases lifetime risk for negative childhood and adult experiences including discrimination and victimization [1, 2], which

are associated with negative mental and physical health outcomes [3–5].

Much of what is known about links between negative early experiences and adult health and well-being comes from the CDC-Kaiser Permanente, Adverse Childhood Experiences (ACE) study conducted from 1995 to 1997 [6]. The original ACE study utilized an ACE index that included items pertaining to abuse (physical, emotional, and sexual), neglect (physical and emotional), and other household challenges (exposure to mother being treated violently, parental divorce or separation, and a household member with substance abuse problems, incarceration history, and/or mental illness) experienced during the first 18 years of life [6]. Numerous studies have since included ACEs in their research and have consistently found a dose-response relationship between exposure to childhood adversity and poor adult outcomes [6–8]. Studies have linked ACEs to health risk behaviors [6], chronic health conditions [6, 8], mental illness [6, 9], premature death [10], and decreased life opportunities (e.g., educational attainment, income, and employment) [11]. The science, though, has been largely based on samples over-represented by non-Hispanic, heterosexual whites. Thus, additional research is needed to better understand the nature of cumulative ACE burden and its impact on minority populations, including those that live at the intersection of dual minority statuses, such as BMSM.

ACE Burden: Race/Ethnicity

Evidence regarding the differential burden of ACEs by race/ethnicity is varied. Some studies using conventional ACE measures with community- or clinic-based samples have not identified differences in ACE exposure between black and white respondents [6, 12]. Other studies utilizing a large telephone-based probability sample have found that non-Hispanic blacks more frequently report exposure to multiple ACEs [8, 13]. Findings, though, are mixed with respect to whether non-Hispanic black respondents report the lowest prevalence or the highest prevalence on each ACE category compared to non-Hispanic white respondents [8]. Efforts to measure early adversity in samples with greater proportions of racial/ethnic minorities as well as nonconventional ACE measures (e.g., adversities that extend beyond the child's home) [12, 14] suggest that non-Hispanic black children compared to white children have a higher magnitude of exposure to adversities that include nonconventional

ACEs, such as discrimination and neighborhood violence [12]. Furthermore, a parallel literature documents poor, urban, and racial/ethnic minority children that are highly exposed to community violence [15–17].

ACE Impact: Race/Ethnicity

Given links between early adversity and poor adult health [6], it is plausible to assume that the impact of ACEs on minorities, particularly dual minorities, may contribute to the development of mental and physical health inequities. National studies have found that, although blacks have lower current and lifetime rates of major depression than whites, that depression is more persistent, severe, disabling, and untreated among blacks [18]. Due to gaps in the literature, it is not known whether differential ACE exposure may explain race/ethnic differences in depression severity. One study that may provide insight, but is limited in generalizability due to use of a correctional sample, found that although black men and women reported less ACE exposure, specific adversities—physical and sexual victimization—placed them at greater risk for depression compared to their white and Hispanic counterparts [19].

ACE Burden: Sexual Orientation

Evidence regarding the unequal distribution of ACE burden by sexual orientation is more consistent. For example, Andersen and Blosnich found that compared with heterosexual respondents, lesbian/gay and bisexual (LGB) persons more frequently reported all ACE categories with the exception of gay/lesbian respondents and parental separation/divorce [1]. Another study indicated that LGB youth reported higher odds of exposure to child physical and sexual abuse and housing adversity than heterosexual youth [20]. What remains unclear is whether ACE exposure differs for individuals who report dual minority status and to what extent this impacts their present mental and physical health outcomes.

ACE Impact: Sexual Orientation

Studies have indicated disparities exist between sexual minorities and their heterosexual peers in health risk behaviors [21–23], physical health outcomes [24], as

well as mental illness [20]. Explanations for these relationships have not been clearly identified, but some researchers point to sociocultural stressors including experiences of childhood victimization. Indeed, McLaughlin and colleagues found greater exposure to early adversity explained up to 20% of the relative excess of suicidality, depression, tobacco use, and symptoms of alcohol and drug abuse among LBG youths compared to their heterosexual peers [20]. Likewise, Hughes and colleagues found that childhood victimizations were associated with greater risks of substance abuse disorders, but these associations varied by sexual identity such that among women who reported childhood neglect, lesbians had significantly higher odds of reporting alcohol dependence compared to heterosexual women who experienced neglect; moreover, although gay men were more likely to experience victimization in childhood, these victimizations did not appear to increase risk of substance abuse in adulthood [25]. Blossnich and Andersen reported that LGB status was significantly associated with mental distress; however, when early adversity was accounted for, sexual orientation was no longer a significant predictor of mental health outcomes [26]. Similarly, Austin, Herrick, and Proescholdbell found that LGB individuals had a higher prevalence of all ACEs than heterosexuals, but after adjustment for cumulative exposure to ACEs, sexual orientation was no longer associated with poor physical health and risk behaviors [27]. These results further highlight that higher ACE prevalence among LGB individuals may account for some of the excess risk of poor adult health and well-being [29]. As many of these samples are predominantly white, it remains unknown how race impacts these findings.

ACE Impact: BMSM

To date, we are aware of two studies that have examined relationships between childhood experiences and physical and mental health outcomes specifically for BMSM. One study examined the independent effects of child sexual abuse and other nonsexual childhood adversities (e.g., separation from parents, family disorganization or violence, and family substance abuse) on depression using a sample of black HIV-positive men who have sex with men and women [28]. The study findings were consistent with prior research regarding the impact of early adversity on depression in adulthood. A second

study examined links between adolescent mental health and factors not traditionally measured as adverse childhood experiences—racial and antigay discrimination—using a sample of black lesbian, gay, and bisexual adolescents and found positive associations between these forms of discrimination and depressive symptoms [4].

Collectively, the presented studies suggest that differential burden of childhood adversity and/or childhood adversity in combination with later adult experiences may influence health outcomes for BMSM. To our knowledge, there are no studies that have thoroughly investigated the impact of ACEs on physical and mental health among BMSM. This study will provide additional information on ACE prevalence among BMSM and will address gaps in the literature by investigating the unique contribution that each type of early adversity may have on adult mental and physical health outcomes. In addition, the cumulative association of ACE exposure on mental and physical health outcomes will be explored. This research may prove valuable for efforts to reduce health disparities in this population positioned at the intersection of two minority statuses. Moreover, a better understanding of these associations may be used to inform various trauma-informed health interventions.

Method

Participants

A community sample of BMSM was recruited to participate in an HIV intervention study—Black Men Evolving (B-ME). Participants were recruited from community- and clinic-based venues throughout Chicago from August 2012 to September 2014 using active and passive recruitment methods, including distributing flyers at STD clinics, the Department of Health, bars and clubs, Gay Pride, community forums, posting advertisements on rail and bus lines, street, college, and community outreach, referrals from friends of participants, and popular opinion leaders in the community. To be eligible, participants had to identify as black/African American male, be 18 years of age or older, sexually active in the past 30 days (i.e., one or more instances of vaginal sex or anal sex with a male or female), have at least one instance of condomless anal or oral sex with a male-identified partner in the past 12 months, the ability to provide written informed consent, and willingness to

participate in a 2-day weekend retreat if randomly selected for the intervention arm of the study. Exclusion criteria included: identified as a transgender woman, planned to move before the end of the study, previously participated in the *Critical Thinking and Cultural Affirmation* intervention, or received an evidence-based HIV or substance use prevention intervention in the past 180 days. Men did not need to know their HIV status in order to participate in this study. Of the 1798 potential participants screened, 765 (43%) were eligible and 536 (70%) agreed to participate in the study. All study participants were compensated for completing the baseline assessment (\$25). The study protocol was approved by the Institutional Review Board of Loyola University Chicago.

Materials

Only baseline data of a larger study testing the efficacy of an HIV intervention program are presented in this paper. Using an audio-computer-assisted self-interview, participants completed demographic, attitudinal, and behavioral risk assessment items including substance use and sexual risk behaviors. Participants also completed information on ACEs and current physical and mental health.

Adverse Childhood Experiences The questions developed from the original ACE study consist of 10 items assessing exposure to 10 types of early adversity, including abuse (physical, emotional, and sexual), neglect (emotional and physical), and household challenges (household mental illness, household substance abuse, household incarceration, parental separation/divorce, and mother treated violently) during the first 18 years of life [6]. Dichotomous (Yes/No) exposure variables corresponding to each of the 10 ACE categories adapted from the original ACE study were used. As a measure of overall ACE exposure, a composite score was created for each participant by summing the 10 constructed ACE category variables and ranges in value from 0 to 10 corresponding to the total number of ACEs experienced by the participant.

Physical Health Outcome A single item included in the physical and mental health history portion of the questionnaire was used to assess general physical health. The content of this item is as follows: *In general, what do you consider your health to be?* Responses included:

“Poor” (1), “Fair” (2), “Good” (3), and “Excellent” (4). Physical health was dichotomized (Poor/Good) whereby scores of 1–2 were considered *poor health* and scores of 3–4 were considered *good health*.

Mental Health Outcome Several items were used to assess mental health. The outcome variable of interest for mental health was: *In the last 3 months, approximately how many days did you feel sad or depressed for most of the day?* Responses ranged from “Never” (1) to “More than a month” (6). The item was dichotomized based on common conceptualizations of mental distress; everyone who reported a score of 1–3 (Less than a week) was classified as having good mental health, and those reporting 4–6 (for a couple of weeks or more) were classified as having poor mental health. Additional items were used to characterize the mental health of participants and included: *Have you ever been told by a doctor or psychiatrist that you have a mental illness?* Participants were also asked to indicate their mental health diagnosis from a list and if they had ever been hospitalized for a mental illness (yes/no).

Data Analysis

Descriptive statistics were used to identify the prevalence of ACEs, poor physical and mental health. Point-biserial correlations were estimated among ACE score and the outcome variables. Adjusted odds ratios (AORs) and 95% confidence intervals (CIs) derived from logistic regressions were used to determine the relationship between cumulative ACE score and outcomes variables, as well as the bivariate associations between each ACE category and outcome. The following information from participants was included in all models as adjustment factors: self-reported HIV status, age, and educational attainment. Correlations revealed multicollinearity among the 10 ACE items hampering our ability to quantify the increase in risk of adult health outcomes associated with experiencing a particular ACE after adjusting for the other ACEs.

Results

Participants

Under 3% of the men indicated that they were Hispanic ethnicity (2.6%). Ages ranged from 18 to 57 years of

age ($M = 39.19$, $SD = 11.26$). Just under half of the participants indicated that they were HIV positive (42.7%). The majority of men had at least some college education (57.7%). Many were unemployed, but looking for work (44.4%), and made less than \$10,000 (44.7%). The majority of participants reported that they were in good or excellent health (77.9%), good mental health (76.4%), and had never been diagnosed with a mental illness (66.0%). Among the 180 men who indicated they had been diagnosed with a mental illness during the past 3 months, 21.0% reported being diagnosed with major depression, 13.3% anxiety, 13.3% bipolar disorder, 3.6% schizophrenia, and 2.2% indicated other. Just over 100 men (18.9%) reported that they had been hospitalized in their life because of their mental illness. Characteristics of the study population are provided in Table 1.

ACE Prevalence

Table 2 presents ACE prevalence data for each category of ACE as well as the ACE composite score. The most common ACE was having separated or divorced parents (62.6%) followed by living in a household with someone who abused substances (51.1%), experiencing emotional abuse (42.1%), and physical abuse (38.6%; categories not mutually exclusive). Almost 90.0% of the sample experienced at least one ACE, and nearly half of the sample (44.9%) experienced four or more ACEs. Exposure to ACEs did not vary by HIV status (data not shown).

ACE Score and Mental Health

Point-biserial correlations revealed a significant association between ACE score and adult mental health ($r = .23$, $p < .001$). A multiple logistic regression model revealed that there was a significant relationship between ACE score and poor mental health ($AOR = 1.21$, 95% CI [1.12, 1.30]) after controlling for age, HIV status, and educational attainment. Results indicate that for each incremental increase in ACE score, the likelihood of reporting poor mental health increases by 21.0%.

The bivariate associations between each ACE category and mental health were examined. Each ACE category was significantly associated with mental health after adjusting for age, education, and HIV status. For example, individuals who reported experiencing

Table 1 Characteristics of 536 black men who have sex with men

	Total N (valid %)
Hispanic	14 (2.6)
Age	$M = 39.2$ years ($SD = 11.3$)
HIV positive	229(42.7)
Education	
Less than high school	76 (14.2)
High school diploma or equivalent	150 (28.0)
Some college/technical school	221 (41.3)
College graduate	88 (16.4)
Employment status	
Employed full time	87 (16.3)
Employed part time	111 (20.8)
Unemployed looking for work	237 (44.4)
Unemployed, student, not seeking work	39 (7.3)
Unemployed, not a student, not seeking work	60 (11.2)
Income	
Less than \$10,000	236 (44.7)
\$10,000–\$19,999	99 (18.8)
\$20,000–\$29,999	52 (9.8)
\$30,000–\$39,999	71 (13.4)
\$40,000–\$49,999	23 (4.4)
\$50,000–\$59,999	7 (1.3)
\$60,000 or more	40 (7.5)
In poor/fair physical health	118 (22.1)
Poor mental health	126 (23.6)
Diagnosed with a mental illness	180 (33.7)

Percentages are based on valid responses and exclude missing data

emotional neglect had 2.43 ($AOR = 2.43$, 95% CI [1.60, 3.70]) times the odds of reporting poor mental health in adulthood compared to those who did not experience emotional neglect. See Table 3 for bivariate estimates.

ACE Score and Physical Health

Point-biserial correlations revealed that there was not a significant association between ACE score and adult physical health ($r = .07$, $p = .10$). As such, further investigations between the cumulative ACE score and adult physical health were not explored. Analysis of bivariate associations between each ACE category and general physical health revealed that, individually, both physical neglect and household substance abuse was significantly associated with increased odds of reporting

Table 2 Adverse childhood experience (ACE) prevalence of 536 black men who have sex with men (B-ME Study)

	Total N (%)
Adverse childhood experience	
Emotional abuse	225 (42.1)
Physical abuse	206 (38.6)
Sexual abuse	194 (36.3)
Emotional neglect	193 (36.3)
Physical neglect	103 (19.4)
Household mental illness	140 (26.2)
Incarcerated household member	165 (30.9)
Mother treated violently	141 (26.5)
Household substance abuse	273 (51.1)
Parental separation/divorce	333 (62.6)
ACE score	
0	60 (11.2)
1	88 (16.4)
2	81 (15.1)
3	66 (12.3)
4	51 (9.5)
5	46 (8.6)
6	33 (6.2)
7	43 (8.0)
8	26 (4.9)
9	26 (4.9)
10	15 (2.8)

poorer physical health compared to those who did not experience physical neglect and household substance abuse (AOR = 1.69, 95% CI [1.02, 2.74] and AOR = 1.57, 95% CI [1.03, 2.40], respectively). See Table 3 for bivariate estimates.

Discussion

In the present study, we sought to better understand the prevalence of ACEs and their association to adult health outcomes among a dual minority sample of BMSM. The sample included both HIV-positive and HIV-negative BMSM, but associations between ACEs and HIV status were not significant. Our analyses revealed that ACEs are prevalent in this sample (e.g., the overwhelming majority had experienced at least one ACE, and many experienced multiple ACEs). While we cannot make direct comparisons to other samples, it is notable that

in a study utilizing 2010 BRFSS data [8] nearly 60% of the entire sample and 70% of the non-Hispanic black respondents reported at least 1 ACE, whereas 90% of respondents reported at least one ACE in the current sample. Similarly, about 15% of the 2010 BRFSS respondents and 22% of the non-Hispanic black respondents reported experiencing four or more ACEs [8], while nearly 45% of the current sample reported experiencing four or more ACEs. The extremely high prevalence of ACEs may be reflective of factors associated with childhood experiences that the current survey was not designed to illuminate (e.g., poverty) or it may be suggestive of increased burden faced by men who, over the course of development, find themselves living at the intersection of multiple, marginalized identities.

ACEs were significantly associated with self-reported mental health outcomes among BMSM in this sample. Similar to previous research involving predominantly white, heterosexual populations [6, 9], we found that an increase in ACE score was associated with a 21% increase in odds of reporting poor adult mental health. Additionally, each ACE category was significantly associated with poorer self-reported mental health in adulthood (AORs ranged from 1.57 to 2.40). The relationship between living in a household with someone with a mental illness as a child and poorer mental health in adulthood had the highest magnitude, which suggests that household mental illness may have been particularly challenging for participants in this sample.

The relationship between ACEs and physical health was varied. Physical neglect and household substance abuse were significantly associated with self-reported poor physical health. Counter to previous research [6, 8], we did not find a dose-response pattern between ACE score and self-reported physical health. The lack of associations may partially be due to the way that health was measured. In previous studies, specific illnesses have been included (e.g., heart disease, obesity) as opposed to a general measure of perceived health. In addition, distal adversity (i.e., ACEs) may have less of an association with current health outcomes when proximal adversity is also present. For BMSM, adult adversity may have a larger association with current health assessments.

Our results suggest that BMSM may experience a high degree of early adversity, which may exacerbate inequities seen in health outcomes by race and sexuality. General and/or specific factors that create a level of

Table 3 Adjusted bivariate relationships among adverse childhood experiences (ACEs) and adult outcomes (B-ME Study)

Poor physical health (<i>N</i> = 118)			Poor mental health (<i>N</i> = 126)		
ACE (<i>N</i>)	Adjusted odds ratio	95% CI	ACE (<i>N</i>)	Adjusted odds ratio	95% CI
Sexual abuse			Sexual abuse		
No (<i>N</i> = 65)	1.00	Ref.	No (<i>N</i> = 61)	1.00	Ref.
Yes (<i>N</i> = 39)	1.08	0.70–1.65	Yes (<i>N</i> = 54)	2.13	1.42–3.22***
Emotional abuse			Emotional abuse		
No (<i>N</i> = 52)	1.00	Ref.	No (<i>N</i> = 50)	1.00	Ref.
Yes (<i>N</i> = 52)	1.39	0.91–2.10	Yes (<i>N</i> = 65)	2.35	1.56–3.56***
Physical abuse			Physical abuse		
No (<i>N</i> = 58)	1.00	Ref.	No (<i>N</i> = 58)	1.00	Ref.
Yes (<i>N</i> = 46)	1.22	0.80–1.86	Yes (<i>N</i> = 57)	2.03	1.35–3.06***
Emotional neglect			Emotional neglect		
No (<i>N</i> = 63)	1.00	Ref.	No (<i>N</i> = 54)	1.00	Ref.
Yes (<i>N</i> = 41)	1.25	0.81–1.92	Yes (<i>N</i> = 60)	2.43	1.60–3.70***
Physical neglect			Physical neglect		
No (<i>N</i> = 75)	1.00	Ref.	No (<i>N</i> = 82)	1.00	Ref.
Yes (<i>N</i> = 29)	1.69	1.02–2.74*	Yes (<i>N</i> = 32)	2.19	1.35–3.53**
Household mental illness			Household mental illness		
No (<i>N</i> = 75)	1.00	Ref.	No (<i>N</i> = 70)	1.00	Ref.
Yes (<i>N</i> = 30)	1.10	0.68–1.73	Yes (<i>N</i> = 44)	2.40	1.55–3.72***
Incarcerated household member			Incarcerated household member		
No (<i>N</i> = 68)	1.00	Ref.	No (<i>N</i> = 68)	1.00	Ref.
Yes (<i>N</i> = 37)	1.08	0.69–1.67	Yes (<i>N</i> = 47)	1.57	1.03–2.39*
Household physical violence			Household physical violence		
No (<i>N</i> = 72)	1.00	Ref.	No (<i>N</i> = 74)	1.00	Ref.
Yes (<i>N</i> = 32)	1.34	0.84–2.11	Yes (<i>N</i> = 40)	1.87	1.21–2.90**
Household substance abuse			Household substance abuse		
No (<i>N</i> = 40)	1.00	Ref.	No (<i>N</i> = 43)	1.00	Ref.
Yes (<i>N</i> = 65)	1.57	1.03–2.40*	Yes (<i>N</i> = 71)	1.77	1.17–2.69**
Parental separation/divorce			Parental separation/divorce		
No (<i>N</i> = 44)	1.00	Ref.	No (<i>N</i> = 32)	1.00	Ref.
Yes (<i>N</i> = 60)	0.80	0.53–1.23	Yes (<i>N</i> = 81)	1.68	1.09–2.65*

All estimates have been adjusted for age, educational attainment, and HIV status

* $p < .05$; ** $p < .01$; *** $p < .001$

acceptance or tolerance for violence—for instance, disproportionate negative media portrayals of black men and/or LGBT, climate of tolerance, or discrimination regarding various groups of people—as well as things that create and sustain gaps between different segments of society, such as health, educational, economic, or social policies, can contribute to a context that makes it more difficult for children who identify as racial and/or sexual minorities to thrive.

Interventions attempting to improve adult health outcomes particularly for minority groups should consider the potential impact of early adversity on outcomes and might incorporate trauma-informed approaches to mitigate the impact of early adversity on adult outcomes. Moreover, given that many adults in our sample were living in poverty, and that children living in families with a low socioeconomic status (SES) have rates of child abuse and neglect that are five times higher than those of

children living in families with a higher SES [29], it is important to also develop structural-level interventions that reduce economic disparities that increase risk for adversities. For example, policies that strengthen economic support for families (e.g., tax credits) and support family-friendly work environments (e.g., paid leave) can reduce risk factors associated with early adversity [30]. Policy interventions also have an opportunity to reach a broader segment of society, increasing the impact on health and well-being for all people.

Future research might consider whether additional types of early adversity are disproportionately experienced by BMSM, including discrimination, bullying, and sibling violence, to determine what impact these additional experiences have on adult outcomes. Studies involving samples that are racially, ethnically, and sexually diverse would enable researchers to compare experiences and outcomes across populations and identify unique differences or commonalities among populations for targeted interventions. Not every child who experiences ACEs will have poor adult outcomes, and thus, it would be helpful to investigate what protective factors are critical for buffering the impact of childhood adversity on adult well-being among minority groups. Moreover, intervention studies, including HIV prevention and mental health, could benefit from studying how exposure to ACEs may moderate the efficacy of an intervention on targeted outcomes.

The findings from this study are informative, but not without limitations. First, this was a convenience sample consisting of BMSM enrolled in a randomized controlled trial. The findings from these analyses should not be generalized to other populations because of potential biases such as self-selection into the study. In addition, these data are cross-sectional and do not allow us to make causal inference between ACEs and adult outcomes. The ACE score has been used in many studies as a reliable and valid measure of early adversity [6–8], but it does not provide information about the many dimensions of early adversity that impact outcomes [14], such as severity, age of onset, and chronicity, which may limit our understanding of the associations between childhood experiences and adult outcomes. ACEs were also retrospectively reported and highly correlated. Furthermore, our analyses were limited to one general, self-reported measure of physical health, which likely does not capture the complex dimensions of physical health. Moreover, the health items were developed by the research team, and despite their

collective expertise, we have limited information on the validity of such items.

The wide-ranging health and social consequences of adverse childhood experiences underscore the importance of preventing ACEs before they happen. Preventing early adversity requires understanding why some children and families are at greater risk than others. Our research lends support to the growing evidence that membership in racial and sexual minority groups may increase one's lifetime risk for negative childhood and adult experiences including victimization, which have important implications for adult health and well-being. As such, comprehensive approaches that affect all levels of the social ecology, including the societal culture, community involvement, relationships among families and neighbors, and individual behaviors, are needed. High-quality research and interventions focused on modifying policies, practices, and societal norms to create safe, stable, nurturing relationships, and environments for all children can make the most of every child's potential [31], resulting in improved adult health and well-being.

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