Exposure to Community Violence: Trauma Informed Care in the Pediatric Medical Home

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Ohio AAP Annual Meeting
September, 2016
Disclosure

I have no personal financial relationships in any commercial interest related to this CME.

I do not plan to reference off label/unapproved uses of drugs or devices.
Recording Your Responses

Paper Form
• For your convenience, we have created paper answer forms that are in your packet. The staff session leader also has hard copies.
• Please enter your ABP diplomate number and answers on the form.
• Turn the form into Ohio AAP staff member at the door on the way out of the session.
• Credit will be entered into your ABP profile within 3 business days.

Electronic Link
• If you prefer to use the web link, enter the following link into your browser, select step 4 and start quiz: OhioAAP.org/MOCPartII/Trauma
• If you experience any technical issues, in the interest of time, a paper form will be given to you.
Learning Objectives

1. Understand the frequency and extent of exposure to different forms of violence by children and adolescents according to developmental stage.

2. Describe possible behavioral or emotional responses by children exposed to community violence, strategies to identify children at risk for prolonged or maladaptive reactions, and interventions that are supported by evidence, either in pediatric practice or with community partners.

3. Apply the concepts of trauma-informed pediatric practice, including interviewing techniques, staff development and office policies to avoid repeat or continued trauma experienced by children previously exposed to community violence.
Culture of Violence

• Continuum of violence
  – From child abuse and intimate partner violence
  – through bullying and peer violence
  – to youth violence and criminality
• Eco-bio-developmental model for understanding and prevention
• Requires the pediatric medical home to become trauma-informed
Shifting Paradigms

• The origins of lifelong health are in early childhood
• Consider neuro-developmental trajectories rather than behaviors
• Strength-based assessment
  – Risk and Protective Factors
• Population Health (upstream) Perspective
  – Distribution of health outcomes
  – Health determinants that influence distribution
  – Policies that affect determinants
• Community Engagement
Childhood Exposure to Violence

• Home
  – Child maltreatment
  – Intimate Partner Violence
  – Sibling assault

• Community
  – Bullying, non-sibling assault
  – Sexual assault, dating violence
  – Other community or school violence

www.DefendingChildhood.org
Exposure at Home

• 40% of teens report exposure to at least one type of IPV over lifetime
• 1 in 6 children have been exposed to physical IPV over lifetime, about 13.6 million
• 14% report past year maltreatment from a parent or caregiver, 10 million children
Exposure in the Community

• 60% of children and youth report that they have experienced or witnessed violent victimization in the past year
• About 3 in 10 children report moderate or frequent bullying
• Over a third of girls aged 14 to 17 report sexual victimization over their lifetime
Polyvictimization

• 11% of children report exposure to 5 or more different kinds of violence in the past year
• Children exposed to one type are at higher risk of other types
  – 4 to 6 times higher risk of serious victimization, injury or assault with weapon
  – Most likely to report post-trauma symptoms
Racial and Ethnic Inequity

• Structural violence related to racism and ethnic prejudice compounds the risk of exposure to community violence
• Particularly important for Native American, Alaskan Native and African American children
• Spatial racism, criminal justice inequities (policing, sentencing)
• Hate or bias crimes
Consequences of Exposure

• Youth exposed to violence at higher risk of criminal behavior
• Exposure associated with lower academic achievement and higher absenteeism
• Adverse Childhood Experiences study found associations with a plethora of poor adult physical and mental health outcomes
• Racism compounds poor outcomes
National Survey of Children’s Exposure to Violence (NatSCEV)

• 4,549 children and adolescents, two groups
  • Representative sample
  • Oversample of exchanges associated with high density (70%) of African-American, Latino or low-income communities

• Telephone survey, adults provided demographics, children surveyed

• Screening questions included 48 types of victimization
Screening Questions

- Conventional crime
  - Assault, robbery, kidnapping
  - Hate or bias crime
- Child maltreatment
- Sexual victimization
- Peer and sibling victimization

- School violence and threat
- Internet victimization
- Witnessing and indirect victimization
Exposure by Developmental Age

• Middle Childhood
  – Assault without a weapon
  – Physical bullying
• Early Adolescence (10 to 13)
  – Assault with weapon
  – Kidnapping
  – Witnessing family assault

• Older Adolescents most likely to experience more serious forms of violence
  – Assaults with injury, gang assaults
  – Sexual victimization
  – Exposure to shooting, school bomb threat
Some Survey Results

• 60% past year, 10% five or more past year
• More than 70% witnessed violence to another person over lifetime
• 3.5% preschoolers had witnessed shooting, more than one in five 14 to 17 year olds
• Boys more likely to witness murder, shootings and other forms of community violence
Adverse Childhood Experiences

• 10 original ACEs
  – Child abuse
  – Child neglect
  – Household dysfunction
• Additions
  – Economic stress
  – Bullying, school violence
  – Community violence

• Medical Stress
• Refugee Stress
• Natural Disasters
• Mass trauma events
  – Shootings
  – Terrorism
SAMHSA’s Concept of Trauma

• Refers to emotional trauma.

• Defined as an event, series of events, or set of circumstances that is experienced as by an individual as physically or emotionally harmful and that has lasting adverse effects on the person’s functioning and mental, physical, emotional or spiritual well-being.

  • SAMHSA’s Guidance for a Trauma-Informed Approach (2014)
Cumulative Burden of Recurrent or Persistent Exposure to Trauma

- Alterations in brain architecture
- Changes in gene expression
- Endocrine and immune imbalance
- Decreased executive function and affect regulation
- **Interference with relational health**
- Behavioral allostasis
- Chronic illness, health disparities, decreased quality and length of life
Effects on Brain Architecture

- Epigenetic-interaction with hormones and inflammatory factors
- Neurons that fire together, wire together
- Decreased grey matter volume
- Smaller hippocampus
- Decreased prefrontal dendritic proliferation and decreased activity
- Amygdala hypertrophy
Effects on NEI Function

• Epigenetic change in control of chronic stress response
• Prolonged activation Flight-Fight-Freeze (amygdala)
• Alterations in hormones that enhance and sustain pro-social behavior
• Imbalance of activation and suppression of inflammatory cytokines
Dose Response Increased Risk

- Alcoholism and alcohol abuse
- Liver disease
- Smoking
- Chronic obstructive pulmonary disease
- Illicit drug use
- Ischemic heart disease
- Depression
- Suicide attempts

- Intimate partner violence
- Early initiation of sexual activity
- Multiple sexual partners
- Sexually transmitted diseases
- Unintended pregnancies
- Prematurity, small for gestational age
- Fetal death
ACE Study Conclusion

• Adverse childhood experiences may be among the basic factors that underlie health risks, illness, and death, and can be identified early by routine screening of all children.

• Early identification of children at risk allows for stratified, targeted intervention in order to buffer the effects and change the developmental trajectory.
Functional Correlates to Stress Activation

• Increased sympathetic tone
  • Toileting difficulties, regression of milestones
  • Enuresis, Encopresis

• Anxiety related inhibition of satiety
  • Food hording
  • Loss of appetite or stuffing

• Overstimulation of reticular activating system
  • Difficulty with sleep onset
  • Nightmares
Behavioral Reactions to Trauma

• Normative behavioral reactions
  – Resolve within a few weeks

• Acute vs. Chronic Exposure

• Mediators
  – Attachment
  – Resilience

• Maladaptive responses
  – Externalizing
    • Non-compliance
    • Impaired self-regulation
  – Internalizing
    • Depression
    • Anxiety
    • Post traumatic stress disorder
Normative Responses to Acute Trauma

- Sleep problems
  - Nightmares
  - Night awakenings
- Eating problems
- Sadness
- Anxiety
- Irritability

- Difficulty with concentration
- Exacerbation of risk-taking behavior
- Developmental regression
  - Bedwetting
  - Tantrums
Overview of Attachment

- John Bowlby 1907-1990
- Emotional bonds are basic for survival
- Interactive systems to maintain proximity or ready access
- Working models of self and other in mind
- Care seeking/care giving are complementary
Attachment Patterns

Secure
• Seeks primary (secure base) when distressed
• Curious, exploring environment
• Self-confident
• Asks for help

Insecure
• Avoidant
  – Passive, withdrawn
  – Avoids feelings, doesn’t express distress
• Resistant
  – May be charming, clinging or overactive like ADHD
  – Entertaining to adults, may be indiscriminant
• Chaotic
Resilience

• The ability to avoid physiologic and behavioral damage from exposure to chronic stress
• The process of adapting well in the face of adversity
• The result of using protective factors to manage multiple stressful circumstances without toxic effects
• Transforms toxic stress to tolerable stress
Resilient Children Have in Common

• At least one stable, caring and supportive relationship
• A sense of self-efficacy or mastery over life circumstances
• Strong executive function and self-regulation
• Solid grounding in faith or cultural traditions
Other Character Traits

• Sense of humor
• Ability to form attachments
• Inner psychological space that protects
  – Inner locus of control
  – Tendency to grow when presented with adversity
• Three you can’t do without
  – Flexibility, ability to improvise
  – Acceptance of reality
  – Strong faith that life has meaning
“We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed.”

– Victor Frankl, MD
How Does Resilience Develop?

- Combination of innate, intrinsic and extrinsic factors
- Also combination of supportive relationships, skill-building and positive experiences
- Resilience is the result of multiple interactions between environmental protective factors and highly responsive biologic systems.
  - Harvard Center on the Developing Child
Resilience Can Be Learned

• Important relationships vary over the life course
  – Parents, grandparents, siblings, peers, intimate partners
  – Grounded in early experiences
• Self-regulation and other executive functions stimulated in early childhood
• Non-cognitive skills (empathy) can be taught as late as adolescence
• Contemporary emphasis on two-generational interventions
Resilience and Relational Health

The most important and frequent commonality of children who succeed is that they have had at least one stable and committed relationship with a supportive parent, caregiver or other adult.

Harvard University Center on the Developing Child
http://developingchild.harvard.edu
Traumatic event occurs
• Everything from taking a test, to the loss of a loved one, to experiencing abuse or bullying

Child stabilizes
• Improves own internal strengths
• Learns to utilize external supports

Child experiences stress
• Emotional response
• Physiological response

Child receives support
• Parental reassurance
• Social supports
• Internal strengths
Inspiration

https://www.youtube.com/watch?v=-LGHtc_D328
Pediatric Medical Trauma

• Pain
• Procedures
• Sedation/loss of consciousness
• Separation/Isolation
• Exposure to sickness/death
• Life-threatening episodes/relapse

• Response and intervention dependent on developmental age
  – Pre-existing factors
  – Personal resilience

• Family Crisis
  – Cultural understanding
  – Parental role adjustment
  – Sibling reaction
Can Hospitalization Precipitate Toxic Stress?

Shah AN, Jerardi KE, Auger KA, Beck AF. PEDIATRICS Volume 137, number 5, May 2016: e20160204
Trauma-Informed Pediatrics

• Family-centered, trauma-informed care
• Complex care management strategies
  – Apply care coordination
  – Screen for signs of trauma, also for family strengths
  – Maintain resource for linking to services
• Multidisciplinary (multiagency) team
• Build on family strengths
Family-Centered Care

• Respects each child and family, and honoring racial, ethnic, cultural, and socioeconomic background and experiences
• Ensures flexibility in policies, procedures, and practices in order to adapt services to the needs, beliefs, and cultural values
• Shares complete, unbiased information
• Provides formal and informal support
• Collaborates with patients and families at all levels
• Builds on family strengths, empowering decisions

American Academy of Pediatrics (AAP) Committee on Hospital Care and Institute for Patient-and Family-Centered Care (2012)
Trauma-Informed Care

- Understands the proximal and distal effects of adverse childhood experiences
- Recognizes the signs and symptoms of trauma
- Integrates knowledge of trauma into policies and procedures, and practice management
- Resists re-traumatization

www.samhsa.gov/nctic/trauma-interventions
Elements of family-centered and trauma-informed pediatric care

FAMILY-CENTERED CARE
- Focus on dignity & respect for patient / family
- Maximize family involvement in care
- Respect patient / family wishes for interdependence & privacy

TRAUMA-INFORMED CARE
- Integrated in every patient interaction
- Share information with patient and family
- Encourage family presence
- Recognize family strengths & needs
- Cultural competence

- Minimize potential for trauma during medical care
- Address distress
- Promote emotional support
- Encourage return to daily activities when possible

www.healthcaretoolbox.org
Trauma-Informed Primary Care (TIPC)

- Foundations
- Environment
- Screening
  - History of Trauma
  - Risk and Protective Factor

Machtinger et. al. From Treatment to Healing: The Promise of Trauma-Informed Primary Care. *Women’s Health Issues.* 2015;25(3) 193-197

- Primary prevention
  - Strengthening Families
  - Promoting relational health

- Response
  - Integrated primary care
  - Coordination with community programs
Foundations of TIPC

• Safety
• Trustworthiness and Transparency
• Peer Support
• Collaboration and Mutuality
• Empowerment, Voice and Choice
• Recognition of historical trauma, adoption of policies and processes responsive to cultural, racial and ethnic needs
Physical Environment

• Healthcare settings in which children and families feel safe, physically and emotionally

• Soothing office environments
  – Noise level, therapy dog
  – Welcoming architectural features, signage

• Parking lots, bathrooms monitored, well lit

• Make sure patients (and staff) have clear access to the exam room door
Emotional Environment

• Respect personal history and experience
• Ensure staff maintain safe interpersonal boundaries and can manage conflict effectively
• Maintain open, compassionate communication
• Be aware of cultural differences regarding trauma, safety and privacy
Modifications of Health Care Delivery

• Emphasize relationships during health promotion visits
  – Strengthening Families Framework
  – Promote relational health
    • Circle of Security
    • Promoting First Relationships

• Screen
  – History of trauma, current exposure
  – Risk and protective factors
  – Trauma related symptoms
Strengthening Families
Center for Study of Social Policy

- Two Generational Approach
- Consideration of Culture
  - From cultural competence to cultural humility
- Strength-based perspective
- Biology of Stress
- Resilience theory
- Focus on Well-being
- Awareness of Risk and Protective Factors
Protective Factors Framework

• Parental resilience
• Knowledge of parenting and child development
• Social connections
• Concrete support in times of need
• Social and emotional competence of children
Promote Caretaker Resilience

• Identify strengths and protective factors in the family, nurture parental self-esteem
• Encourage social connectedness
• Remember that being connected means giving help in addition to receiving help
• Provide guidance, mentoring to improve self-efficacy
• “put the oxygen mask on yourself first”
• Encourage self-reflection in parent, child and mutual activities, keep child in mind
The Circle of Security

CIRCLE OF SECURITY®
PARENT ATTENDING TO THE CHILD'S NEEDS

- I need you to...

- Secure Base
  - Protect me
  - Comfort me
  - Delight in me
  - Organize my feelings

- Safe Haven
  - Watch over me
  - Delight in me
  - Help me
  - Enjoy with me

- Support My Exploration
  - Welcome My Coming To You

Always: be BIGGER, STRONGER, WISER, and KIND.
Whenever possible: follow my child’s need.
Whenever necessary: take charge.

www.circleofsecuritynetwork.org/the_circle_of_security.htm
Promoting First Relationships

http://pfrprogram.org
Screen for Trauma

• Universal screening in primary care reduces potential bias
• A positive screen is a disclosure and the emotional environment must be ready to hold the trauma.
• Screening should always benefit the patient—must be addressed in some way
• If positive for one type of trauma, ask about other symptoms and exposures
• Re-screening should be avoided.
Young Children

- ASQ-SE
- M-Chat-R
- Preschool Pediatric Symptom Checklist
- Strengths and Difficulties Questionnaire
School Age through Adolescence

• Find your ACE score  https://acestoohigh.com
• Strength and Difficulties Questionnaire
• Pediatric Symptom Checklist
• Anxiety: SCARED
• PTSD: PC-PTSD
• Substance Abuse: CRAFFT (preferred) or CAGE-AID
Depression

Adolescents
• Preferred:
  – PHQ-2 and PHQ-9
  – PHQ- A
• ASK suicide screen
• Alternate:
  – Beck Depression Inventory
• Each year from 12 to 18

Maternal Depression
• Preferred:
  – PHQ-2 and PHQ-9
• Alternate:
  – Edinburgh
  – CES-D
• 1, 2, 4 and 6 months
### Nadine Burke-Harris, MD


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<td>Alcohol and/or Drug Abuser in the Household</td>
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<td>5.</td>
<td>Incarcerated Household Member</td>
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<td>6.</td>
<td>Someone Chronically Depressed, Mentally Ill, Institutionalized, or Suicidal</td>
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<td>Mother Treated Violently</td>
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<td>One or No Parents, Parental Separation, or Divorce</td>
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<td>Child Protective Services Involvement</td>
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You may consider

- SEEK Safe Environment for Every Kid
  - [http://theinstitute.umaryland.edu/frames/seek.cfm](http://theinstitute.umaryland.edu/frames/seek.cfm)
- Intimate Partner Violence
  - Parent Screening Questionnaire
    - Have you been in a relationship in which you were physically hurt or threatened by a partner?
    - In the past year, have you been afraid of a partner?
    - In the past year, have you considered getting a court order for protection?
  - Do you feel safe at home?
- Has anything bad, sad or scary happened since last time we met?
Screening Instruments

SCARED

Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children (TSCC and TSCYC)
http://www4.parinc.com

Child PTSD Symptom Scale (CPSS)
foa@mail.med.upenn.edu

Univ. of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSDRI)
http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm
SCREENING
- Inquiry about current & lifelong abuse, PTSD, depression and substance use.

RESPONSE
- Onsite and community-based programs that promote safety and healing.

ENVIRONMENT
- Calm, safe, empowering for both patients and staff.

FOUNDATION
- Trauma-informed values, robust partnerships, clinic champions, support for providers and ongoing monitoring and evaluation.

Response: Practice Considerations

- All staff should be trained in
  - Trauma informed care
  - Conflict resolution
  - Cultural Humility
- Maintain referral resource
- Engage partners
  - Home visitors
  - Peer mentors
- Consider integrated primary care
Response: Management of Acute Exposure

- DEF of trauma informed care
- Guidance for parents and families
  - Recognizing trauma related symptoms
  - Management of media exposure
- When to refer
- Evidence based therapies
- Link to community resources
- Attend to secondary trauma
Trauma-Informed Pediatrics—DEF Model

• Reduce **Distress**
  – Provide child as much control as possible
  – Provide information, repeat back

• Promote **Emotional** Support
  – Listen, empower
  – Respect experience and expertise

• Remember the **Family**
  – Encourage self-care
  – Respect cultural and religious traditions
Ill or Injured Children

• Reduce Distress
  – Assess and manage pain
  – Ask about fears and worries,
  – Consider grief and loss

• Promote Emotional Support
  – Ask who and what the patient needs now. What do you need?
  – Find out if there barriers to mobilizing existing support.

• Remember the Family
  – Assess the distress of other family members.
  – Gauge pre-existing family protective and risk factors
  – Address other needs, social determinants of health
    – http://www.nctsn.org
Psychological First Aid

• Acute intervention to help children, youth and families in immediate aftermath of disaster

• Evidence based

• *Listen, Protect and Connect*

• Five principles
  – Safety -- Self and Community Efficacy
  – Calming -- Hope
  – Connectedness
Psychological First Aid: Activities

• Establish human connection
• Provide physical and emotional comfort
• Calm and orient
• Offer practical assistance to address immediate needs
• Connect with family, neighbors, friends

• Support adaptive coping, strengths, resilience
• Encourage adults, youth and families to take active role
• Link to response team or community resources
PFA mobile
Psychological First Aid

National Centre for PTSD
The National Child Traumatic Stress Network

American Academy of Pediatrics
Dedicated to the Health of all Children
Ohio Chapter

TRIUMPH OVER TRAGEDY
Guidance for Parents

• Sleep disturbance
  – Consistent bedtime
  – No screen time before bed
  – Night light
  – Accept, empathize with fears
  – Re-introduce transitional object

• Eating Disturbance
  – No reprimands or force-feeding
  – Play

• Toileting
  – Eliminate negative associations
  – Reward system
Guidance for Parents: Emotions

• Model by labeling own emotions and expressing emotions in a controlled manner
• Give directions positively and calmly
• Don’t take behavior personally
• Practice relaxation and self-calming skills with child
• Schedule special playtime
• Return to usual routine as soon as possible
Guidance for Parents: Communication and Media

• Vary the amount of information about a disaster or mass violence according to developmental level
• Turn off media to limit secondary exposure and further trauma (also clinic reception area)
• Older children benefit from more information
• For younger children, start with simple, basic facts and take the lead from questions
Maladaptive Response to Trauma

- **Internalizing**
- **Dissociation**
  - Detachment, Numbness
  - Depression, Anxiety
- More often girls, young children or those who were powerless

- **Externalizing**
- **Arousal**
  - Hypervigilance
  - Aggression, disordered conduct
  - Exaggerated response
- More often boys, older and witness to violence
When to Refer

- “Hair trigger” emotional response, difficulty regulating arousal
- Reluctance to turn to others for help
- Inability to discuss feelings
- Insecurity or excessive anxiety about safety or social connectedness
- Significant pre-existing risk
  - Loss, attachment disturbance
  - Family chaos, parental difficulty coping
  - Nature of trauma
  - Other SDH
PTSD

• Conditioned response to specific trauma
• Intrusion symptoms, avoidance, hyper-reactivity, dissociation, self-injury, triggers
• NEI dysfunction
  – Increase catecholamines, increased CV response
  – Amygdale hyperactivity, fear and anger, failure of regulation by medial PFC
  – PFC volume low, lack of executive control- inability to distinguish threats from non-threats
  – Hippocampus volume decrease- memory disturbance
PTSD in Children Under Six

• Potentially traumatic situations: child maltreatment, war, natural disasters, dog bites, invasive medical procedures

• Intrusive thoughts, avoidance, exaggerated reactivity

• DSM 5 modifications change the need to remember the event

• Sub-cortical memory, somato-sensory
# EB Therapies - Early Childhood

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<td>Triple P- Positive Parenting Program</td>
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<td>Child Parent Psychotherapy (CPP)</td>
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<td>Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)</td>
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Additional Therapies for Older Children and Adolescents

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<td>Dialectical Behavioral Therapy (DBT)</td>
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Pharmacotherapy

• No specific treatment
• Symptom modification, treat co-morbidities
  – Depression, other mood disorders
  – ADHD, anger dyscontrol
  – Substance abuse
  – Other anxiety disorders
Care of Caretakers

• Be aware that caretakers (including office staff, nurses, doctors) often have their own trauma histories
• Be ready to apply PFA to responders, coworkers and colleagues in addition to parents
• Be prepared with referral options.
• Model problem focused behavior and emotional regulation.
• Help parents set clear boundaries for themselves and their children.
Relational Home

Developmental trauma occurs when “emotional pain cannot find a relational home in which it can be held.”

Question #1

The National Survey of Children Exposure to Violence (NatSCEV) surveyed over 4,500 children and adolescents by anonymous telephone interviews. The survey revealed what percent of children were exposed to violence in the previous year?

A. Less than 50%
B. About a third
C. More than 60%
D. Nearly 90%
The NatSCEV concluded that children in the US are more likely to be exposed to violence than adults. Which group is most likely to experience exposure to assault with a weapon?

A. Late Adolescence
B. Middle Childhood
C. Toddlers
D. Preteens and Early Adolescence
Question #3

Which of the following statements describes exposure to community violence according to gender, age or timeframe?

A. Children exposed to one type of violence are at far greater risk of experiencing other types of violence.
B. Boys and girls are equally likely to witness community violence.
C. Reports of lifetime exposure were generally the same as reports of exposure during the previous year.
D. Less than 10% of 14 to 17 years olds report witnessing a shooting over their lifetime.
The patterns of exposure change over childhood and adolescence. Which of the following statements describes the risks of exposure by age group?

A. Older adolescents are least likely to experience more severe forms of violence.
B. Kidnapping is at highest risk for middle adolescents.
C. There is a 25-fold increase in rates of witnessing community violence from toddlers to older adolescents.
D. Preteens and early adolescents (10 to 13) are most likely to be assaulted with a weapon.
In the immediate wake of a crisis, while triaging or examining children, pediatricians may engage which of the following strategies to minimize exposure by children to repeat trauma?

A. Turn off TVs in waiting area.
B. Keep curtains open in triage and treatment areas.
C. Make sure staff maintain open communication with families about media reports as it happens.
D. Physicians and other pediatric providers should be encouraged to openly express their distress as a joining procedure with families.
Question #6

Which of the following is most likely to be included in anticipatory guidance for parents about the most common reactions by children after an episode of mass violence or disaster?

A. Advise that children should be allowed to set their own routine.
B. Counsel that children may have trouble falling asleep or waking with nightmares.
C. Make sure that they are watching television accounts so they have all the information.
D. Ask them to not talk about either the event or their feelings about the event.
Question #7

Which of the following increases the risk of adjustment problems after a crisis?

A. Preexisting losses, trauma or attachment disturbances
B. Immediate reunification with parents
C. Supportive family communication style
D. Strong connection with community support systems
Psychological First Aid (PFA) is an intervention first applied in schools but it useful for other community members, including staff of pediatric practices. Which of the following is a PFA strategy?

A. Offer reassurance even if false.
B. Listen, Protect and Connect
C. Isolate families form non-involved family members in order to limit further trauma.
D. RACE (rescue, alarm, contain, extinguish).
E. Suicide
Expanded media coverage of mass violence has led to a larger population at risk for both primary and secondary exposure. Which of the following may be anticipatory guidance for parents following a catastrophic event?

A. Parents should not limit exposure to media coverage.
B. Older children should follow reports on social media.
C. Make sure children view the traumatic event in graphic detail so the reality will sink in.
D. Turn off media if no further understanding can be gained.
Question #10

When eliciting trauma symptoms, pediatricians can support families by which of the following?

A. Openly express anger, frustration and grief.
B. Encourage problem-solving building on family strengths.
C. Avoid direct discussion of events.
D. Inform families that they are powerless and nothing can help them now.
Trauma related symptoms are expected physiologic responses of the HPA axis and immune system and may be misinterpreted by families. Which of the following describes a trauma related physiologic response?

A. Excessive sleep caused by reticular activating system activation
B. Increased or decreased appetite resulting from anxiety and dysregulation of the satiety center
C. Increased or decreased appetite resulting from anxiety and dysregulation of the satiety center
D. Encopresis resulting from decreased sympathetic tone
Behavioral response to trauma, particularly recurrent events, can be either internalizing or externalizing. Which of the following does not describe the distribution of behavioral responses among boys and girls?

A. Dissociation and psychic numbing are most common in girls.
B. Depression is equally common in girls and boys.
C. Hyperactivity and aggression are more common in boys.
D. Anxiety is more common in boys.
Response to Exposure

Question #13

Exposure to early childhood trauma may result in underdevelopment of parts of the brain responsible for executive function. Which of the following is not an activity of the prefrontal cortex that might affect school performance?

A. Attention, concentration
B. Working memory
C. Impulse control
D. Flight/Fight/Freeze reaction
E. Recent trauma or stress
Question #14

Because trauma is so common, formal screening at health supervision visits may be reasonable. Which of the following is an appropriate response to disclosure of trauma?

A. Try to remain business like, revealing no emotion.
B. Explore other symptoms and other exposures.
C. Record the results of a check list, then move on.
D. Tell the parents that they have failed to adequately protect their child.
Parents may be traumatized, frustrated, confused or angry by either a catastrophic event or disclosure of trauma by their child. Which of the following is an appropriate two-generational approach to care?

A. Tell the parents that you don’t have time to hear the parent’s problems.
B. Help parents identify own support system and family strengths.
C. Advise that the children should eat on their own schedule.
D. Encourage parents to step up and solve problems on their own.
Question #16

Parents may have their own trauma history. Which of the following fails as an appropriate response by a pediatrician when a parent discloses trauma?

A. Be prepared with referral options.
B. Model problem focused behavior and emotional regulation.
C. Tell them that you are the child's doctor and their problems are not relevant.
D. Help parents set clear boundaries for themselves and their children.
When to refer and to whom is often a difficult question for pediatricians when assessing children exposed to trauma. Which if the following is a correct statement about assessment and treatment?

A. Pre-existing emotional problems are not significant predictors for poor outcomes.
B. Younger children are helped by a two-generational approach such as Parent-Child Interaction Therapy (PCIT).
C. The intensity of adversity is not correlated with serious or enduring emotional and physiologic disturbance.
D. The most effective evidence-based treatment (EBT) for children younger than 5 years is Trauma Focused Cognitive Behavioral Therapy.
Resilience can be considered a capacity, outcome or process. What is the single most important finding that is associated with children doing well despite serious hardship?

A. Genetic factors influencing temperament  
B. The presence of one stable, committed relationship with a supportive adult  
C. Family socio-economic status  
D. Frequent separations during early childhood
Question #19

Which of the following is a key capacity or skill set that enables children to respond successfully to adversity?

A. Ability to multi-task
B. Capacity to plan, monitor and regulate emotional responses
C. Insistence on predictability
D. Establishment of external locus of control to blame for adversity
Resilience results from an interaction between internal predispositions and external experiences. Which phrase best describes the development of resilience?

A. Being a favored child, first in a sib-ship
B. Interaction of supportive relationships, gene expression and adaptive biologic systems
C. Solely a function of personal factors, commonly known as “grit”
D. Interaction of zip code at birth and parental ethnicity
Resilience can be strengthened at any age. Which of the following is a true statement about interventions that may strengthen the capacity to bounce back after adversity?

A. Alternative and complimentary interventions such as mindfulness practice and yoga are ineffective
B. Physical exercise is of no importance in the expression of stress related inflammatory factors
C. Active skill building programs for young adults may improve executive functions and cognitive flexibility
D. Improving parental resilience has no effect on the children
In addition to the availability of at least one stable relationship, factors that predispose children to positive outcomes despite significant adversity include which of the following?

A. Quick and strong emotional reactions
B. Exposure to parental substance abuse or mental illness
C. Identification with an affirming faith or cultural tradition
D. Protection by family from exposure to stress
Trauma-Informed Care

Question #23

Trauma informed care (TIC) in a medical setting implies full integration of knowledge about trauma into policies, procedure and practices, seeking to resist re-traumatization. Which of the following statements does not describe trauma informed care?

A. Recognition of how trauma may affect patients, families, staff and providers.
B. Ability of office staff to manage fractures as well as apply splints and casts
C. Integration of knowledge of trauma into policies, procedures and practices for health care delivery
D. Active resistance against further trauma to children or families involved in the health system
Medical traumatic stress refers to emotional reactions to injury, illness or treatment in both patients and families. What is one way that a pediatric practice might decrease the effect of potentially traumatic event?

A. Train only physicians in psychological first aid (PFA).
B. Ignore the level of distress, maintain standardized treatment.
C. Keep the parents in a separate area during possible painful procedures.
D. Adopt the DEF protocol (reduce Distress, Emotional support and remember the Family)
E. There was no statistically significant difference between those patients treated with CBT alone, fluoxetine alone and CBT + fluoxetine.
Trauma-Informed Care

Question #25

Family centered care and trauma informed care overlap in what ways?

A. Physician leadership assumes control over all decisions
B. Communication limited to what is necessary to get the job done
C. Involvement of families in decisions and emphasis on collaboration of care
D. Provider self-care is irrelevant
References for Trauma-Informed Care


• SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach. (2014) [http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf](http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf)

• Key Ingredients for Successful Trauma-Informed Care Implementation. *Center for Healthcare Strategies.* (2016) [http://www.chcs.org/media/ATC_whitepaper_040616.pdf](http://www.chcs.org/media/ATC_whitepaper_040616.pdf)
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