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Adverse childhood experiences among youth reported to child welfare: Results from the national survey of child & adolescent wellbeing

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ABSTRACT

The negative influence of adverse childhood experiences (ACEs) on social, emotional, and behavioral (SEB) outcomes are well documented. However, no research to date has examined the effect of ACEs on SEB outcomes in youth who received mental health services after reporting to the child welfare system. This study's analyses of data from the National Survey of Child and Adolescent Well-Being II revealed that the most prevalent ACEs included hospitalization for a medical condition, neglect, and exposures to domestic and community violence. Logistic regression of this data showed that the odds of being diagnosed with internalizing problems increased with age and when sexual abuse was reported. The results also showed that compared to Caucasian youth, Latinos were less likely to be diagnosed with externalizing behaviors, even when sexual abuse had been reported. Contrary to one of this study's hypotheses, mental health service use within the past 18 months increased the odds of being diagnosed with SEB problems. These findings highlight the persistence of SEB problems despite receipt of mental health services. Future research should assess the impact of interventions that aim to mitigate poor SEB outcomes due to ACEs, especially sexual abuse.

1. Introduction

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) is one of the largest investigations of childhood trauma and its association with adult health and well-being. The original ACE Study included more than 17,000 adult participants, documenting seven adverse life events: psychological, physical, and sexual abuse; violence against mother; and living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. Nearly two thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. Additionally, an ACE score, or total sum of the different categories of ACEs reported by participants, was used to assess cumulative childhood stress. A dose-response relationship between ACEs and negative health and well-being outcomes (e.g., alcoholism/alcohol abuse, depression, illicit drug use, heart disease, and sexually transmitted infections) was observed across the life course, meaning that greater exposure to ACEs yielded a stronger effect on health and well-being outcomes (Centers for Disease Control and Prevention [CDC], 2016).

Both the original ACE Study (Felitti et al., 1998) and replications (e.g., Anda et al., 2006; Briere, Kaltman, & Green, 2008; Brown

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et al., 2010; Dube et al., 2009; Fuemmeler, Dedert, McClernon, & Beckham, 2009; Hyman et al., 2008) have shed great light on the prevalence and impact of ACEs and their role in adult morbidity and mortality. In fact, ACE has become part of our common lexicon when considering the lasting effects of traumatic childhood events on health and well-being. Yet, important gaps remain due to significant methodological limitations in the original study and its replications, including lack of prospective studies of the consequences of ACEs during childhood and adolescence, retrospective reporting of events that occurred several decades prior, and use of a limited range of adverse life events (Greeson et al., 2014).

2. Literature review

2.1. Prevalence studies

Recent studies have sought to address the aforementioned limitations by using data from a large clinic-referred sample of children and adolescents across the United States who were exposed to developmentally salient traumatic events, including major adversities not found in the original ACE studies (e.g., Greeson et al., 2014; Layne et al., 2014). Specifically, Greeson et al. (2014) used data from the National Child Traumatic Stress Network (NCTSN) to document the prevalence of 20 diverse trauma types and their association with child/adolescent behavior problems among a national, clinic-referred sample of children and adolescents assessed and treated for trauma exposure ($n = 11,028$). On average, participants experienced approximately three types of trauma. Traumatic loss/separation and domestic violence were experienced by nearly half of the sample. Impaired caregiver was experienced by almost 40% of the sample, as was emotional abuse. Nearly 31% of the sample experienced physical abuse and also neglect. Twenty-four percent of the sample experienced sexual abuse, 16% experienced community violence, and almost 10% experienced illness/medical trauma.

The use of the NCTSN dataset has been extended to investigate patterns of traumatic experiences among children and youth in foster care, who represent a particularly vulnerable group of young people. For example, Greeson et al. (2011) used the NCTSN data to examine complex trauma exposure among children and adolescents placed in foster care and referred to a NCTSN site for treatment ($n = 2251$). Complex trauma was defined as physical abuse, sexual abuse, emotional abuse, neglect, or domestic violence. This study observed high rates of complex trauma exposure: 70.4% of the sample reported at least two of the traumas that constitute complex trauma; 11.7% reported all five types. Although this study shed light on the occurrence of complex trauma among young people in foster care, it was limited in that it did not investigate forms of trauma beyond maltreatment and familial violence.

2.2. ACE and social-Emotional-Behavioral functioning

Both of the aforementioned studies that used data from the NCTSN also investigated the association between exposure to childhood trauma and child/adolescent behavior problems. Greeson et al. (2014) found a significant dose-response relationship between total number of trauma types and behavior problems for all scales on the Child Behavior Checklist (CBCL) except sleep. Each additional trauma type endorsed significantly increased the odds for scoring above the clinical threshold on the CBCL. Similarly, Greeson et al. (2011) found that compared to youth with other types of trauma, those with complex trauma histories had significantly higher rates of internalizing problems, posttraumatic stress, and clinical problems or symptoms.

Data from the National Survey of Child and Adolescent Well-Being (NSCAW) corroborated the above findings. In one study, researchers investigated whether witnessing violence and violence victimization were associated with children's internalizing and externalizing behavior problems and also examined the mediating role of posttraumatic stress (PTS) symptoms in these relationships ($n = 2064$; Yoon, Steigerwald, Holmes, & Perzynski, 2016). Being a victim of violence in the home was directly associated with more internalizing and externalizing behavior problems, whereas witnessing violence was not directly related to either internalizing or externalizing behavior problems. PTS symptoms mediated the effects of witnessing violence and violence victimization on internalizing behavior problems.

Data from the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) further corroborated the association between child maltreatment and behavior problems among children and adolescents involved with the child welfare system (CWS). Lewis, McElroy, Harlaar, and Runyan (2016) compared internalizing and externalizing behavior problems of those with a history of childhood sexual abuse (CSA) to those with a history of maltreatment, but not sexual abuse ($n = 977$). Their findings indicated significantly more problems over time in the CSA group than the maltreated group without CSA. Internalizing problems were higher for sexually abused boys compared to girls. For sexually abused girls, internalizing problems, but not externalizing problems, increased with age relative to boys. This pattern was similar among maltreated but not sexually abused youth.

2.3. ACE and mental health service use

Prevalence studies on child/adolescent trauma are prolific, as are correlational studies that document the association of trauma with behavior problems. In terms of how to address the impact of ACE on children/youth referred to the CWS, we know far less about whether intervening with services can disrupt the dose-response trajectory documented in the studies reviewed here and elsewhere (Fraser et al., 2013). Overall, studies have shown that mental health service use can function protectively and improve child behavior problems associated with ACE (Bethell, Gombojav, Solloway, & Wissow, 2016; Flynn et al., 2015; Silverman et al., 2008). For example, in a population-based study of 9417 children aged 6–17, Bethell et al. (2016) investigated the use of mindfulness-based approaches for children and youth with emotional, mental, and behavioral conditions, many of whom had multiple ACEs. Their findings revealed that, though mindfulness-based methods are largely under-utilized, such methods hold promise for attenuating the

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