Adverse Childhood Experiences and Resilience: Addressing the Unique Needs of Adolescents

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ABSTRACT

Adolescents exposed to adverse childhood experiences (ACEs) have unique developmental needs that must be addressed by the health, education, and social welfare systems that serve them. Nationwide, over half of adolescents have reportedly been exposed to ACEs. This exposure can have detrimental effects, including increased risk for learning and behavioral issues and suicidal ideation. In response, clinical and community systems need to carefully plan and coordinate services to support adolescents who have been exposed to ACEs, with a particular focus on special populations. We discuss how adolescents' needs can be met, including considering confidentiality concerns and emerging independence; tailoring and testing screening tools for specific use with adolescents; identifying effective multipronged and cross-system trauma-informed interventions; and advocating for improved policies.

KEYWORDS: adolescent health policy; adolescents; adverse childhood experiences; resilience; trauma

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ADVERSE CHILDHOOD EXPERIENCES (ACEs) are increasingly a focus of both research and interventions nationwide, given emerging evidence of their high prevalence and lifelong health impacts. To date, much of the ACEs literature has focused on children and adults. Greater attention should be paid to the distinct developmental needs of adolescents and how the systems that serve them can more adequately respond.

Distinct from both childhood and adulthood, adolescence is a unique developmental stage of rapid growth during which physiologic, cognitive, social, and emotional changes occur simultaneously. During this time (ages 11 to 21 years), adolescents experience physical and sexual maturation, develop more abstract and long-term thinking, and engage in risk-taking behaviors as they establish their independence. Adolescents who have experienced ACEs may be less able to successfully navigate this transformational stage as a result of the damaging effects of traumatic experiences on their emotional and cognitive development and/or lack of or limited positive supports.

A large body of research has demonstrated that investments in early childhood can yield significant social and economic returns in adulthood and that this developmental stage should be prioritized for investments, particularly for disadvantaged youth.[1,2] However, this research also supports the notion that to maximize returns, there is a concurrent need to invest resources to address the needs of adolescents, particularly for those who may not have received needed supports in early childhood and/or who continue to experience ACEs into adolescence.

Thus, adolescence represents a key window of opportunity to ameliorate the short- and longer-term impacts of trauma and positively alter the life course trajectory. High rates of trauma exposure have led to a pressing need to identify youth who have been exposed; recognize the varied ways in which youth respond to these experiences; identify effective strategies to provide trauma-informed care; and develop policy recommendations to prevent and respond to the impacts of ACEs.

There are many aspects of ACEs that affect adolescent health and warrant in-depth exploration. Here we provide an overview of these issues, with the hope that it helps identify areas for further analysis and critique in the literature.

PREVALENCE AND IMPACTS OF ACEs IN ADOLESCENCE

Researchers have defined ACEs as including physical or emotional abuse or neglect, sexual abuse, domestic violence, substance abuse or mental illness in the home, parental separation or divorce, having an incarcerated household member, and not being raised by both biological parents.[3] Recent research indicates that over half (54%) of all adolescents aged 12 to 17 years in the

United States have been exposed to at least one of these experiences, and over one-quarter (28%) experienced 2 or more.[4] Children living in homes with lower household incomes or in less safe and supportive neighborhoods, as well as those who qualified as having special health care needs, were more likely to experience ACEs.[5] Furthermore, certain subgroups of adolescents face heightened risks, including youth who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ) and those who are incarcerated or involved in the juvenile justice system.[5–7] Despite the high prevalence, the majority of adolescents with trauma exposure do not receive needed health services that are critical to identifying and addressing these concerns.[8]

The effects of trauma during childhood and adolescence have impacts on adolescent health and educational status, including a greater likelihood of repeating a grade in school, lower resilience, increased risk for learning and behavioral issues, suicidal ideation, and early initiation of sexual activity and pregnancy.[5,8–10] In fact, there is a much higher prevalence of these negative impacts among adolescents aged 12 to 17 after experiencing more than one ACE. With 3 or more ACEs, nearly half (48%) of youth experience low engagement in school, 44% cannot stay calm and controlled, and 41% demonstrate high externalizing behaviors.[11] Moreover, exposure to trauma in childhood and adolescence can lead to negative consequences in adulthood, including chronic illness and decreased productivity,[12,13] especially when they are experienced cumulatively or chronically.[4,5,14–17]

Despite the negative impacts of ACEs, literature is emerging on the countereffects of resilience and protective factors. Resilience theories focus on strengths that individuals possess internally, such as coping skills, and externally, such as family and community supports, rather than risks and deficits, and how these strengths can help them overcome risk exposure or traumatic experiences.[17–20] Positive individual-, family-, and community-level factors, including high levels of family functioning and parental engagement, are associated with favorable outcomes for children and adolescents who have been exposed to ACEs.[21–23] Family functioning in particular is a protective factor against poverty, neighborhood violence, poor parental relationships, and adolescent mental health concerns.[24–26] One national study found that resilience, defined as "staying calm and in control when faced with a challenge," lessened the impacts of ACEs on grade repetition and poor school engagement.[5] Another study examining similar data found that many factors mediate the relationship between increasing ACEs exposure and negative outcomes, including residing in a safe neighborhood, attending a safe school, and parental monitoring of friends and activities. Understanding, identifying, and nurturing protective home, school, and community elements may help diminish the overall impact of youth's exposure to ACEs.[4]

Responding to the Unique Needs of Adolescents

Adolescence represents a unique period for major social, psychological, and physical development, and a time in which youth frequently have unmet physical and mental health needs. For example, 20% of younger adolescents (10–15 years) and 27% of older adolescents (16–17 years) did not receive annual well-child visits, and 64% of adolescents with mental disorders did not receive services to address their illnesses.[27–29] Furthermore, those from disadvantaged backgrounds are at the highest risk of not having regular health maintenance visits or receiving needed mental health care.[27,29–31] Many adolescents also tend to engage in health behaviors that place them at risk for the leading causes of morbidity and mortality.[32] As adolescents begin to gain greater independence and assume individual responsibility for daily health habits, develop new social relationships, and individuate from their parents, these changes bring new opportunities and challenges for improving health and preventing disease. In response, clinical and community health, educational, and social welfare systems need to carefully plan and coordinate services to support adolescents who have been exposed to ACEs, with a particular lens on special populations—for example, youth who have been in the foster care system; those who have been incarcerated, homeless, or substance dependent; and/or LGBTQ youth.

Confidentiality Concerns

Pediatric care for youth aged 0 to 21 typically includes a strong focus on parental involvement. However, patient privacy is vital to assuring patient-centered services during adolescence, when the complexity of medical and behavioral health needs increase. Professional guidelines recommend that health care providers spend time alone with their adolescent patients beginning in early adolescence (11 to 14 years).[33] These encounters help adolescents learn how to manage their health with greater independence—for example, by learning how to manage a chronic health condition, avoid health-damaging behaviors, and navigate successful relationships with health care providers. However, one study of national data found that only 34% of adolescents had time alone with their providers, with younger girls and Hispanics youths of all ages being less likely than their peers to have time alone.[34] Adolescents who have experienced trauma are particularly in need of time alone with providers, as it provides the opportunity to begin to develop trusting relationships to safely disclose their experiences.

In addition to time alone with providers, adolescents need assurances that sensitive information they share will be confidential. In fact, adolescents who engage in high-risk health behaviors are likely to cite confidentiality concerns as a reason for foregoing health care.[35] There are confidential care laws that allow adolescents to consent to their own health care without parental notification. These laws differ by state, but they appropriately allow