The Heart of Trauma-Informed Care

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I have no financial relationships with any commercial interests.

Objectives
• Identify key concepts in stress physiology, toxic stress, and adverse childhood experiences.
• Define a framework for trauma-informed care.
• Describe ways to screen for trauma and potentially traumatic events.
• Describe clinical aspects of trauma-informed care.
• Identify the importance of addressing secondary traumatic stress for providers.
Stress Response

Allostatic Loading

The Biology of Trauma


National Scientific Council on the Developing Child, Harvard University
Toxic Stress is Biologically Embedded
Anatomic Brain Changes

Prefrontal cortex
Amygdala
Hippocampus

Toxic Stress is Biologically Embedded
Neuroendocrine and Immune Systems

Toxic Stress is Biologically Embedded
Genetics and Epigenetics

- Epigenetic changes
  - DNA methylation
  - Histone modification
  - Genetic predispositions
  - Mood disorders
  - PTSD

References:


**Critical Periods of Development**

**Brain Plasticity throughout Life**


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**Ecological Context of Child Health**


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**Eco-Bio-Developmental Framework**

Adverse Childhood Experiences (ACEs)

**CHILD MALTREATMENT**
- Physical
- Sexual
- Emotional
- Neglect

**FAMILY DYSFUNCTION**
- Incarceration
- Substance abuse
- Mental illness
- Domestic violence


ACE Study

Strong graded relationship between ACEs and health behaviors associated with leading causes of death in adults.


Additional Source: cdc.gov

ACEs Linked to Morbidity and Mortality in Adults

- Heart disease
- Cancer
- Chronic lung disease
- Liver disease
- Autoimmune disease
- Depression
- Violence
- Violence victimization
- Suicide

- Lower sense of well-being
- Poorer access to medical and MH services
- Increased health care utilization

Prevalence of ACEs

- 64% of the adults in the Felitti study had at least one ACE
- ACEs are prevalent across diverse social economic and racial populations
- Over 20% experienced physical abuse, sexual abuse or substance abuse in the home
- Co-occurrence common with 13% having 4 or more ACEs
- Caution with interpretation of the # of ACEs
- Specific combinations of ACEs produce particular outcomes
- Timing in development
- Presence of protective factors at the time of the adversity


Second Generation Research on ACEs

- Original ACEs not systematically determined
- Some ACEs alone may not be strong predictors, or may not be the same stressor now like in the 1950’s (i.e., parental divorce)
- Other childhood adversities predict negative long-term outcomes
  - Bullying
  - Social isolation and rejection by peers
  - Community violence
  - Poverty or financial strain
  - Food insecurity
  - Homelessness
  - Violent crime
- Improved overall statistical prediction


The Scope of the Problem

- 3 million children investigated annually
- About 676,000 victims
- National victimization rate of 9.1 per 1000 children
- 1,780 died from neglect or abuse in 2016

Substantiated Maltreatment by Type

- **Neglect**
- **Physical Abuse**
- **Sexual Abuse**
- **"Other"**

NCANDS 2016
Examples of Childhood Traumatic Experiences

- Abuse
- Neglect
- Parental separation
- Serious illness or loss of a loved one
- Witnessing interpersonal violence
- MVA
- Experiencing a natural disaster
- Conditions of war
- Dog bites
- Invasive medical procedures
- Systems-induced trauma (foster care)

ACEs: Trauma
Complex trauma
Child traumatic stress
stress
Medical traumatic stress
Potentially traumatic events
PTSD

Potentially Traumatic Events (PTEs)

Threatens physical safety
Associated with feelings of fear, horror, hopelessness

Prevalence: 68-90%


Defining Trauma-Informed Care

A program, organization or system that realizes the impact of trauma, responds fully to it, integrates knowledge about trauma, seeks to actively resist re-traumatization.

Education
Screening
Identification
Resources
Treatments
Trauma-Informed Care

• History – universally ask about PTE’s
• ROS – include trauma-informed
• Physical exam – any findings c/w abuse or neglect
• Trauma-specific anticipatory guidance
• Evidence-based, trauma-informed resources

TIC Pyramid


How Do We Begin?

• Training and education for all
• Screen for trauma exposure, post-traumatic symptoms, well-being, family functioning
• Recognize and respond to trauma exposure in children, caregivers, and providers
• Trauma-exposed children are like special needs children with similar complex needs
• Consider a Medical Home Model
• Know community resources that are trauma-focused and evidence-based
Screening for PTEs in Primary Care

Routinely ask at well child visits

“Because traumatic events are so common and because they have direct, long-lasting effects on physical and mental health, I ask all of my patients about stressful or difficult experiences they may have had.”

“Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family?”

Age 8 and up: Ask child directly
Follow with brief screen for PTSD

History
Universal Trauma Precautions

The American Academy of Pediatrics
“The medical home approach to identifying and responding to exposure to trauma.”
Screening for ACEs

**CHILD**

**PARENT**

Screening

**UNIVERSAL**
- Posters in waiting area explaining the effects of stress and to share with your doctor
- Offer resource lists and website links posted or as hand-outs
- “Did you know” statements on office clipboards given to parents for paperwork
- Consider a parent advisory group
- “Since the last time I saw you, has anything really bad, sad, or scary happened to you or your family?”

**TARGETED**
- Suspicion of child maltreatment
- When unexplained somatic complaints
- Unexplained acute change in behavior
- School failure
- Multiple missed medical appointments
- All foster children

Post Traumatic Stress Disorder (PTSD) DSM V

- Cluster A: Exposure
  - Direct experience, witnessing event, hearing about event in close loved one, extreme or repeated exposure to personal details of traumatic event, such as in one’s work
  - Excludes media exposure unless through one’s work
- Cluster B: Intrusion Symptoms (nightmares, flashbacks)
  - Repetitive play with trauma themes
  - Recurrent frightening dreams
  - Trauma re-enactment during play
- Cluster C: Assistance of Reminders
- Cluster D: Distorted Cognitions (detachment, fear, guilt, anger, shame)
- Cluster E: Hyperarousal, Hypervigilance (heightened startle, concentration, sleep disturbance)
- Criterion F: Greater than 1 month
- Criterion G: Functional significance
- Criterion H: Exclusion of other diagnoses
- Preschool criteria for 6 years and younger
- Dissociative subtype (depersonalization, derealization)
Abbreviated Screening for Trauma Symptomatology

UCLA PTSD REACTION INDEX
PARENT SCREENING VERSION

ABREVIATED PC-PTSD FOR PRIMARY CARE


SAMHSA Trauma-Specific Screening Tools

TRAUMA SYMPTOM CHECKLIST FOR CHILDREN

• 54 item scale, 15-20 min
• Ages 8-16 years
• TSCYC: For young children ages 3-12 years

UCLA PTSD REACTION INDEX

• Child/adolescent self-report
• Caregiver report
• Older than 6 years

For Children Involved with Child Welfare

• Think beyond Child Safety and Permanency

    • Well Being
    • Child and Adolescent Needs and Strengths (CANS) Tool

• Mental Health Needs
  • Strengths & Difficulties Questionnaire

• Family Functioning
  • Consider including foster parents in case planning

APAC Advisor, Nov 2018 Edition, Trauma-Informed Care
### Differential Diagnosis
**Consider Child Neglect**

- Injury with delay in seeking care
- Injury secondary to lack of supervision
- Multiple injuries
- Poor growth
- Poor hygiene
- Poorly controlled chronic disease
- Developmental delays
- Social emotional delays
- School problems
- Withdrawn
- Acting out
- Emotionally promiscuous
- Risk taking behaviors
- Runaway
- Functional abdominal pain
- Tension headaches
- Anxiety
- Depression

### Differential Diagnosis
**Consider Physical Abuse**

- Skin finding
- Injury
- Disclosure
- Parent child interaction
- Externalizing behaviors
- Aggressive behaviors
- Developmental delays
- School problems
- Bully involvement
- Runaway
- Hypervigilant, hyperactive
- Functional abdominal pain
- Tension headaches
- Anxiety
- Depression
Differential Diagnosis
Consider Sexual Abuse

- Behavioral changes
- Sexualized behaviors
- Early sexual debut
- Dysuria or other urinary complaints
- Genital pain, bleeding, discharge
- Enuresis
- Encopresis
- Vague complaints, chronic pain not otherwise medically explained
- School problems
- Bully victimization
- Developmental delays
- Functional abdominal pain
- Chest pain
- Tension headaches
- Anxiety
- Depression

Behavioral Responses to Trauma

<table>
<thead>
<tr>
<th>Dissociation/Detachment</th>
<th>Arousal/Hyper arousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depressive</td>
<td>1. Attention deficit</td>
</tr>
<tr>
<td>2. Female</td>
<td>2. Girls</td>
</tr>
<tr>
<td>3. Younger children</td>
<td>3. Teen children</td>
</tr>
<tr>
<td>4. Ongoing trauma/pain with inability to defend self</td>
<td>4. Males</td>
</tr>
<tr>
<td>5. Depressive</td>
<td>5. ADHD</td>
</tr>
<tr>
<td>6. Attention deficit</td>
<td>6. ODD, Conduct disorder</td>
</tr>
<tr>
<td>7. Developmental delay</td>
<td>7. Bipolar</td>
</tr>
</tbody>
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Trauma-Informed Review of Systems

The American Academy of Pediatrics
"The medical home approach to identifying and responding to exposure to trauma."
Developmental and School Difficulties

Physical Exam

• Trauma-Informed Patient Centered Care

• Signs of abuse or neglect

Physical Exam
Trauma-Informed Patient Centered Care

• Ask about comfort
• Explain first
• Give choices when possible
• Minimize anxiety
• Give patient sense of control
“D-E-F” Protocol for TIC

D • Reduce Distress

E • Emotional support

F • Remember the Family

“T-I-C” Protocol

T • Think about possible Trauma

I • Inform who you are and what you’re doing

C • Comfort, Choice

Physical Exam

Signs of Abuse or Neglect

• Affect and caregiver/child interaction
• Growth
• Development
• Injuries
• Hygiene/dental hygiene
• Chronic illnesses
• Skin
• Genital anal inspection
Case Example: Primary Care

John is a 3 year-old male with speech delay, and he comes to you with his foster parent for his well child visit. You are aware of his past history of physical abuse at age 2 when he presented with an unexplained fracture of the right humerus that led to a confession of inflicted injury by the mother’s boyfriend at the time.

Knowing his past trauma history, you begin by offering him a choice to stay on the foster mother’s lap or come to the exam table, which he chooses. As a male provider, you feel sensitive to approaching him with gentle ease and offer verbal reassurances that you two together will “play check up,” to try to ease any tension he may feel by an approaching new adult male. You offer him a toy stethoscope, and proceed “together” with the exam, offering him additional choices such as “which ear first?” when you examine his ears, and modelling slow deep breathing with him when you auscultate his chest.

Case Example: Inpatient

Sara is a 10 year-old female admitted to the pediatric ward for management of an asthma exacerbation.

On rounds, the team discusses that she is having set-backs at attempts to wean her albuterol treatments at night.

This prompts more thorough review of her medical record, and you find that she had disclosed sexual abuse from age 6-8 years by her live-in uncle, who would enter her room at night and abuse her.

This additional history informed the team to approach night-time assessments by nursing, clinicians, or respiratory therapists differently—everyone was informed to introduce themselves upon entering the room and explain who they are and their role prior to proceeding with any treatments or assessments.

The child was also referred to psychiatry for further evaluation and treatment for any residual PTSD symptoms from her abuse.

What to Do Next...

• Empathize, normalize
• Explain how stress can impact health
• Assess readiness for change
• Possible screening tools
• Anticipatory guidance
• Offer resources
• Maybe refer
• Maybe report to Child Protective Services
Therapeutic Listening

• Understand that listening is therapeutic.
• When something becomes speak-able, it becomes more tolerable.
• Helps make the connection between the emotional brain and the thinking brain.
• A step toward healing and integration.

Trauma-Specific Anticipatory Guidance

Excessive response to normal stimuli
- Don't take behaviors personally
- Stay calm
- Anticipate reaction and redirect
- Model and teach calming skills
- Difficulty putting words to feelings
- Allowing emotions for awhile to settle
- Help child find a child-like response
- Tell child it's okay to feel their emotions and help label them

Challenging caregivers
- Reassure child relationships to basics, friend or family member
- Use language of safety, trust, comfort, peace
- Don't take personally
- Functional abdominal pain
- Increase fiber, decrease lactose
- Clarify if "same" or "different" pain and limit attention, reinforce well-behavior
- Distraction, positive self-talk, relaxation techniques
Evidence-Based Programs
Standards of Evidence Criteria

• Randomized controlled trial or quasi-experimental assessment with comparison group
• Measures with validity and reliability
• At least one long-term follow-up assessment (at least 6 months after intervention) showing statistically significant results
• Results replicated at least once

Society for Prevention Research
Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination

Evidence-Based Model
Universal Trauma Precautions

SEEK Model
• Educational training
• Parent Screening Questionnaire
• Harsh parenting
• Substance use
• Intimate partner violence
• Stress / social support
• Food insecurity
• Assess current services and readiness for change
• Resident and parent handouts
• Social work referral

Triple P Positive Parenting Program
• Supports positive parenting strategies at the individual, family, and community levels
• Targeted educational and social campaigns

Evidence-Based Models for Trauma-Specific Care

“The medical home approach to identifying and responding to exposure to trauma.”
Evidence-Based Treatment
Trauma-Specific Care

TF-CBT
- 5 years and older
- Sexual abuse, physical abuse
- > 10 RCTs

Parent Child Psychotherapy
- 0 – 6 years
- Attachment

Parent Child Interaction Therapy
- 2-12 years
- Improve positive parenting
- Decrease disruptive behaviors

Evidence-Based Treatments Help

Evidence-based treatments (EBTs) improve outcomes for children. Below are percentages of clients who dropped experiencing these major life problems after receiving EBTs:

- 85%
- 82%
- 70%
- 65%
- 75%
- 60%
- 70%
- 50%

Evidence-Based Treatments Help

EBTs can help reduce trauma symptoms. 75% of children who had PTSD when their EBT was initiated no longer had PTSD at the end of the treatment.
Evidence-Informed Model
Complementary and Integrative Care

Trauma-Informed Yoga

- Adjunctive therapy for chronic treatment-resistant PTSD in 64 female victims
- Based on yoga (postures, breathwork, and mindfulness) increasing sensory awareness, safety, and mastery over one’s body while learning to interpret and tolerate physiologic and affective states
- May help address implicit memories, whereby talk therapy mostly targets explicit narrative memories
- Random assignment to trauma-informed yoga versus supportive women’s education class
- 10 week, 1 hour/week
- At week 10, 52% of the yoga group no longer met criteria for PTSD versus 21% in control group


Trauma-Informed Care

Recognize, Respond, and Resist trauma in
- Children
- Caregivers
- Providers

Understanding Your Own History and Reactions to Other’s Trauma

- Secondary Traumatic Stress - The emotional distress resulting from an encounter with a traumatized and suffering patient
- More than everyday stress and may become Compassion Fatigue or Burnout Syndrome and mimic PTSD
  - Emotional exhaustion
  - Depersonalization
  - Reduced sense of accomplishment
- Barriers to self-care
  - Feeling penalized for taking care of oneself
  - Inappropriate expectations
  - A culture of silence
Understanding Your Own History and Reactions

Health Correlates of Stress
• Headaches
• GI symptoms
• Muscle tension
• Hypertension
• Cold/flu episodes
• Sleep disturbances
• Changes in appetite
• Mental health symptoms

Provider Self-Care is Necessary for Quality Care
• Overall clinician burnout has been assessed at 48%—almost double the rate for the general US working population (Shanafelt, et al., 2015)
• Physicians have twice the rate of suicide versus the general population (Andrew & Brenner, 2015)
• Clinician burnout and compassion fatigue have been associated with
  • Decreased patient satisfaction
  • Lower quality of care
  • Medical errors
  • Implicit bias
  • Higher employee absenteeism and greater turnover
  • Economic inefficiencies

Burnout, Medicine, and Child Abuse Pediatrics
Some Burnout Factors

BURNOUT CREATION
- Work overload
- Lack of control
- Insufficient rewards
- Breakdown of community
- Unfairness
- Value conflicts
- Lack of fit between person and job

BURNOUT PREVENTION
- Sustainable workload
- Feelings of choice and control
- Recognition and reward
- A sense of community
- Fairness, respect, justice
- Meaningful valued work
- High job-person fit


Steps Toward Resiliency

Addressing Secondary Traumatic Stress and Burnout

**Individual**
- Take time for yourself
- Set appropriate personal boundaries
- Accept uncertainty
- Embrace self reflection
- Cultivate supportive relationships
- Maintain interests outside of work

**Institution**
- Safety culture
- Establish teams
- Identify sources of stress
- Debriefing opportunities
- Increase ethics discussions
- Offer training sessions on resiliency

Creating Trauma-Informed Institutional Systems

- Complementary to family-centered care practice, with expansions and shifts in knowledge, attitudes, and practice
- Training and education
  - General training for all professionals and support staff
  - Specialized training for each patient population
- Shift in culture, integrate into the mission and values, strategic plan and daily practice
- Incorporate into practice as a universal precaution
- May partner with patients and families as stakeholders in improving care practices


Trauma Informed Care

Keep Trauma Exposure on the Differential...

- Injuries not clearly explained
- Behavioral or school problems
- Changes in behavior
- Poor growth
- Problems related to toileting, sleep, or feeding
- Somatic complaints with normal exams and not otherwise explained

Overview of Principles of Trauma-Informed Care

- Universal trauma precautions
  - Patient-centered care
  - Understanding the health effects of trauma
  - Understanding your own history and reactions
- Universal trauma screening in primary care
- Framing Statement
  - "Since your last visit, has anything scary or very upsetting happened to your child or someone in your family?"
- Trauma-specific care
  - Focused screening
- ROS, physical exam, anticipatory guidance that are trauma-informed
- Evidence-based trauma-informed resources and referrals
- Self-care
Some References

AAP Connected Kids Program for violence prevention. www.2aap.org/connectedkids/
APSAC Advisor, Trauma-Informed Care, Nov 2018 Edition.

Some Online Resources

Child Traumatic Stress Network > Center for Pediatric Traumatic Stress >
https://www.childtraumastress.org
AAP > Trauma Toolbox for Primary Care > http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-initiatives/trauma-toolbox
SAMHSA (Substance Abuse and Mental Health Services Administration) >
https://www.samhsa.gov
National Child Traumatic Stress Network >
http://www.nctsnet.org