



Pediatric Approach to Trauma,  
Treatment and Resilience

## PATTeR CHAT LEVEL 2

*Child Health Advice for Trauma (CHAT)*

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN®

# PATTeR CHAT

**The following is designed to be a resource for those who have completed the Pediatric Approach to Trauma, Treatment and Resilience (PATTeR) course.**

These resources are intended to be used as reminders of curricular material, tools that can be adapted for office or clinic use, and handouts to share with colleagues or patients. This is not intended to be a review or summary of the course and is not intended to substitute for participation in the PATTeR program. The resources are organized by the lessons of PATTeR Level 1 and 2.

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*For more information about the PATTeR project or to request a hard copy of the manual, visit [www.aap.org/PATTER](http://www.aap.org/PATTER)*

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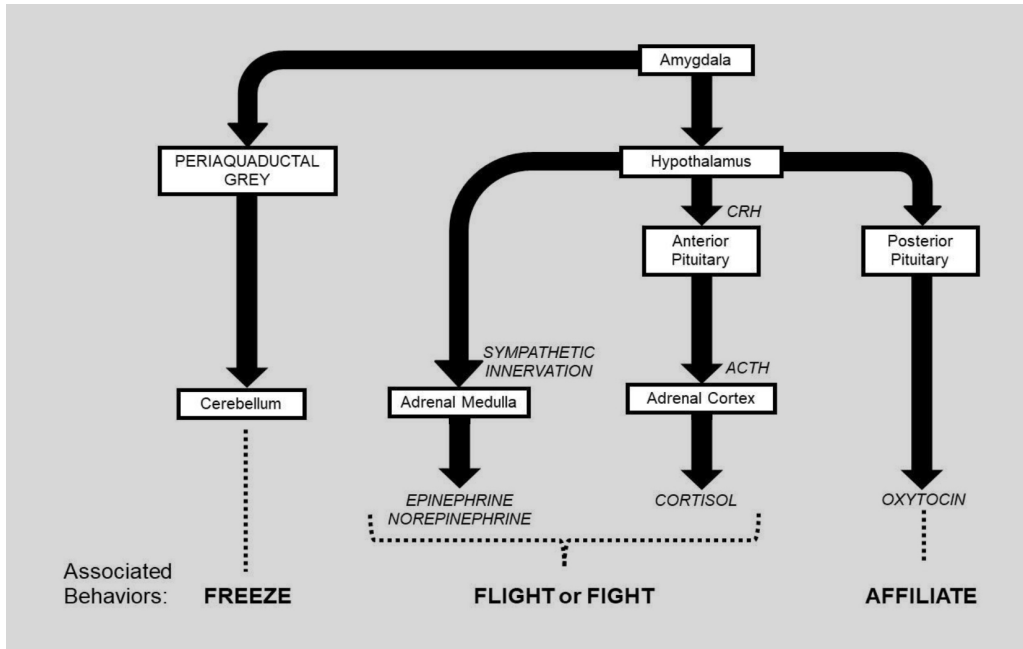
**LEVEL 2**  
**LECTURE 1**

# Burnout and Secondary Traumatic Stress

**Learning Objectives:**

- Identify the symptoms of burnout and secondary traumatic stress
- Recognize the four types of human stress response and how they contribute to burnout and secondary traumatic stress (STS)
- Consider the role of affiliate response in preventing burnout and STS
- Develop a strategy to promote the affiliate response in the workplace

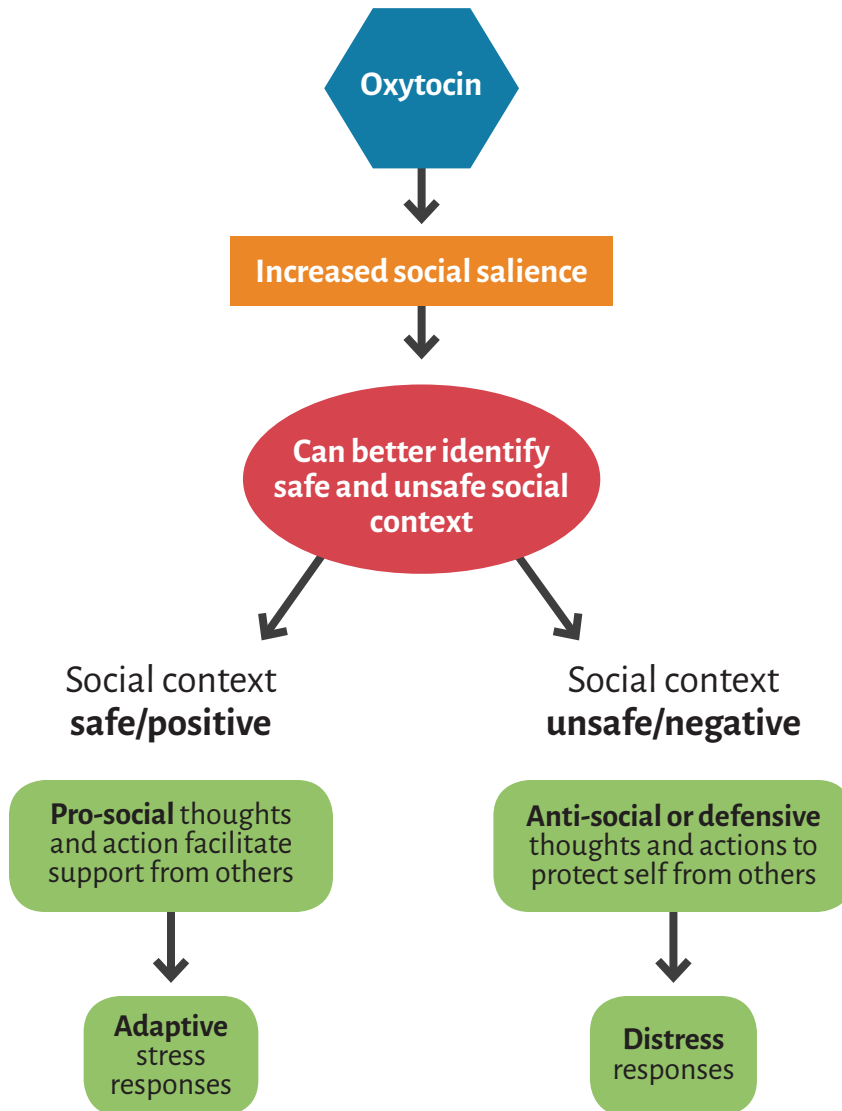
# Variable Responses to Threat



SOURCE: Garner AS, Saul RA. Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health. Itasca, IL: American Academy of Pediatrics; 2018



## ROLE OF OXYTOCIN IN IMPACTING SOCIAL SALIENCE







#### SOURCES

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2. Olff, M., Frijling, J. L., Kubzansky, L. D., Bradley, B., Ellenbogen, M. A., Cardoso, C., . . . van Zuiden, M. (2013). The role of oxytocin in social bonding, stress regulation and mental health: an update on the moderating effects of context and interindividual differences. *Psychoneuroendocrinology*, 38(9), 1883-1894. doi:10.1016/j.psyneuen.2013.06.019
3. Taylor SE. Tend and befriend: biobehavioral bases of affiliation under stress. *Current Directions in Psychological Science*. 2006;15(6):273-277.
4. Taylor SE, Klein LC, Lewis BP, Gruenewald TL, Curung RA, Updegraff JA. Biobehavioral responses to stress in females: tend-and-befriend, not fight-or-flight. *Psychol Rev*. 2000;107(3):411-429.

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**LEVEL 2**  
**LECTURE 2**

# Epigenetics and Trauma

## **Learning Objectives:**

- Review the basic mechanisms of epigenetic changes that affect health. Using historical lessons, these mechanisms will demonstrate the application to population health.
- Identify the changes that can occur in children secondary to epigenetic alterations.
- Illustrate the current application of epigenetic principles to primary care practice.

## **Epigenetics**

Epigenetics is the study of changes in gene expression that are stable and potentially heritable and do not change the DNA sequence.



# Epigenetics

Epigenetics, the change in gene expression without actual change in the gene sequence, can lead to the ability of the body to alter our biologic response to our environment and our experiences and change how we physiologically adapt to the world and people around us. Prolonged significant stress without buffering by relationships leads and resulting changes in cortisol alters gene expression so that the brain structures that help us recognize and deal with danger are heightened at the expense of the thinking, learning and regulatory areas of the brain.

## **Adult-Onset Diseases are Adult-Manifest Diseases from Childhood Exposures and Events**

Through epigenetic mechanisms, early childhood ecology is biologically embedded and potentially leads to changes in the way the genetic blueprint is expressed.

- Epigenetic changes can occur in utero
- Changes can affect postnatal development of the infant/child and can occur in germ cells (sperm or ovum)
- Changes can be secondary to environmental influence and passed on to subsequent generations
- Trans-generational effects may emerge in 1-2 generations
- Monozygous twins demonstrate some divergence in methylation rates of certain genes (in about 1/3 of MZ twins)

## **Key Factors That Can Result in Epigenetic Changes**

- Asthma
- Chemical exposures
- Diet during slow growth period
- Endocrine disrupting compounds (BPA)
- Hypoxia
- Maternal diabetes
- Maternal habitus, maternal age, placenta size
- Maternal smoking
- Psychosocial stress
- Psychological trauma

## **Implications of Epigenetics for Pediatric Practice**

- Dynamic changes over time—positive and negative
- Epigenetic changes not fixed but not easily malleable either
- Multiple exposure points
- Potential lifetime effects
- Potential multi-generational effects
- Trauma-informed care can potentially ameliorate some effects and their transgenerational passage
- Never too late to make a difference!

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**LEVEL 2**  
**LECTURE 3**

# Understanding Attachment: A Deeper Dive

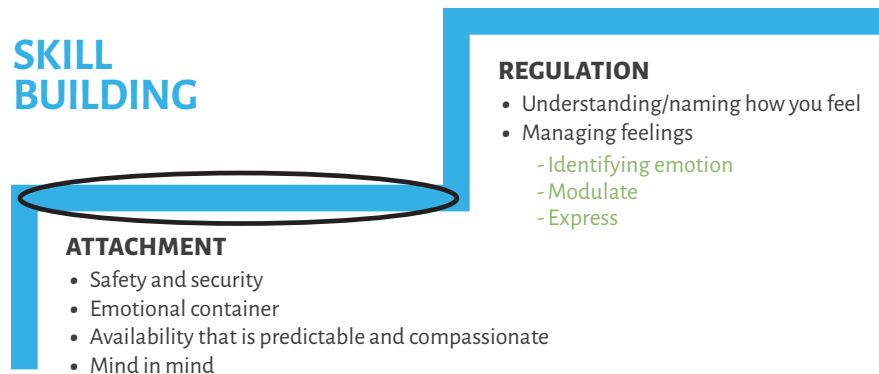
## **Learning Objectives:**

- Recognize that attachment provides a safe haven and a secure base and that a main function of attachment is emotional regulation.
- Identify characteristics of secure attachment in children and in adult relationships.
- Explain the first steps to take with caregivers to restore attachment.

# Attachment Patterns

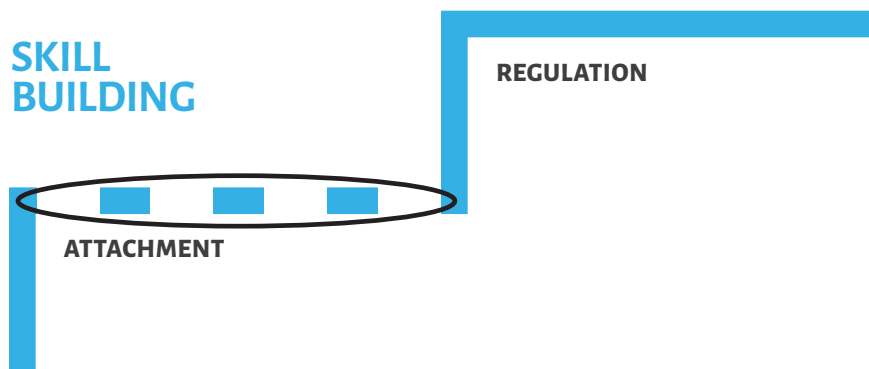
## 1. Secure Attachment

In the context of a safe, nurturing caregiver who is stable over time in the child's life, the child comes to view their caregiver as loving and dependable and the self as lovable and worthy of care. The **secure attachment relationship** is one in which the caregiver displays sensitive responsiveness, warmth and affection and is attuned to signs of the child's distress. The caregiver interprets the child's affect and emotions accurately and responds appropriately, promptly and predictably. The caregiver engages in their child's activities in ways that are cooperative and helpful without interfering. The child comes to view the caregiver as predictable and nurturing. In the context of their responsive, attuned, stable caregiver, the child learns how to regulate their emotions, enabling the thinking and learning brain to master age-appropriate developmental tasks. The secure attachment relationship is one in which the bottom stair of the staircase to resilience is solid and secure.



## 2. Ambivalent Attachment

In ambivalent attachment, the child's efforts to regulate are met with inconsistent caregiver response and the child keeps trying, but only gets the support they need sometimes. In the face of an inconsistently responsive caregiver, such as a parent with substance use disorder, a child may intensify their signs of distress and angry protests (tantrums) to force attention and responsiveness from a caregiver who lacks psychological attunement. The infant turns up the dial to elicit care, a demanding strategy that works sometimes. The attachment pattern becomes ambivalent because the desire for care is intermingled with feelings of deprivation and frustration caused by an inconsistently available caregiver. Both the caregiver and child develop resentment due to this coercive behavior. If you consider our stair analogy, the attachment step is shaky. Children are not sure if support will be provided when needed, as it sometimes is and sometimes isn't. It is consistently inconsistent.



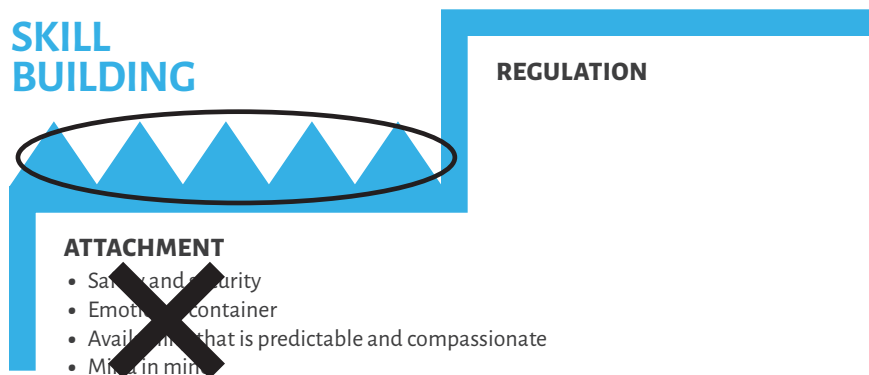
## 3. Avoidant Attachment

The avoidant attachment pattern most often develops when caregivers are rejecting. The rejecting behavior may be subtle or overt and caregivers may even try to suppress how they feel toward the child. Caregivers with mental illness or substance use disorder may be averse to body contact, irritated by the child's demands, rigid, compulsive, or may not want to be interrupted by the infant; they may become frustrated quickly when the infant does not comply. Avoidance is a response to the caregiver who is consistently emotionally unavailable or to the irritable caregiver who communicates, "don't bother me with your needs." The child's efforts to regulate are not supported and the child is forced to regulate as best they can by themselves. In the stair analogy, there is no bottom step and so there is no one but self to turn to for regulating.



#### 4. Disorganized Attachment

Finally, in some cases of parental mental illness or abuse, the caregiver is either frightened or frightening and misreads the child's cues, leading to disorganized attachment. The caregiver may be overwhelmed or overly intrusive so that the child is fearful and tries to "escape" the caregiver. This fear is superimposed on another predominant attachment pattern (secure, avoidant, or ambivalent). In these relationships, the most basic strategy for reducing fear, seeking the caregiver, only exacerbates the fear, and the child then has no way to resolve their fear. Disorganized attachment is fright without solutions. The caregiver not only does not respond appropriately to the child, but is the cause of the child's fear, making relationships and attachment something to actively reject. Sometimes this is called "attachment trauma." In our stair analogy, the attachment step is not solid, but is also not absent. Rather, the caregiver (or step) is dangerous and injurious and the relationship is to be avoided and/or sabotaged.



#### SOURCE

Allen JG. Restoring Mentalizing in Attachment Relationships: Treating Trauma with Plain Old Therapy. Arlington, VA: American Psychiatric Publishing; 2013.

# Attachment Patterns in Childhood, Adult Relationships and Parenting

## Attachment Patterns and their Consequences in Childhood and Adulthood

Attachment Type	Impact on Child Development	Impact on Relationships In Adulthood	Impact on Caregiving
<b>Secure attachment</b>	<ul style="list-style-type: none"> <li>• Good self-regulation of emotional distress with others and on their own</li> <li>• Easygoing</li> <li>• More socially competent</li> <li>• Empathetic and caring</li> <li>• More positive relationships</li> <li>• Curious and persistent in problem solving</li> <li>• Seek help when need it—effective dependence (not independence)</li> </ul>	<b>Secure attachments</b> <ul style="list-style-type: none"> <li>• Comfortable in relationships</li> <li>• Able to seek support from partner</li> </ul>	<b>Secure attachments</b> <ul style="list-style-type: none"> <li>• Sensitive responsive</li> <li>• Consistently emotionally available</li> </ul>
<b>Ambivalent attachment</b>	<ul style="list-style-type: none"> <li>• More anxious and easily frustrated</li> <li>• Passively helpless and excessively dependent</li> <li>• Less able to perform well in novel situations</li> </ul>	<b>Preoccupied attachment</b> <ul style="list-style-type: none"> <li>• Fears rejection from partner</li> <li>• Strong desire to maintain closeness</li> </ul>	<b>Ambivalent</b> <ul style="list-style-type: none"> <li>• Inconsistent</li> <li>• Emotionally unavailable</li> <li>• Under-involved</li> </ul>
<b>Avoidant</b>	<ul style="list-style-type: none"> <li>• Most isolated</li> <li>• Tend to be hostile and emotionally insulated</li> <li>• Will bully and victimize ambivalent children</li> <li>• Most disliked</li> </ul>	<b>Dismissing</b> <ul style="list-style-type: none"> <li>• Greater sense of autonomy</li> <li>• Cuts themselves off emotionally from others</li> </ul>	<b>Avoidant</b> <ul style="list-style-type: none"> <li>• Rejects infant's attempt to seek comfort when distressed</li> <li>• Unemotional with infant</li> <li>• OR Intrusive, controlling, overstimulating</li> </ul>
<b>Disorganized</b>	<ul style="list-style-type: none"> <li>• Emotionally dysregulated or dissociated</li> <li>• May be controlling—punitive or overly caregiving</li> </ul>	<b>Disorganized</b> <ul style="list-style-type: none"> <li>• Fears intimacy or vulnerability</li> <li>• Little empathy for others</li> <li>• Does not understand boundaries</li> <li>• Extreme rage or anger responses</li> </ul>	<b>Disorganized</b> <ul style="list-style-type: none"> <li>• Frightened/frightening behavior</li> <li>• Dissociative states</li> <li>• Hostile intrusiveness (mocking infant) or fearful withdrawal (silence)</li> <li>• Emotionally overwhelmed by child's distress</li> <li>• Role confusion and contradictory cues (encourage closeness while physically withdrawing)</li> <li>• Disabled caregiving or abdication of care</li> </ul>





#### SOURCES

1. Ainsworth MD. Attachments beyond infancy. *The American psychologist*. 1989;44(4):709-716.
2. Allen JG. Restoring Mentalizing in Attachment Relationships: Treating Trauma with Plain Old Therapy. Arlington, VA: American Psychiatric Publishing; 2013
3. Benoit D. Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & child health*. 2004;9(8):541-545.
4. Hughes DA, Baylin J. The Neurobiology of Attachment-Focused Therapy: Enhancing Connection and Trust in the Treatment of Children and Adolescents. New York: W.W. Norton & Company; 2016.
5. Perry RE, Blair C, Sullivan RM. Neurobiology of infant attachment: attachment despite adversity and parental programming of emotionality. *Current opinion in psychology*. 2017;17:1-6.
6. Porges SW. Social engagement and attachment: a phylogenetic perspective. *Annals of the New York Academy of Sciences*. 2003;1008:31-47. 14.

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**LEVEL 2**  
**LECTURE 4**

# Parental Adverse Childhood Experiences (ACEs)

**Learning Objectives:**

- Describe the impact of a parent's own ACEs on their parenting capacity.
- Discuss ways in which parental toxic stress can present in the pediatric health care setting.
- Discuss specific ways in which pediatric health care providers can assist a parent with toxic stress.

# Parental ACE Associated with Negative Outcomes for Children

- For each point increase in parent ACE score, there is a 19% increase of odds of poor child overall health (odds of asthma increase by 17%)<sup>1</sup>
- Mothers with an ACE exposure of > 3 were 2.23 more likely to have children with suspected developmental delay than those with ACE < 3<sup>2</sup>
- As parent ACE score increases, likelihood of child ACE increases<sup>3</sup>

## When to Consider Parent ACEs

- Missed appointments
- Chronically late
- Lack of compliance
- Lost medications

Parents may also show FRAYED symptoms similar to those of children. Parents may have excessive anxiety/worry about their child's health or other concerns. They may have difficulty regulating their emotions and lose their temper quickly. Some parents may have attunement problems, which include difficulty reading their child's physical and emotional needs and responding to them appropriately. Parents may struggle with alcohol or substance abuse. Parents may yell at their children frequently, respond disproportionately to a situation or they may simply appear to be exhausted (beyond what is typical). Overwhelmed parents may seem detached, attending to a cellphone screen in the exam room without eye contact with the provider.

### **Parental FRAYED Symptoms**

- **F**ear, **F**ighting, **F**retting
- **R**egulation difficulties – inability to control emotions and temper
- **A**ttunement challenges – difficulty reading child needs and responding appropriately
- **A**lcohol and Substance abuse
- **Y**elling, harsh/punitive parenting
- **E**xhaustion
- **D**efeated/**D**etached/**D**epressed

### **We Want to Promote Caregiver THREADS**

- **T**hinking – problem solving, remaining curious
- **H**ope – looking ahead
- **R**egulation/Self control of emotions
- **E**fficacy – belief that they can be a good parent
- **A**ttunement to child – ability to read child's needs and moods and react appropriately
- **D**etached Empathy and Self Care – not relying on children as a barometer of their own self-worth, healthy parenting allows some distance and includes self-care
- **S**ocial Connectedness

#### **To support these:**

- Address psychological, emotional and physical safety needs
- Promote healthy relationships and attachment
- Encourage foundational coping skills as they emerge
- **R**elationship – the most important vital sign



## SOURCES

1. *Félice Lê-Scherban, Xi Wang, Kathryn H. Boyle-Steed, Lee M. Pachter.* Intergenerational Associations of Parent Adverse Childhood Experiences and Child Health Outcomes. *Pediatrics*. 2018;141(6):e20174274; DOI: 10.1542/peds.2017-4274
2. *Alonzo T. Folger, Emily A. Eismann, Nicole B. Stephenson, Robert A. Shapiro, Maurizio Macaluso, Maggie E. Brownrigg, Robert J. Gillespie.* Parental Adverse Childhood Experiences and Offspring Development at 2 Years of Age. *Pediatrics*. 2018;141(4)
3. *Randell KA, O'Malley D, et al.* Association of parental adverse childhood experiences and current child adversity. 2015 *JAMA Pediatr* 169(8) : 786-7.

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**LEVEL 2**  
**LECTURE 5**

# Positive Purposeful Parenting

**Learning Objectives:**

- Discuss engaging families around family context and parenting goals.
- Review positive parenting principles viewed through a developmental lens.
- Illustrate how modifying parenting approaches in face of trauma can promote resilience.



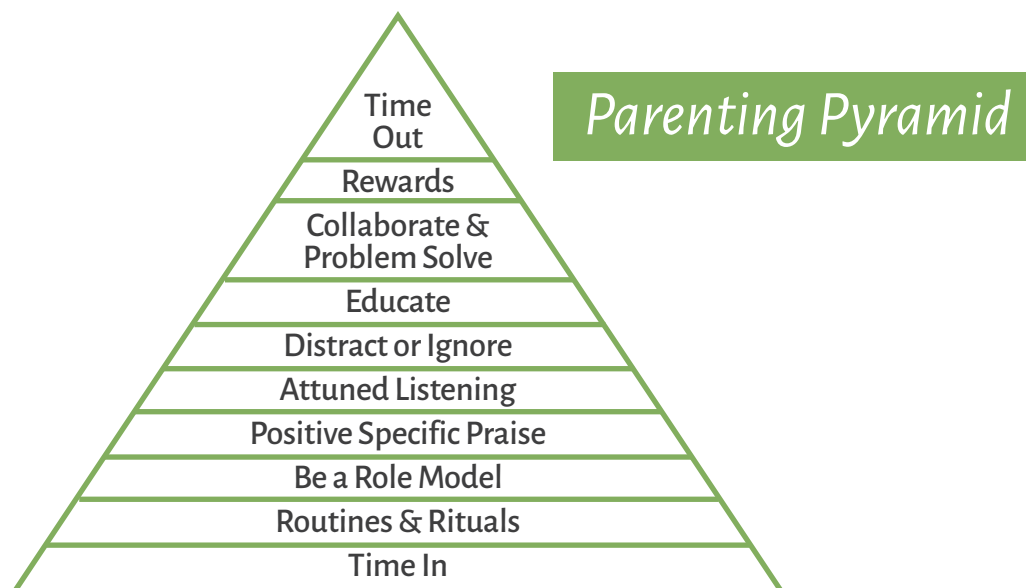
# Questions to Engage Families Around Parenting

## For Families with Newborns or Family New to You

- How were you raised and how are you planning to raise your child/children?
- What are your goals for your family or your child?
- For those with parent partner: Are you both on the same page when it comes to raising children?

## For Families You Already Have a Relationship With

- Are you raising your child(ren) the same way you were raised?
- Tell me about your family.
- Help me understand what is important to you about parenting or raising children?
- What do you find rewarding or stressful about parenting?



## Parenting Approach: LACE<sup>1</sup>

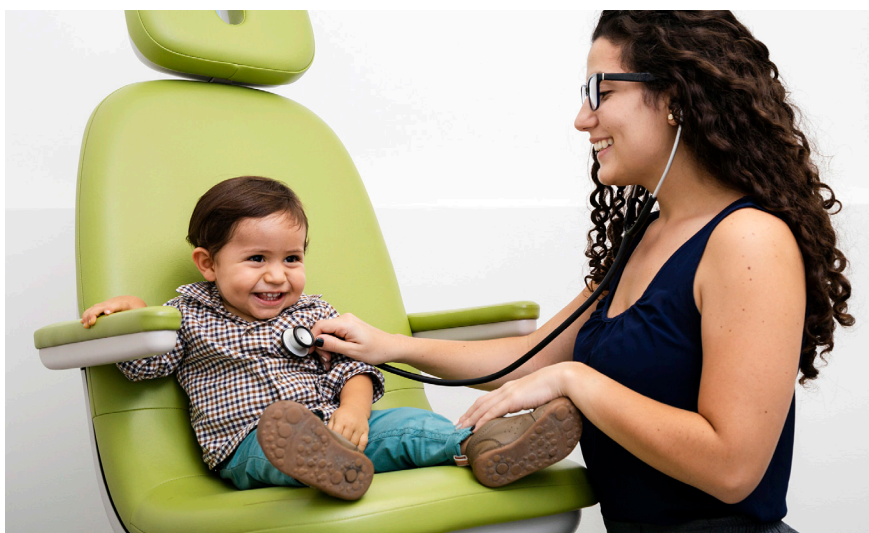
- **L**ighthearted – Use humor
- **A**cceptance – Remain calm, think before you speak, be an emotional container
- **C**uriosity – Be curious, not furious
- **E**mpathy – child is doing best he/she can in the circumstances

## Supporting the Parent with a Trauma History

- Focus on SAFETY for both parent and child
- Validate that “parenting is hard work” and point out any successes parent has had or shown, even small ones
- Build hope: “you can do it” and that we will work on this together (partnering)
- Ask them what tried and what has worked
- Remind parents that if behaviors escalate, they are not failing, child is adapting
- Offer a short menu of skills and let them choose which one to work on first:
  - Special time in: set aside a set amount of time each day to focus fully on your child (10 minutes)
  - Specific praise
  - Reassure, Return to routine, Regulate
  - Distraction
- Break down each skill into smaller steps to make more doable; success breeds success
- Close follow-up

### SOURCE

1. Hughes DA, Baylin J. The Neurobiology of Attachment-Focused Therapy: Enhancing Connection and Trust in the Treatment of Children and Adolescents. New York: W.W. Norton & Company; 2016.



## 3 Rs

### Reassure

Let child know they are safe. This can be said with words, or conveyed via hugs, safe spaces in the home.

- Say, “Yes that happened, but you are safe now.”
- Touch for reassurance— hand on shoulder, hand on back, high fives; if appropriate, hugs, rubbing back
- Safe places within home: set up a tent in bedroom for child, canopy or dome over bed, own safe chair, weighted blankets, a small quiet area

### Return to Routine

Routines for meals, bedtime, household schedules, mornings and transitions all help children to know what to expect.

- Create charts for routines with or without visual (picture) prompts depending on age— bedtime, mealtime, homework, chores charts
- Explain if there will be a change in the schedule, prepare kids ahead of time
- Set up routines for before and after visits with parents in cases of foster/kinship care or parent separation, changes in schedule (e.g., before visit read same story, look at pictures of parents and foster family, after visit have same game, book, meal etc.) Some children need quiet time after transitions while others need to run off their energy so caregiver should adapt transition support to their child’s needs.
- Family traditions and rituals can connect or reconnect children and adults with their own culture, traditions, faith and community and provide support and security, especially in coping with stress.

### Regulate

Discuss skills for self-calming (belly breathing, stretching, relaxation), name feelings (colors of emotions, words for feelings), and manage emotions.

- Teach relaxation techniques— guided relaxation, belly breathing, guided visualization, tense and release of muscles, yoga poses, stretching
- In calm moments, discuss words for feelings, do feelings charades (act out hungry, disappointed, satisfied, proud etc.), think of colors for moods, talk about where in the body child feels emotion (stomach, head, chest etc.)
- Practice skills to use when a child gets upset or angry. Practice seeking adult attention or comfort (asking for a hug or to talk with adult)

Positive parenting principles are the same across the age span but might be applied somewhat differently. For example, the “serve and return” between caregiver and newborn becomes attuned attentive listening and conversation with an older child or adolescent.

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**LEVEL 2**  
**LECTURE 6**

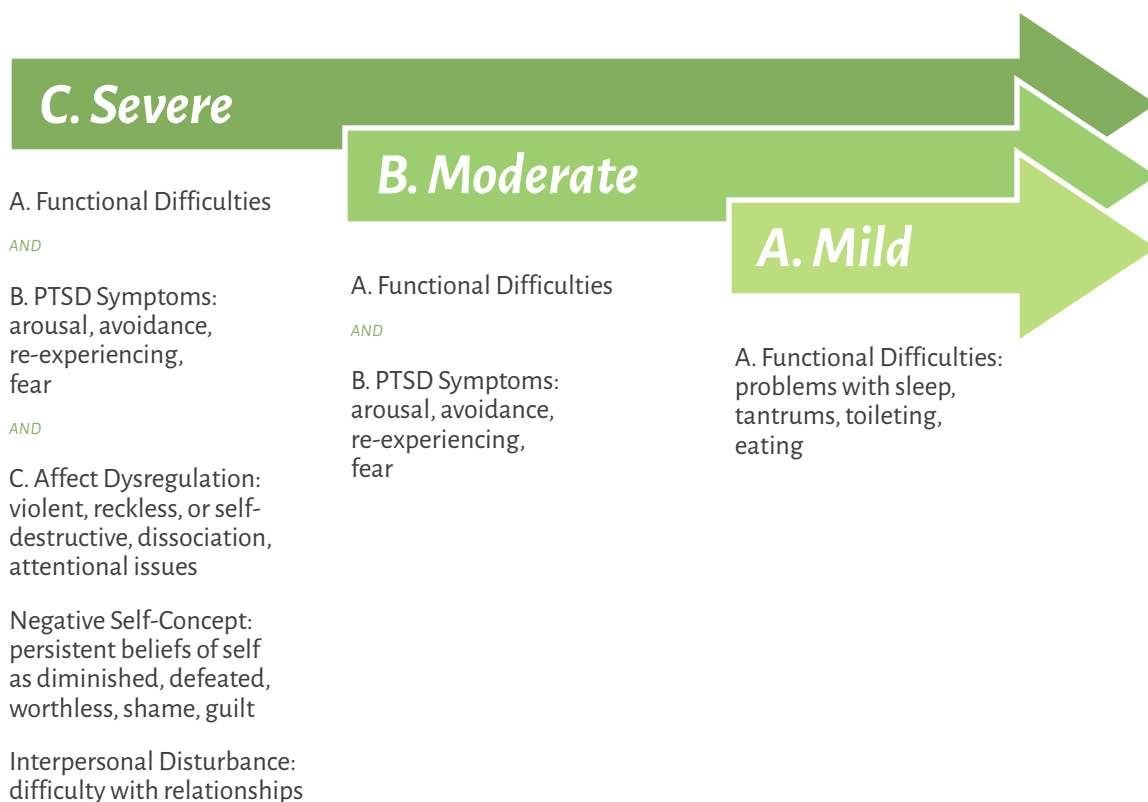
# Trauma Hierarchy: Differential Diagnosis of Trauma

## **Learning Objectives:**

- Recognize that trauma includes a spectrum of symptoms
- Apply FRAYED construct to identify trauma symptoms children may present with
- Identify clinical presentations of FRAYED symptoms and link them to the physiology of trauma

# Trauma Hierarchy

How Adjustment Disorder, PTSD and Complex Trauma (Developmental Trauma Disorder) are linked



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**LEVEL 2**  
**LECTURE 7**

# Culture and Trauma

**Learning Objectives:**

- Define culture
- Articulate the intersection between culture and trauma
- Define cultural responsiveness
- Define cultural humility and describe how to practice it in the provision of services
- Identify strategies to be culturally responsive



# Weaving the Threads of Culture

- Every area of human development has a cultural component. Your culture helps define HOW you attach to others and parent children. HOW you express emotion. HOW you learn. HOW you stay healthy.<sup>1</sup>
- Culture frames and shapes how we perceive the world and our experiences including health and health care.
- Culture plays a significant role in transmitting, perceiving, buffering, responding to, and healing and recovering from trauma.<sup>2,3</sup>
- Culture acts as a template for interpreting and responding to traumatic events.<sup>4</sup>

## Culture Helps to Define

- What is considered a health problem
- What patients and health care providers believe about the causes of disease
- How illness/trauma and pain are experienced and expressed
- How health care information is received
- Who should provide treatment for the problem and what type of treatment should be given

And because health is conceptualized through a cultural lens, cultural issues are actually central in the delivery of quality culturally sensitive health care services.

## Common Traumatic Stress (FRAYED) Reactions in Response to Racial Trauma

Trauma Symptoms	Historical and race-based trauma symptoms
<b>F</b> Frets and fear, chronic fear, anxiety	<ul style="list-style-type: none"> <li>• Fear that trauma and loss will continue for self and for future generations</li> <li>• Internalized feelings of fear engendered by elders' stories</li> </ul>
<b>R</b> Regulation difficulty: lack of self-regulation, emotional and behavioral dysregulation	<ul style="list-style-type: none"> <li>• Self-destructive behavior</li> <li>• Self-hatred resulting from assaults on one's sense of self</li> <li>• Hypersensitivity to threat, even to minimal threat</li> <li>• Increased vigilance and suspicion</li> <li>• Rage</li> <li>• Violent behavior</li> </ul>
<b>A</b> Attachment difficulty	<ul style="list-style-type: none"> <li>• Negative cognitive frames about relationships with people outside own racial group</li> <li>• General mistrust</li> </ul>
<b>Y</b> Yelling and Yawning, Yucky Feeling	<ul style="list-style-type: none"> <li>• More pervasive irritability, oppositional behavior, sleep problems, somatic concerns</li> </ul>
<b>E</b> Educational and developmental delays, impaired learning and thinking	<ul style="list-style-type: none"> <li>• Erosion of personal identity and cultural identity</li> </ul>
<b>D</b> Defeated, dissociating, or depressed feeling	<ul style="list-style-type: none"> <li>• Sense of a foreshortened future</li> <li>• General loss of both meaning and sense of hope</li> <li>• Despair</li> <li>• Perceiving the world as a hostile place Internalized devaluation and voicelessness</li> <li>• Poor or altered sense of self</li> </ul>

## When Threats and Danger Are in the Air: MIST

Historical trauma, race-based trauma, and other traumatic events experiences are like a MIST<sup>5</sup> for specific cultural groups: they permeate the air. Some traumatic experiences may be subtle, pervasive or even intended as a compliment, such as MIST that hangs in the air.

- **M**icroaggressions
- **I**mplicit bias
- **S**tereotype threat
- **T**argeted identities

These threats in the air can trigger traumatic stress.

### Microaggressions

Microaggressions are the everyday experiences of discrimination, racism, and daily hassles that target individuals from diverse racial and ethnic groups. These can be verbal, nonverbal, interpersonal and environmental, intentional or unintentional. They communicate hostile, derogatory or negative messages to targeted persons based on their marginalized group membership.<sup>6</sup>

These frequent contemporary experiences can perpetuate historical trauma.

For example: Changing behavior according to a presumption that a Black person is dangerous or violent. One example is moving away or grabbing one's purse or wallet.

### Implicit Bias

Implicit bias is the unconscious attribution of particular qualities to a member of certain social group. Implicit stereotypes are influenced by experience, and are based on learned associations between various qualities and social, ethnic and cultural categories.

For example: Assuming a child or caregiver is exaggerating symptoms on the basis of their socioeconomic status or ethnic-racial background.

### Stereotype Threat

A stereotype threat is the risk of confirming a negative stereotype about an individual's racial, ethnic, gender, or cultural group.<sup>7</sup> Stereotype threats can affect anyone, depending on the prevailing stereotypes in a given context.

For example: Filling out a questionnaire highlighting one's race or gender prior to taking a test may be enough to trigger stereotype threat and underperformed.

## **Targeted Identities**

Social and cultural identities, such as African Americans and Native Americans, with historically less power and less access in their given context.<sup>8</sup>

## **To Counteract MIST We Need TRUST**

- **T**ender compassion – offering predictable compassionate availability in a culturally responsive way means collaborating with patients and families to integrate their culture into their care
- **R**eassure, Return to Routine, Regulate – using the 3 Rs to improve our cultural attunement
  - Reassure: Assure safety affirming and validating trauma reactions as normal responses to abnormal experiences and emphasize culture as a healing base
  - Return to routines: Help reestablish or adapt family and traditional cultural routines, including protective factors, to promote security and healing. Familiarity and routines provide comfort and evoke a sense of safety.
  - Regulate: Consider cultural traditions, customs and practices that calm self and name emotions
- **U**nderstanding – understanding the culture in which you work and the connections to the community you serve, understand your own beliefs and biases
- **S**afety – for young children, perception of safety is closely linked to the perceived safety of their caregivers
- **T**end to culturally-attuned listening – It takes time to develop trust in any relationship. It takes longer when there are cultural barriers and even longer when there has been historical trauma or racial trauma. Explore the trauma attuned to the child's and caregiver's cultural identity.

## **To Be Culturally Responsive**

It begins with cultural humility and providing CARE (key elements in providing culturally humble and informed care).

- Cultural Humility is the lifelong practice of critiquing and reflecting on one's own culture while striving to understand others, recognizing power imbalances, and contributing to partnerships that are mutually beneficial.<sup>9</sup>
- Be aware of how one's own cultural biases can shape how problems are interpreted and how interventions are developed.

## Cultural Humility and CARE

<b>Curiosity</b>	<ul style="list-style-type: none"> <li>Express genuine interest in knowing more about the child and family's culture, socioeconomic background, and, in the case of immigration, the home country's history.</li> </ul>
<b>Attuned, attentive listening</b>	<ul style="list-style-type: none"> <li>Explore the experience of trauma by using culturally attuned, attentive listening; integrating the child's or family's terms for their experiences into our language; and developing a sense of what their traumatic experiences mean for them.</li> <li>Ask rather than assume.</li> </ul>
<b>Respect</b>	<ul style="list-style-type: none"> <li>Strive to recognize the different life experiences, emotions, and responses that even people from the same cultural group (racial, ethnic, or other) may have in response to trauma.</li> <li>Recognize that perceptions of trauma and traumatic stress responses vary by culture.</li> <li>Recognize that communities of color may have negative experiences with "helping systems," such as mental and physical health care professionals. These encounters can be distressing and result in significant mistrust.</li> </ul>
<b>Empathy</b>	<ul style="list-style-type: none"> <li>Strive to be empathic and support children and families in feeling safe. Help patients make meaning of what happened to them at the intersection of trauma and culture. Recognize that trauma breaks meaning and culture makes meaning.</li> </ul>

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**LEVEL 2**  
**LECTURE 8**

# How Trauma Presents Across the Age Span

## **Learning Objectives:**

- Identify how FRAYED symptoms present differently based on a child's developmental level.
- Become familiar with how the lower brain (safety) develops at the expense of the higher brain.
- Define the role of the default mode network in child development.
- Consider how intrapersonal, neurocognitive, interpersonal, and regulation (INIR) competencies are impacted at each developmental level.



# Impact of Trauma on Development: How the INIR Self can be Impacted

Competencies impacted are those that require buffering by caregivers

## Trauma Without Buffering Can Cause Core Deficits in: <sup>2</sup>

- Intrapersonal competencies – sense of self and self-development
- Neurocognitive competencies – capacity to engage executive functions and other cognitive abilities to interact meaningfully on the world
- Interpersonal competencies – capacity to form and engage in relationships with others
- Regulatory competencies – ability to recognize and modulate emotional, behavioral and physiological experience



## FRAYED Symptoms by Age / Stage of Development and Helpful Caregiver Responses <sup>1, 2, 3, 4</sup>

Age Group	Child's Symptoms	Education for Caregiver about Helpful Responses
<b>Infants</b>	<ul style="list-style-type: none"> <li>• May scream or cry excessively</li> <li>• Alternatively, may be shut down and be subdued</li> <li>• May be or may appear to be developmentally delayed</li> <li>• Poor appetite, poor growth, or digestive problems</li> </ul>	<ul style="list-style-type: none"> <li>• Focus on security and routines; responsive care teaches the child that their needs will be attended to; builds trust</li> <li>• Reassure children that they are safe physically and emotionally, using words and nonverbal clues. Children need to feel safe in order to move from their lower brain to their higher brain.</li> <li>• Routines – one important way that we transmit safety to children is through predictable routines for bedtime, the day, transitions, etc.</li> </ul>
<b>Toddlers</b>	<ul style="list-style-type: none"> <li>• After trauma, child brain defaults to perceiving situations as dangerous so they rapidly go to self-defense without drawing in extra information from the higher brain.</li> <li>• Clues that a toddler is stuck in lower brain: poor verbal skills, memory problems; more generalized fear; highly reactive.</li> <li>• Response is out of proportion to the stimulus (e.g. severe tantrum after minor change or parent request)</li> </ul>	<p>Promote parent attunement by:</p> <ul style="list-style-type: none"> <li>• Helping parent understand emotions behind a child's behaviors</li> <li>• Explaining that child's behaviors are a normal response to abnormal things that have happened to them</li> </ul> <p>Teach parent how to help the child by responding with both verbal and nonverbal safety cues:</p> <ul style="list-style-type: none"> <li>• 3 Rs (<a href="#">see page 23</a>)</li> <li>• Gentle touching, rocking, singing, hugs, verbal reassurance</li> <li>• Special time in (<a href="#">see page 55</a>)</li> </ul>
<b>Preschool/ Young School Age</b>	<ul style="list-style-type: none"> <li>• May present with developmental delays or learning problems</li> </ul>	<p>Promote parent attunement by:</p> <ul style="list-style-type: none"> <li>• Helping parent understand emotions behind a child's behaviors</li> <li>• Explaining that child's behaviors are a normal response to abnormal things that have happened to them</li> </ul> <p>Teach parent how to help the child by responding with both verbal and nonverbal safety cues:</p> <ul style="list-style-type: none"> <li>• 3 Rs (<a href="#">see page 23</a>)</li> <li>• Special time in (<a href="#">see page 55</a>)</li> <li>• Teach words for emotions</li> <li>• Gentle touch, high fives, sharing laughs</li> <li>• Parent role as emotional container</li> <li>• Use visual cues for schedules &amp; routines</li> <li>• Prepare child for transitions</li> <li>• Create a "cozy corner" or "nest" for child</li> <li>• Create opportunities (some physical and emotional space) for quiet time, allowing child to spend time with mind at rest where introspection and reflection occur and the amygdala quiets</li> </ul>

Age Group	Child's Symptoms	Education for Caregiver about Helpful Responses
<b>School Age Children</b>	<ul style="list-style-type: none"> <li>• May have persistent concern over their own safety and the safety of others</li> <li>• These children may be preoccupied with their own actions during the event</li> <li>• Impaired mental maps and unsafe inner life means they can't understand situations without assigning blame to themselves.</li> <li>• May experience guilt or shame over traumatic event</li> <li>• May engage in constant retelling of the traumatic event</li> <li>• May describe being overwhelmed by their feelings of fear or sadness</li> <li>• May present as hyperactive, impulsive, easily frustrated or aggressive</li> <li>• May have difficulty learning in school</li> </ul>	<p>Promote parent attunement by:</p> <ul style="list-style-type: none"> <li>• Helping parent understand emotions behind a child's behaviors (see Cognitive Triangle on page 47)</li> <li>• Explaining that child's behaviors are a normal response to abnormal things that have happened to them</li> </ul> <p>Teach parent how to help the child by:</p> <ul style="list-style-type: none"> <li>• Being an emotional container (remaining calm when child is upset) to promote regulation</li> <li>• Create opportunities for quiet time, allowing child to spend time with mind at rest where introspection and reflection occur</li> <li>• When child is upset, validate their feelings and offer empathy while remaining calm (regulated). "I see that you are angry. You threw the cookie on the floor even though I know you like cookies. There must be a reason."</li> <li>• Techniques to try: 3 Rs. Special time in. Teaching child words for emotions. Using visuals to teach skills. Engage child in self-calming behaviors (yoga, meditation, deep-breathing, exercise, dance). Sensory-based supports (fidget toys, manipulative toys, chewing gum, etc.).</li> </ul>
<b>Teens</b>	<ul style="list-style-type: none"> <li>• Self-conscious about their emotional responses</li> <li>• Fear, vulnerability, and concern over being labeled "abnormal" or different</li> <li>• Shame and guilt about the traumatic event</li> <li>• Feel alienated or isolated</li> <li>• May struggle with understanding, tolerating, and managing feelings</li> <li>• Without age-appropriate coping skills, may rely on unhealthy strategies (substance use, high-risk behaviors, self-injury, sexual activity)</li> <li>• Trouble forming and maintaining safe connections; lack of trust in others</li> <li>• Mistrust may lead to isolation or to filling relational needs in ways that leave them vulnerable to further victimization</li> <li>• May feel damaged and incapable</li> <li>• May lack faith in their own ability to succeed</li> <li>• Have sense of foreshortened future</li> <li>• Struggle with problem solving</li> <li>• May feel worthless and unlovable</li> <li>• Impact on sexual development potentially leading to precocious sexual activity or more inhibitions</li> <li>• Can develop a sense of self that is marked by negativity, confusion and fragmentation</li> </ul>	<ul style="list-style-type: none"> <li>• Strong emotions are a normal response to traumas. Now we can work on ways to respond that may be healthier.</li> <li>• Advise caregiver to use LACE to encourage teen self-reflection. Guidance involves listening and asking teen what they think about what happened, or how they might respond next time, or how they might solve a problem they are having.</li> </ul> <p>How caregivers can help teens:</p> <ul style="list-style-type: none"> <li>- Allow space for child to do some self reflection</li> <li>- Provide and encourage words for emotions</li> <li>- Special time in with caregiver still important</li> <li>- Routines and expectations still important</li> <li>- Attuned attentive listening</li> <li>- Support caregiver as emotional container – don't take emotions personally when child acts out as emotions not about caregiver</li> </ul>

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**LEVEL 2**  
**LECTURE 9**

# Trauma Assessment and Suicide Prevention

## Learning Objectives:

- Review different approaches for systematically detecting trauma symptoms among pediatric patients.
- Discuss how to systematically screen for suicide using both screening tools and standardized interview questions.
- Discuss how to effectively incorporate trauma symptom severity and functional impairment/challenges when making treatment/referral decisions.
- Review the Pediatric Traumatic Symptom Screener – a screening tool to assess trauma symptoms and suicidality, validated in children and adolescents receiving care in primary care settings.

# Ways We Identify PTSD

PTSD is diagnosed when the following symptoms last for more than 1 month, cause clinically significant distress or impairment in functioning, and are not attributable to the physiological effects of a substance or other medical condition:

- The child was exposed to actual or threatened death, serious injury or sexual violence in one of four ways: directly experienced, witnessed in person, learned that happened to close family member or friend, or repeatedly exposed to aversive details.
- The traumatic event is re-experienced through intrusive thoughts, nightmares, flashbacks or emotional reactions when exposed to reminders.
- Avoidance of thoughts, feelings, or conversations about traumatic event or of people, places or activities that remind child of traumatic event.
- Negative alterations in cognition or mood such as inability to recall some details of event(s), distorted beliefs about causes of event(s), persistent negative beliefs about oneself/others/the world, persistent negative emotional state, feelings of detachment or estrangement from others, diminished interest in activities, inability to experience positive emotions
- Hyperarousal: irritable behavior, angry outbursts, reckless behavior, hypervigilance, exaggerated startle response, difficulty focusing, sleep disturbance

## The Care Process Model Follows a Stepwise Process

- Determine if reportable event (mandated reporter issue)
- Assess suicide risk
- Assess need for trauma treatment

## Pediatric Traumatic Symptom Screener

Pediatric Traumatic Symptom Screener is a brief validated pediatric stress symptom screener.

- <https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906>
- Both parent (ages 6-17) and teen self-report (ages 11-17)
- Free
- Available in English and Spanish

The Pediatric Traumatic Symptom Screener includes:

- Two validated surveillance questions about whether bad things have happened
- PHQ-9 question about suicidal ideation/intent
- Has 12 questions scored on a Likert scale from mild to severe that includes questions about symptoms which are grouped into: sleep issues, avoidance and arousal

Scoring:

- Severe: >20
- Moderate: 11-20
- Mild: <11

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**LEVEL 2**  
**LECTURE 10**

# Evidence-Based Treatments for Childhood Trauma

**Learning Objectives:**

- Identify 3 evidence-based treatments for childhood trauma
- Describe key components of trauma-informed treatment
- Describe components of Trauma-Focused Cognitive Behavioral Therapy – the most rigorously tested treatment for childhood trauma to date

# What Does It Mean to be Trauma-Informed

- Trauma-informed systems are structured with an understanding of the causes and effects of traumatic experiences, along with practices that support recovery
- Collaborative approach requires involvement by all stakeholders working with the child
- Schools, physicians, caseworkers, lawyers for all parties, judges, providers, birth parents, childcare, early childhood educators, and caregivers (foster parents and kinship caregivers)
- Providers can improve outcomes for children and their families by:
  - Recognizing the impact of trauma
  - Responding appropriately
  - Resisting practices that may re-traumatize families
  - Supporting families' recovery and capacity for resilience
- National Child Traumatic Stress Network's definition of a trauma-informed child-serving system, available at <http://www.nctsn.org/resources/topics/creating-trauma-informed-systems>

## Evidence-Based Treatment (EBT) vs. Evidence-Informed Practice (EIP)

- EBT: Treatments have strong research support
  - Clinical trials and Randomized Controlled Clinical Trials (RCTs)
  - Typically involve a manual, series of training and consultation to learn the treatment model
- Some suggest that EIPs provide more innovation and flexibility in implementation/can be better fit to meet needs of organization
  - EIPs – guided by research and evaluation, but do not require scientific research or rigorous evaluation to prove positive results
- Availability in communities an issue for both

# Components of Trauma-Informed Treatment

- Promoting safety, including emotional and psychological safety for the child and family
- Screening/Assessment
- Building a strong therapeutic relationship
- Psychoeducation about normal responses to trauma
- Parent/caregiver support/training, conjoint sessions
- Knowledge of child development
- Help child with emotional expression and regulation skills
- Help family with anxiety management, relaxation skills and stress management
- Cognitive processing or reframing of the traumatic experience(s)
- Trauma narration/processing/organization ie telling the story about their traumatic experience(s)

## Examples of Treatments for Complex Trauma – EBT and EIT

- The California Evidence-based Clearinghouse for Child Welfare - Information and Resources for Child Welfare Professionals
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
- Trauma Affect Regulation: A Guide for Education and Therapy (TARGET)
- Integrative Treatment of Complex Trauma (ITCT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Real Life Heroes
- Trauma Systems Therapy (TST)
- Child Parent Psychotherapy (CPP)
- Attachment Self-Regulation & Competency (ARC-EIP)
- Parent-Child Interaction Therapy (PCIT)
- Child and Family Traumatic Stress Intervention (CFTSI)





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**LEVEL 2**  
**LECTURE 11**

# Promoting Caregiver and Child Regulation

**Learning Objectives:**

- Describe the two components of regulation
- Identify the normal evolution of regulation from parent regulation to dyadic co-regulation to self-regulation
- Review the steps a caregiver needs to take to understand dysregulation (ABC) and promote regulation (Curiosity, Distress tolerance and Encouraging purposeful action – CDE)
- Develop strategy to support caregivers who have difficulty with regulation of self and child

# After Attachment, Regulation is the Most Critical Skill

## States of Regulation: D. A.R. E

- **D**istressed and overwhelmed (unsafe)
- **A**ble to **R**eflect – (now can get curious)
- **E**ngaging in purposeful action – (combination of capacity and resources)

## Typical Development of Self-Regulation in Children

Caregiver provides regulation for child → Dyadic Co-regulation → Child self-regulation

## Helping Children Develop Self-Regulation

- Stimulation and soothing – Caregiver alternates stimulation and soothing; caregiver attunes their words, vocal tones, behaviors to help child regulate when child is distressed and helps restore the child to baseline.
- Reflection – can be verbal (you look like you are getting sleepy) or behavioral (responds to child laughter with smiling); mirroring through facial expressions, words and actions is how child learns to interpret experience and emotions and how to regulate them.
- Modeling – Child reads caregiver expression and emotion. This provides visual cues to child for understanding affect; models coping. Includes coaching and allowing opportunity for practice.



# Caregiver Self-Regulation Steps<sup>2</sup>

## Step 1. Identify what makes some moments difficult

- Assess what makes moments difficult
  - Child factors—behaviors that push buttons, emotions that trigger strong reaction in caregiver, emotions that lead to danger or crisis or feelings or experiences that are hard to understand
  - Factors affecting caregiver world—money, housing, work, sleep, interpersonal relationships
  - Factors from caregiver's own experience—reminders of own life, what makes caregiver less confident
- Balance—build self monitoring and self modulation skills
- Connection with others—identify supports

## Step 2. Build Self-Monitoring and Self Modulation Skills

- Physiological (heart rate, breathing) and Cognitive (automatic thoughts)
- Modulation
  - Consider what can be done to modulate in advance of an interaction
  - Consider what can be done to modulate in the moment when a child is dysregulated
  - Consider what can be done after the interaction with the child to help the caregiver modulate
  - Consider what can be done as part of caregivers' daily routine to promote modulation

## Step 3. Identify Support System

- Consider social mapping, don't use other children in home

# Child Self-Regulation

Regulation of emotions requires several steps. First, the child must recognize the emotion and have some insight into what the emotion is (or understand it). Then the child will be able to label it. The next step is to learn to express the emotion in appropriate ways which requires learning some regulation skills. Caregivers may need to develop their own skills first and then might need support to help their child. Caregivers also have to recognize that a child behavior is the expression of an underlying emotion. This can be a challenging step for some parents.

As providers, we help the parent learn to co-regulate with the child by:

- Helping them learn these basic skills (of recognizing, understanding, labeling, expressing and regulating emotions)
- Recognizing the link between emotions and behaviors
- Learning how to help the child express them through co-regulation

## Reasons Children May Dysregulate – A, B, C

### Avoiding Danger

For children who have experienced trauma, avoiding danger becomes a primary driver of behavior, since that fear is often uppermost in thoughts and feelings. Children display increased vigilance and have difficulty attuning to caregivers. So they may misread cues (innocuous facial expressions might be interpreted as anger, neutral statements might be considered threatening). Additionally, danger triggers drive behavior in ways that observers may not understand. A child's perception of a smell, vocal tone or touch as reminiscent of a past harm may only make sense to the child. Thus behaviors that are responses to triggers can seem random, exaggerated and inexplicable to others.

### Behavior Addresses a Need

Behavior may also represent an effort to get needs met. These needs might be physiologic needs or emotional needs. Hoarding food, lying and constant demands for attention may seem to a caregiver to be behaviors without cause. It may not be related to the actual need in the moment. Thus, we have to consider if the child is demonstrating behaviors that address an actual present need or a perceived need based on prior experience.

The need may also be that of avoiding danger. We can see variations of freeze, fight, flight and compliance behaviors when children perceive danger and revert to coping mechanisms similar to those that were employed at the time of the original threat.

### Calming to Baseline

The ability to calm and regulate requires resources that children who have experienced trauma may not have. Trauma experienced in the early years, when the regulatory structures of the brain are forming, means that children may not have experienced co-regulation with their caregiver, such as soothing when they were distressed. Without the normal development of these skills, primitive self-soothing techniques are all that is left to the child. As a child ages, these self-soothing strategies may increasingly look like “problem behaviors” or regressive behaviors. These behaviors seem like problems in and of themselves, but are, in fact, efforts to calm and regulate. Failure to recognize the underlying issues will mean treating symptoms instead of the problem, most likely with limited success.

## Ways Caregivers Can Help Children to Regulate – C, D, E <sup>2</sup>

### Get Curious Not Furious

Remembering that behavior always has a meaning will hopefully result in the caregiver getting curious, not furious. Caregivers will need, again and again, to regulate themselves to stay open to exploring underlying reasons for behavior.

### Distress Tolerance

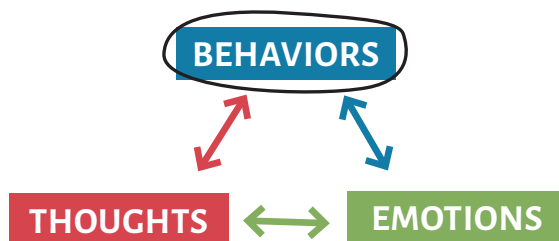
Getting curious and not furious in the face of behaviors that can seem inappropriate, personal or dangerous can be a herculean task for a caregiver. It requires skills in frustration tolerance, problem-solving, impulse-control, self-soothing, cognitive organization, and the availability of social support. Caregivers will need to seek advice, guidance and support for themselves at times to accomplish this. The ability of the caregiver to calm themselves is a large part of what calms the child. The message to the child from the parent who can remain calm and curious is that they are in it together, that they can fix the problem, that the child is worthy and loved.

### Engage in Purposeful Action

Finally, the caregiver ideally models what the child should do to regulate. Practicing over and over again is the only way this can be achieved. Initially, this can be done through actions or words and actions. As children get older, caregivers can engage them in planning for potential problems or debrief with the child and strategize for future situations.

*Curiosity—see the behavior, consider the thoughts and emotions that impact it*

### Cognitive Triangle<sup>3</sup>







#### SOURCES

1. Hughes DA, Baylin J. *The Neurobiology of Attachment-Focused Therapy: Enhancing Connection and Trust in the Treatment of Children and Adolescents*. New York: W.W. Norton & Company; 2016.
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3. Cohen, J., Mannarino, A., Deblinger, E. *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: Guilford Press; 2006.

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**LEVEL 2**  
**LECTURE 12**

# Treating Trauma: When (and How) to Entertain a Very Judicious Use of mEdications (WEAVE)

## Learning Objectives:

- Integrate the request for medication to treat a child who has experienced trauma into the THREAD and FRAYED construct
- Consider what role medications play in supporting a child
- Review what medications and what protocols have the strongest evidence in the context of trauma
- Consider how to deprescribe medications



## PTSD<sup>1</sup>

Evidence based therapy: TF - CBT best evidence; Child Parent Psychotherapy for youngest children



Other options: Eye Movement Desensitization Reprocessing, Trauma and Grief Component Therapy, others



Sleep symptoms: nightmares, hyperarousal – augment with **melatonin** or **prazosin**



Persistent intrusive or arousal – augment with **clonidine**, **guanfacine**

**AVOID:** Pharmacotherapy without psychotherapy, polypharmacy, antipsychotics or benzodiazepines, multiple concurrent antihypertensive medications

## ADHD<sup>1</sup>

Observe for trauma symptom overlap



If unsafe or ADHD symptoms persist with home stabilization and trauma treatment consider medication



**Psychostimulant** (methylphenidate or amphetamine, short or long acting)



If ineffective: **monotherapy with another stimulant or alpha 2 agonist**



If ineffective: **combination of extended release alpha 2 agonist with psychostimulant or trial atomoxetine**

**AVOID:** Antipsychotics and multiple concurrent anti-hypertensive medications

## Anxiety<sup>1</sup>

Exposure based Cognitive Behavioral Therapy or other evidence-based treatment intervention



Moderate or severe or inadequate response to CBT: **fluoxetine** or **sertraline** alone or with CBT



Not helpful or adverse effects: switch to other **SSRI**, continue CBT

**AVOID:** Polypharmacy, Antipsychotics, Benzodiazepine

## Depression<sup>1</sup>

Psychoeducation and psychosocial interventions



Psychotherapy



**Fluoxetine** or combine **fluoxetine** with CBT or Interpersonal Psychotherapy (*consider **escitalopram** if 12 or older*)



No response – switch to another SSRI



Inadequate response: increase psychosocial intervention, medication dose



Augment with alternate psychosocial intervention (CBT, IPT)

**AVOID:** Polypharmacy, Antipsychotic augmentation

## Deprescribing consideration: SPIRAL<sup>2,3</sup>

**S**—Side effects

**P**—Prevention

**I**—Invalid indication

**R**—Redundant, problem resolved

**A**—Added as part of a cascade

**L**—Large burden on patient and family

### SOURCES

1. Keeshin B, Forkey HC, Fouras G, MacMillan HL. Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication. *Pediatrics*. 2020:e20193751.
2. Bellonci C, Carlson GA. Deprescribing in Child and Adolescent Psychiatry: Where, When, and How to Safely Reduce Polypharmacy in Clinical Settings. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2016;55(10):S37.
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## LEVEL 2

# Extra Material

The Cognitive Triangle Explained ..... *page 53*

Becoming an Emotional Container ..... *page 54*

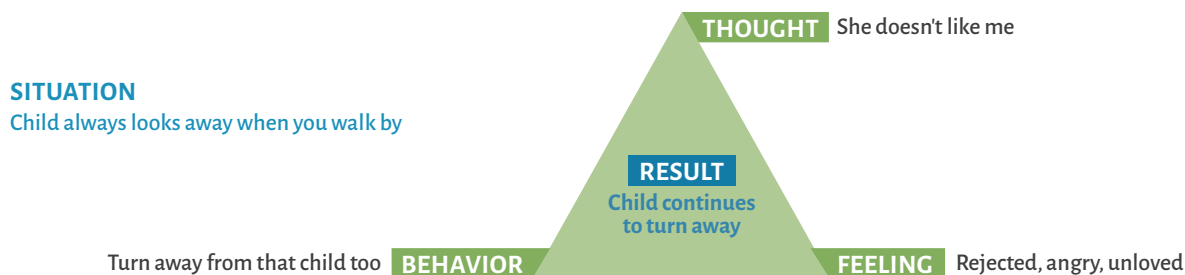
Special Time In ..... *page 55*

# The Cognitive Triangle Explained

Cognitive coping refers to ways to explore thoughts in order to challenge and correct ideas that are inaccurate. This helps to change emotions and behaviors. The cognitive triangle is an easy way to start this.

- First: Discuss the difference between thoughts and feelings (thoughts are what your brain says to you (self-talk) and feelings are the reactions to those thoughts. Those thoughts can be inaccurate and lead to feelings, and then behaviors, that can hurt us or others.
- Second: Identify that you CAN change what you think.
- Third: Discuss how changing what you think will change how you feel, and that can change what you do, and in turn, that can change how you think!

## Thoughts lead to feelings and behaviors which reinforce thoughts and feelings



SITUATION	THOUGHT	FEELING	BEHAVIOR	RESULT
Child always looks away when you walk by	She doesn't like me →	Rejected, angry, unloved →	Turn away from that child too →	Child continues to turn away
	He's mean and wants to fight →	Scared, nervous, anxious →	Be aggressive with the boy →	Child fights with you
	She's shy →	Sad for her →	Try to be friends with the girl →	You and child become friends
Teacher blames you for something you didn't do	She hates me →	Scared, worried, angry →	Yell at teacher first →	Child gets punished
	He just doesn't understand the situation →	Hopeful, confident →	Calmly explain situation →	Child gets listened to and they understand the mistake

# Becoming an Emotional Container

Consider what it takes to hold the strong emotions of a child who has experienced trauma and is reacting strongly to a trigger or reminder. The child's reaction may be out of proportion to the present situation. Here are some tips for holding all of those emotions for the child:

1. Get curious not furious – consider why a child would be reacting the way they are. Behaviors tell us about the feelings and thoughts of the child. Once the child calms down, explore what happened BEFORE the reaction that may have been a trigger.
2. Model calm reactions for the child, both when the child is acting out, and when you deal with your own emotions. If someone cuts you off in traffic, try to explain why you got upset, and model positive cognitive coping: "I'm frustrated because they almost hit me, but I bet they didn't see me here. I'll get out of their way."
  - If you feel you are getting stressed or overwhelmed, try to remain present in the moment. Be aware of your feelings. If you feel too stressed, and you know you can't remain calm, it's okay to step away for a moment. Let your child know that you are having strong emotion. You can say "I'm going to stand over there and take deep breaths, that will help me to calm down and then I will help you."
3. Match affect – if the child has a strong emotion, react with energy, but walk the child back by bringing the intensity of your voice down as you speak. If the child is sad, respond slowly and bring the energy in your voice up as you talk.
4. Name the emotion or invite the child to while validating child: "It seems like you are frustrated or tired. It makes this activity hard to do when you feel that way."
5. Think about being the eye of the storm, and focus on your own breathing so you can remain calm while the child may be acting out around you. Consider whether the child's words or actions are triggering you and how your reaction may relate not to just this child at this moment, but to your own thoughts and feelings or what has happened to you in the past.
6. Identify the safe people who can be your container and support you both before and after you are working with the child.



# Special Time In

## How to do “Special Time In”

1. Set aside a set amount of time each day to focus fully on your child (10-20 minutes). Choose a time to be fully present.
2. During this time, minimize distractions – cell phones are off or not allowed.
3. Your “homework” is to spend that time with the child in a child-directed activity (not chores or a video game)
4. The child picks the activity. For younger children, you may need to offer a few choices the child enjoys and let the child choose.
5. Follow your child’s lead during this time. Set a timer to signal when time is up and begin the transition to something else.

Please note: your child’s negative behaviors and demands for more time might escalate at first, and this is expected. It is important to follow-up with your medical provider in the week beginning after special time, to strategize how to deal with challenges that arise, such as worsening behaviors. Consider what makes the time go well, and what might be impacting that time if it doesn’t go well – these observations will be useful as you discuss your special time in with your doctor.







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