Trauma informed care: Transforming your practice

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Disclosures

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

- Learn the importance of trauma informed care principles & strategies for applying to your practice.
- Review evidence based prevention and treatment to support resilient patients, families, and yourself.
- Identify developmentally appropriate strategies for assessing, diagnosing and treating trauma and trauma-related disorders.
Why this matters.

• Trauma is ubiquitous.
• Patients, staff, ourselves – we can all experience its effects.
• Trauma informed care can help
  • Frame for approaching kids and families regardless of diagnosis.
  • Provide principles for increasing engagement & supporting resiliency for ourselves and our patients.
~60% adults report at least 1. 25% adults report 3 or more ACES.

From ACES study (90s, middle class, Kaiser)
Association between ACEs and Negative Outcomes

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.

Risk for Negative Health and Well-being Outcomes

# of ACES

0 1 2 3 4 ≥5

*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.*
<table>
<thead>
<tr>
<th>Leading Causes of Death in the U.S., 2017</th>
<th>Odds Ratios for ≥ 4 ACEs (relative to no ACEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Heart disease</td>
<td>2.1</td>
</tr>
<tr>
<td>2 Cancer</td>
<td>2.3</td>
</tr>
<tr>
<td>3 Accidents (unintentional injuries)</td>
<td>2.6</td>
</tr>
<tr>
<td>4 Chronic lower respiratory disease</td>
<td>3.1</td>
</tr>
<tr>
<td>5 Stroke</td>
<td>2.0</td>
</tr>
<tr>
<td>6 Alzheimer’s or dementia</td>
<td>11.2</td>
</tr>
<tr>
<td>7 Diabetes</td>
<td>1.4</td>
</tr>
<tr>
<td>8 Influenza and pneumonia</td>
<td>Risk unknown</td>
</tr>
<tr>
<td>9 Kidney disease</td>
<td>1.7</td>
</tr>
<tr>
<td>10 Suicide (attempts)</td>
<td>37.5</td>
</tr>
</tbody>
</table>
Trauma Types: Expanded ACES

- Bullying
- Community Violence
- Complex Trauma
- Disasters
- Medical trauma
- Refugee trauma
- Terrorism
- Traumatic Grief
Historical & Racial Trauma

• Historical – impacts entire communities, cumulative and transmitted across generations
  • Mechanisms include social as well as biologic transmission
  • Ex. African American communities and legacy of slavery, displacement of Native Americans and boarding schools

• Racial - trauma due to witnessing or experiencing racism, discrimination or structural prejudice
  • Increased vigilance, suspicion, sensitivity to threat, sense of foreshortened future
  • Understandable response to stress, particularly in communities with increased risk for community violence and victimization.

National Child Traumatic Stress Network
Role of primary care

• Supportive relationship over time.
• A safe place:
  • Patient centered medical home.
• Targeting modifiable/preventable ACES.
• Leveraging BCES & resilience factors.
Trauma informed care (TIC): Framework

- **Understanding** the prevalence of trauma & adversity & its impacts.
- **Recognizing** the effects of trauma & adversity on health and behavior.
- **Training** leadership, providers, and staff on responding with TIC best practices.
- **Integrating** knowledge about trauma into policies, procedures, practices.
- **Resisting re-traumatization** by approaching patients with non judgmental support.
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.
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.
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.

• **Differential dx:** ADHD, depression, anxiety, trauma-related
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.
- **ACES (3+)**: separated parents, substance use, incarceration…
Trauma informed care principles with Jon

• Team-based approach for Jon and family
  • How to start relationship with regards to space, time, orientation?
  • Who screens? Which screens?
  • Who follows up if positive?

• Taking care of oneself as provider (compassionate boundaries)
  • What do you need to assess and treat this family?
  • How do you get additional help?
  • What are your limits?
## Trauma informed care key ingredients

<table>
<thead>
<tr>
<th>Organizational</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Leading and communicating about the transformation process</td>
<td>▪ Involving patients in the treatment process</td>
</tr>
<tr>
<td>▪ Engaging patients in organizational planning</td>
<td>▪ Screening for trauma</td>
</tr>
<tr>
<td>▪ Training clinical as well as non-clinical staff members</td>
<td>▪ Training staff in trauma-specific treatment approaches</td>
</tr>
<tr>
<td>▪ Creating a safe environment</td>
<td>▪ Engaging referral sources and partnering organizations</td>
</tr>
<tr>
<td>▪ Preventing secondary traumatic stress in staff</td>
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<tr>
<td>▪ Hiring a trauma-informed workforce</td>
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</tbody>
</table>

Menschner & Maul, 2016
When is stress “Toxic”?

- Stress is a normal and necessary part of development.
- Toxic when prolonged; in absence of protective relationships.
Biology of trauma

• Begins before birth with epigenetics.
• Brain not structurally complete at birth.
  • Myelination, synaptic connections, glial and circulatory development continue.
    • Depends on adequate nutrition, no toxins.
    • Critical sensitive periods of development.
    • Guided by “good enough” environment/cues

• Impacted: executive function, emotion regulation

• Polymorphisms
• Telomeres
• Methylation
TELOMERE

Telomeres are specialized nucleoprotein complexes located at the end of chromosomes that promote chromosomal stability.

Telomeres are required due to the ‘end DNA replication problem’ where DNA polymerase can only replicate DNA in the 5’ to 3’ direction.

In germ cells and stem cells, a cellular enzyme, telomerase, functions to extend telomeres. However, telomerase is not present in the majority of somatic cells and therefore telomere length shortens with each successive cellular division.
Telomere length and percent of life in Romanian institutions

**Girls at baseline (22months)**

**Boys through 54 months**

Drury et al., 2012 *Molecular Psychiatry*
Biological marker

• Telomere length may represent an objective epigenetic biomarker of early adversity and putatively one mechanism by which early adversity gets ‘under the skin’ and into our biology.
Challenges in primary care

• Trauma may not be easily or willingly disclosed.
• Question of ongoing trauma with desire to trust parents and build relationships.
• Overlapping sx: Trauma, ADHD, depression, & anxiety.
• Traumatic stress severity known to increase suicide risk.
Learning objectives

- Learn the importance of trauma informed care principles & strategies for applying to your practice.
- Learn evidence based prevention and treatment to support resilient patients, families, and yourself.
- Identify developmentally appropriate strategies for assessing, diagnosing and treating trauma and trauma-related disorders.
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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
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
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
PTSD patterns over time: Fortunately, most improve

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).
What predicts persistent symptoms?

Home & community violence (IPV) are common predictors

• Substantiated by many previous studies
• Some trauma screens do not include witnessing violence
• Indirect exposure to trauma must be included in assessment
Resilience: What tips the balance?

Adverse Events

Benevolent Events
Framing why we ask

Conduct inquiry for presence of trauma

Inquiry + conversation + screening tool (as needed) = Better understanding of patient’s history, needs and resilience factors
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)
### Protective factors

<table>
<thead>
<tr>
<th>Community:</th>
</tr>
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<tbody>
<tr>
<td>• School engagement.</td>
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<tr>
<td>• Family &amp; neighborhood.</td>
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<tr>
<td>• Participation in after school activities.</td>
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<table>
<thead>
<tr>
<th>Relationships:</th>
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<tbody>
<tr>
<td>• Relationships with one supportive adult</td>
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<tr>
<td>• Friends</td>
</tr>
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<table>
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<tr>
<th>Individual:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positive thoughts of self</td>
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<tr>
<td>• Self-regulation</td>
</tr>
<tr>
<td>• Social competence</td>
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<tr>
<td>• Flexible thinking</td>
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</tbody>
</table>
Trauma informed care principles with Jon

• A team-based approach
  • Registration or clinical staff
    • Screening for ACES using PEARLS & BCES in parents.
    • Screening for youth ACES using PEARLs & BCES.
  • Provider reviews, follows algorithm, documents ACEs score/billing code
    • Billing codes
    • Time for follow-up
    • Psychoeducation and assessment.
Universal Screening tools

- ACES/BCES for parents
- ACES/PEARLS for youth
- 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 “QB.” 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:
Jon, 10 yr old boy

High risk based on ACES score & HTN…

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

<table>
<thead>
<tr>
<th>Score of 1-3</th>
<th>Score of 4+</th>
</tr>
</thead>
<tbody>
<tr>
<td>With</td>
<td>With or without</td>
</tr>
<tr>
<td>associated health</td>
<td>associated health</td>
</tr>
<tr>
<td>conditions</td>
<td>conditions</td>
</tr>
</tbody>
</table>

Provide education about toxic stress, its likely role in patient's health condition(s), and buffering.
Parenting with ACEs

As an adult, you may still feel the effects of your own Adverse Childhood Experiences (ACEs). What does this mean for your own well-being? It depends on how many ACEs you experienced as a child and on whether you’ve had certain positive experiences that help you manage the effects of stress. These positive experiences are known as protective factors.* Did a friend, family member, or mental health provider help you during your childhood? Do you have a support system in place now? These experiences help reduce the impact of ACEs. The impact of ACEs also depends on factors such as personal resilience, personal management of stress. Let’s start by talking about the stress response.

The stress response

Your body’s stress response is designed to help you survive. When you sense danger or feel stressed, your body’s natural reaction is to increase blood pressure and heart rate and release energy to run or fight back. Another reaction is to freeze and shut down. This is your body’s way of trying to keep you safe. When used from time to time, these stress responses can work well. However, when you experience frequent or severe stress during childhood, you may learn to respond to small problems as if they were big ones. This could be worries like a screen addiction or fear of the dark. Even a toddler’s tantrum or spilled milk, can feel overwhelming. It can also explain why your child may sometimes feel anxious and threatened even when in a safe and calm place. When you are only a little stressed, you may feel alert, aware, and able to cope well. But when you are overly stressed, you may feel panicked and anxious. You may also feel numb, empty, and emotionally drained.

Breaking the ACEs Cycle

In addition, being a parent with ACEs can increase the risk that your children will also have ACEs. It’s important to know about this connection. Ensuring that you and your child live in a safe, trusting and healthy environment is one of the most important steps you can take to protect your child. If you need resources, your health care provider or a mental health professional can help.

The good news!

Although people with ACEs may be at higher risk for many health issues, it’s never too late to get support! Because bodies and brains are constantly growing and changing, things you do to improve your health today can make a big difference over time! Learning healthy ways to cope with stress and build resilience can help. This skill-building means developing healthy habits for stress management now that improve your ability to handle difficult situations in the future. Also, learning about what’s age-appropriate for your child can give you perspective when his behavior is challenging.

How to reduce the effects of ACEs

Many lifestyle changes can help reduce the effects of ACEs. Relationships with other supportive adults can help your brain and body turn down the stress response and build resilience. Making time to relax, engage in a fulfilling hobby, or participate in a fun activity can help a lot, too! Good sleep habits, healthy eating, and regular exercise are other important tools to manage stress. Mindfulness practices can also help. Some parents find it helpful to seek out mental health professionals for their own exposure to ACEs and trauma. Talk to your own doctor about the health risks associated with ACEs at your next medical visit. Together, these protective factors can help improve the health and well-being of your whole family!
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 your child
- Manage your own stress
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
Stepped care: Prevention tiers

Indicated –
- Referral to appropriate services + treatment

Selected –
- Leveraging BCES; extra outreach
- Psychoeducation buffering toxic stress; reaching “newborn parents”
- More direct questions about ongoing trauma

Universal –
- Screen for ACES, BCES, PEARLS, SDH, and ongoing trauma.
- Develop scaffolding relationship with family.
- Entire visit experience from receptionist to paying the bill matters.
Learning objectives

Learn the importance of trauma informed care principles & strategies for applying to your practice.

Learn evidence based prevention and treatment to support resilient patients, families, and yourself.

Identify developmentally appropriate strategies for assessing, diagnosing and treating trauma and trauma-related disorders.
Trauma sx developmentally

**Preschool:**
- Reduced play

**School-age:**
- New fears
- Regression

**Adolescent:**
- Reckless behavior
- Self-imposed restrictions
Frayed: signs of trauma

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

• Strategies for screening:
  ➢ Promote safety.
  ➢ Include choice.
  ➢ If suspicious, ask separately.
  ➢ Listen. Listen. Listen.
  ➢ Be clear about your role and reason for asking specific questions.
  ➢ Review confidentiality.
Asking developmentally

• Strategies for screening:
  ➢ Promote safety.
  ➢ Include choice.
  ➢ If suspicious, ask separately.
  ➢ Listen. Listen. Listen.
  ➢ Be clear about your role and reason for asking specific questions.
  ➢ Review confidentiality.

“Has anything bad happened to you or your child since I last saw you?”
Asking developmentally

• Strategies for screening:
  ➢ Promote safety.
  ➢ Include choice.
  ➢ If suspicious, ask separately.
  ➢ Listen. Listen. Listen.
  ➢ Be clear about your role and reason for asking specific questions.
  ➢ Review confidentiality.

“Stressful and scary events sometimes happen. Has there been a time where you felt really scared for your safety or someone else’s at home or in the community?”
What do you do when a kid screens positive?

- Acknowledge
- Validate
- Follow up
- Report if required
What do you do when a kid screens positive?

- Acknowledge
- Validate
- Follow up
- Report if required

“I’m sorry that happened to you. That sounds like it might have been confusing and scary...”
What do you do when a kid screens positive?

- Acknowledge
- Validate
- Follow up
- Report if required

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

FOLLOW the 3-step process

1. Report if required (see page 9)
   Call DCFS if child maltreatment is suspected (1-855-323-3237).

2. Respond to suicide risk (see page 10)
   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).

3. Stratify treatment approach (see page 12)
   - 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.
### Treatment Stratification

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Poor functioning?</th>
<th>Clinical decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe symptoms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Score ≥ 21**          | YES or NO         | Restorative Approach  
Ref: evidence-based trauma treatment (see page 14). |
| Moderate symptoms     |                   |                   |
| Score 11–20**         | YES               | Resilient Approach  
Ref: MHI or community/private mental health (see page 14). |
| Mild symptoms         |                   |                   |
| Score ≤ 10**          | YES or 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)

<table>
<thead>
<tr>
<th>Sleep problems</th>
<th>Hypervigilant/intrusive symptoms</th>
<th>Avoidance/negative mood symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep education</td>
<td>Belly breathing</td>
<td>Behavioral activation</td>
</tr>
<tr>
<td>Belly breathing</td>
<td>Guided imagery</td>
<td>Return to routine</td>
</tr>
<tr>
<td>Guided imagery</td>
<td></td>
<td>Parent-child communication</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
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</tr>
</tbody>
</table>

Possible medication roles:
- Trauma-related sleep problems (see page 16)
- Pre-existing anxiety, depression or severe ADHD. See Depression and ADHD CPMs.
TABLE 7. Teach a Helpful Response (for details see page 23)

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<td>• Guided imagery</td>
<td>• Return to routine</td>
</tr>
<tr>
<td>• Guided imagery</td>
<td>• Progressive muscle relaxation</td>
<td>• Caregiver support</td>
</tr>
<tr>
<td></td>
<td>• Mindfulness</td>
<td></td>
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</tbody>
</table>
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
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
Working with kids and caregivers

- Psychoeducation to parents.
- Moving 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.

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.
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
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/
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
Building Resilience - Individual and Organizational

Expectations
- Realistic ones for yourself
- Realistic ones for others

Boundary Setting
- Know what you want/can say ‘yes’ to

Staff Culture
- Connecting with colleagues in a way that heals & helps

Self-Care
- Mind
- Spirit
- Strength
- Heart
The 5-4-3-2-1 Coping Technique

Ease your state of mind in stressful moments.

- Acknowledge 5 things that you can see around you.
- Acknowledge 4 things that you can touch around you.
- Acknowledge 3 things that you can hear around you.
- Acknowledge 2 things that you can smell around you.
- Acknowledge 1 thing that you can taste around you.
Takeaways

Trauma is ubiquitous & most youth are resilient.

Most severe trauma sequelae 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?
References & Resources

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