Addressing Traumatized Children: New Guide for Primary Care Clinicians to Support Foster and Adoptive Families

In partnership with the Dave Thomas Foundation for Adoption and the Jockey Being Family, the American Academy of Pediatrics (AAP) has developed materials to help pediatricians support adoptive and foster families by learning to identify traumatized children, educating families about toxic stress, and empowering families to respond to their child's behavior in a manner that acknowledges past trauma.

The following materials are MCPAP best picks:


**AAP Foster Care Coding Fact Sheet**

**Parenting After Trauma: Understanding Your Child's Needs**
This guide for families explains how trauma can impact a child and provides tips for making him or her feel safe in his or her new home. This is a helpful guide for clinicians to give to foster and adoptive parents.

Q & A with Heather Forkey, MD: Helping Foster and Adoptive Families Cope with Trauma Guide
(Heather C. Forkey, MD, FAAP, a pediatrician, is the director of the Foster Children Evaluation Service (FaCES) at the UMass Memorial Children’s Medical Center. Irene Tanzman is the program administrator for the Massachusetts Child Psychiatry Access Project.)

Irene Tanzman: You led the team that developed the AAP Guide: “Helping Foster and Adoptive Families Cope With Trauma.” What were your goals for usage of this guide? Why was this guide developed? What was your goal for the Parent Guide and other accompanying materials?

Dr. Heather Forkey: The Dave Thomas Foundation for Adoption approached the American Academy of Pediatrics (AAP) to develop a guide for physicians and families on how to recognize and respond to childhood trauma. We were honored to have the opportunity to develop a short, user-friendly document to be a resource for physicians who are caring for children who have been adopted or are in foster care.

A good deal of research about the effects of trauma on the developing brain has recently been published, but there are currently few resources for pediatricians with practical practice guidelines. Of particular concern is the fact that children who have experienced trauma may be diagnosed with other disorders that mimic trauma. If trauma is the true cause of the symptoms, but goes untreated, the mental and physical health consequences can be severe. Thus, the guide is designed to help pediatricians to recognize trauma, differentiate it from other disorders, and respond.

This resource summarizes the science, translates theory into office-based guidelines, and makes recommendations for management, and if necessary, referral. Billing and coding are also addressed. The accompanying parent guide is a brief summary for families that can be distributed by pediatricians to reinforce their recommendations or to follow up on an office conversation about trauma exposure or patient symptoms. We hope that these materials will make the identification, diagnosis, and management of childhood trauma a little easier and more accessible for pediatricians and families.

Irene Tanzman: Are there plans to distribute the guide in hard copy? Are you planning to present this material in other formats such as webinars or conferences?

Dr. Heather Forkey: The guide will be distributed to AAP members with the July issue of the AAP journal, Pediatrics. On June 19, I and some of the other authors of the guide will be presenting this material in an AAP-sponsored webinar. (To access the webinar, go to: https://www3.gotomeeting.com/register/524005398.)

Irene Tanzman: What is epigenetics? Is it important for primary care clinicians to gain an understanding of this field? What do you see as the future for epigenetics as it relates to trauma?

Dr. Heather Forkey: Epigenetics refers to functionally relevant modifications to the genome that do not involve a change in the DNA nucleotide sequence. These modifications regulate gene activity and play a role in acute regulation of genes in response to changes in the
Epigenetics has been proposed as one possible mechanism for how early adversity can confer risk for later psychiatric and medical problems. Indeed, this is an important area for physicians to become informed about, and a number of recent publications in *Pediatrics* and other journals have addressed this issue (ref: Yang, BZ, Zhang, H. et al. Child abuse and epigenetic mechanisms of disease risk. *Am J Prev Med.* 2013; 44 (2):101-107; Johnson, S.B. Riley, A.W. et al. The science of early life toxic stress for pediatric practice and advocacy. *Pediatrics* 2013; 131: 319-327). The AAP has a new epigenetics website at [www.geneticsinprimarycare.org](http://www.geneticsinprimarycare.org).

In fact, research studies from molecular biology, genomics, immunology, and neuroscience have all begun to inform our science-based strategies for helping children exposed to toxic stress. We strongly encourage physicians and families to learn more about these aspects of our medical response to toxic stress. For many physicians, the pressures of a busy practice and competing commitments preclude such study, so this guide is a distillation of the multiple aspects of scientific inquiry, which may inform their office practice. This guide is meant to be an introduction for physicians and families new to the topic and a resource that translates the science into practical measures to be used with patients.

**Irene Tanzman:** Why was the Adverse Childhood Experiences (ACE) study so important for physicians and others in clinical practice? How did the AAP team use the information from the ACE study in the development of the guide?

**Dr. Heather Forkey:** The ACE study was published in 1998 and was the first and largest population-based study that connected the dots between toxic stress in childhood and poor health outcomes in adults. The value of this study and the many studies that followed cannot be understated. Ultimately, as health care providers, recognizing the link between toxic stress and mental and physical health is a mandate to address the issue. It was certainly a big factor in why and how we developed the guide.

**Irene Tanzman:** If a child has already been exposed to significant toxic stress that affects brain development, is there hope that interventions might cure or alleviate this condition? The guide recommends certain therapies for traumatized children. Are these therapies readily available in Massachusetts? What role does anticipatory guidance play?

**Dr. Heather Forkey:** Science that demonstrates the impact that the early environment has in shaping and tuning development and behavior in childhood is both a warning that primary prevention and attention to the vulnerable developmental periods are crucial and a reason for optimism about the promise of intervention for those who are affected by toxic stress.

Thanks to the efforts of some Massachusetts mental health agencies and grant funding from SAMHSA and the National Child Traumatic Stress Network (NCTSN), we DO have a number of therapies available for young children, older children, and those exposed to non-relational and complex trauma. Importantly, efforts are being
made to develop anticipatory guidance guidelines to provide more primary prevention; this is both a challenge and an opportunity for pediatricians to begin to impact the health and well-being of children and families for generations to come.

**Irene Tanzman:** Much of the information in the guide could pertain to any child or youth who has experienced trauma. Is the scope of this guide directed only to addressing trauma concerns in adoptive or foster children, or could this information be used to help any child who has experienced trauma?

**Dr. Heather Forkey:** Yes. While we have specifically addressed children who are in adoptive or foster care in this guide, most of the information applies to any child who has experienced trauma. The AAP is currently negotiating with the NCTSN to develop additional resources, which may include clinical guidelines and education resources for physicians and families. The AAP already has a website called the Medical Home for Children Exposed to Violence, which is a great resource ([www.aap.org/medhomecev](http://www.aap.org/medhomecev)).

**Irene Tanzman:** How can MCPAP help primary care clinicians support foster and adoptive families? How can the National Network of Child Psychiatry Access Programs help?

**Dr. Heather Forkey:** MCPAP and the National Network of Child Psychiatry Access Programs are already great resources for primary care clinicians, which can help foster and adoptive families in many ways. Differentiating trauma from its mimics can be tricky and may require the collaborative efforts of MCPAP staff and primary care providers. Helping primary care physicians consider trauma before making a diagnosis and before starting treatment can make the process much smoother for children and families.

MCPAP and the National Network may find that the guide gives pediatricians the information and guidelines they need to provide better care for children who have experienced toxic stress. In some cases, children who have experienced trauma may need more mental health attention than primary care physicians can provide on their own. MCPAP and the National Network can be a huge resource in guiding primary care physicians to the mental health resources in the community that provide trauma informed and/or trauma specific treatments for children.

**Irene Tanzman:** Is there anything else that you would like our readers to know about the guide, the accompanying Coding Tip Sheet, or the Parenting Guide?

**Dr. Heather Forkey:** The information in the guide is an excellent starting place, but certainly does not replace consultation with MCPAP or other mental health professionals. Users are welcome to copy and use the guide with families or colleagues as they see fit. The included summary sheet can be used as a discharge form a charting tool or as another parent management guide.

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**Mental Health Mimics of Trauma**
During an office visit, a three-year-old boy is withdrawn and doesn’t speak or make eye contact. This presentation suggests autism spectrum disorder (ASD). Another patient, a once lively adolescent girl, has shut down and has lost interest in activities she once enjoyed. This presentation suggests depression.

However, both patients’ symptoms may not indicate behavioral health conditions but may be caused by trauma. “Trauma is the great masquerader,” says Christopher Bellonci, MD, a child and adolescent psychiatrist in Needham, Mass., and former MCPAP child psychiatry consultant. “A traumatized child can appear to have many conditions in the diagnostic nomenclature. Trauma classically presents as depression and anxiety but can also present as autism or ADHD.”

Children with behavioral health and mental health symptoms that stem from trauma are often misdiagnosed. This is a serious issue because standard treatments for behavioral health conditions are not effective in treating trauma-based symptoms. For example, treatments such as medications and conventional psychotherapy for depression and stimulants for attention difficulties cannot address these conditions if they are rooted in trauma. “If you treat trauma as a behavioral health or mental health condition, the child won’t get better. There are excellent evidence-based treatments for trauma. If you treat the trauma, co-morbid ADHD, autism, depression, and anxiety resolve,” says Dr. Bellonci.

**Consider Trauma in Evaluating Patients**

Children from all racial and socioeconomic groups can experience trauma. The 2011 National Survey of Children’s Exposure to Violence, which involved about 4,500 youths aged one month to 17 years, found that approximately 22 percent of participants had witnessed violence in their family or their neighborhood in the past year. The survey also found that 14 percent of children had repeatedly experienced maltreatment, including physical abuse, by a caregiver.

In evaluating children who present with behavioral health symptoms, consider the possibility of trauma. “Trauma should be among the causes that need to be ruled out. If I don’t think about trauma, I may not be able to make the correct diagnosis,” says Heather Forkey, MD, a pediatrician at Foster Children Evaluation Service (FaCES) at UMass Memorial Children’s Medical Center.

“Certain family constellations, such as those with domestic violence, mental illness, neglect, and addiction, should increase the index of suspicion for trauma,” says Dr. Bellonci. In particular, children who have been in foster care or adopted are more likely to have experienced trauma. The American Academy of Pediatrics (AAP) guide, “Helping Foster and Adoptive Families Cope with Trauma” (see above article) suggests that pediatricians “assume that all children who have been adopted or fostered have experienced trauma.”
You can request records for foster children from the Massachusetts Department of Children and Families (DCF). Getting records for adopted children may be more difficult, especially if it was a foreign adoption, but the parent may have some information about the child’s history.

Assessing the home environment and caregiver relationships are key elements of a behavioral health evaluation. “If you start a conversation with parents about whether the child has experienced trauma, you may not get an answer right away, but the parent may return and acknowledge the problem. Sometimes parents need your help to recognize that there is a problem,” says Dr. Forkey.

**Pathophysiology of Trauma**

In diagnosing trauma, bear in mind that it disrupts normal brain development and also adversely affects the development of other organ systems and regulatory functions. Early adversity can also produce genetic alterations (see above interview with Dr. Forkey). When a child experiences ongoing “toxic stress” or trauma, the amygdala becomes larger and the frontal lobe and hippocampus do not fully develop, reports Dr. Forkey. Children who live with constant danger have physiologic hyperarousal and produce more stress hormones. These neurological and physiological changes affect behavior and mental health. (See the AAP guide for more information.)

**Distinguishing Trauma from Other Behavioral Health Conditions**

Symptoms that come on suddenly and are out of character may indicate that the child or adolescent has experienced or is experiencing trauma. Young children will exhibit regressive behavior. “A child who was toilet trained will have accidents, a child with language skills can become mute, and a child who was progressing will fail to thrive,” says Dr. Bellonci. Trauma in young children may be revealed during play with drawings or toys. “The child may draw police cars or ambulances or enact sexual activity between two dolls,” says Dr. Bellonci.

Sleeping problems, a common symptom of trauma, can be a sign of sexual abuse, which often happens at night, or of an overproduction of adrenalin. When attention difficulties are present only in specific situations, they may indicate trauma rather than ADHD. Adolescents who get into fights, are disorganized, and are unable to complete tasks “may lack self-regulation due to trauma,” says Dr. Forkey.

During office visits, children who experience trauma “will be easily startled, hypervigilant to signs of danger, may not want to see the pediatrician without the parent, or be more anxious when the parent is present,” says Dr. Bellonci.

In distinguishing ASD from trauma-related withdrawal, consider whether the child is unable or afraid to make eye contact and if there is a language or development delay, which increases the likelihood of ASD, suggests Dr. Bellonci.
If you have made a diagnosis and prescribed treatment and the child isn’t improving, “go back and see if there’s anything you’ve missed, including trauma,” says Dr. Bellonci. “Until you address the trauma, you can’t address the disease process,” says Dr. Forkey.

Pediatricians are often the first to observe symptoms when they begin to manifest and can prescribe treatment before the child develops more serious problems. They can also address problems in the family environment that are affecting the child’s emotional and physical development and enable the family to get the help it needs.

For more information about trauma, including types of trauma, diagnosing trauma, and evidence-based treatments, see the article “Toxic Stress and Trauma-Informed Pediatric Care” in the June 2012 issue of MCPAP news at http://www.mcpap.com/pdf/Vol1No6MCPAPNews.pdf.

Resources for Supporting Foster and Adoptive Families in Primary Care

Clinical Reports:

(MCPAP-enrolled primary care clinicians who have questions about the mental health review or issues of adjustment should feel free to call their regional MCPAP team.)

“International Adoption: A 4 Year-Old Child With Unusual Behaviors Adopted at 6 Months of Age,” Pediatrics, November 2004
This case study illustrates behavioral symptoms of the most severely affected internationally adopted children. A group of experts analyzes and discusses this case.

Rating Scales:
Childhood Stressful Experiences Scale – Rates the child’s or youth’s stressful experiences
Childhood Stressful Experiences Scale, Parent and Child - Rates the stressful experiences of the child or youth and the parent

The above referenced rating scales were developed by the Healthy Steps/Enhancing Developmentally Oriented Primary Care Program in Illinois. We thank our sister program, Illinois DocAssist, for bringing these rating scales to our attention, and we thank Healthy Steps for allowing us to distribute them. These rating scales have not yet been tested for sensitivity and specificity.

Other Resources:
A Message from a Child Formerly in Foster Care, American Academy of Pediatrics, Healthy Foster Care America