

Trauma and Adverse Childhood Experiences (ACEs)

Mary: Good evening, for my presentation I will be discussing Trauma and Adverse Childhood Experiences (ACE's). This is an area I am passionate about having recently taken on the role of working within a setting providing wellbeing support to children. I will give an overview of Trauma and ACE's, identifying the diagnosis process, barriers children may face and a strategy to support learners who have experienced Trauma and or ACE's.

I WILL SHARE MY SCREEN..... (share screen).... CAN EVERYONE SEE MY PRESENTATION CLEARLY?

Trauma and Adverse Childhood Experiences (ACEs)

Trauma refers to the psychological and emotional responses to distressing events that overwhelm an individual's ability to cope (SAMHSA, 2014). These responses may include fear, emotional dysregulation, and long-term behavioural and cognitive changes (American Psychiatric Association, 2013; WHO, 2019). Trauma is shaped not only by the event itself but by how it is experienced and interpreted, highlighting the importance of resilience and environmental support (Sweeney et al., 2018; Masten, 2014). This reinforces the view that trauma cannot be reduced to a purely biological or individual response.

Adverse Childhood Experiences (ACEs) are traumatic experiences before the age of 18, including abuse, neglect, and household dysfunction (Felitti et al., 1998). Research demonstrates a strong relationship between cumulative ACEs and poorer mental, physical, and social outcomes in adulthood (Hughes et al., 2017). However, the ACE framework has been criticised for oversimplifying trauma by reducing experiences to numerical scores and overlooking context, severity, and protective factors (Finkelhor, 2018; Lacey and Minnis, 2020). This

reductionist approach aligns with medicalised thinking that prioritises quantification. ACEs should therefore not be viewed deterministically, as many individuals demonstrate resilience despite adversity (Masten, 2014).

In the UK, ACEs are widely recognised as a significant public health issue. Welsh research found that individuals with four or more ACEs are more likely to experience poor mental health, substance misuse, and health-harming behaviours (Bellis et al., 2015). ACE exposure has also been linked to chronic illnesses such as cardiovascular disease and diabetes (Public Health Wales, 2018). However, ACE research is largely correlational, and individuals affected by ACEs are also more likely to experience poverty and social inequality (Marmot et al., 2020). In Wales, ACE prevalence is higher in deprived communities, suggesting wider social conditions strongly influence outcomes (Welsh Government, 2022). This supports a social model perspective that structural inequality is central to understanding trauma-related outcomes.

Childhood trauma can disrupt brain systems involved in stress responses and emotional regulation, including the amygdala and prefrontal cortex (McCrory et al., 2017). While this research contributes to understanding trauma, critics argue it may reinforce deterministic and medicalised interpretations focused on neurological damage rather than recovery. Overemphasis on brain changes risks pathologising individuals and neglecting social context. Evidence of neuroplasticity demonstrates recovery remains possible with appropriate support (Masten, 2014). Trauma may also affect attachment and social development, although attachment theory has been criticised for cultural limitations and reductionist assumptions (Bowlby, 1988).

These debates highlight tensions between the medical and social models of disability. The medical model focuses on diagnosis, impairment, and treatment, often locating problems within the individual. Within trauma research, this is reflected in focus on symptoms, brain function, and psychiatric classification. While useful for accessing treatment, it risks framing individuals as inherently

damaged and promoting dependency on services. In contrast, the social model emphasises social, economic, and institutional barriers. From this perspective, trauma outcomes are shaped by poverty, inequality, and access to support. However, the social model may underestimate the real psychological effects of trauma. A purely social explanation risks minimising individual suffering. Therefore, an integrated approach is necessary, recognising both lived experience and structural inequality.

In response to awareness of trauma and ACEs, Wales introduced the Trauma-Informed Wales Framework (Welsh Government, 2022), promoting trauma-informed approaches across services. However, implementation remains inconsistent, reflecting gaps between policy and practice.

Diagnosis Process

Diagnosing trauma and ACE-related difficulties is complex because symptoms vary and overlap with other conditions. Trauma cannot be identified through a single diagnostic test; instead, it requires holistic assessment incorporating psychological, social, and environmental factors (NICE, 2018). This complexity challenges biomedical approaches that prioritise standardised diagnostic criteria and measurable symptoms.

Clinical interviews and psychosocial assessments are central to identifying trauma as they explore personal histories and context. However, effective assessment depends on disclosure, which may be limited by stigma, fear, or lack of trust (Hughes et al., 2017). Individuals may minimise or conceal experiences due to shame, increasing the risk of underdiagnosis or misdiagnosis.

ACE screening tools are often used to identify exposure to adversity. While structured, they are criticised for oversimplifying trauma and failing to capture resilience or protective factors (Finkelhor, 2018; Lacey and Minnis, 2020). Their use reflects a medical model emphasis on measurement and categorisation, which may obscure complexity and reinforce deterministic interpretations.

Multi-agency collaboration is emphasised in Welsh policy as trauma affects multiple life domains (Welsh Government, 2022). Collaboration between health, education, and social care services can improve understanding. However, barriers such as information-sharing restrictions, professional boundaries, and limited resources hinder effective partnership working (NHS Wales, 2021). This highlights structural limitations within services.

Diagnostic frameworks such as the DSM-5 (American Psychiatric Association, 2013) and ICD-11 (WHO, 2019) provide criteria for trauma-related disorders including PTSD and Complex PTSD. These frameworks align strongly with the medical model, focusing on symptoms rather than causes (Sweeney et al., 2018). While useful, they may fail to capture the complexity of lived experiences, particularly in developmental trauma.

Misdiagnosis is a major concern, especially among children. Trauma-related behaviours such as hyperactivity or aggression are often interpreted as ADHD or behavioural disorders (Ford et al., 2018; McCrory et al., 2017). This reflects a systemic bias towards biomedical explanations. Misdiagnosis can lead to inappropriate interventions, including medication or punitive responses, which may worsen trauma (Sweeney et al., 2018). A social model perspective reframes these behaviours as adaptive responses to adversity, challenging deficit-based interpretations.

Barriers to Identification and Support

Stigma and Disclosure

Stigma is a key barrier to identifying and supporting individuals affected by trauma and ACEs. It operates at internalised, social, and structural levels (Hughes et al., 2017).

Internalised stigma involves shame and self-blame, discouraging disclosure. Social stigma involves fear of judgement, while structural stigma reflects

institutional barriers such as concerns about confidentiality or social services involvement.

Research shows individuals with ACEs are often reluctant to seek support due to stigma (Hughes et al., 2017). In Wales, stigma surrounding abuse contributes to underreporting (Public Health Wales, 2019). Consequently, many individuals remain unsupported.

Delayed disclosure leads to delayed diagnosis and reduced access to early intervention (NICE, 2018). Stigma damages trust and discourages help-seeking.

Importantly, stigma should be understood through a social model lens. It is shaped by societal attitudes and institutional practices rather than individual weakness (Thornicroft, 2016; Link and Phelan, 2014). Negative attitudes reinforce silence, while inflexible services perpetuate exclusion (Clement et al., 2015). Addressing stigma requires systemic change, not just individual intervention.

Lack of Professional Awareness

A lack of professional awareness is another major barrier. Many practitioners lack sufficient understanding of trauma-informed approaches, increasing the risk of misinterpretation (Sweeney et al., 2018).

Behaviours such as withdrawal or aggression are often treated as misconduct rather than adaptive responses (Ford et al., 2018). Healthcare systems may prioritise symptom-based diagnosis, reflecting medical model dominance.

Although Wales has trauma-informed policies, implementation is inconsistent (Welsh Government, 2022). Differences in training and resources contribute to unequal support.

Misunderstanding trauma can lead to re-traumatisation, ineffective interventions, and punitive responses such as exclusion (DeJong, 2019). However, these

issues are not solely individual failings. Structural factors such as workload pressures and limited resources significantly shape practice (Timimi, 2017; NHS Wales, 2021). A social model perspective highlights the importance of addressing these systemic constraints.

Support Strategy: Trauma-Informed Care (TIC)

Trauma-informed care (TIC) is a key strategy for responding to trauma and ACEs. It involves recognising trauma's impact and adapting services to promote safety, trust, collaboration, and empowerment (SAMHSA, 2014).

Principles of Trauma-Informed Care

Core principles include safety, trustworthiness, collaboration, empowerment, and cultural sensitivity. These aim to create supportive environments that reduce re-traumatisation. In Wales, TIC is embedded within national policy (Welsh Government, 2022).

Evidence of Effectiveness

Research suggests TIC can improve outcomes, including service engagement and emotional regulation (Sweeney et al., 2018; Berger, 2019). In Welsh schools, it has been linked to reduced exclusions and improved wellbeing (Public Health Wales, 2020).

However, evidence is largely observational, limiting causal conclusions (Maynard et al., 2019). Improvements may reflect broader organisational changes rather than TIC alone.

Limitations of Trauma-Informed Care

Despite its benefits, TIC has limitations. Implementation varies across services due to differences in resources and training (Welsh Government, 2022). There is also a risk of superficial adoption as a “tick-box” exercise (Sweeney et al., 2018).

TIC does not directly address wider social determinants such as poverty or inequality (Marmot et al., 2020). From a social model perspective, this is a significant limitation, as these factors shape both trauma exposure and recovery.

A purely medicalised application may focus on individual resilience while ignoring systemic inequality. Conversely, a purely social approach may neglect psychological needs. Effective practice requires integrating both perspectives.

Conclusion

Trauma and ACEs are major public health issues linked to poorer outcomes across the lifespan. However, outcomes are not deterministic, as resilience and social context play key roles.

Diagnosis is complex due to overlapping symptoms. While diagnostic frameworks are useful, they often reflect medical model assumptions and may overlook context. Stigma, limited disclosure, and lack of awareness further hinder identification.

The medical model supports understanding and treatment but risks individualising trauma. The social model highlights inequality but may underplay psychological impact. A combined approach is therefore essential.

Trauma-informed care provides a valuable framework but is limited by inconsistent implementation and failure to address structural inequality. Improving outcomes requires both trauma-informed support and broader social change addressing poverty, inequality, and access to services.

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