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Original Article

Lived Experience of Adverse Childhood Experiences (ACEs) Among Adolescents and Young People in Pakistan: A Qualitative Evidence Synthesis

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ABSTRACT

Background: Adverse childhood experiences (ACEs), including abuse, neglect, household violence, peer violence, community violence, and family dysfunction, are associated with poorer mental, behavioral, social, and physical health. Although an expanding quantitative literature has documented the prevalence and cumulative health burden of ACEs, fewer studies have examined how adolescents and young adults in Pakistan experience, interpret, and respond to childhood adversity. Objective: To synthesize the available qualitative evidence concerning the lived experiences and perceived consequences of childhood adversity among adolescents and young people in Pakistan and to interpret these findings within the wider Pakistani and international ACE literature. Methods: A qualitative evidence synthesis was undertaken using published Pakistan-based qualitative studies involving adolescents or young adults who described childhood adversity, emotional crises, self-harm, or related psychosocial experiences. Because the direct qualitative evidence base was limited, Pakistan-specific cross-sectional studies and international systematic reviews and meta-analyses were used to contextualize, but not generate, the qualitative themes. Findings from the included qualitative studies were compared narratively, and related concepts were grouped into higher-order interpretive themes. Quantitative findings were reported separately and were not treated as qualitative evidence. Results: Two Pakistan-based qualitative studies directly contributed to the synthesis: a phenomenological study of 10 university students with elevated ACE exposure in Lahore and an interview study involving 16 adolescents aged 12–18 years presenting with self-harm. Five overarching themes were identified: persistent physical and psychological distress; emotional dysregulation and interpersonal conflict; distrust, social withdrawal, and impaired relationships; disruption of academic and everyday functioning; and reflection, coping, and prevention. Contextual Pakistani studies reported a high burden of ACE exposure and significant associations with poor mental well-being, depression, and anxiety. International evidence similarly demonstrated that cumulative ACE exposure is common and is associated with reduced resilience, substance misuse, justice involvement, and adverse physical health outcomes. Conclusion: The limited qualitative evidence from Pakistan suggests that childhood adversity is experienced through interconnected physical, emotional, relational, and educational difficulties. Interpersonal conflict, emotional crises, distrust, impaired functioning, and limited access to effective support recur across the available accounts. The findings should be interpreted cautiously because the

evidence is based on small, geographically concentrated samples. Further direct qualitative research involving school-aged adolescents, rural communities, boys, marginalized populations, and young people outside formal education is required. Keywords: adverse childhood experiences; adolescents; young adults; qualitative evidence synthesis; self-harm; mental health; Pakistan

INTRODUCTION

Adverse childhood experiences refer to potentially traumatic or harmful events occurring during childhood and adolescence. These may include physical, emotional, or sexual abuse; neglect; exposure to domestic or community violence; bullying; family separation; household mental illness; parental substance use; and other forms of family or social instability. ACEs frequently co-occur, and cumulative exposure is associated with progressively poorer health and developmental outcomes.

A meta-analysis of 65 studies involving 490,423 children from 18 countries estimated that 14.8% had experienced four or more ACEs, with higher exposure among adolescents and children involved in residential care or juvenile offending (1). A separate meta-analysis of 206 studies involving 546,458 adults found that 16.1% had experienced four or more ACEs, with substantially higher prevalence among people with mental health conditions, substance-use problems, and socioeconomic disadvantage (2). A systematic review of community studies using the Adverse Childhood Experiences International Questionnaire similarly reported that approximately three-quarters of participants had experienced at least one ACE, with emotional abuse and bullying among the most commonly identified exposures (3).

Emerging evidence indicates that ACE exposure is also highly prevalent among Pakistani young adults. Mahmood and Fatmi studied 454 college students aged 18–25 years in Rawalpindi and reported that 98% had experienced at least one ACE and 82.4% had experienced three or more. Community violence, peer violence, and household violence were particularly frequent, while exposure to six or more ACEs was associated with 3.39 times higher odds of poor mental well-being (4). Fazal et al. studied 388 university students aged 19–25 years in Islamabad and Rawalpindi and found that 74.7% reported ACE scores between one and three, while 24.7% reported scores between four and six. ACE exposure was significantly associated with depression and anxiety (5).

These findings indicate a substantial burden of childhood adversity, but quantitative measures alone cannot explain how young people understand these experiences, how adversity affects their relationships and everyday functioning, or how they attempt to cope. Liaqat et al. characterized ACEs as a hidden threat in Pakistan and emphasized the need for stronger, locally grounded research (6). Qualitative research is therefore essential because it can illuminate meanings, emotional responses, interpersonal dynamics, and perceived pathways between childhood adversity and later health. The available Pakistan-based qualitative evidence remains limited. Fatima et al. conducted a phenomenological study involving university students in Lahore and identified chronic health struggles, mental health disorders, emotional and social difficulties, distrust, and academic underperformance (7). Naz et al. examined the lived experiences of adolescents presenting with self-harm and identified interpersonal conflict, emotional crises, regret, perceived consequences, and prevention-related perspectives (8). Although the self-harm study did not exclusively investigate ACEs, its findings are relevant because it examined emotional and relational experiences commonly associated with childhood adversity.

The purpose of this review was to synthesize the qualitative evidence concerning childhood adversity among Pakistani adolescents and young adults and to place these findings within the broader Pakistani and international literature. The review focused on lived experiences and perceived effects rather than prevalence estimation or causal inference.

The review aimed to examine how adolescents and young adults in Pakistan described the physical and psychological consequences of childhood adversity, how these experiences affected emotional regulation, relationships, education, and daily functioning, and which interpersonal and contextual

factors contributed to crisis, self-harm, or impaired well-being. It also sought to explore young people's perspectives on coping, recovery, and prevention and to identify the principal gaps in Pakistan's qualitative evidence base on adverse childhood experiences.

MATERIAL AND METHODS

Design

This study was conducted as a qualitative evidence synthesis with contextual narrative integration. Pakistan-based qualitative studies provided the primary evidence from which the synthesized themes were generated. Pakistan-based quantitative studies, international systematic reviews, meta-analyses, and large observational studies were used only to contextualize the qualitative findings and demonstrate how the emerging themes corresponded with the wider evidence base. The review was not designed as a prevalence review or meta-analysis. Quantitative estimates were not pooled, and statistical findings were not used to generate or determine the qualitative themes.

Eligibility Criteria

Studies were considered directly eligible for the qualitative synthesis when they were conducted in Pakistan; included adolescents or young adults; used interviews, phenomenology, thematic analysis, or another recognizable qualitative approach; examined childhood adversity, psychosocial crisis, self-harm, emotional distress, or related lived experiences; and reported sufficiently detailed themes or participant accounts. Pakistan-based quantitative studies were included as contextual evidence when they examined the prevalence of ACEs or their associations with mental health among adolescents or young adults. International systematic reviews, meta-analyses, and large observational studies were selectively included when they provided relevant comparative evidence concerning ACE prevalence, resilience, substance use, justice involvement, family adversity, or physical health consequences.

Studies reporting quantitative data alone were not used to generate qualitative themes. Studies were also excluded from the thematic synthesis when they did not include Pakistani participants, did not address childhood adversity or closely related psychosocial experiences, or focused on unrelated chronic health conditions without a clear conceptual connection to ACEs.

Evidence Identification

The synthesis drew on studies and bibliographic information available to the authors. The final manuscript should report the databases searched, search dates, complete search strings, duplicate-removal procedure, and study-screening process. A representative search strategy combined terms relating to childhood adversity, qualitative research, age group, and geographical setting: ("adverse childhood experiences" OR childhood adversity OR child abuse OR child maltreatment OR neglect OR violence OR self-harm) AND (qualitative OR interview OR phenomenology OR lived experience OR thematic) AND (adolescent OR youth OR young adult) AND (Pakistan OR Pakistani). Reference lists of relevant primary studies and reviews were also examined to identify additional potentially eligible publications.

Data Extraction

Data were extracted from the included studies using a structured approach. Extracted information included the author and year of publication, study setting, participant age and sample size, study design, data-collection method, principal findings or themes, relevance to ACEs, contribution to the qualitative synthesis, and reported methodological limitations. Information from quantitative and international studies was extracted separately and used only to provide epidemiological or comparative context.

Synthesis Approach

The findings of the Pakistan-based qualitative studies were read repeatedly and compared iteratively. Author-reported themes, interpretations, and participant experiences were examined for conceptual similarities and differences. Related concepts were grouped into preliminary categories, which were subsequently refined into higher-order themes representing recurring patterns across the included studies. The synthesis explicitly distinguished among direct qualitative evidence, contextual quantitative evidence from Pakistan, and international comparative evidence. Themes were neither counted nor ranked according to frequency and should not be interpreted as prevalence estimates. Findings originating from a single small or context-specific sample were identified as such and were not generalized to all adolescents or young adults in Pakistan.

RESULTS

Participants in the Lahore phenomenological study described chronic physical and psychological difficulties that they associated with childhood adversity. These included headaches, migraine, gastric complaints, altered eating patterns, recurrent illness, depression, anxiety, emptiness, and persistent sadness (7).

These accounts demonstrate that adversity may be experienced simultaneously through physical symptoms and emotional distress. Somatic complaints may be especially important in settings where mental health terminology is less familiar or where direct disclosure of psychological suffering is stigmatized. However, the qualitative findings cannot establish that ACE exposure medically caused the reported physical conditions. They represent participants' interpretations of the relationship between earlier adversity and later health.

The adolescents interviewed by Naz et al. also described emotional crises preceding self-harm, indicating that distress may intensify when interpersonal difficulties, hopelessness, and limited coping resources converge (8). Self-harm should not be considered an inevitable consequence of ACE exposure, but it may emerge as a maladaptive response among some adolescents experiencing acute emotional dysregulation or relational distress.

Table 1. Pakistan-Based Studies Contributing to the Review

Study	Setting and sample	Design	Principal findings	Role in review
Mahmood and Fatmi, 2025 (4)	454 college students aged 18–25 years, Rawalpindi	Cross-sectional quantitative	98% experienced at least one ACE; 82.4% experienced at least three; community violence 88%, peer violence 83%, household violence 73%; six or more ACEs associated with 3.39 times higher odds of poor mental well-being	Contextual evidence only
Fazal et al., 2022 (5)	388 university students aged 19–25 years, Islamabad and Rawalpindi	Cross-sectional quantitative	74.7% had ACE scores of 1–3 and 24.7% had scores of 4–6; significant associations with depression and anxiety	Contextual evidence only
Fatima et al., 2024 (7)	10 university students with elevated ACE scores, Lahore	Qualitative phenomenological study	Chronic health struggles, mental health disorders, emotional and social difficulties, paranoia or distrust, and academic underperformance	Core qualitative evidence
Naz et al., 2021 (8)	16 adolescents aged 12–18 years presenting with self-harm	Qualitative interviews	Interpersonal conflict and emotional crises as predisposing factors; regret and realization, perceived impact, and prevention strategies	Core qualitative evidence related to crisis and adversity

The direct qualitative evidence was concentrated in Lahore and in a clinical sample of adolescents presenting with self-harm. Neither study can be considered nationally representative. The quantitative studies nevertheless demonstrate that the qualitative accounts arose within a wider context of high ACE exposure and significant mental health burden among Pakistani young adults (4,5).

Qualitative Synthesis

Table 2. Synthesized Themes From the Pakistan-Based Qualitative Evidence

Synthesized theme	Description	Contributing evidence
Persistent physical and psychological distress	Longstanding somatic complaints, depression, anxiety, emptiness, hopelessness, and emotional crisis	Fatima et al. (7); Naz et al. (8)
Emotional dysregulation and interpersonal conflict	Difficulty regulating emotions, conflict with family or others, anger, fear, and acute crisis preceding self-harm	Fatima et al. (7); Naz et al. (8)
Distrust, social withdrawal, and impaired relationships	Fear of authority, difficulty trusting others, relational insecurity, social isolation, and impaired communication	Fatima et al. (7)
Disruption of academic and everyday functioning	Reduced concentration, inability to participate confidently, perceived underachievement, and impaired daily functioning	Fatima et al. (7); supported contextually by Mahmood and Fatmi (4) and Fazal et al. (5)
Reflection, coping, and prevention	Regret, realization of consequences, attempts to make sense of crisis, and views regarding prevention and support	Naz et al. (8)

Pakistan-based quantitative findings support the broader relevance of these experiences. Mahmood and Fatmi reported substantially poorer mental well-being among young adults with high cumulative ACE exposure, while Fazal et al. identified significant associations between ACE scores, depression, and anxiety (4,5).

Emotional Dysregulation and Interpersonal Conflict

Emotional and social difficulties were central to both qualitative studies. Participants described problems managing fear, anger, sadness, and interpersonal tension (7,8). In the self-harm study, interpersonal conflict and emotional crises were identified as important predisposing factors (8).

These findings suggest that adversity may affect both internal emotional regulation and the ability to manage conflict within relationships. Young people may experience intense reactions, difficulty communicating distress, or a sense of being overwhelmed when support is unavailable or when relationships themselves are the source of harm.

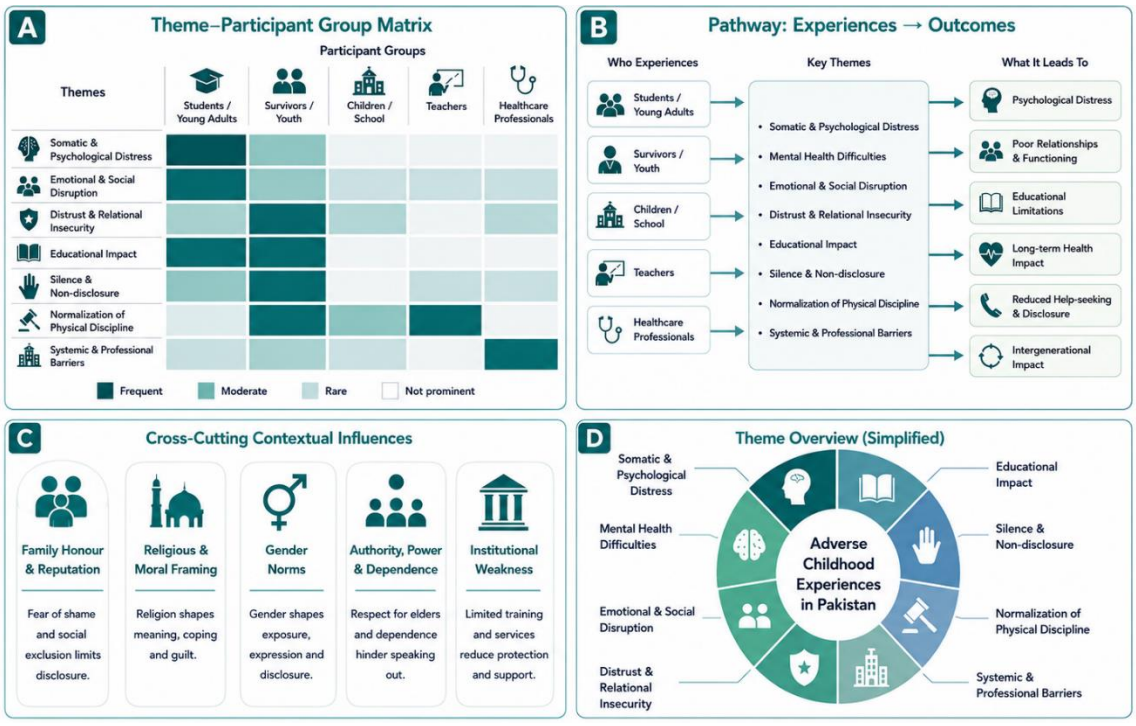

Figure 1 summarizes the thematic synthesis of adverse childhood experiences in Pakistan by mapping key themes across participant groups, illustrating pathways from lived experiences to psychological, relational, educational, and long-term outcomes, and highlighting cross-cutting influences such as family honour, religious and moral framing, gender norms, authority, dependence, and institutional weaknesses.

The available studies do not establish a single pathway from childhood adversity to self-harm or emotional instability. Family conflict, peer difficulties, psychiatric symptoms, social stress, and individual coping capacities may interact. The synthesis therefore supports an ecological interpretation in which psychological crisis develops through the interaction of individual vulnerability and stressful interpersonal environments.

Distrust, Social Withdrawal, and Impaired Relationships

Fatima et al. reported that participants experienced distrust, relational insecurity, social withdrawal, and difficulty communicating with authority figures (7). Some participants described fear when interacting with teachers or individuals in positions of power, while others expected that close relationships would reproduce earlier conflict or instability.

These findings may reflect hypervigilance or learned expectations of threat. The term “paranoia” should be used cautiously unless a formal clinical assessment was conducted. In a qualitative synthesis, the experiences are more accurately described as distrust, relational insecurity, and heightened sensitivity to potential rejection or harm.

Relational insecurity may also reduce help-seeking. A young person who expects blame, disbelief, punishment, or rejection may avoid disclosing distress even when support is urgently required. The current evidence does not adequately examine disclosure pathways, family responses, or the role of trusted adults, representing an important area for future research.

Disruption of Academic and Everyday Functioning

Participants in the Lahore study connected childhood adversity with reduced concentration, fear of speaking in class, difficulty communicating with teachers, and a sense of having underachieved academically (7). These experiences suggest that ACE-related distress may interfere with attention, confidence, classroom engagement, and educational progression.

The findings are consistent with the broader Pakistani quantitative evidence showing associations between cumulative adversity and poor mental well-being, depression, and anxiety (4,5). However, the available studies do not establish that ACEs alone caused academic underperformance. Educational outcomes may also be affected by poverty, school quality, family expectations, learning difficulties, physical illness, and other environmental factors.

The theme is therefore best understood as participants’ perceived disruption of functioning rather than as a quantified causal effect.

Reflection, Coping, and Prevention

Naz et al. identified regret and realization, perceived consequences, and prevention strategies among adolescents who had engaged in self-harm (8). These findings are important because they demonstrate that participants were not defined solely by crisis. They reflected on their experiences, recognized consequences, and articulated views about how similar episodes might be prevented.

This theme points toward the importance of early emotional support, non-judgmental communication, accessible counseling, and trusted relationships. It also suggests that prevention strategies should include young people’s own perspectives rather than relying only on adult assumptions.

The current Pakistan-based qualitative evidence provides limited information regarding resilience, adaptive coping, peer support, spirituality, family protection, or successful recovery. Future studies should examine not only adversity and impairment but also how young people create safety, maintain hope, and develop effective coping strategies.

Contextual Evidence From Pakistan and Comparable Settings

The high ACE prevalence reported among Pakistani university and college students indicates that the experiences described qualitatively are situated within a wider burden of childhood violence and adversity (4,5). Mahmood and Fatmi found particularly high exposure to community, peer, and household violence, demonstrating that ACE frameworks in Pakistan may need to extend beyond the traditional household-focused categories developed in earlier Western research (4).

Comparable evidence from South Asia also indicates a substantial burden. Dar et al. reported an ACE prevalence of 88.2% among 800 university students in Kashmir, with verbal abuse, threats, and physical violence among the most frequently reported experiences (9). Fernandes et al. studied 9,010 young people in India and found that approximately half reported child maltreatment and family ACEs. Family and collective ACEs were strongly associated with substance misuse (10).

These studies support the relevance of family, peer, community, and collective adversity in South Asian contexts. They also caution against treating ACE exposure as a uniform household phenomenon. Political conflict, community violence, socioeconomic insecurity, educational pressure, and neighborhood conditions may contribute substantially to young people's cumulative adversity.

Comparison With International Evidence

Table 3. International Evidence Relevant to the Synthesized Themes

Evidence area	Study	Main finding	Relevance to current synthesis
Global ACE prevalence in children	Madigan et al., 2024 (1)	14.8% experienced four or more ACEs; exposure higher among adolescents and high-risk groups	Supports the importance of adolescence and cumulative exposure
Global ACE prevalence in adults	Madigan et al., 2023 (2)	16.1% experienced four or more ACEs; prevalence higher in mental health and substance-use populations	Supports links between ACE burden and later psychological vulnerability
Community ACE measurement	Pace et al., 2022 (3)	Approximately 75% reported ACEs; emotional abuse and bullying were prominent	Supports broad inclusion of interpersonal and peer adversity
Justice-involved youth	Malvaso et al., 2021 (11)	87% experienced at least one traumatic event; markedly higher exposure than comparison youth	Demonstrates concentration of adversity in high-risk populations
Children of parents who use substances	Muir et al., 2022 (12)	Themes included unpredictability, emotional impact, creating safety, coping, and support	Provides a comparative qualitative account of coping and self-protection
Resilience	Morgan et al., 2021 (13)	ACE exposure was negatively associated with resilience	Supports attention to coping resources and protective factors
Substance use	Rogers et al., 2022 (14); Sebalo et al., 2023 (15)	Multiple ACEs consistently associated with alcohol, cannabis, and other drug use	Demonstrates behavioral pathways that require investigation in Pakistan
Cancer risk	Hu et al., 2021 (16)	Two to three ACEs and four or more ACEs were associated with progressively higher cancer risk	Illustrates potential long-term physical health burden
Pelvic pain and dysmenorrhea	Moussaoui and Grover, 2022 (17)	ACE number and severity were associated with dysmenorrhea and pelvic pain conditions	Supports possible links between adversity and later somatic health
Harmful sexual behavior	Faure-Walker and Hunt, 2022 (18)	Trauma and sexual victimization were common among affected children and adolescents	Highlights the complexity of trauma-related behavioral outcomes
Sibling experiences	Donagh et al., 2022 (19)	Adversity affecting one sibling often affected others; older siblings could provide protection	Supports family-level rather than exclusively individual analysis

The international evidence broadly supports the physical, emotional, relational, and behavioral consequences identified in the Pakistan-based qualitative studies. However, the international literature also illustrates the importance of protective processes, family dynamics, substance use, justice involvement, and long-term physical health, which remain poorly examined in Pakistani qualitative research.

Cumulative Exposure and Mental Health

The global meta-analytic evidence demonstrates that multiple ACEs are common and are concentrated among populations experiencing mental illness, substance misuse, socioeconomic disadvantage, or institutional involvement (1,2). This corresponds with Pakistani findings linking higher cumulative ACE scores to poor mental well-being, depression, and anxiety (4,5).

The evidence supports a cumulative-risk interpretation but does not imply that every exposed young person will develop psychopathology. Outcomes are shaped by the type, timing, severity, duration, and social context of adversity, as well as by protective relationships and access to support.

Coping and Resilience

Morgan et al. reported a negative association between ACE exposure and psychological resilience, suggesting that cumulative adversity may reduce young people's capacity to adapt effectively (13). Muir et al., however, demonstrated that children living with parental substance use actively attempted to create safety, resist disruption, and seek support despite highly unpredictable circumstances (12).

The Pakistan-based literature has focused more heavily on impairment than on adaptation. Future qualitative work should examine how young people use peer relationships, siblings, education, faith, creativity, sport, counseling, or other resources to protect themselves and recover.

Substance Use and Other Behavioral Outcomes

Systematic reviews have consistently associated multiple ACEs with alcohol, cannabis, and other substance use among young adults (14,15). Fernandes et al. similarly identified strong associations between family and collective ACEs and substance misuse in Indian young people (10).

These outcomes have not been adequately explored within Pakistan's qualitative ACE literature. Given the high prevalence of cumulative adversity reported among Pakistani students, research should examine whether substance use functions as avoidance, emotional regulation, peer conformity, or self-medication.

Family and Sibling Context

Donagh et al. demonstrated that adversity is often shared within families and that older siblings may attempt to protect younger children (19). This perspective is important because ACE research frequently treats exposure as an individual characteristic even when adversity arises from household-level conditions.

Pakistani family systems may include siblings, grandparents, and extended relatives who can function as either sources of stress or sources of protection. Direct qualitative investigation of these relational roles is needed.

Long-Term Physical Health

Meta-analytic evidence has associated cumulative ACE exposure with increased cancer risk and with dysmenorrhea, pelvic pain, and dyspareunia among adolescents and young adults (16,17). These findings provide international support for the somatic difficulties described by participants in the Lahore study (7).

Nevertheless, the Pakistani qualitative findings should not be interpreted as evidence of specific disease causation. They indicate subjective experiences of physical distress and perceived connections with childhood adversity.

Implications for Practice and Policy

Mental health assessment should consider the possibility that adolescents and young adults presenting with depression, anxiety, self-harm, recurrent physical complaints, social withdrawal, or academic

decline may have experienced childhood adversity. Assessment should be conducted privately, non-judgmentally, and in a developmentally appropriate and trauma-informed manner, with particular attention to immediate safety and the availability of clear referral options. Clinicians should avoid coercive questioning and should explain the limits of confidentiality, especially when there is an immediate risk of harm to the young person or others.

The findings of Naz et al. indicated that interpersonal conflict and emotional crisis may precede self-harm among some Pakistani adolescents (8). Prevention strategies should therefore emphasize early identification of emotional distress, access to counseling, family- and school-based conflict support, crisis-response pathways, appropriate restriction of access to means, and structured follow-up after an episode of self-harm. Adolescents' own views regarding prevention should also be incorporated into service design. Self-harm should not be dismissed as attention-seeking behavior but should be recognized as a marker of substantial psychological distress requiring careful and timely assessment.

Universities, colleges, and schools should establish confidential counseling and referral systems and train staff to recognize significant changes in attendance, concentration, participation, academic performance, behavior, and social engagement. Support should not be restricted to students who formally disclose abuse, because many young people may initially present with anxiety, somatic complaints, withdrawal, emotional dysregulation, or academic difficulty. Educational institutions should therefore adopt proactive, student-centered approaches that facilitate early identification and referral without stigmatization.

The high prevalence of community, peer, and household violence reported by Mahmood and Fatmi suggests that ACE prevention in Pakistan must extend beyond the family environment (4). Policy responses should address bullying and peer aggression, community violence, domestic and household violence, unsafe educational environments, online harassment, gender-based violence, and the broader social conditions that repeatedly expose young people to threat. Prevention strategies should therefore be multisectoral and should involve educational institutions, healthcare services, social welfare agencies, community organizations, and legal and child-protection structures.

Screening alone is unlikely to improve outcomes when appropriate support services are unavailable. Healthcare and educational institutions should therefore develop coordinated referral networks linking mental health professionals, social welfare services, child-protection authorities, emergency services, and legal assistance. These pathways should clearly define professional responsibilities, referral thresholds, documentation procedures, and follow-up arrangements so that identification of adversity is accompanied by meaningful protection and care.

Research Priorities

Future research in Pakistan should prioritize direct qualitative engagement with currently school-aged adolescents and should include rural and underserved communities, provinces and regions beyond the major cities of Punjab, boys and male survivors of abuse, children with disabilities, out-of-school and working children, street-connected, displaced, and institutionalized young people, and minority and marginalized populations. Greater attention should also be given to sibling and extended-family experiences, resilience and successful coping, substance-use pathways, disclosure and help-seeking, longitudinal consequences, and the evaluation of culturally adapted interventions.

Researchers should report sampling and recruitment procedures, researcher characteristics and reflexivity, interview language, translation processes, coding methods, ethical safeguards, and procedures for responding to participant distress or disclosure. Greater methodological transparency would strengthen confidence in the findings and improve comparability across future studies.

Strengths and Limitations

This review integrates the limited qualitative evidence concerning childhood adversity among Pakistani adolescents and young adults and interprets it alongside national, regional, and international research. A particular strength is the explicit separation of theme-generating qualitative evidence from contextual quantitative findings, thereby reducing methodological conflation and preserving the interpretive basis of the synthesis.

The principal limitation is the small qualitative evidence base. Only two Pakistan-based studies directly contributed to the thematic synthesis, and one focused on adolescents presenting with self-harm rather than ACE exposure specifically. The samples were small, geographically restricted, and drawn from specific educational or clinical contexts; consequently, the findings cannot be generalized to all adolescents and young adults in Pakistan.

The review also relied on published study-level findings rather than original interview transcripts. The synthesis was therefore influenced by the themes, quotations, and interpretations selected by the authors of the original studies. In addition, a formal assessment of confidence in each synthesized finding could not be undertaken from the available information.

Several Pakistan-based quantitative studies and international reviews were included to provide context and strengthen interpretation. However, these sources do not compensate for the shortage of direct qualitative evidence from Pakistan. The conclusions should therefore be regarded as provisional and as a foundation for more comprehensive, geographically diverse, and methodologically rigorous research.

CONCLUSION

The available qualitative evidence suggests that childhood adversity among Pakistani adolescents and young adults is experienced through persistent physical and psychological distress, emotional dysregulation, interpersonal conflict, distrust, social withdrawal, impaired relationships, and disruption of academic and everyday functioning. Adolescents experiencing self-harm also described regret, recognition of consequences, and views regarding prevention.

These findings are consistent with Pakistan-based quantitative studies documenting high ACE exposure and associations with poor mental well-being, depression, and anxiety. They also correspond with international evidence linking cumulative childhood adversity to reduced resilience, substance misuse, justice involvement, and adverse physical health outcomes.

The conclusions must remain cautious because the qualitative evidence is limited to small and geographically concentrated samples. The current literature does not adequately represent school-aged adolescents across Pakistan, rural communities, boys, marginalized populations, or young people outside formal education.

A stronger national evidence base will require ethically rigorous qualitative research that examines not only harm and dysfunction but also disclosure, coping, resilience, family protection, and recovery. Clinical and policy responses should provide trauma-informed mental health support, self-harm prevention, safer educational environments, violence-prevention strategies, and functioning referral pathways for young people experiencing adversity.

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