Maine AAP CME Fall Conference Keynote Address

Promoting Child & Family Health & Wellbeing: The Critical Need for Pediatricians to Address Adverse Childhood Experiences

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~~Shi~~ning a Light: Hidden Circumstances Affecting the Health and Wellbeing of Children and Families

"Pediatrics provides a powerful yet underused platform for **translating scientific advances into innovative early childhood policies**, and practicing pediatricians are ideally positioned to participate "on the ground" in the design, testing, and refinement of *new models of disease prevention, health promotion, and developmental enhancement* beginning in the earliest years of life." (AAP)

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Gratitude

3

Trauma As An Urgent Public Health Issue

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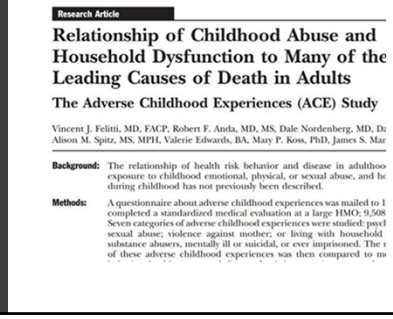
The ACEs Study: Seminal Research in Adverse Childhood Experiences

Behavioral Risk Factor Surveillance System (BRFSS)

CDC

http://www.cdc.gov/violenceprevention/acestudy/index.html



Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, Da
Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Mar

Background: The relationship of health risk behavior and disease in adulthoo exposure to childhood emotional, physical, or sexual abuse, and he during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 1 completed a standardized medical evaluation at a large HMO; 9,508 Seven categories of adverse childhood experiences were studied: psycl sexual abuse; violence against mother; or living with household substance abusers, mentally ill or suicidal, or ever imprisoned. The of these adverse childhood experiences was then compared to m

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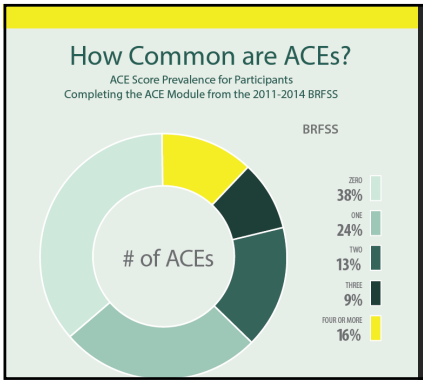

Prevalence of ACEs from BRFSS

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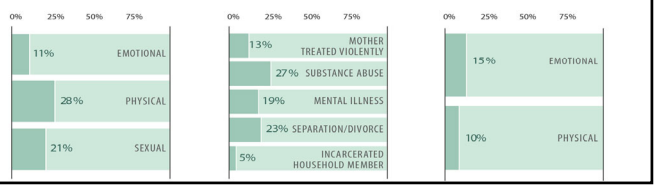
TYPES *of* ACES

The ACE study looked at three categories of adverse experience: **childhood abuse**, which included emotional, physical, and sexual abuse; **neglect**, including both physical and emotional neglect; and **household challenges** which included growing up in a household were there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation/divorce or had a member of the household go to prison. Respondents were given an **ACE score** between 0 and 10 based on how many of these 10 types of adverse experience to which they reported being exposed.



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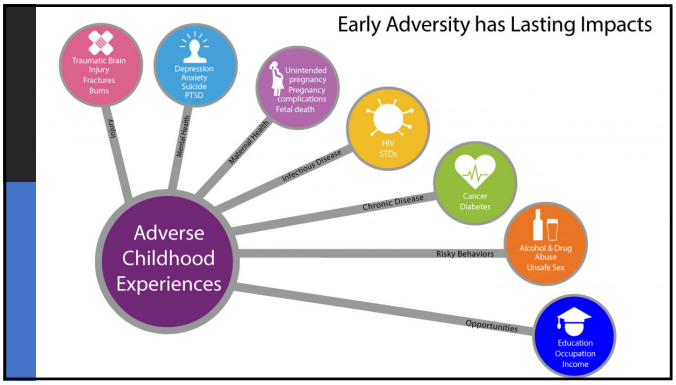

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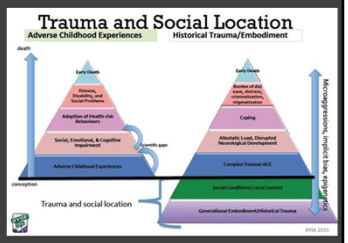
The Broader Context

- Historical Trauma
  - Racial trauma
- Social Conditions
  - Local context
  - Social determinants of health



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Real Life Examples: COVID-19 & Vulnerable Populations: Early Lessons (Shonkoff & Williams, 2020)

The impacts will be disproportionate

- Short-term – unstable housing, food insecurity, social isolation, etc.
- Increasing rates of substance abuse, family violence, and untreated mental health problems

Scientific knowledge is more critical than ever

- Supportive relationships
- Social distancing

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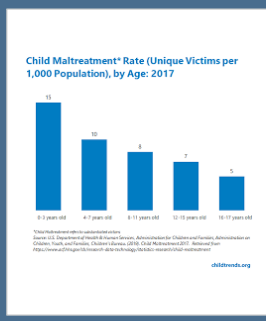

Prevalence of trauma in young children

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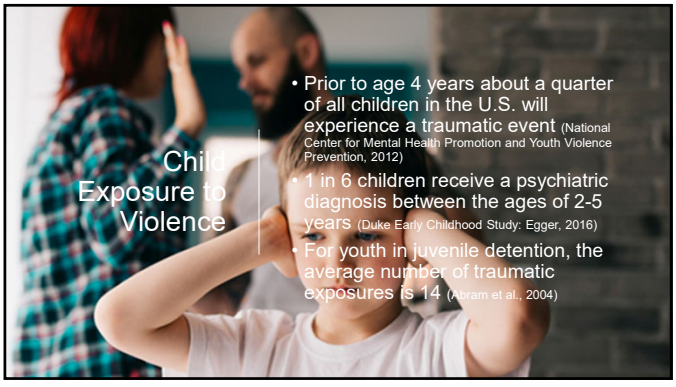

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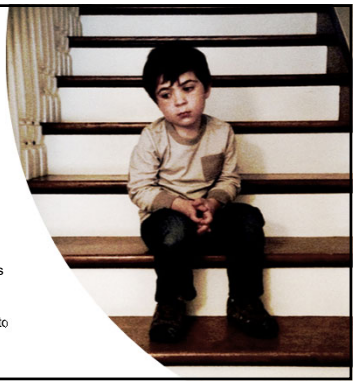
Young Children and Mental Illness



- Contrary to typical views, young children CAN suffer from mental health problems
  - 1 out of 7 U.S. children aged 2 to 8 years have a diagnosed mental, behavioral, or developmental disorder (National Survey of Children's Health, 2012)
- Addressing mental health problems early is key, as they will disrupt brain development and hinder the capacity to learn and grow
- Young children are particularly vulnerable to the impacts of adversity

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What We Believed About Young Children

- He/she won't remember what happened
- Young children are resilient
- Adversity makes you stronger
- It might be distressing or re-traumatizing to bring it up

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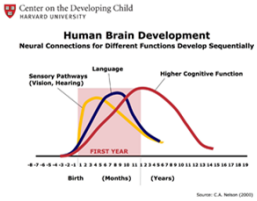
What We KNOW About Early Childhood



- Every second more than a million new neural connections are created during the first few years of life
- Both genes and the baby's experiences form these connections
- Built through serve and return interactions
- These connections form the "brain architecture – the foundation upon which all later learning, behavior, and health depend."

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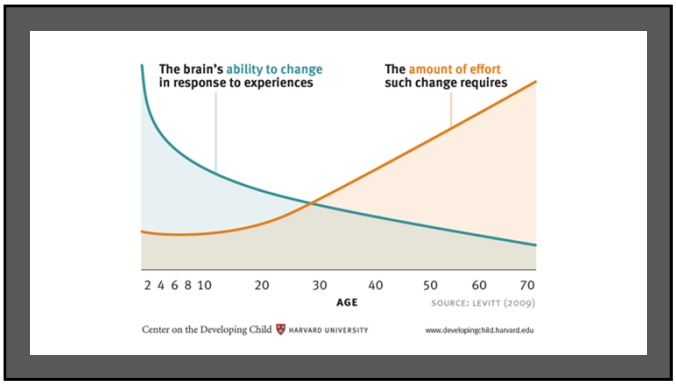

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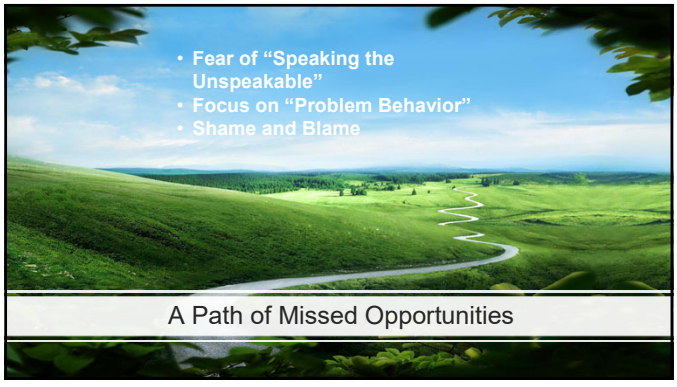

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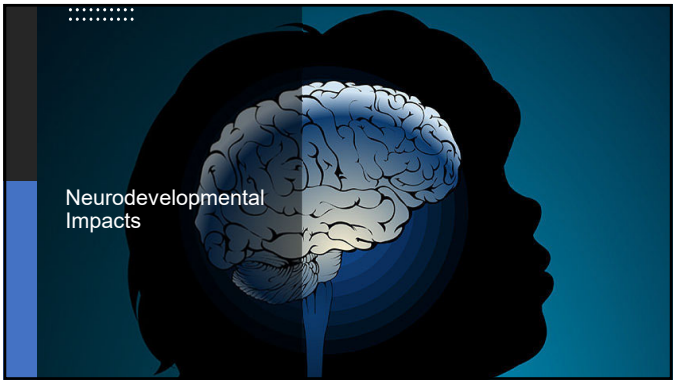

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Neuroception

"Neuroception represents a neural process that enables humans and other mammals to engage in social behaviors by distinguishing safe from dangerous contexts" (p. 5).

- **Temporal cortex – amygdala**
  - Intention of voices, faces, and hand movements (familiar individuals & those with prosodic voices and warm, expressive faces = sense of safety
- **Viscera – from afferent feedback**
  - "Functionally, visceral states color our perception of objects and others" (p. 6)
  - Insula – detects internal body states and represent in a subjective feeling

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Relationships: Mediator of Fear

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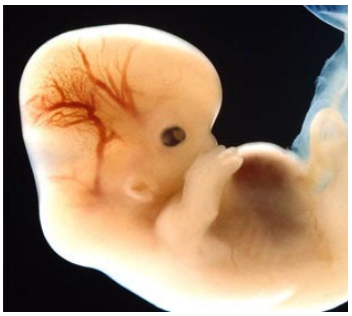
In Utero Experiences

- Somatosensory cues
- Rhythmic
  - 40, 60, 80 beats per minute
- Once born the caregiver provides pleasure and safety
  - Rocking
  - Bouncing
- Causes the release of hormones that calm
- Rhythm and regulation are associated
- As are experiences with caregivers (relief from distress)



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Safety & Relationships

"You keep me safe and help me to believe that others can be safe" = ATTACHMENT

"You see me, understand me, and help me understand myself" = ATTUNEMENT

"You notice when I am distressed and help me to calm down" = CO-REGULATION

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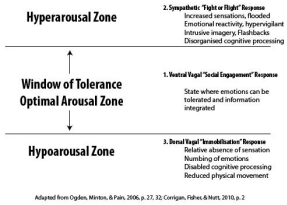
Window of Tolerance



Adapted from Ogden, Minton, & Pain, 2006, p. 27, 32; Corrigan, Fisher, & Nutt, 2010, p. 2

The Stress Response System via Polyvagal Theory (Porges)

1. Ventral vagal parasympathic (safety)
   - The default mode of arousal
   - "Rest and digest"
   - Slows the fear response and allows for connection and co-regulation
2. Sympathetic (hyperarousal)
   - Danger or play and joy
   - Overrides the ventral vagal
   - Results in bodily changes (increased heart rate, mobilization, rage & panic)
3. Dorsal vagal parasympathetic (hypoarousal)
   - Life threat or deep rest and contemplation
   - Overrides sympathetic
   - Activated by helplessness and shame/humiliation

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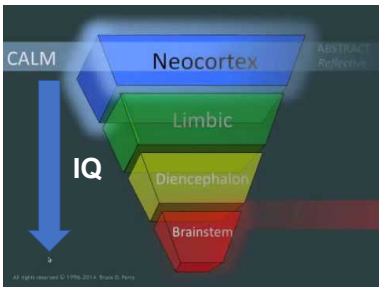
State Dependent Functioning (Bruce Perry, MD, PhD)



Abstract thinking
Future-oriented planning

Emotional thinking
Focus on hours and minutes

Reflexive thinking
No sense of time

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State Dependent Functioning (Bruce Perry, MD, PhD)

Internal State	CALM Reflect	ALERT Flock	ALARM Freeze	FEAR Flight	TERROR Fight
Brain Regulating Region	NEOCORTEX Subcortex	SUBCORTEX Limbic	LIMBIC Midbrain	MIDBRAIN Brainstem	BRAINSTEM Autonomic
Arousal Continuum	REST	VIGILANCE	RESISTANCE Crying	DEFIANCE Tantrums	AGGRESSION
Dissociative Continuum	REST	AVOIDANCE	COMPLIANCE Robotic	DISSOCIATION Fetal Rocking	FAINTING
Cognitive Style	Abstract	Concrete	Emotional	Reactive	Reflexive
Sense of time	Extended Future	Days Hours	Hours Minutes	Minutes Seconds	No Sense of Time
Brain Region Accessibility	Neocortex = 85% Limbic = 90% Lower Brain = 10%		Neocortex = 10% Limbic = 60% Lower Brain = 60%		Neocortex = 5% Limbic = 30% Lower Brain = 85%

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The Fear Response: The Path Most Taken

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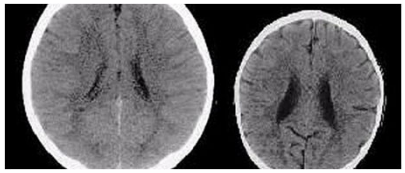

Neglectful Experiences & Lack of Brain Integration

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"How States Becomes Traits" (Bruce Perry, MD, PhD)

- Persistent states of arousal become neutrally-based habits of responding
  - "Neurons that fire together, wire together"
- Sensitization of the fear response – (a.k.a., the "kindling effect")

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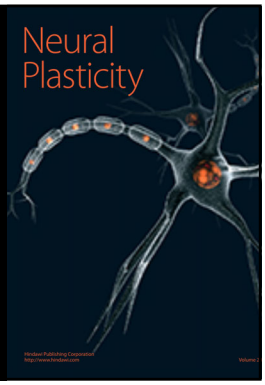
Disrupted Neurodevelopment

Earlier to Develop – Decreased Plasticity

- Brain Stem
  - ANS functions
- Cerebellum and Diencephalon
  - Motor control
  - Arousal level
- Limbic System
  - Emotions
  - Relationships
- Prefrontal Cortex
  - Executive functions



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Disrupted Neurodevelopment: Brain Stem Functioning (AAP)

Response to Trauma: Bodily Functions

FUNCTION	CENTRAL CAUSE	SYMPTOM(S)
Sleep	Stimulation of reticular activating system	1. Difficulty falling asleep 2. Difficulty staying asleep 3. Nightmares
Eating	Inhibition of satiety center, anxiety	1. Rapid eating 2. Lack of satiety 3. Food hoarding 4. Loss of appetite
Toileting	Increased sympathetic tone, increased catecholamines	1. Constipation 2. Encopresis 3. Enuresis 4. Regression of toileting skills

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Externalizing Behavior Problems

Externalizing behavior problems are represented by the diagnoses (ADHD, ODD, and CD)

Empirical evidence links externalizing behavior problems to:

- Childhood maltreatment
- Family violence
- Community violence
- Maladaptive parenting

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Internalizing Behavior Problems

- Children who have experienced some from of victimization display those symptoms as:
  - Separation anxiety disorder
  - Panic disorder

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Behavioral Manifestations of Trauma (AAP)

Response to Trauma: Behaviors[15,16]

CATEGORY	MORE COMMON WITH	RESPONSE	MISIDENTIFIED AS AND/OR COMORBID WITH
Dissociation (Dopaminergic)	• Females • Young children • Ongoing trauma/Pain • Inability to defend self	• Detachment • Numbing • Compliance • Fantasy	• Depression • ADHD Inattentive Type • Developmental delay
Arousal (Adrenergic)	• Males • Older children • Witness to violence • Inability to fight or flee	• Hypervigilance • Aggression • Anxiety • Exaggerated response	• ADHD • ODD • Conduct disorder • Bipolar disorder • Anger management difficulties

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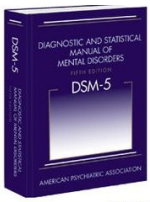
Post-Traumatic Stress Disorder

A. Exposure to death, violence, injury
B. Intrusion
   1. Distressing memories – recurrent, involuntary, intrusive
   2. Nightmares
   3. Dissociative reactions – flashbacks
   4. Intense distress at exposure to reminders
   5. Physiological reactions
C. Avoidance – memories, thoughts, feelings, external reminders
D. Negative alterations in cognitions and mood
E. Alterations in arousal – Irritability, recklessness, hyper-vigiliance



DSM-5 2013

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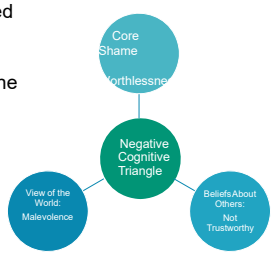
Negative Alterations in Cognitions and Mood

Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world



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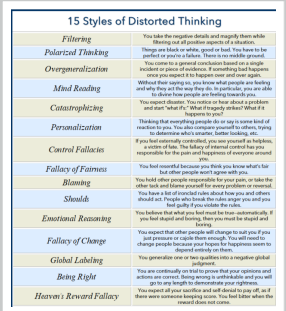
Negative Alterations in Cognitions and Mood

- Distorted cognitions about the cause or consequences of the event (e.g. self blame)
- Persistent negative emotional state
- Markedly diminished interest in activities
- Feelings of detachment
- Inability to experience positive emotions



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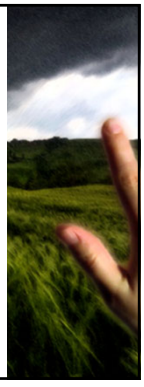
Subtypes of PTSD Adaptation

1. Trauma-related altered states of consciousness (TRASC) – Hypo-arousal
2. Normal waking consciousness/significant distress (NWC) – Hyper-arousal



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Dissociation as Protection

(Goldsmith, Barlow, & Freyd, 2004)

- The severity and chronicity of trauma determine dissociative tendencies
- "***Betrayal traumas***" such as CSA and/or PA result in the experience of dissociation more so than things like accidents
- Dissociation during IPV could lead to "**betrayal blindness**"
- Substances can promote dissociation

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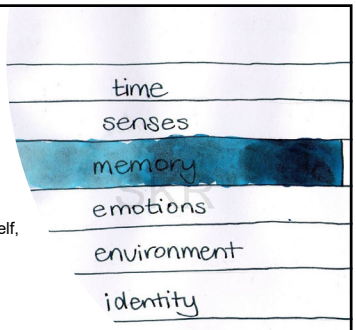
What is Dissociation?

(International Society for the Study of Trauma and Dissociation)

- "…the disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness" (p. 1)



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Four Dimensions of Consciousness Affected by Psychological Trauma (Frewen & Lanius, 2015)

TIME (TEMPORALITY)

THOUGHT (NARRATIVE)

BODY (EMBODIMENT)

EMOTION (AFFECT)

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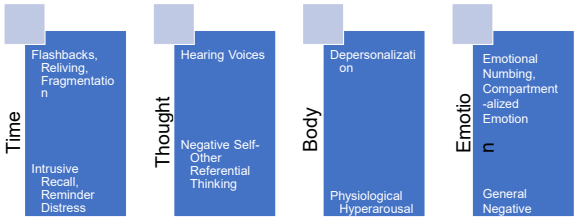
4-D Model of the Traumatized Self



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Neurophenomenology

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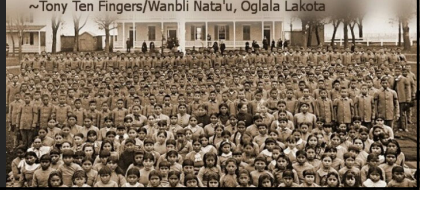
Familial Impacts

The multi-generational transmission of violence and trauma

Historical trauma is entirely different than consciously holding onto the past when it resides in your ancestral memory and DNA. It results in numerous defense mechanisms, developmental malfunctions, and behavioral issues. This is scientific and is supported in studies.

~Tony Ten Fingers/Wanbli Nata'u, Oglala Lakota



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Violence is Ubiquitous

- Child Maltreatment
- Domestic Violence
- Interpersonal Violence
- Sexual Assault
- Child Exposure to Violent Media

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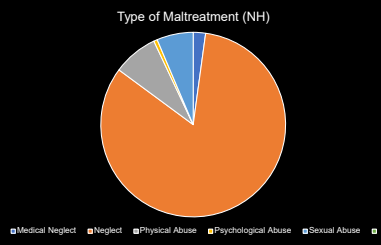
Child Maltreatment in in 2017

National Child Abuse and Neglect Data System (NCANDS) – 2017 NH Child Maltreatment Report



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Perpetration of Maltreatment

National Child Abuse and Neglect Data System (NCANDS) – 2017 Child Maltreatment Report

- Its typically someone we know…
- 91.6% of the maltreatment experienced by children is at the hands of a parent vs. someone outside the home
  - Only 2.9% of perpetrators are partner's of parents
  - 47% of the time it is a relative
- Biological mothers are the most likely to maltreatment children
  - Mothers represent 40.8% of the perpetrators
  - Fathers are the perpetrator 21.5% of the time
  - In 20.4% of the cases, it is both the mother and father
- White people represent the largest percentage of perpetrators of abuse at 50.3%

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Intergenerational Transmission of Child Maltreatment

(Kim et al., 2010)

There is strong evidence for the notion that children who experience abusive parenting will abuse their own children

- About 1/3 of all individuals who were abused or neglected as children will subject their children to maltreatment (Child Welfare Information Gateway)

Childhood sexual abuse histories are associated with daughters' sexual abuse experiences

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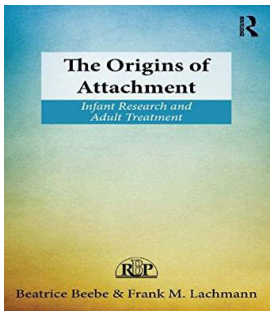
Understanding the Roots of Attachment Problems

- Beatrice Beebe – The Origins of 12-Month Attachment
- Caregiver responses to infant distress (4 months)
  - Affect recognition
  - Co-regulation
- The follow-up
  - Strange Situation at 12 months
  - The Adult Attachment Interview
- The importance of distress
- "Being known by the caregiver"



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Avoidance

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Societal Denial of Violence: What it Looks Like

(Goldsmith, Barlow, & Freyd, 2004)

- Overly focused on "outsiders" as the perpetrators of violence
- Preference for trauma that occurs to large groups of people
  - Sexual abuse committed by clergy
- The use of language to invalidate or pathologize
  - Borderline personality disorder
- Sensationalizing of mental illness by the media
  - DID

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Arousal State	Brain Region	Memory	Type of Memory	Content	Experience
Calm & Connected	Prefrontal Cortex	Explicit Memory	Semantic Episodic	Facts & general knowledge Personal events	**Known & Purposeful**
Distressed & Disconnected	Brain Stem & Limbic System	Implicit Memory	Procedural Priming Classical Conditioning	Motor & cognitive skills Enhanced identification	**Unknown & Uncontrollable (no conscious awareness)**

Memory & Distress: "Name it to tame it" (Siegel)

56

Relationships Become Biological Structure

- "Attachment schemas are implicit memories that are known without being thought…they reflect the transduction of interpersonal experience into biological structure" (Cozolino, 2006, p. 148).

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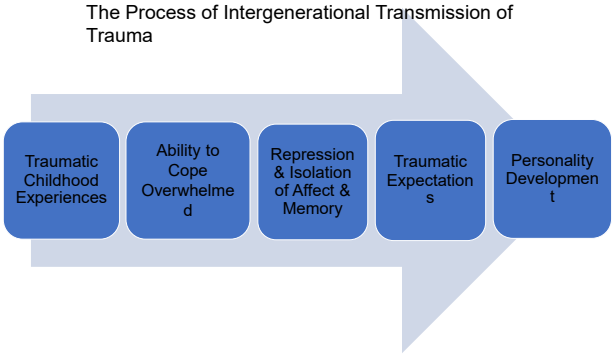
The Process of Intergenerational Transmission of Trauma



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Trauma Awareness is Critical for Ending the Cycle

"However, it is precisely because denial and dissociation contribute to the reenactment of violence that we must insist on awareness for personal and societal trauma. Any climate that explicitly or implicitly reduces discussion about abuse awareness and abuse accuracy increases the secrecy and unawareness about abuse, thus perpetuating its continuation."

60

Societal Impacts

The Preschool to Prison Pipeline

61

Poly-Victimization & Poly-Treatment

- Youth with complex mental/behavioral health issues frequently receive a host of diagnosis (Saldana et al., 2014)
- Intervention typically involves poly-pharmacological & poly-treatments
  - With limited effectiveness for this complex population (Holtmann et al., 2011)
  - And can be associated with poor outcomes
- Poly-intervention leads to fragmentation and overwhelming and/or conflicting approaches

62

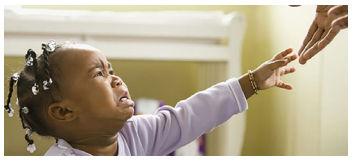
Psychiatric Diagnosis and Risk

- Risk for trauma & victimization is increased with psychiatric diagnosis
  - And, poly-victimization results in more symptoms and diagnosis (McLaughlin et al., 2013)
- Negative experiences in psychiatric settings has been documented

63

Disruptive Behavior & Caregiver Disruption

- Disruptive behavior in the context of an unprepared system often results in psychiatric hospitalization and/or multiple out-of-home placements….
  - And caregiver disruptions
- About 30-50% of youth in out-of-home placements have multiple diagnosis and poly-victimization experiences
- Less than 5% are identified with PTSD (in research or practice) (D'Andrea et al., 2012)



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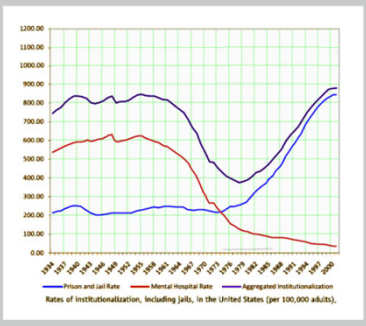
The Mental Health System: "Taking Care of the Problem"

- "Transinstitutionalization"
  - The movement of people across institutions
    - Prisons
    - Homelessness
- The revolving door of psychiatric hospitalizations and incarceration



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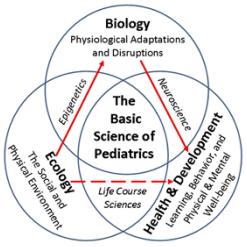
Health Promotion & Disease Prevention

The Critical Role of Pediatricians In Addressing Child Trauma

Health promotion and prevention of disease across the lifespan

66

The Ecobiodevelopmental (EBD) Framework



- "…framework for understanding the evolution of human health and disease across the lifespan."
- Based in multidisciplinary contributions to science
  - **Biology** – physiological adaptations and disruptions
  - **Health & Development** – learning & behavior, physical & mental well-being
  - **Ecology** – the social and physical environment

PEDIATRICS

67

Ecobiodevelopmental Framework

- There is a strong association between "the ecology of childhood" & developmental and lifespan trajectories
- Developmental neuroscience and epigenetics elucidate the mechanisms that drive these associations

"Rooted in a deepening understanding of **how brain architecture is shaped** by the interactive effects of both **genetic predisposition and environmental influence, and how its developing circuitry affects a lifetime of learning, behavior, and health** and advances in the biological sciences underscore the foundational importance of the early years and support an EBD framework for understanding the evolution of human health and disease across the lifespan."

68

Addressing ACEs in Primary Care (AAP)

- Challenges:
  - Time
  - Resources
  - Discomfort

(Addressing ACEs & Other Types of Trauma in the Primary Care Setting)

(The Medical Home Approach to Identifying & Responding to Exposure to Trauma)

69

The Trauma-Responsive Pathway

Identification → Assessment → Trauma-Responsive Services

70

Screening for Trauma

- The first step in the process
- Opening the discussion
- Using a formal screening measure
- Using screening to change perceptions

71

Screening for Trauma (AAP)

Trauma Surveillance/Screening Tools (See pocket materials for additional tools in the public

TOOL	DESCRIPTION	NUMBER OF ITEMS AND FORMAT	AGE GROUP	ADMIN AND SCORING TIME	CULTURAL CONSIDERATIONS
UCLA PTSD- RI: Post Traumatic Stress Disorder Reaction Index*	Assesses exposure to trauma and impact of events	20-22 items depending on child, parent or youth version	Child and Parent: 7-12 years; Youth 13+	20-30 min to administer 5-10 min to score	English, Spanish
Abbreviated UCLA PTSD RI	Elicits trauma related symptoms	9 items for child 6 items for adult	8-16 years 3-12 years	2-5 minutes	English, Spanish
TSC-C Trauma Symptom Checklist for Children	Elicits trauma related symptoms	TSC-C: 54 items TSC-YC: 90 items, caregiver report for young children	8-16 years 3-12 years	15-20 min	English, Spanish

72

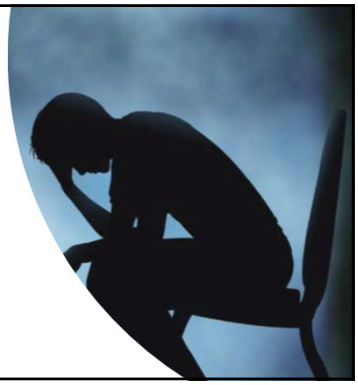
Do No Harm

The sensitivity of this topic introduces important ethical issues about how trauma is addressed in the mental health field

73

Is It Distressing?

- Most studies show that research that asks questions about trauma causes minimal distress (Binder & Freyd, 2004; Cook & Bosley, 1995; DePrince & Chu, 2008; Larsen & Berenbaum, 2014)
- Studies have indicated that participants report minimal distress as a result of talking about traumatic events (Kassam-Adams & Newman, 2005)



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"It's OK to Ask About Past Abuse"

(Edwards, Dube, Felitti, & Anda, 2007)

- The ACE study as an example of asking about abuse
  - No use of the hotline for a 24-month period
  - A healthy response rate (68%)
  - Nonresponse rates on ACE items was 1.3% to 6.9%

75

Addressing ACEs in Primary Care: Starting the Conversation (AAP)

- 4-step process:
  1. Why are we addressing ACEs/trauma in this setting?
  2. What are we trying to determine—what are we looking for?
  3. How will we do this?
  4. What will we do with the information?

76

Addressing ACEs in Primary Care: Engaging Caregivers in the Discussion (AAP)

- Avoid shame and blame
- Emphasize the importance of these issues and the impact on their child and themselves
- Let them know it is okay to talk about these things with you
- You're not alone

77

Differential Diagnosis & ACEs

Diagnosis through the "trauma lens"

78

Trauma & Misdiagnosis (NCTSN)

- complex trauma symptoms will NOT meet the full criteria for PTSD
- According to large studies, about 95% of children with traumatic stress symptoms will not meet PTSD criteria
- Trauma symptoms are often misdiagnosed as other DSM diagnoses and treated in a way that is not effective because it does not address the root of the

79

Symptom Overlap with Child Trauma & Mental Illness

(AACAP, 2010)

DSM Diagnosis	Overlapping Symptoms
Bipolar Disorder	Hyper-arousal & anxiety which mimic hypomania, traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping as in pseudo-manic statements
ADHD	Restless, hypoactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hyper-vigilant motor activity
ODD	Predominance of angry outbursts and irritability
Panic Disorder	Striking anxiety & hyper-arousal on exposure to feared stimuli, sleep problems, hypervigilance, and & increased startle reaction
MDD	Self-injurious behaviors - avoidant coping with traumatic reminders, social withdrawal, affective numbing, and/or sleep difficulties
Substance Abuse	Use of substances to numb or avoid trauma reminders
Psychotic Disorder	Severe agitation, hypervigilance, flashbacks, sleep disturbance, numbing and/or social withdrawal, unusual perceptions

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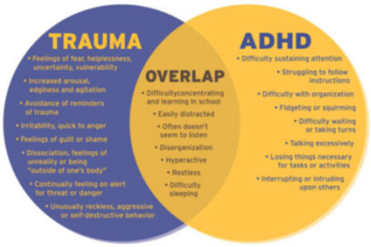
Trauma & ADHD



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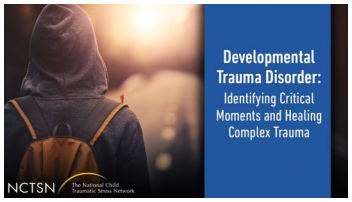
Developmental Trauma Disorder

(van der Kolk)

- Children exposed to trauma develop symptoms beyond what is described by PTSD
  - Panic
  - Separation anxiety
  - Disruptive behavior disorders



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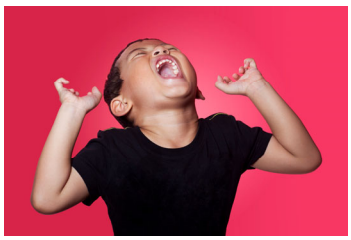
Developmental Trauma Disorder

- Dysregulation across systems:
  1. Somatic (physiological, motoric, medical)
  2. Emotion or somatic dysregulation
  3. Attentional or behavioral
  4. Relational- or self-dysregulation



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Complex Trauma

- Exposure to multiple traumatic events AND the long-term impact of this exposure
  - Severe and pervasive
  - Early in life
  - Disrupts development and identity formation
  - Attachment disturbance

(http://www.nctsnet.org/trauma-types/complex-trauma)

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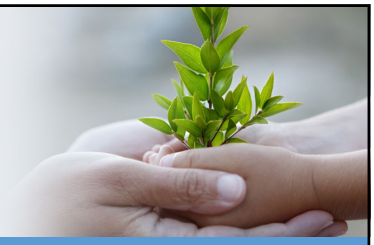
NCTSN
The National Child Traumatic Stress Network



Trauma Psychoeducation

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How Do People Change

"…based upon the premise tha attempting to improve the human condition through behavior change (e.g., education, behavioral health treatment) will be most effectiv if behavior itself is the primary focus, rather than less tangible concepts such as the mind an willpower." (www.bcba.com/aboutbehavio nalysis.com)

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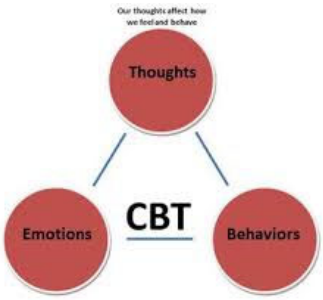
How Do People Change? Cognitive Behavioral Approaches



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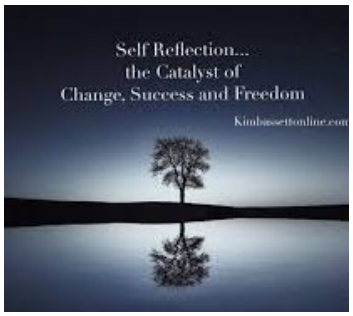
How Do People Change? Regulation Theory

- Safety
- Connection
- Hope
- Reflection



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Providing Psychoeducation (AAP)

1. Normalization of the trauma response
   - Behavior as a healthy response to an unhealthy threat
2. Pathophysiology of the trauma response
   - Innate nature of the fear response (FFFF and dampening of explicit memory)
3. Caregiver affective awareness and recognition
   - Getting in touch with the threat response and memory impairment

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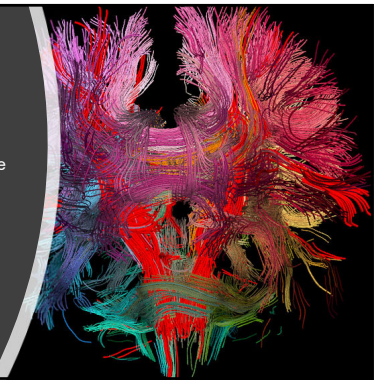
Providing Psychoeducation cont. (AAP)

4. Assist caregiver to extrapolate from own experience to understand toxic stress
   - Prolonged activation of the stress response
5. Neurodevelopmental understanding
   - "Neurons that fire together wire together"



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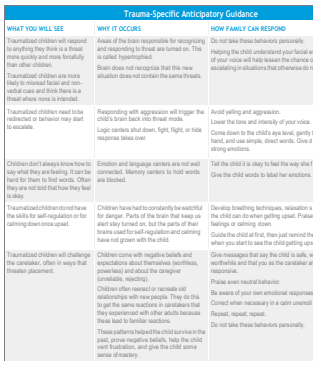
Providing Trauma-Specific Anticipatory Guidance
(AAP)


Trauma-Specific Anticipatory Guidance

WHAT YOU WILL SEE	WHY IT OCCURS	HOW FAMILY CAN RESPOND
Traumatized children will respond to anything they think is a threat more quickly and more forcefully than other children. Traumatized children are more likely to misread facial and non-verbal cues and think there is a threat where none is intended.	Areas of the brain responsible for recognizing and responding to threat are turned on. This is called hypervigilance. Brain does not recognize that this new situation does not contain the same threats.	Do not take these behaviors personally. Helping the child understand your facial e of your voice will help lessen the chance o escalating in situations that otherwise do n
Traumatized children need to be redirected or behavior may start to escalate.	Responding with aggression will trigger the child's brain back into threat mode. Logic centers shut down, fight, flight, or hide response takes over.	Avoid yelling and aggression. Lower the tone and intensity of your voice. Come down to the child's eye level, gently l hand, and use simple, direct words. Give c strong emotions.
Children don't always know how to say what they are feeling. It can be hard for them to find words. Often they are not told that how they feel is okay.	Emotion and language centers are not well connected. Memory centers to hold words are blocked.	Tell the child it is okay to feel the way she f Give the child words to label her emotions.
Traumatized children do not have the skills for self-regulation or for calming down once upset.	Children have had to constantly be watchful for danger. Parts of the brain that keep us alert stay turned on, but the parts of their brains used for self-regulation and calming have not grown with the child.	Develop breathing techniques, relaxation s the child can do when getting upset. Praise feelings or calming down. Guide the child at first, then just remind th when you start to see the child getting ups
Traumatized children will challenge the caretaker, often in ways that threaten placement.	Children come with negative beliefs and expectations about themselves (worthless, powerless) and about the caregiver (unreliable, rejecting). Children often reenact or recreate old relationships with new people. They do this to get the same reactions in caretakers that they experienced with other adults because these lead to familiar reactions. These patterns helped the child survive in the past, prove negative beliefs, help the child vent frustration, and give the child some sense of mastery.	Give messages that say the child is safe, w worthwhile and that you as the caretaker ar responsive. Praise even neutral behavior. Be aware of your own emotional response Correct when necessary in a calm unemoti Repeat, repeat, repeat. Do not take these behaviors personally.

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Referrals to trauma-informed evidence-based practices

The next link in the chain…

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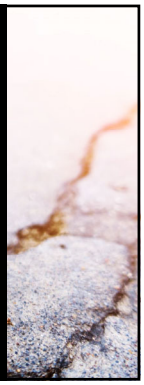
Addressing Toxic ~~S~~tress & Multigenerational Trauma

"Pediatricians should be **vocal advocates for the development and implementation of new, evidence-based interventions…that reduce sources of toxic stress and/or mitigate their adverse effects on young children**, as they are likely to produce better outcomes and potentially be more cost-effective than trying to treat or remediate the numerous consequences of excessive childhood stress that reach



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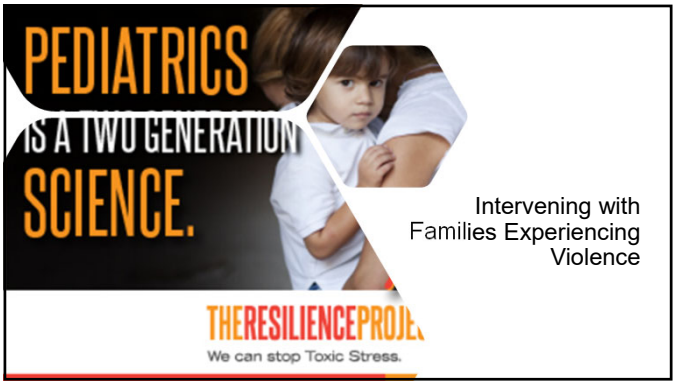

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Referrals to Evidence-Based Trauma-Informed Interventions

Young children
- **Child-parent psychotherapy (CPP)**
- Parent-Child Interaction Therapy (PCIT)

Older children
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Complex trauma
- Attachment, Self-Regulation, and Competency (ARC)
- Trauma Systems Therapy (TST)

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Evidence-Based Intervention: Child-Parent Psychotherapy | CPP

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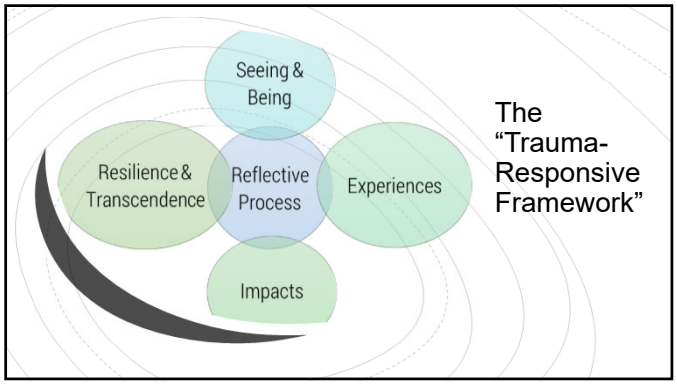

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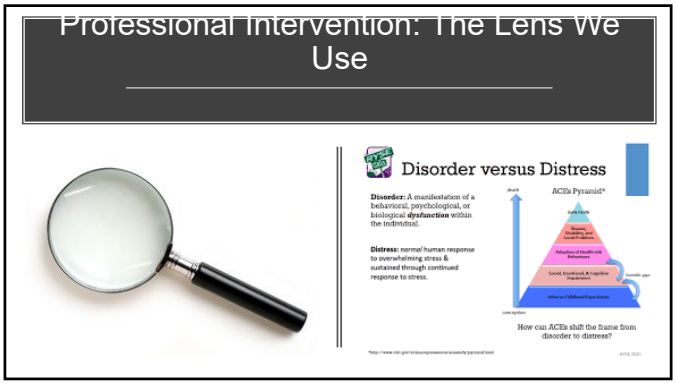

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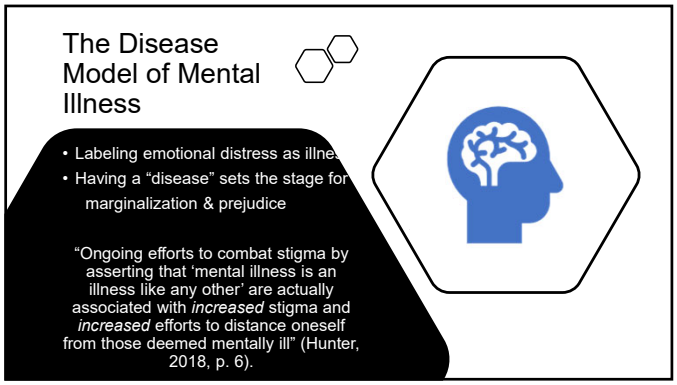

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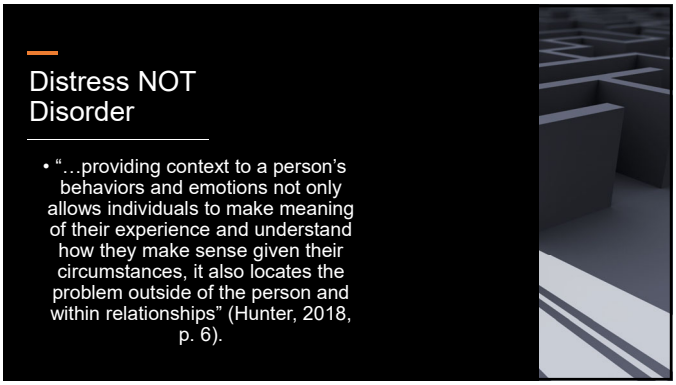

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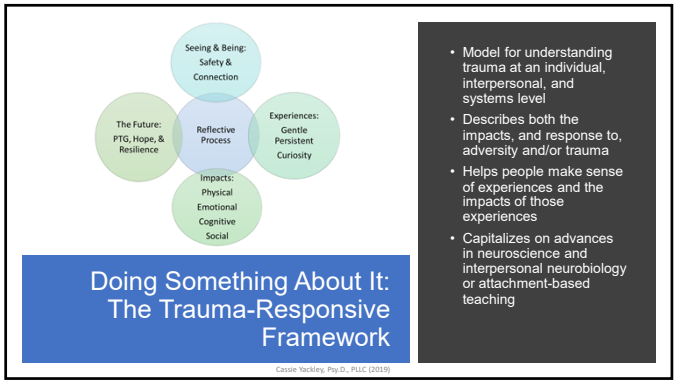

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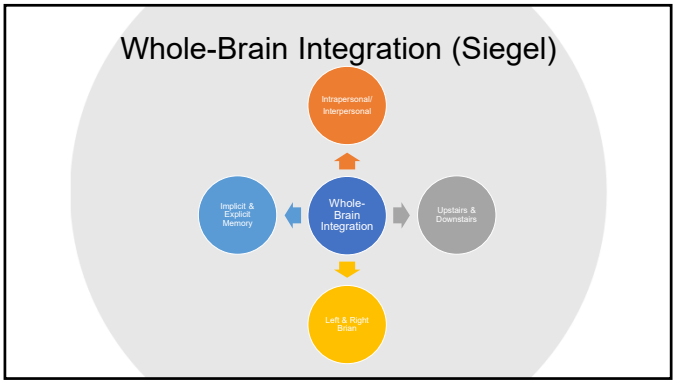

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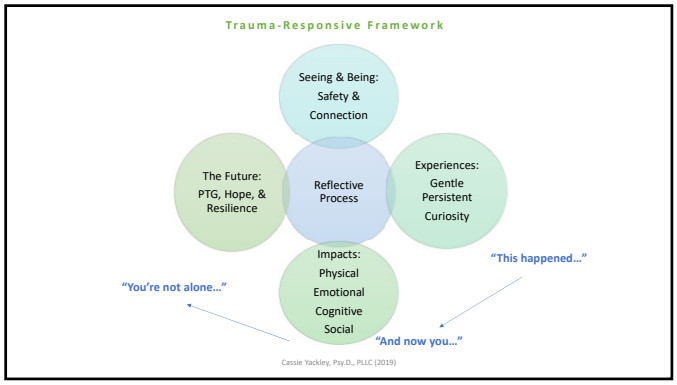

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Trauma-Responsive Framework

1. Check in with myself
   - History of relationships
   - Current circumstances
   - Capacity for reflection
2. Allow for safety—connection
   - Attunement
   - Share power

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Trauma-Responsive Framework

4. Narrate experiences
   - Gentle, persistent curiosity
   - Co-create story
5. Acknowledge & recognize
   - Neurodevelopmental (biopsychosocial) impacts
   - Interpersonal (emotion contagion)
   - Societal/systemic (anti-oppressive)
6. Transcendence & resilience
   - Post-traumatic growth

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Trauma-Responsive Framework

This happened…

And now I/you/we…

We're in this together and there is HOPE

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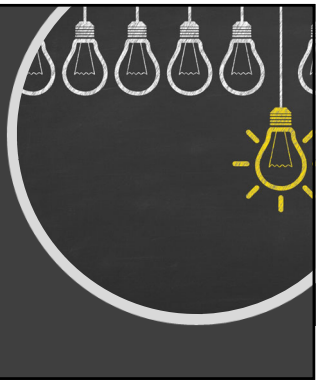
AAP Statement of the Role of Pediatricians in Addressing ACEs

- "Pediatricians should adopt a more **proactive leadership role in educating parents, childcare providers, teachers, policy makers, civic leaders, and the general public** about the long-term consequences of toxic stress and the potential benefits of preventing or reducing sources of significant adversity in early childhood."
- "Protecting young children from adversity is a promising, science-based strategy to address many of the most persistent and costly problems facing contemporary society, including limited educational achievement, diminished economic



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Caregiver Transformation: An Example

I am so excited that I just have to share this story…This is a TRUE STORY, that just happened.

I just left a visit with a family. Mom and dad both work full-time, and I was visiting during the brief 2 hours they have together during their shifts'. Dad walks in the door shortly after I got there visibly exhausted from a long day at work. There are twin one y/o's eating lunch in their highchairs, a 5 y/o and an 8 y/o all fighting for a brief second of attention from anybody. Mom's trying to get ready to go to work, I'm there on my first visit trying to explain our home visiting program and get out of their hair so they can go about their routine. It was a little chaotic. Dad was barking orders at his wife while also yelling at the kids to stay in the room and stop bothering "Home Visitor so she can get this done". He clearly is not in the mood to work on any goals and wants me gone as soon as possible.

Then mom looks at me and starts' telling me how they never listen and their behavior is just awful. BEHAVIOR!! IT'S THE WORD!

The 8 year-old boy has been talking about dogs since I had arrived. Then he looks at me and says his grandma and grandpa's dog bit him on the head and then they had to burn his bones. Dad immediately scolds him saying, "you know we do NOT talk about that day". Mom covers it up to me saying he is lying and that is not what happened. The child lowers his head in shame. (Cassie by now my heart is pounding as I'm reciting in my head how I am going to say what I'm about to say that I just learnt from you yesterday. This is the perfect scenario so far, almost word for word what you trained us. BUT I COULDN'T MESS IT UP)

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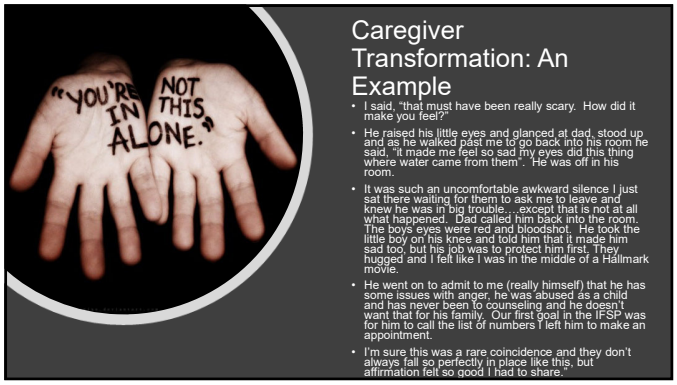

Caregiver Transformation: An Example

- I said, "that must have been really scary. How did it make you feel?"
- He raised his little eyes and glanced at dad, stood up and as he walked past me to go back into his room he said, "it made me feel so sad my eyes did this thing where water came from them". He was off in his room.
- It was such an uncomfortable awkward silence I just sat there waiting for them to ask me to leave and knew he was in big trouble…except that is not at all what happened. Dad called him back into the room. The boys eyes were red and bloodshot. He took the little boy on his knee and told him that it made him sad too, but his job was to protect him first. They hugged and I felt like I was in the middle of a Hallmark movie.
- He went on to admit to me (really himself) that he has some issues with anger, he was abused as a child and has never been to counseling and he doesn't want that for his family. Our first goal in the IFSP was for him to call the list of numbers I left him to make an appointment.
- I'm sure this was a rare coincidence and they don't always fall so perfectly in place like this, but affirmation felt so good I had to share.

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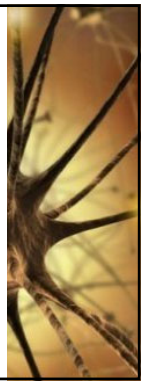
Experiences Change the Brain

- Neurogenesis
- Neuroplasticity



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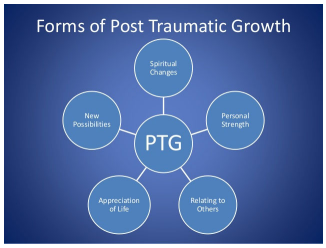
Post-Traumatic Growth



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Altruism Born of Suffering

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The Future: Transcendence & Resilience

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Thank You!

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