RESEARCH LETTER

Prevalence of Adverse and Positive Childhood Experiences in Adolescents, 2016-2023

Adverse childhood experiences (ACEs) are potentially traumatic childhood events.[1] Positive childhood experiences (PCEs), as defined in the Health Outcomes from Positive Experiences (HOPE) framework,[2] are experiences that engage the parent or child to achieve positive health outcomes. Both ACEs and PCEs have been found to impact diverse health outcomes.[1,3]

Supplemental content

Most Americans report experiencing at least 1 ACE (64%)[1] and 4 or more PCEs (90%).[3] However, few studies examine the prevalence of individual ACEs or PCEs at the population level, as they may change over time. Research has typically focused on cumulative scores (eg, count of ACEs experienced) and retrospective adult reports rather than data on current adolescents. The purpose of this study was to describe the prevalence of specific ACEs and PCEs among US adolescents aged 12 to 17 years using data from the 2016-2023 National Survey of Children's Health (NSCH).

Methods | The NSCH is a nationally representative, parent-reported survey of noninstitutionalized US children aged 0 to 17 years, administered via web and mail.[4] In this study, the 2016-2023 NSCH datasets were combined for analysis following technical recommendations and weighting guidelines from the NSCH.[4] For the analysis, we report the number of adolescents aged 12 to 17 years (N = 125 564) experiencing each ACE and PCE from 2016 to 2023, with parents responding on their adolescent's behalf. Annual sample sizes ranged from 8909 to 20 708. Complete methodological details are available on the NSCH website.[4]

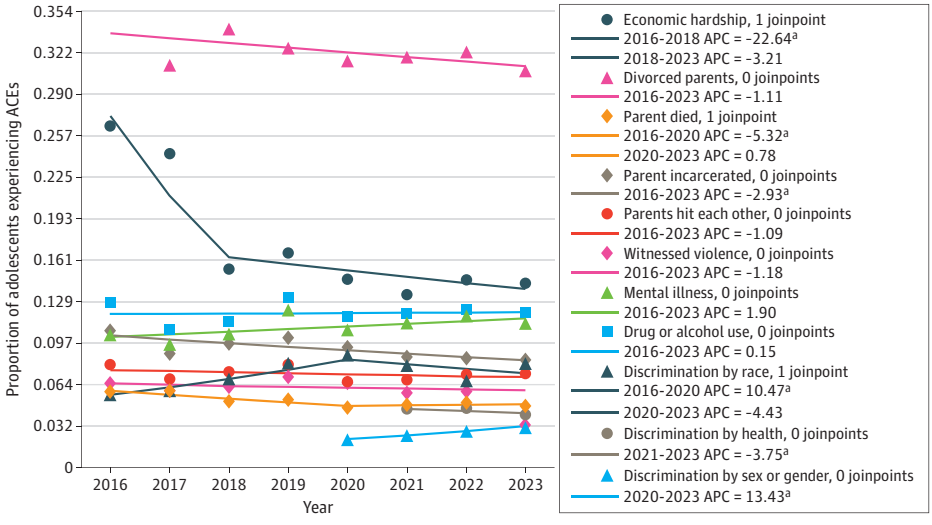
The ACEs analyzed followed the NSCH's definitions and conceptualizations and included (1) economic hardship, (2) parental divorce or separation, (3) parental death, (4) parental incarceration, (5) domestic violence, (6) neighborhood violence, (7) household mental health concern, (8) household substance use, (9) racial discrimination, (10) gender- or sexuality-based discrimination, and (11) health- or disability-based discrimination.

The PCEs analyzed consisted of several variables organized into 7 items using the same methodology and reporting procedures as prior literature[5] and included (1) adult mentorship, (2) family resilience, (3) organized activity participation, (4) service participation, (5) neighborhood support, (6) neighborhood safety, and (7) sharing ideas. Additional details outlining how NSCH items were created are available online.[6]

The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines were followed in this study; however, the publication format limits inclusion of many of the details. This study was exempt from institutional review board approval, as it was a secondary analysis of public data. Full details are available from the corresponding author.

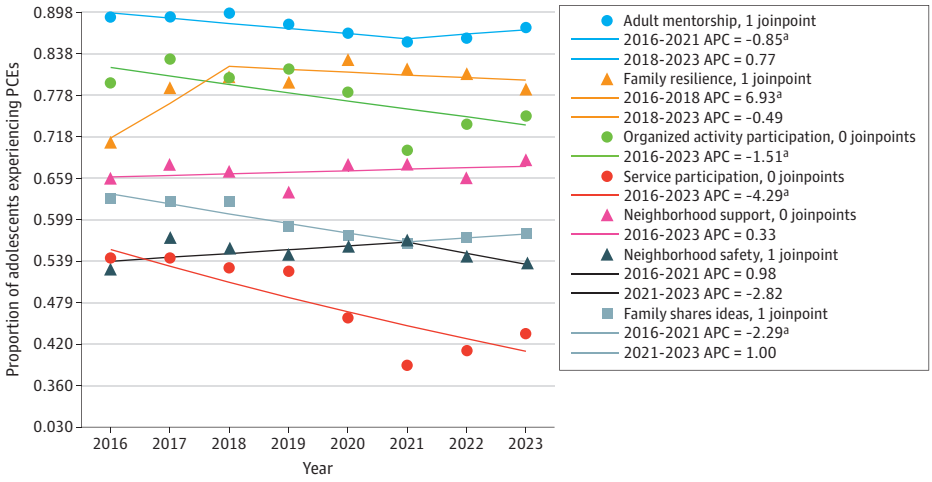
Results | **Figure 1** and **Figure 2** present the prevalence of ACEs and PCEs, respectively, from 2016 to 2023. Full prevalence data

Figure 1. Adverse Childhood Experiences (ACEs) Prevalence in Adolescents by Year



APC indicates annual percentage change.

Figure 2. Positive Childhood Experiences (PCEs) Prevalence in Adolescents by Year



APC indicates annual percentage change.

are available online.[6] There was little variance in the proportion of adolescents experiencing individual ACEs over time. Specifically, the range of proportion values for 5 ACEs was 0.015 or less over the 8-year period, and 10 of 11 ACEs varied by less than 0.04.

The variability in the proportion of adolescents experiencing individual PCEs was low, although there was more variability observed year to year in PCEs than ACEs. Specifically, the range of proportion values for 4 of the 7 PCEs was 0.065 or less, while the remaining 3 varied by less than 0.13.

Discussion | National prevalence rates remained relatively stable, with most ACEs varying by less than 2% and PCEs by less than 7% over the 7 years of data examined. Some ACEs and PCEs showed greater variability, highlighting the need to examine each individually. Unlike prior research, which analyzes cumulative counts, this study provides population-level estimates for each individual ACE or PCE. Limitations include parent report, no age control, exclusion of items related to abuse, ad hoc PCE definitions, and minor methodological changes in NSCH data collection over time.

The key implication of the stability in prevalence rates is that efforts to reduce ACEs and promote PCEs may not be leading to population-level change. These findings provide a vital baseline for evaluating the impacts of these initiatives based on data collected during and after multiple states have undergone efforts to understand and prevent ACEs and promote PCEs.

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<u>Das HOPE-Schema (Health Outcomes from Positive childhood Experiences)</u>
nach Sege & Harper-Browne, 2017 (in deutscher Übersetzung)

In fürsorglichen, unterstützenden Beziehungen leben

mit:

- sicheren Bindungen;
- herzlichen, aufmerksamen, dauerhaften Beziehungen;
- einem körperlich und geistig gesunden Elternteil;
- einem Elternteil, der aufgrund seiner besonderen Eigenschaften und der Umstände das Kind gut unterstützen und begleiten kann;
- vertrauensvollen Beziehungen zu Gleichaltrigen und anderen Erwachsenen.

In einer sicheren, stabilen, schützenden und gerechten Umgebung leben, sich entwickeln, spielen und lernen

d.h. verfügen über:

- ein sicheres und stabiles Zuhause;
- ausgewogene Ernährung und ausreichend Schlaf;
- Qualitativ hochwertige Lernmöglichkeiten;
- Möglichkeiten zum Spielen und für körperliche Aktivitäten;
- Zugang zu hochwertiger medizinischer und zahnmedizinischer Versorgung.

Möglichkeiten für konstruktives soziales Engagement und der Entwicklung eines Gefühls der Verbundenheit

Folgendes erleben:

- sich an sozialen Aktivitäten beteiligen können;
- Spaß und Freude an Aktivitäten (allein und/oder mit anderen) haben;
- etwas leisten können;
- sich der eigenen kulturellen Bräuche und Traditionen bewusst sein;
- sich anderen zugehörig fühlen und sich selbst wertschätzen.

Soziale und emotionale Kompetenzen erlernen

Folgendes lernen bzw. entwickeln:

- verhaltensbezogene, emotionale und kognitive Selbstregulierung;
- Selbstmanagementfähigkeiten;
- positive Charaktereigenschaften;
- Selbstbewusstsein und soziale Kompetenzen;
- angemessene und produktive Reaktionen auf Herausforderungen.

Quelle: Sege RD, Harper-Browne C (2017). Responding to ACEs with HOPE: health outcomes from positive experiences. Academic Pediatrics 17: S79-S85.

Risiko- und Schutzfaktoren in der psychosozialen Entwicklung von Kindern und Jugendlichen

nach Felder-Puig, 2018

Ebene des Kindes /Jugendlichen	Risikofaktoren	Motorische und sprachliche Entwicklungsdefizite
		Mangelnde Aufmerksamkeits- und Konzentrationsfähigkeit
		Mangelnde Emotionsregulation und Impulskontrolle (z.B. häufige und schnelle Wutausbrüche, unkontrollierte Traurigkeit)
		Eingeschränktes Problemlösungsverhalten (z.B. häufige Verwendung von Aggression zur Konfliktlösung)
		Chronischer Stress
		Unkritische Nutzung von (digitalen) Medienangeboten
		Suchtmittelkonsum
		Trauma-Erfahrungen
	Schutzfaktoren	Spezielle Talente und/oder Hobbies
		Positives Selbstwertgefühl
		Aktives Bewältigungsverhalten (z.B. konstruktive Problemlösungen)
		Fähigkeit, sich von ungünstigen Einflüssen zu distanzieren (psychisch und räumlich)
		Selbstbezogene Kontrollüberzeugung
		Vorausplanendes Verhalten
		Selbsthilfefertigkeiten (z.B. Wissen um soziale Unterstützung bei Schwierigkeiten)
Familie	Risikofaktoren	Unsichere Bindungen
		Ungünstiges Erziehungsverhalten (z.B. Überbehütung des Kindes oder harte Bestrafungen)
		Ungünstige Eltern-Kind-Interaktionen (z.B. geringe Rücksichtnahme auf Bedürfnisse des Kindes in Alltagssituationen, mangelnde oder inadäquate Zuwendung)
		Niedriger sozioökonomischer Status und damit assoziierte Lebensbedingungen (chronischer Geldmangel, beengte /schlechte Wohnverhältnisse, niedriger elterlicher Bildungs- und/oder Beschäftigungsstatus)
		Psychische Erkrankung in der Familie (z.B. Depression der Mutter)
		Chronische eheliche /partnerschaftliche Disharmonie
	Schutzfaktoren	Sichere Bindung zu mindestens einer Bezugsperson (Eltern, Großeltern, …)
		Offenes, unterstützendes Erziehungsklima
		Familiärer Zusammenhalt
		Positives Bewältigungsverhalten der Familie (z.B. gute Problemlösefertigkeiten, vorhandenes soziales Netzwerk)
Sozialraum	Risikofaktoren	Schulschwierigkeiten (wegen Teilleistungsstörung, mangelnder Unterstützung, …)
		Soziale Ausgrenzung
		Drogen-affines Milieu
		Sozialer Druck durch digitale Medien
	Schutzfaktoren	Soziale Unterstützung (in Kindergärten, Schulen, Sportvereinen, …)
		Dauerhafte, unterstützende Freundschaften; positive respektvolle Gleichaltrigen-Beziehungen
		Unterstützende Beziehungen in der Nachbarschaft
		Frühförderungen und andere unterstützende Angebote
		Zugang zu ökonomischen und kulturellen Ressourcen

von Felder-Puig (2018), modifiziert nach: Berufsverband deutscher Psychologinnen und Psychologen (2007): Bericht zur Kinder- und Jugendgesundheit in Deutschland. www.bdp-verband.org; Bundesministerium für Familie, Senioren, Frauen und Jugend (2009): Kinder- und Jugendbericht. Berlin: BMFSFJ und basierend auf Berk, L. (2005): Entwicklungspsychologie. München: Pearson; Lenhard, W. (2016): Psychische Störungen bei Jugendlichen. Ausgewählte Phänomene und Determinanten. Berlin: Springer.