

SHORT THESIS FOR THE DEGREE OF DOCTOR OF
PHILOSOPHY (PHD)

**Association between Adolescents'
Adverse Childhood Experiences and
their Current Mental and Behavioral
Symptoms and Subjective Health Complaints**

by Beáta Kovács-Tóth MA
clinical psychologist

Supervisor: Ildikó Kuritárné Szabó PhD



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DOCTORAL SCHOOL OF HEALTH SCIENCES

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By Beáta Kovács-Tóth, MA
clinical psychologist

Supervisor: Ildikó Kuritárné Szabó, Ph.D.

Doctoral School of Health Sciences
University of Debrecen

Head of the **Defense Committee:**

Róza Ádány, Ph.D., D.Sc.

Reviewers:

Judit Balázs, Ph.D., D.Sc.

Judit Inántsý Pap, Ph.D.

Members of the Defense Committee:

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Anikó Égerházi, Ph.D.

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1. INTRODUCTION

Estimates suggest that up to 1 billion children worldwide may be affected by abuse, which means that every second 2-17-year-old child will experience some form of abuse every year. Also, about 120 million girls are the victims of some form of sexual violence before the age of 20. Every third child is affected by emotional abuse, and every fourth child worldwide lives with a mother who is the victim of domestic violence.

The Adverse Childhood Experiences Study (hereinafter: ACE study), was initiated in 1995 in the USA, and aimed to examine the effect of adverse experiences one had in their childhood (before the age of 18) on their adult health. This research including 17,000 participants has been going on for over 20 years; its results show that prolonged and accumulated adverse childhood experiences lead to serious mental health damages and somatic injuries that span into or develop in adulthood. The ACE study resulted in studies initiated worldwide to assess these adverse experiences and the associated mental and somatic symptoms.

In children/adolescents who undergo terrifying experiences on a repetitive, sometimes daily basis without being provided support and the basic safety they would need, all aspects of personality development will be seriously affected.

These children would desperately need help; this is why it is extremely important to find these children exposed to adverse experiences, and provide them with proper treatment. Unfortunately, Hungary is still at an early stage both in terms of identifying these children and providing them with therapeutic support. The field of childhood adversities and their consequences has been undeservedly neglected by research, even though this knowledge would be highly useful in planning and carrying out appropriate preventive and therapeutic interventions.

Our research aims to fill in this gap we experience as left open in East-Central Europe, including Hungary. In addition to the assessment of adverse childhood experiences, we also assessed the related mental and behavioural symptoms, as well as subjective health complaints reported by adolescents. For this aim, our study included not only the normal population living with their own family, but also adolescents living in child protection care.

2. STUDY AIMS

Aim 1: To assess the prevalence of adverse childhood experiences (ACEs)

To assess the accumulation and patterning of ACEs (rates of prevalence of direct maltreatment: abuse, neglect, and indirect adversities: household dysfunction), and the prevalence of the different types of ACEs by groups and gender, as well as to describe the differences between groups. We compared the data obtained from 12-17-year-old adolescents included in child protection care, more exactly in family-style group care (FGC) to teenagers living with their own family/parents.

Aim 2: To assess the prevalence of social, emotional, and behavioural symptoms

To examine the prevalence of social, emotional, and behavioural symptoms by groups and gender, as well as to describe the differences between groups (12-17-year-old adolescents living in FGC and teenagers living with their own family).

Aim 3: To assess the prevalence of subjective health complaints

To define the prevalence in the two groups, as well as to describe the differences between groups (12-17-year-old adolescents living in FGC and teenagers living with their own family).

Aim 4: To assess the association between ACEs and social, emotional, and behavioural symptoms, as well as subjective health complaints

International studies show there is a dose-effect relationship between the experienced adversities and subsequent health damages, i.e. the more types of adversities the individual suffered from in their childhood, the higher the risk of some subsequent health damage is. No research has been conducted so far in a Hungarian adolescent sample to confirm these results.

3. MATERIALS AND METHODS

The conduct and circumstances of the study, study participants

The data were collected from adolescents living in FGC settings provided by the Child Welfare System, and adolescents living with their own family. The data collection on adolescents under child protection services was carried out in 31 FGCs in 3 counties, while the data on adolescents living with their own

parents/ family were obtained from students of 10 schools in 4 different counties. Altogether 756 mentally sound adolescents aged 12–17 were included in our study, with 240 of them living in FGC, and 516 teenagers living with their own parents and family. The study sample comprised the 240 adolescents living in FGC, and the control group consisted of the 516 adolescents living with their own family.

Study materials

The *demographic data* of the studied adolescents were assessed using a self-developed questionnaire with items asking for information on gender, age, nationality, school type, grade, residential location, parental educational attainment, as well as the circumstances of adolescents' placement in institutional care.

ACEs were assessed by using the *Adverse Childhood Experiences Questionnaire (ACE questionnaire)*, which is a retrospective self-report questionnaire consisting of 10 items. The questions in this survey aim to assess 10 types of early ACEs suffered before the age of 18, which can be classified into three categories: abuse (physical, emotional, and sexual abuse), neglect (physical, emotional), and household dysfunction (parental separation/divorce, household physical violence,

household substance abuse, household mental illness or suicide attempt, incarcerated household member).

For the assessment of social, emotional, and behavioural symptoms the *Skills and Difficulties Questionnaire (SDQ)* was employed. The items of this questionnaire can be grouped in 5 factors as follows: hyperactivity, emotional problems, behavioural disorders, peer relationship problems, and prosocial conduct.

Subjective health complaints were assessed using the relevant questions of the *Health Behaviour in School-aged Children Questionnaire (HBSC-2014)*. Adolescents were interviewed on the prevalence of nine subjective health complaints (psychic and somatic symptoms such as headache, stomachache, backache, feeling low, irritability, nervousness, sleeping difficulties, dizziness, fatigue).

Statistical analysis

The data were processed using IBM SPSS Statistics version 23. The normality of data distribution was tested with Kolmogorov–Smirnov in all cases; parameters with normal distribution were analysed with parametric methods, while variables without a normal distribution were evaluated with non-parametric tests. To compare the sociodemographic data of adolescents living in FGC and those living with their biological

parents, Mann–Whitney test was carried out for age, while for the rest of the demographic data Chi-square test was used for all comparisons. To determine the accumulation of ACEs and the prevalence of the different types of adverse experiences, the prevalence of social, emotional, and behavioural symptoms, as well as that of subjective health complaints broken down by population and gender, Chi-square statistics was applied. The relationship between the accumulation of ACEs and social, emotional, and behavioural symptoms was described with the help of linear models; the relationship between the accumulation of ACEs and subjective health complaints was studied by using logistic regression analysis. Both analyses were adjusted for age, gender, and residential location. The significance level was set at 0.05 in all cases.

4. RESULTS

Demographic features of the sample

Regarding the adolescents living in FGC, 45.8% of them were male, and 54.2% were female; while 40.3% of the adolescents living with their own family were male, and 59.7% female.

In terms of residential location, adolescents dwelling in urban settings were most represented in both groups: 60.6% of adolescents living in FGC and 52% of adolescents living with

their own family live in towns or cities. Results showed that 10.6% of adolescents living in FGC were institutionalised at the age of 0–3, and 8.9% were placed in an institution around the age of 4 or 5. The highest rate in the sample, 40.7% belonged to the adolescents institutionalised between the age of 6–11, and almost the same rate, namely 39.8% of them were placed in this setting after the age of 12.

The prevalence of accumulated adverse experiences

As many as 40.4% of adolescents living in FGC reported having four or more adverse experiences, which was experienced by 7.6% of the adolescents living with their own family. In FGC settings, 70.2% of teenagers reported 2 or more adverse experiences, while the same was reported by 24.4% of those living with their biological parents. Altogether 29.9% of adolescents living in a FGC setting related having no or only one adverse experience, with 75.5% of teenagers living with their own family reporting the same data. The distribution between the two groups was found to be significant ($p < 0.001$). No significant *gender difference* was found between the adverse experiences adolescents living in FGC settings have gone through; while among teenagers living with their biological parents a significant gender difference was revealed for adverse experiences, with girls having higher scores. Results show that

teenage girls living in families experience the accumulation of adverse experiences significantly more frequently ($p=0.017$); 10.1% have suffered four or more adverse experiences, and 29.2% have experienced two or more such events. Compared to boys, nearly twice as many girls have gone through three adverse experiences, and two and a half times more girls have had four or more such experiences.

After grouping ACEs into direct (maltreatment: abuse+neglect) and indirect (household dysfunction) adversities and studying them separately, we found that 44% of *adolescents living in FGC* reported having experienced no maltreatment. As for household dysfunction, 10.8% reported no household dysfunction, and 41% related no or only one such dysfunction. The difference between genders was not significant.

Regarding *teenagers living with their own family*, 73.2% of the participants related no maltreatment, with 63.1% of them reporting no household dysfunction either. A significant difference in girls' favour was detected in maltreatment among adolescents living with their biological family ($p=0.013$).

The average ACE score of maltreatment was more than twice as much, and the average ACE score of household dysfunction was four times as much in adolescents living in FGC compared to those living with their own family. Comparing the rate of ACE score for maltreatment and household dysfunction in the

two groups, we can see that those living in FGC reported nearly twice as much household dysfunction on average as maltreatment, while there was no such difference in adolescents living with their own family: these teenagers reported roughly the same amount of maltreatment as household dysfunction.

Compared to the adolescents living with their own family, those in family-style group care reported significantly more adverse experiences, both in relation to direct abuse and neglect ($p < 0.001$), and household dysfunction ($p < 0.001$).

The prevalence of the individual types of adverse experiences

In both groups, the most prevalent type of adversity was parental separation/divorce (71.2% and 24.8%). Among *adolescents in family-style group care* this adversity was followed by the category of incarcerated household member (48.5%), household substance abuse (32.5%), emotional abuse (32.1%), and emotional neglect (30.1%). The prevalence of other adversities ranged from 25.2% (physical abuse) to 13.6% (sexual abuse). Among *adolescents living with their own family* the second most common adverse experience was emotional neglect (16.2%), followed by emotional abuse (15.2%), household substance abuse (8.9%), and household mental illness (8.1%). The prevalence of the rest of the adversities

ranged from 7.7% (incarcerated household member) to 3.9% (emotional neglect).

A significant difference was found in all types of adverse experiences between adolescents living in FGC and those living with their biological family; all types of adversities were more frequent among those living in FGC ($p < 0.001$). In terms of gender, the prevalence of the different types of adverse experiences showed significant difference in three cases: compared to boys, emotional abuse ($p = 0.008$), emotional neglect ($p < 0.001$), and household mental illness ($p = 0.023$) was more common in girls living with their own family.

Differences in the prevalence of adversity types experienced by adolescents in FGC and those living with their biological parents

To determine the differences in the prevalence of adversity types experienced by adolescents in FGC and those living with their biological parents logistic regression (adjusted for age, gender and residential location) was performed, with positive and negative responses to ACE categories as outcome variables. Adolescents living in FGC were more likely to report all types of childhood adversities: odds ratios ranged from 2.58 (emotional neglect) to 12.44 (incarcerated household member) ($p < 0.001$).

The prevalence of social, emotional, and behavioural symptoms

Among *adolescents living in FGC* the rate of prevalence of clinically significant problems was as follows: 17% of them were emotional symptoms, 32.5% were behavioural problems, 14% were hyperactivity/attention deficit disorders, 41% of them were peer relationship problems, 26.4% were overall difficulties. No significant difference was detected between genders among these adolescents.

At the same time, among *adolescents living with their own family*, 14.6% of the sample experienced emotional symptoms, and 18.3% of these teenagers had behavioural symptoms. The rate of adolescents with peer relationship problems was 21.7%. On the basis of their self-report, 15.0% of the adolescents were affected by hyperactivity disorder. Regarding the difference in genders, boys were significantly more affected by behavioural symptoms ([24.9%]; $p < 0.001$), whereas girls experienced a significantly higher prevalence of peer relationship problems ([21.7%]; $p = 0.022$), as well as emotional problems ([18.0%]; $p = 0.018$).

In summary, peer relationship problems had the highest prevalence in both groups (41.0% and 21.7%, respectively), followed by behavioural (32.5% and 18.3%, respectively) and emotional (17.0% and 14.6%, respectively) symptoms. We

managed to detect a significant difference in peer relationship problems ($p < 0.001$), behavioural problems ($p < 0.001$), and total symptom score ($p = 0.013$) between the two groups.

The prevalence of subjective health complaints

After combining its relevant categories, we defined the prevalence of subjective health complaints as a binary variable (several times a week vs. less than several times a week).

The most common health complaints reported by *adolescents living in FGC* were fatigue, nervousness, feeling low, sleeping difficulties (affecting nearly half of the sample), with the rest of the subjective health complaints having a prevalence of over 20% (the majority around 30%). Nearly half of the FGC adolescents reported being affected by fatigue (49.4%) and nervousness (45.1%); over one third of them suffering from feeling low (41.9%), sleeping difficulties (37.2%) and irritability (33.5%). Over quarter of them (29.6%) complained of headache, backache (28.8%), and stomachache (25.1%) experienced several times a week.

On the other hand, 54.8% of *adolescents living with their biological parents* reported suffering from fatigue; 37.5% of them experienced nervousness, and 28.6% reported feeling low. One quarter of them (26.1%) have headache and suffer from difficulty falling asleep (24.8%) several times a week.

Except for headache and fatigue, all the subjective health complaints were significantly more prevalent among adolescents living in FGC; these complaints were also highly prevalent among those living with their own family.

Regarding the *difference between genders* in adolescent living in FGC every measured subjective health complaint – except for fatigue – was significantly more frequent in girls compared to boys ($p < 0.05$). In those living with their own family, each subjective health complaint – except for sleeping difficulties – was significantly more frequent in girls ($p < 0.05$).

The association between adverse experiences and social, emotional, and behavioural symptoms

To determine the association between adverse childhood experiences, and social, emotional, and behavioural symptoms generalised linear model was used, adjusted for age, gender, residential location, and maternal education. Adolescents having experienced two ($B=2.092$; $p=0.001$), three ($B=3.594$; $p < 0.001$) or four or more adversities ($B=3.990$; $p < 0.001$) reported a higher number of overall difficulties compared to adolescents without ACEs. This association was found to be strong and cumulative.

When separately modelling the association between ACEs and social, emotional, and behavioural symptoms, we found a similar relationship, with lower B coefficients.

The association between adverse experiences and subjective health complaints

Logistic regression adjusted for age, gender, residential location, and maternal education was employed to analyse the relationship between ACEs and subjective health complaints. After combining its categories, we defined the prevalence of subjective health complaints as a binary variable (several times a week vs. less than several times a week). Adolescents living with cumulative adversities were at a several times higher risk of experiencing subjective health complaints several times a week, compared to adolescents without ACEs (EH: 1.776 – 3.853; $p < 0.05$).

5. DISCUSSION

Adverse childhood experiences

Adolescents living in FGC had less favourable results in terms of ACEs compared to the teenager population living with their biological parents. Over five times as many of them had experienced four or more adverse experiences (40.4%) as in the

other group; and their mean cumulative ACE score was also three-fold, which reflects that the exposure to multiple adverse experiences is also higher among adolescents in FGC (4 or more adverse experiences).

An unexpected result obtained in the group of adolescents *living with their own family* was that 24.4% of them had had at least two, and 7.6% of them had had four or more adverse experiences; they are the population at an unrecognised risk. The obtained results should raise public awareness to the fact that exposure to adverse experiences does not only affect children and teenagers under child welfare protection, and more awareness raising and prevention is needed to support adolescents living with their biological parents.

After classifying ACEs into direct and indirect adversities, we were surprised to see in connection with maltreatment that 44% of adolescents in FGC reported having experienced no maltreatment, and nearly two-third (65.4%) had suffered from one or no maltreatment. A further important result regarding the distribution/patterning of adverse experiences is that a substantial part of the adolescents in FGC reported significantly less maltreatment (half less) than household dysfunction, while this distribution is much more balanced among adolescents living with their own family. Several explanations have been suggested to account for FGC

teenagers' willingness/unwillingness to report adversities. Generally, the willingness to report about sensitive issues is lower among adolescents. Also, it frequently happens that driven by the need to preserve the ties with their carers, institutionalised adolescents will deny and trivialise the abuse they had suffered, and idealise the family they had lost. It also often happens that those exposed to abuse fail to recognise *abuse* itself, and do not consider it as such. Another possibility is that they do not interpret their experience as *abuse*; this is especially true in our post-Soviet/East-Central European culture, where it used to be impossible for a long time to discuss intrafamilial childhood traumatisation in public, or do research in the topic.

When analysing *household dysfunction*, we found that adolescents living in FGC reported a substantially higher number, nearly twice as much household dysfunction as abuse. According to the Hungarian Central Statistical Office (KSH – Hungarian abbreviation), 62% of insititutionalisations are due to environmental problems, followed by financial issues (14%), familial and parental lifestyle (13%), interparental and intrahousehold conflicts (8%), and inappropriate housing conditions (6%). Official statistics show neglect to account for 10%, and household abuse to only account for 3% of problems. The higher proportion of household dysfunction reported in

FGC, including the outstandingly high proportion of incarcerated household member (48.5%), presumably follows the social gradient, and household dysfunction is more common lower down. All this suggests that in our sample the authorities' decision on the removal of the child from the family may have been based on the poverty and low socioeconomic status of the family serving as a significant background assessment factor. The data obtained from adolescents living in FGC make us conclude that even though fewer adolescents are willing to report direct maltreatment than household dysfunction, their number is still higher (34.6% of them had suffered from two or more cases of direct maltreatment) than the one recognised and reported officially by the child protection services (see KSH data). This data suggests that direct maltreatment is quite underrecognised in Hungarian child protection.

The prevalence of adverse experience types

The most common type of adverse experience in both groups was parental divorce or separation (71.2% and 24.2%).

In the group represented by *FCG teenagers* this was followed by incarcerated household member (48.5%), household substance abuse (32.5%), emotional abuse (32.1%) and emotional neglect (30.1%). In most cases, emotional abuse and emotional neglect were closely related to the lifestyle of the

family and chronic exposure to stress, resulting in a circle of abuse in these families. Both the rate of reported physical and sexual abuse was much higher compared to the other group, which further confirms the result of studies on the association between the different adversities, as well as the need for prevention and therapeutic support.

Among adolescents living with their own family the second most common ACE was emotional neglect (15.7%), followed by emotional abuse (14.7%). The prevalence of these two adversities was higher in our sample than the frequency shown by international East-Central European studies conducted in other generations. Adolescents are especially sensitive to emotional events and personal concern, and the quality of parental care. Most of the participants in this group seem to regard the care they receive as not enough. Emotional abuse is a hidden, less obvious form of abuse. According to our clinical observations, a lot of parents tend to use it instead of overt physical abuse, to compensate for their inappropriate parenting skills. This may be due to a variety of reasons including abuse suffered by the parents themselves, or inappropriate primary object relations and attachment patterns. These forms of abuse (emotional abuse and emotional neglect) are less obvious for the outside world; therefore, studies relying on self-report are especially important in identifying these adversities.

The rate of the rest of reported ACEs was below 10% among adolescents living with their biological parents. Out of all the types of adverse experiences physical neglect was the least common (3.9%), indicating that only a small percentage of the studied adolescents living with their own family suffers from inappropriate financial/ physical conditions.

Social, emotional, and behavioural symptoms

The prevalence of social, emotional, and behavioural symptoms suggests that at an age when the developmental challenges posed by adolescence prove to be quite serious themselves, the adolescents (in our sample) must cope with several mental symptoms. Regarding social, emotional, and behavioural symptoms, our results are highly consistent with those reached in other similar studies indicating high prevalence. Every sixth *adolescent living with their biological parents* related some emotional symptom, and about one fifth of our sample complained of behavioural problems. Hiperactivity/attention-related problems affected 15.0% of the sample. According to international studies, the prevalence of subthreshold ADHD is wide-ranging (0.8–23.1%), the comorbidity of subthreshold ADHD is high, and there are several areas where subthreshold ADHD has a significant impact on functioning. Nearly one fifth of adolescents have peer relationship problems; therefore, as

peer relationships and the presence of friends are of key importance in adolescence, their disorder or absence may have serious consequences later.

As for *gender*, the results of our study are in line with previous study results: behavioural symptoms are significantly more frequent in boys, while peer relationship and emotional problems are more prevalent among girls. In terms of overall difficulties, the present Hungarian sample is middle-ranking, compared to the 10 studied European countries.

Subjective health complaints

Nearly half of the sample comprising *FGC adolescents* were affected by fatigue, nervousness, feeling low, sleeping difficulties, and the rest of the subjective health complaints also had a prevalence of over 20%, with the majority around 30%. More than half of the *adolescents living with their own family* reported suffering from fatigue; over one third of them experienced nervousness and feeling low. One quarter of them said they have headache and suffer from difficulty falling asleep several times a week. Apart from biological /hormone-related changes typical of adolescence, all these symptoms may be caused by problems inherent in the present schooling system, the excess load students are exposed to, or factors related to the educational system.

Allmost all the subjective health complaints were significantly more common among girls than boys, in both groups, which is also consistent with international research results. This may be due to girls being more willing to report, or the fact that somatisation tendency is higher among women. Our results confirm the results of previous HBSC research, which found that the prevalence of subjective health complaints was particularly high in the general adolescent population; what is more, it exhibits an increasing tendency.

The relationship between ACEs and the studied symptoms

A significant relationship was found between exposure to adverse experiences and social, emotional, and behavioural symptoms, as well as subjective health complaints. Our results reveal that ACEs have a significant impact on the mental health and the subjective health of adolescents.

In addition, there is a dose-effect relationship between ACEs and social, emotional, and behavioural symptoms, where the multiple accumulation of adverse experiences results in multiple symptoms. The effect of ACEs on the prevalence of feeling low, stomachache, irritability, nervousness, sleeping difficulties, and headache is also strong and cumulative.

6. NEW SCIENTIFIC RESULTS OF THE DISSERTATION

1. We were the first in East-Central Europe to assess the prevalence of different types of adverse childhood experiences, and the prevalence of their accumulation in adolescents living with their own family and teenagers living in a special form of child protection services care.

No similar study employing the ACE test has been conducted in Europe so far, neither in adolescents living with their own family/parents, nor in teenagers under child protection services. Few international studies are available on the prevalence of ACEs among adolescents living with their biological parents, and the majority of previous research related to child protection services was aimed at the exploration of direct maltreatment. The novelty of our study lies in the fact that in addition to adversities related to direct maltreatment we also explored the prevalence of household dysfunction, and the patterning/distribution of the ACE score.

2. We examined a wide range of outcomes/consequences, and assessed not only social, emotional, and behavioural symptoms, but subjective health complaints as well.

Most studies only focus on the association of ACEs with certain symptoms; our study, however, collected data regarding a wide range of outcomes.

3. We were the first in Hungary to assess the relationship between ACEs and social, emotional, and behavioural symptoms, as well as subjective health complaints in adolescents.

Our results confirm those of previous international studies which found a dose-effect relationship between ACEs and social, emotional, and behavioural symptoms, with multiple accumulation of adverse experiences resulting in multiple symptoms. Furthermore, the effect of ACEs on the prevalence of subjective health complaints (feeling low, stomachache, irritability, nervousness, insomnia, headache) is also strong and cumulative.

4. We examined the differences in the distribution/patterning of adverse experiences between FGC adolescents and those living with their own family.

Among FCG adolescents the number of reported household dysfunctions is higher than that of reported maltreatment. This may indicate that child protection services in Hungary tend to recognise household dysfunction more easily, while instances

of direct maltreatment (abuse+neglect) of children remain hidden. On the basis of our results we can conclude that in Hungary the decision on the removal of the child from the family may be influenced by the poverty and low socioeconomic status of the family, which serve as a significant background assessment factor.

5. For future research: in the case of children taken care by child protection services, the cumulative ACE score (an integer number between 0 and 10, showing how many types of adverse experiences the individual was affected by in their childhood) may blend the rate of traumatic experiences (direct adversities – maltreatment) and environmental adversities probably resulting partly from participants’ disadvantaged situation (indirect adversities). Therefore, however useful an indicator the ACE score is, the related results must be handled with reservations in this population.

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Subject: PhD Publication List

Candidate: Beáta Kovács-Tóth
Doctoral School: Doctoral School of Health Sciences
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List of publications related to the dissertation

1. **Kovács-Tóth, B.**, Oláh, B., Papp, G., Kuritárné Szabó, I.: Assessing adverse childhood experiences, social, emotional, and behavioral symptoms, and subjective health complaints among Hungarian adolescents.
Child Adolesc Psychiatry Ment Health. 15 (1), 1-12, 2021.
DOI: <http://dx.doi.org/10.1186/s13034-021-00365-7>
IF: 3.033 (2020)
2. **Kovács-Tóth, B.**, Oláh, B., Kuritárné Szabó, I.: Can the Cumulative Adverse Childhood Experiences (ACE) Score Actually Identify the Victims of Intrafamilial Childhood Maltreatment? Findings from a Study in the Child Welfare System.
Int. J. Environ. Res. Public Health. 18 (13), 1-13, 2021.
DOI: <http://dx.doi.org/10.3390/ijerph18136886>
IF: 3.39 (2020)

List of other publications

3. Kaszás, B., Oláh, B., **Kovács-Tóth, B.**: Az izomdiszmorfia összefüggése a testképpel és a korai maladaptív sémákat kialakító szülői magatartással.
Psychiatr Hung. 36 (2), 113-123, 2021.
4. **Kovács-Tóth, B.**, Tury, F.: Traumatikus életesemények és evészavarok kapcsolata - terápiai lehetőségek.
Lege Artis Med. 30 (4-5), 191-197, 2020.
DOI: <http://dx.doi.org/10.33616/LAM.30.017>
5. **Kovács-Tóth, B.**: A részek egésze állnak össze - egy érzelmileg traumatizált gyermek fázisorientált traumaterápiája.
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6. Túry, F., **Kovács-Tóth, B.**: A traumatizáció szerepe az evészavarokban. Terápiás lehetőségek - különös tekintettel a kognitív-viselkedésterápiás módszerekre = The role of traumatization in eating disorders. The possibilities of the therapy - with special regard to the cognitive behavioral methods.
Psychiatr Hung. 34 (4), 419-425, 2019.
7. **Kovács-Tóth, B.**, Kazimir, Á.: A bizalom újraépítése: egy 8,5 éves dadogó fiú vizsgálata és terápiája.
In: Klinikai gyermekpszichológiai esettanulmányok. Szerk.: Bugán Antal, Nagy Beáta Erika, Didakt Kiadó, Debrecen, 251-288, 2008.

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