THE ROLE OD EARLY ADVERSE AND POSITIVE EXPERIENCES IN YOUTH MENTAL HEALTH

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BACKGROUND

Youth aged 16–24 are coming of age in a time of global uncertainty and rapid social change. Navigating the critical transition from late adolescence into emerging adulthood, they face unique developmental and emotional challenges that shape their mental health and well-being. This period is especially sensitive to the long-term effects of early life experiences because the foundations of emotional regulation, relational patterns, and resilience—often established in childhood—become particularly relevant as young people encounter new demands and responsibilities.

While the negative impact of Adverse Childhood Experiences (ACEs) is well-established, growing research highlights the protective role of Positive Childhood Experiences (PCEs) in fostering resilience and supporting mental health. PCEs, such as emotional safety, belonging, and supportive relationships, may buffer the effects of adversity and promote long-term well-being.

Our study explored how ACEs, PCEs, and current factors—such as personal and societal worries, sleep, gender, and age—shape both subjective mental health outcomes (e.g., stress, anxiety, depression, flourishing, life satisfaction) and objective indicators (diagnosed and self-identified mental health problems, help-seeking) among Slovenian youth in this critical life stage.

AIM

The study aimed to examine how Adverse Childhood Experiences (ACEs), Positive Childhood Experiences (PCEs), and other psychosocial predictors shape mental health outcomes and well-being among Slovenian youth (ages 16–24).

METHODOLOGY

Sample
A non-probability sample was recruited through the JazeVem online panel (Valicon).
Additional data collection was carried out in schools, youth centers, and youth organizations.
A total of 1,059 completed surveys were included in the analysis following quality and relevance checks..

Data Collection
Data were collected via a standardized, self-administered online questionnaire.
Pilot testing: n = 34 (March 2024; ethics approval obtained)
Main data collection period: May – November 2024

Demographics (unweighted):
Gender: 334 (31.5%) male, 725 (68.5%) female.
Age groups:
16–18 years: 626 (59.1%)
19–21 years: 207 (19.5%)
22–24 years: 226 (21.3%)

Data Analysis
Data were analyzed using regression and binary logistic regression models, with weighting applied for gender and age.
Analyses were conducted using IBM SPSS Statistics 25.

Survey Content
Standardized Scales:
- Positive Childhood Experiences (Bethell, 2019): 7-item measure of emotional safety, belonging, and support during childhood
- Adverse Childhood Experiences (Anda et al., 1994): 10-item measure of childhood adversity
- Flourishing Scale (Diener et al., 2009): 8-item measure of psychological well-being
- DASS-21 (Lovibond & Lovibond, 1995): 21-item scale assessing depression, anxiety, and stress
- Revised UCLA Loneliness Scale (Russell, 1996): 6-item measure of loneliness

Composed indicators:
- Personal worries: 4-item PCA-based index (housing, education, relationships, finances)
- Societal concerns: 12-item PCA-based index (climate change, war, economic crises)

Self-Reported Measures:
- Life satisfaction, physical health, and mental health (single items, 5-point Likert scale)
- Sleep adequacy (categorized as less than, recommended, or more than recommended)
- Diagnosed and self-diagnosed mental health issues (Yes/No)
- Help-seeking behavior (Yes/No)
- Self-harm, suicidal ideation, and suicide attempts (Yes/No)

Demographics:
- Gender, age, family socioeconomic status (SES).

RESULTS

Regression (Table 1) and binary logistic models (Table 2) examined the impact of adverse and positive childhood experiences, sleep, personal and societal worries, and sociodemographic factors on a range of mental health outcomes. These included:
- Stress, anxiety, depression, and loneliness
- Flourishing, life satisfaction, and self-rated physical and mental health
- Diagnosed and self-diagnosed mental health issues
- Help-seeking behavior
- Self-harm, suicidal ideation, and suicide attempts

Table 1
Regression results (95 % CI β) for different mental health outcomes

	Stress	Anxitey	Depression	Life-staisfaction	Mental health	Physical health	Flourishing	Loneliness
ACEs	[0.11; 0.22]	[0.12; 0.22]	[0.05; 0.16]		[-0.15; -0.04]	[-0.15; -0.03]		[0.04; 0.14]
PCEs	[-0.26; -0.15]	[-0.32; -0.21]	[-0.47; -0.36]	[0.26; 0.37]	[0.30; 0.42]	[0.20; 0.32]	[0.52; 0.61]	[-0.47; -0.36]
Personal worries	[0.04; 0.09]	[0.04; 0.09]	[0.01; 0.05]	[-0.15; -0.08]	[-0.18; -0.10]	[-0.17; -0.10]	[-0.15; -0.08]	[0.14; 0.21]
Societal concerns	[0.10; 0.18]	[0.07; 0.15]	[0.12; 0.19]					
Sleep	[0,03; 0,24]	[0.04; 0,25]	[0.02; 0.22]	[-0.34; -0.12]				
Gender (F)	[0,21; 0,43]	[0.08; 0.29]		[0.04; 0.27]	[-0.26; -0.03]	[-0.32; -0.08]		
Age		[-0.05; -0.01]						
SES							[-0,24; -0,04]	
R^2	0.298	0.304	0.351	0.167	0.263	0.188	0.396	0.334

Table 2
Binary logistic regression results (95 % CI OR) for different mental health outcomes

	Diagnosis	Self-diagnosis	Help-seeking	Self-harm	Suicidal ideation	Suicidal attempts
ACEs	[1.28; 1.53]	[1.07; 1.29]	[1.29; 1.54]	[1.20; 1.48]	[1.15; 1.40]	
PCEs	[0.76; 0.91]	[0.79; 0.92]		[0.76; 0.98]	[0.78; 0.98]	
Mental health		[0.38; 0.54]	[0.50; 0.72]	[0.49; 0.83]	[0.36; 0.60]	
Loneliness					[1.02; 1.91]	[1.10; 4.87]
Gender (F)		[1.72; 3.07]		[1.93; 5.42]		[0.11; 0.82]
Age	[1.00; 1.16]		[1.07; 1.22]	[0.82; 0.99]		
SES			[1,02; -1,22]			
R^2	0.199	0.353	0.248	0.246	0.302	0.121

Statistically significant predictors are reported (p<0.05)

Positive Childhood Experiences (PCEs) emerged as the strongest protective factor across all outcomes:
Associated with lower levels of stress, anxiety, depression, and loneliness
Predicted better self-rated physical and mental health, greater life satisfaction, and higher levels of flourishing
Linked to lower likelihood of both diagnosed and self-diagnosed mental health problems, self-harm, and suicidal ideation

Adverse Childhood Experiences (ACEs) were a consistent risk factor in most models:
Predicted higher levels of stress, anxiety, depression, and loneliness
Associated with poorer self-rated physical and mental health
Linked to a higher risk of diagnosed and self-diagnosed mental health problems
Predicted greater likelihood of using therapy or counseling services
Not significantly associated with life satisfaction or flourishing

Personal worries (related to housing, work, education, relationships) consistently predicted poorer mental health across all outcomes.
Societal concerns (e.g., war, climate crisis, economic instability) were associated with higher stress, anxiety, and depression, but did not significantly affect flourishing or life satisfaction.
Sleep deprivation was associated with increased stress, anxiety, and depression, as well as lower life satisfaction. Both insufficient and excessive sleep were linked to poorer outcomes in the case of depression.

Gender differences:
Female respondents showed higher levels of stress and anxiety, lower self-rated physical and mental health, and greater risk of self-diagnosed mental health issues and self-harm.
However, they also reported higher life satisfaction and a lower likelihood of suicide attempts compared to males.

Age differences:
Older youth had a higher likelihood of diagnosed mental disorders, were more likely to use therapy or counseling services, and showed a lower risk of self-harm.

CONCLUSIONS

Positive Childhood Experiences (PCEs) are the most robust protective factor for youth mental health and well-being. In contrast, Adverse Childhood Experiences (ACEs), personal worries, societal concerns, and sleep deprivation are key risk factors.

Implications for Practice and Policy
Promote safe and supportive childhood environments: Strengthen protective PCEs in families, schools, and communities.
Implement early interventions for children exposed to ACEs to mitigate long-term psychological risks.
Address youth concerns about transitions to adulthood—especially regarding housing, education, and relationships—within mental health strategies.
Promote healthy sleep routines as a cost-effective and accessible intervention for improving well-being.
Tailor mental health programs by gender and age to enhance relevance, accessibility, and impact.

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