Trauma-Informed Care for Children and Adolescents

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It is generally understood that children or adolescents who have experienced trauma, such as child maltreatment, will experience physical and psychological effects as an increasing body of evidence has demonstrated a strong direct relationship between these adverse childhood experiences (ACEs) and adult physical and psychological health.\(^1\) Two decades after the groundbreaking publication by Felitti et al.\(^1\) on this association between our experiences in childhood and health, it is recognized that ACEs include exposures to trauma beyond abuse, neglect, and household dysfunction to include housing insecurity,\(^2\) peer victimization,\(^3\) racial discrimination, community violence exposure, and family separation.\(^4\) The identification of ACEs and trauma symptoms in children is a surveillance tool as the associations with the development of chronic disease are clear, and because childhood adversity is the public health crisis of the 21st century. However, screening for ACEs in practice may have limitations. Adverse experiences are chronic and prolonged rather than single exposures, and screening as a means of preventing harmful outcomes implies that providers have access to effective or helpful interventions.\(^5\) Furthermore, screening may not identify the positive experiences and relationships that build resilience and protect children and adolescents from the effects of trauma. Developing an approach in primary care practice may not require specific tools but rather active listening and acknowledgment of the effects of trauma, and engagement of strategies that families can use in the home in partnership with the primary care provider.

Although many pediatricians are now knowledgeable about ACEs, few providers are incorporating screening for ACEs into practice either in children or in a dyadic approach to include caregivers.\(^6,7\) This reflects both a need for further training as well as a need for validated tools and approaches that can be easily incorporated into practice. In the article “Screening for Adverse Childhood Experiences in Pediatric Primary Care: Pitfalls and Possibilities,” Dr. Robert J. Gillespie provides an overview of this incorporation of the dyadic approach in practice as well as education on navigating difficult conversations with families and identifying resources for families. Through such a dyadic approach in practice, the author identified a direct correlation between caregiver ACEs and development delay in young children.\(^8\)

Employing a dyadic approach in screening for childhood adversity and toxic stress assumes that the primary care provider recognizes the importance of the parent or caregiver’s role in providing a nurturing positive relationship to buffer the effects of trauma. The article, “New Approach to Pediatric Treatment Planning to Support Caregivers Living with Adversities,” by Dr. Anu Partap provides an essential glimpse into the world of the caregiver whose own adversity may prevent them from providing a secure base of attachment for the child. Dr. Partap discusses how a primary care provider can identify conditions that suggest family based adversity and develop a treatment plan that assists the caregiver in becoming a buffering support for their child.

Once a primary care provider has recognized the role stress plays on a child physically and psychologically, the provider is “Putting Your Trauma Lens On,” according to the article’s author, Dr. Heather Forkey. Dr. Forkey provides an approach to recognize and respond to trauma symptoms in children through the organization of the most common trauma symptoms into a framework that can be easily used by the provider to develop practical guidance for families so that the caregiver can focus on attachment and the family can rebuild resilience skills.

It is not uncommon for the first experience with partner violence to occur in adolescence. There is a complex relationship between childhood adversity and an increased risk for adolescent relationship abuse (ARA) and sexual violence (SV). It is important for primary care providers to recognize adolescents who are at heightened vulnerability for violence victimization as well as recognize signs and symptoms associated with exposure to ARA and
SV. In the article, “Trauma-Informed Approaches to Adolescent Relationship Abuse and Sexual Violence Prevention,” Dr. Elizabeth Miller discusses the critical role primary care providers have in developing a trauma-informed practice as well as in providing universal education and anticipatory guidance to adolescents.

The last article, “Pediatrician’s Practical Approach to Sleep Disturbances in Children Who Have Experienced Trauma,” by Drs. Brooks R. Keeshin, Steven J. Berkowitz, and Robert S. Pynoos, addresses the most common challenge facing children who have experienced trauma. The authors provide a framework to understand specific sleep difficulties and to differentiate symptoms of sleep deprivation from childhood disorders. Recognition of the specific sleep disturbance, through an understanding of the trauma exposure, can lead to a treatment partnership between the caregiver and primary care provider with an improvement in the child’s sleep.

It is my hope that this issue provides a framework for developing a trauma-informed approach to children, adolescents, and caregivers exposed to childhood adversity and toxic stress and brings us closer to universal surveillance in a dyadic approach as caregivers play a central role in building resilience in children.

REFERENCES

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Nancy S. Harper, MD, FAAP, is an Professor of Pediatrics at the University of Minnesota, and the Medical Director for the Otto Bremer Trust Center for Safe & Healthy Children at University of Minnesota Masonic Children’s Hospital and Hennepin Healthcare. Dr. Harper graduated from the Geisel School of Medicine in 1995 and completed her pediatric residency in 1998 at Naval Medical Center Portsmouth in Virginia. After graduation, Dr. Harper served as a staff pediatrician and child abuse consultant for Naval Medical Center Portsmouth and the US Naval Hospital Okinawa in Japan. In 2004, Dr. Harper resigned from the US Navy and entered fellowship training in Forensic Pediatrics at Brown University, graduating in January 2007.

Dr. Harper is board certified in general pediatrics and child abuse pediatrics. From 2007 to 2014, Dr. Harper served as the Medical Director for the CARE Team at Driscoll Children’s Hospital in Corpus Christi, TX. Governor Rick Perry appointed Dr. Harper to the statewide Blue Ribbon Task Force to Reduce Child Abuse and Neglect (2009-2011) and the Task Force to Reduce Child Abuse and Neglect and Improve Child Welfare (2011-2013).

Dr. Harper also served as the Program Chair for the American Academy of Pediatrics (AAP) Section on Child Abuse and Neglect from 2012 through 2017 and as Program Chair for the AAP Trauma-Informed Pediatric Provider Course in 2019. Dr. Harper is invested in improving educational opportunities on child maltreatment both nationally and internationally.

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