

Do No Harm: Impact of Medical Trauma and Strategies for Improved Care

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Conflict of Interest Disclosure Statement

I, Bradley C. Stolbach, have no conflicts of interest to disclose.

I am, however, willing to entertain offers. Interested parties, please see me after the presentation.

Trauma Symptoms in Pediatric Burn Patients Admitted to an Urban Burn Center

n = 40

70% reported clinical levels of Posttraumatic Stress Symptoms

<u>PTSS LEVELS</u>	<u>N</u>	<u>%</u>
<u>No or few trauma symptoms</u>	12	30
<u>Moderate/Consistent with Partial PTSD</u>	20	50
<u>Severe/Consistent with Full PTSD</u>	8	20

Stolbach, Fleisher, Gazibara, Gottlieb, Mintzer, & West, 2007

Trauma History

65% reported history of prior trauma exposure including 52.5% who had experienced two or more prior traumas

M = 1.55 prior trauma exposures Range = 0-6 prior trauma exposures

<i>Potentially Traumatic Event</i>	<i>N</i>	<i>Percentage of Sample</i>
Burn	40	100
Death or serious injury of loved one	19	47.5
Witnessed neighborhood violence	16	32.5
Victim of neighborhood violence	7	17.5
Domestic violence	6	15
Physical abuse	4	10
Natural disaster	3	7.5
Other bad accident	2	5
Seen dead body	2	5
Sexual abuse	2	5
Homelessness	1	2.5

Prior trauma exposure was correlated with level of trauma symptoms experienced by children following burns ($p < .05$), while “objective” estimates of burn severity (e.g., TBSA) and child characteristics were not.

	Non-clinical levels of PTSS	Clinical levels of PTSS
Burn Only	N = 7	N = 7
Prior Trauma	N = 5	N = 21

75% of children with clinical PTSS had prior trauma history

86% (18/21) of children with histories of 2 or more prior traumas experience clinical levels of PTSS

Results suggest that prior trauma exposure increases the risk for PTSD and that all pediatric medical trauma patients should be screened for history of other trauma.

Stolbach et al., 2007

There is no such thing as
an event, especially
when children are
involved.

American Academy of Pediatrics Statement on Early Childhood Adversity, Toxic Stress and the Role of the Pediatrician

All health care professionals should adopt [an] ecobiodevelopmental framework as a means of understanding the social, behavioral, and economic determinants of lifelong disparities in physical and mental health. Psychosocial problems and the new morbidities should no longer be viewed as categorically different from the causes and consequences of other biologically based health impairments.

Garner, Shonkoff et al., 2011

4/26/12

"Exposure to Violence During Childhood is Associated with Telomere Erosion from 5 to 10 Years of Age: A Longitudinal Study," Idan Shalev, Terrie Moffitt et al. Molecular Psychiatry, April 24th. doi:10.1038/mp.2012.32

The new report in the journal Molecular Psychiatry shows that a subset of those children with a history of two or more kinds of violent exposures have significantly more telomere loss than other children. Since shorter telomeres have been linked to poorer survival and chronic disease, this may not bode well for those kids.

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The findings suggest a mechanism linking cumulative childhood stress to telomere maintenance and accelerated aging, even at a young age. It appears to be an important way that childhood stress may get "under the skin" at the fundamental level of our cells.

"An ounce of prevention is worth a pound of cure," said Moffitt, who is the Knut Schmidt Nielsen Professor of Psychology and Neuroscience. "Some of the billions of dollars spent on diseases of aging such as diabetes, heart disease and dementia might be better invested in protecting children from harm."

Adverse Childhood Experiences Study (ACES)*

Physical abuse by a parent

Emotional abuse by a parent

Sexual abuse by anyone

An alcohol and/or drug abuser in the household

An incarcerated household member

Someone who is chronically depressed, mentally ill, institutionalized, or suicidal

Domestic violence

Loss of a parent

Emotional neglect

Physical neglect

Felitti et al. 1998

Adverse Childhood Experiences Study (ACES)*



Felitti et al. 1998

The Co-Occurring Nature of Trauma

“Individuals with a trauma history rarely experience only a single traumatic event, but rather are likely to have experienced several episodes of traumatic exposure.”

Cloitre et al., 2009

(Retrospective studies, e.g., Kessler, 2000; Stewart et al., 2008; Coid et al., 2001; Dong et al., 2004)

Finkelhor et al. (2009)

Nationally Representative Sample (n=4549)

Nearly 40% had experienced two or more types of direct victimization in the past year.

NCTSN Core Data Set (2012)

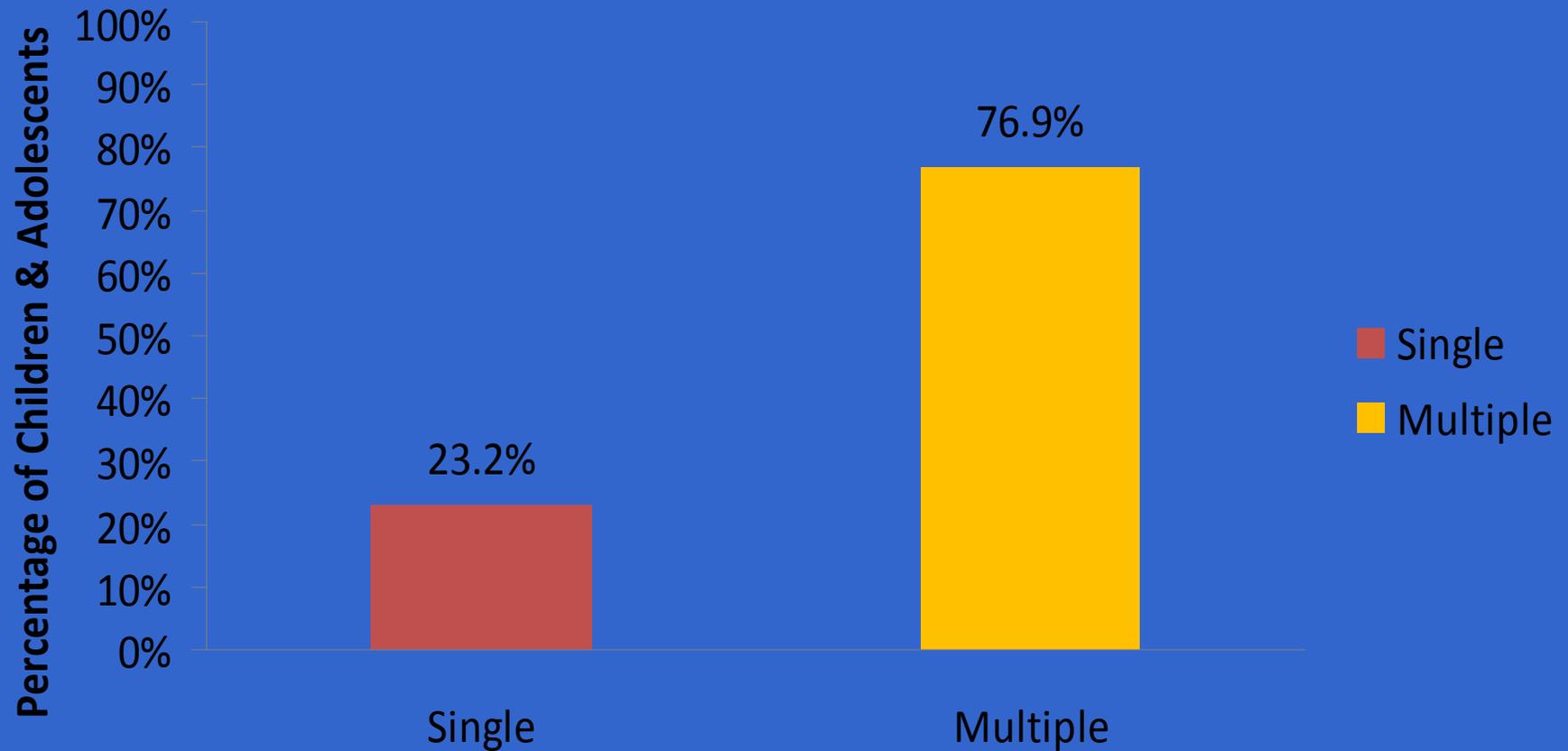
Children Served in the National Child Traumatic Stress Network (n=11,138)

Fewer than 24% had experienced only one type of trauma or ACE.

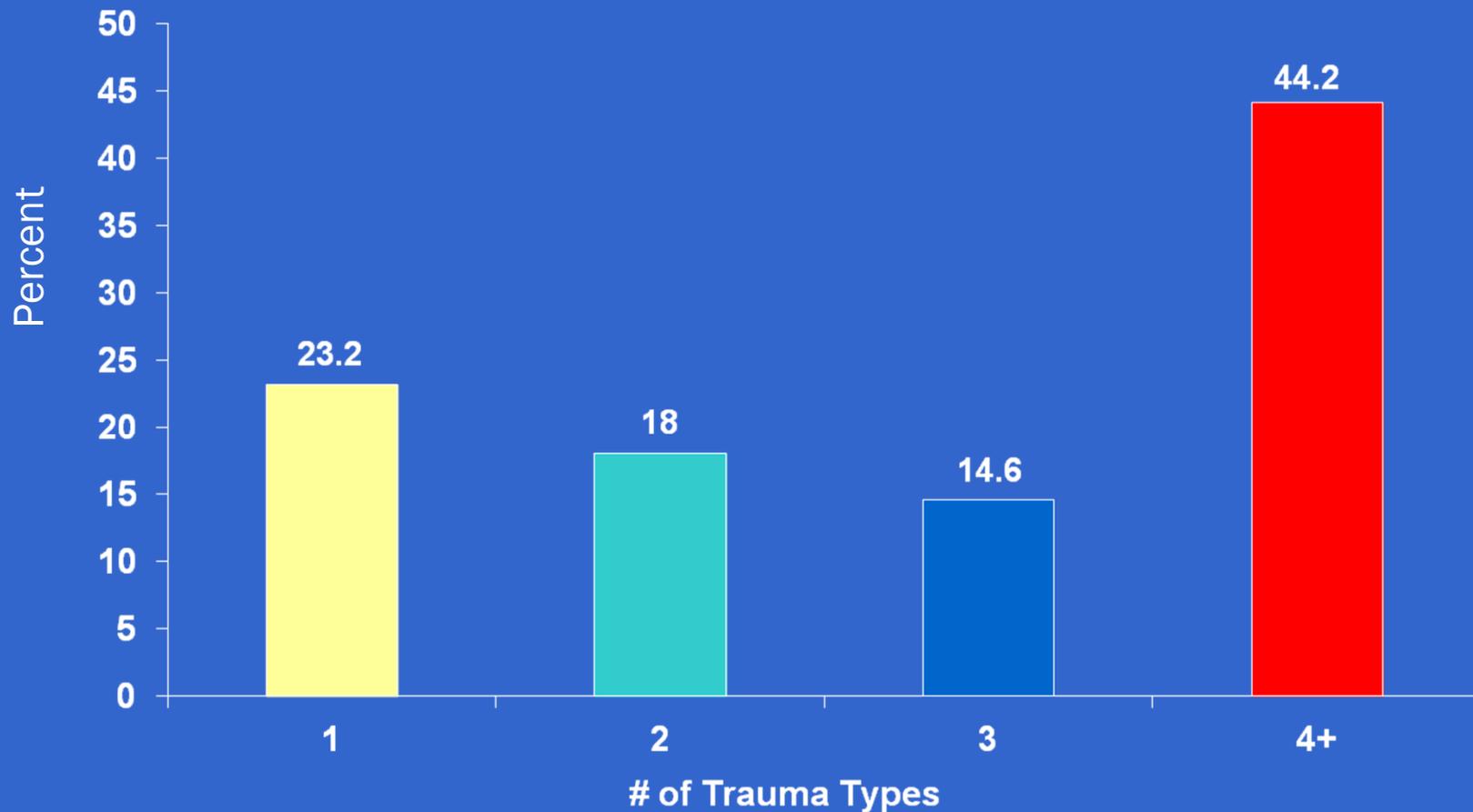
Over 40% had experienced 4 or more.

Trauma Exposure in Children Served in the National Child Traumatic Stress Network

Single vs. Multiple Trauma Types



Percentage of Children in the NCTSN Core Data Set Experiencing Cumulative Traumas



Traumatic Stressors Experienced by Children Served in FY12

Sexual Abuse	55%
Witnessed Domestic Violence	48%
Physical Abuse	44%
Witnessed Physical or Sexual Abuse	36%
Traumatic Loss (e.g., by homicide or suicide)	26%
Witnessed Community Violence	21%
Medical Trauma (e.g., Burns, MVA, Dog Attack)	15%
Victim of Extrafamilial Violent Crime	8%
Witnessed Homicide	6%
Fire	5%

Other trauma types include school violence, abduction, torture, witnessing serious injury, trafficking

Mean # of Types of Traumatic Stress = 2.88 73% Exposed to 2 or More

Trauma Exposure

91% experienced at least one form of interpersonal trauma.

74% experienced at least one form of family violence.

69% experienced at least one form of ongoing traumatic stress.

Other Adverse Experiences (Children Served in FY12)

Impaired Caregiver (e.g., mentally ill, substance abusing)	63%
Placement in Foster Care	55%
Neglect	41%
Unresolved Trauma History in Caregiver	41%
Emotional Abuse	30%
Death of Significant Other (not TL)	26%
Incarcerated Family Member	26%
Exposure to Prostitution or other Developmentally Inappropriate Sexual Behavior in Home	24%
Exposure to Drug Use or Criminal Activity in Home	21%
Substitute Care (not foster care)	18%
Homelessness	12%

Mean # of Types of Other ACES = 3.6

74% Experienced 2 or More

Mean Combined Total Types of
Traumatic Stressors +
Other Adverse Childhood Experiences =

6.51

74% Experienced 4 or More

Range = 1 - 16

Fewer than 10% experienced only 1 type.

There is no such thing as
an individual, especially
when children are
involved.

The Attachment Behavioral System

Attachment: an evolved behavioral system that functions to promote the protection and safety of the attached person

Attachment system is activated strongly by internal and external stressors or threats.

It is through healthy attachment (i.e., a behavioral system that effectively protects and comforts the infant or child) that a child develops the capacity for emotional and behavioral self-regulation, as well as a coherent self.

Attachment

Internal Working Models: complementary representations of the self and the attachment figure

These models reflect the child's appraisal of, and confidence in, the self as acceptable and worthy of care and protection, and the attachment figure's desire, ability, and availability to provide protection and care. – Solomon & George, 1999

Some Basic Assumptions About Psychological Traumatization

Traumatic experiences are those which overwhelm an individual's capacity to integrate experience in the normal way. (e.g., Putnam, 1985)

Following exposure to trauma, if integration does not occur, traumatic experience(s) are split off and an individual alternates between functioning as if the trauma is still occurring and functioning as if the trauma never occurred. (e.g., Nijenhuis et al., 2004)

Although traumatic memories and associations remain inaccessible to consciousness much of the time, they have the power to shape an individual's daily functioning and behavior. (e.g., Allen, 1993)

Posttraumatic Stress Disorder

A. Event

B. Reexperiencing

C. Avoidance/Numbing/Amnesia

D. Hyperarousal

Traumatic stress symptoms

Re-experiencing

Thoughts & feelings pop into one's mind.
Re-living what happened - feels like it's happening again.
Get upset at reminders.

Avoidance

Try to block it out & not think about it.
Try to stay away from reminders.
Feel numb or no emotions.

Increased arousal

Always afraid something bad will happen.
More easily startled / jumpy.
Trouble with sleep or concentration.

Dissociation

Things feel unreal -- like a dream.
Trouble remembering parts of what happened.

DSM-IV PTSD Criterion A

- ❖ Exposure to traumatic event in which both of the following were present
 - ❖ Experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - ❖ The person's response involved intense fear, helplessness, or horror

Proposed DSM-5 PTSD Criterion A

The person was exposed to the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:

Experiencing the event(s) him/herself

Witnessing the event(s) as they occurred to others

Learning that the event(s) occurred to a close relative or close friend

Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse)

Met Full Criteria for PTSD



Pynoos et al., 2008

Limitations of PTSD Diagnosis for Children

- Conceptualized from an adult perspective
- Identified as diagnosis via Vietnam vets and adult rape victims
- Focuses on single event traumas
- Fails to recognize chronic/multiple/on-going traumas
- Is not developmentally sensitive and does not reflect the impact of trauma on brain development
- Many traumatized children do not meet full diagnostic criteria
- Does not direct clinical attention to attachment history and attachment-related injuries

Children's Posttraumatic Reactions: Risk for Misdiagnosis and Mislabeling

Children presenting with complex trauma-related symptoms are at risk of being misdiagnosed with a variety of disorders and functional difficulties particularly when a comprehensive assessment for complex trauma issues is not conducted

- ✓ ADHD
- ✓ Depressive Disorders
- ✓ Oppositional Defiant Disorder
- ✓ Conduct Disorder
- ✓ Reactive Attachment Disorder
- ✓ Psychotic Disorders
- ✓ Specific Phobias
- ✓ Learning/ academic difficulties
- ✓ Juvenile Delinquency

“Of course being in a family where you get beaten up by the people who are supposed to take care of you would be different from getting burned or being in a fire or something. Why do they have only one diagnosis?”

Eva Griffin-Stolbach (age 8), personal communication,
January 2009

What is Complex Trauma?

Exposure to multiple form of violence and other potentially traumatic stressors in the context of attachment behavioral systems that are unable to provide protection, care, and comfort

Focus on cumulative trauma and the developmental context in which exposure occurs rather than on discrete episodes

Proposed Developmental Trauma Disorder Criterion A:

- A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:
 - A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
 - A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

Beyond Posttraumatic Stress Disorder

Complex Trauma, Type II Trauma, Betrayal Trauma, Developmentally Adverse Interpersonal Trauma and Maltreatment, ACEs, Extreme Stress Not Otherwise Specified....

have profound effects on development, functioning, personality, and the capacity to live, love, and be loved.

These effects are not accounted for in our current diagnostic classification system, nor are they addressed in standard simple PTSD treatment approaches.

Beyond Posttraumatic Stress Disorder

Developmental Trauma Disorder (van der Kolk, 2005) proposes that following exposure to multiple, chronic adverse interpersonal stressors, including neglect, emotional abuse, violence, children develop symptoms of dysregulation across multiple areas :

Affective (emotional)

Somatic (physiological, motoric, medical)

Behavioral (re-enactment, cutting)

Cognitive (dissociation, confusion)

Relational (clinging, oppositional, distrustful)

Self-attribution (self blame, hate)

Histories of Trauma Exposure in Former Child Soldiers in Uganda

Abduction	99%
Exposure to Armed Combat	92%
Physical Assault	90%
Witnessed Killing	88%
Community Violence	56%
Rape by Rebels	26%
Physical Abuse	26%
Sexual Assault in Community	24%

Klasen et al., 2011

PTSD, MDD & DTD in Former Child Soldiers in Uganda

Posttraumatic Stress Disorder	33%
Major Depressive Disorder	36%
Developmental Trauma Disorder	78%
PTSD Only	1%
MDD Only	3%
DTD Only	32%
Two Diagnoses	30%
All Three	17%
None	17%

Klasen et al., 2011

Key Developmental Capacities Shaped by Attachment and the Experience of Safety/Danger

Ability to modulate, tolerate, or recover from extreme affect states

Regulation of bodily functions

Capacity to know emotions or bodily states

Capacity to describe emotions or bodily states

Capacity to perceive threat, including reading of safety and danger cues

Capacity for self-protection

Capacity for self-soothing

Ability to initiate or sustain goal-directed behavior

Coherent self, Identity

Capacity to regulate empathic arousal

Key Messages for Trauma Recovery

1. It is not happening now.

The trauma is over. It is in the past. You are here in the present.

2. You are safe.

The adults here are responsible for your safety and you are worthy of care and protection.

3. You are not inherently dangerous/toxic.

What is inside you (thoughts, feelings, dreams, impulses, etc.) cannot hurt you or others.

4. You are good.

Whatever you have experienced and whatever you have had to do to survive, you are a good, strong person who can contribute to your community.

5. You have a future.

What is a trauma-informed system?

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*“Trauma-informed” refers to all of the ways in which a service system is influenced by having an **understanding of trauma**, and the ways in which it is modified to be **responsive to the impact of traumatic stress**. A program that is “trauma-informed” operates within a model or framework that incorporates an understanding of the ways in which trauma impacts an individual’s socio-emotional health. This framework should, theoretically, **decrease the risk of retraumatization**, as well as contribute more generally to **recovery from traumatic stress**. (Harris & Fallot, 2001)*

Key Principles

Trauma awareness:

Trauma-informed systems incorporate an awareness of trauma into their work. This may include establishing a philosophical shift, with the overall system taking a different perspective on the **meaning of symptoms and behaviors**. Staff training, consultation, and supervision are important aspects of organizational change to incorporate trauma awareness. Practices within the agency should also reflect an awareness of the impact of trauma, including changes such as **screening for trauma history** and increasing **access to trauma-specific services** and **staff self care** to reduce the impact of vicarious trauma.

Key Principles

Emphasis on safety:

Because trauma survivors are often sensitized to potential danger, trauma-informed service systems work towards building **physical and emotional safety** for consumers and providers. The system should be **aware of potential triggers** for consumers and strive to avoid retraumatization. Because interpersonal trauma often involves boundary violations and abuse of power, systems that are aware of trauma dynamics establish **clear roles and boundaries** developed within a collaborative decision-making process. Privacy, confidentiality, and mutual respect are also important aspects of developing an emotionally safe atmosphere. **Diversity is accepted and respected** within trauma-informed settings, including differences in gender, ethnicity, sexual orientation, and so on.

Key Principles

Opportunities to rebuild control and empowerment:

Because control is often taken away in traumatic situations, trauma-informed service settings emphasize the importance of **choice and empowerment for consumers**. They create predictable environments that allow consumers to re-build a sense of efficacy and personal control over their lives. This includes **involving consumers in the design and evaluation** of services.

Key Principles

Strengths-based approach:

Trauma-informed systems are **strengths-based, versus punitive or pathology driven**. This type of system assists consumers in identifying their own strengths and developing coping skills. Trauma-informed systems are future-focused, and utilize skill-building to further develop resiliency.

Dr. Paul Farmer: "Structural violence is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people. Neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress."

Child Trauma, “Race” and Urban Poverty

Urban Black and Brown families face a unique set of adversities and stressors. The massive historical traumas of attempted genocide and slavery have never been addressed, yet create the context in which present traumas occur and are dealt with. Those of us working with children and families whose daily existence is shaped by the legacy of slavery and racial injustice cannot optimally intervene if we fail to understand and address the effects of the trauma of the past.

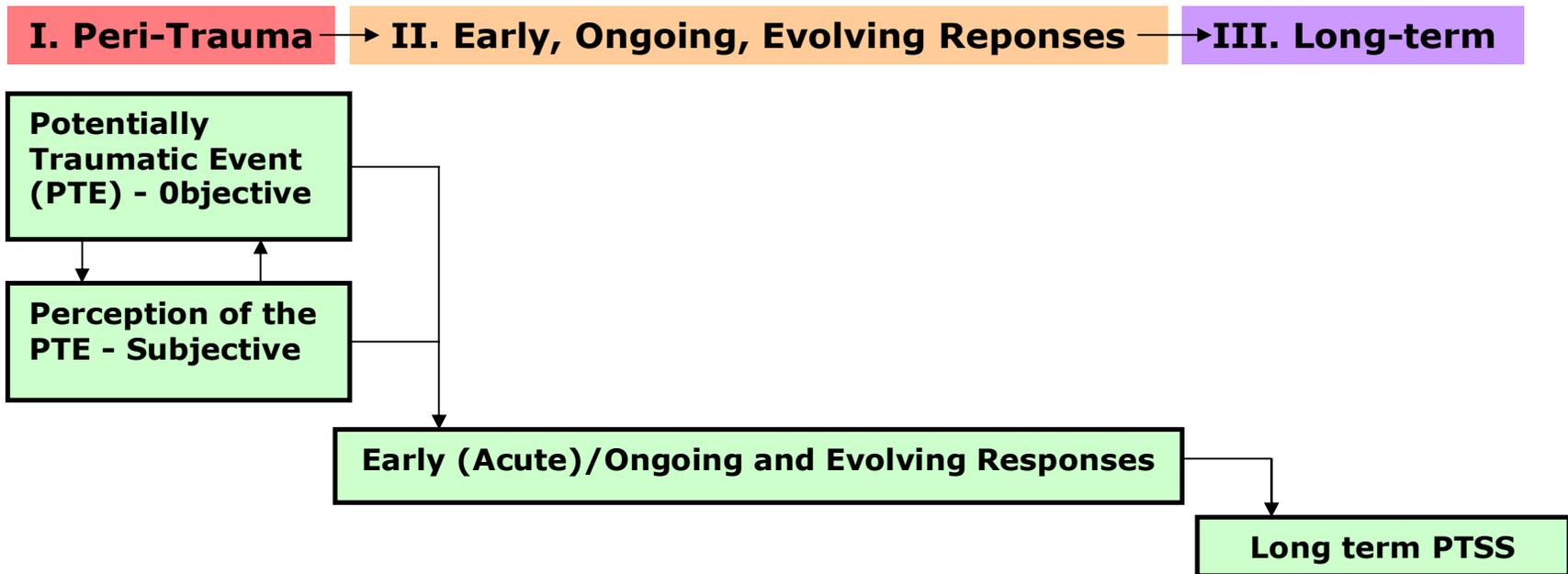
Societal Traumatization and the Legacy of Imperialism, Attempted Genocide, & Slavery

Just as in cases of individual traumatization, avoidance of acknowledging and addressing the traumatic past makes it impossible for integration to occur.

As long as historical trauma remains taboo, the racial divisions that pervade every aspect of American life will persist.

A Model of PMTS

Three stages of response.....



... with different implications for intervention.



Kazak, A., Kassam-Adams, N., Schneider, S., Alderfer, M., Zelikovsky, N., & Rourke, M. (2006). An integrative model of pediatric medical traumatic stress. *Journal of Pediatric Psychology*.

Traumatic Stress in Ill or Injured Children

AFTER THE ABC'S CONSIDER THE DEF'S

D

Distress

- Assess and manage pain.
- Ask about fears and worries.
- Consider grief and loss.

E

Emotional Support

- Who and what does the patient need now?
- Barriers to mobilizing existing supports?

F

Family

- Assess parents' or siblings' and others' distress.
- Gauge family stressors and resources
- Address other needs (beyond medical)?

Providing Trauma-Informed Pediatric Care

1. Screen
2. Support Attachment Behavioral System
3. Acknowledge the Impact
4. Normalize
5. Explain What is Happening and Why
6. Identify Potential Triggers
7. Provide Control

Providing Trauma-Informed Pediatric Care

8. Minimize Pain

9. Provide Safety

10. Reassure

11. Be Clear about Your Role

12. Reassure

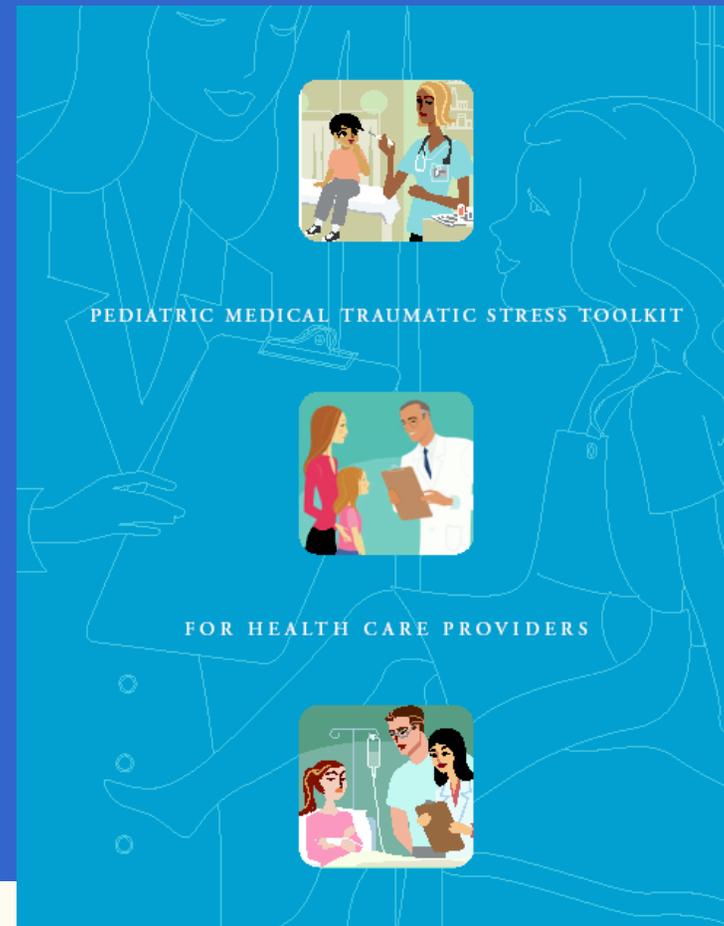
13. Plan for Future

14. Reassure

Pediatric Medical Traumatic Stress Toolkit for Health Care Providers

Print/download from:
www.nctsn.org/medtoolkit

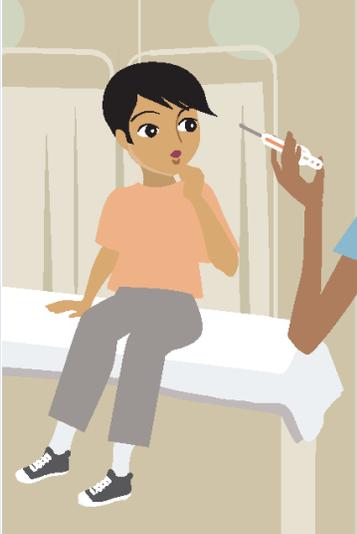
Stuber, M., Schneider, S., Kassam-Adams, N., Kazak, A. & Saxe, G. (2006). The Medical Traumatic Stress Toolkit. *CNS Spectrums*, 11, 137-142.



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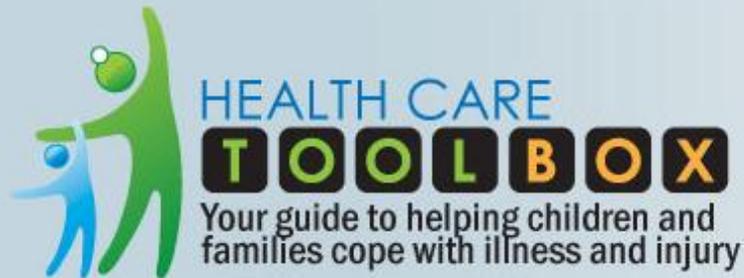
Pocket cards

D	Distress	How to Assess: Distress TRAUMATIC STRESS IN ILL OR INJURED CHILDREN
		<p>Pain: Use your hospital's pediatric pain assessment. Ask:</p> <ul style="list-style-type: none">• Current pain: "How is your pain right now?"• Worst pain: "What was the worst pain you have had since this happened?" <p>Fears and Worries:</p> <ul style="list-style-type: none">• "Sometimes children are scared or upset when something like this happens. Is there anything that has been scary or upsetting for you?"• "What worries you most?" <p>Grief or Loss:</p> <ul style="list-style-type: none">• Anyone else hurt or ill?• Other recent losses? (loss / damage to home, pet, etc.)

How to help: Distress

Tips to help families of injured or ill children

- 1 Provide the child with as much control as possible over the clinical encounter. The child should:**
 - understand what is about to happen
 - have a say in what is about to happen
 - have some control over pain management
- 2 Actively assess and treat pain.**
 - Use your hospital's pain management protocol
- 3 Listen carefully to hear how the child understands what is happening.**
 - After explaining diagnosis or procedure, ask the child to say it back to you.
 - Remember that the child's understanding may be incomplete or in error.
- 4 Clarify any misconceptions.**
 - Provide accurate information.
 - Use words and ideas the child can understand.
- 5 Provide reassurance and realistic hope.**
 - Describe what is being done to help the child get better.
 - State that there are many people working together to help the child.
- 6 Pay attention to grief and loss.**
 - Mobilize your hospital's bereavement service and/or grief protocols.
 - Encourage parents to listen to their child's concerns and be open to talking about their child's experience.



- Download patient handouts
- Find assessment tools
- Learn quick interventions
- Understand patient perceptions
- Download provider resources

- + How Providers Make a Difference
- + What Providers Need to Know
- + What Providers Can Do
- + Cultural Considerations
- + Research Summaries
- + Tools and Resources
- + Patient Education Materials
- + Self-Care for Providers
- + Online Education for Providers
- + For Parents and Children

Basics of Trauma-Informed Care

REDUCE DISTRESS

D • Ask about fears and worries.

EMOTIONAL SUPPORT

E • Who and what does the patient need now?

REMEMBER THE FAMILY

F • Gauge family stressors and resources.

How Providers Make a Difference

Healthcare providers are experts in treating illness and saving lives. After attending to the basics of physical health (A-B-C: Airway, Breathing, Circulation), you can promote psychosocial recovery by paying attention to the D-E-F (Distress, Emotional Support, Family).



Latest News

Tools You Can Use

"En el hospital: Cómo ayudar a mi hijo a sobrellevar la situación"

Download parent tipsheets in [Dog bites & traumatic stress](#)

In a recent study from China, Dr. Li Ji, a researcher and pediatrician, along with his team found th

Managing pediatric pain

Dr Leora Kuttner, PhD is a pediatric clinical psychologist who specializes in treating children's

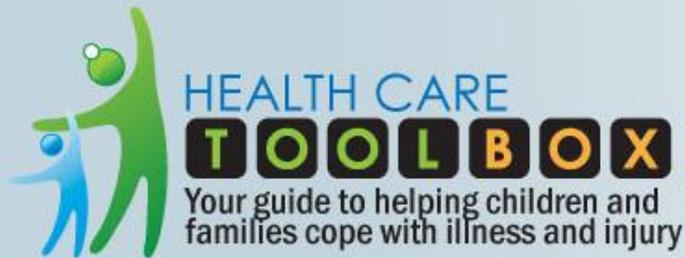
NICU parent stress persists

Recent studies document parent traumatic stress when a child is admitted to the NICU. Parents

Give Us Your Opinion

How many of your pediatric patients have a difficult time coping with their illness or

What is Trauma-Informed Pediatric Care?



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Child Development and Traumatic Stress

+ How Providers Make a Difference

What Providers Need to Know

Fast Facts

Prevalence

Signs & Symptoms

Who is at Risk?

Developmental Issues

Understanding the Family's Experience

Traumatic Stress Trajectory

What is Traumatic About Medical Experiences?

+ What Providers Can Do

+ Cultural Considerations

+ Research Summaries

+ Tools and Resources

+ Patient Education

The way that children respond to potentially traumatic medical events is influenced by their age and development.

Click each heading below to expand:

Younger Children

Younger children's responses to traumatic events tend to be more behavioral; they will SHOW you that they are upset, rather than tell you.

Direct observation of child behavior and parent report are the best ways to assess the impact of traumatic events on young children. In addition, they:

- Can regress behaviorally (bed-wetting, thumb-sucking, etc.) in response to distress
- May have strong startle responses, nightmares, and outbursts since their brains do not have the ability to calm fears
- Think in images and are more likely to process trauma through play, drawing, and storytelling
- Depend on parent presence and support to soothe and calm them, more than any other age group.



TIPS FOR PROVIDERS

Traumatic Stress: ED Clinician Roles

Example: 3-year-old burn patient - Sam

Distress

- ❖ Sam is too calm for a 3-year-old in this situation: *Provide calming adult for Sam, maintain role for mom as caregiver*

Emotional Support

- ❖ Provide developmentally appropriate explanation to Sam: *helps him cope and integrate experience*
- ❖ Provided non-judgmental space for mom to communicate what happened: *mom is experiencing this trauma, too*
- ❖ Recognize that mom's role as primary caregiver makes her supportive to Sam despite her reaction: *keep Sam and mom connected while helping mom calm down*

Family:

- ❖ Mom is chaotic and hysterical but also needs to be there for Sam: *reassure and help her calm down*
- ❖ Remember practical issues: *who is caring for siblings, what do they know about what happened*

Barriers:

- Simultaneous, emergent medical treatment
- Mom is interfering
- Resources and physical layout of ED

National Child Traumatic Stress Network Definition of a Trauma-Informed Child- and Family-Service System

A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

A service system with a trauma-informed perspective is one in which programs, agencies, and service providers: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.

References & Resources

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www.HealthCareToolbox.org

www.nctsn.org

www.nctsn.org/medtoolkit

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