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Original research article

Adverse childhood experiences and aggressive behavior of adolescents in residential educational programs in the Czech Republic

Pavla Doležalová [1] *, Karel Červenka [2], Věra Vojtová [2]

[1] *St. Elizabeth University of Health and Social Work, Bratislava, Slovak Republic*
[2] *Masaryk University, Faculty of Education, Department of Special and Inclusive Education, Brno, Czech Republic*

Abstract
Introduction: Adverse childhood experiences and aggressive behavior of adolescents placed in residential programs in the Czech Republic represent significant risk indicators in their current and future lives. The text presents selected partial findings of the research.
Aim: The aim was to map and compare general trauma and specific traumatic events, the level of dissociative conditions, and aggressive behavior in vulnerable girls and boys placed in residential programs.
Methods: The study cohort consisted of 204 adolescents aged 15–19 years. The primary data collection instruments were the A-DES, ETISRS-F, and Buss–Perry Aggression Scale questionnaires. Statistical descriptive analysis of the dataset was performed using different methods.
Results: The findings showed extensive rates of traumatic experiences in early childhood among vulnerable adolescents. The findings confirm considerable vulnerability in both genders. However, girls experienced more traumatic experiences, particularly childhood sexual trauma and dissociative states.
Conclusions: These indicators have implications for mental health, wellbeing, and the life path of these adolescents. The findings can be used for holistic approach to these adolescents.

Keywords: Adverse childhood experiences; Aggressive behavior; Residential educational programs; Vulnerable adolescents

Introduction

In this text, we focus on the aggressive behavior aspects of adolescents temporarily living in residential educational programs in the Czech Republic. These are young people who have been court-ordered to be placed under protective care. This formal step was a response to their difficult life situation and complicated behavior. These adolescents were most often diagnosed with an Emotional and Behavioral Disorder (EBD). The EBD is associated with a variety of risky personality characteristics combined with a multifactorial adverse family environment that negatively affects the individual's current and future life.

Together with the high rate of trauma and aggressive behavior that children with EBD often display, specific needs can be expected in these children. These needs are based on characteristics related to their life experiences, psychosocial and social development, and education. In this context, an EBD often manifests itself in the child's aggressiveness and hostility towards others, combined with behavior that transgresses social norms. Associated comorbidity is often associated with self-harming, ADHD, anxiety, depression, post-traumatic stress disorder (PTSD), and learning deficiencies. Diagnosing EBD is difficult, and it is easily confused with other similarly manifested phenomena. In more severe cases, the emotional and behavioral disorder should be diagnosed by a multidisciplinary team, who actively collaborate to set up early intervention and regular review and re-diagnosis. However, if the adolescent does not receive early adequate treatment and therapy, then he/she may develop an antisocial personality in adulthood (Ptáček, 2006).

The emotional and behavioral disorder in childhood point to the risks of limiting the development of personal potential. This has very real implications for their prospects and quality of life in the future and in adulthood. It is for this reason that we have focused on exploring the issues of aggression, trauma, and dissociation in children with EBD. We understand developmental trauma and aggressive behavior as risk factors that influence the level of resilience and vulnerability of the child – and consequently their life.

In our research, the results of which are reported in this text, we have focused, among other things, on mapping the extent and prevalence of general trauma, physical, emotional, and sexual trauma as a spectrum of adverse childhood expe-

* **Corresponding author:** Pavla Doležalová, St. Elizabeth University of Health and Social Work, Námestie 1. Mája 1, 810 00 Bratislava, Slovak Republic, detached workplace Praha; e-mail: pdolezalova1@gmail.com
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riences. We also mapped the prevalence of dissociative states and aggressive behavior. We also looked at differences in the prevalence of these variables and variations. The premise was that mapping severity scores and recognizing differences between girls and boys may subsequently help guide options for targeted interventions. The present paper draws on partial research findings from the 2019 project.

In the following text, we first present the theoretical background of our research and the relevant findings of our research.

Characteristics of adolescents in residential programs

A common characteristic of adolescents with emotional and behavioral disorders is a history of substance abuse, ADHD, and in some cases borderline personality disorder. Emotional and behavioral disorders (EBD) can also be classified as "internalized" (e.g., PTSD, depression, and anxiety) or "externalized" (e.g., CD – conduct disorder) (Ogundele, 2018).

Risks in psychosocial development, dropping out of school and aggressive behavior in the school environment are associated with EBD. Experimentation with addictive substances since childhood, the inability to regulate emotions and delay gratification, reinforces risky behaviour (Currie and Bray, 2019). Common origins of risk indicators in these vulnerable adolescents include untreated trauma with later symptom development, specifically in externalized or internalized behavioral disorders and other interconnected symptomatology. These complications also occur with long-term risks in family cohabitation and are often conditioned by early traumatic family environments (Doležalová et al., 2022). There is a trend toward increased trauma due to general neglect, emotional attachment disorders and abuse, domestic violence, and drug use in the family environment (Muchiri and dos Santos, 2018; Zvara et al., 2015). Based on the unstable and traumatic development of these adolescents, a spectrum of defense mechanisms, primitive defenses that have developed as coping strategies in early childhood, can be traced.

Adverse childhood experiences and general trauma are perceived as risk factors. Adversity may include various traumatic events, especially those to which an individual was exposed in early childhood. Exposure to traumatic developmental experiences, especially in the family, leads to a disruption of the integrity, security, and safety of the individual. Serious adverse factors in childhood include the period of loss of emotional attachment, abuse, loss of a parent, serious illness in the family, and various environmental traumatic events that significantly interfere with the individual's life in childhood.

Externalized and internalized emotional and behavioral disturbances

Several studies have documented the high prevalence of early exposure to trauma and the development of psychopathology across the lifespan, particularly criminal behavior, and psychiatric complications (Craparo et al., 2013; Schimmenti et al., 2015). The experience of trauma in early childhood, and emotional abuse in conjunction with neurobiological and temperamental dispositions plays a significant role in the development of the severe psychopathic characteristics observed in offenders. The effect of insecure, disorganized early emotional attachment has been significantly associated with aggressive behavior, high levels of anxiety, and depression in individuals in residential care (Doležalová et al., 2022). Two tendencies, manifested in externalized and internalized forms, are associated with early developmental trauma and emotional attachment. Although the concept of externalized and internalized behaviors is not entirely uniform and symptoms overlap, they can be generally distinguished.

Dissociative symptoms and dissociative disorder

Dissociative states or symptoms are among the most common adaptive mechanisms of trauma and can be diagnosed as a dissociative disorder. Dissociative disorder is most often caused by trauma and PTSD symptoms (Mayo Clinic, 2017). According to Mayo Clinic (2017), symptoms and signals of the dissociative disorder include: (1) loss of memory (amnesia) or parts of the memory of events, people, and personal information; (2) feeling disconnected from oneself and one's emotions; (3) perception of people and things around as unrealistic distortions; (4) blurred perception of one's own identity; (5) significant tension and problems in relationships, at the workplace, or in other important areas of life; (6) inability to control emotions or stress; (7) mental health problems such as depression, anxiety, suicidal thoughts, and behaviors. The American Statistical Manual of Mental Disorders (DSM-5) lists four types of disorder:

A. Dissociative amnesia – a characteristic inability to remember personal information.
B. Dissociative identity disorder, characterized by more than one identity present in the personality.
C. Depersonalization/derealization disorder, characterized by feelings that objects or people in the environment are unreal, change shape, size, and the individual may have feelings of disconnection from their own body.
D. Non-specific dissociative disorders.

Diseth (2005) demonstrates the correlation of dissociation with trauma experienced during childhood, as well as the association with physical and sexual abuse. Soukup et al. (2009) state that dissociation results in risks in social relationships, isolation, and the development of personal pathology. The severity of dissociation correlates with poorer prognosis and outcome in treatment. Based on his study, Soukup et al. (2009) confirms higher rates of dissociation in abused, self-harming adolescents than in those who have never been abused. Soukup et al. (2009) also state that "this concept of dissociation is often misunderstood, and its role and importance in the treatment of psychological disorders is often underestimated".

In the context of other research, significant dissociation in traumatized children and adolescents has been confirmed. To better understand the phenomenon of trauma and dissociation, the view of PTSD and somatic disorders as a specific form of the dissociative process can be categorized as "trauma-related dissociative disorders" (Diseth, 2005; McLaughlin et al., 2017).

Dissociative disorder is most often caused by trauma and PTSD symptoms (Mayo Clinic, 2017). Dissociation often arises in childhood as a defensive response to prolonged physical, sexual, or emotional abuse and/or unpredictable home environment.

During childhood, personality and identity are still being formed, so the younger the child, the more vulnerable and unable to cope with and overcome trauma they are (Hébert et al., 2018). The child learns to dissociate to resist the traumatic experience, and this response is a coping mechanism for stressful situations. Dissociation allows the child to survive prolonged trauma and maintain a semblance of normalcy by masking social adjustment in the environment or primitive defenses.

The experience of early trauma affects cognitive abilities and emotion regulation. If the accumulated energy is not washed away, dissociation can develop into a chronic form of

psychiatric illness and various symptomatology. This appears to be a set of related forms of split consciousness that are associated with psychiatric illness (Doležalová, 2018).

Aggressive behavior of vulnerable adolescents

Aggression is a wide-ranging combination of bio-psycho-social aspects manifested throughout an individual's life. Aggression is a developmental instinct linked to individual personality traits, temperament, impulsivity, an individual's upbringing or contextual situation, and societal norms. The primary determinant of the occurrence of aggression in a person is his or her personality and character; if developmentally disturbed, then aggression is linked to developmental trauma and changes in personality development. Aggression is a tendency to manifest itself in primitive defenses of regressive and violent behavior that occur in individually tense situations. Aggressive expressions take different forms such as anger, hostility, violence, or even assertiveness (Dolejš et al., 2016). Investigations of aggression confirm gender differences, with men displaying higher levels of aggression in the general population. Also, these differences have been disappearing. Men are more aggressive in their expressions than women, especially in physical aggression. Women are closer to anger and passive aggression (Hofmann and Müller, 2020). Hostility is more common in more anxious or depressed individuals. Physical aggression tends to be associated with impulsiveness (Dolejš et al., 2016).

In adolescence, dynamic changes occur in the emotional sphere, thinking, and behavior. Vulnerable adolescents are generally hypersensitive, emotionally unstable, moody, relational, easily tired, and irritable. As a result of adversive experiences in childhood, a spectrum of health problems can manifest in later life. (Doležalová, 2018). The consequences of their adverse development then led to emotional and behavioral disorders and diverse comorbidities, lower resilience, risky behaviors, and higher vulnerability (Hrušková and Mrhálek, 2018).

Materials and methods

The research, partial results of which we draw on here, was conducted in 2019. The aim of the research was, among other things, to map and compare general trauma and specific traumatic events, rates of dissociative states, and aggressive behavior in vulnerable girls and boys.

This was quantitative research involving adolescents who had experienced several years in institutional care due to multiple cumulative adverse life circumstances.

The research field was therefore residential facilities from several regions of the Czech Republic. The construction of the research population was carried out in two steps. First, several residential facilities were selected and approached. In the next step, specific respondents were selected. These adolescents are placed in residential education programs based on a court order. These decisions are most often related to a variety of ways that these young people violate legal norms, to truancy or drug use, or to a neglectful and risky family environment (Doležalová, 2019).

The facility selection was based on several factors. Considering the sensitive nature of the topic, which is closely linked to the theme of trust and safety, in the context of the best interests of the child, we tried to ensure the safest possible situation for the data collection – *i.e.*, from the respondents' point of view, the situation of filling in the submitted questionnaires. Therefore, we surveyed 16 residential facilities. In addition to the type of facility, the main selection criterion was that these were facilities with which the team members had already established cooperation. This aspect was also important because residential education facilities are facilities with limited access and can be considered quasi-total institutions. It should be noted that one of the selective factors that co-determined the respondent's nomination to the research group was their voluntary participation (or non-participation) in our research.

The research was declared by the informed consent of the respondents. Participation in the research was voluntary and the clients were allowed to refuse to participate without giving any reason (including when the research was already underway), to not answer any of the questions, and, if necessary, to express disagreement with the processing of certain data or information. Participating respondents received and signed information about the research project and were informed about their role in the research project and the rights associated with it, as well as the methods of data handling (anonymization). Prior to each field entry for data collection, consent was also obtained from the management of the respective school facility. In addition, the date of implementation and the conditions of data collection were chosen by agreement. Respondents received and signed information about the research project and were informed about their role in the research project and how to handle the anonymized data. An informed consent form was created in accordance with GDPR. All documents, both electronic and hard copy, are stored securely in accordance with the ethical requirements of the study implementers.

The data collection was oriented toward a quantitative survey among boys and girls living in institutional juvenile correctional school facilities in 2019. Data analyses were conducted using SPSS software. The findings were arrived at using statistical procedures. Statistical descriptive data analysis was used with the variation of validation parametric and non-parametric statistical methods.

We used three survey instruments:

a) *Buss–Perry Aggression Questionnaire (BPAQ)* focuses on overall aggression, but also looks at how aggression may manifest itself in an individual. It assesses aggression based on four factors – physical aggression, verbal aggression, anger, and hostility. The Buss and Perry Aggression Questionnaire consists of 29 items in total. The instrument has good psychometric properties with good internal consistency and good reliability and extensive validity. Verbal and physical aggression represent the stimulus component of behavior and harm to others. Hostility represents resentment and hostility in the cognitive domain of behavior. Anger represents the physiological trigger and preparation for aggression, characterizing the affective component of behavior. These factors are considered the bridge between the instrumental and cognitive components of aggression (Buss and Perry, 1992). The Czech version of the method was standardized by Dolejš and colleagues in 2014 (Dolejš et al., 2016).

b) *Adolescent Dissociative Experiences Scale (A-DES)* is used for a brief self-assessment screening of dissociative states for adolescents, or for interview and diagnostic interventions. The tool contains 30 items examining pathological dissociation in adolescents but is insufficient to make or exclude a diagnosis of dissociative disorder and is not suitable for somatoform disorders. Items on the A-DES questionnaire explore, for example, the following domains: dissociative amnesia; absorption

and imaginative preoccupation, including confusion between reality and fantasy; experiences of passive affect/interference (loss of free control over one's own body and perceptions); depersonalization and derealization (feeling detached from one's own body and the world); and includes items on dissociated relationality (feeling that interpersonal relationships are erratic and unreal) (Soukup et al., 2009). The instrument is characterized by good psychometric parameters. In the Czech setting, the A-DES questionnaire is used to screen for dissociation in adolescents. These are mainly patients with multiple symptoms, e.g., hyperactivity, impulsivity, a weak ability to regulate emotions, attention deficit hyperactivity disorder with more complex behavioral disorders, impulse control disorders, ADHD, or a history of traumatic experiences. The score is an indicator of the severity of dissociative symptoms, and it should be emphasized that a high score does not confirm a diagnosis of dissociative disorder, just as a low score does not exclude it. The Czech version of the method was standardized (Soukup et al., 2009).

c) *Early Trauma Inventory Self Report-Short Form (ETISRS-F)* contains 29 items. This short self-report questionnaire measures childhood trauma occurring before 18 years of age. It includes the following trauma domains: physical, emotional, sexual abuse, and general trauma. It focuses on frequency, onset, emotional impact, and other aspects. It has good psychometric properties (Jeon et al., 2012). It is a tool that provides good validity, internal consistency, and reliability in different cultural settings. Respondents answer by indicating yes as 1 and no as 0. At the end of the questionnaire, there are three items asking the respondent to select one event that had the greatest impact on his or her life, and two more items measuring subsequent reactions, such as fear or depersonalization. The instrument is used for complementary research and has not been standardized in the Czech setting.

Characteristics of the research group

The research sample consisted of 204 respondents (girls and boys) aged 15–19 years who were in residential educational programs at the time. The respondents were staying in one of 15 facilities within the network of institutions throughout the Czech Republic, which consists of 25 institutions of this type. More girls are represented in the research population (N = 121), as institutions, where girls are placed, were more willing to cooperate with this research than institutions where boys are placed (N = 83). Also, facilities, where boys are represented, were less accessible.

It is useful to put the characteristics of the research sample in context with the relevant characteristics of the target population. In the 2018/19 school year, a total of 933 young people of both sexes (348 girls, and 585 boys) were in juvenile correctional institutions in the Czech Republic. Meanwhile, our research sample consisted of 204 respondents, which is approximately 1/5 of the target population of young people placed in juvenile correctional institutions during the period.

Results

The results of our research describe in four tables the results of the examination by gender differences between girls and boys in residential educational programs in the Czech Republic. In Table 1, we present the results of the general trauma score, the physical trauma score and the emotional trauma score. Table 2 presents the results of the sexual trauma score. Table 3 presents the dissociative state scores in general and by gender. Table 4 describes the aggression scores in overall and by gender.

Table 1. Average results by gender and type of trauma (general, physical, emotional)

Gender	*N*	General trauma (mean)	Physical trauma (mean)	Emotional trauma (mean)
Men	83	4.06	2.96	2.51
Women	121	4.50	3.42	2.84
Total	204	4.32	3.24	2.71

Testing shows higher scores of general traumas, physical and emotional trauma in girls compared to boys.

Table 2. Average results by gender and sexual trauma

Gender	*N*	Sexual trauma (mean)
Men	83	1.34
Women	121	1.99
Total	204	1.73

Tests, including non-parametric, confirm significantly higher sexual trauma scores in girls compared to boys. Non-parametric indicators of the testing using Kendall's Tau-b coefficient, Gamma coefficient, and Spearman's ordinal correlation coefficient confirm significantly higher scores of sexual trauma in girls. Similarly, according to Pearson Chi-Square 0.008 or Likelihood Ratio there is a relatively significant representation of sexual trauma (only 42% of respondents "without" such experience; in the rest the occurrence of at least one or more forms of negative sexual experience from the set of 6 questions). The number of missing items in the sexual trauma battery of questions in the ETISRS-F questionnaire was as high as 10%. Some personally sensitive questions respondents may not have wanted to complete.

The descriptive statistics processed by gender show that the overall score of dissociative states (A-DES) was higher in girls than in boys. Regarding the statistical distribution of A-DES scores, it seems that according to the Kolmogorov–Smirnov test, this distribution does not meet the requirement of a normal distribution. Therefore, in addition to the (parametric) ANOVA method, non-parametric indicators were used to test the statistical significance of gender differences in A-DES scores. Testing the significance of gender differences in A-DES scores, ANOVA (parametric indicators) is significantly higher at 0.012. Differences in A-DES scores between boys and girls are statistically significant according to all methods used. The significance of higher A-DES scores for girls over boys' scores is confirmed by both parametric indicators (ANOVA) and non-parametric indicators (*i.e.*, Kendall's correlations, Spearman's coefficient, Gamma coefficient) and is *significantly higher at 0.011*.

Descriptive statistics compiled by gender show that the overall aggression score was higher for girls than for boys. *The total aggression score was significant for both genders at 0.054.* The distribution of aggression scores according to the Kolmogorov–Smirnov test is not significantly different from the normal distribution. Although the statistical distribution of the aggression score did not differ from the normal distribution, we used ANOVA (parametric procedure) to test the sig-

Table 3. Total scores of dissociative states and by gender

		N	Average	Kolmogorov–Smirnov Test for normality of distribution	
				Test statistics (normal)	Asymp. Sig. (2-tailed)
Total score A-DES	Men	81	84.8	0.084	0.2
	Women	118	106.9	0.078	0.075
	Total	199	97.9	0.06	0.083
"Average answer" on 0–10 scale	Men	81	3.0	0.078	0.2
	Women	118	3.6	0.084	0.04
	Total	199	3.4	0.067	0.028

Table 4. Aggression scores, overall and by gender of respondents

		N	Average	Kolmogorov–Smirnov Test for normality of distribution	
				Test statistics (normal)	Asymp. Sig. (2-tailed)
Total aggression	Men	81	36.67	0.075	0.2
	Women	120	39.71	0.071	0.2
	Total	201	38.48	0.051	0.2

nificance of the differences in the score between the genders. The differences in aggression scores between boys and girls, however, were not statistically significant (neither the ANOVA nor the subsequent so-called robust tests of differences were significant). According to our results, it appears that girls who received an institutional education are approximately as aggressive as boys, or the differences are small and on the borderline of statistical significance.

Discussion

We may speculate that both general trauma and general aggression are more highly represented in girls. In the other areas studied, emotional, physical, and sexual trauma, dissociation, and aggression were higher in girls. Sexual trauma was significantly higher in girls than in boys. The findings suggest that girls are highly vulnerable and thus more at risk for personal development and interpersonal and intrapersonal risks. These vulnerable adolescents have extensive adverse childhood experiences and coping with anxiety and emotional pain manifests as defensive or offensive behavioral strategies. Similarly, adverse childhood experiences were associated with many negative behaviors, health-related outcomes, and suicidal behaviors among high school students (Korpics et al., 2021).

Aggression has been linked to several risk factors including individual characteristics and temperament, disrupted family dynamics, neglect and uninspiring parenting, exposure to violence, and the influence of emotional attachment disorders (Ogundele, 2018). Risky behavior, mental health problems, and defensive forms of behavior can, in particular, be found in in aversive experiences and transgenerational traumas in the family environment. As a result of an unstable early life and a spectrum of childhood trauma, vulnerable adolescents are at risk of mental health and health risks (Gabínio et al., 2018).

Strategies based on positively influencing the personality characteristics of the group can be used alongside special education approaches that primarily target individual students with behavioral problems, as well as targeted therapeutic one-to-one methods in a tailored treatment and development of a positive education plan to change behavior.

Limitations of the research

Limitations include the amount of missing data for questions related to trauma, and in particular sexual trauma. Some adolescents refused to answer certain questions due to traumatic experiences in early childhood. The missing data mostly related to the parents in terms of neglect, biological parent abuse, parental drug use or domestic violence, and placement in early institutional care. Also, not knowing the biological parents, as well as incarceration of one or both parents, drug distribution, prostitution of the mother, or endangering the health and development of the child. Adolescents responded by not completing the questions due to negative emotional attunement. Further, the selection of respondents was voluntary within the selected institutional care settings. These were only respondents who consented to the research survey. Data were obtained more from girls' institutions because they were more likely to complete the questionnaire and cooperate with the researchers than boys (who were more likely to refuse to participate). There was some degree of avoidance and distrust of the researcher or fatigue after school, while disinterest in completing questionnaires also played a role. In the data collection, the fact that these adolescents are impulsive and have fluctuations in emotions and concentration and have psychiatric diagnoses due to early trauma or neglect may have played a role. The adolescents studied did not have intellectual disabilities.

The data collection for the battery of tools took an hour. Time was also a limitation because the adolescents did not have the patience to fill out longer questionnaires, they came tired, or the facility staff did not inform the adolescents sufficiently in advance about the survey. Also, data collection was not rewarded with incentives, everything was based on their motivation and voluntary cooperation.

Conclusions

Our findings regarding aggression, trauma, and dissociation, indicate high rates of traumatic experiences and adverse childhood experiences in these adolescents. Significant findings confirm the extensive vulnerability of both genders, and girls are much more at risk later in life for health and social consequences.

The identification of appropriate special education, therapeutic, and treatment interventions depends on a careful assessment of the individual's prevailing symptoms, family and caregiver influences, the wider socioeconomic environment, the child's level of development, and physical health. It is essential to focus on the individual's needs and to differentiate and design gender-differentiated interventions, as girls are more at risk of further adverse development due to specific needs and high levels of vulnerability.

It is also advisable to consider a holistic approach that can be used to improve educational programs' opportunities for children with difficult behavior. School-based support strategies for children with EBD have traditionally focused on group social-emotional skills and anger management, but a focus on positive behavior interventions and resiliency may be the most effective strategy.

The residential programs should be responsive to the needs of the individual and foster stability, security, and resilience in the institutional setting. The model of a client-centered approach puts high demands on the expertise of the multidisciplinary team in the residential setting and a wide external network of collaborating experts. Good cooperation between the individual's family or foster care providers is essential. They also necessarily increase the demands on the erudition of staff in institutional juvenile correctional programs.

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Ethical aspects and conflict of interests
The authors have no conflict of interests to declare.

Nežádoucí zážitky z dětství a agresivní chování adolescentů v pobytových vzdělávacích programech v České republice

Souhrn
Úvod: Nepříznivé zážitky z dětství a agresivní chování dospívajících umístěných v pobytových zařízeních v České republice představují významné ukazatele rizik v jejich současném i budoucím životě. Text představuje vybraná dílčí zjištění výzkumu.
Cíl: Cílem bylo zmapovat a porovnat obecné trauma a specifické traumatické události, úroveň disociativních stavů a agresivní chování u ohrožených dívek a chlapců umístěných v pobytových programech.
Metody: Výzkumný soubor tvořilo 204 dospívajících ve věku 15–19 let. Primárními nástroji sběru dat byly dotazníky A-DES, ETISRS-F a Buss–Perryho škála agresivity. Ke statistické deskriptivní analýze dat byl použit program SPSS, s variací validačních parametrických a neparametrických statistických metod.
Výsledky: Zjištění ukázala rozsáhlou míru traumatických zážitků v raném dětství u zranitelných adolescentů. Zjištění potvrzují značnou zranitelnost u obou pohlaví. Dívky však zažily více traumatických zážitků, zejména sexuální trauma v dětství a disociativní stavy.
Závěr: Tyto ukazatele mají dopady pro duševní zdraví a duševní pohodu a následnou životní dráhu těchto adolescentů. Zjištění lze využít pro inovativní a holistický přístup k těmto adolescentům.

Klíčová slova: adverzivní zážitky v dětství; agresivní chování; institucionální výchovně-vzdělávací programy; vulnerabilní adolescenti

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