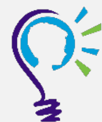

Trauma informed care: Working with youth and families post-pandemic

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Assistant Professor, Psychiatry; Upstate Medical University
&
Victor M. Fornari, MD, MS
Professor of Psychiatry & Pediatrics; Zucker School of Medicine at Hofstra/Northwell

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Speaker:

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Professor of Psychiatry & Pediatrics
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Disclosures

Neither we nor our spouses/partners has a relevant financial relationship with a commercial interest to disclose.

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Learning objectives

- Identify developmentally appropriate strategies for screening, diagnosing PTSD and trauma related disorders.
- Review evidence based strategies for supporting resiliency.
- Apply trauma informed care principles to clinical practice.

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Why this matters: Post-pandemic.

- Trauma is ubiquitous.
  - Patients, staff, ourselves – we can all experience its effects.
- Pandemic increased stress & trauma
  - Increased MH crisis, sexual exploitation, & emergency room visits for suicidal behavior.
- Trauma informed care can help
  - Provide frame & principles for approaching kids and families & supporting resiliency for ourselves and our patients.

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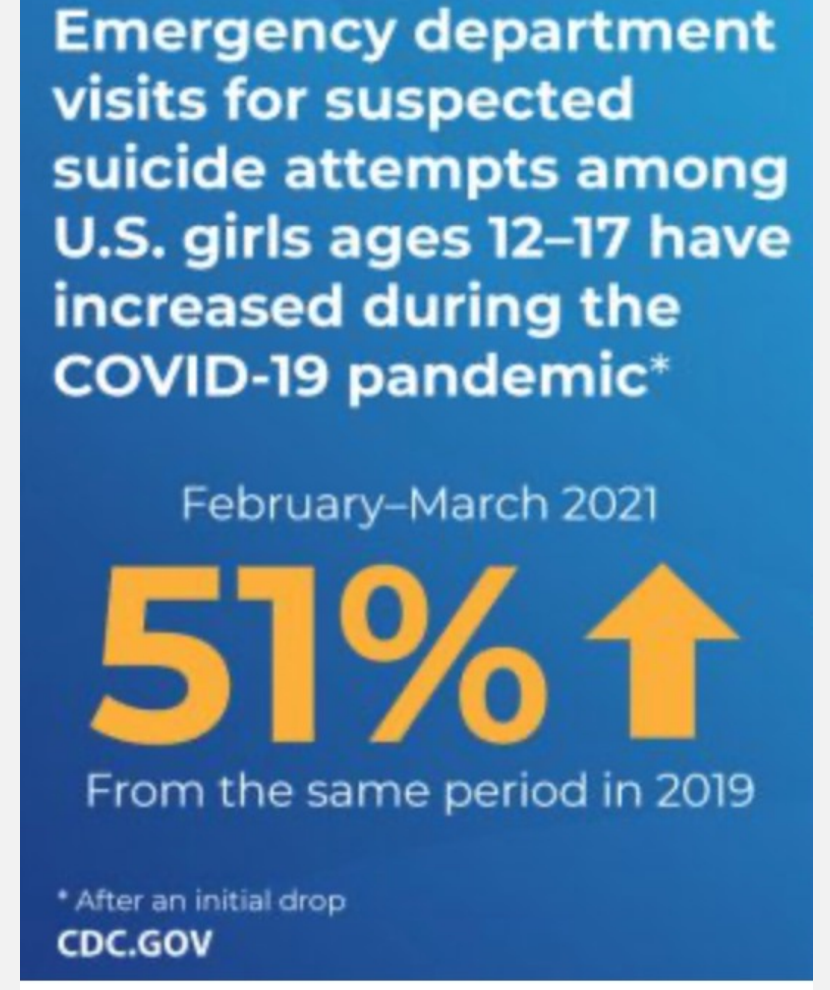
Pre pandemic vs post pandemic crisis

- Suicide – second leading cause of death 10-25 years.
- Rates among black youth have risen faster than any other racial/ethnic group.
- Healthcare disparities affect access & treatment.



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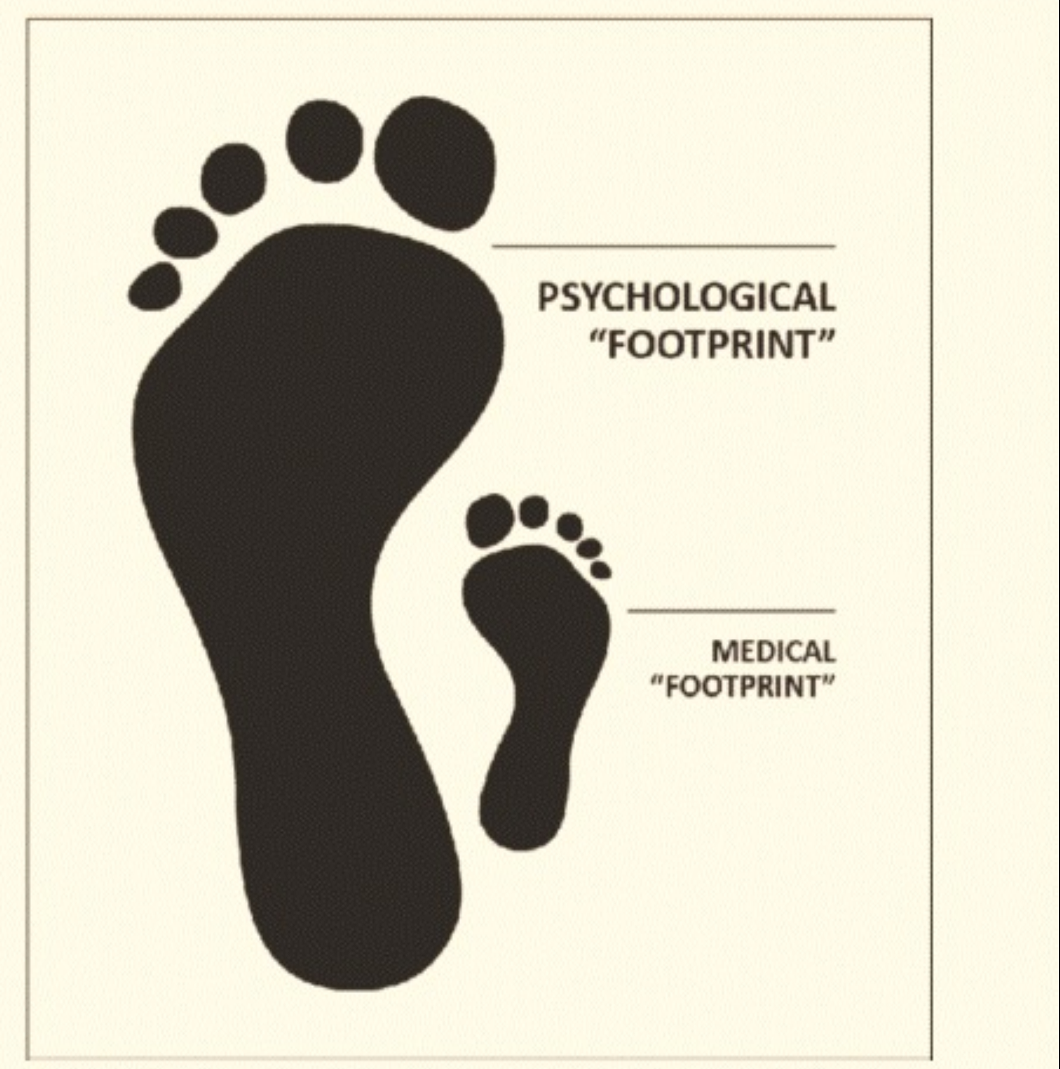
In a disaster, the size of the psychological "footprint" greatly exceeds the size of the medical "footprint."



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COVID Pandemic impact on Youth

Impacts on families

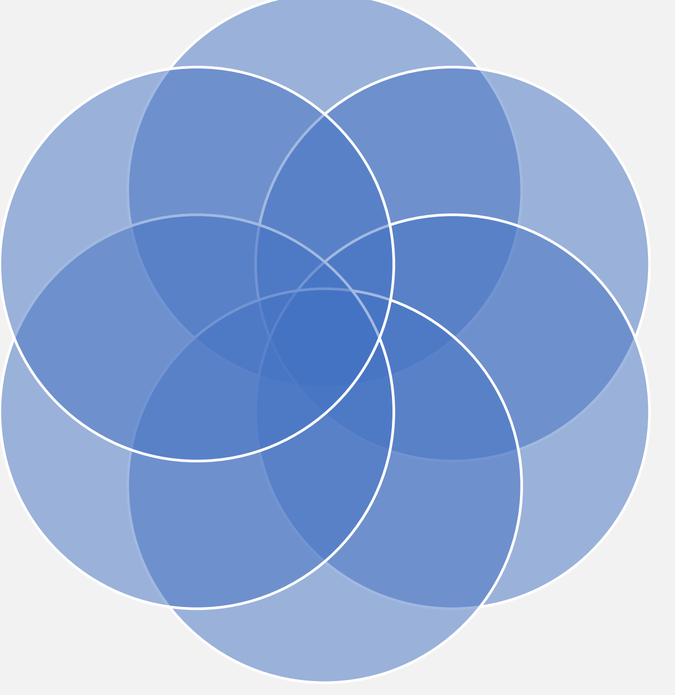
- Increased trauma, abuse, parental mental health issues, grief

Risk for vulnerable populations

- Exacerbations of existing pathology
- Situational development of psychopathology
- Access to care

Economic impacts

- Food insecurity
- Housing
- Unemployment



School

- Education Loss

Technology

Social isolation

Wagner 2020; Russell 2020; Clary 2020; Bhatia 2020; Racine 2020

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On Adverse Childhood Experiences

- https://projectteachny.org/prevention-science/
- Prevention science webpage has more information these topics, including impact of ACES, racism, and resources for trauma-informed care and resiliency.

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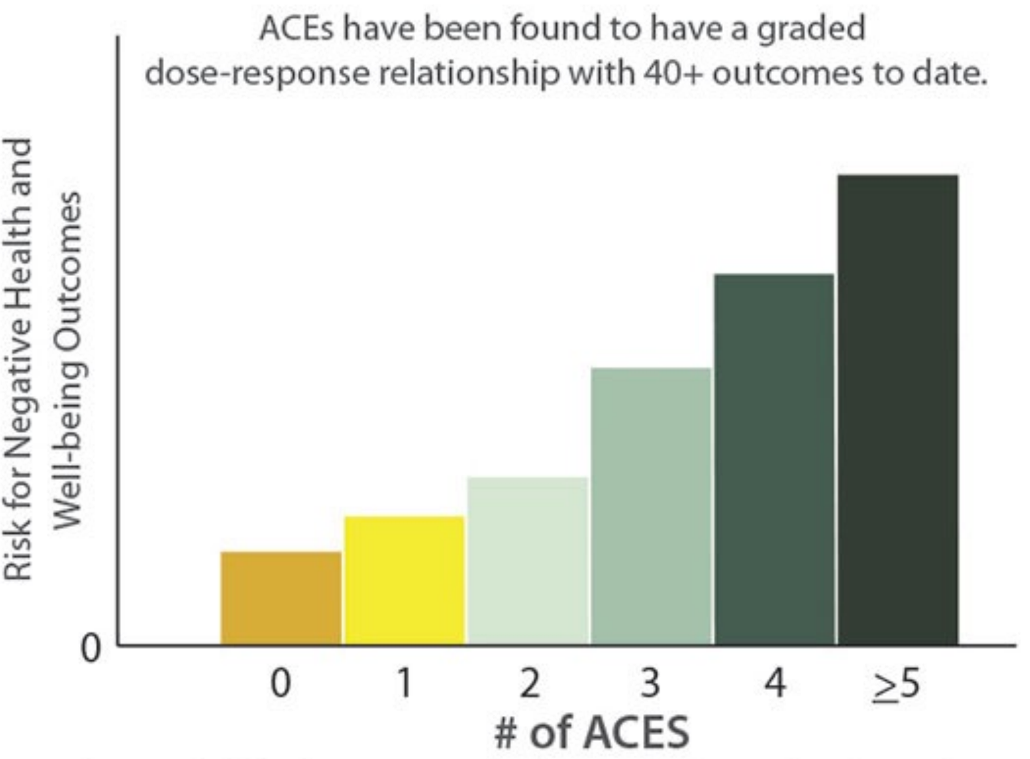

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Figure 2: Leading Causes of Death in the U.S.

	Leading Causes of Death in the U.S., 2017	Odds Ratios for ≥ 4 ACEs (relative to no ACEs)
1	**Heart disease**	2.1
2	**Cancer**	2.3
3	**Accidents** (unintentional injuries)	2.6
4	**Chronic lower respiratory disease**	3.1
5	**Stroke**	2.0
6	**Alzheimer's** or dementia	11.2
7	**Diabetes**	1.4
8	**Influenza and pneumonia**	Risk unknown
9	**Kidney disease**	1.7
10	**Suicide** (attempts)	37.5

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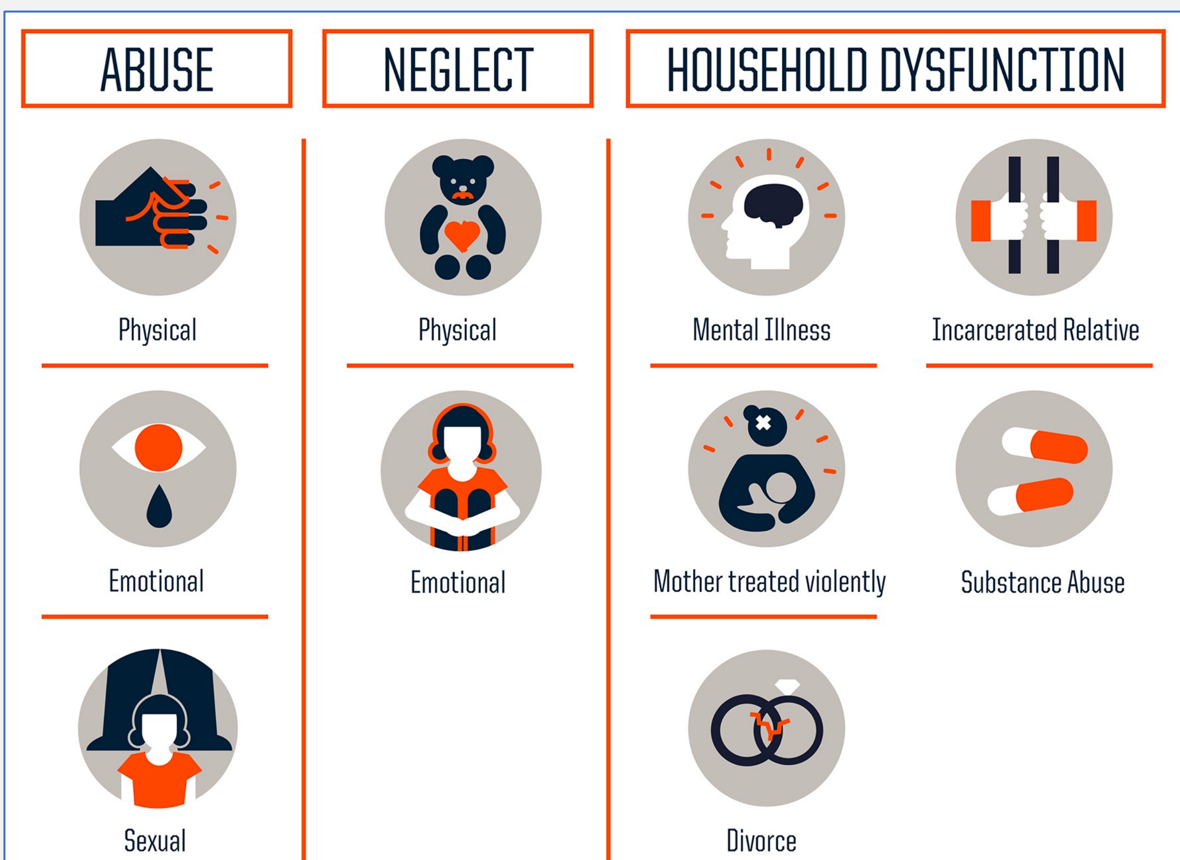
Trauma types: Expanded ACES



- Community Violence
- Bullying
- Disasters
- Medical trauma
- Refugee trauma
- Terrorism
- Traumatic Grief
- Historic & Racial trauma

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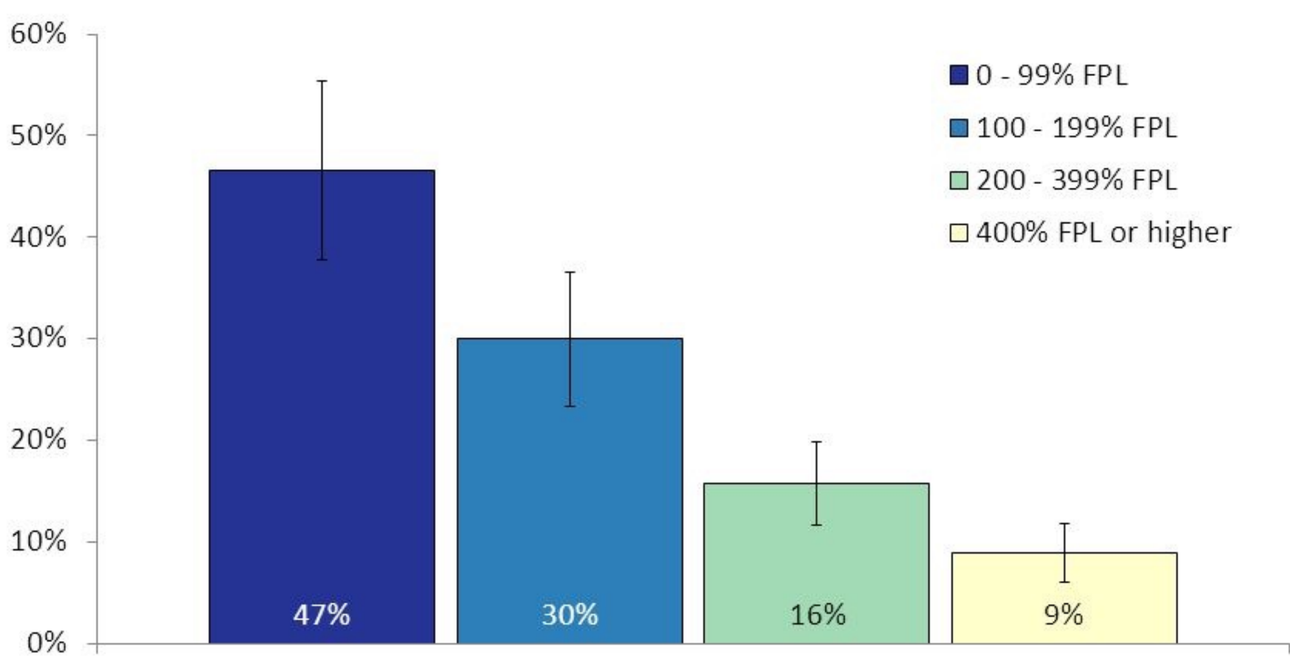
Social determinants of ACEs



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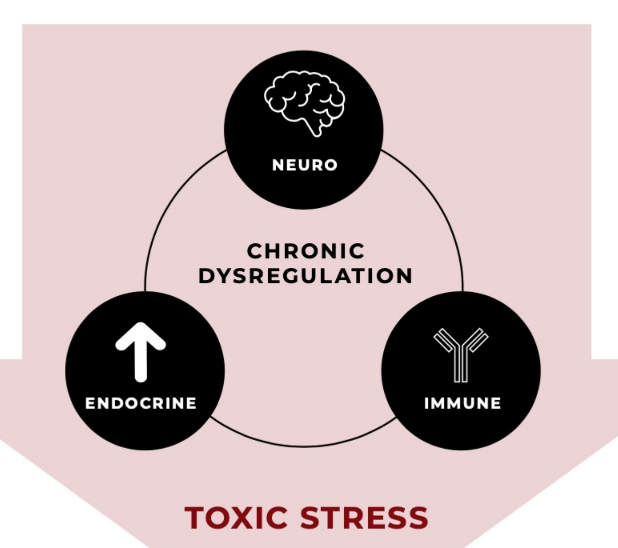
Biology of trauma

- Begins before birth with epigenetics.
- Myelination, synaptic connections, glial and circulatory development
  - Depends on adequate nutrition, no toxins.
  - Guided by “good enough” environment/cues
- Critical sensitive periods of development.

Van der kolk, (2003)



Adapted from *Bucci et al.*, 2016[16]

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Resilience: what tips the balance?

Adverse Events

Benevolent Events

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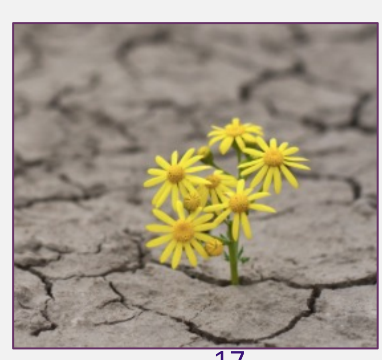
Benevolent childhood experiences

- Did you have…a care giver with whom you felt safe?
- At least one good friend?
- Any beliefs that gave you comfort?
- At least one teacher who cared about you?
- Likes school?
- Good neighbors?
- An adult who could provide you with support or advice?
- Opportunities to have a good time?
- Did you like yourself or feel comfortable with yourself?
- A predictable home routine?

- Higher levels associated with less PTSD and stressful life events in pilot study with pregnant women (Narayan, Rivera, Bernstein, Harris, Lieberman; 2018)



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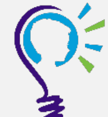

Protective factors

Community:	• School engagement. • Family & neighborhood. • Participation in after school activities.
Relationships:	• Relationships with one supportive adult • Friends
Individual:	• Positive thoughts of self • Self-regulation • Social competence • Flexible thinking

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Jon, 10 yr old boy

- **CC:** Aggression at dad’s house and refusing to go.
- **Background:** Split households; h/o dad incarceration and drug use; historical traumas present and pattern of disrupted families.
- **On exam:** Jon presents as youth with peer social difficulties, negative outlook.

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- **On exam:** Jon presents as youth with peer social difficulties, negative outlook.

- **Differential dx:** ADHD, depression, anxiety, trauma-related

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Jon, 10 yr old boy

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- **Background:** Split households; h/o dad incarceration and drug use; historical traumas present and pattern of disrupted families.
- **On exam:** Jon presents as youth with peer social difficulties, negative outlook.

- **ACES (3+):** separated parents, substance use, incarceration…

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Trauma sx developmentally

Preschool:	School-age:	Adolescent:
• Reduced play	• New fears • Regression	• Reckless behavior • Self-imposed restrictions

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Frayed: Signs of trauma

- Fits, frets, fear
- Restricted development
- Attachment difficulty
- Yelling and yawning
- Educational delays
- Defeated, dissociation

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TRAUMA SPECTRUM: FUNCTIONAL SYMPTOMS, PTSD AND COMPLEX TRAUMA

A. Trauma mild or with support

Functional difficulties –

Sleep, tantrums, toileting, eating

B. Severe incident trauma with support

Functional difficulties AND

PTSD sx : Arousal, avoidance, re-experiencing, fear

C. Early interpersonal trauma, no support

Functional difficulties AND

PTSD sx: Arousal, avoidance, re-experiencing, fear AND

Affect dysregulation – violent reckless or self destructive, dissociation, attentional issues

Negative self-concept – persistent beliefs as diminished, defeated, worthless, shame, guilt

Interpersonal disturbances – difficulty with relationships

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How to assess trauma disorder

Four Approaches to Trauma Inquiry

- Assume a history of trauma without asking
- Screen for the impacts of past trauma instead of for the trauma Itself
- Inquire about past trauma using open-ended questions
- Use a structured tool to explore past traumatic experiences

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Screening for PTSD

- Child and Adolescent Trauma Screen
  - Self report, children 7-17
  - Caregiver report 3-17
  - Score >12 suggests need to refer and possibly treat
- Child PTSD Symptom Scale
  - Self report, 8-18
  - Score >15 suggests PTSD highly likely.
- UCLA Brief COVID-19 Screen for youth PTSD
  - Available in English and Spanish
  - Score >20 potential PTSD
- Pediatric Traumatic Stress Screening Tool

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PTSD in DSM-5

- Traumatic event (Criterion A) + 4 clusters + impairment x one month
- Clusters:
  - B: **Intrusive symptoms**
    - For kids – repetitive play with trauma themes
    - Frightening dreams without recognizable content
    - Trauma reenactments during play
  - C: **Persistence avoidance**
  - D: **Negative changes in cognition and mood**
  - E: **Hyperarousal and reactivity changes**

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Trauma and Stressor Related Disorders

- Acute Stress Disorder
- Adjustment Disorders
- Post traumatic stress Disorder
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Other Specific Trauma and Stressor Related D/O
- Unspecified Trauma and Stressor Related D/O

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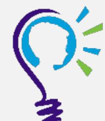

Trauma informed care principles with Jon

- A team-based & relationship-based approach
  - How to start relationship right with regards to space, time, orientation?
  - Who screens? Which screens?
  - Who follows up if positive?
- Taking care of oneself as a provider (compassionate boundaries)
  - What do you need to assess and treat this family?
  - How do you get additional help?
  - What are your limits?

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Universal Screening tools

- ACES/BCES for parents
- ACES/PEARLS for pediatric practices
- SEEK for 0-5 youth
- BCES for youth
- Care process model

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:

1. Has your child ever lived with a parent/caregiver who went to jail/prison?
2. Do you think your child ever felt unsupported, unloved and/or unprotected?
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?

   Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child?

   Or has any adult in the household ever hit your child so hard that your child had marks or was injured?

   Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*

Add up the "yes" answers for this first section:

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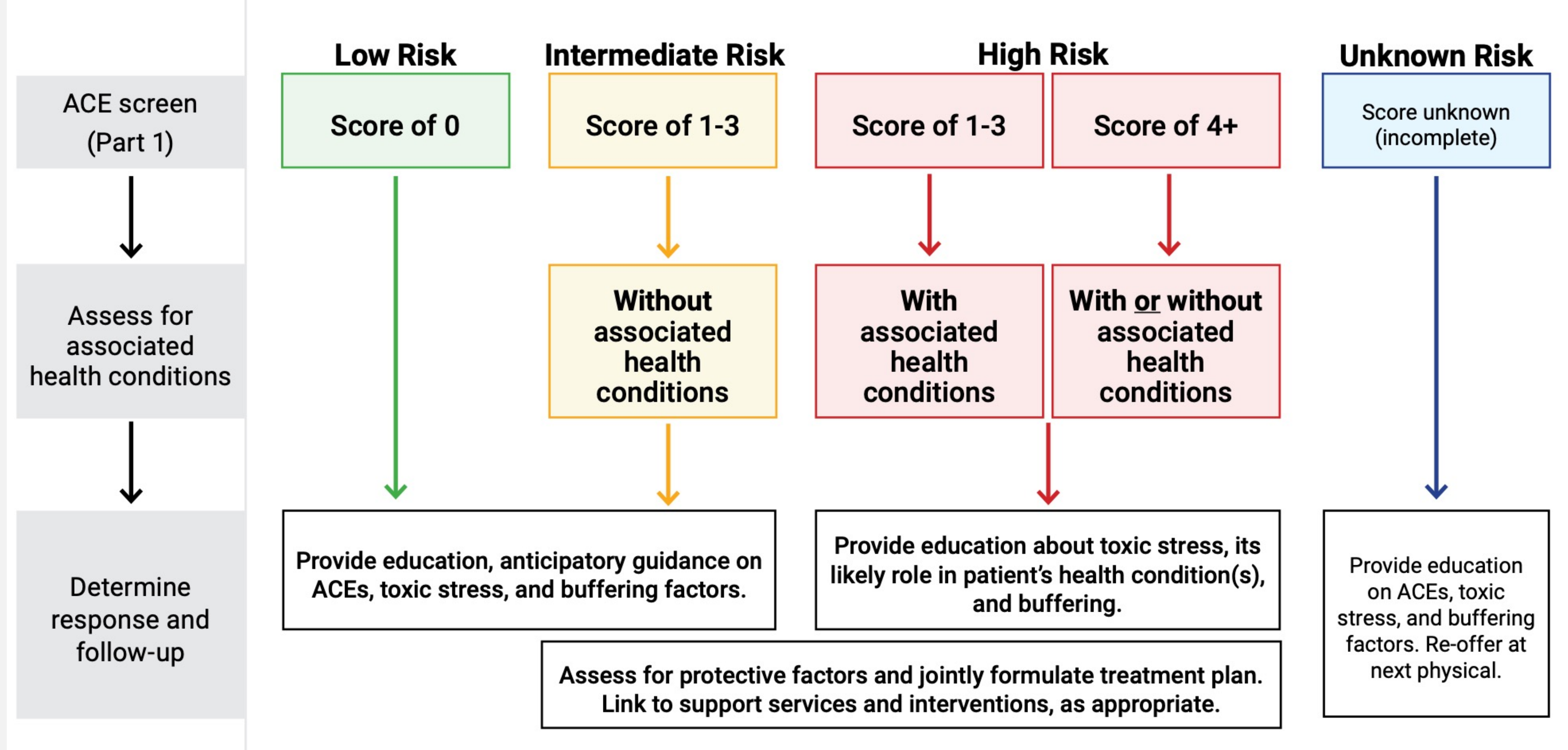
ACES Screening



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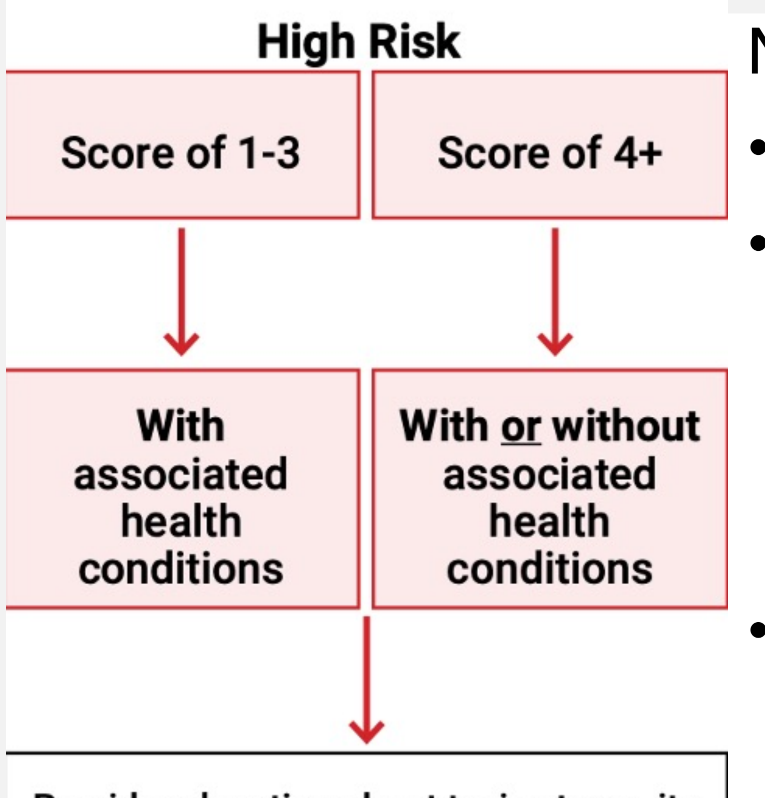
Jon, 10 yr old boy



Next steps…

- Psychoeducation
- Reinforce BCES & parents working together
  - BCES include supportive caregiver who he feels safe with, opportunities to play.
- Assess need for specialized services.

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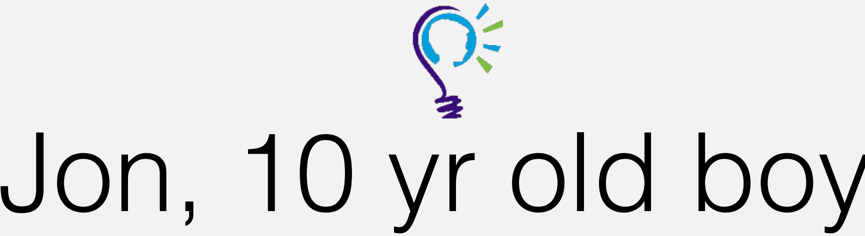

Jon, 10 yr old boy

- **Screening for trauma related sequelae:**
  - Pediatric traumatic stress screening tool: 15, suggesting moderate PTSD
  - CES-DC (depression scale for youth): 9
  - No acute safety concerns for Jon.

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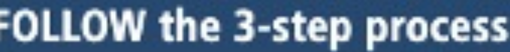
Care Process Model

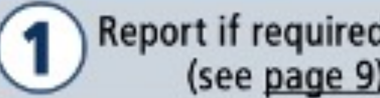
ROAD MAP OF CARE: PEDIATRIC TRAUMATIC STRESS IN PRIMARY CARE SETTINGS (6 – 18 years of age)

Child screens positive for a potentially traumatic experience* using the Pediatric Traumatic Stress Screening Tool (pages 33 – 36)

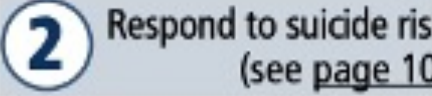
* Traumatic experiences may include:

- Abuse
- Violence
- Serious accidents
- Natural disasters
- Medical trauma

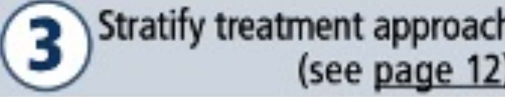




Call DCFS if child maltreatment is suspected (1-855-323-3237).



Follow Intermountain's *Suicide Prevention CPM* if child reports thinking about being better off dead or of harming themselves in some way (see page 10).



- Refer to the **Pediatric Traumatic Stress Screening Tool** to assess symptom severity (see pages 33 – 36).
- Inquire about child's functioning in daily activities.
- Use the treatment stratification chart below to determine next steps.

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When to refer to specialized trauma tx

Treatment Stratification		
Symptoms	**Poor functioning?**	**Clinical decision**
Severe symptoms Score ≥21**	YES or NO	**Restorative Approach** Refer to evidence-based trauma treatment (see page 14).
Moderate symptoms Score 11–20**	YES / NO	**Resilient Approach** Refer to MHI or community/private mental health (see page 14).
Mild symptoms Score ≤10**	YES / NO	**Protective Approach** Provide strengths-based guidance and continue monitoring (see page 14).

Scores from **Pediatric Traumatic Stress Screening Tool. See page 9 for more information and pages 33–36 for copies of the screening tool.

PROVIDE a brief in-office intervention (see page 15)	
Sleep problems	• Sleep education • Belly breathing • Guided imagery • Medication
Hypervigilant/intrusive symptoms	• Belly breathing • Guided imagery • Progressive muscle relaxation • Mindfulness
Avoidance/negative mood symptoms	• Behavioral activation • Return to routine • Parent-child communication

Possible medication roles:

- Trauma-related sleep problems (see page 16)
- Pre-existing anxiety, depression or severe ADHD. See *Depression* and *ADHD* CPMs.

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PTSD Tx Components in Primary care

Understanding a person's reaction to the trauma, without necessarily going into the trauma itself.

Stress management techniques

Planting psychoeducation seeds.

Meeting families where they are in regards to acknowledgement.

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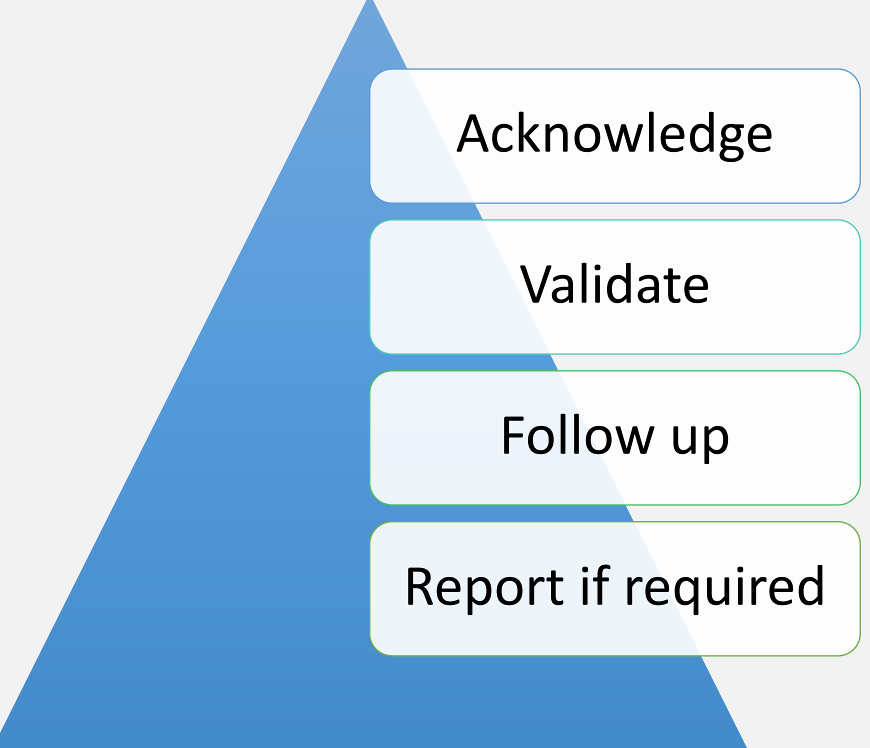
What do you do when a kid screens positive?



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What do you do when a kid screens positive?

"I'm sorry that happened to you.
That sounds like it might have been confusing and scary…"

- Acknowledge
- Validate
- Follow up
- Report if required

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What do you do when a kid screens positive?

"You are not alone, it is not your fault, and I will help."

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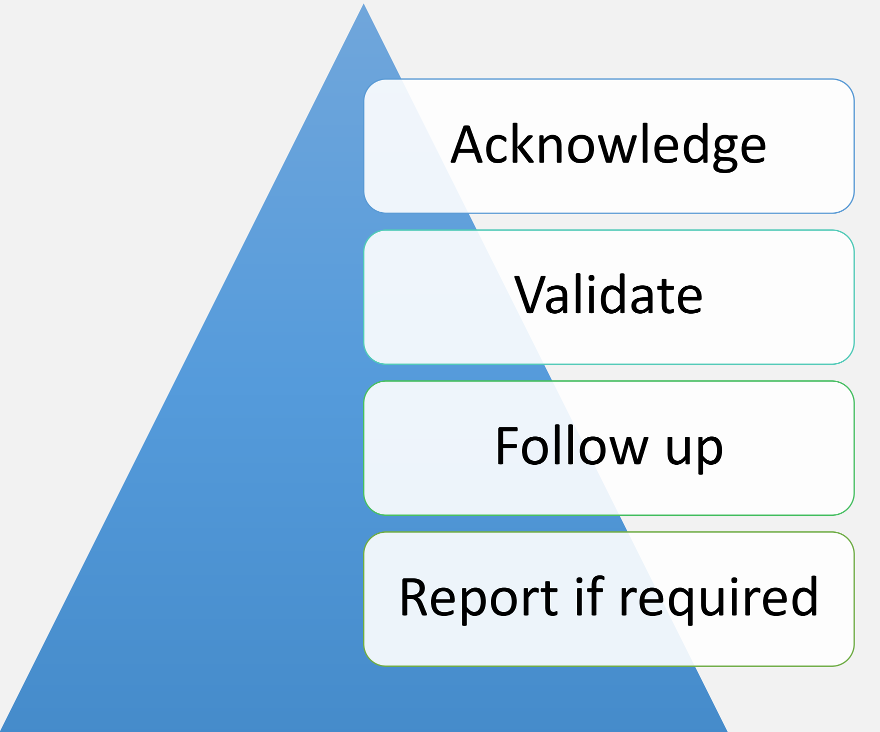
What do you do when a child/family endorse trauma/ACES?



"I am sorry this happened to you. Thank you for sharing with me. This information can help me understand how best to care for you. Trauma can continue to affect our lives and health. Do you feel like this experience affects your health or well being?"

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Brief interventions

If you checked 'yes' on either question above, please continue below.

Select how often your child had the problem below in the past month.
Use the calendars on the right to help you decide how often.

FREQUENCY RATING CALENDARS

	How much of the time during the past month...	None	Little	Some	Much	Most
1	My child has bad dreams about what happened or other bad dreams.	Sleep problems				
2	My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	Both				
3	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	Hypervigilance and Intrusive Symptoms				
4	When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.					
5	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.					
6	My child has trouble concentrating or paying attention.					
7	My child gets upset easily or gets into arguments or physical fights.					
8	My child tries to stay away from people, places, or things that remind him/her about what happened.	Avoidance and Negative Mood				
9	My child has trouble feeling happiness or love.					
10	My child tries not to think about or have feelings about what happened.					
11	My child has thoughts like "I will never be able to trust other people."					
12	My child feels alone even when he/she is around other people.					
13	*Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Suicide				

TABLE 7. Teach a Helpful Response (for details see page 23)

Sleep problems	• Sleep education • Belly breathing • Guided imagery
Hypervigilant / intrusive symptoms	• Belly breathing • Guided imagery • Progressive muscle relaxation • Mindfulness
Avoidance / negative mood symptoms	• Behavioral activation • Return to routine • Caregiver support

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ACEs Aware Self-Care Tool for Pediatrics

When a child or teen has experienced significant Adverse Childhood Experiences (ACEs), their body may make more or less hormones than is healthy. This can lead to problems with a child s physical and/or mental health, such as asthma, poor growth, depression, or behavior problems. Safe, stable, and nurturing relationships and environments where children feel safe emotionally and physically can protect children s brains and bodies from the harmful effects of stress. You can help your child be healthier by managing your own stress response and helping your child do the same. Healthy nutrition, regular exercise, restful sleep, practicing mindfulness, building social connections, and getting mental health support can help to decrease stress hormones and prevent health problems. Here are some goals your family can set together to support your child s health. [*Check the goals that you are picking for yourself and your family!*]

- ❑ **Healthy relationships.** We ve set a goal of...
  - ❑ Using respectful communication even when we are upset or angry
  - ❑ Spending more high-quality time together as a family, such as:
    - ❑ Having regular family meals together
    - ❑ Having regular no electronics" time for us to talk and/or play together
    - ❑ Talking, reading, and/or singing together every day
  - ❑ Making time to see friends to create a healthy support system for myself and our family

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What's the best way to respond to a child's ACEs? If possible, prevention of ACEs is best. In addition, you can:

- Modelling and scaffolding how to
  - Tune in and learn child's signals
  - Learn how to soothe your child and yourself
  - Talk and play with you child
  - Manage your own stress

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Evidence-based tx

At-risk youth

- Multiple ACES/At-risk youth
  - Parent-child interactive therapy
  - Child parent psychotherapy to help child & parent attune

PTSD & Complex trauma

- Complex trauma
  - ARC: Attachment, regulation, competency
  - ITCT: Integrative treatment of complex trauma
- PTSD
  - Trauma focused CBT (ages 3+)
  - Child and family traumatic stress intervention

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PTSD essential tx components

Direct exploration of trauma – building narrative, exposure

Stress management techniques

Exploration and correction of inaccurate attributions regarding trauma (cognitive reprocessing)

Parental inclusion if possible, to help understand and validate trauma narrative

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Working with kids and caregivers

- Psychoeducation to parents.
- Shifting from “It was my fault” or “Nothing is safe anymore”to validation/safety.
- Attributional distortions explored and challenged beyond mere reassurances.
- Accomplished by step-by-step logical analysis during therapy.

- Example:

Jon was able to say with father present that he believed it was his fault that father went to jail. Dad able to correct this distortion in session.

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Psychopharmacology

- Adjunctive - NOT one of the established elements of treatment
- Theories; some reports of med efficacy; no randomized trials.
- Medications used to treat prominent symptoms or co-morbid psychiatric conditions.

Core PTSD sx

- Hyperarousal - alpha agonists

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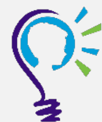

ACES Story can seem overwhelming

The good news is that there is something we can do about it.

Anchoring: 2 feet, 1 breath

Two Feet – feel our feet on the ground

and a breath – be aware through one breath cycle

And continue into the room. A little more present.

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The cure for burnout isn’t and can’t be self care. It has to be all of us caring for each other.

~Emily & Amelia Nagoski

Dare to lead Podcast with Brene Brown

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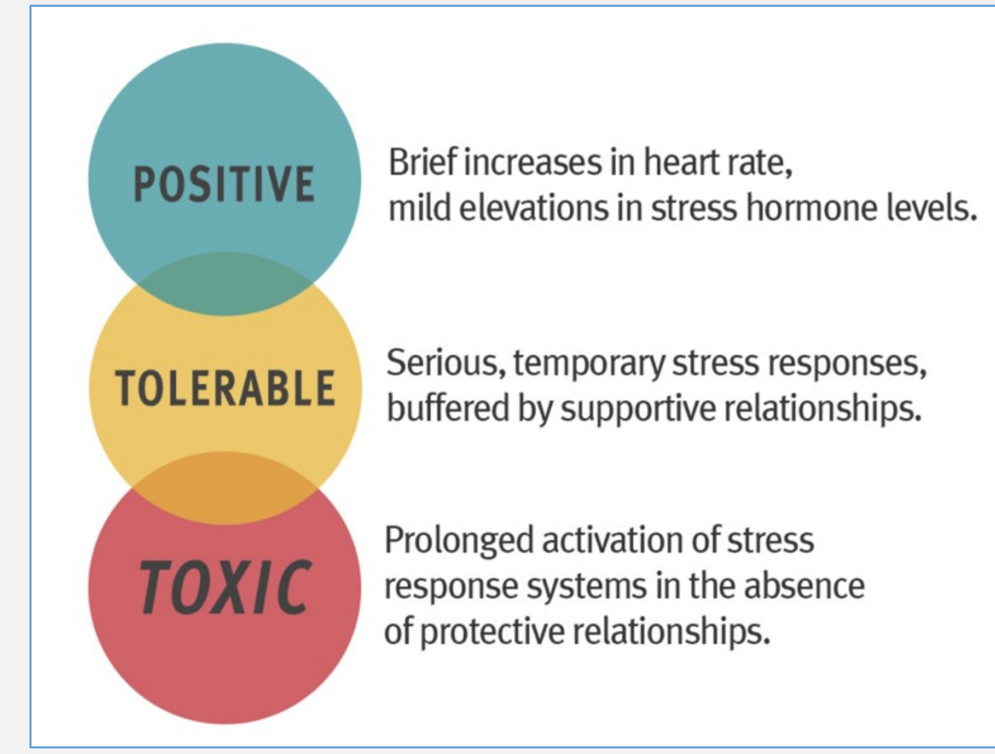
The importance of relationships

- As a buffer against toxic stress.
- Role of care givers in attachment development.
- Role of primary medical home in scaffolding positive relationships and being a secure base.

- Stress is toxic in absence of protective relationships



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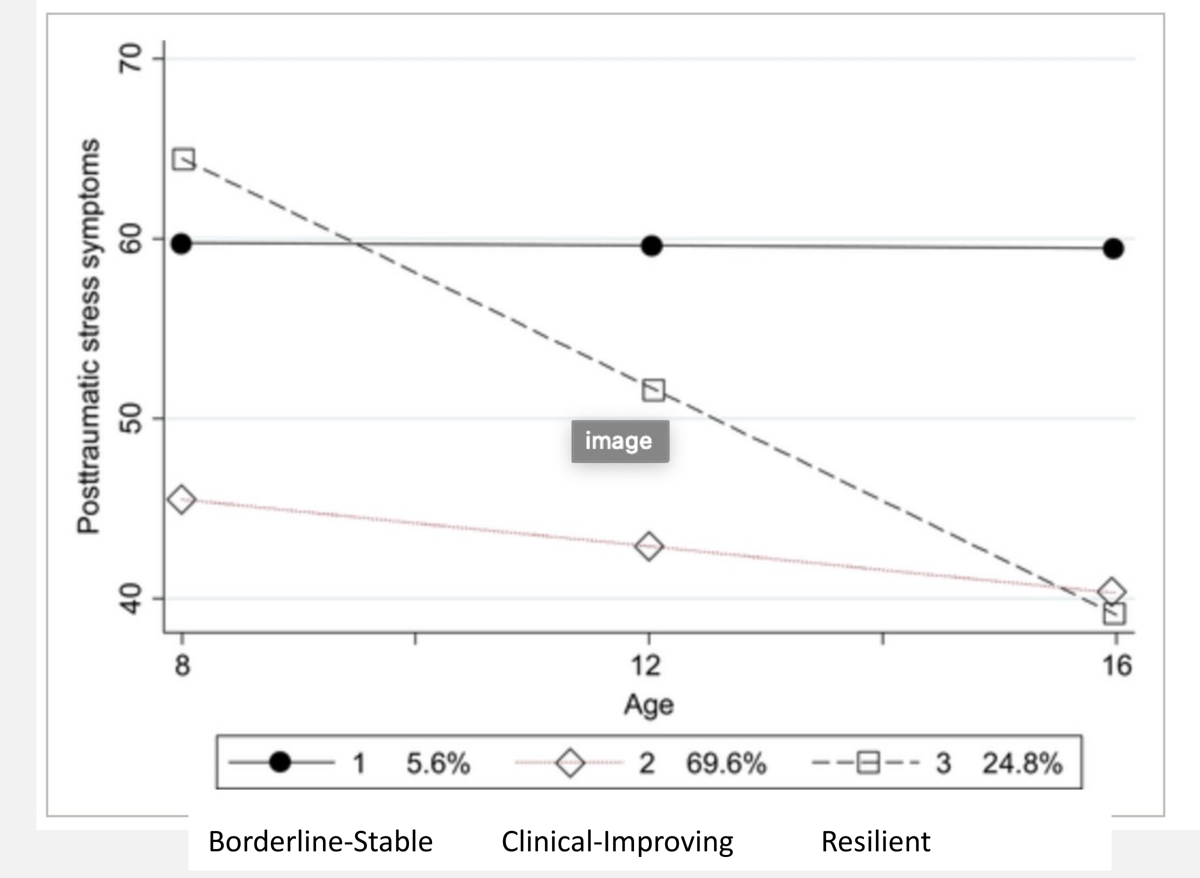
PTSD patterns over time: Most improve with support

3 patterns of symptoms:
- 70 % Resilient
- 25 % Clinical-Improving
- 5 % Borderline-Stable

- From longitudinal Study of Child Abuse & Neglect
  - N = 1,178 at-risk children
  - Multiple evals between 4-18 years of age.

(Miller-Graff & Howell, 2017).



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Role of primary care: A secure base

- Supportive relationship over time.
- A safe place:
  - Patient centered medical home.
- Targeting modifiable/preventable ACES.
- Leveraging BCES & resilience factors.

CIRCLE OF SECURITY

PARENT ATTENDING TO THE CHILD'S NEEDS

I need you to...

Support My Exploration

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

SECURE BASE

SAFE HAVEN

I need you to...

Welcome My Coming To You

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

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

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4 Rs of Trauma-Informed Care: Framework

Realize the widespread impact of trauma and understand potential paths for recovery

Recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system

Respond by fully integrating knowledge about trauma into policies, procedures, and practices

Resist re-traumatization of children, as well as the adults who care for them

Source: Childtrends.org – This figure is adapted from Substance Abuse and Mental Health Services Administration (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

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CARE COMPASS NETWORK

Trauma informed care: principles

Establish physical and emotional safety of patients and staff.	Build trust between providers and patients.	Recognize the signs and symptoms of trauma exposure on physical and mental health.
Promote patient-centered, evidence-based care.	Ensure collaboration by bringing patients into process of goal-setting, treatment-planning.	Provide culturally sensitive care.

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Trauma informed care principles with Jon

- Team-based approach to approaching Jon and family
  - Take/make time to get to know Jon and family and follow up.
  - Set realistic & compassionate expectations for each visit.
  - Get support around screening and follow up.

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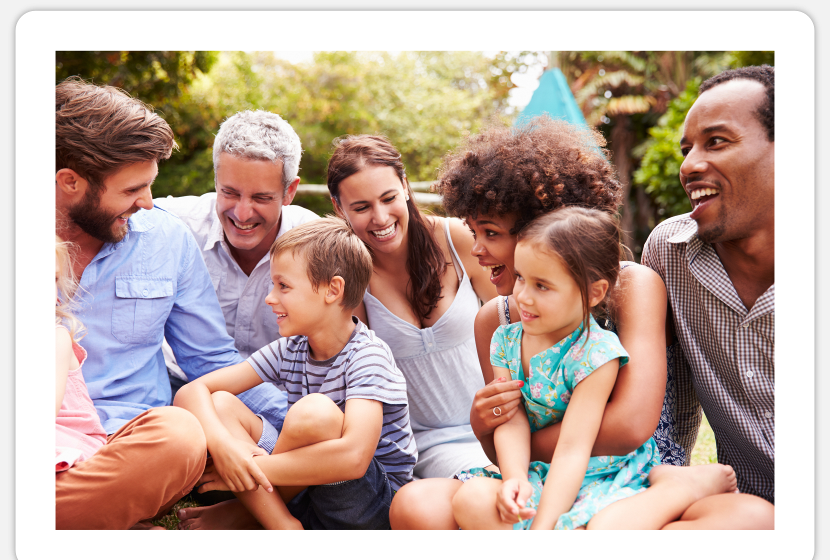
TIC approaches: Highlight strengths

- In the past, which strengths have you or your family relied on to bounce back after difficult experiences?



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TIC approaches: Strength based questions

- Lead with questions of family and strengths and encourage parents to reflect on strengths.
- Gather info about family supports.

- Tell me a little bit about yourself. What are some things you are really proud of? What are your parent really proud of?
- If something difficult were to happen, who would be available to help you?
- If something good were to happen, who would be cheering for you?"
-

[Applying Trauma-Informed Practices to the Care of Refugee and Immigrant Youth: 10 Clinical Pearls (nih.gov)](nih.gov)

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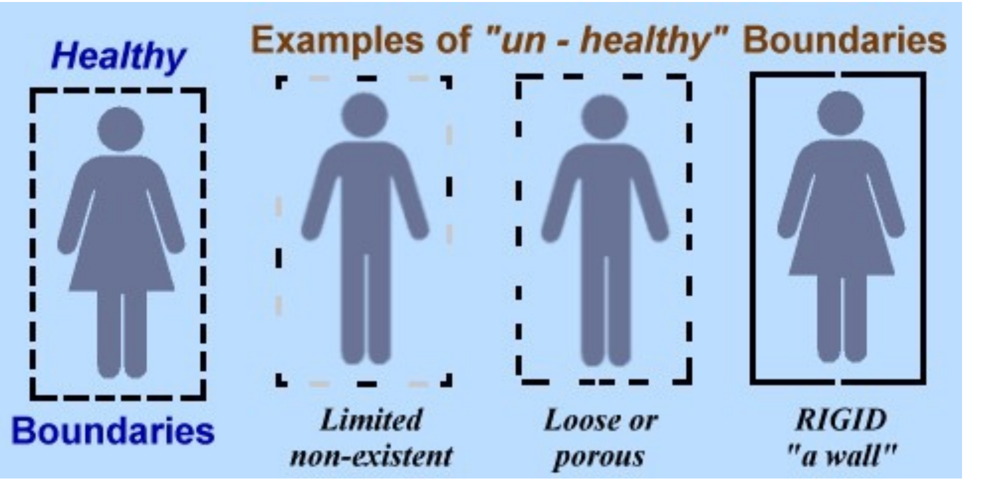
Trauma informed community begins with ourselves

- Setting compassionate expectations for yourself
- Setting compassionate boundaries
- Advocating for what you need
- Strengthen resources (internal & local)
- Cannot do this work alone!



https://compassionresiliencetoolkit.org/

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Building Resilience - Individual and Organizational

Expectations	Boundary Setting	Staff Culture	Self-Care
• Realistic ones for yourself • Realistic ones for others	• Know what you want/can say 'yes' to	• Connecting with colleagues in a way that heals & helps	• Mind • Spirit • Strength • Heart

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Take aways

- Trauma is ubiquitous & most youth are resilient. With support.
- Most severe trauma sequalae occurs in context of absent protective relationships.
- You can have an important role in promoting resilience in a child & family's life.
- What changes are needed to embody and integrate TIC into your practice?

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References & Resources

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More Resources

- https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
- https://www.acesaware.org/
- https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906
- https://projectteachny.org/prevention-science/
- https://Thenationalcouncil.org
- http://developingchild.Harvard.edu

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