Title: Opening the time capsule of ACEs: reflections on how we conceptualise children’s experiences of adversity and the issue of temporality

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Abstract

In this paper we engage with some of the fundamental concepts underpinning the original Adverse Childhood Experiences (ACE) study and subsequent work, while recognising that the terminology of ACEs has, in some ways become reductionist and problematic. Although an imperfect concept covering a range of childhood adversities at a personal, intra-personal and community level, ACEs have utility in bridging scientific and lay communities. The evidence clearly identifies that ‘numbers matter’ and that whereas children may be able to cope with a little adversity over a short period of time when they have good support networks, too much adversity over too long a time period, even with good support, will be problematic for the child and their family. Alongside exploring the cumulative impact of adversity, social workers and other professionals need to engage with the temporal component of when adversity is experienced, and for how long, together with the consequences for helping services in deciding when to intervene and for what period of time. This opens the discussion of who is best placed to support children and families experiencing certain types of adversity, and how we think about structural issues such as poverty and community violence within the ACEs discourse.

Keywords: ACEs; adversity; child welfare; lifecourse

Introduction

In our previous paper (Spratt et al., 2019) we presented a history of the development of Adverse Childhood Experiences (ACEs) research, outlining its uptake by researchers and identifying its influence on social policy development across the UK nations, with particular reference to child and family policy. In this paper we seek to develop our engagement with this literature, including critiques, looking specifically at the issue of ‘time’ as a central and core concept within both the research and subsequent professional and methodological debates, as well as the construction of the concept of adversity in childhood.
As noted by Kelly-Irving and Delpierre (2019), there has been a burgeoning of the scientific, policy and practice literature in relation to ACEs, emanating from the publication of a short and seminal paper in the American Journal of Preventive Medicine by Vincent Felitti and colleagues (1998). The ACE study is not the only, nor the first study to seek to explore either the impact of childhood adversity in both the immediate and longer term, nor the cumulative impact of different types of adversity over time (for example, see Rutter, 1980; Finkelhor, 1995; Davidson et al., 2010). However, it did seem to act as a catalyst for lobbying and action for two distinct groups. The first were those for whom this was already their frame of reference, and therefore felt empowered by the scientific support. The second group were those for whom this offered a new paradigm to conceptualise children’s experiences and later adult outcomes, thereby helping to shape their thinking and practice. Within this latter group, as Finkelhor (2017, p.1) notes, there was considerable interest in Felitti et al.’s paper (1998) amongst the professional community. In part, this was because professionals felt that the conclusions drawn by Felitti and colleagues affirmed their own practice experience, namely that children they frequently had contact with had experienced significant adversity, and that this adversity had the potential to impact negatively on their childhood and life chances.

These developments coincided with advances in neuroscience, and the development of a number of theories about the factors and processes both promoting and impeding brain development, particularly in children (Shonkoff et al., 2012). During the 1990s, the National Institutes of Health in the United States of America invested significant resources into understanding both normal and pathologic neuronal development and function, in what was to become known as the “Decade of the Brain” (Goldstein, 1994). One such stream of work sought to explore the ‘nature v nurture’ debate as to the factors most likely to influence who we are, and what we become. Although genetic variability had been shown to play a role in how we all respond to stress, there was a growing debate about the potential impact of early life experiences and environmental influences. The publication of data from the ACE study, and subsequent debates have been helped by an increasing focus within public health of the impact of social factors on longer term physical and mental health (for example, Hardcastle and Bellis, 2019).
Some authors have rightly expressed caution about this ‘new’ science, expressing concern that “there is a clear focus on reproduction and maternal behaviours, paralleled by a pervasive lack of explicit reference to the alleviation of poverty and social disadvantage” (White and Wastell, 2017). There is also a growing, but as yet, inconclusive evidence base about the actual development of the brain and biological pathways and developmental mechanisms (Steptoe et al., 2019) to rush headlong into new ways of working with individuals and groups (for example, manualised programmes), at the expense of doing other things (for example, poverty alleviation). The ACEs literature and the subsequent ways in which the knowledge from the ACEs research has been adopted and utilised has garnered critiques which we have summarised and addressed elsewhere (Spratt et al., 2019). In short, they centre upon the limited way in which adversity is conceptualised within the original ACE study, and the ways in which the findings from the study have been used, for example: not including a broader range of adversities, such as a child’s illness or disability; neglecting structural issues such as poverty and community violence; the adoption of the research questionnaire as a screening tool by practitioners, which is not what it was designed for; the lack of a more detailed and nuanced understanding about the pathway from the experience of or exposure to an adversity and any later outcome (whether negative or positive); and the deterministic nature of debates about ACEs, resulting in the potential for homogenisation of how we think about children’s individual experiences and life pathways. While it is right to be cautious about how we interpret and apply the findings from any research, especially in fields of enquiry where there are large gaps in our knowledge and understanding, it is equally important that our caution and critique do not become so critical and dismissive that we shut down lines of useful study and exploration, in a war of the paradigms.

In this paper we are keen to engage with some of the fundamental concepts that underpin both the original ACE study and subsequent work, while also recognising that the terminology of ACEs has, in some ways become reductionist (McLaughlin, 2016). We start from the position that adversity is a proxy concept for the description of a range of experiences and conditions that have been found to increase probability of undesired outcomes. As such, it is an imperfect concept, constructed as something of a ‘catch-all’, but with utility for use in both scientific and lay
communities, and providing a conceptual bridge between them. While there may be some agreement that children’s exposure to and experience of particular issues is generally felt to be problematic (for example, pre-pubescent children’s engagement in sexual activity), the evidence for the long term consequences of particular forms of adversity is less than straightforward (see Davidson et al., 2010). We do believe, though, that children can be negatively impacted by structural issues in society (such as living in poverty, or with community violence), the personal characteristics of the child (such as having a significant illness or disability), the behaviours of others towards them (such as bullying, maltreatment or racism), and the consequences of wider family issues (such as parental imprisonment, domestic violence or problematic substance use). There is a strong evidence base of high quality qualitative and quantitative research which attests to this (for example, Bunting et al., 2017; Rosen et al., 2018; Steketee et al., 2019). We are also convinced by the evidence that the more adversity which children experience, both in terms of the number of discrete adversities, and the length of time they experience any of these adversities for, increases the likelihood of children being impacted and of these impacts persisting into the future. However, we need to be cautious about assuming that all children’s experiences are uniform, that children will automatically be negatively impacted by an adversity, and that poorer outcomes as adults are solely, or mainly attributable to childhood experiences (Frederick and Goddard, 2007; Steptoe et al., 2019). We therefore would like to differentiate between the ACE study – which is one piece of very useful research – and the wider literature on adversity in childhood, which incorporates and addresses many of the critiques about the limitations of the original ACE study.

One of the critiques of the ACEs literature focuses on the (over) reliance on retrospective reports of adults about their experiences in childhood, on a limited range of issues, typically collected using the original ACE study questionnaire (Kelly-Irving and Delpierre, 2019; White et al., 2019). There is, however, a wide range of other data that supports the conclusions that many children experience a range of adversities in childhood, and that experiencing one adversity usually increases the likelihood of experiencing multiple issues (e.g. Cicchetti and Toth, 2005; Finkelhor, Ormrod and Turner, 2007; Radford et al., 2011). Using the Growing Up in Scotland longitudinal dataset, Marryat and Frank (2019) set out to determine the prevalence of
ACEs at age 8 in a recent prospective birth cohort, and to examine associations between risk factors in the first year and cumulative ACEs, alongside the collection of a significant amount of information about both the child’s living circumstances, well-being and development over time. The children were born in Scotland in 2004/5 and were identified using Child Benefit Records and followed up for 7 years (n=3119). ACE scores and sample characteristics were calculated and described. Logistic regression models were fitted to explore associations between risk factors (sex, mother’s age and education, household income, area level deprivation and urban/rural indicator) and ACE scores. Around two-thirds of children had experienced one or more ACEs, with 10% experiencing three or more in their lifetime. Higher ACE scores were associated with being male, having a young mother, low income and living in urban areas. In one way these findings confirm what we know from the pre-existing ACEs research, but also the much wider and longer standing research on child well-being – that the majority of children will face some sort of adversity during childhood, and that some children experience a range of adversities, and that this experience of multiple adversities increases the potential for later social and health difficulties (Hughes et al., 2017). Yet, we also know not all of these children will necessarily go on to experience longer-term difficulties, and we have an incomplete understanding of how protective and resilience factors influence whether an individual child will have negative outcomes in later life (Steptoe et al., 2019).

**Trauma and Resilience**

The debates about the ACE study have been supplemented by parallel discussion about trauma and resilience within the wider literature on children’s experiences of adversity, how they are impacted and how they cope. Psychological trauma is defined as the unique individual experience of an event or enduring condition in which the individual’s ability to integrate his/her emotional experience is overwhelmed; or the individual experiences (subjectively) a threat to life, bodily integrity or sanity (Pearlman and Saakvitne, 1995). As van der Kolk (2017) notes, the field of traumatic stress has started to use the term “complex trauma” to describe the experience of multiple, chronic and prolonged, developmentally adverse traumatic
events, most often of an interpersonal nature (e.g. physical or sexual abuse abuse, war, community violence) with an onset during early life. However, within the ACE field there has been a growing conflation of the concept of trauma with the concept of adversity. This is drawn from a broader literature that recognises that children’s well-being can be affected by a range of factors that are often referred to as adversities. Some of these can be experienced as traumatic, but others are more chronic and pernicious, such as poverty, or being a young carer, which may include positive as well as negative aspects (McGibbon et al., 2019). As such, there is a need to be cautious about conflating our understandings about adversity and trauma, and our desire to do something about this. Some adversities may be traumatic, and some may go on to result in trauma – but not all adversities can be seen as traumatic, although that does not mean they may not have consequences.

As much as we focus on adversity and its negative impact, we also need to be looking at the issue of why so many individuals who report high ACE scores appear to be coping and getting on with life. What is different about them and/or their situation that results in such radically different life trajectories? In reality, this appears to be the majority of the population. While it may be explained in part by acknowledging that the literature relating to adversity, and in particular ACEs, focuses on the increased risk of specific negative outcomes, this is not the case for most people who have experienced these forms of adversity. For example, in Huang et al.’s (2015) study on type 2 diabetes, comparing participants without the ACEs under study, persons who reported an exposure of ACEs had a 32% increased risk of developing type 2 diabetes later in life. Moreover, there were notable differences in the effects associated with various specific ACEs, being neglected having the strongest effect and physical abuse the least. This highlights the elevated risk of developing type 2 diabetes, but not its inevitably. We know that not all individuals experience the same event in the same way. We all live in different contexts, are able to call upon particular personal qualities, together with a range of external supports which can help us navigate the challenges we face in life, although this does change with time and growing independence. We could, though, map potential interventions against whether they are seeking to mitigate the negative impact of an adversity (for example, providing families in poverty with greater welfare benefits for each child they have), compensate for the impact of the adversity (for example,
ensuring that children with a parent in prison are supported to maintain a relationship), or remediate for the negative impact of an adversity (for example, ensuring that children who experience domestic violence all receive individual counselling).

One of the consistent findings from the research based on the original ACE study is that the most significant predictor of negative outcomes arising from the experience of adversity in childhood is that ‘numbers matter’ (Spratt, 2012). That is, the greater the number of adversities experienced the greater the likelihood of developing poor physical and mental health, coming into conflict with the law, and experiencing less stable and less well paid employment. This is sometimes referred to as polyvictimisation (for example, Finkelhor et al., 2007; Dierkhising et al., 2019) or cumulative harm (for example, Bryce 2018; Sheehan, 2019), although often authors are referring to forms of adversity which are about maltreatment or poor parenting, rather than the wider range of adversities that many children experience.

**Temporality**

What is less well understood is whether this experience of multiple adverse childhood experiences has a temporal component aside from the ability to observe these negative outcomes at a future time point. Current work on this area is largely concerned with investigations that seek to go beyond the ‘dose effect’. If we know that more adverse experiences increase the probability of poor outcomes, we also need to better understand how the timing of such experiences may impact the severity of the outcome. Much of the neurological research in this area has, for example, concentrated on the idea that ACEs may have greater impact if experienced during developmentally sensitive periods, with evidence emerging that this is so (Pechtel et al., 2014). For example, more severe symptoms in adults have been reported for those exposed to ACEs between the ages of 3 and 5 years (Kaplow and Widom, 2007). Schalinski and colleagues (2016) acknowledge that while we are beginning to understand something of timing effects, there nevertheless is further work required to more fully appreciate timing associations and effects:

> While current results suggest vulnerable time windows particularly for sexual abuse, loss of a parent and traumatic experiences, understanding whether
this sensitivity is type and time-specific in their interaction with the vulnerability to mental illness requires a more comprehensive assessment of the various ACE in fine-grained developmental periods. (p.2).

As such, research by Merrick et al. (2020) demonstrates the ways in which different childhood experiences, both adverse and positive, may confer unique pathways to risk and resilience through adulthood. Looking at three distinct phases of childhood, early (0-5yrs), middle (6-12 yrs) and later (13-18yrs), experiences that began earlier were more predictive of later poor outcomes than experiences that began later in childhood.

We also need to explore whether the outcomes for children are different if they experience adversities for longer periods of time compared to other children; in parallel rather than in sequence; and whether there is a relationship between the particular nature of the experience and the type of outcome. With regard to the latter, there is evidence that proximal exposures (direct experiences of abuse rather than secondary exposure to family dysfunction) are associated with greater susceptibility to poor mental health across the life-course (Lindert et al., 2014).

Whilst progress is being made with regard to the effects of timing in relation to the age of the child and the particular adversities experienced, we cannot say the same with regard to the timing of interventions and their nature, aside from the default policy and practice position that early is better than late, and preventative is preferable to ameliorative. However, we do not, as yet, have a robust understanding of whether particular negative outcomes are less likely dependent on how quickly support and therapeutic services are provided to the child, and their family; and whether there is a relationship between the length of time that children are exposed to adversity, and the length of time that services are required to be involved with the child and family. This poses particular challenges for policy makers, who rightly view ACEs as a public health issue, but lack a fully evidenced suite of intervention measures, and for service providers, who may be tempted to rebrand their current services as ‘ACE aware’ or ‘trauma informed’ whilst lacking commensurate measures for their efficacy (Spratt and Kennedy, in press).

We know that the issue of temporality is important as there is some evidence to indicate that children may be less impacted by experiences of adversity that are
singular, and are of a short-term nature, typically because they may experience the adversity as less traumatic, especially if they receive early and focused help. Taking the example of children’s exposure to domestic violence, in a study exploring the impact of domestic violence on 687 children participating in a community-service program, children who had only one disclosed experience of abuse had a lower risk for dissociation than children who experienced more than one episode (Spilsbury et al., 2007). Therefore, helping families earlier, rather than waiting until a pattern of such incidents emerges, may be a more effective longer-term approach than current practice (Millar et al., 2019). Additionally, there is now strong evidence of the co-occurrence of domestic violence alongside child maltreatment, but contradictory evidence about whether children experiencing the “double whammy” of domestic violence and child maltreatment (Hughes et al., 1989 as cited in Silverman and Gelles 2001) are impacted more than children who experience solely domestic violence or child maltreatment (Kimbell, 2016).

At present, the current iterations of the ACE study have not sought to quantify the ‘dose’ of a particular adversity experienced by individuals in order to start to disentangle whether this has a moderating effect upon whether an adversity has an enduring and negative impact. This is not merely an academic query, but one which has profound implications for the debates about prevention and early help that are part of the professional discourse. When we talk about thresholds we are actually discussing strategies for rationing increasingly scarce resources (Devaney, 2019). Do we spread support thinly in the hope that by providing a little help to many we might do enough to nudge some individuals and families in the right direction, while recognising that this will not be sufficient for some for whom we need to create safety nets for when they fall off the cliff? Alternatively, do we reserve resources for the critical few, knowing that many of those with lower level needs will still be able to avoid the cliff edge through using their own resources?

Without a clearer understanding of how much of an adversity is too much for particular children in specific situations, we run the risk of either over reacting to some high profile adversities, and under reacting to others which, although less visible, may actually be more harmful. There is also a concern that seeking to intervene early may result in greater surveillance of and interference with families by professionals, even though the intentions are well meant (White et al., 2019). This
fits with current critiques of the child welfare system, whereby issues of perceived risk (for example, of physical or sexual abuse) obscure children’s wider needs (for example, addressing the effects of growing up in poverty or the experience of parental imprisonment) (Featherstone et al., 2018). As an illustration of how our view of risk and need amongst children is skewed, the number of children impacted by parental imprisonment is thought to be more than three times the number of children in State care, five times the number subject to a child protection plan and more than double the number affected by divorce in the UK (Butler et al., 2015). Yet the provision of services for this large group of children is negligible (Barnardo’s 2014), in spite of the robust evidence highlighting how children in such circumstances are at greater risk of experiencing significant negative outcomes in relation to well-being and development (Bell et al., 2018).

**Conceptualising measurement**

Our second major reflection regarding the current ACEs literature relates to the simplistic way that the data is being presented and discussed. There is a danger that in ‘counting ACEs’ we can obscure the logic inherent in the maxim ‘numbers matter’. This is particularly tempting for social workers undertaking assessments. Essentially, this is because, despite all assessments being conducted as a way of predicting future outcomes beyond the level of ‘common sense’, they usually lack an empirically informed measurement scale (they are not usually validated instruments) to aid the practitioner in decision-making. ACE scores are different, in that they do reflect statistical probability, and offer a measure to scale this. Whilst they are not designed for use as predictive tools at the individual level, such imperfections may be taken lightly by services seeking to fill the current lacuna in evidence based assessment instrumentation. Nevertheless, we need to be cognisant that some children may experience adversity at different points throughout childhood, and in different ways, for example, living in poverty while a baby, but experiencing parental separation later in childhood after a period of living in a relatively stable household. Parental separation after domestic violence may actually improve a child’s situation. Other children, though, may experience a number of adversities in tandem, such as a settled and affluent childhood, redundancy of a parent leading to poverty and
growing relationship strain between parents, deteriorating mental health, increased substance use, and then parental separation resulting in moving away from friends in their community and school who acted as supportive buffers to the consequences of the negative adversities. The implication for practice is that while multiple adversities do matter in raising our alertness to the potential for a child to be impacted negatively, it is then important to explore in greater depth what this means for a particular child at a point in time, and over time. This requires a high level of skill to build upon an understanding of the cumulative impact of adversities in supporting children and parents to talk about their life experiences, while also being able to analyse what this might mean in respect of supports and access to services or help from a strengths based relational perspective (Coulter et al., 2019). It may also call upon a broad range of research methodologies to explore these factors. For example, Park et al. (2020) explored the histories of 2675 individuals diagnosed with bipolar disorder to analyse the relationship between childhood trauma and clinical outcome in patients with and without exposure to ACEs. While the number of ACEs had the most significant effect on clinical outcomes, it was specific ACEs, such as physical abuse, that had a considerable influence. Moreover, post-childhood adverse experiences had a weaker effect on clinical outcomes than ACEs did.

At present, we have limited data about whether experiencing adversity in tandem or in sequence is better or worse, or whether it is as simple as numbers matter, irrespective of the order in which adversities occur. However, such information is important in thinking about how our child welfare system should operate. Is there a need to identify vulnerable children and embrace them tightly with low level supports until they reach adulthood, or should we work to resolve issues with short intensive interventions, and then let families get on with life? Currently, we debate these issues with reference to the availability of resources, a belief that we might foster dependency, or a fear of overstepping the mark of intrusive interference in the private sphere of the family, rather than in relation to the potential needs of a child in overcoming the adversity they have faced, and the long term cost to the individual and society of not intervening. At the same time, while the governments in the UK have committed to ending child poverty, primarily on the basis of the long term negative consequences for children in such circumstances, there is a need for a more nuanced conversation to disentangle the relationship between the direct effect
of poverty through material hardship or lack of money to buy in support, and the indirect effect through parental stress and neighbourhood conditions (Bywaters et al., 2016). This is a particularly vexed question as there is a danger of a concentration on the social determinants of social and health outcomes being presented as polarised and oppositional with respect to the relative influences of poverty and biopsychosocial factors. As Kelly-Irving and Delpierre (2019) observe:

This biological plausibility of the ACEs framework, consistency of findings and dose response relationships all contribute to the evidence that psychosocial experiences occur during the first two decades of life are likely to set certain groups of the population on chronic disease health trajectories. This does not exclude the existence of alternative pathways via deprivation or poverty, and, furthermore, there is a lot of evidence that poverty and deprivation underlie the exposure of certain populations to these adversities (p.6).

This is supported by Lewer et al. (2019) who used data from police, social services, schools and other community statistics in England to calculate population rates of events that represent childhood adversity, such as rates of child maltreatment, information on numbers of parents in alcohol or drug treatment and street level crime involving weapons. The authors constructed an ‘ACE Index’ that summarised the relative frequency of ACEs at local authority level, informed by methods used to combine indicators in the Index of Multiple Deprivation, exploring associations between the ACE Index and local characteristics in cross-sectional ecological analysis. The results showed that:

…local areas with high rates of child poverty also have a high frequency of ACEs. This suggests that the known association between deprivation and ACEs among adults is unlikely to be explained by recall bias or selective migration but is because children growing up in these areas have higher risk of adverse experiences. It also provides evidence for a process in which deprivation increases the risk of adverse experiences in childhood. (p.6)

*Responses to children’s experiences of adversity*
Finally, the debates about the ACE study, and the ways these have shaped and informed both professional and public discussions of children’s needs and how to meet them, have thrown into sharp relief the conundrum of how society should respond to children’s experiences of adversity – at the level of the individual child and their family, or the family and wider community. For example, in their evidence review for Public Health Wales of interventions to prevent and address adversity across the life course, Di Lemma and colleagues (2019) focus almost exclusively on interventions at the level of the child, parent(s) or family, with no mention of societal issues, such as community cohesiveness, or the role of poverty and the literature on family income, and its role in both preventing and moderating various forms of adversity, in addition to poverty as an adversity. In a way, this is a harking back to the construction of child maltreatment as a form of psychopathology, rather than seeking to incorporate a wider range of both causal and intervening mechanisms to help us understand and respond in ways which are humane and effective. For example, one US study used changes in family income to explore the impact on child maltreatment. Raissian and Bullinger (2017) found that a $1 increase in the minimum wage was associated with a 10% decline in neglect reports, providing evidence in support of Bywaters and colleagues’ (2016) conclusion that improvements in socioeconomic status can lead to a decrease in childhood adversity. Similarly, addressing deprivation and economic downturns, which are associated with social problems including drug and alcohol dependence, involvement in crime, mental health problems, homelessness, unemployment and debt, is likely to also be beneficial (Lewer et al., 2019), and reduce the lottery of professionals and services seeking to find the families in need, and the children at risk amongst the general population.

One way of allocating resources with a view to helping both the many and the critical few is through strategic provision in widely available, natural and less stigmatised services such as schools (Sulkowski and Michael, 2014), where varied levels of support can be provided to children and young people. Multitiered systems of support (MTSS) is a commonly accepted public health framework for service provision in schools where services are coordinated at three levels. Tier 1 involves support provided to all students, such as the development of a positive and supportive school climate (Chafouleas et al., 2016). This promotes resilience, coping
skills, connectedness and well-being for all, including those who may be affected by adversity and trauma (Reinbergs and Fefer, 2018). Tier 2 may include helping particular students with the development of social support systems, or assisting them to learn emotional regulation skills (Chafouleas et al., 2016). Support can involve more targeted small group sessions, and include assistance for parents and teachers (Reinbergs and Fefer, 2018). Tier 3 is for students who may require more intensive and comprehensive support (Chafouleas et al., 2016), which may be delivered in school settings by either school-based or external mental health professionals (Reinbergs and Fefer, 2019). Schools can be key places to identify at-risk children early and provide support in a setting where they spend much of their time (another aspect of temporality) (Alisic et al., 2012; Sulkowski and Michael, 2014). Not all service provision may need to be implemented directly by social service or mental health professionals, as, for example, teachers can be assisted through consultancy support to develop helpful strategies which they can carry out on a daily basis to address and limit negative consequences of adversities for children in their care (Alisic et al., 2012; Cicchetti, 2017). With careful planning, school-based support can be accessed more readily and be provided over a longer time frame than is possible within the often less accessible services of community or clinical agencies (Chafouleas et al., 2016; Sulkowski and Michael, 2014).

Conclusion

In conclusion, in this article we have argued that the original ACE study and subsequent work and discussion has been helpful in opening up a space for a broad audience to engage in debates about children’s experiences of adversity, and the potential for negative consequences if we do not provide children with support to ameliorate these effects. We firmly believe that ‘numbers matter’ and that while children may be able to cope with a little adversity, over a short period of time, when they have good networks of support, too much adversity, over too long a period of time, even with good support, will be problematic for the child and their family. This support need not necessarily be from professionals, but neither should it be assumed that families can do this by themselves, and that when they cannot, they themselves are then perceived as the problem. In seeking to understand and to
respond to children’s experiences of adversity we need to be inquisitive about the temporal aspect of adversity to more fully begin to grasp a child’s experiences, and the potential ways in which they might be helped. This will require us to use a broad range of methods, from biographical narrative interviews, to structural equation modelling, to explore and explicate the nature and pathways between experience and outcome.

The original ACE study has been a useful beginning, but we now need to move beyond this, rather than allowing the original ten ACEs to become the defacto definition of childhood adversity. In doing so, we have greater potential to broaden the debates about how we support and help children and their families to include how communities and wider society can play a useful role in valuing and nurturing children, but also in having social and economic policies which prevent some adversities, and allow earlier and better quality help whenever other adversities do arise. In seeking to use the concept of time to inform our thinking and actions, we can begin the process of thinking about the child today, and the adult tomorrow, and to engage with thinking about children’s needs and how they are shaped and shift over time.

References


