



A child's health, shaped by trauma, healed through listening

By Claudia M. Gold, M.D. | December 20, 2016

Alicia was diagnosed with ADHD by a colleague in my group pediatrics practice. Her distracted and flighty behavior in kindergarten led her teachers to recommend an evaluation, and she met the criteria according to standardized checklists. She was treated for years, with many medication adjustments.

Over the years, she showed some improvement in her ability to focus, but she continued to struggle, particularly with social interactions. As she entered adolescence she began to gain weight; by age 16, she had early signs of type 2 diabetes. Eventually, police were called to her home when her father, in a drunken rage, became physically abusive to her mother.

Only then did we learn that he had a history of PTSD and had been actively drinking and intermittently violent throughout Alicia's childhood. But because we had spent so many years focusing exclusively on her behavior or "symptoms," the family situation, throughout her childhood, had drawn little attention.

Alicia's life is a demonstration of the social determinants of health – and of the CDC-Kaiser Permanente Adverse Childhood Experiences

(ACE) Study – unfolding before our eyes, aided and abetted by a model of care that promotes treatment of behavior over taking time to listen for the meaning of that behavior.

Beyond the lessons specific to pediatrics, it suggests that doctors who are attuned to patients' backgrounds – and not just their immediately obvious symptoms – may be able to offer better treatment at lower cost.

The ACE Study began in 1995 as an investigation into the root causes of obesity. Researchers soon discovered that risk not only for obesity but also for a wide range of long-term problems – including depression, alcoholism, intimate partner violence, unintended pregnancies, ischemic heart disease, and type 2 diabetes – was highly associated with ten significant adverse childhood experiences.

The experiences fell into three categories: abuse, including emotional, physical, and sexual abuse; neglect, including emotional and physical neglect; and household dysfunction, including domestic violence, substance abuse, parental mental illness, parental separation or divorce, and an incarcerated household member.

The researchers found a direct correlation between the number of adverse childhood experiences and the number of chronic illnesses. They developed an ACE score to quantify these experiences. The ongoing study, now in its third decade, has clearly shown that the higher the score, the greater the long-term consequences. The risk of a wide range of problems increases in a strong and graded fashion in accordance with the number of adverse childhood experiences.

While this research has implications for how we address emotional and behavioral problems throughout the lifespan, its greatest potential lies in prevention.

A number of pediatric practices use the ACE Study in creative ways. A pioneer is pediatrician Nadine Burke Harris, founder and CEO of the Center for Youth Wellness in San Francisco. Burke and her colleagues use the ACE score to guide intervention. Drawing on evidence that adverse experiences affect the brain and body on a molecular level, they view childhood trauma as a medical problem. Treatment may include psychological interventions and alternative therapies such as yoga and meditation.

Recognizing that a person's history of trauma has significant impact on his or her own parenting behavior, some practices routinely obtain parents' ACE scores. Had Alicia's parents been evaluated this way, it is possible that her father's history of PTSD, as well as the ongoing substance abuse and domestic violence, would have been brought to light and addressed. There might have been opportunity to prevent transgenerational transmission of trauma.

However, as Alicia's story demonstrates, the current standard of care is to assess a child's "problem behavior" with an ADHD evaluation. In pediatric practice, this usually involves a standardized questionnaire such as the Conners Rating Scale, and often a visit with only one parent present. The child's symptoms are then attributed to ADHD. An opportunity to address the meaning of the behavior is lost.

The ACE Study shows us that as primary care pediatricians, we must listen for these stories before they have opportunity to exert their harmful effects on the developing body and brain— and the health of the whole family. While questionnaires may be useful, parents often feel terrible shame about their behavior and share these stories only when we offer protected time for nonjudgmental listening, fostering an environment of psychological safety.

And for practitioners outside of pediatrics, the study suggests a path toward engaging patients, building their trust, and helping them to become proactive partners in their own care. Listening is our most effective preventive intervention.

Claudia M. Gold, M.D. is a pediatrician and author. Her next book, out in February, is "The Developmental Science of Early Childhood: Clinical Applications of Infant Mental Health Concepts from Infancy Through Adolescence."



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