Trauma-Informed Care

Heather Forkey, MD, FAAP, a Moira Szilagyi, MD, PhD, FAAP, b Erin T. Kelly, MD, FAAP, FACP, c James Duffee, MD, MPH, FAAP, d

THE COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON CHILD ABUSE AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

Most children will experience some type of trauma during childhood, and many children suffer from significant adversities. Research in genetics, neuroscience, and epidemiology all provide evidence that these experiences have effects at the molecular, cellular, and organ level, with consequences on physical, emotional, developmental, and behavioral health across the life span. Trauma-informed care translates that science to inform and improve pediatric care and outcomes. To practically address trauma and promote resilience, pediatric clinicians need tools to assess childhood trauma and adversity experiences as well as practical guidance, resources, and interventions. In this clinical report, we summarize current, practical advice for rendering trauma-informed care across varied medical settings.

INTRODUCTION

Experiences in childhood, both positive and negative, have a significant effect on subsequent health, mental health, and developmental trajectories. For many children and adolescents, traumatic experiences are all too common. Almost one-half of American children, or 34 million younger than 18 years, have faced at least 1 potentially traumatic early childhood experience.1–7 Such traumas may include those originating outside the home, such as community violence, natural disasters, unintentional injuries, terrorism, immigrant or refugee traumas (including detention, discrimination,6,8,9 or racism), and/or those involving the caregiving relationship, such as intimate partner violence, parental substance use, parental mental illness, caregiver death, separation from a caregiver, neglect, or abuse, originally defined as adverse childhood experiences (ACEs).10 For many children, medical events, such as injury, medical procedures, and/or invasive medical treatments, can be traumatic. Given the robust science explaining the physiologic consequences of accumulated trauma experiences on the brain and body,11–14 there have been calls for pediatric clinicians to address childhood trauma and child traumatic stress.10,14–16 However,
practical guidance about how to consider, address, and operationalize this care, although necessary, has been insufficient.

Pediatric clinicians are on the front lines of caring for children and adolescents and, thus, have the greatest potential for early identification of and response to childhood trauma. Data indicate that, although pediatric providers intuitively understand the negative effects of trauma, they report a lack of knowledge, time, and resources as major barriers to providing trauma-informed care (TIC).5,6 Yet, experts believe that the complete assessment of child and adolescent behavioral, developmental, emotional, and physical health requires consideration of trauma as part of the differential diagnosis to improve diagnostic accuracy and appropriateness of care.17,18

TIC is defined by the National Child Traumatic Stress Network as medical care in which all parties involved assess, recognize, and respond to the effects of traumatic stress on children, caregivers, and health care providers. This includes attention to secondary traumatic stress (STS), the emotional strain that results when an individual hears about the first-hand trauma experiences of another. In the clinical setting, TIC includes the prevention, identification, and assessment of trauma, response to trauma, and recovery from trauma as a focus of all services. TIC can be conceptualized in a public health stratification, as summarized in Table 1:

- primary prevention of trauma and promotion of resilience;
- secondary prevention and intervention for those exposed to potentially traumatic experiences, including caregivers, siblings, guardians, and health care workers; and
- tertiary care for children who display symptoms related to traumatic experiences.

This clinical report and the accompanying policy statement19 address secondary prevention and intervention: practical strategies for identifying children at risk for trauma and/or experiencing trauma symptoms. “Children,” unless otherwise specified, refers to youth from birth to 21 years of age. These clinical strategies and skills include the following16,20:

- knowledge about trauma and its potential lifelong effects;
- support for the caregiver-child relationship to build resilience and prevent traumatic stress reactions;
- screening for trauma history and symptoms;
- recognition of cultural context of trauma experiences, response, and recovery;
- anticipatory guidance for families and health care workers;
- avoidance of retraumatization;
- processes for referral to counseling with evidence-based therapies when indicated; and
- attention to the prevention and treatment of STS and associated sequelae.

Pediatricians have a powerful voice and reach that could promote the policies and procedures necessary to transform pediatric health care into a TIC system. This guidance for pediatric clinicians is organized around 5 strategies for implementation to become trauma informed: awareness, readiness, detection and assessment, management, and integration. The companion policy statement19 outlines broad recommendations for implementing TIC in child health systems.

**TABLE 1** Range of Trauma Experiences, Symptoms, and Response

<table>
<thead>
<tr>
<th>Potentially Traumatic Experiences</th>
<th>Trauma Symptoms (Table 5)</th>
<th>Office Response</th>
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<tbody>
<tr>
<td>None</td>
<td>None to some</td>
<td>Primary prevention: anticipatory guidance; resilience promotion</td>
</tr>
<tr>
<td>Single-incident or minor trauma</td>
<td>None or latent or mild</td>
<td>Secondary prevention: anticipatory guidance; resilience promotion; trauma-informed care; close monitoring; screen for trauma history and symptoms</td>
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<tr>
<td>Major event or cumulative</td>
<td>Mild to moderate</td>
<td>Secondary and tertiary prevention: anticipatory guidance; resilience promotion; psychoeducation; trauma-informed care; close monitoring; follow-up; possible referrals to community services, mental health</td>
</tr>
<tr>
<td>Major event or cumulative</td>
<td>Moderate to severe</td>
<td>Tertiary prevention and treatment: anticipatory guidance; resilience promotion; psychoeducation; trauma-informed care; close monitoring; follow-up; avoidance of retraumatization; referrals to community services; referral to evidence-based and evidence-informed trauma mental health services</td>
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Safe, Stable, and Nurturing Relationships

The most fundamental adaptational mechanism for any child is a secure relationship with a safe, stable, nurturing adult who is continuous over time in the child’s life.24 This is usually the child’s parent or caregiver but can involve extended family and biological or fictive kin. It is in the protective context of this secure relationship that the child develops the varied resilience skills that will prevent or ameliorate the effects of cumulative adversities. The nurturing caregiver protects the child from harm, mediates the world for the child, and helps the child to develop the adaptive skills to manage stressful experiences. Physiology, in addition to psychology, is affected by protective relationships.14,25–27

Toxic Stress and Trauma

All children experience some stress and adversity at some point in life, but when it is managed within the context of these nurturing relationships, such events can be weathered and even used for growth. Adverse events that lead to the frequent or prolonged activation of the stress response (see Fig 1) in the relative absence of protective relationships has been termed “toxic stress” in the pediatric literature.14

Toxic stress responses result from events that may be long lasting, severe in intensity, or frequent in occurrence. The available caregiver support is insufficient to turn off the body’s stress response. It is critical to note that the toxic stress response has 2 components: the significant stressors and the relative insufficiency of protective relationships. In sum, there is a marked imbalance between stressors and protective factors.28

Toxic stress responses can result in potentially long-lasting or lifelong impairments in physical and mental health through biological processes that embed developmental, neurologic, epigenetic, and immunologic

<table>
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<tr>
<th>Stress Responses</th>
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<tr>
<td><strong>Freeze</strong></td>
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<tr>
<td>• Originates in central nucleus of the amygdala and mediated by hypothalamus and superior colliculus222</td>
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<tr>
<td>• Typically brief response, forces the organism to alert to danger</td>
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<tr>
<td>• Can be followed by the fight-or-flight responses</td>
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<tr>
<td>• Parasympathetic and vagal response can lead to dissociation or faint</td>
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<tr>
<td><strong>Fight or flight</strong></td>
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<tr>
<td>• Results from adrenal release of epinephrine and cortisol that allow the threat to be addressed</td>
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<tr>
<td>• Short term: physiological changes, including increased heart rate and blood pressure</td>
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<tr>
<td>• Excess or frequent activation in childhood can result in long-term changes in HPA axis function, which leads to dysregulation of the neuroendocrine stress response and consequent physiologic changes (see Table 2)12,223</td>
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<tr>
<td><strong>Affiliate (gather social support, “tend and befriend”)</strong></td>
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<tr>
<td>• Higher brain response mediated by oxytocin,224,225 appears to mediate stress within the social context by promoting the ability to look to others in the environment for support in managing a threat (social salience)70,226</td>
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<tr>
<td>• With the provision of support, stress response declines70,227</td>
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<tr>
<td>• Having no support or a hostile environment leads to negative perceptions of others, induces less adaptive responses and antisocial behaviors, and leads to increased perception of stress and increased cortisol70,228,230</td>
</tr>
<tr>
<td>• Emerging science underlying the affiliative response elucidates how safe, stable, nurturing relationships can buffer adversity and promote resilience</td>
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*FIGURE 1* Stress responses. HPA, hypothalamic-pituitary-adrenal.
changes. The lifelong effects of toxic stress are statistically related to many adult illnesses, particularly those related to chronic inflammation, and causes for early mortality. The robust literature on the physiologic effects of toxic stress is beyond the scope of this clinical report yet briefly summarized in Table 2.

Trauma is a broader term used to describe both a precipitant and a human response. The Substance Abuse and Mental Health Services Administration defines trauma as an event, series of events, or circumstances experienced by a person as physically or emotionally harmful that have long-lasting adverse effects on the person’s functioning and well-being (emotional, physical, or spiritual). This definition accounts for the fact that people may respond differently to potentially traumatic events and informs TIC with appreciation that the traumas people experience can result in behavioral changes that may allow them to manage the trauma in the short-term but can have lasting negative effects on conduct. These difficulties should not be viewed as malicious actions or even intentional but as consequences of adversity.

Because these epidemiological and physiologic studies provide the background and impetus for TIC, understanding the terminology derived from this literature is important in appreciating the scope, variety, and nuances of TIC and how to actualize them. These are summarized in Table 2.

**High-risk Populations**

It is important to be aware that the exposures of some child populations and their families put them at particular risk of experiencing trauma but also that the components of TIC can benefit these children and families. More than 7.4 million children, or nearly 1 in 10 children, are reported as potential victims of child abuse and neglect annually. In 2019, more than 670,000 children spent time in foster care. Children who remain at home after child protective services investigation or are moved to kinship care resemble their peers in foster care in having an extremely high prevalence of significant childhood trauma. Immigrant and refugee children may have left poverty, war, and violence, may have encountered abuse or separation from family members, and can be at risk for deportation, detention, and separation and discrimination. Poverty, or near poverty, affects approximately 43% of US children, and both urban and rural poverty have been linked with multiple stressors and increased risk of trauma. Children of underrepresented racial, ethnic, and religious groups are more likely to be exposed to discrimination. The psychological, interpersonal, and perhaps physiologic effects of trauma inflicted on a community (particularly because of race, identity, or ethnicity) may be passed to succeeding generations and is referred to as historical trauma.

Community violence and bullying, along with cyberbullying, are experienced by many children and recognized as traumatic exposures included in expanded definitions of ACEs. Lesbian, gay, bisexual, transgender, and queer children and adolescents, children of color, American Indian and Alaskan native children, immigrant children, neurodiverse children and adolescents, children and adolescents with overweight and obesity are all more likely to experience discrimination, both overt and as a series of microaggressions (small slights, insults, or indignities either intentional or unintentional) that accumulate over time. Additionally, children of military families have a higher prevalence of trauma, abuse, grief, and loss. Populations at higher risk for pediatric medical traumatic stress include preterm infants, children with complex and/or chronic medical conditions, and those suffering from serious injury or illness. Up to 80% of children and family members experience trauma.
TABLE 3 Definitions of Terminology in TIC

<table>
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<tr>
<th>Terminology of Traumas</th>
<th>Definitions</th>
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<tr>
<td>Acute stress disorder and Post-traumatic stress disorder (PTSD)</td>
<td>Psychiatric diagnoses that include having experienced or witnessed a traumatic event and then having persistent symptoms that include the following: reexperiencing (intrusive thoughts, nightmares, or flashbacks), avoidance (feeling numb, refusing to talk about the event), hyperarousal (irritability, exaggerated startle response, always expecting danger); acute stress disorder: symptoms occur 3 d to 1 mo after traumatic exposure (^81); PTSD: symptoms must occur ≥3 mo after the trauma (^235)</td>
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<tr>
<td>ACEs</td>
<td>Stressful or traumatic events, including child abuse and neglect, that occur within the primary caregiving relationship; often breach the parent-child relationship, which is fundamental to nurturing healthy development; linked in population studies to physiologic and behavioral changes impacting the health and well-being of patients over their life course with a wide array of health problems, including associations with substance misuse. (^10,21,24,80) The original ACEs (from initial study published in 1998) are the following: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, mother treated violently, substance misuse within household, household mental illness, parental separation or divorce, and incarcerated household member. Subsequent studies have expanded the original ACE panel to include other adversities, (^6,234) including the following: experiencing racism, experiencing bullying, separation from caregiver (resulting from immigration, foster care, incarceration, death, or any other reason), witnessing violence, community violence, (^49) adverse neighborhood experience, (^213) and financial insecurity (^236)</td>
</tr>
<tr>
<td>Complex childhood trauma (as defined by the National Child Traumatic Stress Network)</td>
<td>Encompasses both a child’s exposure to multiple interpersonal traumatic events, including maltreatment and household dysfunction, and the broad, pervasive, and predictable impact this exposure has on the individual child (^237); can disrupt a child’s attachment with caregivers, development, and sense of self</td>
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<tr>
<td>Developmental trauma disorder (DTD)</td>
<td>A proposed diagnosis based on evidence that children exposed to complex trauma are at risk for severe pervasive disruptions in their development in the domains of emotional health, physical health, attention, cognition, learning, behavior, interpersonal relationships, and sense of self, sometimes used interchangeably with complex childhood trauma; describes problems in affect dysregulation, negative self-concept, and difficulty with relationships that occur as a result of trauma-related developmental impairments; symptoms overlap or co-occur with several PTSD symptoms, but DTD includes a fuller spectrum of dysregulation resulting from the insults to multiple pathways in the developing brain when nurturing and is seen as a result of complex childhood trauma; more accurately describes the outcomes of such trauma in children than does the diagnosis PTSD (^238)</td>
</tr>
<tr>
<td>Pediatric medical traumatic stress (PMTS)</td>
<td>The distress that children and family members experience during hospitalization for a perceived life-threatening diagnosis or while living with or caring for someone with life-altering chronic conditions (^239–241); often related to the person’s subjective experience of the medical event rather than its objective severity and is mitigated by SSNRs that promote resilience</td>
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<tr>
<td>Secondary traumatic stress (STS)</td>
<td>A response that may occur in parents, other family members, and health care workers such as physicians, nurses, other hospital staff (including nonclinical staff), first responders, and therapists who are exposed to the suffering of others, particularly children (^242); may have many of the same long-term effects on health that affect children exposed to trauma; individual trauma histories can contribute to the reaction</td>
</tr>
<tr>
<td>Social determinants of health (SDohs)</td>
<td>Conditions of the greater ecology or environment, occurring where people live, learn, work and play, which affect the neuroendocrine stress response and affect a wide range of health risks and outcomes (^8,22); can be mitigated by an SSNR and other protective factors and exacerbated by ACEs and intrafamilial and interpersonal trauma; examples include: poverty, food insecurity, homelessness, and lack of access to health care; examples that also overlap with the expanded ACEs include racism, discrimination, and community violence</td>
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<tr>
<td>Trauma</td>
<td>An event, series of events, or set of circumstances an individual experiences as physically or emotionally harmful that can have lasting adverse effects on the person’s functioning and mental, physical, emotional, or spiritual well-being (^45); can occur outside caregiving relationships (eg, dog bites, natural disasters), within the context of the caregiving relationship (eg, exposure to domestic violence, various forms of abuse or disordered caregiving because of parental mental illness or substance use disorder), or in the context of relationships outside the family (racism, bias, discrimination, bullying)</td>
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**READINESS**

TIC transforms the fundamental questions in medical care from “What is wrong with you?” to “What happened to you?” and, finally, to “What’s strong with you?” A trauma-informed approach acknowledges the biological effects of adversity without suggesting that childhood adversity is destiny. It requires a compassionate approach that does not suggest blame. It requires pediatric health care workers at every level to understand the context of a child’s relationships, especially within the family, and ask, “What are the caregiver’s strengths and challenges?” “What are the child’s strengths and challenges?” and “Who supports you?” This changes the pediatric role from “I must fix you” to “I must understand you (and the relationships that created you and can help you heal).” \(^25,58\) Thus, readiness includes an understanding of what provides resilience and how to promote it.
Relational Health Care

TIC is fundamentally relational health care, the ability to form and maintain safe, stable, and nurturing relationships (SSNRs). Pediatricians are able to support the caregiver-child relationship, the context in which there can be recovery from trauma and the restoration of resilience. Fundamental to these concepts is an understanding of attachment.

Attachment

Attachment describes the emotionally attuned give-and-take between caregiver and child and the trust, safety, and security provided to the child that promotes healthy brain growth, development of accurate mental maps of self and others, development of resilience, and protection from trauma. Fundamentally, the predictable compassionate availability of the caregiver promotes the secure attachment of the child. Recent studies show attachment remains malleable beyond infancy, even into adolescence and adulthood, to some extent.63,64

Effective Parenting

Effective parenting encompasses the skills that caregivers bring to the task of parenting and is the context in which secure attachment develops and is relied on during and after traumatic experiences. Although caregivers approach parenting with a range of skills, attitudes, and beliefs rooted in their cultural and family contexts, studies have shown that effective or positive parenting has some universal features.65–67

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It is through secure attachment with a predictably empathic caregiver that children learn to regulate their emotions. Children start by turning to a caregiver when upset. The caregiver comforts the child by touch, words, and compassion, which shuts down the stress response and restores emotional regulation. Secure attachment happens as a child predictably receives this sympathetic support from the caregiver when the child is distressed and the child comes to confidently anticipate that support. This relationship becomes a reliable source of safety, and the caregiver is a secure base from which the child can explore their environment. Multiple studies have shown that a secure attachment relationship is the best means for building or rebuilding resilience in children; it is also the context for promoting healthy brain growth and development. With these positive affiliative experiences, modulation of the stress response begins and includes the release of oxytocin, a potent hormone regulator of the sense of safety and well-being.

Thus, the first step of TIC is to assess this aspect of the relationship, observing the child-caregiver interaction, including the caregiver’s attention to the child, the caregiver’s ability to read and respond to the child in developmentally appropriate ways, and the child’s ease, comfort, and response to the caregiver. Discussion can begin by focusing on the caregiver’s and child’s strengths and noting the constructive aspects of the relationship while providing the caregiver with empathy. When attachment is strained, caregivers have often lost empathy for the child. The positive regard and attuned attentive listening provided before and while raising concerns supports the caregiver. The empathy provided to the caregiver thus allows the opportunity for them to reattune to the child.

Resilience

Resilience is defined as a dynamic process of positive adaptation to or despite significant adversities. This is not a static or innate quality but includes skills children can learn over time with reliable support from attachment figures. The development of resilience includes aptitudes that are attained through play, exploration, and exposure to a variety of normal activities and resources. Studies have shown that development can be robust, even in the face of severe adversity, if certain basic adaptational mechanisms of human development (resilience factors) are protected and in good working order. These mechanisms include attachment to a competent caregiver, cognitive development with opportunity for continued growth, mastery of age-salient developmental tasks, self-control or self-regulation, belief that life has meaning, hope for the future, a sense of self-efficacy, and a network of supportive relationships. On the other hand, if those basic adaptational mechanisms or protective factors are absent or impaired before, during, or after the adversity, then the outcomes for children tend to be poorer (see Table 4).

TABLE 4 Adapational Mechanisms of Resilience

| T | Thinking and learning brain, with opportunity for continued growth; cognitive development |
| H | Hope, optimism, faith, belief in a future for oneself |
| R | Regulation (self-regulation, self-control of emotions, behaviors, attention, and impulses) |
| E | Efficacy (self-efficacy) or sense that one can impact their environment or outcomes |
| A | Attachment, secure attachment relationship with safe, stable, and nurturing caregiver or competent caregiver |
| D | Development, mastery of age-salient developmental tasks |
| S | Social context, or the larger network of healthy relationships in which one lives and learns |

Robust implementation of TIC is strength-based, building on family protective factors rather than emphasizing deficits. At almost every encounter, from early childhood through adolescence, pediatric care can include resilience promotion, building on identified strengths. Because resilience is a dynamic process of positive adaptation, routine anticipatory guidance about development or safety can be used to promote relational health and positive childhood experiences, including achievements at home, at school, and in neighborhoods, which enhance resilience. When addressing adversities or concerns about development, surmounting the challenges can be framed with resilience and positive experiences as the goal. For example, when speaking with a caregiver about a child learning to fall asleep on their own, sleep skills can be framed as building resilience by supporting self-regulation and self-efficacy. Alternatively, when a caregiver expresses concern about a child or teenager who had been sleeping until experiencing a traumatic event, the discussion can be framed around what resilience factors are being challenged (developmental skill mastery, self-efficacy, self-regulation) and which ones can be used to support the child’s recovery (attachment and thinking).

**DETECTION AND ASSESSMENT**

Detection involves both surveillance and formal screening to identify children and families with the history of exposure to potentially traumatic experiences as well as those who exhibit signs and symptoms of trauma. Although TIC is common in social services and other mental health settings, in a health care environment, TIC can be conceptualized by using a medical model. Similar to other medical conditions, TIC includes purposeful triage, engagement, history-taking, surveillance and screening, examination, differential diagnosis, sharing of the diagnosis, and management, which may include office-based anticipatory guidance, referral, psychopharmacology, and/or follow-up or recommendations.

Surveillance for maladaptation after experiencing trauma includes consideration of all those who may be affected by exposure to the direct suffering of the child. Health care workers, such as first responders, nurses, social workers, trainees, physicians, and nonclinical hospital or clinic employees, may be deeply affected by witnessing or hearing about the traumatic experiences of children. Parents (biological, foster, kinship, or adoptive) are particularly at risk for prolonged trauma reactions that may impair their ability to care for and comfort their children. Siblings may also be affected, particularly when there is complex trauma or exposure to suffering, such as having a sibling with cancer or another life-altering disease that involves chronic pain.

**Peri-trauma**

Peri-trauma refers to situations in which medical providers are caring for children as the traumatic events are unfolding. One example is pediatric medical traumatic stress. Pediatric medical traumatic stress is a situation in which children experience medical procedures or other aspects of medical care as traumatic events. The effects of such trauma can be mitigated by attending to the child’s and family’s experience of medical care and reducing (as much as possible) frightening or painful aspects of necessary care and procedures. This mitigation can include asking children (and caregivers) about their fears and worries, optimizing pain management and comfort measures, and working with caregivers to increase their ability to provide effective support for their child. The Healthcare Toolbox includes a number of specific suggestions, including assessing distress (D), providing emotional support (E), and addressing the family needs (F)—a D, E, F protocol to follow the A, B, Cs of resuscitation.

Another comprehensive strategy used by schools and community agencies when a mass trauma or disaster occurs is Psychological First Aid (PFA). Developed by the National Child Traumatic Stress Network, PFA is an evidence-informed program that is designed to help children, families, adults, and other witnesses in the immediate aftermath of a disaster or terror event. Core skills for implementation of PFA are identical to TIC: establish an emotionally safe environment, connect with primary support persons (relational health), link to community resources, and provide psychoeducational materials to help understand the potential responses of children to the exposure.

**Triage**

The first step in medical care is to identify an emergency versus nonemergency situation. When dealing with trauma, its causes, or its consequences, consideration of whether a child may be emergently at risk requires assessment and response as a top priority. In practicing TIC, protocols and practices to identify and address child or family safety issues, both physical and psychological, are integral to care.

Trauma may result from children being in unsafe settings because of abuse, neglect, or impaired caregiving. When the practitioner suspects maltreatment or failure of the caregiver to protect a child at any point in a health encounter, referral to child protective services
is necessary and mandated. These issues need to be considered even before screening and addressed with standard protocols to respond to identified risks.76–78

Other immediate safety issues may arise when a consequence of trauma is self-harm or intent to injure others. Screening for suicidality, self-injury, or intent to harm others is included in TIC along with clear protocols for how to address positive endorsement of these issues.

Engagement
TIC creates a respectful and emotionally safe space in which to engage children, adolescents, and families around the discussion and management of these issues and to prevent retraumatization. Discussion of trauma may raise stress levels, and appropriate engagement reassures the child and family that the setting is safe. Culture can also affect how trauma is experienced and understood by families, and cultural awareness can ease the conversation. Engaging children and families begins with greeting the patient and family and being fully present in the moment while maintaining a balance between professionalism and friendliness. It involves initially asking open-ended questions, followed by more specific and probing questions as needed and that are elicited by caregiver and child or adolescent responses. It involves listening in an active, nonjudgmental, attuned way, reflecting back to the family what is heard for clarification and confirmation, seeking clarification when necessary, paraphrasing, attending to and reflecting on the emotions that accompany the information, and summarizing what is discussed. Implicit bias can affect the provider’s ability to be nonjudgmental in these conversations.46,79 Acceptance, curiosity, and empathy are conveyed to the patient or caregiver in the process of attentive listening.61 Engagement also involves mutual regard between the provider and family. Adolescents and capable children bring their own perspective. Each brings expertise to the TIC of the child or adolescent. The provider has expertise in medicine, whereas the patient and family have expertise about the child, what happened, and their situation, beliefs, strengths, and culture.

When working with families and patients who have experienced trauma, the provider’s body language, affect, and tone of voice can promote or inhibit care. Affect describes the facial and body expressions that reflect our emotional state. Individuals who have experienced trauma are more sensitive to body language, facial expressions, and tone of voice.70 Approaching children slowly and calmly or letting them sit with a caregiver and using higher pitched, more musical speech may ease a child’s tension because these sounds are associated with the release of oxytocin in the amygdala, resulting in calming of this threat-sensitive brain area. A shift to low tones during a discussion may alert a child or caregiver to potential danger and stimulate defensive responses.61

History
Much of the information needed to integrate TIC into practice may be obtained as part of the routine health evaluation. Social, developmental, and medical history are all opportunities to identify risks, stressors, and strengths. The health history provides an opportunity to assess child and family resilience factors, social connectedness, parenting attitudes, and skills. The review of systems allows the medical provider to collect symptoms of trauma that may not have been identified in the chief complaint but that can offer valuable insight into the current impact of trauma on the patient.80,81 Symptoms may be functional, neurodevelopmental, or related to immune function.

1. Functional symptoms: Manifestation of the symptoms of trauma may evolve over time. Functional complaints can result after single-incident traumas (eg, automobile crash, hurricane) or may be early manifestations of complex trauma.82–84 Sleep difficulty, changes in appetite, toileting concerns (eg, constipation, abdominal pain or enuresis), and challenges with school functioning (eg, poor attention or attendance) may be the early presentation of ongoing trauma.84,85 Diagnostic criteria for attention-deficit/hyperactivity disorder and adjustment disorder overlap with some of these functional symptoms. When these signs and symptoms are noted, it can be useful to include trauma in the differential diagnosis.17,86,87

2. Neurodevelopmental symptoms: Some of the most recognizable manifestations of early trauma result from the effect on areas of the rapidly developing brain of young children. Developmental skill acquisition (higher brain) can be hindered as recognition of and response to threat is prioritized (lower brain).88,89 Specific areas of the brain affected are the limbic system, hippocampus, and prefrontal cortex.12,13,90–92 The prefrontal cortex is involved in cognition, emotional regulation, attention, impulse control, and executive function. Consequently, children may have developmental delay and behave as if they are younger than their actual age89,93 (see Table 5 for an easy way to remember these effects). Other
TABLE 5 Most Common Symptoms of Trauma Exposure

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<th>F</th>
<th>R</th>
<th>A</th>
<th>Y</th>
<th>E</th>
<th>D</th>
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<tbody>
<tr>
<td></td>
<td>Frets (anxiety and worry) and fears</td>
<td>Regulation difficulties (disorders of behaviors or emotions; hyperactive, impulsive, easily becomes aggressive or emotional; inattentive)</td>
<td>Attachment challenges (insure attachment relationships with caregivers); poor peer relationships</td>
<td>Yawning (sleep problems) and yelling (aggression, impulsivity)</td>
<td>Educational and developmental delays (especially cognitive, social-emotional, and communication)</td>
<td>Defeated (hopeless), depressed, or dissociated (separated from reality of moment, lives in own head)</td>
</tr>
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observed symptoms may include the following:
- rapid, reflexive response to stimuli, reminders, or triggers;93,94
- inattention, poor focus, hyperactivity, and difficulty completing tasks;88,95
- difficulty tolerating negative mood so the child seeks ways to defuse the tension through hyperactivity, impulsive behaviors, aggression, self-harm, such as cutting and suicidality, or engagement in health risk behaviors (substance use, sexual activity)89,95,96;
- reactions to stimuli, triggers, or reminders can be transient and flip suddenly back to “normal”; this appears to the observer as emotional lability;88,92; and
- negative world view and self-narrative; flat affect; difficulty engaging socially or viewing themselves as worthwhile.88,92,97

3. Immune function symptoms: When a child is exposed to early, severe, or prolonged trauma, the immune system is chronically pressed into action, and, over time, changes can occur in the inflammatory system and humoral immunity.80,89 A persistent inflammatory response can leave children vulnerable to diseases, such as asthma and metabolic syndrome.80,89,90 Humoral immunity may be impaired so that children are more susceptible to infection. Additionally, immune system stimulation may result in the “sick syndrome,” which is a perception of feeling unwell that can include headaches, stomachaches, and lethargy.80,81

Surveillance
Surveillance or monitoring is the process of recognizing children who might be at risk for being affected by trauma and is modeled after developmental surveillance. Surveillance is less formal than screening and can be conducted at every visit. Asking about caregivers’ concerns, obtaining a trauma history, observing the child, and identifying risk and protective factors provides information about resilience supports and trauma exposure.100 Surveillance requires attention to relationships and engagement. Questions such as “Has anything scary or concerning happened to you or your child since the last visit?” are a way to more specifically explore the possibility of adverse experiences.85 Recognizing that certain symptoms may indicate exposure to childhood adversities, we can ask, “What has happened to you (or your family)?” For adolescents, these questions can be asked as part of the HEADSSS (questions about Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/ depression, and Safety) psychosocial interview.101,102 Questions that are considered less threatening are asked first and followed with questions that may be perceived as more intrusive.101 Providers may be concerned that asking questions about a family’s needs, a child’s trauma history, or a child’s symptoms may distress the child or caregiver, but studies in which this topic has been explored indicate that, when the topic is raised, families respond well to having the issues acknowledged and addressed in a supportive setting.85,103,104

Children only heal from trauma in the context of SSNRs, so it is also necessary to ask about the strengths that are already present in the family. Starting these conversations with questions about child, adolescent, or family strengths frames the conversation in a positive and resilience-focused way.105,106 For instance, a clinician may ask how the child, adolescent, or family copes with stress, what a teenager does well, whether they have frequent family meetings to talk about solving problems, and whether each member of the family has someone to turn to for safety and comfort when they are upset. Trauma that occurs because of problems in the primary attachment relationship represents the greatest threat to the child or adolescent and may be the most challenging for providers to explore. Caregivers may have their own trauma histories or mental health struggles, substance use issues, and/or multiple stressors related to social determinants of health (SDoHs), including poverty, housing instability, and violence exposure that affect their parenting. Exploring parenting stressors, strengths, and attitudes in conversation can help the provider to pinpoint specific leverage points to help children but may also create an opportunity for the caregiver to reflect about the effects of their parenting or stressors on the child. TIC is compassionate and assumes that all caregivers love their children and are doing the best they can. It also assumes that children
Screening

Valued screeners used at preventive health care visits can provide valuable information about child development, mental health, and behavior. They can be reassuring when normal or alert the pediatric provider to symptoms or risks when borderline or abnormal. Commonly used tools, such as the Ages and Stages Questionnaire, the Pediatric Symptom Checklist, the Strengths and Difficulties Questionnaire, and the Patient Health Questionnaire-9 may elicit symptoms that are the possible result of trauma (developmental delays, social-emotional problems, anxiety, etc.). Perinatal depression screening may not only identify symptoms of this illness but provide opportunities to explore maternal stressors and strengths. Those exposed to known traumas can be evaluated by using standardized posttraumatic stress disorder (PTSD) screening tools such as the PTSD Reaction Index Brief Form, and those exposed to medical traumas can be evaluated by using a tool such as the Psychosocial Assessment Tool. The Pediatric Traumatic Stress Screening Tool in the Intermountain Care Process Model has been recently developed to screen for pediatric traumatic stress in the primary care setting, either as a universal screen or with targeted screening when traumas are known. These tools effectively help identify the diagnostic criteria for PTSD, although they are not designed to identify the full spectrum of symptoms of complex trauma (developmental trauma disorder [DTD]).

Screening, per American Academy of Pediatrics (AAP) guidelines, suggests using instruments that are standardized and validated and have defined psychometric properties (sensitivity, specificity, positive predictive value). By that definition, there are currently no screening tools for ACEs and only a few validated screening tools for SDoHs. However, standardized (but not validated) tools are being used in some pediatric settings to assess ACEs and SDoHs and are using aggregate risk scoring to target providing increased support. Many of the available screening tools expanded on the domains included in the original Centers for Disease Control and Prevention/Kaiser ACE study to include additional items applicable to urban and minority populations, including witnessing neighborhood violence and experiencing bullying or discrimination. Parental ACE screening may offer the opportunity to align with caregivers and build a partnership to explore issues that may be affecting their parenting. Indeed, several recent studies suggest that parental ACEs can be linked with concerning outcomes for children. Concurrent resilience screening offers the opportunity to identify protective factors that can buffer identified stressors, thus providing more nuanced understanding of a child's risk. Screening also offers the opportunity to then frame the discussion around promoting strengths in the caregiver-child relationship to protect a child from toxic stress and build adaptive skills. Similar to ACE screening, there are few available standardized validated resilience screening tools, although the Connor-Davidson Resilience Scale and Brief Resilience Scale assess caregiver resilience. (Readers are referred to the AAP Screening Technical Assistance Web site at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/About-Us.aspx for developmental and SDoH screening tools.)

A limitation of ACE and SDoH screening tools is their lack of nuance: they identify risk factors that have been derived from epidemiological studies, not outcomes at the individual level. Those outcomes are the result of the physiologic response to adversities. Although currently only available in the research setting, biomarkers of this physiologic response have the potential to be more accurate measures of the effects of adversity at the individual level. Eventually, clinic-friendly, noninvasive biomarkers could also be used to identify patient-specific response to both stressors and therapeutic interventions.

Screening health care workers for the effects of hearing about and addressing the trauma experiences of others is most commonly achieved with informal self-assessment strategies to identify symptoms or experiences that may be associated with burnout or STS. Substance use disorder, depression, and suicidality may be associated with exposure to secondary trauma, and there appears to be overlap between burnout and STS. An example of a screening tool for health care workers is the Professional Quality of Life Scale, which includes subscales for compassion satisfaction, burnout, and STS.
Cultural considerations affect all aspects of TIC, including screening. Instruments that are not normed for the population or translated and validated in the language of the patient and family can result in misleading results. Thus, it is important to consider screening results cautiously with consideration of the family’s culture and ethnicity in relation to the screening tool being used.146

Examination
Blood pressure measurement at preventive health visits or when stress is a potential etiologic factor for concerns is indicated.147 Elevated blood pressure may be the first symptom of childhood traumatic stress, especially as youth age.148,149 Abnormalities in hearing, vision, and growth parameters can be clues to adversities.150,151 Overweight and obesity have been associated with ACEs.152–154 Physical examination may reveal signs of neglect or abuse. The immunologic effect of trauma may result in inflammatory or infectious consequences identifiable on examination.1,80,99,155,156 Children who have sustained cumulative ACEs and traumas may exhibit certain common behaviors the provider may witness during physical and mental health evaluation (refer to history and symptoms described earlier).

Differential Diagnosis
Considerations and Comorbidities
The provider is encouraged to consider trauma as a possible etiology in the assessment of developmental, mental health, behavioral, and physical symptoms in all pediatric encounters because of the following: (1) the experience of adversity is so common; (2) the symptoms of trauma overlap with the symptoms of other common pediatric conditions97,95; and (3) failure to do so might lead to an incorrect or incomplete diagnosis and treatment, enabling the effects of trauma to further embed.17,157,158 Trauma may be mistaken for other conditions, such as attention-deficit/hyperactivity disorder, and includes symptoms that overlap with other diagnostic categories, such as anxiety and depression.86,87,159 It has been proposed that trauma may result in a different “ecophenotype” of common conditions that have a different trajectory and different response to common treatments.93 Children may also have comorbid conditions, such as ADHD, anxiety, depression, or developmental and learning issues, because they frequently accompany childhood trauma. A more detailed description of diagnoses that are commonly confused with trauma or comorbid with it are covered in the AAP clinical report “Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication.”487

Diagnostic Continuum
Pediatric providers may encounter children with a wide range of symptoms resulting from trauma. As noted, trauma can result in short-term changes in behavior or have a more lasting impact depending on the child, the trauma itself, and the supports or emotional buffers in a child’s life. When traumatic events are more severe, prolonged, or less buffered by a caregiver, effects on various aspects of functioning can be more severe.1,160–163 Children exposed to chaotic households, abuse, or neglect, especially in the early years of life, may have more severe symptoms and symptoms that evolve over time.94,159,164,165 Diagnostically, this may result in children who have functional symptoms (short-term problems with sleeping, eating, toileting), adjustment disorder, PTSD, or complex trauma symptoms.163,166,167

MANAGEMENT
Sharing the Diagnosis With Children and Caregivers
Some parents and caregivers may come to understand the role of adversities in their child’s symptoms through discussion of the trauma history and symptoms, and others will require the provider to explain this connection before they can appreciate the provider’s advice and recommendations. Psychoeducation is the first step in management of childhood trauma and includes empathic, nonjudgmental sharing of diagnostic information and provider concerns about the etiology of a child’s symptoms. The provider’s role is to integrate the child or adolescent and caregiver’s concerns, the child or adolescent’s symptoms, and elements of a thorough history and examination into an explanation of why this raises a concern about trauma exposure or why trauma may be the underlying cause or one of the causes of a child’s symptoms, much as is done for any diagnosis. A simple explanation of the pathophysiology of trauma may help the caregiver to move from frustration with the child or adolescent’s behaviors or symptoms to empathy. In some situations, the explanation may also provide the caregiver with insight into their own history of trauma and its impact on their parenting behaviors or responses to their child’s behaviors, or how an event that affected their child may have traumatized the caregiver as well.

Psychoeducation includes acknowledging that a trauma history can affect behavior and thoughts, with some discussion of how that happens. Table 6 has information on specific psychoeducation. The variable responses of children to trauma can be frustrating or confusing. Discussion of the emerging data on the biological sensitivity to context may be useful.
Genetic variations in how a person responds to stress may contribute to a child’s sensitivity to adversity. Yet, those with high reactivity who are supported and learn to channel that reactivity to positive activities and passions may have the greatest potential. This information, along with specific suggestions about how to support children, can address some of the constellation of caregivers regarding children’s heterogeneous responses to both adversity and interventions.

**Office-Based Anticipatory Guidance and Management**

Trauma-informed anticipatory guidance provided by pediatricians can help families promote resilience and begin to address the effects of trauma. If screening for SDoHs is being conducted and/or social needs are identified, referral to applicable community-based services is indicated (e.g., food bank, pro bono legal aid, etc). Having a list of community providers, such as Early Head Start, Head Start, evidence-based maternal, infant, and early childhood home visiting programs, state Maternal Child Health Title V programs, and Family to Family Health Information Centers ready for distribution, directly contacting the referral provider with the patient present, or providing formal care coordination all facilitate family engagement and help families connect to needed community resources. For older children and adolescents, trauma-informed schools and teenager crisis centers may be available in the community. In trauma-informed schools, personnel at all levels have a basic realization about trauma and an understanding of how trauma affects student learning and behavior in the school environment.

Every encounter in an office setting, from those with young children to those with adolescents, is an opportunity to strengthen the attachment between a child and caregiver. Through techniques such as reinforcing positive back-and-forth interactions between a parent and a child (serve and return), helping the caregiver to understand the child’s experience (keeping the child’s mind in mind), helping the children to learn words to describe a variety of emotions, and promoting self-reflection concerning the caregiver’s own trauma history, the pediatric clinician can render primary prevention against the development of anxious and maladaptive attachment patterns and promote regulation. Examples of relevant anticipatory guidance include advice, resources, or referrals to community programs, including Reach Out and Read; developmentally appropriate play with others; promoting positive, authoritative (in contrast to punitive or authoritarian) parenting styles; and mindfulness. Table 7 includes specific advice to promote regulation after trauma.

**Referral for Treatment**

The presence of complex symptoms, mental health diagnoses, substance abuse, and/or a significant trauma history are indications for referral to evidence-based trauma-informed mental health services.
TABLE 7 Anticipatory Guidance

<table>
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<th>Office-Based Guidance to Promote Regulation After Trauma</th>
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<td>Restoring safety</td>
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<td>Routines</td>
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<td>Relaxation techniques</td>
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<td>Time-in or special time</td>
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<td>Small successes</td>
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<td>Emotional container</td>
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<td>Distraction</td>
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<td>Positive parenting techniques</td>
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The most effective therapies are evidence-based treatments (EBTs) with demonstrated efficacy for children who have experienced trauma. Treatments that are designated as evidence based have had the most rigorous evaluation, whereas evidence-informed treatments range from newly emerging practices that are building evidence support to less rigorously studied tools. Sege et al published an overview of evidence-based individual and family-based psychotherapeutic interventions. Gleason et al specifically outlined services for the treatment of young children. Having these services available on-site or through direct communication with colleagues in mental health (a “warm handoff”) has been revealed to be the most effective approach. It is important for caregivers who have their own history of trauma to seek individual therapy, and the pediatric provider may find it useful to have a list of adult mental health providers who address trauma. As research continues to elucidate the neurocognitive basis of trauma symptoms and methods to address those effects, new treatment modalities are being developed and may offer increased therapeutic resources for both adults and children.

Even if therapies are not available on-site, it is useful to familiarize self and staff with evidence-based trauma therapies, how they work, how to refer locally and how to incorporate principals of treatment into pediatric anticipatory guidance. A quick reference for EBTs that includes a brief description of each and the level of evidence can be found on the California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/). Some EBTs have been successfully adapted for telehealth, and, in the wake of the coronavirus disease 2019 pandemic, opportunities for EBT via telehealth have expanded. Telehealth is a mechanism to provide EBT in rural and other underresourced communities.

**Psychopharmacology**

No medication, to date, is approved by the US Food and Drug Administration for trauma-specific symptoms or PTSD in children and adolescents. Medications may be judiciously considered for specific symptoms that are interfering with a child’s ability to function normatively in specific ways. Readers are referred to the AAP clinical report “Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication” for discussion of medication use in identified comorbid mental health conditions.

**Role of Close Follow-up and Support**

A commitment to working with the family over time may prevent or reduce feelings of abandonment or rejection, especially when community and mental health resources are in short supply. The pediatric provider who is continuous over time can continue to listen attentively and offer practical trauma-informed advice that reinforces resilience building and healing. Obtaining consent to share information with a mental health provider may also be reassuring to the caregiver or patient even after a referral and linkage to mental health care is established.

**Integration**

Once these aspects of care are part of a provider’s repertoire of care, integrating knowledge about trauma into policies and procedures and daily practice are the next steps in creating a trauma-informed medical setting.

**Train All Staff in TIC**

All staff, from schedulers to billers to nurses and care coordinators, can benefit from training in TIC that is thorough and discipline specific and includes information about physiology, presentation, recognition, and response. This training would ideally promote patient empowerment and include caregiver and patient perspectives. Implementing TIC in any setting is effective when there is consideration of clinic workflow to maintain efficiency. Specific strategies can include a warm and welcoming waiting room, clear communication of expectations and procedures, and providing choices when possible (eg, do you want blood pressure taken on right arm or left?). As noted earlier, the care of a child who has experienced trauma requires an approach that is similar to addressing other health concerns. TIC can include members of the staff, all aware of and empowered to emphasize safety, patient self-efficacy, and a trauma-informed approach. Use of formalized training in TIC for all staff has been found to be effective in changing staff-reported beliefs and behaviors for caregivers of children in residential care and in improving child functioning and behavioral regulation. In pediatrics, training of pediatrics residents caring for substance-exposed infants in TIC was effective at changing attitudes and improving therapeutic relationships.

Office personnel may engage with caregivers and patients in ways that trigger strong emotions, especially if they themselves have experienced adversity or trauma. Financial considerations, scheduling, and conflict in the small spaces of an office can also be explored from a TIC perspective. Personnel would ideally engage in some planning.
about how to handle a crisis or difficult situations that occasionally arise, such as the following: patients or caregivers who are indifferent or shut down, demanding, provocative, rejecting or hostile, or inattentive and distracted; or a child who is out of control and threatening to elope from the office. It is helpful to monitor one’s own response when difficult situations arise and resist the urge to be angry or retaliate. It is less provocative to focus or comment on the emotion than the behavior: “I can see that you are angry, worried, sad, upset, etc,” or “You probably don’t want to be here right now.” These responses are more affiliative and can help to shut down the stress response of the patient or caregiver whose fight-or-flight response may have been triggered by the health care setting, the interaction, or the medical stressor.

**Integrated Health Care**

Many providers find that the most efficient TIC can be provided by integrating physical and mental health services and social supports. Integrated care has been found to increase social-emotional screening rates through colocation of services with clear strategies for medical provider introduction of the patient to the behavioral health consultant in real-time (warm handoff), by reducing the stigma of a mental health referral, or through facilitated or prearranged referral protocols. Financial and staffing resource issues vary significantly by region, but investigating opportunities for primary care and mental health integration, social work, and/or formal engagement of referral sources and partnering organizations may increase the efficiencies of TIC. Providing case management to address the social modifiers of health (eg, referral to food bank, legal aid) can help to increase family resilience and prevent the consequences of trauma. Referring to resources has been revealed to be associated with increased employment, use of child care, and a decrease in the use of homeless shelters.

**Two-Generation Approach**

Growing evidence has linked increasing parental ACE scores and negative effects on child health and development, providing compelling evidence that taking a 2-generation approach is important. Families may customarily live in multigenerational family units, and this is a cultural norm for some. The opioid crisis has produced many kinship and grand-families, emphasizing the need for multigenerational care because both children and caregivers have suffered traumatic losses and may be influenced by their own trauma histories. Addressing how adversity experienced by a caregiver in childhood may affect their parenting and resilience can have profound effects on a child’s health and outcomes. This approach can include asking these questions in engagement, surveillance, and screening: careful consideration of how the provider or practice can and will respond to elicited issues is important before integrating this into practice flow.

**Community Partnerships**

Pediatric offices can develop methods to coordinate trauma-related care with schools, child care, early educators, courts, legal supports, child welfare services, and other community partners (see policy statement).

**Staff and Provider Support**

Addressing the trauma experiences of others can have significant consequences for health providers and staff. Per the National Child Traumatic Stress Network, STS is the emotional distress that results when an individual hears about the first-hand trauma experiences of another. The essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Burnout is a syndrome characterized by a high degree of emotional exhaustion and depersonalization (ie, cynicism) and a low sense of personal accomplishment from work. Burnout refers more to general occupational stress and is not used to describe the effects of indirect trauma exposure specifically. At least one meta-analysis concluded that job burnout contributes to, or at least increases the risk of, STS. Recent surveys of medical students and residents reveal a high rate of depression (Patient Health Questionnaire-9 score >10) of 25% to 30%. Some data indicate that more than 50% of the physician workforce in the United States suffers from burnout related to their profession. For the individual physician, burnout can result in increased rates of apathy, depression, substance abuse, and suicide and can affect personal relationships. STS similarly affects providers, although it is more often discussed in the mental health and child welfare literature rather than the medical literature.

Detailed discussion of the response to burnout and STS is beyond the scope of this clinical report. However, effective TIC includes recognition of the effect of indirect trauma exposure on the workforce and safeguards to protect those caring for children and caregivers. Acknowledgment that these are issues and providing resources to address them, with attention to leadership and supervision, have been cited as the most important first steps. For both burnout and STS, support from the immediate supervisor and
organizational leadership have been demonstrated to be effective ways to combat the effects of trauma. Team-based care, efficiencies in practice, and opportunities to share successes and frustrations with peers can all be helpful. Promoting self-care remains an important part of TIC, with adequate time for rest, distance from the office or hospital, exercise, healthy diet, and prayer, meditation, or mindfulness shown to reduce symptoms of burnout and STS. Such interventions are integral to developing and sustaining a trauma-informed practice and include all members of the health care team.

SUMMARY
TIC recognizes that exposure to adversities is common to many, if not most, children and that the developmental, behavioral, and health consequences can be profound and long lasting. Pediatric clinicians with an understanding of the physiology of both resilience and trauma are in a position to promote resilience, recognize and respond to traumas, and promote recovery.

Key Points
1. TIC is fundamentally relational health care, the ability to form and maintain SSNRs. Pediatric clinicians are well positioned to use a 2-generation approach, evaluate attachment relationships, and harness these attachments to encourage the caregiver’s role in promoting regulation and resilience.
2. Providing TIC is achieved through common pediatric practices, starting with engagement and providing a safe setting for patients and families. Obtaining history, using surveillance or screening tools appropriate to the pediatric setting and clinical need, and effecting a response involving the pediatric provider and other community resources is consistent with addressing most health-related issues.
3. Trauma symptoms can vary, from changes in eating and sleeping to severe physical and mental health effects requiring extensive treatment. Individual differences in trauma symptoms relate to the interplay of exposures and buffering from SSNRs as well as genetic variations impacted by the early environment (biological differential sensitivity to context).
4. Treatment can begin in the office setting with psychoeducation and brief guidance for caregivers. Facilitating linkages to community resources for families to programs that promote positive parenting skills, regulation, and self-efficacy; address the SDoHs (poverty, housing, food insecurity, etc); or provide EBT further supports those at risk and can effectively treat those who are symptomatic.
5. Integrating this relational model of care to prevent and mitigate the impact of trauma so that all members of the care team feel supported and valued is integral to TIC. Addressing safety and supporting relationships that promote affiliative responses, decrease stress responses, and promote building resilience are principles of TIC for children, caregivers, and health care personnel.

Lead Authors
Heather Forkey, MD, FAAP
Moira Szilagyi, MD, PhD, FAAP
Erin T. Kelly, MD, FAAP, FACP
James Duffee, MD, MPH, FAAP

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Elaine Stedt, MSW, ACSW – Administration for Children, Youth and Families, Office on Child Abuse and Neglect

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Müge Chavdar, MPH
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Staff
Carolyn Lullo McCarty, PhD

ABBREVIATIONS
ACE: adverse childhood experience
DTD: developmental trauma disorder
EBT: evidence-based trauma
PFA: Psychological First Aid
PTSD: posttraumatic stress disorder
SDoH: social determinant of health
SSNR: safe, stable, and nurturing relationship
STS: secondary traumatic stress
TIC: trauma-informed care

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