Putting Your Trauma Lens On

HEATHER FORKEY, MD

WEBINAR ON TRAUMA INFORMED CARE
NJ PEDIATRIC PSYCHIATRY COLLABORATIVE

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Dedicated to the health of all children
New Jersey Chapter

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- I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

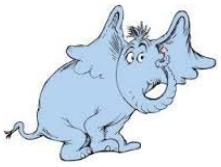
Learning Objectives

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 folks 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 -

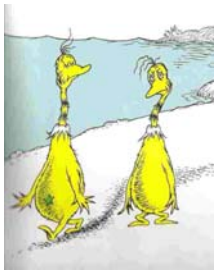
When its dog bites or car wrecks or tornadoes too.

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.

Its 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,

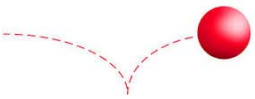
Part of my job is to get at the threat,

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

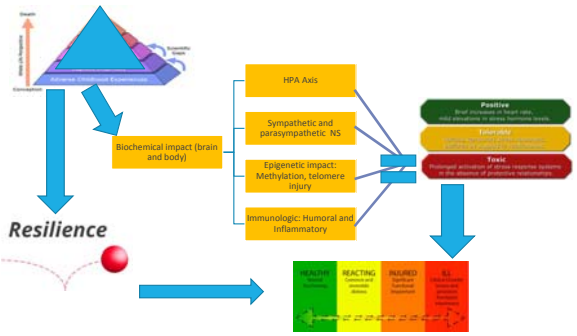
Resilience



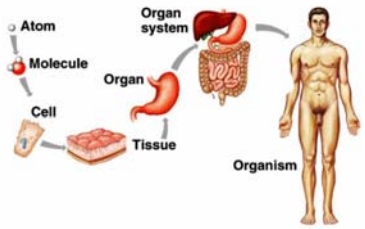
Positive
Brief increases in heart rate, mild elevations in stress hormone levels.

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

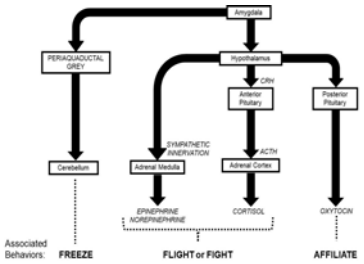
Toxic
Prolonged activation of stress response systems in the absence of protective relationships.



How does it translate to what you see



Variable responses to threat

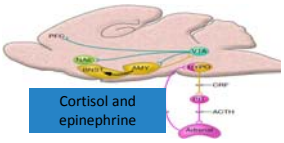


Garner, A and Saul B.. Thinking Developmentally, AAP Press, 2018

So what we see as the stress response…

Hypothalamic-Pituitary-Adrenal Axis (HPA)

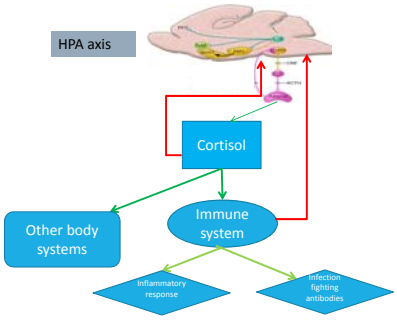
- Stress activates axis.
- Peripheral release of epinephrine and cortisol.
- Stimulates multiple areas of body and immune system.



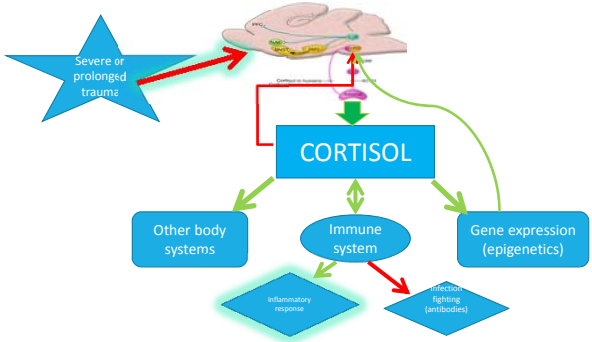
With trauma…

Stress and the tiger

- Bodies designed to respond to stress
- Adrenalin and cortisol help us run from tiger or hide
- Threat of short duration

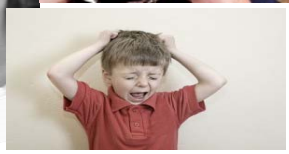


BUT…when the tiger lives in your home, neighborhood or life

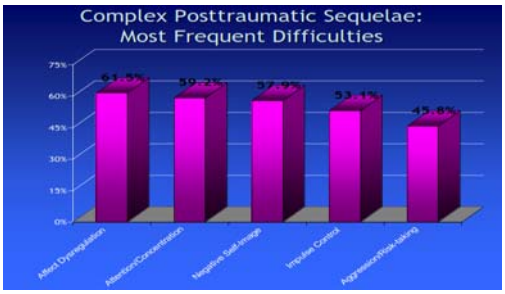


What does that trauma response look like in children

What trauma looks like in children



Diagnoses seen in children exposed to trauma from NCTSN data



Spinazzola, J et al. Survey evaluates: Complex trauma exposure, outcome, and intervention among children and adolescents. Psychiatric Annals. 2005; 35(5): 433-439

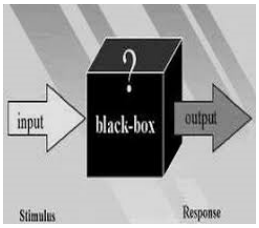
So with kids…when we put on the trauma lens, we will see something different than what we see with adults

So **what** are we looking for then with our trauma lenses?

When we just see at the stress response, we have forgotten the 2nd 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 safety and security, holding emotions of child, 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

- For kids, the pathways to resilience are rooted in:
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Masten's "Ordinary Magic"

Resiliency comes from:

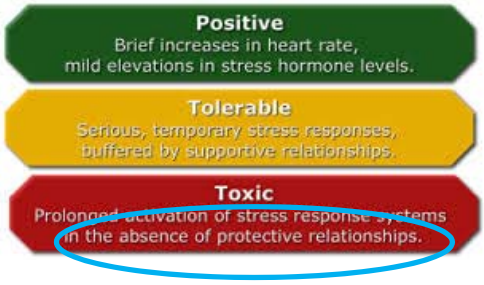
- Attachment relationships
- Learning and thinking brain
- Mastery of age salient developmental tasks
- Self control: self regulation
- Belief life has meaning, hope for the future
- Self efficacy

Magic of resilience achieved with THREADS

Resiliency skills the THREADS of childhood:

- **T**hinking and learning brain
- **H**ope
- **R**egulation or self control
- **E**fficacy
- **A**ttachment
- **D**evelopmental skill mastery
- **S**ocial connectedness

If then you experience trauma without 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:

- **T**hinking and learning brain – *shuts down*
- **H**ope –*to deal with present danger, looking ahead shut down*
- **R**egulation or self control – *shuts down - need impulses to deal with threat*
- **E**fficacy – lost – *reacting to situation, not controlling it*
- **A**ttachment – *acting alone, not available in toxic stress*
- **D**evelopmental skill mastery – *learning shut down*
- **S**ocial connectedness – *alone with threat*

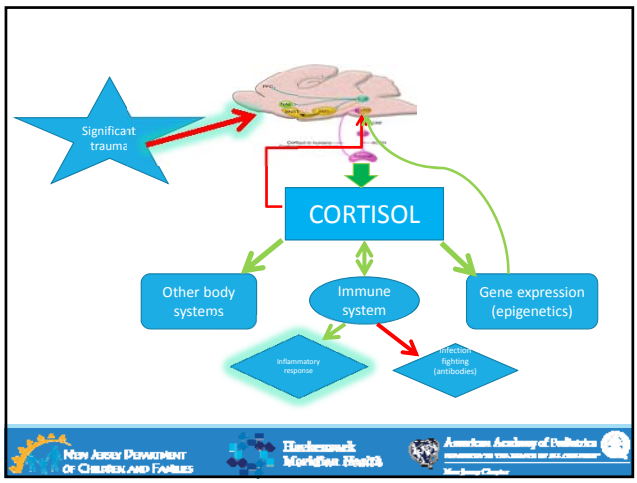
Trauma results from being psychologically alone in unbearable emotional pain; dysregulated; FRAYED

You are FRAYED (and at the end of your rope)

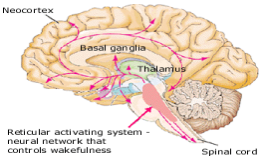
- **F**its, **F**rets and **F**ear
- **R**estricted development
- **A**ttachment disorders
- **Y**elling and **y**awning
- **E**ducational delays
- **D**efeated/**d**issociation

So what does FRAYED look like in the clinic, office or hospital

Lets 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)

- **F**its, **F**rets and **F**ear
- **R**estricted development
- **A**ttachment disorders
- **Y**elling and **y**awning
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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:

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Will need to use the THREADS still available to you

Resiliency skills the THREADS of childhood:

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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

Regulating : Psychological holding the mind in mind

Regulating through **attachment** and **social connectedness**

Suppose instead of sleep, the symptom is tantrums

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

What you are told about is the skills that are FRAYED

FRAYED (and at the end of your rope)

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Reassuring, Restoring Routine, Regulating

Reassurance: Caregivers Have To Model Calm Behavior Despite The Distress, Promotes Efficacy

Explaining role of caregiver as an emotional container

Reassurance: Provide predictable compassionate availability

Regulating: Calming the stress response

Regulation: 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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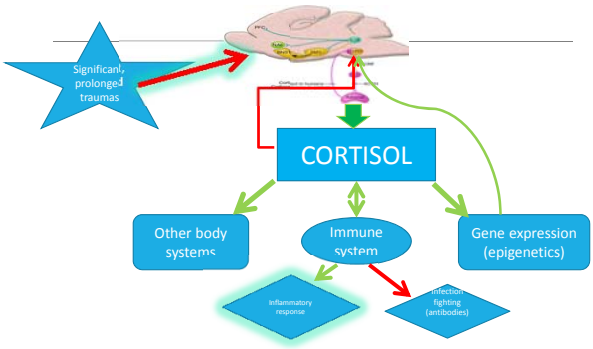
You're skeptical; cute mnemonic, but won't work in cases that are more complicated….

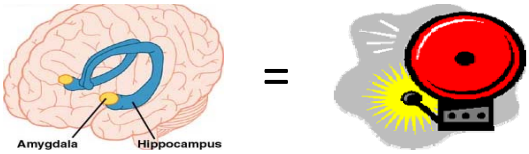
Other end of the spectrum, child in foster care after experiencing DV, neglect, abuse



Neurobiology of Trauma

Amygdala

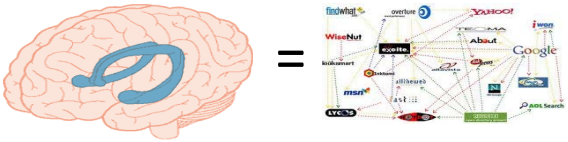
- Amygdala: Input from sensory, memory and attention centers
  - Emotional memory system =The brain's alarm system



Neurobiology of Trauma

Hippocampus

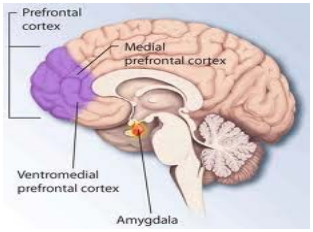
- Interface between cortex and lower brain areas.
- Major role in memory and learning.
  - The brain's file cabinet or search engine.



Neurobiology of Trauma

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)

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Child comes with invisible suitcase because there was no predictable compassionate availability

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)

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Look to a toolbox of skills to grow/repair each of the THREADS

Reassuring, Restoring Routine, Regulating

Reassurance

Danger

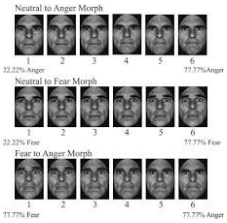
Routines communicate safety, shutting down stress response

Routines of positive interactions: predictable compassionate availability

Regulation: Emotional Development Impacts

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

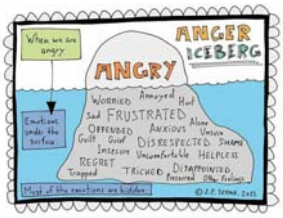
Anger example



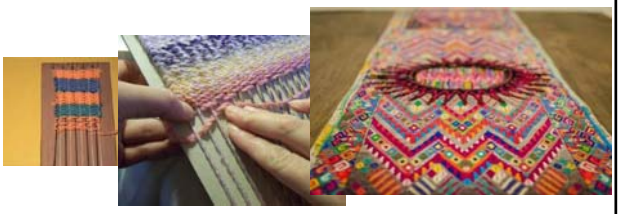
Source:
1. Doretto V, Scivoletto S. Effects of Early Neglect Experience on Recognition and Processing of Facial Expressions: A Systematic Review. *Brain Sciences*. 2018;8(1):10. doi:10.3390/brainsci8010010.
2. Thomas, L. A., M. D. De Bellis, R. Graham and K. S. LaBar (2007). "Development of emotional facial recognition in late childhood and adolescence." Dev Sci **10**(5): 547-558.

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

Anger example



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: *safety (often communicated through routines), predictable compassionate availability, caregiver as emotional container*

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*

Changes you may wish to make in practice

1. Consider how to promote THREADS with the anticipatory guidance in routine visits
2. Consider developing handouts or web links to THREADS enhancing strategies to keep on hand to offer to families
3. Apply FRAYED construct to behavioral concerns to consider if trauma could be cause; identify THREADS which is frayed. Apply RRR. Then repeat 1,2,3

Collaborative Hub Procedure

Referring to the Hub: After required routine screening and/or based on clinical judgement following the exam, providers can fax the PPC Hub. Providers should send a complete consult l form, screening tools, and any other clinically relevant information.

What Does the Hub Staff Need? All of the information the PPC Hub staff needs is on the referral form, including relevant background information, current clinical picture, demographic information, and reason for referral. Some providers may choose to send notes from previous visits as well, which can be very helpful, but is not required.

Communicating with the Family: Please be sure you have discussed the PPC Hub with the patient and family prior to faxing a referral to the PPC Hub, so that the family is aware that a Hub staff psychologist/LCSW/other mental health specialist will be contacting them to discuss current concerns and suggestions for support/treatment.

Collaborative Hub Procedure Cont'd

- What will the PPC Hub Staff Do? Hub staff will call the patient's family and complete a clinical intake. The family will discuss their main concerns. Case managers will evaluate for severity and level of care. Depending on the patient's needs, Hub staff will:
  - Recommend an appropriate level of care (inpatient, PHP, IOP, or outpatient) - the family is sent a list of referrals for therapy services to address current mental health concerns.
  - Match the patient with a therapist based on their insurance and geographical location – the referrals are researched by staff psychologists/LCSWs, and most often accept patient insurance.
- "Closing" the Loop: Hub staff will communicate with you, sending you notes on what occurred with the family. They will also encourage the family to call them back if they need another resource. Hub staff will also follow-up with referred families 3 and 9 months after initial referral.

Suggested Reading

Garner, A. S. and J. P. Shonkoff (2012). "Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health." Pediatrics **129**.

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Questions?

Please contact:
NJAAP
Mental Health Collaborative
609-842-0014
mhc@njaap.org