

Breaking Through

Kiera: I didn't have a good childhood. When I was six, my mom's boyfriend killed my little sister in front of me.

[Music]

Kiera: He punched her in her stomach and -- because she peed on herself. She was two.

Felisha: I was addicted to methamphetamines, and it got to the point where I didn't think I was going to come back.

Carlos: There's like basically no family structure. I was at aunt's house, at grandma's house, at dinner here, dinner there, maybe no dinner. Sometimes all I would have is like school lunch. Paula: I didn't know how to stop. I didn't know where to go, who to turn to. I just didn't know. I had this battle and I had this addiction that had a strong hold on me and I didn't -- I didn't know what to do with it.

Christina: I had little brothers I had to protect, but at the same time, I indulged in her addiction with her. I was no longer a child. I was just there.

Molly: When I was nine, there was a secret that my dad was an alcoholic and he committed suicide. We were all in the house. He shot himself in the head.

Kahtea: It wasn't really until I -- until the next relationship where I almost died that I really began to understand what had happened to me as a child and how those things permitted this -- the subsequent events to happen.

Denise Dowd: It was many years ago, about 20 years ago, and the paper here in Kansas City had published an article accompanied by all these pictures of young people who'd lost their lives to homicide. And so I was looking at this just sort of overwhelmed with the -- how many faces were there, young faces. And I was with a colleague of mine, an older colleague, and she looked over my shoulder and she looked at the newspaper and she said, "That was my patient, that was my patient, he was my patient, she was my patient. In fact, most of these kids that you're looking at right now were our patients here at the children's hospital." And I happened to look through these medical records at these kids and they typically would go something like this: At the age of two months, a baby comes in to be evaluated for bruising. Child Protective Services is called. There's a hotline that is made and there's a diagnosis of abuse made. Taken out of the home maybe for a few months, returned to the home. At the age of two years, multiple documentation of missed visits for immunizations at the Well Child Clinic, just not showing up. At the age of four or five, coming in without a controlled behavior, diagnosed with ADHD, put on medication. At the age of 10, coming in for fighting in school, maybe a fracture of the hand from punching. It's called a "boxer's fracture," actually. Diagnosis made, in addition to fracture, of oppositional defiant disorder, put on more medication. At the age of 12, comes into the emergency department after a fight for a jaw fracture. And then at the age of 14, comes in with a full trauma activation, cardiac arrest from a gunshot wound to the chest. Everywhere along the line that we had an opportunity as a health care person, as a health care system, hospital, to do something.

Nadine Burke-Harris: The challenge I was having as a doctor was that if I have a child who has a heart problem, I refer them to the cardiologist, where if they have allergies, I refer them to the allergist. But if

I have a child who's experiencing the multiple sequelae of early adversity and are demonstrating systems of toxic stress in clinic, there's no place for me to refer them.

Denise: This is a chronic disease. It's not just something that happens. From the time that they're born leading up to that point, there are multiple things happening in their lives to put them in that situation. And it was before we used the terms "toxic stress." It was before the -- we used the term "ACEs." But that's exactly what that was.

Nadine: We know that the cascade of stress hormones that flood through a child's body when they're exposed to chronic adversity, that's leading to heart disease, that's leading to chronic obstructive pulmonary disease. That's leading to increased risk of obesity. But these things happen later. The behavioral issues are the ones that we see when a child is two and three and four years old, and they portend long-term health problems, and we can see that in kids when they're little.

Brijin Gardner: Toxic stress is something that we see every day. It's -- early experiences organize the brain. And the early experiences that many of our children have are traumatic. A lot of our kids are living with parents who are mentally ill, who are being exposed to drug use and at risk. They're living in poverty every day. They're hungry, they're neglected, they're abused.

Nadine: What we see in kids who are exposed to chronic adversity is that this fight-or-flight system which is supposed to be a once in a very longtime life-saving response is activated over and over and over again. And so it goes from being life-saving to health-damaging. It goes from being adaptive to being maladaptive. And so we see these kids when they are trying to sit still in the classroom and learn, right? It's one of the biggest places that we see this maladaptive response.

Amy Reames: We focus a lot on social-emotional wellness here. So we really put a lot of that into the curriculum. If we don't have that foundation, then we can't -- we can't do anything else. You know, if you have a child that is not socially or emotionally well, then we can't expect them to sit down and do a lesson on math or literacy or something. Nadine: "ACEs" stands for Adverse Childhood Experiences, and that comes from the real seminal study that was done in this field by Dr. Vince Felitti and Dr. Robert Anda. What they found was for those adults who had a history of adverse childhood experiences -- and these experiences include physical, emotional, or sexual abuse, physical or emotional neglect, a parent with mental illness, substance dependence, or who had been incarcerated, domestic violence or parental separation or divorce. There were two things that they found that were tremendously striking in this study. One was just how common it was even among their middle-class population. So 64% of their population had at least one adverse childhood experience, and 12.6% of their population had four or more adverse childhood experiences. The second thing that they found was there was a dose response relationship between early adversity and numerous health and behavioral outcomes.

Denise: The more ACEs you had, numbered them, right, zero to nine or ten, the more likely it was that you were going to have one of these diagnoses.

Nadine: What was really an eye-opener for the medical community was that if you had four or more adverse childhood experiences, your risk of chronic obstructive pulmonary disease was 260% as compared to someone with an ACE score of zero. For hepatitis, it was 250%. If you were a woman and you got pregnant, your risk of having a miscarriage, if you had four or more adverse childhood experiences, was 180%, almost double that of a woman who got pregnant and had no adverse childhood experiences. And so we've really begun to understand that there were biological and

physiologic underpinnings and a direct connection between early adversity and health problems in adulthood.

Denise: Currently, medical practice in general does not include asking about ACEs, all right -- ascertaining ACEs. And importantly it implies that pediatrics, pediatric care is a two -- at least a two-generation process. Right? Because if you think about it, your patient, the little kid, are going to achieve many of their ACEs, neglect, abuse, through their parent or somebody related to them. So you have to address the ACEs in both of those generations and try to get -- first of all, asking about it, really uncovering it, and then getting the help that people need.

Donna O'Malley: We have a lot of young mothers who they themselves have experienced toxic stress from many exposures in their lives where their trauma's never been treated and now they're trying to parent.

Denise: The most important vital sign that you can assess as a physician is the vital sign of the relationship between the parent and the child.

Nadine: The focus on early childhood, on the social-emotional learning that happens during that time, and some of the programming their doing here at Operation Breakthrough is really a model for best practices in terms of how we can do early intervention with our kids and start to lay the foundation for healing work in terms of responding to ACEs.

Amy: We have an arc program that we use that is for -- it's our Head Start Trauma Smart program, so it's basically on how to help children that go through a lot of trauma. We try to take the approach from the whole child which includes the family. That's why we have an interdisciplinary team that we work with, so it includes the teachers and the education coordinator, but also we have a therapy department, we have our children's Mercy Clinic, and we have the family advocates here. So we try to work as closely as we can with the families because we know we can't do it without them.

Brijin: We are a tiny, tiny mental health center in this huge Head Start setting. This is -- it's unheard of to have mental health on site in a Head Start center. There are consultants that come in and only see, you know, four to five kids, but we are here and we're able to see, you know, 60 kids, 126 kids, and then generally the population, and through the partnership with Children's Mercy, through partnerships with other medical facilities, we're able to get kids into services that they need to be successful in school, to be successful in life, to maintain their family situation, to maintain their living situation.

Felisha: My oldest was three and she's been a part of Operation Breakthrough since we got here, and they, through therapy and everything else, I mean, I've stayed sober for almost six years now, and I owe a lot of that to the advocates and the therapy department.

Shawna: It's wonderful. They're my village. They're my little village. I wish I could put them in my purse and take them with me everywhere.

Brijin: This organization provides so much safety and care for these people. When we do intakes and assessments, a lot of the parents talk about Operation Breakthrough as if it's a person, just "Operation Breakthrough is here for me." Operation Breakthrough is the first place a lot of families go after a crisis has happened. Female: How you feeling today?

Child: Happy.

Jim Caccamo: There aren't a lot of Operation Breakthroughs, frankly. And so Head Start offers a really high-quality early learning program for the children, but more importantly, it's a comprehensive program. It's a program that address health needs, dental needs, mental health needs, very, very supportive of parents. We do a great amount of work with parents to help them learn skills that really will benefit them life-long.

Sister Berta Sailer: These kids are bright and talented. Their parents are good people, are trying so hard. We have to have hope. I mean, I think that's what they've taken from the urban core. What society has taken is hope in tomorrow. If there's no tomorrow, it doesn't matter what I do today. And I think the hope is that if these children and families get the services they need, the children do well. Our alternative is to pay to put them in prison, and that costs much more than providing the services they need so they can grow up safe with an education. And these are good people. The kid that could cure cancer could be in this building today.

Kiera: Sister Berta had gotten my two younger brothers, and then she found out about me and she got me, too. So from there on, that was like -- that's when I felt like I actually had a childhood. I could be a kid. We were there maybe a year. I don't know exactly how long, but then my grandma got custody of us, and from there it was no more of that.

Denise: What makes a person survive? What creates resilience? What protects a person? We know a little bit. I think that we know interest in learning is one thing. A degree of emotional intelligence is another thing. A supportive adult in the home.

Kiera: I feel like I was smarter than the average child. Living with my grandma, I was put in situations where I could have been raped, molested, so many things that could have happened to me, but I was smart enough, like I recognized danger. I could sense it. I had a man who I used to babysit for, and I remember being at his house and I was watching his son. He was trying to show me something in his bedroom, and just all, you know, all the warning signs, I just felt it, and I was like no. Nadine: Her ability to know that danger is coming is critical for her being able to avoid dangerous situations and reduce her cumulative life dose of trauma. The research is telling us that social-emotional buffering, being in a caring relationship, having adults in your life who are able to self-regulate and who are able to model self-regulation helps children to be aware of when that is not happening. And sometimes all you need is that one.

Brijin: We see that the brain can change. It's not -- it's not you're traumatized and you're traumatized forever. We know we can make change, and we have modalities and evidence-based practices that can do that, and that's hopeful. But we know it, so let's do it.

Nadine: For each individual pediatrician, what you can be doing on the ground is universal screening of your patients for adverse childhood experiences. The question that we always ask is, okay, well, how can you screen if you don't have a response? Right? And thinking about what that response would be for your own clinic, who are the trusted resources in the community that you can refer to, who do you know can get shelter for a mom experiencing domestic violence, who is going to be a high-quality therapist in your community who you know does trauma-informed cognitive behavioral therapy. Making those connections is going to be, on the individual level, critically important to even being able to screen, right?