Putting Your Trauma Lens On

Heather Forkey, MD
September 27, 2018
NJ AAP Conference

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Learning objectives

At the conclusion of this activity, the participant should be able to:

• Define the 3 characteristics of a caregiving relationship necessary for healthy attachment
• Recognize the most common symptoms of trauma in children
• Identify seven resilience skills that should be supported in children
• Formulate a strategy to respond to children who present with trauma symptoms

Putting on Your Trauma Lens

Which are the challenges most severe,
That keep pedi docs from addressing fear?
And what are the gaps that need to be filled -
So docs can treat trauma in ways that are skilled?
A small bit is training, but they pick that up quick,
Easily learn how stress makes kids sick.
Practically speaking they know what to do -
When its dog bites or car wrecks or tornadoes too.

Where we are stymied - not early adopters,
Is when trauma at home is the job of the doctors.
When adults talk ACES there’s more of a buffer,
A faraway place, long ago did they suffer.
ACEs in adults are less a taboo,
Time means the culprits the doc never knew.
No one to embarrass, no one to take blame,
Discussion can happen without the same shame.

Unspoken norms keep the Peds from the topic,
And families too expect we’re myopic.
Docs know that its bad, know they sh’d go there -
In day to day practice - they just never dare!
How do you ask about violent scenes?
Food insecurity, drugs and poor means?
W’out insinuating fault of a parent-
In that interaction blame is inherent.

And pediatricians don’t like confrontation,
Encouragement, guidance, joy our vocation!
We deal with bad things like diseases to halt,
Bad genes and accidents are nobody’s fault.
We might do resilience, that’s more up our alley -
We like to take on cheerleading and rally.
It still takes some time, and requires a shift -
Of words and perspective and how to be swift.

So that’s problem one,
how to then pivot,
And change the focus
of that family’s visit.
Asking what’s
happened? Not, what’s
wrong with you?
These questions of
traumas are actu’ly
taboo.
Asking what happened is uncharted land -
It violates constructs and is not what is planned.
Pedi docs do have most parent’s great trust,
But the script is restricted, things not discussed.

It's ok to talk about germs or syndromes,
But **not** to suggest that the cause could be homes.
Not unlike in past when breast cancer was missed -
‘Cause no one could mention a breast could exist!
Issue two merges expectations of both,
Patients and those under Hip’cratic oath.
All pedi docs train for years in a place -
Where issues are urgent and at a quick pace.

Docs drilled for years to solve problems quick,
To rapidly separate well ones from sick.
Each med encounter - a mys’try to solve,
But quick, there’s no time for talk to evolve.
A patient shows up, a complaint is lodged,
A clock starts ticking, solutions not dodged.
The fastest answers for families and docs -
Come from a bottle, not engaged in talks.

With kids failing school, not sleeping at night,
Parents want something to quick make it right.
They’ve come for solutions, not probing or blame -
Both in the encounter have the same aim.
Family’s not come with trauma in mind,
For the doc to go there puts them in a bind.
More than the time just to tease out the threat,
Their expectations just won’t be met.

And so when we ask what are gaps we can fill?
How to raise the tough topic, not order a pill?
Expectations of what we can say need to shift-
We need ways to say it, and ways to be swift.
Quick applications to use in the office,
To raise and respond to a child’s hard losses.
Things that a family can use right away,
Make up for a drug they expected that day.

But maybe the main thing I need to know how,
Is convince both myself and the family that now,
Part of my job is to get at the threat,
To diagnose things they’d rather forget!
Our trauma lens on - we can be most effective -
Put the bad stress in healthy perspective.
*That* is the way we will manage good health,
When trauma and treatment are no longer stealth.

Putting on your trauma lens
THE IMPORTANT THING IS TO SEE WHAT OTHERS CANNOT SEE

Resilience

Positive
Brief increases in heart rate, mild elevations in stress hormone levels.

Tolerable
Serious, temporary stress responses, buffered by supportive relationships.

Toxic
Prolonged activation of stress response systems in the absence of protective relationships.
Biochemical impact (brain and body)

HPA Axis
Sympathetic and parasympathetic NS
Epigenetic impact: Methylation, telomere injury
Immunologic: Humoral and inflammatory

Resilience

How does it translate to what you see
Variable responses to threat

With trauma...

- Stress and the tiger
  - Bodies designed to respond to stress
  - Adrenalin and cortisol help us run from tiger or hide
  - Threat of short duration
So what we see as the stress response...

Hypothalamic-Pituitary-Adrenal Axis (HPA)

- Stress activates axis.
- Peripheral release of epinephrine and cortisol.
- Stimulates multiple areas of body and immune system.
BUT...when the tiger lives in your home, neighborhood or life

**CORTISOL**

- Immune system
- Gene expression (epigenetics)
- Other body systems
- Inflammatory response
- Severe or prolonged trauma
- Infection fighting (antibodies)
What does that trauma response look like in children

What trauma looks like in children
Diagnoses seen in children exposed to trauma from NCTSN data

So with kids...when we put on the trauma lens, we will see something different than what we see with adults

So what are we looking for then with our trauma lenses?
When we just see at the stress response, we have forgotten the 2\textsuperscript{nd} half of the toxic stress definition.
The context of trauma (and resilience) is always relationships, or the attachments children have.

Yes, I said it: THE “A” word.
Attachment prototype

That secure attachment comes from predictable compassionate availability
With a secure base from a predictable compassionate available caregiver one can grow

And that brings us to the question of grow, HOW? Answer: Grow in our RESILIENCE:

• As defined by from Ann Masten, PhD.
• Resilience is a dynamic process of positive adaptation to or in spite of significant adversities; can be applied to a child, family, system or community or ecosystem.
  • For children, the pathways to resilience are rooted in
    • the give and take of safe, stable and nurturing relationships that are continuous over time (attachment), and in
    • the growth that occurs through play, exploration and exposure to a variety of normal activities and resources
Masten called this Resilience: Ordinary Magic

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Masten’s “ordinary magic”

- Resiliency comes from:
  - Attachment relationships
  - Learning and thinking brain
  - Mastery of age salient developmental tasks
  - Self control: self regulation
  - Belief life has meaning, hope for the future
  - Self efficacy

Magic of resilience achieved with THREADS

- Resiliency skills the THREADS of childhood:
  - Thinking and learning brain
  - Hope
  - Regulation or self control
  - Efficacy
  - Attachment
  - Developmental skill mastery
  - Social connectedness
If then you experience trauma without protective relationships

- **Positive**: Brief increases in heart rate, mild elevations in stress hormone levels.
- **Tolerable**: Serious, temporary stress responses, buffered by supportive relationships.
- **Toxic**: Prolonged activation of stress response systems in the absence of protective relationships.

Under threat, you are alone, dysregulated, and in need of support to regulate.
Another way to think about trauma is that it acts against all the factors that correlate with resilience

• Resiliency skills the THREADS of childhood:
  • Thinking and learning brain – shuts down
  • Hope – to deal with present danger, looking ahead shut down
  • Regulation or self control – shuts down - need impulses to deal with threat
  • Efficacy – lost – reacting to situation, not controlling it
  • Attachment – acting alone, not available in toxic stress
  • Developmental skill mastery – learning shut down
  • Social connectedness – alone with threat

Trauma results from being psychologically alone in unbearable emotional pain; dysregulated; FRAYED

• You are FRAYED (and at the end of your rope)
  • Fits, Frets and Fear
  • Restricted development
  • Attachment disorders
  • Yelling and yawning
  • Educational delays
  • Defeated/dissociation
So what does FRAYED look like in the clinic, office or hospital

Let's think about the example of the child who won't sleep after experiencing trauma
Not sleeping
What you are told about is one skill that is off, suggesting that the child is FRAYED

- Without it, you are FRAYED (and at the end of your rope)
  - Fits, Frets and Fear
  - Restricted development
  - Attachment disorders
  - Yelling and yawning
  - Educational delays
  - Defeated

The child became dysregulated (traumatized) because of experience of being alone with unbearable fear
The other way to think of it that the child has had some of their resilience skills challenged

• Resiliency skills the THREADS of childhood:
  • Thinking and learning brain
  • Hope
  • Regulation or self control
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  • Attachment
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Will need to use the THREADS still available to you

• Resiliency skills the THREADS of childhood:
  • Thinking and learning brain
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  • Social connectedness
Look to a toolbox of skills to grow/repair each of the THREADS

Reassuring, Restoring Routine, Regulating
Reassuring, Restoring Routine

Routines Communicate Safety, Shutting Down Stress Response

BEDTIME ROUTINE CHART
1. Take Bath
2. Brush Teeth
3. Put On Jammies
4. Story Time
5. Hugs

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Regulating: Calming the stress response

Regulating: Psychological Holding the mind in mind
Regulating through social connectedness

Suppose instead of sleep, the symptom is tantrums
And let's talk about those teens!

What you are told about is the skills that are FRAYED

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For tantrums we often say (outside of trauma) ignore them, but kids who experienced trauma need more supports

Reassuring, Restoring Routine, Regulating
Reassurance: Caregivers Have To Model Calm Behavior Despite The Distress, Promotes Efficacy

3r’s for Improving Self - Regulation
Explaining role of caregiver as an emotional container

Provide Predictable Compassionate Availability
That can look a little different depending on the age of the child

It starts with attachment and security, and that allows you to build (or rebuild) each of these

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You’re skeptical; cute mnemonic, but won’t work in cases that are more complicated....

Our cases are complicated, child in foster care after experiencing DV, neglect, abuse
Neurobiology of Trauma

Amygdala

- Amygdala: Input from sensory, memory and attention centers
  - Emotional memory system = The brain’s alarm system
Neurobiology of Trauma

**Hippocampus**
- Interface between cortex and lower brain areas.
- Major role in memory and learning.
  - The brain’s file cabinet or search engine.

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**Prefrontal cortex**
- Executive function
  - Impulse control
  - Working memory
  - Cognitive flexibility
What you are told about is many skills impacted, suggesting that the child is FRAYED

• FRAYED (and at the end of your rope)
  • Fits, Frets and Fear
  • Restricted development
  • Attachment disorders
  • Yelling and yawning
  • Educational delays
  • Defeated
Child comes with invisible suitcase because there was no predictable compassionate availability

• I am in danger
• I am worthless
• I am powerless
• You are not reliable
• You cannot protect me
• You will be dangerous or rejecting
When so many things have happened the attachment to a predictable compassionate and available caregiver has been challenged

• FRAYED (and at the end of your rope)
  • Fits, Frets and Fear
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Look to a toolbox of skills to grow/repair each of the THREADS
Reassuring, Restoring Routine, Regulating

Reassurance

Danger
Routines of positive interactions: predictable compassionate availability

Routines communicate safety, shutting down stress response
Regulation: Emotional Development Impacts

- Trauma limits self regulation, ability to describe feelings or internal states, and ability to communicate wishes and desires

Caregiver needs to help child develop language (thus identification) of emotions
Anger example

Source:
In a setting of a predictable, compassionate and available caregiver, we can work with THREADS we have left to weave him back to health.

The goal then is to promote resilience, putting in place all those features of resilience:

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Learning objectives

At the conclusion of this activity, the participant should be able to:

• Define the 3 characteristics of a caregiving relationship necessary for healthy attachment: **predictable compassionate availability**

• Recognize the most common symptoms of trauma in children: **FRAYED**

• Identify seven resilience skills that should be supported in children: **THREADS**

• Formulate a strategy to respond to children who present with trauma symptoms: Consider which **THREADS** are frayed, giving you the **FRAYED** symptoms; look for which **THREADS** are present to work with, and pull out your sewing kit to help child and family weave back to health

Suggested Reading


