



A Case for Trauma-Informed Care

Trauma is both a critical issue for children’s health practitioners to understand, and an emerging policy front for advocates working to improve children’s health care. The phrase ‘trauma-informed care’ appears often in the literature, but it can be difficult to know what it refers to and how it fits into children’s health advocacy work more broadly. Nationally, we are in the early stages of understanding how trauma or adverse childhood experiences (ACEs) affect people throughout their lives. As information becomes available, advocates must continue to learn and find ways to incorporate trauma-informed approaches into their advocacy work in order to protect and expand health coverage, promote health innovation and systems change, and strengthen the health care workforce. This issue brief outlines what trauma is, how it is measured, and how we can better address it in order to improve children’s long-term health outcomes.

What is trauma?

Trauma is best defined as an injury or a devastating event. Particularly in childhood, experiencing trauma is extremely common. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), [two thirds of youth ages 16 and younger report having experienced at least one traumatic event](#). These experiences can range from living through war, to enduring physical violence, sexual assault, or, increasingly, a [school shooting](#), to the emotional pain of a parental divorce during childhood. Categorizations of trauma have changed over time and expanded to include experiences related to environmental or socioeconomic conditions, such as living in poverty and everyday encounters with racism. Trauma can be an isolated event or a cumulative exposure to painful experiences that manifests over time. Practitioners and advocates must recognize that what is traumatic for a child may not be traumatic for an adult, and that some events will trigger a trauma response for some children, but not others.

While every demographic has a large prevalence of trauma, data shows that children of color experience more traumatic events than their white peers. One reason for this is that [there is a larger proportion of children of color living in poverty](#). The experience of poverty is itself traumatic and is also associated with other potentially traumatic exposures, such as neighborhood instability, higher rates of street violence, and food insecurity. Additionally, children of color are likely to encounter racism regularly. These experiences – whether they are intense, isolated events or frequent and more subtle interactions – lead to high levels of stress and anxiety and a diminished sense of self-worth. Studies show that ACEs influence brain development and have [lifelong impacts](#) on physical, mental, and behavioral health. ACEs are also [associated with early death and numerous chronic illnesses](#).

How do we measure trauma?

There are multiple methods for assessing trauma exposure, including those that identify the type, severity, and symptoms of trauma. Many of these tools are specific to a particular context and are designed for adults, such as screening for Post-Traumatic Stress Disorder (PTSD) among veterans. Children can be particularly difficult to assess because clear symptoms may not appear until adulthood. A child may have more subtle symptoms or invisible symptoms that they do not have the capacity or desire to verbally express. For these reasons, it is particularly important to rely on [tools specifically designed to identify and understand childhood trauma](#).



There are three ways to administer childhood trauma screenings: the child can be screened, the caregiver can be screened, or a clinician or caseworker can fill out a screening tool based on existing reports and observations. The type of administration will depend on a variety of factors including the child's language abilities, age of the child, engagement with the family, and clinical protocols. When it comes to innovation and changes to standard practice, the pediatric field trails behind the adult medicine field. There are additional protections for children that exist for good reason, but can also slow positive change and innovation. One of the concerns people have about screening children for trauma is that the screening process itself may trigger a stress response and re-traumatize a child. Administering screenings to a child's caregiver, clinician, or caseworker can be a way to bypass these concerns and be able to assess a child's trauma history.

One of the most commonly used screening tools is the Adverse Childhood Experiences (ACEs) screening. This tool has gone through multiple iterations over time, which reflects ongoing research and increasing understanding of experiences that are considered traumatic to children. You may visit the [American Academy of Pediatrics](#) to access ACEs questionnaires and other clinical assessment tools.

In every trauma assessment, regardless of the tool used, engaging the child's caregivers in the process is paramount to the child's healing and whole health. Family engagement may look different depending on the age of the child and whether or not there are signs of abuse. Engagement can include:

- Explaining the purpose and results of the screening,
- Referring the child and/or family members to mental health or behavioral health services, and
- Reassuring the family that the child's reactions are a normal response and that there are ways to build resilience and healthy coping mechanisms.

How do we mitigate harm and foster resilience?

The American Psychological Association defines '[resilience](#)' as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress." In the children's health field, we often use the word to mean the ability to bend and not break when faced with adversity. Resilience is not an innate trait. Like many other skills, we can develop resilience during childhood, but it requires long-term practice and support. Children can be resilient in some settings and struggle in others.¹ For example, some children may respond well to the structure of school, but may have difficulty navigating interpersonal relationships. Other children might struggle in school, but thrive at home and make strong connections with their peers. Meaningful relationships with family members, caregivers, and community members fosters resilience. However, some parents and other caregivers have also experienced trauma and may not have developed resilience themselves. As a result, the parent or caregiver might need support so they can respond appropriately to their children's experiences.

Programs and policies that provide communication training and counseling supports to families can help build and strengthen a caregiver's ability to buffer their child's experiences with trauma and toxic stress.² Furthermore, we must support parents and guardians by addressing barriers they have to being responsive caregivers – these include, but are not limited to domestic violence, substance use disorders,

¹ The National Child Traumatic Stress Network (n.d.) *Resilience and Child Traumatic Stress*. Retrieved from https://www.nctsn.org/sites/default/files/resources/resilience_and_child_traumatic_stress.pdf.

² Weor, Kirsten. American Psychological Association (2017). *Maximizing Children's Resilience*. Retrieved from <http://www.apa.org/monitor/2017/09/cover-resilience.aspx>



parental depression and poverty. If we want to support children, it is [imperative we also support their families](#).

While it is important to establish programs that are tailored to address specific issues and meet the needs of families caring for children who have experienced trauma, trauma-informed care is an approach that can be broadly implemented and benefit all children and families. It is comprised of four components:

- 1) Acknowledging trauma is widespread;
- 2) Recognizing the signs and symptoms of trauma;
- 3) Creating policies and practices that address trauma; and
- 4) Actively working to avoid re-traumatization.³

Although implementation will differ by setting and organization, potential changes include:

- Being mindful of language and comments that make light of a traumatic event,
- Alterations to the physical space to be more welcoming and calming, and
- Co-creating the care plan with the child and family.

Applying a trauma-informed approach to any type of work with children and families is important not only because there may be invisible or undisclosed traumas, but because the principles of trauma-informed care advance a culture of transparency, collaboration and mutual respect. To learn more about the principles of a trauma-informed approach and components of trauma-specific interventions, please refer to [SAMHSA's National Center for Trauma-Informed Care](#).

Conclusion

As children's advocates and supporters of the Affordable Care Act, the Children's Health Insurance Program, and Medicaid, we need to be vigilant in identifying opportunities to integrate a trauma-informed approach into systems meant to serve children and families. Trauma is both widespread and distributed inequitably, with children of color and children living in poverty experiencing trauma at vastly higher rates than their peers. Addressing trauma and building resilience are inextricable from our fights for coverage, service delivery and workforce development. It is time to build support for addressing trauma and ensuring that policies, programs and systems integrate a trauma-informed approach to care.

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³ Substance Abuse and Mental Health Services Administration. *Trauma-Informed Approach and Trauma-Specific Interventions*. Retrieved from <https://www.samhsa.gov/nctic/trauma-interventions>.