



MCPAP Clinical Conversations: Beyond the ACE Score – Practical Screening and Trauma Informed Care

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June 22, 2021

Outline

- Introductions
- Discussion of Format
- Presentation
- Comments and Questions (15-20 mins)

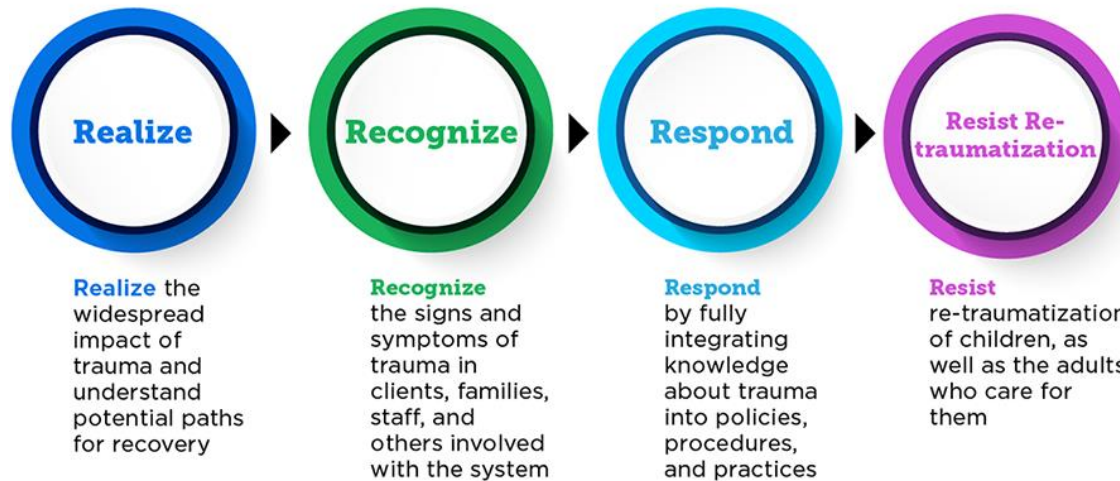
Overview

1. What is trauma informed care?
2. What does trauma do physiologically that leads to health consequences?
3. How do we practically provide trauma informed care?
4. What is all this hub bub about ACE screening?
5. How do we help families impacted by trauma from the pediatric setting?

Trauma Informed Care (TIC)

- *Trauma-informed care* (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 experiences on children, caregivers, and healthcare providers.

The Four Rs of Trauma-Informed Care



Realize: ACE study! ACE score?



Realize the widespread impact of trauma and understand potential paths for recovery



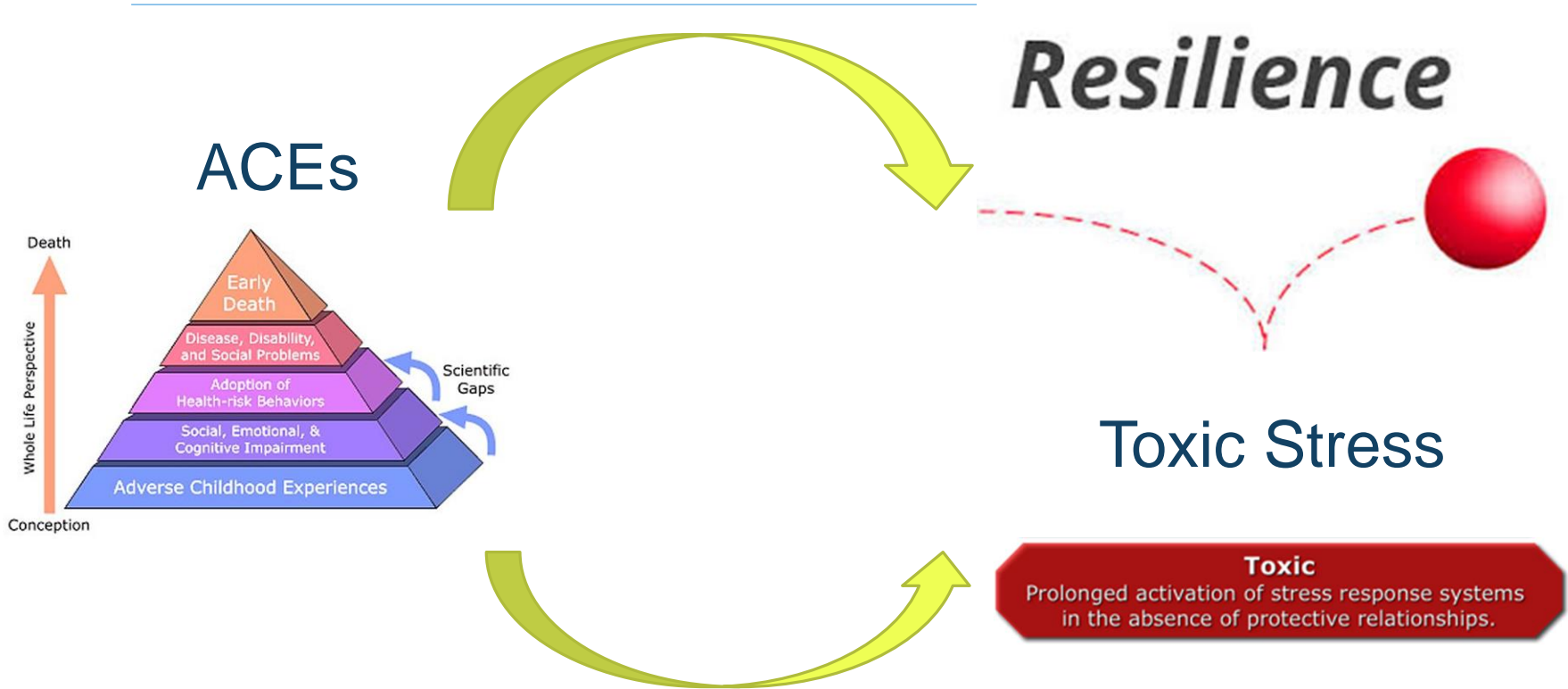
ACE Screening enthusiasm related to odds ratios for populations...

Cumulative ACES & Mental Health^{1,2}



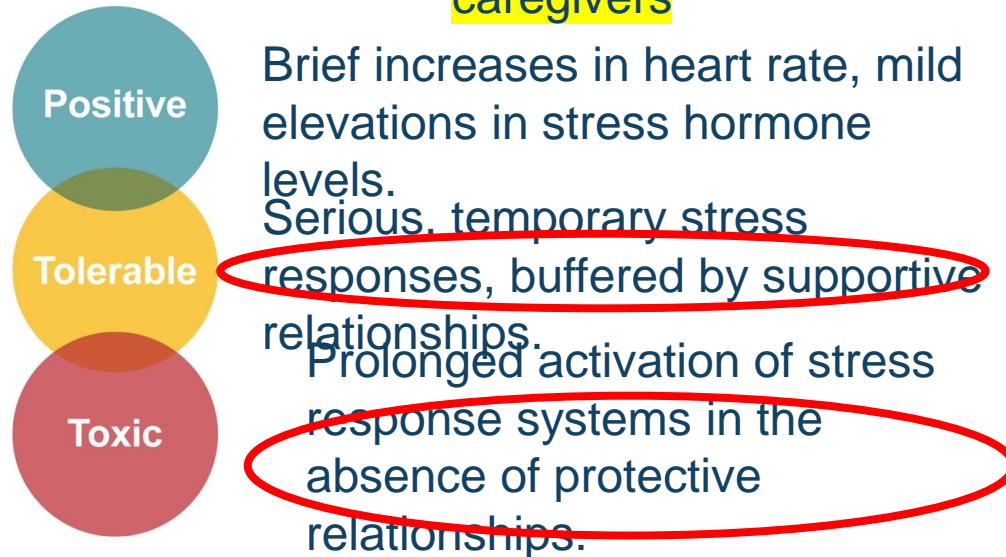
¹Data from the National Comorbidity Survey-Replication Sample (NCS-R).

²Putnam, Harris, Putnam, J Traumatic Stress, 26:435-442, 2013.



Definition of Toxic Stress

Excessive or prolonged activation of stress response systems in the absence of buffering protection from adult caregivers

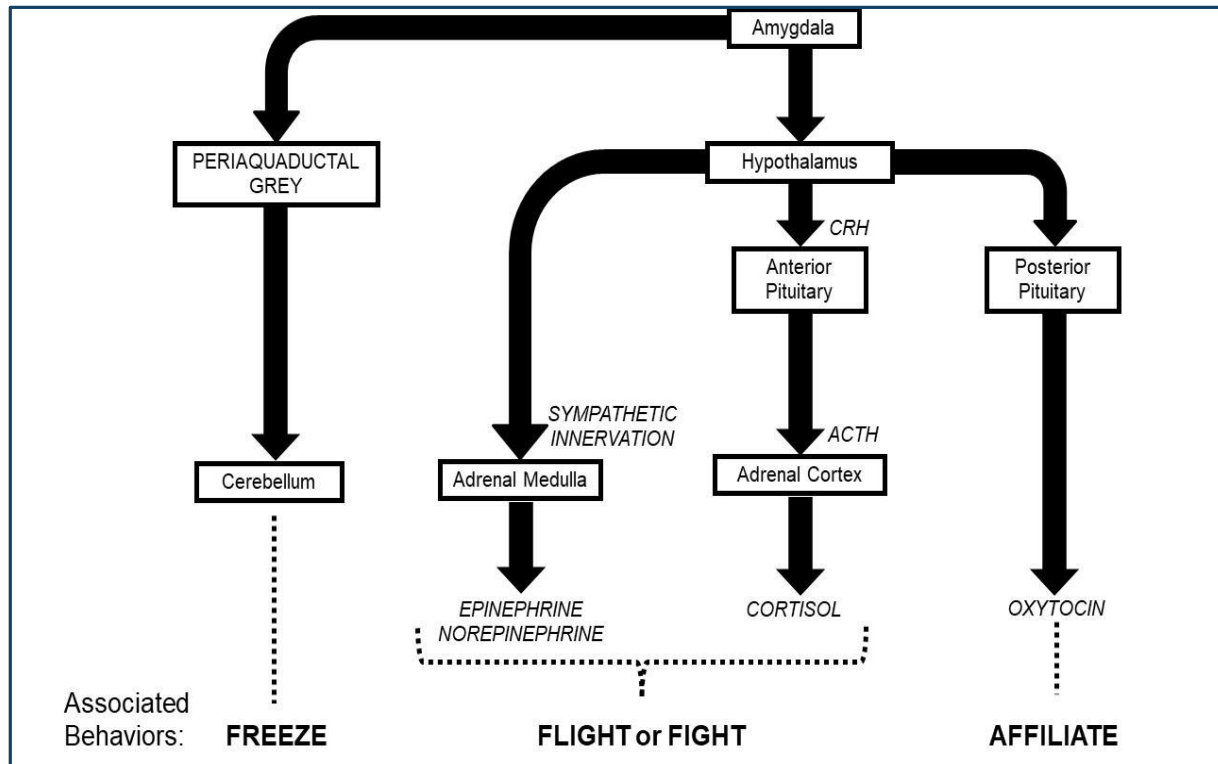


Source: Permission granted by center on the Developing Child at Harvard University. <https://developingchild.harvard.edu/>



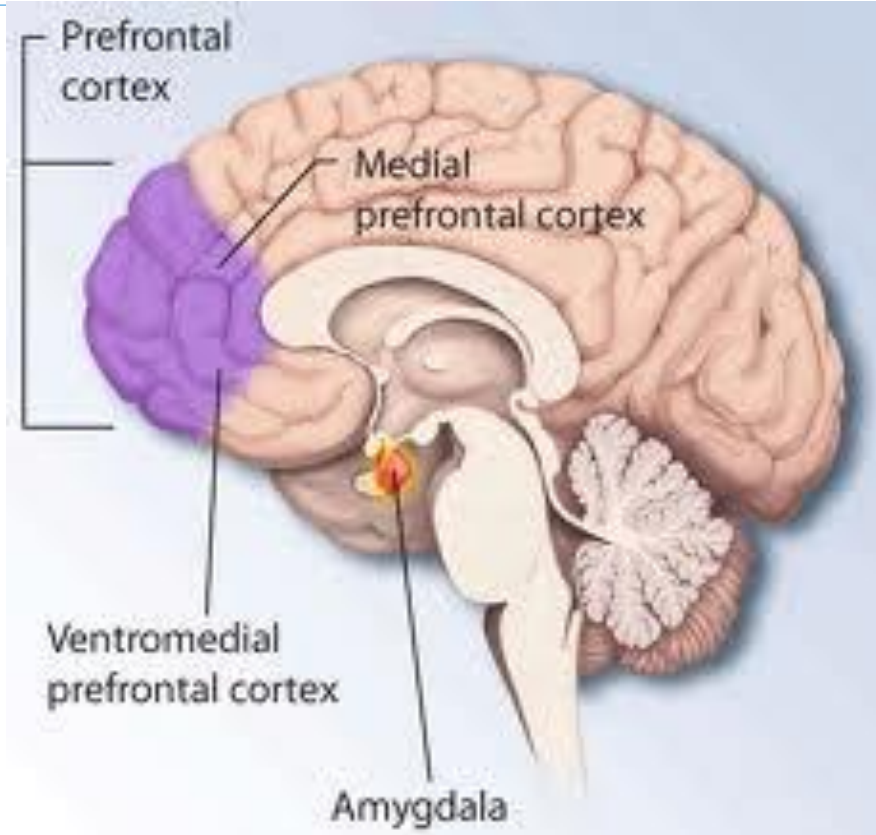
The Context is Always Relationships, or the Attachments Children Have

Variable responses to threat



Garner, A and Saul B.. Thinking Developmentally, AAP Press, 2018

Trauma
effects on the
developing
brain,
immune
system,
epigenome...





Overdevelop limbic system: Prioritization of developmental tasks and skills of survival

At cost of cortex: Interference with other developmental tasks dependent on availability of a safe attachment system

Trauma Symptom Spectrum

C. Early interpersonal trauma, no support

A. Functional difficulties AND

B. PTSD symptoms AND

C. Developmental trauma disorder

•**Affect Dysregulation:** Violent reckless or self destructive, dissociation, attentional issues

•**Negative self-concept:** Persistent beliefs as diminished, defeated, worthless, shame, guilt

•**Interpersonal disturbances:** Difficulty with relationships

B. Severe incident trauma with support

A. Functional difficulties

AND

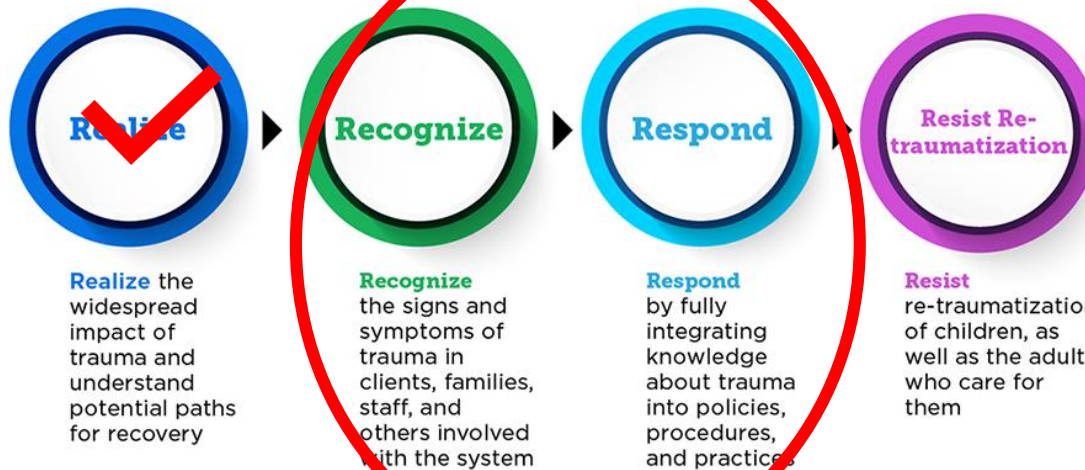
B. PTSD symptoms : arousal, avoidance, re-experiencing

A. Trauma mild or with support

A. Functional difficulties –
Sleep, tantrums, toileting, eating

What are the goals

The Four Rs of Trauma-Informed Care



Trauma-informed care (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 experiences on children, caregivers, and healthcare providers.

This figure is adapted from: Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and Guidance for a trauma-informed approach. HHS publication (SMA) 14-4682. Rockville, MD: Substance Abuse and Mental Health Services Administration.



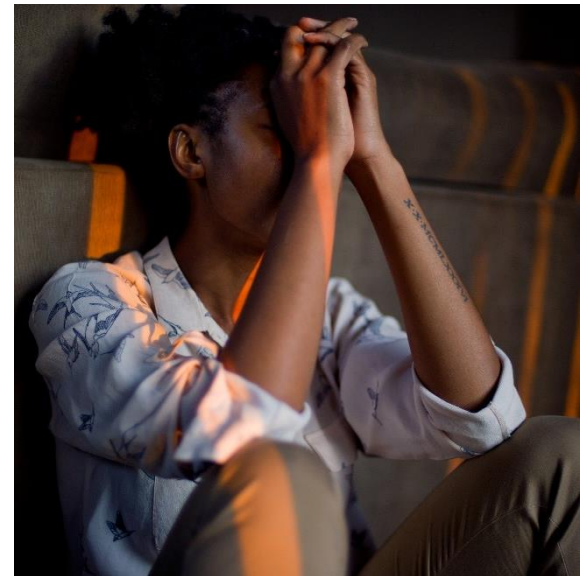
“But I already do that!”

Many patients come
in with concerns that
overlap with trauma...

ADHD?

Depression?

Sleep concerns?



Many patients come in with concerns that overlap with trauma...

ADHD?

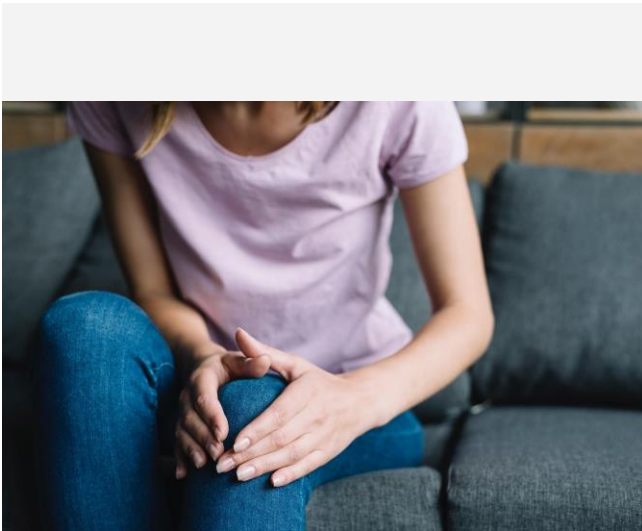
Depression?

Sleep concerns?

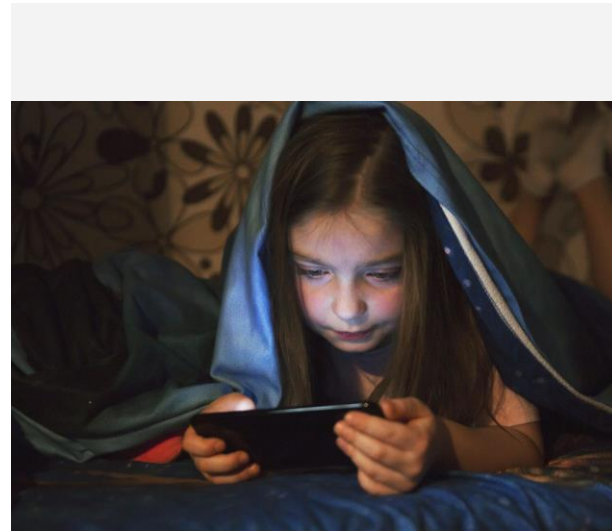


How Care of an Orthopedic and Trauma Complaint Are the Same (and a Little Different)

Orthopedic complaint: My knee hurts



Trauma complaint: Child won't sleep





The Context is Always Relationships, or the Attachments Children Have

So how to begin...

You
had
me at
“hello”



Engage - Form a Therapeutic Relationship



“Let’s think about this together”
***“What is your understanding
of...?”***

NCTSN. Sharing power: A tool for reflection. Accessed at: <https://www.nctsn.org/resources/sharing-power-tool-reflection>

Ortho Problem: Knee Pain

“Oh dear, how did that happen?”

“Boy, you look like you are in pain”

“Help me understand how that happened?”



Trauma Problem: Not Sleeping

“Ugh, not sleeping. How exhausting for you.”

“Can you tell me more about when that started?”

“Ok, now lets think about this together.”



Consider differential immediately

Traumatic

- Soft tissue injury
- Fracture
- Non-accidental trauma

Non-traumatic

- Orthopedic (Osgood Schlatter, Legg Calve Perthes, Slipped Capital Femoral Epiphysis (SCFE))
- Rheumatologic
- Infectious
- Malignancy
- Hematologic (Sickle Cell)

Traumatic

- Single incident
- Chronic ongoing
- Developmental trauma disorder

Non-traumatic

- Environmental
 - Caffeine, sleep space, TV, lack of routine
- Illness/pain

History of Present Illness: parallels

ORTHOPEDIC COMPLAINT

Obtaining history:

- When did the pain start
- Where exactly does it hurt
- When do you notice the pain (with walking, running, resting)
- What is pain like – sharp, dull, aching
- Any new activities cause different use
- Any new illness, meds
- **Was there a trauma to knee**

TRAUMA COMPLAINT

Obtaining history

- When did the not sleeping start
- When do you notice the sleep issue (every day, on weekends)
- What is the sleep problem like (falling asleep, staying asleep)
- Any changes in routine
- TV in room, meds, caffeine, illness pain
- **Was there a trauma**

Past Medical History (PMH): parallels

- Has this knee hurt before?
- Was knee injured before?
- Any other non-trauma issues: illnesses noted (infections, rheumatologic, oncologic)
- Was sleep ever a problem before, has it always been a problem?
- Prior single incident, other traumas known
- Other non-trauma issues: illness, caffeine intake

Family History /Social History: Parallels

- FH: Any illnesses run in the family that might be relevant (rheumatologic, IBD, chromosomal or bony disorders)
- SH: Social issues that might impact living conditions, safety, composition of family, occupation of parents
- FH: Do parents have history of trauma?
- SH: Is the family dealing with something now (divorce, new boyfriend in the home, moving, deployment)?

Physical Exam: Parallels

Range of motion

“Range of motion”:
severity – is caregiver
ready to snap?

Referred pain: Check joints
above and below for

- SCFE
- Hip fracture

"Referred pain": Check for
issues that not primary
sleep issue, but sleep is
manifestation

- Substance use
- Violence in home
- Chaos of home

Diagnostic Studies

Imaging

- Just radiograph everyone?
- Consider the best modality given your most likely issue (radiograph, US, MRI, CT)
- Check joints above and below
- Compare with other side

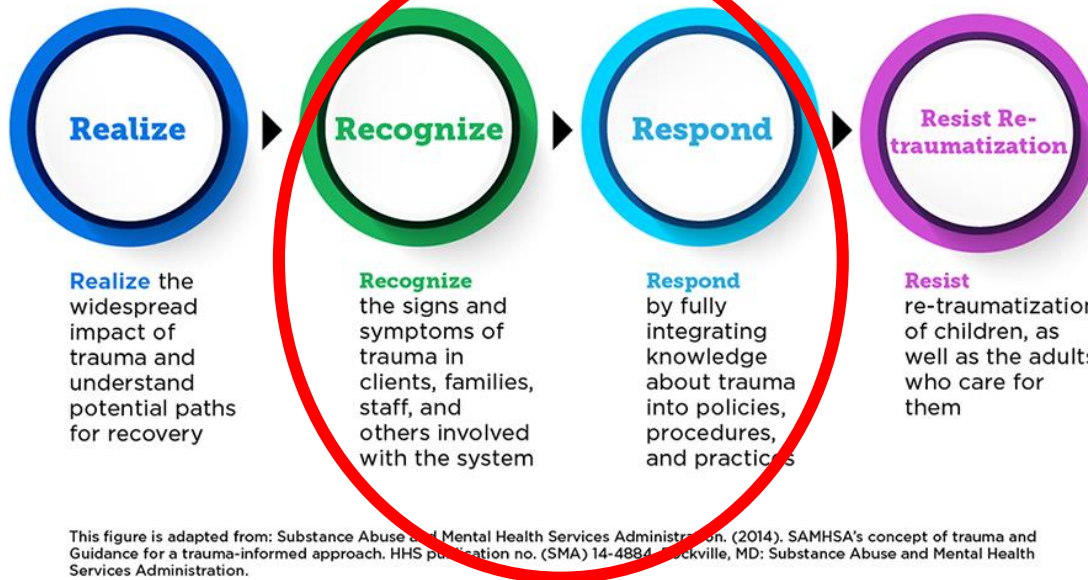
Lab studies

- If this is an infection or endocrine related



What are the goals

The Four Rs of Trauma-Informed Care



Trauma-informed care (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 experiences on children, caregivers, and healthcare providers.

Identify what you want to know... (what will impact care provided to child/family)

CAREGIVER

Risk

- Social Determinants of Health (SDOH) screeners
- ACE's parent experienced

Resilience

Function/Symptoms (caregiver)

- Surveillance
- Screening
 - Edinburg Depression Scale
 - Parenting Stress Index

CHILD

Risk

- Social Determinants of Health (SDOH) screeners
- ACE's child experienced

Resilience

Function/Symptoms (child)

- Surveillance (functional symptoms)
- Screening
 - PTSD (DSM criteria)
 - Complex trauma (DTD)



Respond: must be able to address screener

SDOH screening – Family - Hunger VitalSign

Hunger VitalSign™

The Hunger Vital Sign™ identifies individuals and families as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

“ Within the past 12 months we worried whether our food would run out before we got money to buy more.”

“ Within the past 12 months the food we bought just didn't last and we didn't have money to get more.”


SDOH – Caregiver - WE CARE

WE CARE SURVEY

Our goal at the Harriet Lane Clinic is to provide the best possible care for your child and family. We would like to make sure that you know all the resources that are available to you for your problems. Many of these resources are free of charge. Please answer each question with an "X" and hand it in to your child's doctor at the beginning of the visit. Thank You!


1. Do you have a high school degree?

YES


NO
 If NO, would you like help to get a GED?  YES NO MAYBE LATER

2. Do you have a job?

YES


NO
 If NO, would you like help with finding employment?  YES NO MAYBE LATER

3. Do you smoke cigarettes?

YES
 If YES, would you like help to quit?  YES NO MAYBE LATER


NO

4. Do you or does anyone else in your home use drugs?

YES
 If YES, would you like help with it?  YES NO MAYBE LATER


NO

5. Do you or does anyone else in your home have a problem with alcohol?

YES
 If YES, would you like help with it?  YES NO MAYBE LATER

NO

6. Are you feeling sad or hopeless a lot of the time?

YES
 If YES, would you like help with it?  YES NO MAYBE LATER

NO

Risk “screening” vs surveillance for ACEs

ACE Surveillance in children

- Since the last time I saw you (your child) has anything really scary or upsetting happened to you (your child) or anyone in your family?



Cohen, J., Kelleher, K., Mannarino, A. *Identifying, Treating, and Referring Traumatized Children: The Role of Pediatric Providers*. Arch Pediatr Adolesc Med, 2008. **162**(5): p. 447-452.

ACE Surveillance - children

More specific than single question

1. Are there any behavior problems with child at home or school?
2. Any dramatic changes in the child's mood or personality?
3. Has anyone gone or come from household lately?
4. Any problems with sleep or toileting or eating?
5. Has your child ever witnessed anyone being harmed at home or in the community?

ACE screening – Parent



To the parents in my practice,

None of us grew up in a perfect family. Some of us, however, grew up in very dysfunctional or unsafe homes. As your pediatrician, it is helpful for me to know specifically what you experienced while growing up. It helps me to better think about how to support your own parenting skills through what might be challenging times or experiences. For example, if you grew up in a household where you did not have enough to eat, will that make it harder to know how much your child should eat at any given age? If you were physically abused as a child, how will you feel or react when your toddler hits you out of frustration or anger?

AND, it is also very important to know that an unsafe or dysfunctional home is only *part* of anyone's story. We also know that resilience, the ability to 'bounce back', is just as important as adversity.

On the reverse side of this letter is a questionnaire asking about your own Adverse Childhood Experiences (ACEs) followed by a questionnaire about resilience. Thank you for sharing this information with me. Your personal information will be kept confidential. We will track overall information obtained in order to make decisions about services to offer within the clinic.

For more information about ACEs and the importance of resilience, the following websites may be helpful:

acestudy.org
resiliencecrumpsaces.org

Thank you,

Finding Your ACE Score

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

1. Did a parent or other adult in the household **often** or **very often**... Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often** or **very often**... Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____
4. Did you **often** or **very often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often** or **very often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often or **very often** pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Resilience Score

Please answer the questions below using the following scoring guide:

0	1	2	3	4
Definitely Not True	Probably Not True	Not Sure	Probably True	Definitely True

1. I believe my mother loved me when I was little. 0 1 2 3 4
2. I believe that my father loved me when I was little. 0 1 2 3 4
3. When I was little, other people helped my parents take care of me and they seemed to love me. 0 1 2 3 4
4. I've heard that when I was an infant, someone in my family enjoyed playing with me and I enjoyed it too. 0 1 2 3 4
5. When I was a child, there were relatives in my family who helped me feel better when I was sad or worried. 0 1 2 3 4
6. When I was a child, neighbors or my friends' parents seemed to like me. 0 1 2 3 4
7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me. 0 1 2 3 4
8. Someone in my family cared about how I was doing in school. 0 1 2 3 4
9. My family, friends neighbors and friends talked about making our lives better. 0 1 2 3 4
10. We had rules in our house and were expected to keep them. 0 1 2 3 4
11. When I felt really bad, I could almost always find someone I trusted to talk to. 0 1 2 3 4
12. As a youth, people noticed that I was capable and could get things done. 0 1 2 3 4
13. I was independent and a go-getter. 0 1 2 3 4
14. I believe that life is what you make it. 0 1 2 3 4
15. There are people I can count on now in my life. 0 1 2 3 4

Total Score: _____

Source: https://www.aap.org/en-us/Documents/resilience_ace_screening_parents.pdf

ACE “Screening” - Child



Pediatric ACEs and Related Life Events Screener (PEARLS)
CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.
Please note, some questions have more than one part separated by "OR" if any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:

1. Has your child ever lived with a parent/caregiver who went to jail/prison?
2. Do you think your child ever felt unsupported, unloved and/or unprotected?
3. Has your child ever lived with a parent/caregiver who had mental health issues?
(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Has your child ever lacked appropriate care by any caregiver?
(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?
 Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched, beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child?
 Or has any adult in the household ever hit your child so hard that your child had marks or was injured?
 Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?
9. Has your child ever experienced sexual abuse?
(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)?
(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)

Add up the "yes" answers for this first section:

  **UCSF Benioff Children's Hospital**
Division of Pediatric Behavioral Science

This tool was created in partnership with UCSF School of Medicine.

Please continue to the other side for the rest of questionnaire
Child (Parent/Caregiver Report) - Deidentified

ACE cautions raised

Was developed for population based research studies, not individual clinical care

SO....

- ACE numbers have meaning in average for population – but number does NOT have meaning for individual, particularly in childhood

AND...

- May have associated harms in pediatric setting....

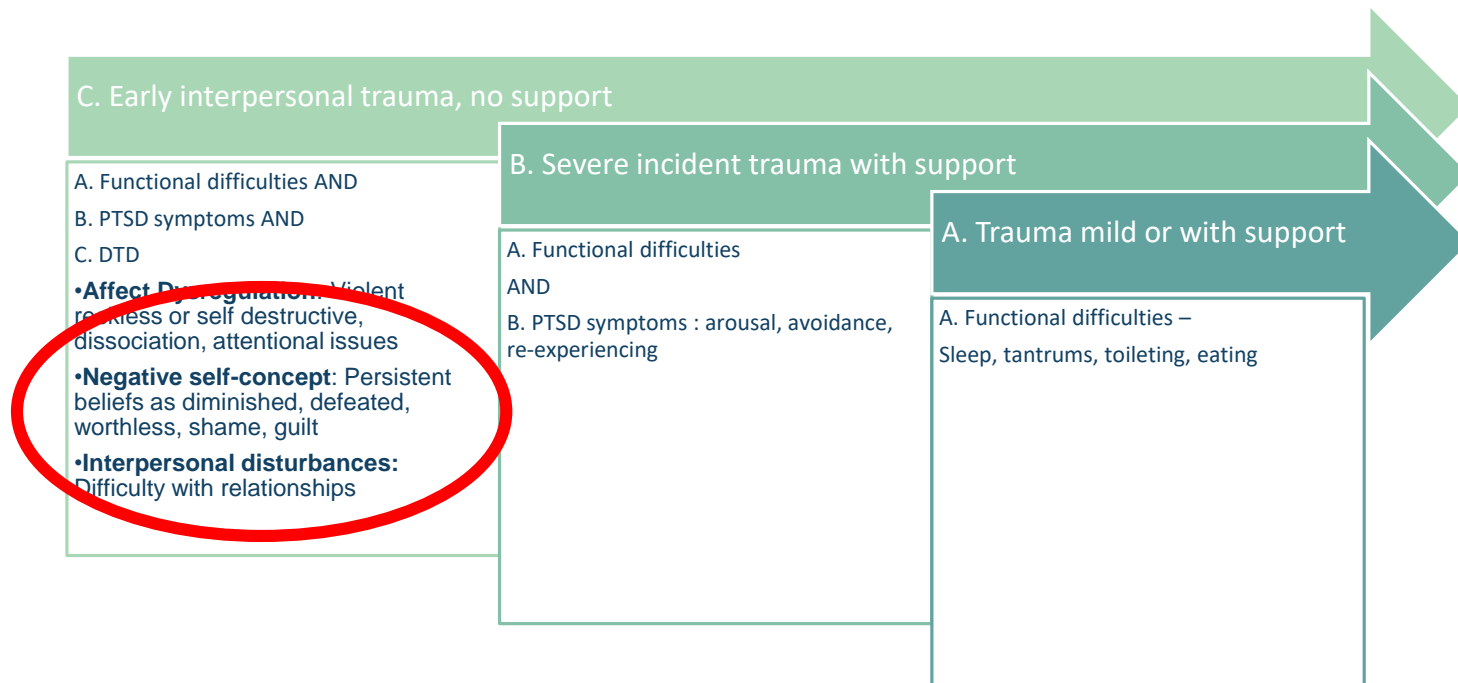
What are the goals: Do no harm

Trauma-informed care (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 experiences on children, caregivers, and healthcare providers.



Resist
re-traumatization
of children, as
well as the adults
who care for
them

Trauma Spectrum: adjustment disorder, PTSD and complex trauma (or DTD) part of spectrum



Do no harm?

Leave people with “my number”
as proxy for care

Danger of screening and not
addressing

Increased rate of reporting to
child welfare

Increased risk to provider – what
to do/secondary trauma



How is screening different?

Brief assessment to identify children who should receive more intensive assessment to determine if they have a **particular** problem



But not really...

Many traumas **not accounted for**

Severity of consequences related to

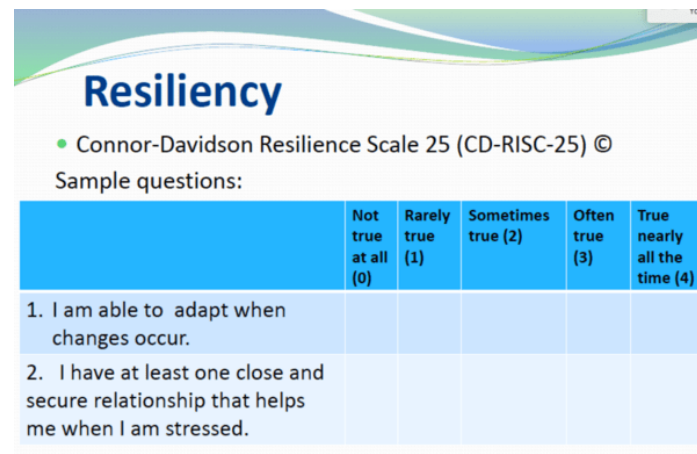
- specific ACE,
- frequency,
- intensity of adversity,
- synergy between ACES,
- current distress and functioning,
- developmental timing
- **ALL NOT ACCOUNTED FOR**



Resilience screening – Usually for caregiver

Resilience scales can help to put risk into perspective

May change tone of conversation with family if start with resilience focus

A graphic titled "Resiliency" for the Connor-Davidson Resilience Scale 25 (CD-RISC-25). It includes a list of sample questions and a response scale. The scale has five columns: "Not true at all (0)", "Rarely true (1)", "Sometimes true (2)", "Often true (3)", and "True nearly all the time (4)". Two sample questions are listed in the first column of a table.

	Not true at all (0)	Rarely true (1)	Sometimes true (2)	Often true (3)	True nearly all the time (4)
1. I am able to adapt when changes occur.					
2. I have at least one close and secure relationship that helps me when I am stressed.					

Connor KM, D.J., *Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC)*. Depression and Anxiety, 2003. **18**: p. 71-82

3. Did you do anything regularly to help others (e.g., volunteer at a hospital, nursing home, church) or do special projects in the community to help others (food drives, Habitat for Humanity)? Yes _____

4. Were you regularly involved in organized sports groups (e.g., soccer, basketball, track, or other physical activity (e.g., competitive cheer, gymnastics, dance, marching band)? Yes _____

5. Were you an active member of at least one civic group or a non-sport social group such as scouts, church, or youth group? Yes _____

6. Did you have an engaging hobby — an artistic or intellectual pastime either alone or in a group (e.g., chess club, debate team, musical instrument or vocal group, theater, spelling bee or reading a lot)? Yes _____

PACES: Protective And Compensatory Experiences

What about not looking at risk/history, but symptoms?

Risk (for child or for caregiver)

- ACEs
- Social Determinants of Health (SDOH)

Resilience

Function/Symptoms

- Symptom surveillance
- Screening
 - PTSD
 - Complex trauma

Trauma Symptom Screening – PTSD – UCLA PTSD RI

UCLA PTSD REACTION INDEX FOR CHILDREN/ADOLESCENTS - DSM-5©

Child/Adolescent Name: _____	ID # _____	Age: _____	Sex: <input type="checkbox"/> Girl <input type="checkbox"/> Boy
Grade in School _____	School: _____	Teacher: _____	City/State _____
Interviewer Name/I.D. _____	Date (month, day, year) ____/____/____ (Session # _____)		

TRAUMA/LOSS HISTORY SCREENING QUESTIONS

- Serious Accidental Injury:** Have you ever been in a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where you or someone else was or could have been badly hurt or killed? Have you ever seen a bad accident where someone was badly hurt or killed?
- Illness/Medical Trauma:** Have you ever been so sick that you and your parents (or people taking care of you) were scared that you might die? Did you have a medical treatment that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?
- Community Violence:** Did you ever see a bad fight or shooting in your neighborhood, like between gangs? Were you afraid of getting badly hurt or killed? Have you seen someone mugged, robbed, stabbed or killed in your neighborhood?
- Domestic Violence:** Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?
- School Violence/Emergency:** Were you ever at school when something really scary happened, like a shooting, a stabbing, a fire, where you or someone got badly beaten up or someone attempted or committed suicide?

• Source: Nctsnadmin. Administration and Scoring of the UCLA PTSD Reaction Index for DSM-5 Video. The National Child Traumatic Stress Network. <https://www.nctsn.org/resources/administration-and-scoring-ucla-ptsd-reaction-index-dsm-5-video>. Published April 2, 2018. Accessed April 19, 2019.

Trauma symptoms screening

– PTSD and suicidality –

Intermountain Health

• <https://utahpips.org/cpm/>

Pediatric Traumatic Stress Screening Tool

6–10 years of age

Sometimes violent or very scary or upsetting things happen. This could be something that happened to your child or something your child saw. It can include being badly hurt, someone doing something harmful to your child or someone else, or a serious accident or serious illness.

Has something like this happened to your child recently? Yes No

If 'Yes,' what happened? _____

Has something like this happened to your child in the past? Yes No

If 'Yes,' what happened? _____

If you checked 'yes' on either question above, please continue below.

Select how often your child had the problem below in the past month.

Use the calendars on the right to help you decide how often.



How much of the time during the past month...	None	Little	Some	Much	Most
1 My child has bad dreams about what happened or other bad dreams.	0	1	2	3	4
2 My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	0	1	2	3	4
3 My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1	2	3	4
4 When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	0	1	2	3	4
5 When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1	2	3	4
6 My child has trouble concentrating or paying attention.	0	1	2	3	4
7 My child gets upset easily or gets into arguments or physical fights.	0	1	2	3	4
8 My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1	2	3	4
9 My child has trouble feeling happiness or love.	0	1	2	3	4
10 My child tries not to think about or have feelings about what happened.	0	1	2	3	4
11 My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4
12 My child feels alone even when he/she is around other people.	0	1	2	3	4
13 *Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Not at all	Several days	More than half the days	Nearly every day	

*Adapted from Patient Health Questionnaire (PHQ-C)

Patient Health Questionnaire (PHQ-A)

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Are you currently: on medication for depression not on medication for depression not sure? In counseling

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/going to sleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, — or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total each column				

10. If you are experiencing any of the problems on this form, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

11. In the past year, have you felt depressed or sad most days, even if you feel okay sometimes?
 YES NO

12. Has there been a time in the past month when you have had serious thoughts about ending your life?
 YES NO

13. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?
 YES NO

Pediatric Traumatic Stress Screening Tool — 11 years and older

Sometimes violent or very scary or upsetting things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened recently? Yes No

If 'Yes,' what happened? _____

Has something like this happened in the past? Yes No

If 'Yes,' what happened? _____

If you checked 'yes' on either question above, please continue below:

How much of the time during the past month...	None	Little	Some	Much	Most
1 I have bad dreams about what happened or other bad dreams.	0	1	2	3	4
2 I have trouble going to sleep, waking up often, or getting back to sleep.	0	1	2	3	4
3 I have upsetting thoughts, pictures, or sounds of what happened come to mind when I don't want them to.	0	1	2	3	4
4 When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.	0	1	2	3	4
5 When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
6 I have trouble concentrating or paying attention.	0	1	2	3	4
7 I get upset easily or get into arguments or physical fights.	0	1	2	3	4
8 I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
9 I have trouble feeling happiness or love.	0	1	2	3	4
10 I try not to think about or have feelings about what happened.	0	1	2	3	4
11 I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
12 I feel alone even when I'm around other people.	0	1	2	3	4

(available for download at either: <https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906> or <https://utahpips.org>).

Visual patterns of responses help indicate symptom severity level

Mild symptoms

above, please continue below.

Fill in below in the past month, decide how often.



How much of the time during the past month...	None	Little	Some	Much	Most
1 My child has bad dreams about what happened or other bad dreams.	0	1 ✓	2	3	4
2 My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	0	1 ✓	2	3	4
3 My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1 ✓	2	3	4
4 When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	0	1 ✓	2	3	4
5 When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1 ✓	2	3	4
6 My child has trouble concentrating or paying attention.	0	1	2	3	4
7 My child gets upset easily or gets into arguments or physical fights.	0	1 ✓	2	3	4
8 My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1 ✓	2	3	4
9 My child has trouble feeling happiness or love.	0	1	2 ✓	3	4
10 My child tries not to think about or have feelings about what happened.	0	1	2	3	4
11 My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4
12 My child feels alone even when he/she is around other people.	0	1	2	3	4
13 *Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Not at all ✓	Several days	More than half the day	Nearly every day	

Moderate symptoms

above, please continue below.

Fill in below in the past month, decide how often.



How much of the time during the past month...	None	Little	Some	Much	Most
1 My child has bad dreams about what happened or other bad dreams.	0	1 ✓	2	3	4
2 My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	0	1	2 ✓	3	4
3 My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1	2 ✓	3	4
4 When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	0	1 ✓	2	3	4
5 When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1	2 ✓	3	4
6 My child has trouble concentrating or paying attention.	0	1	2	3	4
7 My child gets upset easily or gets into arguments or physical fights.	0	1	2	3	4
8 My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1	2 ✓	3	4
9 My child has trouble feeling happiness or love.	0	1	2 ✓	3	4
10 My child tries not to think about or have feelings about what happened.	0	1	2	3	4
11 My child has thoughts like "I will never be able to trust other people."	0	1 ✓	2	3	4
12 My child feels alone even when he/she is around other people.	0	1	2	3	4 ✓
13 *Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Not at all	Several days ✓	More than half the day	Nearly every day	

Severe symptoms

above, please continue below.

Fill in below in the past month, decide how often.



How much of the time during the past month...	None	Little	Some	Much	Most
1 My child has bad dreams about what happened or other bad dreams.	0	1	2	3	4 ✓
2 My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.	0	1	2	3	4 ✓
3 My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	0	1	2	3	4 ✓
4 When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.	0	1	2	3	4 ✓
5 When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	0	1	2	3 ✓	4
6 My child has trouble concentrating or paying attention.	0	1	2	3	4
7 My child gets upset easily or gets into arguments or physical fights.	0	1	2 ✓	3	4
8 My child tries to stay away from people, places, or things that remind him/her about what happened.	0	1	2	3 ✓	4
9 My child has trouble feeling happiness or love.	0	1	2	3	4 ✓
10 My child tries not to think about or have feelings about what happened.	0	1	2	3	4 ✓
11 My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4 ✓
12 My child feels alone even when he/she is around other people.	0	1	2	3	4 ✓
13 *Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?	Not at all	Several days	More than half the day ✓	Nearly every day	

Pediatric Traumatic Stress Screening Tool, as shown below.

if you checked 'yes' on either question above, please continue below.

Select how often your child had the problems below in the past month.
Use the calendar on the right to help you decide how often.

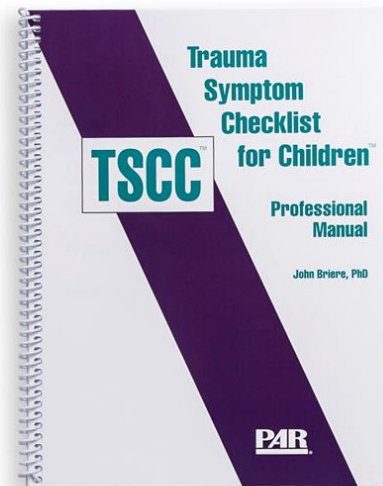
		FREQUENCY RATING CALENDARS				
		None	Little	Some	Much	Most
1	My child has bad dreams about what happened or other bad dreams.	Sleep problems				
2	My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.					
3	My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to.	Both				
4	When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.					
5	When something reminds my child of what happened, he/she gets very upset, afraid, or sad.	Hypervigilance and Intrusive symptoms				
6	My child has trouble concentrating or paying attention.					
7	My child gets upset easily or gets into arguments or physical fights.	Avoidance and negative mood				
8	My child has trouble talking to other people, friends, or others that remind him/her of what happened.					
9	My child has trouble feeling happiness or love.					
10	My child tries not to think about or have feelings about what happened.					
11	My child has thoughts like "I will never be able to trust other people."	Suicide				
12	My child feels alone even when he/she is around other people.					
13	"Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way?"					

TABLE 3. Brief In-office Interventions (for details see page 23)

Sleep problems	<ul style="list-style-type: none"> • Sleep education • Belly breathing • Guided imagery • Medication
Hypervigilant / intrusive symptoms	<ul style="list-style-type: none"> • Belly breathing • Guided imagery • Progressive muscle relaxation • Mindfulness
Avoidance / negative mood symptoms	<ul style="list-style-type: none"> • Behavioral activation • Return to routine • Parent-child communication

(available for download at either: <http://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906> or <https://utahpips.org>).

Trauma Symptom Screening – DTD – Trauma Symptom Checklist



The items that follow describe things that youth sometimes think, feel, or do. Reach each item, then mark how often it happens to you by drawing a circle around the correct number.

- Circle **0** if it **never** happens to you. 0 1 2 3
- Circle **1** if it happens **sometimes**. 0 1 2 3
- Circle **2** if it happens **lots of times**. 0 1 2 3
- Circle **3** if it happens **almost all the time**. 0 1 2 3

For example, if you are late for school **sometimes**, you would circle the **1** for this item, like this:

Being late for school. 0 ① 2 3

	Never	Sometimes	Lots of times	Almost all of the time
1. Bad dreams or nightmares	0	1	2	3
2. Feeling afraid something bad might happen	0	1	2	3
3. Scary ideas or pictures just pop into my head	0	1	2	3
4. Wanting to say dirty words	0	1	2	3
5. Pretending I am someone else	0	1	2	3
6. Arguing too much	0	1	2	3
7. Feeling lonely	0	1	2	3
8. Touching my private parts too much	0	1	2	3
9. Feeling sad or unhappy	0	1	2	3
10. Remembering things that happened that I didn't like	0	1	2	3
11. Going away in my mind, trying not to think	0	1	2	3
12. Remembering scary things	0	1	2	3
13. Wanting to yell and break things	0	1	2	3

Source: Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC), Professional Manual. Odessa, FL: Psychological Assessment Resources.

Other information you may already have:

Developmental or MH screening tools

- *Infancy and early childhood*
 - Development
 - Pediatric Evaluation of Developmental Status (PEDS)
 - Emotional function
 - Brief Infant-Social Emotional Assessment (BITSEA)
 - Both
 - Ages and Stages Questionnaire: Social-Emotional (ASQ – SE)
 - Survey of Well Being of Young Children (SWYC)
- *Early Childhood to Adolescence*
 - General
 - Pediatric Symptom Checklist (PSC)
 - Pediatric Health Questionnaire (PHQ)
 - Symptom specific
 - Vanderbilt ADHD Screening Tool
 - Screen for Child Anxiety Related Disorders (SCAReD)

Some Concerns Go Beyond Routine Office Care and Need Referral



First steps: What we do right away depends on urgency

Right to operating room

- Tissue dying
 - Compartment syndrome
 - Necrosis of bone
- Infection may involve whole body soon
 - Open fracture
 - Septic joint

Right to emergency mental health

- Patient thinking about dying
 - Suicidal
 - Homicidal
- All aspects of life involved
 - can't manage school, home etc.

First Steps: Orthopedic

Stabilization / pain management

- Avoid further injury: immobilize
 - Sometimes also one joint above and one joint below
- Pain management:
 - Ice
 - Analgesia



First Steps: Trauma

Stabilization / pain management

- **S**ay trauma may be the cause
- **P**roblem solve/ **P**rioritize: what is needed to get everyone able to calm down right now
- **L**anguage for child about the problem (why they cant sleep)
- **I**nvestigation further(do you need to ask more, call child welfare)
- **N**ormal response for sleep to be impacted with trauma
- **T**reatment / **T**herapy – things to do at home, if needed referral for treatment

Therapy for trauma

Evidence Based Trauma Therapy: therapies best supported by evidence

- Young children
 - Child Parent Psychotherapy (CPP): 0-6 years
 - Parent Child Interaction Therapy (PCIT): 2-12 years
- Children and Adolescents (3-18 yo)
 - Trauma Focused – Cognitive Behavioral Therapy (TF-CBT)
 - Eye Movement and Desensitization and Reprocessing (EMDR)
- Complex trauma
 - Attachment, Self Regulation and Competency (ARC)

1-855-LINK-KID

For Both, There Are Things to Do at Home

Rest

Ice

Compression

Elevate

Positive parenting

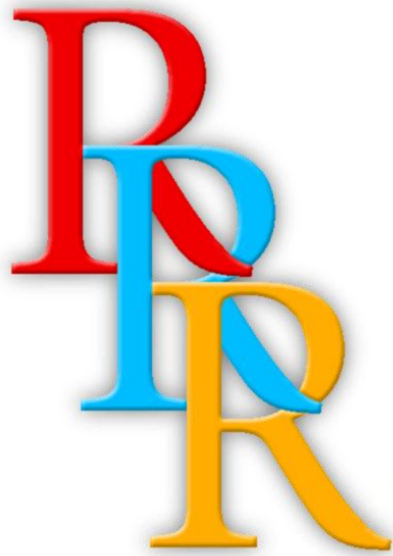
Affective modulation

Self soothing,
relaxation

Triangle training

Attachment

PASTA: Positive Parenting:
Reassuring, Restoring Routine, Regulating



Routines Communicate Safety, Shutting Down Stress Response

Bedtime routine

Brush teeth
Put on jammies
Read story
Get in bed
Kisses
Lights out



Regulating



PASTA: Affect Regulation

Staying calm,
modulating response



Naming feeling, validating





PASTA: Self soothing: 5 senses, relaxation, vestibular and deep proprioceptive

PASTA: Triangle –Processing The Cognitive Triangle





PASTA: Attachment

You already do this: Caregiver provided with empathy— so they can provide empathy for child

Not “I must fix you”, but “I must listen and understand you”



Confident
expectation
of recovery



Questions and Comments