Incorporating 
TRAUMA INFORMED CARE 
in Pediatric Practice

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Disclosures

Neither I nor my spouse has a relevant financial relationship with a commercial interest to disclose.
“ACE studies are as revolutionary now as germ theory was for the 19th century”

-Sandra Bloom, MD, National Collaboration on ACEs (NCAR), 2013
Objectives

• Understand the rationale for trauma informed approach

• Acknowledge how our own perceptions affect the care we provide

• Acquire a framework for incorporating trauma informed care into practice*

*“Put your own oxygen mask on before helping others”
What is Trauma-Informed Care?

- SAMHSA (2015) concept of a trauma-informed approach - A program, organization, or system that is trauma-informed:
  - *Realizes* the widespread impact of trauma and understands potential paths for recovery
  - *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system
  - *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices
  - *Seeks* to actively resist *re-traumatization.*
Trauma Informed Care Models

• Embrace & demonstrate new mental models informed by trauma theory
• Missouri Model (2014)
  • Stages of becoming “Trauma Informed”
• Schnyder (2015)
  • Psychotherapies for PTSD: What do they have in common?
• “Three Pillars” (Bath, 2008)
  • Safety
  • Connections
  • Managing emotions
Rationale

Why become trauma informed?
• Trauma is pervasive
• Impact is far-reaching
• Affects how people approach health care and other services
• Helping services can be inadvertently re-traumatizing

Focus on:
• Recovery and healing are possible
  • neuroplasticity, neurogenesis
• Protective factors facilitate healing and resilience
• Healing takes place in the context of safe and supportive relationships
I. Safety

• Creating a safe place
  • Consistency
  • Reliability
  • Predictability
  • Availability
  • Honesty
  • Transparency
  • Include child in decision-making
  • Provision of knowledge about their circumstances (where appropriate)
II. Connections

• Restructure these associations so that the child/adolescent can develop positive emotional responses (e.g., happiness, joy, feelings of security) with some adults

• Learn to accurately distinguish between those who threaten harm and those that do not

• Peer Support – including families of traumatized children or with hx of trauma

• The qualities of the therapeutic relationship itself account for twice as much positive change as the particular therapeutic technique
III. Emotion & Impulse Management

• A primary focus of work with traumatized children needs to be on teaching and supporting them to learn new ways of effectively managing their emotions and impulses
  • Teaching self-regulating skills
  • May need adults who are willing to “co-regulate” with them when their emotions run wild, rather than relying on coercive approaches (Bath, 2008)
  • The basic skills of active listening have a central role, especially the reflective skills which promote the labelling of feelings.
Coping with Secondary Exposure to Trauma

• “The Cost of Caring” (Figley, 1982)
• Signs & Sx
  • Secondary Traumatic Stress
  • Vicarious Trauma/ Compassionate Fatigue
  • Burnout
• Managing Risk
  • UB School of SW – “Self Care Starter Kit”
    • Awareness
    • Balance
    • Connection
• Process for incorporating into practice
  • Champion
  • Normalize
Summary

- Kids who have experienced developmental trauma need
  - adults in their lives who can understand the impact of their experiences
  - People who can recognize the pain from ruptured connections that can lead to challenging behaviors
  - A trauma-informed approach that promotes healing and connections

- Important to consider cultural, historical, and gender issues
  - Efforts must be culturally sensitive and free of prejudices based on biases and stereotypes
References

- European Journal Psychotrauma. 9(5); 265.