The Heart of Trauma-Informed Care

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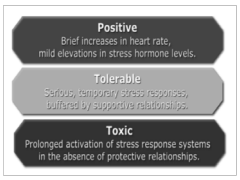
Disclosures

I have no financial relationships with any commercial interests.

Objectives

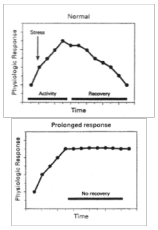
- Identify key concepts in stress physiology, toxic stress, and adverse childhood experiences.
- Define a framework for trauma-informed care.
- Describe ways to screen for trauma and potentially traumatic events.
- Describe clinical aspects of trauma-informed care.
- Identify the importance of addressing secondary traumatic stress for providers.

Stress Response



National Scientific Council on the Developing Child, Harvard University

Allostatic Loading

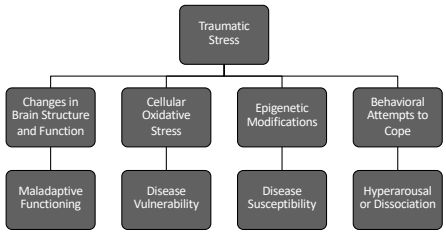


Allostasis

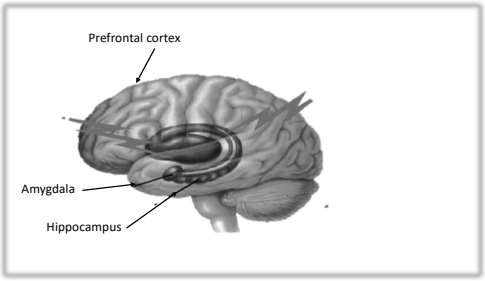
Allostatic Load

McEwen, B. (2000). Allostasis and Allostatic Load: Implications for Neuropsychopharmacology. *Neuropsychopharmacology* (22) 2: 109-124

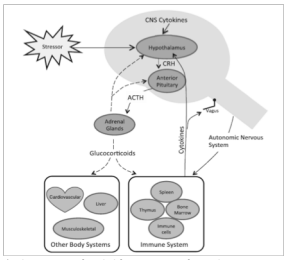
The Biology of Trauma



Toxic Stress is Biologically Embedded
Anatomic Brain Changes



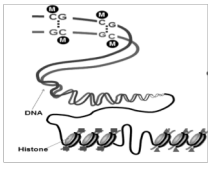
Toxic Stress is Biologically Embedded
Neuroendocrine and Immune Systems



Johnson, et al. (2013). The science of early life toxic stress for pediatric practice and advocacy. *Pediatrics* 131 (2): 319-327.

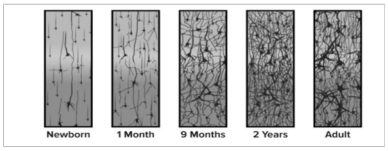
Toxic Stress is Biologically Embedded
Genetics and Epigenetics

- Epigenetic changes
  - DNA methylation
  - Histone modification
- Genetic predispositions
  - Mood disorders
  - PTSD



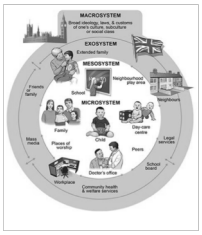
Shonkoff JP, et al. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 129 (1): 232-246.
Russo, et al. (2012). Neurobiology of resiliency. *Nature Neuroscience* 15 (11): 1475-1484.

Critical Periods of Development Brain Plasticity throughout Life



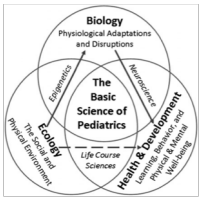
Corel, JL. *The Postnatal Development of the Human Cerebral Cortex*. Cambridge, MA: Harvard University Press, 1975.

Ecological Context of Child Health



Bronfenbrenner. (1986). Ecology of the family as a context for human development. *Developmental Psychology* 22 (6): *723-742*.

Eco-Bio-Developmental Framework



Shonkoff JP, et al. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 129 (1): 232-246.

Adverse Childhood Experiences (ACEs)

CHILD MALTREATMENT

- Physical
- Sexual
- Emotional
- Neglect

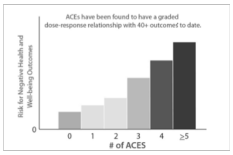
FAMILY DYSFUNCTION

- Incarceration
- Substance abuse
- Mental illness
- Domestic violence

Felitti, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J of Prev Med* 14 (4): *245-258.*

ACE Study

Strong graded relationship between ACEs and health behaviors associated with leading causes of death in adults.



Felitti, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J of Prev Med* 14 (4): *245-258.*
Additional Source: cdc.gov

ACEs Linked to Morbidity and Mortality in Adults

- Heart disease
- Cancer
- Chronic lung disease
- Liver disease
- Autoimmune disease
- Depression
- Violence
- Violence victimization
- Suicide

- Lower sense of well-being
- Poorer access to medical and MH services
- Increased health care utilization

Felitti, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J of Prev Med* 14 (4): *245-258.*

Prevalence of ACEs

- 64% of the adults in the Felitti study had at least one ACE
- ACEs are prevalent across diverse social economic and racial populations
- Over 20% experienced physical abuse, sexual abuse or substance abuse in the home
- Co-occurrence common with 13% having 4 or more ACEs
- Caution with interpretation of the # of ACEs
  - Specific combinations of ACEs produce particular outcomes
  - Timing in development
  - Presence of protective factors at the time of the adversity

Felitti, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J of Prev Med* 14 (4): *245-258.*

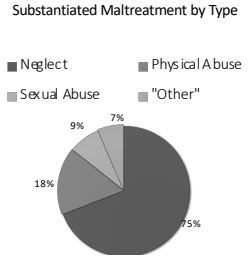
Second Generation Research on ACEs

- Original ACEs not systematically determined
- Some ACEs alone may not be strong predictors, or may not be the same stressor now like in the 1950's (i.e., parental divorce)
- Other childhood adversities predict negative long-term outcomes
  - Bullying
  - Social isolation and rejection by peers
  - Community violence
  - Poverty or financial strain
  - Food insecurity
  - Homelessness
  - Violent crime
- Improved overall statistical prediction

Finkelhor D, Shattuck A, Turner H, & Hamby S. (2015). A revised inventory of adverse childhood experiences. *Child Abuse & Neglect* 48: 13-21. Mersky JP, Janczewski CE, & Topitzes J. (2016). Rethinking the measurement of adversity: Moving toward second-generation research on adverse childhood experiences. *Child Maltreatment* Dec 2016.

The Scope of the Problem

- 3 million children investigated annually
- About 676,000 victims
- National victimization rate of 9.1 per 1000 children
- 1,780 died from neglect or abuse in 2016



NCANDS 2016

Examples of Childhood Traumatic Experiences

- Abuse
- Neglect
- Parental separation
- Serious illness or loss of a loved one
- Witnessing interpersonal violence
- MVA
- Experiencing a natural disaster
- Conditions of war
- Dog bites
- Invasive medical procedures
- Systems-induced trauma (foster care)
- ACEs
- Trauma
- Complex trauma
- Child traumatic stress
- Toxic stress
- Medical traumatic stress
- Potentially traumatic events
- PTSD

Potentially Traumatic Events (PTEs)

Prevalence: 68-90%

Cohen, J.A., et al. (2008). Identifying, treating, and referring traumatized children. *Arch Pediatr Adolesc Med* 162(5): 447-452.

Defining Trauma-Informed Care

A program, organization or system that **R**ealizes the impact of trauma, **R**esponds fully to it, integrates knowledge about trauma, seeks to actively **R**esist re-traumatization.

Education

Screening

Identification

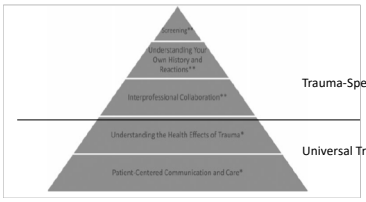
Resources

Treatments

Trauma-Informed Care

- History – universally ask about PTE's
- ROS – include trauma-informed
- Physical exam – any findings c/w abuse or neglect
- Trauma-specific anticipatory guidance
- Evidence-based, trauma-informed resources

TIC Pyramid



Raja, S., et al. (2015). Trauma informed care in medicine. *Fam Community Health* 38 (3): 216-226.

How Do We Begin?

- Training and education for all
- Screen for trauma exposure, post-traumatic symptoms, well-being, family functioning
- Recognize and respond to trauma exposure in children, caregivers, and providers
- Trauma-exposed children are like special needs children with similar complex needs
- Consider a Medical Home Model
- Know community resources that are trauma-focused and evidence-based

Screening for PTEs in Primary Care

Routinely ask at well child visits

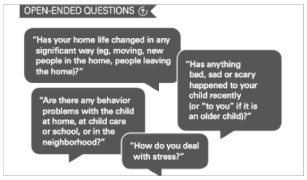
"Because traumatic events are so common and because they have direct, long lasting effects on physical and mental health, I ask all of my patients about stressful or difficult experiences they may have had."

"Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family?"

Age 8 and up: Ask child directly

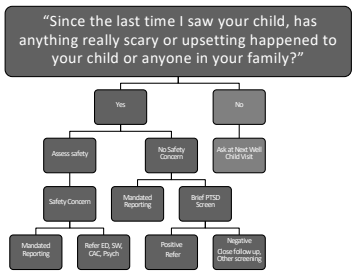
Follow with brief screen for PTSD

History
Universal Trauma Precautions



The American Academy of Pediatrics
"The medical home approach to identifying and responding to exposure to trauma."

Screening for PTEs



Screening for ACEs

CHILD

Trauma Screen

Name	DOB

ACE Category	Hx	Date & Initial	Date & Initial
1 Physical Abuse			
2 Emotional Abuse			
3 Conduct Sexual Abuse			
4 Alcohol and/or Drug Abuse in the Household			
5 Incarcerated Household Member			
6 Witnessed Domestic Violence			
7 Emotional or Physical Neglect			
8 Out or No Parents, Parental Separation, or Divorce			
9 Emotional or Physical Neglect			

Category	Hx	Date & Initial	Date & Initial
Community Violence (Hx or Current)			
Traumatic Accident			
Foster Care Systems (Hx or Current)			
Witness to Violence Abuse			

Others Not Scored	Hx	Date & Initial	Date & Initial
Public Housing			
TANF			
CPS Involvement			

PARENT

Parent ACE Assessment. Name_____Relation to Child_____
Child Name_____MRN_____
Date_____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** or **very often** …
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt? Yes = No

2. Did a parent or other adult in the household **often** or **very often** …
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured? Yes = No

3. Did an adult or person at least 5 years older than you ever …
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you? Yes = No

4. Did you **often** or **very often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other? Yes = No

5. Did you **often** or **very often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes = No

6. Were your parents ever separated or divorced? Yes = No

7. Was your mother or stepmother …
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife? Yes = No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes = No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Yes = No

10. Did a household member go to prison? Yes = No

Rev. 11/2010
Ref: www.acestoohigh.com

Total ACE Score_____

Screening

UNIVERSAL

- Posters in waiting area explaining the effects of stress and to share with your doctor
- Offer resource lists and website links posted or as hand-outs
- "Did you know" statements on office clipboards given to parents for paperwork
- Consider a parent advisory group
- "Since the last time I saw you, has anything really bad, sad, or scary happened to you or your family?"

TARGETED

- Suspicion of child maltreatment
- When unexplained somatic complaints
- Unexplained acute change in behavior
- School failure
- Multiple missed medical appointments
- All foster children

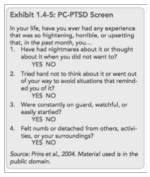
Post Traumatic Stress Disorder (PTSD) DSMV

- Cluster A: Exposure
  - Direct experience, witnessing event, hearing about event in close loved one, extreme or repeat exposure to aversive details of traumatic event, such as in one's work
  - Excludes media exposure unless through one's work
- Cluster B: Intrusion Symptoms (nightmares, flashbacks)
  - Repetitive play with trauma themes
  - Recurrent frightening dreams
  - Trauma-reenactment during play
- Cluster C: Avoidance of Reminders
- Cluster D: Distorted Cognitions (detachment, fear, guilt, anger, shame)
- Cluster E: Hyperarousal, Hypervigilance (heightened startle, concentration, sleep disturbance)
- Criterion F: Greater than 1 month
- Criterion G: Functional significance
- Criterion H: Exclusion of other diagnoses
- Preschool criteria for 6 years and younger
- Dissociative subtype (depersonalization, derealization)

Abbreviated Screening for Trauma Symptomatology

UCLA PTSD REACTION INDEX
PARENT SCREENING VERSION

ABBREVIATED PC-PTSD FOR PRIMARY CARE



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SAMHSA

Trauma-Specific Screening Tools

TRAUMA SYMPTOM CHECKLIST
FOR CHILDREN

- 54 item scale, 15-20 min
- Ages 8-16 years
- TSCYC: For young children ages 3-12 years

UCLA PTSD REACTION INDEX

- Child/adolescent self-report
- Caregiver report
- Older than 6 years

For Children Involved with Child Welfare

- Think beyond Child Safety and Permanency
- Well Being
  - Child and Adolescent Needs and Strengths (CANS) Tool
- Mental Health Needs
  - Strengths & Difficulties Questionnaire
- Family Functioning
  - Consider including foster parents in case planning

APSAC Advisor, Nov 2018 Edition, Trauma-Informed Care

Index of Suspicion
For Child Abuse or Neglect

Differential Diagnosis
Consider Child Neglect

- Injury with delay in seeking care
- Injury secondary to lack of supervision
- Multiple injuries
- Poor growth
- Poor hygiene
- Poorly controlled chronic disease
- Developmental delays
- Social emotional delays
- School problems
- Withdrawn
- Acting out
- Emotionally promiscuous
- Risk-taking behaviors
- Runaway
- Functional abdominal pain
- Tension headaches
- Chest pain
- Anxiety
- Depression

Differential Diagnosis
Consider Physical Abuse

- Skin finding
- Injury
- Disclosure
- Parent child interaction
- Externalizing behaviors
- Aggressive behaviors
- Developmental delays
- School problems
- Bully involvement
- Runaway
- Hypervigilant, hyperactive
- Functional abdominal pain
- Tension headaches
- Chest pain
- Anxiety
- Depression

Differential Diagnosis Consider Sexual Abuse

- Behavioral changes
- Sexualized behaviors
- Early sexual debut
- Dysuria or other urinary complaints
- Genital pain, bleeding, discharge
- Enuresis
- Encopresis
- Vague complaints, chronic pain not otherwise medically explained
- School problems
- Bully victimization
- Developmental delays
- Functional abdominal pain
- Chest pain
- Tension headaches
- Anxiety
- Depression

Trauma-Informed Review of Systems

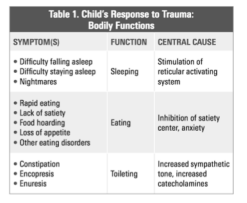

Table 1. Child's Response to Trauma: Bodily Functions

SYMPTOM(S)	FUNCTION	CENTRAL CAUSE
• Difficulty falling asleep • Difficulty staying asleep • Nightmares	Sleeping	Stimulation of reticular activating system
• Rapid eating • Lack of satiety • Food hoarding • Loss of appetite • Other eating disorders	Eating	Inhibition of satiety center, anxiety
• Constipation • Encopresis • Enuresis	Toileting	Increased sympathetic tone, increased catecholamines

The American Academy of Pediatrics
"The medical home approach to identifying and responding to exposure to trauma."

Behavioral Responses to Trauma

DISSOCIATION/DETACHMENT

- Dopaminergic
- Females
- Younger children
- Ongoing trauma/pain with inability to defend self

- Depression
- Inattentive ADD
- Developmental delay

AROUSAL/HYPERVIGILANCE

- Adrenergic
- Male
- Older children
- Witnessed violence and fight or flee

- ADHD
- ODD, Conduct disorder
- Aggression
- Bipolar

Developmental and School Difficulties

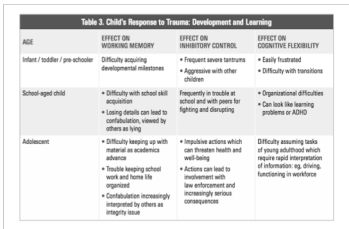

Table 3. Child's Response to Trauma: Development and Learning

AGE	EFFECT ON WORKING MEMORY	EFFECT ON INHIBITORY CONTROL	EFFECT ON COGNITIVE FLEXIBILITY
Infant / toddler / pre-schooler	Difficulty acquiring developmental milestones	• Frequent severe tantrums • Aggressive with other children	• Easily frustrated • Difficulty with transitions
School-aged child	• Difficulty with school skill acquisition • Losing details can lead to confabulation, viewed by others as lying	Frequently in trouble at school and with peers for fighting and disrupting	• Organizational difficulties • Can look like learning problems or ADHD
Adolescent	• Difficulty keeping up with material as academics advance • Trouble keeping school work and home life organized • Confabulation increasingly interpreted by others as integrity issue	• Impulsive actions which can threaten health and well-being • Actions can lead to involvement with law enforcement and increasingly serious consequences	Difficulty assuming tasks of young adulthood which require rapid interpretation of information: eg, driving, functioning in workforce

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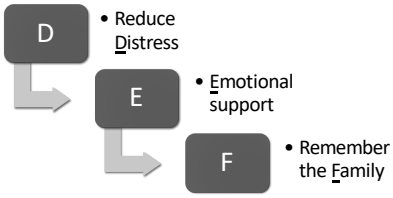
Physical Exam

- Trauma-Informed Patient Centered Care
- Signs of abuse or neglect

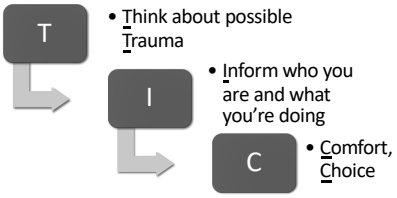
Physical Exam
Trauma-Informed Patient Centered Care

- Ask about comfort
- Explain first
- Give choices when possible
- Minimize anxiety
- Give patient sense of control

"D-E-F" Protocol for TIC



"T-I-C" Protocol



Physical Exam
Signs of Abuse or Neglect

- Affect and caregiver/child interaction
- Growth
- Development
- Injuries
- Hygiene/dental hygiene
- Chronic illnesses
- Skin
- Genital anal inspection

Case Example: Primary Care

John is a 3 year-old male with speech delay, and he comes to you with his foster parent for his well child visit. You are aware of his past history of physical abuse at age 2 when he presented with an unexplained fracture of the right humerus that led to a confession of inflicted injury by the mother's boyfriend at the time.

Knowing his past trauma history, you begin by offering him a choice to stay on the foster mother's lap or come to the exam table, which he chooses. As a male provider, you feel sensitive to approaching him with gentle ease and offer verbal reassurances that you two together will "play check up," to try to ease any tension he may feel by an approaching new adult male. You offer him a toy stethoscope, and proceed "together" with the exam, offering him additional choices such as "which ear first?" when you examine his ears, and modelling slow deep breathing with him when you auscultate his chest.

Case Example: Inpatient

-Sara is a 10 year-old female admitted to the pediatric ward for management of an asthma exacerbation.

-On rounds, the team discusses that she is having set-backs at attempts to wean her albuterol treatments at night.

-This prompts more thorough review of her medical record, and you find that she had disclosed sexual abuse from age 6-8 years by her live-in uncle, who would enter her room at night and abuse her.

-This additional history informed the team to approach night-time assessments by nursing, clinicians, or respiratory therapists differently—everyone was informed to introduce themselves upon entering the room and explain who they are and their role prior to proceeding with any treatments or assessments.

-The child was also referred to psychiatry for further evaluation and treatment for any residual PTSD symptoms from her abuse.

What to Do Next…

- Empathize, normalize
- Explain how stress can impact health
- Assess readiness for change
- Possible screening tools
- Anticipatory guidance
- Offer resources
- Maybe refer
- Maybe report to Child Protective Services

Therapeutic Listening

- Understand that listening is therapeutic.
- When something becomes speak-able, it becomes more tolerable.
- Helps make the connection between the emotional brain and the thinking brain.
- A step toward healing and integration.

Trauma-Specific Anticipatory Guidance

Excessive response to normal stimuli

- Perceived as threat (Hypertrophied amygdala)
- Don't take behaviors personally
  Stay calm
  Anticipate reaction and redirect
  Model and teach child calming skills

Difficulty putting words to feelings

- Memory centers for words blocked, emotions and language not connected
- Tell child it's okay to feel their emotions and help label them

Trauma-Specific Anticipatory Guidance

Challenging caregivers

- Reenact old relationships as familiar, gives them some mastery
- Give message of safety, trust, worthiness, praise
  Repeatedly
  Don't take it personally

Functional abdominal pain

- Increase fiber, decrease lactose
- Clarify if "same" or "different" pain and limit attention, reinforce well behavior
- Distraction, positive self talk, relaxation techniques

Evidence-Based Programs Standards of Evidence Criteria

- Randomized controlled trial or quasi-experimental assessment with comparison group
- Measures with validity and reliability
- At least one long-term follow-up assessment (at least 6 months after intervention) showing statistically significant results
- Results replicated at least once

Society for Prevention Research
Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination

Evidence-Based Model Universal Trauma Precautions

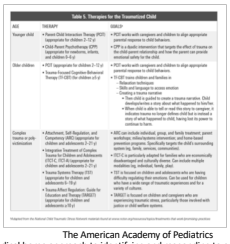
SEEK Model

- Educational training
- Parent Screening Questionnaire
  - Harsh parenting
  - Substance use
  - Intimate partner violence
  - Stress / social support
  - Food insecurity
- Assess current services and readiness for change
- Resident and parent handouts
- Social work referral

Triple P Positive Parenting Program

- Supports positive parenting strategies at the individual, family, and community levels
- Targeted educational and social campaigns

Evidence-Based Models for Trauma-Specific Care

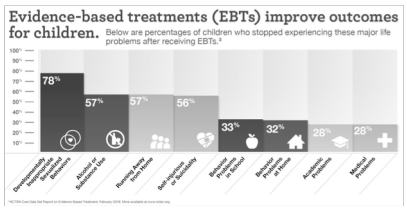


The American Academy of Pediatrics
"The medical home approach to identifying and responding to exposure to trauma."

Evidence-Based Treatment Trauma-Specific Care

TF-CBT	Parent Child Psychotherapy	Parent Child Interaction Therapy
• 5 years and older • Sexual abuse, physical abuse • > 10 RCTs	• 0 – 6 years • Attachment	• 2-12 years • Improve positive parenting • Decrease disruptive behaviors

Evidence-Based Treatments Help



Nationalchildrensalliance.org

Evidence-Based Treatments Help

Nationalchildrensalliance.org

Evidence-Informed Model Complementary and Integrative Care

Trauma-Informed Yoga

- Adjunctive therapy for chronic treatment-resistant PTSD in 64 female victims
- Based on yoga (postures, breathwork, and mindfulness) increasing sensory awareness, safety, and mastery over one's body while learning to interpret and tolerate physiologic and affective states
- May help address implicit memories, whereby talk therapy mostly targets explicit narrative memories
- Random assignment to trauma-informed yoga versus supportive women's education class
- 10 week, 1 hour/week
- At week 10, 52% of the yoga group no longer met criteria for PTSD versus 21% in control group

Van der Kolk, B.A., et al. (2014). Yoga as adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. *J Clin Psychiatry* 75(0): 1-7.

Trauma-Informed Care

Recognize, Respond, and Resist trauma in

- Children
- Caregivers
- Providers

Understanding Your Own History and Reactions to Other's Trauma

- Secondary Traumatic Stress - The emotional distress resulting from an encounter with a traumatized and suffering patient
- More than everyday stress and may become Compassion Fatigue or Burnout Syndrome and mimic PTSD
  - Emotional exhaustion
  - Depersonalization
  - Reduced sense of accomplishment
- Barriers to self-care
  - Feeling penalized for taking care of oneself
  - Inappropriate expectations
  - A culture of silence

Understanding Your Own History and Reactions

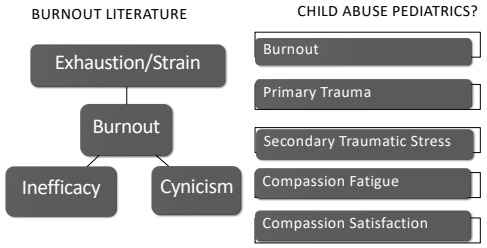
Health Correlates of Stress

- Headaches
- GI symptoms
- Muscle tension
- Hypertension
- Cold/flu episodes
- Sleep disturbances
- Changes in appetite
- Mental health symptoms

Provider Self-Care is Necessary for Quality Care

- Overall clinician burnout has been assessed at 48%--almost double the rate for the general US working population (Shanafelt, et al., 2015)
- Physicians have twice the rate of suicide versus the general population (Andrew & Brenner, 2015)
- Clinician burnout and compassion fatigue have been associated with
  - Decreased patient satisfaction
  - Lower quality of care
  - Medical errors
  - Implicit bias
  - Higher employee absenteeism and greater turnover
  - Economic inefficiencies

Burnout, Medicine, and Child Abuse Pediatrics



Maslach and Leiter, 2008.

Some Burnout Factors

BURNOUT CREATION	BURNOUT PREVENTION
•Work overload	•Sustainable workload
•Lack of control	•Feelings of choice and control
•Insufficient rewards	•Recognition and reward
•Breakdown of community	•A sense of community
•Unfairness	•Fairness, respect, justice
•Value conflicts	•Meaningful valued work
•Lack of fit between person and job	•High job-person fit

Skovholt and Trotter-Mathison. *The Resilient Practitioner.* 2016.

Steps Toward Resiliency

Addressing Secondary Traumatic Stress and Burnout

Individual	Institution
•Take time for yourself	•Safety culture
•Set appropriate personal boundaries	•Establish teams
•Accept uncertainty	•Identify sources of stress
•Embrace self reflection	•Debriefing opportunities
•Cultivate supportive relationships	•Increase ethics discussions
•Maintain interests outside of work	•Offer training sessions on resiliency

Crowe S, Sullivant S, Miller-Smith L, Lantos JD. (2017). Grief and burnout in the PICU. *Pediatrics* 139 (5): 74-78.

Creating Trauma-Informed Institutional Systems

- Complementary to family-centered care practice, with expansions and shifts in knowledge, attitudes, and practice
- Training and education
  - General training for all professionals and support staff
  - Specialized training for each patient population
- Shift in culture, integrate into the mission and values, strategic plan and daily practice
- Incorporate into practice as a universal precaution
- May partner with patients and families as stakeholders in improving care practices

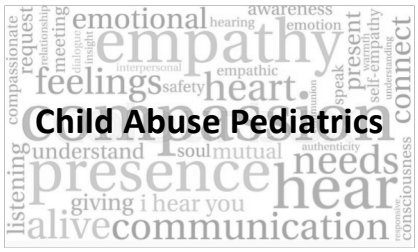
Marsac ML, Kassam-Adams N, Hildenbraqnd AK, Nicholis E, Winston FK, Leff SS, Fein J. (2016). Implementing a trauma-informed approach in pediatric health care networks. *JAMA Pediatrics* 170 (1): 70-77.

Trauma Informed Care
Keep Trauma Exposure on the Differential…

- Injuries not clearly explained
- Behavioral or school problems
- Changes in behavior
- Poor growth
- Problems related to toileting, sleep, or feeding
- Somatic complaints with normal exams and not otherwise explained

Overview of Principles of Trauma-Informed Care

- Universal trauma precautions
  - Patient-centered care
  - Understanding the health effects of trauma
  - Understanding your own history and reactions
- Universal trauma screening in primary care
  - Framing Statement
  - "Since your last visit, has anything scary or very upsetting happened to your child or someone in your family?"
- Trauma-specific care
  - Focused screening
  - ROS, physical exam, anticipatory guidance that are trauma-informed
  - Evidence-based trauma informed resources and referrals
  - Self-care



Child Abuse Pediatrics

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AAP Connected Kids Program for violence prevention. www.2aap.org/connectedkids/

APSAC Advisor, Trauma-Informed Care, Nov 2018 Edition.

Cohen, J.A., et al. (2008). Identifying, treating, and referring traumatized children. *Arch Pediatr Adolesc Med* 162(5): 447-452.

Felitti, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." *Am J of Prev Med* 14(4): 245-258.

Johnson, et al. (2013). The science of early life toxic stress for pediatric practice and advocacy. *Pediatrics* 131(2): 319-327.

Raja, S., et al. (2015). Trauma informed care in medicine. *Fam Community Health* 38(3): 216-226.

Shonkoff J.P., et al. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 129(1): 232-246.

Some Online Resources

Child Traumatic Stress Network → Center for Pediatric Traumatic Stress → https://www.healthcaretoolbox.org

AAP→ Trauma Toolbox for Primary Care→ http://www.aap.org.en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx

SAMHSA (Substance Abuse and Mental Health Services Administration) https://www.samhsa.gov

National Child Traumatic Stress Network http://www.nctsnet.org