Trauma-Informed Primary Care:
Prevention, Recognition, and Promoting Resilience

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Trauma-informed care integrates an understanding of the prevalence of adverse childhood experiences and their impact on lifelong health. The science of early brain development reveals that the environment in which children develop—family, community, and culture—impacts brain development, health, and genetics. In the medical home, being trauma-informed is important for prevention and amelioration of this impact.

Background

In pediatrics, there has been a growing awareness of the impact of trauma on the child and family. While pediatrics has always recognized that the care of the child is in the context of the family, the impact of infant toxic stress, social determinants of health, and protective factors on overall health is better understood. Toxic stress refers to the prolonged activation of stress response systems in the absence of protective relationships [1]. Toxic stress is distinct from other stress that a young child may experience. There is positive stress in which the physiologic stress response is brief, such as separation from the parent, followed by rapid return of the parent when the child cries. Positive stress can actually promote coping skills. Tolerable stress is more serious, but still buffered by a supportive relationship. With toxic stress, persistent elevation of cortisol can disrupt the developing brain's architecture in the areas of the amygdala, hippocampus, and prefrontal cortex (PFC), and therefore ultimately can impact learning, memory, and behavioral and emotional adaptation. This persistent stress response suppresses the immune response, affects other organ systems, and increases vulnerability to infections and chronic health problems for the infant and into childhood and adulthood. Also, different exposures to stressors at critical times can affect how a gene is expressed (epigenetics), subsequently impacting the behaviors and health conditions that are manifested over the life of that person.

The ACE study [2] links adverse childhood experiences (ACEs) and later-life chronic health conditions, poor quality of life, and death. ACEs include: recurrent and severe physical abuse; recurrent and severe emotional abuse; sexual abuse; neglect (physical and/or emotional); alcohol or substance abuse in household family member; imprisoned household family member; mentally ill, depressed, or institutionalized household family member; mother treated violently; and parental separation or divorce. As the number of ACEs the person has experienced increases, the risk for many health and behavioral problems also increases in children, adolescents, and adults [2]. In recognition of the science of early brain development, the American Academy of Pediatrics recommends regularly assessing social-emotional development at well visits [3]. The new AAP Bright Futures, 4th Edition Guidelines for Preventive Care recommends asking about social determinants of health and parental strengths at every well visit, and has a new focus of Promoting Lifelong Health for Families and Communities [4].

Understanding the impact of trauma on health has also revealed the importance of resilience. It is clear that often the outcomes for persons who have experienced similar trauma are quite different, and understanding the role of protective factors is key. Resilience is the process by which a person moves through a traumatic event, utilizing various protective factors for support, and returning to "baseline" in terms of an emotional and physiologic response to the stressor. It is the process of utilizing one's protective factors to navigate successfully through a stressful situation. Resilience provides a buffer between the person and the traumatic event, mitigating the negative effects that could result, such as physical, emotional, and behavioral health issues that can last even into adulthood [5].

A key component of being trauma-informed is promotion of resilience. Analysis of data from the National Survey of Children's Health and from the Modified 2015 Wisconsin Behavioral Risk Factor Survey showed that children with 2 or more ACEs who were also described as resilient were significantly more engaged in school and better able to maintain calm and control. Adults who had 3 or more ACEs and endorsed childhood protective factors (family support, support by friends, sense of belonging in high school, and enjoy-

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ment of community traditions) had lower rates of depression, poor health, obesity, and smoking than adults with 3 or more ACEs who did not endorse these positive childhood experiences [6]. The Strengthening Families framework from the Center for the Study of Social Policy includes Five Protective Factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children [7]. Even when life trajectories seem limited, protective factors can be enhanced and risk factors reduced to improve health and well-being into the future.

Trauma-Informed Care

Trauma-informed care describes an organizational structure and treatment perspective that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed practice recognizes the broad health impact of trauma on children and families. Importantly, a trauma-informed practice also recognizes that trauma survivors can be re-traumatized by well-meaning caregivers and community service providers. Understanding the impact of trauma and promotion of protective factors is an important first steps in developing a compassionate and supportive community.

The National Child Traumatic Stress Network describes a trauma-informed system as: "one in which agencies, programs, and service providers: (1) routinely screen for trauma exposure and related symptoms; (2) use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and col-

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laboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness. These activities are rooted in an understanding that trauma-informed agencies, programs, and service providers: (8) build meaningful partnerships that create mutuality among children, families, caregivers, and professionals at an individual and organizational level; and (9) address the intersections of trauma with culture, history, race, gender, location, and language, acknowledge the compounding impact of structural inequity, and are responsive to the unique needs of diverse communities [8]."

Trauma-informed Primary Care Practice

In a trauma-informed practice environment, there is understanding of the impact of trauma and potential paths to mitigate that impact. The practice seeks to understand the origins of trauma faced by members of communities. In the practice there is also recognition of the signs and symptoms of trauma in patients, families, and staff. A trauma-informed practice integrates knowledge of trauma into policies and procedures, and actively works to prevent re-traumatization.

Primary care has the power to prevent, identify, and address trauma-related problems. It requires close collaboration with specialty services to better serve families who have experienced, or may experience, trauma or significant stress. For this reason, primary care practice that has integrated mental health professionals as part of the medical home team can be particularly effective. In pediatrics, integrated care is the application of mental health competencies

to create team-based care, with primary care and mental health clinicians working together to care for the whole child in the context of the family, school, and community. The mental health professional practices in the clinic alongside the primary care clinician, allowing joint visits, warm handoffs (in-person introductions and transfer of trust) to the mental health professional, brief interventions, and collaboration in facilitating linkages between families and other resources.

Development of a trauma-informed office requires involvement of all staff and leadership to infuse the trauma-informed lens into the organizational structure. Key components of implementation are: communication with families in respectful and supportive ways, education of staff, creation and support of a healthy office environment, and implementation using a quality improvement approach. Including families in the quality improvement planning process is recommended.

All staff and clinicians can help engage families at the start of the visit. In the medical home, the goal is to establish a longitudinal relationship that is characterized by trust. Essential to this, in the effort to develop relationships with families and foster engagement, is a focus on family strengths as well as problems or concerns. Families and patients who have experienced trauma may be anxious or on their guard (without necessarily showing it) or purposely unclear or indirect because what they are trying to express causes them distress, seems shameful, or remains confusing to them. Having a welcoming environment means that all staff needs to have an understanding of trauma.

Engaging Families

In engaging families who have experienced trauma, understanding an effective communication approach and "common factors" is essential. A useful communication approach is described by the HELP mnemonic (see Table 1). Common Factors are family centered techniques that use common skills present in a number of evidence-based interventions that can be used with people of all ages. Common Factors have been shown to be effective in reducing parental distress and increasing the child's functioning across a range of mental health problems. Examples include sleep, exercise, time outdoors, limits on media, and a balanced and consistent diet. Benefits of this engagement approach are that it facilitates real-time response to concerns while awaiting planned referrals and partnership with the family in the plan for care.

Staff Education and Training

Education of all staff has these components: 1) understanding the impact of trauma on families and children; 2) understanding of the importance of addressing trauma-related problems in primary care; 3) understanding of the importance of working with both children and their caregivers (2-generational) to adequately care for the child; and 4) understanding of the importance of being sensitive to patients' cultural and racial backgrounds. Staff training is an ongoing activity (not "one and done"). It covers prevalence and impact on behavior and health, as well as factors that promote resilience. Training would also raise awareness of the possible trauma experience of fellow staff members.

TABLE 1.
HELP Mnemonic

H	**Hope:** Increase the family's hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the patient and family.
E	**Empathy:** Communicate empathy by listening attentively.
L^2	**Language:** Use the patient or family's own language to reflect your understanding of the problem as they see it and to give the patient and family an opportunity to correct any misperceptions. **Loyalty:** Communicate loyalty to the family by expressing your support and your commitment to help.
P^3	**Permission:** Ask the family's permission for you to ask more in-depth questions or make suggestions for further evaluation or management. **Partnership:** Partner with the patient and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and agree on achievable steps aligned with the family's motivation. **Plan:** Establish a plan (or incremental first step) through which the patient and family will take some action(s), work toward greater readiness to take action, or monitor the problem, then follow up with you, based on the patient and family's preferences and sense of urgency.

Source. Wissow LS, Gadomski A, Roter D, et al. Improving child and parent mental health in primary care: a cluster-randomized trial of communication skills training. Pediatrics. 2008;121(2):266-275.

Trauma-informed care requires a 2-generational approach. Understanding parental trauma experience as well as parental strengths and social determinants of health that affect the family is important. Establishing a relationship of trust and respect is necessary. Practices that decide to screen for ACEs, trauma, and social determinants need to carefully develop how to introduce such questions practically and sensitively. Practices should understand tools and validated questions and know which are appropriate for their population and community [9]. Whether such a screen shows risk or not, there should always be a conversation with the family acknowledging their responses and whether they would like assistance.

Primary care clinicians need to understand referrals for children and adolescents who have experienced trauma and be aware of evidence-based interventions, including those for infant and early childhood mental health. Identifying and developing referral relationships with mental health professionals who offer these interventions is key. These include dyadic therapies (ie, Child Parent Psychotherapy [CPP], Circle of Security [COS], and Attachment Biobehavioral Catch-up [ABC]); Parent-child Interaction Therapy [PCIT]; and Trauma-Focused Cognitive Behavioral Therapy [TF-CBT]).

Further, a healthy office environment allows for success-

ful engagement of families. Creating a welcoming atmosphere, both in physical space and interactions, providing privacy for confidential conversations at each stage of the visit, and reduction of wait time and having sufficient visit length are strategies to meet this goal. A healthy office environment also means addressing staff self-care needs to reduce secondary traumatic stress and prevent burnout.

Conclusion

Ideally, all of the providers encountered by families would be trauma-informed. That would include primary care clinicians, mental health professionals (whether integrated in primary care or in community practice), child care providers, educators, and their staff. As providers begin to engage families on these issues, it is essential that they have collaborated and prepared themselves to be able to address concerns and make warm handoffs for families to specialty care and community resources, before they begin asking about trauma and other stressors. For the primary care practice, it is essential to identify resources and develop relationships with county and regional agencies and organizations that can partner to address ACEs and social determinants of health.

From the experiences of primary care practices committed to trauma-informed care, we are learning that: routinely eliciting patient/family strengths is transformative to practice; clinicians and patients/families can discuss social determinants—those that increase risk and those that are protective; ACEs are common, but resiliency can ameliorate their impact; trauma-informed care needs to include a focus on promotion and prevention as well as intervention; engaging the patient/family as a partner is key; and promoting resiliency is central to addressing ACEs and social determinants of health. NCMJ

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