

# PATTeRx

*Pediatric Approach to Trauma,  
Treatment and Resilience*

## **PATTeR CHAT LEVEL 1**

*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.

For the purpose of this document, the term “child” refers to youth through adolescence unless specifically stated, and “parent” refers to primary caregivers acting in the role of parenting including biological, foster, kinship, and adoptive parents.

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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 1**  
**LECTURE 1**

# Overview of Trauma and Resilience

## Learning Objectives:

- Review the connections between ACES, toxic stress and resilience
- Introduce trauma as a developmental disorder, resilience as a developmental prerequisite
- Consider the role of attachment or safe, stable and nurturing relationships in resilience and trauma
- Recognize resilience skills, **THREADS** (*Thinking & learning brain, Hope, Regulation or self-control, Efficacy, Attachment, Developmental skill mastery, Social connectedness*)
- Identify the symptoms of trauma as demonstrated by **FRAYED** (*Fits, Frets and Fear, Regulation difficulties, Attachment difficulties, Yelling and Yawning, Educational delays and Defeated*) behaviors

# Resilience (Ordinary Magic)

Resilience is defined as the dynamic process of positive adaptation to or in spite of significant adversities.<sup>1</sup> For children, the pathways to resilience are rooted in the give and take of safe, stable, nurturing relationships (SSNRs) that are continuous over time (attachment), and in the growth that occurs through play, exploration and exposure to a variety of normal activities and resources.

## Common Resilience Factors

### Common Resilience Factors (Resilience Literature)

### Promotive and Protective Factors (Developmental Psychology Literature)

A safe, stable, nurturing relationship with at least one caregiver who is continuous over time in the child's life

Caring family, sensitive caregiving in which the child develops emotional security and a sense of belonging

Thinking and learning brain; problem solving skills

Executive function skills, problem-solving skills

Sense of self-efficacy or mastery, ability to control situations or adapt, and positive sense of self

Self-efficacy, positive view of self, self-agency

Co-regulation, regulation of emotions and behavior

Self-regulation of emotions and behavior

Developmental mastery of age-salient tasks

Self-agency, ability to adapt

Hope, faith, optimism or sense that life has meaning

Hope, faith, optimism

Social network, well-functioning community (schools, childcare)

Connections with greater ecology

#### SOURCE

1. Masten AS. Ordinary magic: Resilience processes in development. *American Psychologist*. 2001;56(3):22

## The **THREADS** of Resilience

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Thinking and learning brain

**H**ope

**R**egulation or self control

**E**fficacy

**A**ttachment

**D**evelopmental skill mastery

**S**ocial connectedness

## Trauma Frays the Resilience **THREADS** of Childhood

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Thinking and learning brain – *higher brain shuts down under threat*

**H**ope – *to deal with present danger, lose sense of future or ability to optimistically look ahead*

**R**egulation or self-control – *shuts down, need impulses to deal with threat*

**E**fficacy – *this is lost – reacting to situation, not controlling it*

**A**ttachment – *acting alone, not available*

**D**evelopmental skill mastery – *learning shuts down while in lower brain*

**S**ocial connectedness – *alone with threat*





You are **FRAYED** *(and at the end of your rope)*

**F**rets and **F**ear

**R**egulation difficulty

**A**ttachment difficulty

**Y**elling, **Y**awning and **Y**ucky feeling

**E**ducational delays

**D**efeated/**D**issociated/**D**epressed

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**LEVEL 1**

**LECTURE 2**

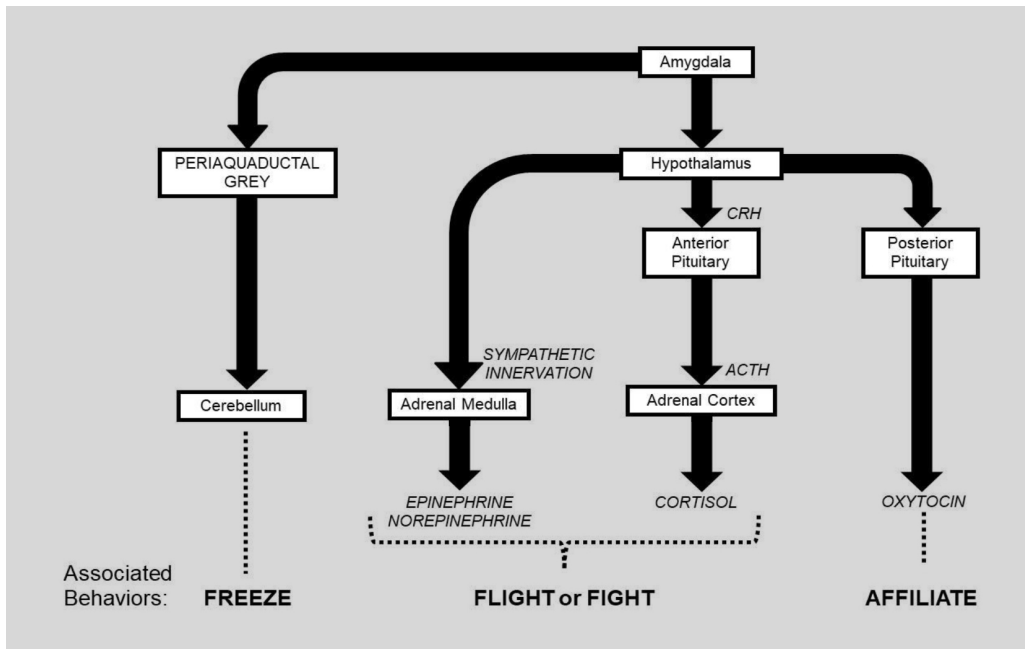
# Physiology of Trauma

## Learning Objectives:

- Review the human stress response
- Identify the long term impact of repeated stimulation of fight or flight and the hypothalamic-pituitary-adrenal axis at the molecular, cellular and organ level and the physiologic and behavioral effects
- Introduce trauma's impact on development through prioritization of developmental tasks and skills of survival at the cost of developmental tasks dependent on availability of safe attachment
- Explore theory of differential sensitivity to context, or orchids and dandelions



# 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

## Ways trauma can impact the brain and body physiologically:

Area	Impact	Specifics
Neurobiologic changes	<ul style="list-style-type: none"> <li>• Cortisol acts on brain structures</li> <li>• Altered gene expression alters brain structure</li> </ul>	<ul style="list-style-type: none"> <li>• Amygdala hypertrophy</li> <li>• Hippocampus atrophy</li> <li>• Prefrontal cortex not accessible</li> <li>• Anterior cingulate cortex and insula blunted</li> <li>• Default mode network does not develop normally</li> <li>• Risk reward pathways blunted</li> </ul>
Epigenetic changes	<ul style="list-style-type: none"> <li>• Methylation patterns impacted by threat</li> </ul>	<ul style="list-style-type: none"> <li>• Methyl groups or histones attach to promoter region or come off promotor regions of genes</li> <li>• Leads to transcription or lack of transcription of genes</li> </ul>
Immune function	<ul style="list-style-type: none"> <li>• Alteration of immune system in response to constant threat in childhood</li> </ul>	<ul style="list-style-type: none"> <li>• Inflammatory system up-regulated</li> <li>• Humoral immunity diminished</li> <li>• Sick syndrome</li> </ul>

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**LEVEL 1**  
**LECTURE 3**

# Promoting Resilience

**Learning Objectives:**

- Become familiar with the definition and concept of resilience
- Understand the adaptive personal factors that promote resilience
- Understand that the attachment relationship (safe, stable, nurturing) is the foundational thread of resilience

# SEAM: Attachment Supported by Caregiver Providing Four Key Factors

## **Safety and Security** – *physical and psychological*

- Make sure child feels safe now – review situations and relationships that may make child feel unsafe (bullying; caregiver, coach or another adult hurting child or living situation concerning child)
- Assure safety with words (you are safe, you can always talk to me, there are no secrets from mom)
- Touch for reassurance – hand on shoulder, hand on back, high fives; if appropriate, hugs, rubbing back
- Reassurance with safe places within home – set up tent in bedroom for child, canopy or dome over bed, own safe chair, weighted blankets

## **Emotional Container**

- Child may have strong emotions with caregivers that are not about the caregiver but occur with the caregiver who should remain calm to help child regulate
- Child's emotions can be appropriate to situations that happened in the past, but are triggered by new situation, thus emotion seems inappropriate
- Caregiver can help child to name emotions once has calmed down

## **Availability** – *predictable and compassionate*

- Caregiver response to child is consistent and constant
- Child knows that caregivers are “on the same page,” and working reliably to address child needs, psychologically “holding” child
- Caregiver warmth, responsiveness and attention to child does not mean child always gets what he wants, but does mean that child knows what to expect and that care is dependable

## **Mind in Mind**

- Caregiver offers empathy and reflects the child's feelings and emotions back to them
- Just as we learn to speak by being spoken to, we learn to understand our emotions by having responsive caregivers attuned to our emotions in a caring, compassionate manner

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**LEVEL 1**  
**LECTURE 4**

# Engagement and Screening

## Learning Objectives:

- Review the role of attachment in parent-child function and in the relationship between the medical provider and child caregiver
- Identify engagement strategies to use to promote relationships with caregivers for children
- Explore the concept of neuroception and how this impacts engagement
- Discuss surveillance and screening and the role of each in care
- Review specific tools for surveillance and screening, organizing the various tools available according to the type of information they provide and their role in trauma informed care

# Specific Engagement Techniques: Affect, Body Language, Cultural Cues and Delivery/Diction

## Affect Modulation

Affect is the facial and body expression of our emotional state

- Emotions, such as anger, sadness, fear, joy and excitement etc. are expressed in our body language and facial expressions and can be interpreted by others without words.
- Some emotions are difficult to hide: Anger in particular is so powerful an emotion that it is almost impossible to prevent it from becoming evident in your facial expressions and vocal tone.
- Emotions as expressed through our facial affect and body language *evoke a similar emotion in the person who perceives them.*

### Helpful response of provider or caregiver:

- Match the affective expression of a child's anger without being angry. She/he/they will experience this as empathy for their anger, and experience this as "my caregiver gets it" and "understands how angry I am about this!"
- Match the affective state but remain *regulated* which helps the child to be more regulated.

### Unhelpful response:

- If rejected, defensive or annoyed by the parent/child's anger, the child (or parent) will perceive that and get angrier and more dysregulated.

## Body Language

Nonverbal communication

- The fastest way to send safety messages to another's person's brain is through *nonverbal* communication.
- Generated and processed in the right hemisphere, nonverbal signals stimulate the emotion-generating right brain limbic system and then are quickly transmitted to the amygdala for assessment of safety or threat.

### Helpful Techniques

- Remain calm
- Project an open demeanor
- Listen attentively
- Lean in

### Unhelpful Responses

- Glance at watch or computer often
- Become defensive, angry, or impatient
- Highly defensive, rejection-sensitive people can disengage or even dissociate with just a change in tone of voice or subtle shift in eye movements

## Cultural Cues

Cultural sensitivity and humility

- Use encounter as an opportunity to learn more about the family's culture.
- Self-awareness is essential. Reflect on one's own privilege, personal values, perceptions and beliefs and how those might impact the care we are providing.
- Building rapport is critical.
- Approach the patient with as few assumptions as possible.
- Be aware of the stigma associated with trauma/emotional issues.
- Utilize collateral sources of data.
- Be aware of disagreements in explanatory models between family members.
- Use cultural consultants/cultural brokers when appropriate.
- Be aware of cultures in which prolonged eye contact is considered rude or as an affront.

### Helpful Techniques

- Attuned, attentive listening
- Reflect back what you heard
- Ask for meaning of what has happened or of the illness in the culture. Be up-front about your desire to learn what they need, and value within their culture.
- Recognize the cultural variations in the perception of trauma and traumatic stress responses
- Begin by following the patient's lead at first
- Ask least intrusive question(s) first
- Use interpreters or cultural brokers if necessary, avoiding the use of family members as translators
- Be open to including kinship networks and other types of practices that the family views as helpful

### Unhelpful Approaches

- Assuming that you understand meaning of what happened in the culture
- Letting your own biases and personal values impact care
- Generalize about groups of people
- Leaping to conclusions and to treatment recommendations
- Failure to use interpreters or cultural brokers

### Delivery/Diction

How tone of voice is interpreted by others:

- There are specific safety sounds: the inner ear interprets higher-pitched sounds—“parent-ese” or child-directed speech—as safe.
- Specific danger sounds: the inner ear interprets lower frequency sounds as more predatory or threatening, likely to be heard as anger; flat sounds may signal depression.
- By focusing middle ear muscles on the intensity of sounds, the ear can detect lower-pitched sounds as speech shifts to anger. Kids who live with threat tune their auditory system to hear the low-pitched sounds of threat, and ignore or suppress the higher more musical sounds of safety. Re-learning to hear safety sounds can be like learning a second language.

### Helpful Provider Techniques

- Approach children and families with higher-pitched sounds that stimulate the release of oxytocin and calm this threat sensitive region

### Unhelpful Provider Approach

- Use of low tones or a shift to low tones in conversation may send a traumatized child or parent into self-defense mode



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**LEVEL 1**  
**LECTURE 5**

# “How To” What to Say and Do in the Office

## **Learning Objectives:**

- Review ways to explain the impact of trauma to families and youth
- Discuss how resilience skills are impacted by trauma
- Prioritization of certain developmental tasks and skills—skills of survival
- At the cost of developmental tasks most dependent on availability of a safe attachment system and context
- Explain concepts of: invisible suitcase, emotional container, mentalizing or keeping the child’s mind in mind
- Develop a toolbox of skills to approach clinical situations which includes the 3 Rs: Reassuring (restoring safety), Return to routine, Regulating



# Office-based Approach: Responding to Concerns of Trauma (SPLINT)

## Say trauma may be the cause

### Problem-solve

- What is needed to help everyone calm down right now?
- Use the 3 Rs: Reassure, Return to routine, Regulate

### Language for parent and child about the problem

- Give child language for what symptoms are
- Give child language for how to explain to others what they feel

### Investigate further

- Do you need to ask more questions to understand the situation, other stressors or to be able to best provide or refer for services?
- Do you need to know more to determine if child is safe?
- Do you need to report to child welfare?

### Normalize symptoms

- Explain that the child is having a normal response to abnormal experiences, to what happened to them

### Treatments and therapy

- Begin treatment with office guidance
- Referral for therapy may be necessary



# SPLINT as a First Response to Trauma

## Say trauma/stress may be the cause

It is important to state that trauma/stress is one consideration of what is causing the problem to allow exploration of the topic.

- Point out that the constellation of symptoms described can sometimes be the result of something the child has experienced that is frightening, scary or hurtful.
- Review key elements of the history if have not already done so

## Problem-solve

Explore with the family: What is the most distressing part of the problem and what would be helpful? What strategies have they tried and how have they tried them? Have any worked?

- Engage the family in thinking through the application of some strategies and what they might be able to implement “right now.” The 3 Rs are often a good start.
- For example, in the child with sleep issues, we can suggest to the caregiver:
  - Reassure the child they are safe with words, touch and comfort
  - Create Routines (calm play followed by bath, brush, book, bed)
  - Regulate by having paired love objects (one with child, one stays with caregiver), putting up sticky notes with words of encouragement, practice deep breathing, simple meditation, etc.

## Language

We can provide language for the child and family about the problem. This gives the child words for what they feel (scared, angry, sad, worried etc.) and helps them to identify emotions that are associated with behaviors.

We can explain that bad things make us move to fight or flight and out of our thinking learning brain so caregivers can then speak with other family members and educators about the behaviors in a helpful and empathic way.

- We can reflect on what we are hearing from the family/child to convey our understanding and to help the parent gain insight into their child’s response.
- We can also offer the caregiver an approach to attuned listening (listen quietly, validate what child is saying, reflect back what you are hearing using child’s words).
- We can help the caregiver understand other feelings that might look like and be mislabeled as anger (disappointment, frustration, worry) or sadness (loss, guilt, fear).

## **Investigate further**

Trauma concerns may need to be explored with the parent privately in another room or after the visit by phone.

- It is often best to have conversations about the child's behavior with the caregiver in private.
- It may also be advisable in some situations to speak with the child in private.
- Other times, information can be safely followed up at a future visit.

Whenever we, as mandated reporters, suspect that a child may be at risk of harm in their current home setting, we are obligated to contact child welfare without delay.

Similarly, suicidal or homicidal ideation, or a plan to seriously harm another individual, requires urgent referral to emergency mental health services.

## **Normalize**

When a child has experienced trauma or adversities:

- It is important to explain to the caregiver that the child is having a normal reaction to an abnormal set of circumstances. Sometimes, the caregiver has been traumatized by the same events or by the impact of trauma on their child, and we may need to remind the caregiver that they too are having an expected reaction to those events.
- When we see these expected responses, in either child or caregiver:
  - Ask "What happened or is happening to you?" (not "What is wrong with you?")
  - Our role becomes "How can I understand or help you?" rather than "How can I fix you?"

## **Therapy, treatment or guidance**

Brief office-based guidance to caregivers and children can start with the 3 Rs.

- Reassurance of the child that they are safe
- Routines
- Regulation strategies (self-soothing)

Referral to community-based services may be helpful for specific symptoms such as developmental delays (early intervention) or learning issues (pre-school or school special education) or to help reduce some family stressors (social services for housing instability, etc.)

Referral to Evidence-based Treatment (EBT) care is indicated when traumatic experiences are resulting in symptoms that are interfering with a child's functioning in daily life (sleeping, behavioral regulation, elimination, eating, anxiety, depression, etc.).

- When referring to outside for EBT services, providers can consult their local public health authorities for resources.
- The online resource, The California Clearinghouse for Child-Welfare, has an exhaustive descriptive list of EBT and parenting education services that are ranked by level of evidence. Providers can use this listing and their local mental health providers to determine which services are available in their communities.
- Close follow-up tailored to the needs of the family enables the provider to monitor progress, engage in further problem-solving, layer on strategies (such as positive parenting approaches), and offer support.

# Immediate Anticipatory Guidance for Trauma Exposure or Symptoms

## 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, 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 child 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.

### 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)

# The Three **R**s

Ways to support your child's resilience

## **Reassure**

*Let child know they are safe. This should be said with words, hugs and safe spaces in the home.*



## **Return to Routine**

*Routines for meals, bedtime, household schedules all help children to know what to expect.*



## **Regulate**

*Skills to calm self: belly breathing, stretching, relaxation*

*Skills to name feelings: colors of emotions, words for feelings*

*Skills for managing emotions*

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**LEVEL 1**  
**LECTURE 6**

# You Already Do This: How to Incorporate Care into your Everyday Practice

**Learning Objectives:**

- Consider how trauma can be addressed in ways similar to other pediatric complaints in the clinical setting
- Review tools which can be used to address trauma in the clinical setting
- Identify a strategy to use with families to address trauma: PASTA – Positive Parenting, Affect Regulation, Self-soothing, Triangle Training, Attachment

# Weaving Care Together – Questions to Consider in Each Visit

## **THREADS** – *Strengths or Resilience Factors*

1. What are this child's strengths or resilience factors (THREADS)?
2. What are the caregiver's or family's strengths or resilience factors?
3. What are the family's or caregiver's social supports?
4. What are the cultural strengths?

## **FRAYED** – *Symptoms and Differential Diagnosis*

1. What are the trauma symptoms (FRAYED) that you identify?
2. What is the physiology behind the symptoms?
3. Is trauma part of the differential diagnosis based on how the patient presents?
4. Are there other diagnostic considerations that will affect care/management?

## **SEAMS** – *Safety, Emotional Container, Availability and Mind in Mind*

What of these (Safety, Emotional container, Availability and Mind in mind) can the parent give or not based on their THREADS and FRAYED?

1. **Safety Concerns:** Are there concerns about the patient's physical, emotional or psychological safety? Is the child safe with the caregiver or is the threat to safety in that relationship?
2. **Emotional Container:** Is the caregiver able to tolerate the distress of this child and hold it? Is the caregiver personalizing the strong emotions? Does the caregiver have an emotional container/supports for themselves?
3. **Predictable Compassionate Availability:** Is there a component of attachment you are concerned about?
  - How would you describe the child's attachment to the caregiver?
  - Is caregiver attuned to the child, consistent in responses?
  - How would you describe the caregiver's empathy for and availability to the child?
4. **Mind in Mind:** Is the caregiver able to present the concerns with the child's mind in mind? Does the caregiver see a trauma from the child's point of view?

## **FABRiC** – *What is the fabric or context in which this is happening*

1. **F**amily: How was the parent of this child raised and how is that informing their parenting? Are there intergenerational trauma considerations?
2. **B**roader social context: What are the current stressors for this caregiver or family? (Social Determinants of Health: poverty, community violence, DV, bullying, discrimination, housing or food insecurity etc.?)
3. **C**ultural Considerations: Are there cultural considerations (race/ethnicity, sexual orientation or identity, immigrant, in out-of-home care etc.)
  - That impact the presentation of trauma?
  - That affect the meaning of trauma to this child/caregiver?
  - That affect how you will engage this child/caregiver around management?

# How Questions Can Be Incorporated Into History

Element of visit	Questions to consider
Chief Complaint (and Engagement)	<p>What brings you/your child here today:</p> <p>Can it be made positive? Not just what is wrong with you, but what is strong with you? What has happened? What are the risks?</p>
History of Present Illness	<p><b>THREADS</b></p> <ol style="list-style-type: none"> <li>1. Have THREADS been challenged recently?</li> <li>2. What THREADS are impacted – by known events, not clear why impacted?</li> </ol> <p><b>FRAYED</b></p> <ol style="list-style-type: none"> <li>1. Do FRAYED symptoms bring the child in today</li> <li>2. Some children have had trauma but no symptoms—consider whether the child is resilient or could be latent symptoms</li> </ol> <p><b>SEAM</b></p> <ol style="list-style-type: none"> <li>1. Safety Concerns: Are there concerns about the patient’s physical, emotional or psychological safety?</li> </ol>
Review of Systems	<p><b>THREADS</b></p> <ol style="list-style-type: none"> <li>1. What are this child’s strengths or resilience factors (THREADS)?</li> <li>2. What are the caregiver’s or family’s strengths or resilience factors?</li> </ol> <p><b>FRAYED</b></p> <ol style="list-style-type: none"> <li>1. Any other FRAYED symptoms that don’t seem related to the reason the child presents today?</li> </ol> <p><b>SEAM</b></p> <ol style="list-style-type: none"> <li>1. Emotional Container: Is the caregiver able to tolerate the distress of this child and hold it? Is the caregiver personalizing the strong emotions?</li> </ol>
Past Medical History	<p><b>FRAYED</b></p> <ol style="list-style-type: none"> <li>1. Has child had somatic concerns previously?</li> <li>2. Has child had FRAYED symptoms previously?</li> <li>3. Are there chronic health problems that might have added an element of medical trauma?</li> </ol>
Developmental History	<p><b>THREADS</b></p> <ol style="list-style-type: none"> <li>1. Has child been able to use thinking brain, developmental skill mastery?</li> </ol> <p><b>FRAYED</b></p> <ol style="list-style-type: none"> <li>1. Are educational or developmental concerns an issue?</li> </ol>



Element of visit	Questions to consider
Family History	<p><b>THREADS</b></p> <ol style="list-style-type: none"> <li>1. What are family THREADS?</li> </ol> <p><b>FRAYED</b></p> <ol style="list-style-type: none"> <li>1. Does family have FRAYED symptoms?</li> </ol> <p><b>SEAM</b></p> <ol style="list-style-type: none"> <li>1. What is the parent-child relationship like? Is the caregiver bonded to the child? Is the child securely attached to the caregiver? Do you see threats to attachment or signs of insecure attachment?</li> </ol> <p><b>FABRIC</b></p> <ol style="list-style-type: none"> <li>1. FAmyly: How was the parent of this child raised and how is that informing their parenting? Are there intergenerational trauma considerations?</li> </ol>
Social History	<p><b>THREADS</b></p> <ol style="list-style-type: none"> <li>1. What are the family's or caregiver's social supports?</li> <li>2. Does this family/caregiver/child's culture offer a sense of belonging, sense of meaning, self-perception, and purpose?</li> </ol> <p><b>FRAYED</b></p> <ol style="list-style-type: none"> <li>1. Are child's symptoms impacting family dynamics?</li> </ol> <p><b>SEAM</b></p> <ol style="list-style-type: none"> <li>1. Does the caregiver have an emotional container/supports for himself?</li> </ol> <p><b>FABRIC</b></p> <ol style="list-style-type: none"> <li>1. FAmyly: Are there intergenerational trauma considerations?</li> <li>2. BRoader social context: What are the current stressors for this caregiver or family? (Social Determinants of Health: poverty, community violence, DV, bullying, housing or food insecurity, historical or racial trauma)</li> <li>3. Cultural Considerations: Are there cultural considerations (race/ethnicity, sexual orientation or identity, immigrant, in out-of-home care etc.)</li> </ol>

# Specific Advice for What Families Can Do at Home to Manage Symptoms **(PASTA)**

## **Positive Parenting**

- Provide child with specific praise and small tangible reward (sticker, privilege etc.) for specific behaviors they want to see
- Encourage behaviors you wish to see; can't teach a "no" (no fighting, no hitting, no running)
- Continue with routine (bedtime, chores, meal routines on chart) and rituals (prayer before meals, cookies and milk after school) which promote safety and organized setting
- Special time in

## **Affect Modulation**

- Encourage the child to remain calm (emotional container) to help the child regulate their emotions (parents must be in relational mode and not survival mode or the child will likely stay in survival mode)
- In calm moments, caregivers can help children build their emotional vocabulary, identify what about distressing time (bedtime, going to school etc.) is upsetting to them and come up with words for feelings
- Caregivers can help children identify colors that match their emotions (e.g. red for angry); reading books together and discussing how characters feel is a good way to build emotional understanding and vocabulary

## **Self-soothing**

- Caregivers can model or do self-relaxation activities with children: meditation, yoga, deep-breathing, massage.
- Use all 5 senses to work on self-soothing.
- Swinging, rocking, dancing (stimulating vestibular system) can help calm and soothe kids who have difficulty calming or falling asleep.
- Please note that many of the behaviors that children engage in to cope with stress (escaping into the electronic universe, taking mid-day naps) make it harder to sleep at night. It is easier for children to give up their less adaptive coping behaviors if we provide them with healthier ways to reduce stress early on (exercise, reading, sleep hygiene).

## Triangle Training (cognitive triangle)

- Behavior ALWAYS tells you about thoughts and emotions, and it is thoughts and emotions that must be investigated.
- Thoughts impact feelings, which then impact behavior, which then impacts behaviors, which can in turn impact thoughts. For example: a child worries they can't fall asleep, then feels stressed, and then cannot fall asleep, thoughts about their inability to fall asleep are reinforced.
- Break the link between the thoughts and the emotions and/or the link between the emotions and the behavior ("It is okay to feel angry, but it is better to tell me that you are angry than to throw your toys and break them. Let's think about how you might let me know how you feel." – labeling the emotions and teaching an alternative behavior).

## Acceptance

- Recognizing and validating that a child has an emotion is the first step in being able to manage that emotion.
- We can encourage caregivers to let the child know that it is the child's feelings, thoughts or wish are what the caregiver wants to understand.
- Acceptance does not mean that the caregiver believes the child's perceptions to be true but that the caregiver understands that this is the child's experience, thought, perception or wish.
  - ~ If a child is afraid of the basement, the caregiver may be tempted to reflect to the child that there is nothing to fear. Taking the child to the basement, and declaring that there is nothing scary, indicates that the child's thoughts and feelings are wrong and that the caregiver is right. Now the child is alone and still afraid, and they are unable to use the attachment relationship for support. Instead, if the caregiver accepts the child's emotions and gently asks questions to understand their fears, they feel safe in talking about their feelings. Only then can both of them work together on ways to manage the fear.





**PATTeRx**   
Pediatric Approach to Trauma,  
Treatment and Resilience

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# THREADS

## Attributes That Support Resilience

Thinking and learning brain

Hope

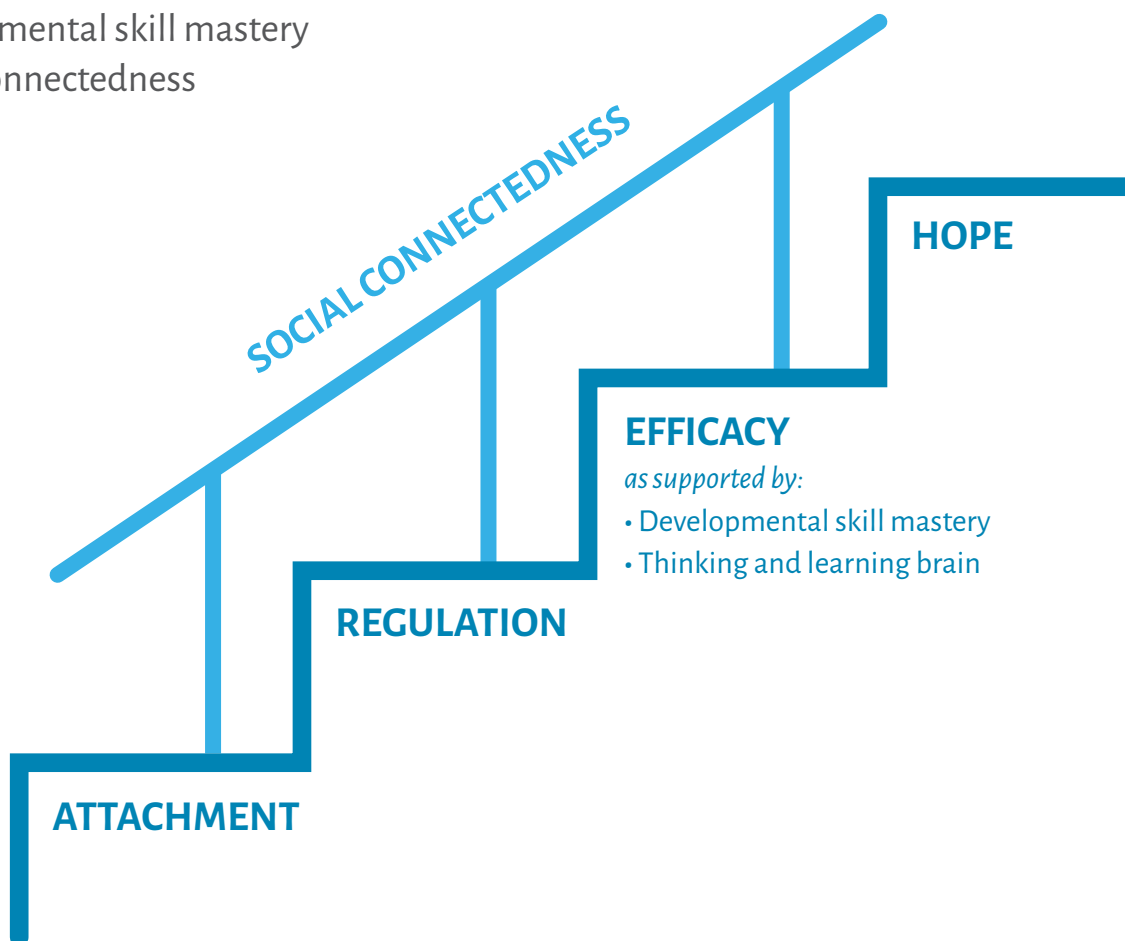
Regulation or self control

Efficacy

Attachment

Developmental skill mastery

Social connectedness



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# FRAYED

## Common Symptoms of Trauma

Common symptoms of trauma include anxiety, externalizing, internalizing and developmental and learning impacts. These are summarized with the mnemonic **FRAYED**.



### **FRAYED symptoms** *(at the end of your rope)*

- F**rets and **F**ear
- R**egulation difficulty
- A**ttachment difficulty
- Y**elling, **Y**awning and **Y**ucky Feelings
- E**ducational delays
- D**ejected/**D**issociated/**D**epressed

Because...

## Trauma can impact all **THREADS**

- T**hinking and learning brain – *higher brain shuts down under threat*
- H**ope – *to deal with present danger, lose sense of future or ability to optimistically look ahead*
- R**egulation or self-control – *shuts down, need impulses to deal with threat*
- E**fficacy – *this is lost – reacting to situation, not controlling it*
- A**ttachment – *acting alone, not available*
- D**evelopmental skill mastery – *learning shut down while in lower brain*
- S**ocial connectedness – *alone with threat*

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# SEAM

## Ways Caregivers Support Attachment

### **Safety and Security** – *physical and psychological*

- Make sure the child feels safe now – review situations and relationships that may make child feel unsafe (bullying; caregiver, coach or another adult hurting child or living situation concerning child)
- Assure safety with words (you are safe, you can always talk to me, there are no secrets from mom)
- Touch for reassurance – hand on shoulder, hand on back, high fives; if appropriate, hugs, rubbing back
- Reassurance with safe places within home – set up tent in bedroom for child, canopy or dome over bed, own safe chair, weighted blankets

### **Emotional Container**

- Child may have strong emotions with caregivers that are not about the caregiver but occur with the caregiver who should remain calm to help child regulate
- Child's emotions can be appropriate to situations that happened in the past, but are triggered by new situation, thus emotion seems inappropriate
- Caregiver can help child to name emotions once has calmed down

### **Availability** – *predictable and compassionate*

- Caregiver response to child is consistent and constant
- Child knows that caregivers are “on the same page,” and working reliably to address child needs, psychologically “holding” child
- Caregiver warmth, responsiveness and attention to child does not mean child always gets what he wants, but does mean that child knows what to expect, that care is dependable

### **Mind in Mind**

- Caregiver offers empathy and reflects the child's feelings and emotions back to them
- Just as we learn to speak by being spoken to, we learn to understand our emotions by having responsive caregivers attuned to our emotions in a caring, compassionate manner

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# FABRIC

## Context for the Child and Family



### 1. Family

How was the parent of this child raised and how is that informing their parenting?  
Are there intergenerational trauma considerations?

### 2. Broader social context

What are the current stressors for this caregiver or family? (SDoH: poverty, community violence, domestic violence, bullying, discrimination, housing or food insecurity etc.)

### 3. Cultural Considerations

Are there cultural considerations (race/ethnicity, sexual orientation or identity, immigrant, in out-of-home care etc.)

- that impact the presentation of trauma?
- that affect the meaning of trauma to this child/caregiver?
- that affect how you will engage this child/caregiver around management?

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# SPLINT

## Office-based Approach to Responding to Concerns of Trauma



### Say trauma may be the cause

#### Problem solve

- What is needed to get everyone able to calm down right now?
- Use the 3Rs: Reassure, Return to routine, Regulate

#### Language for child about the problem

- Give child language for what symptoms are
- Give child language for how to explain to others what they feel

#### Investigate further

- Do you need to ask more questions to understand the situation, other stressors or to be able to best provide or refer for services?
- Do you need to know more to determine if child is safe?
- Do you need to report to child welfare?

#### Normalize symptoms

- Explain that the child is having a normal response to abnormal experiences, to what happened to them

#### Treatments and therapy

- Begin treatment with office guidance
- Referral for therapy may be necessary

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# SPECIFIC ADVICE FOR FAMILIES: PASTA



## Positive parenting

- Provide child with praise and small tangible reward (sticker, privilege etc.) for specific behaviors
- Encourage behaviors you wish to see; can't teach a "no" (no fighting, no hitting, no running)
- Continue with routines (bedtime, chores, meal routines on chart), rituals (prayer before meals, cookies and milk after school) and family traditions which promote safety and organized setting
- Special time in

## Affect modulation

- Encourage the child to remain calm (emotional container) to help the child regulate their emotions (parents must be in relational mode and not survival mode or the child will likely stay in survival mode)
- In calm moments, caregivers can help children build their emotional vocabulary, identify what about distressing time (bedtime, going to school etc.) is upsetting to them and come up with words for feelings
- Caregivers can help children identify colors that match their emotions (e.g. red for angry); reading books together and discussing how characters feel is a good way to build emotional understanding and vocabulary

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## PASTA

continued

### Self-soothing

- Caregivers can model or do self-relaxation activities with children: meditation, yoga, deep-breathing, massage.
- Use all 5 senses to work on self-soothing.
- Swinging, rocking, dancing (stimulating vestibular system) can help calm and soothe kids who have difficulty calming or falling asleep.
- Please note that many of the behaviors that children engage in to cope with stress (escaping into the electronic universe, taking mid-day naps) make it harder to sleep at night. It is easier for children to give up their less adaptive coping behaviors if we provide them with healthier ways to reduce stress early on (exercise, reading, sleep hygiene).



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## 3 Rs

# Anticipatory Guidance for Trauma Exposure or Symptoms

### 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, 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 child 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)

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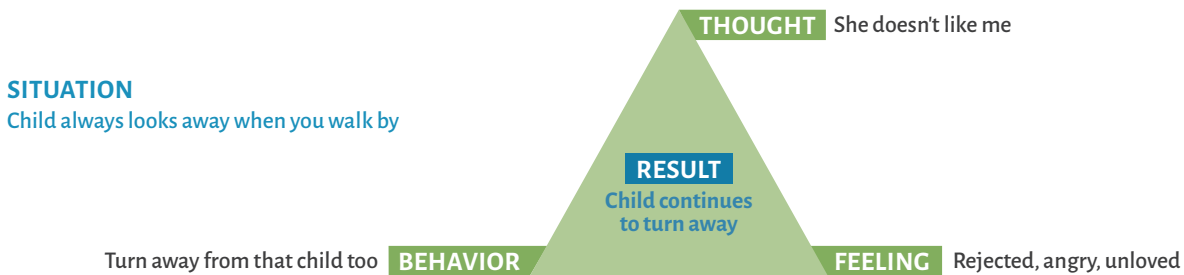
# COGNITIVE TRIANGLE

Cognitive coping provides a way to explore thoughts in order to challenge and correct ideas that are inaccurate because they impact 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 emotional reactions to those thoughts. Those thoughts can be inaccurate and lead to feelings that can hurt us. Feelings in turn lead to behaviors that make sense in context of the thought but may not be adaptive.

**Second:** Remind caregivers and children 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 changes how you think!



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

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# EMOTIONAL CONTAINER



Consider what it takes for a caregiver to hold the strong emotions of a child who has experienced trauma and is reacting to a situation in ways that may seem out of proportion or personally directed at the caregiver. Here are some tips for holding all of those emotions for the child:

1. Get curious not furious – Consider why a child might be reacting the way they are. Behaviors tell us about the feelings and thoughts of the child. Once the child is calm, the caregiver can ask about 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.”
3. Match affect – If the child has a strong emotion, react with energy, but walk the child back by bringing your voice down as you speak. If the child is sad, respond with a slow response and bring the energy in your voice up as you talk. Might be important to validate the child’s feelings first. “I can see you are sad...”
4. Name the emotion or invite the child to, while validating the child: “it seems like you are frustrated or tired, and that makes this activity hard to do when you feel that way.”
5. Think about being the eye of the storm. Focus on your own breathing and staying calm while the child acts out around you.
6. Consider if the child’s words or actions are triggering to you and how your reaction may relate not just to this child and moment, but to your own prior experiences, thoughts and feelings.
7. Identify the safe people who can be your container and support both before and after you work with the child.

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# 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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