# Trauma and Pediatric Primary Care

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**KEYWORDS**

• Trauma • Traumatic stress • Trauma-informed care • Children
• Pediatric primary care • Child and adolescent psychiatry

**KEY POINTS**

- Trauma-informed care is a critical and necessary component of any pediatric primary care practice.
- Pediatricians have an important role to play in the prevention of childhood trauma, identification of children with trauma histories and traumatic stress symptoms, and intervention to support the recovery of children and families with traumatic stress.
- Evidence-based tools, such as the Pediatric Traumatic Stress Screening Tool and its accompanying Care Process Model for Pediatric Traumatic Stress, have been developed to provide pediatricians with the guidance they need to identify and respond to childhood traumatic stress in the primary care setting.
- Regardless of their mode of collaboration, child and adolescent psychiatrists can support pediatricians providing care to children with traumatic stress by sharing expertise about the effects of childhood trauma on mental health and development and taking a trauma-informed approach to their guidance on the psychiatric diagnosis and management of children with traumatic stress.

## INTRODUCTION

Exposure to potentially traumatic events in childhood is common across the world.[1,2] While definitions of trauma vary, the National Child Traumatic Stress Network (NCTSN) defines a traumatic event as "a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity" or the "witnessing [of] a traumatic event

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| Abbreviations | |
|---|---|
| AAP | American Academy of Pediatrics |
| ACE | adverse childhood experience |
| CPM-PTS | Care Process Model for Pediatric Traumatic Stress |
| CPP | child–parent psychotherapy |
| C-SSRS | Columbia Suicide Severity Rating Scale |
| NCTSN | National Child Traumatic Stress Network |
| PTSST | Pediatric Traumatic Stress Screening Tool |
| TF-CBT | trauma-focused cognitive behavioral therapy |

that threatens life or physical security of a loved one."[3] Examples include exposures to child maltreatment, domestic and intimate partner violence, natural disasters, refugee- and war-related violence, and serious, life-threatening accidents and illnesses.[3] Traumatic events place children and adolescents at an increased risk for multiple negative, short- and long-term physical and mental health outcomes, including lung and heart disease, depression, Post-Traumatic Stress Disorder (PTSD), and substance use disorders.[2,4]

Pediatric primary care clinicians are uniquely well-positioned to play a critical role in identifying children who have been exposed to trauma and intervening to provide additional support, including services to address mental health concerns.[5,6] Children are more likely to have routine contact with a pediatrician than with a mental health professional.[5,6] Likewise, families are much more likely to initially present to their pediatrician for a behavioral or mental health concern than to seek care directly from a child and adolescent psychiatrist.[5,6] As a result, the American Academy of Pediatrics (AAP) recommends that pediatricians play an active role in the primary, secondary, and tertiary prevention of trauma and mental health disorders among the children that they serve, including by providing trauma-informed care.[7,8]

Trauma-informed care is defined by the NCTSN as care that "recognize[s] and respond[s] to the impact of traumatic stress on…children, caregivers, and service providers."[9] In the pediatric primary care setting, this includes the identification of children and families who have been exposed to a potential trauma, assessment of their response to the event(s), including any traumatic stress symptoms, and intervention to support a child's and family's recovery after the event(s).[10] It also includes efforts to prevent children's exposure to trauma and build their resilience.[10]

Pediatricians often encounter several barriers to adhering to these recommendations, though, including high patient loads, time constraints, and limited training and comfort with identifying and treating trauma and child and adolescent psychiatric disorders.[11] This has led to the development of alternative models of increasing access to mental health services within the pediatric primary care setting through collaborations between pediatricians and child and adolescent psychiatrists, such as consultation, colocated care, and collaborative or integrated care.[12] Through consultation models, pediatricians can consult with a child and adolescent psychiatrist about their patients over the phone or via telehealth platforms.[12] In colocated care models, child and adolescent psychiatrists work in the same facility alongside pediatricians and coordinate their care of shared patients.[12] Finally, collaborative or integrated care models involve a team-based approach in which pediatricians, child and adolescent psychiatrists, and case managers work closely together to manage patients.[12]

While collaborative or integrated care models may improve children's access to mental health services and mental health outcomes, most pediatricians across the United States still do not practice in facilities with these supports.[12,13] Thus, any proposed approaches for identifying and responding to childhood trauma and traumatic

stress symptoms in pediatric primary care must be flexible. In this article, we highlight the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) as an example to demonstrate key trauma-informed care components necessary for any systematic and evidence-informed response to trauma in primary care settings.[2]

## DISCUSSION

### *Screening for Trauma and Traumatic Stress Symptoms*

Experts have increasingly called for routine screening for trauma and its effects in pediatric primary care to facilitate earlier identification and intervention for children and families that would benefit from additional support.[2,10] Historically, however, barriers to the implementation of these recommendations have included a lack of clear guidance around what questions to ask or tools to use, a paucity of tools that are appropriately designed for the busy pediatric primary care setting, and discomfort among pediatricians in how to respond to positive screens.[2]

Amidst these calls to better identify and respond to childhood trauma in pediatric care, there has been a great deal of discussion around whether pediatricians should screen for adverse childhood experiences (ACEs) in children, parents/caregivers, or both.[2,10] ACEs include a limited set of early life experiences, such as parental incarceration, poverty, and exposure to community violence, which have been associated with an increased risk for certain chronic diseases in adulthood at the population level.[2,5,10] Critics of ACEs screening have argued that, while the practice does help identify at-risk populations, it is not a sensitive or specific way to predict individual-level risks for negative health outcomes.[2,5,10] Furthermore, the lack of defined and/or available interventions to address ACEs means that families may experience ACEs screening as identifying a possible problem without offering any benefit, potentially increasing stigma rather than addressing possible drivers of negative health outcomes.[2,5] Given these concerns, the AAP and the NCTSN have both developed statements that urge caution around the use of ACE screening in pediatric primary care.[5,14]

Instead of ACEs screening, the AAP recommends that primary care providers apply trauma-informed care principles, including screening for traumatic experiences and resultant traumatic stress symptoms.[5] Unlike many ACEs, multiple evidence-based interventions do exist to address traumatic stress symptoms in children and adolescents, including trauma-focused cognitive behavioral therapy (TF-CBT) and child–parent psychotherapy (CPP).[2] Identifying children who are struggling with traumatic stress symptoms early through routine screening gives clinicians the opportunity to connect affected children to interventions like these that can improve their symptoms and functioning.[2]

However, historically, most existing measures of youth traumatic stress symptoms were designed to diagnose PTSD, making them too long and burdensome for pediatric outpatient settings.[2] In other areas of primary care mental health, the most commonly used mental health screeners (eg, the PHQ-9/-A) are short enough to be routinely administered, offer enough information to not only separate out youth with versus without concerns but also stratify the degree of concern, and even provide some guidance as to next steps.[15] To align with this primary care approach, the Pediatric Traumatic Stress Screening Tool (PTSST), adapted from the validated UCLA Brief Screen for Trauma and PTSD (2 trauma exposure items, 11 trauma symptom items), was designed for primary care to screen children for trauma, traumatic stress symptoms, and suicidality (**Figs. 1** and **2**).[2,16,17] The PTSST is further accompanied by a CPM-PTS to guide clinical staff on how to use the tool and appropriately respond to screening

# Pediatric Traumatic Stress Screening Tool
## 6–10 years of age

Sometimes **violent** or **very scary** or **upsetting** things happen. This could be something that happened to your child or something your child saw. It can include being badly hurt, someone doing something harmful to your child or someone else, or a serious accident or serious illness.

Has something like this happened to your child **recently**? ❑ Yes ❑ No

*If 'Yes,' what happened?* _____

Has something like this happened to your child **in the past**? ❑ Yes ❑ No

*If 'Yes,' what happened?* _____

**If you checked 'yes' on either question above, please continue below.**

Select how often your child had the problem below in the past month.
Use the calendars on the right to help you decide how often.

FREQUENCY RATING CALENDARS

| | How much of the time during the past month... | None | Little | Some | Much | Most |
|---|---|---|---|---|---|---|
| 1 | My child has bad dreams about what happened or other bad dreams. | 0 | 1 | 2 | 3 | 4 |
| 2 | My child has trouble going to sleep, waking up often, or has trouble getting back to sleep. | 0 | 1 | 2 | 3 | 4 |
| 3 | My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn't want them to. | 0 | 1 | 2 | 3 | 4 |
| 4 | When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches. | 0 | 1 | 2 | 3 | 4 |
| 5 | When something reminds my child of what happened, he/she gets very upset, afraid, or sad. | 0 | 1 | 2 | 3 | 4 |
| 6 | My child has trouble concentrating or paying attention. | 0 | 1 | 2 | 3 | 4 |
| 7 | My child gets upset easily or gets into arguments or physical fights. | 0 | 1 | 2 | 3 | 4 |
| 8 | My child tries to stay away from people, places, or things that remind him/her about what happened. | 0 | 1 | 2 | 3 | 4 |
| 9 | My child has trouble feeling happiness or love. | 0 | 1 | 2 | 3 | 4 |
| 10 | My child tries not to think about or have feelings about what happened. | 0 | 1 | 2 | 3 | 4 |
| 11 | My child has thoughts like "I will never be able to trust other people." | 0 | 1 | 2 | 3 | 4 |
| 12 | My child feels alone even when he/she is around other people. | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| 13 | *Over the last 2 weeks, how often has your child been bothered by thoughts that he/she would be better off dead or hurting him or herself in some way? | Not at all | Several days | More than half the days | Nearly every day |

*Adapted from Patient Health Questionnaire (PHQ-C)

***Clinicians, please indicate actions taken:***

☐ **No Action Taken**

**Referrals:** (check all that apply)
- ☐ Child Protection (DCFS / CPS)
- ☐ Crisis Evaluation / Emergency Department
- ☐ Trauma Evidence-Based Treatment
- ☐ Mental Health Integration (MHI)

**In-office Interventions:** (check all that apply)
- ☐ Sleep Education
- ☐ Belly Breathing
- ☐ Guided Imagery
- ☐ Progressive Muscle Relaxation

Patient Name: _____ Patient DOB: _____ EMPI _____

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**Fig. 1.** Pediatric traumatic stress screening tool (6–10 years). (With permission from Behavioral Health Innovations (BHI). Retrieved from Intermountain Healthcare: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906. The suite of UCLA PTSD Reaction Index for DSM-5 instruments are available at www.reactionindex.com.)

results (**Fig. 3**; Available for download at either: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906 or https://utahpips.org).[2,17] There is a parent-report version for children ages 6 to 10 years and a self-report version for adolescents 11 to 18 years.[2]

# Pediatric Traumatic Stress Screening Tool

## 11 years and older

Sometimes **violent** or **very scary** or **upsetting** things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened **recently**? ❑ Yes ❑ No

*If 'Yes,' what happened?* _____

Has something like this happened **in the past**? ❑ Yes ❑ No

*If 'Yes,' what happened?* _____

**If you checked 'yes' on either question above, please continue below.**

Select how often you had the problem below in the past month.
Use the calendars on the right to help you decide how often.

FREQUENCY RATING CALENDARS

| | How much of the time during the past month... | None | Little | Some | Much | Most |
|---|---|---|---|---|---|---|
| 1 | I have bad dreams about what happened or other bad dreams. | 0 | 1 | 2 | 3 | 4 |
| 2 | I have trouble going to sleep, waking up often, or getting back to sleep. | 0 | 1 | 2 | 3 | 4 |
| 3 | I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to. | 0 | 1 | 2 | 3 | 4 |
| 4 | When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches. | 0 | 1 | 2 | 3 | 4 |
| 5 | When something reminds me of what happened I get very upset, afraid, or sad. | 0 | 1 | 2 | 3 | 4 |
| 6 | I have trouble concentrating or paying attention. | 0 | 1 | 2 | 3 | 4 |
| 7 | I get upset easily or get into arguments or physical fights. | 0 | 1 | 2 | 3 | 4 |
| 8 | I try to stay away from people, places, or things that remind me about what happened. | 0 | 1 | 2 | 3 | 4 |
| 9 | I have trouble feeling happiness or love. | 0 | 1 | 2 | 3 | 4 |
| 10 | I try not to think about or have feelings about what happened. | 0 | 1 | 2 | 3 | 4 |
| 11 | I have thoughts like "I will never be able to trust other people." | 0 | 1 | 2 | 3 | 4 |
| 12 | I feel alone even when I'm around other people. | 0 | 1 | 2 | 3 | 4 |

| | | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 13 | *Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way? | | | | |

*Adapted from Patient Health Questionnaire (PHQ-A)

***Clinicians, please indicate actions taken:***

❑ **No Action Taken**

**Referrals:** (check all that apply)

- ❑ Child Protection (DCFS/CPS)
- ❑ Crisis Evaluation/Emergency Department
- ❑ Trauma Evidence-Based Treatment
- ❑ Mental Health Integration (MHI)

**In-office Interventions:** (check all that apply)

- ❑ Sleep Education
- ❑ Belly Breathing
- ❑ Guided Imagery
- ❑ Progressive Muscle Relaxation

Patient Name: _____ Patient DOB: _____ EMPI _____

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**Fig. 2.** Pediatric traumatic stress screening tool (11–18 years). (With permission from Behavioral Health Innovations (BHI). Retrieved from Intermountain Healthcare: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906. The suite of UCLA PTSD Reaction Index for DSM-5 instruments are available at www.reactionindex.com.)

Emerging evidence suggests that trauma and traumatic stress screening is feasible in pediatric primary care clinics and can achieve rates of adoption in these settings that are comparable to other recommended screening practices.[18] Data from the Intermountain Health System in the western United States suggest that routine trauma

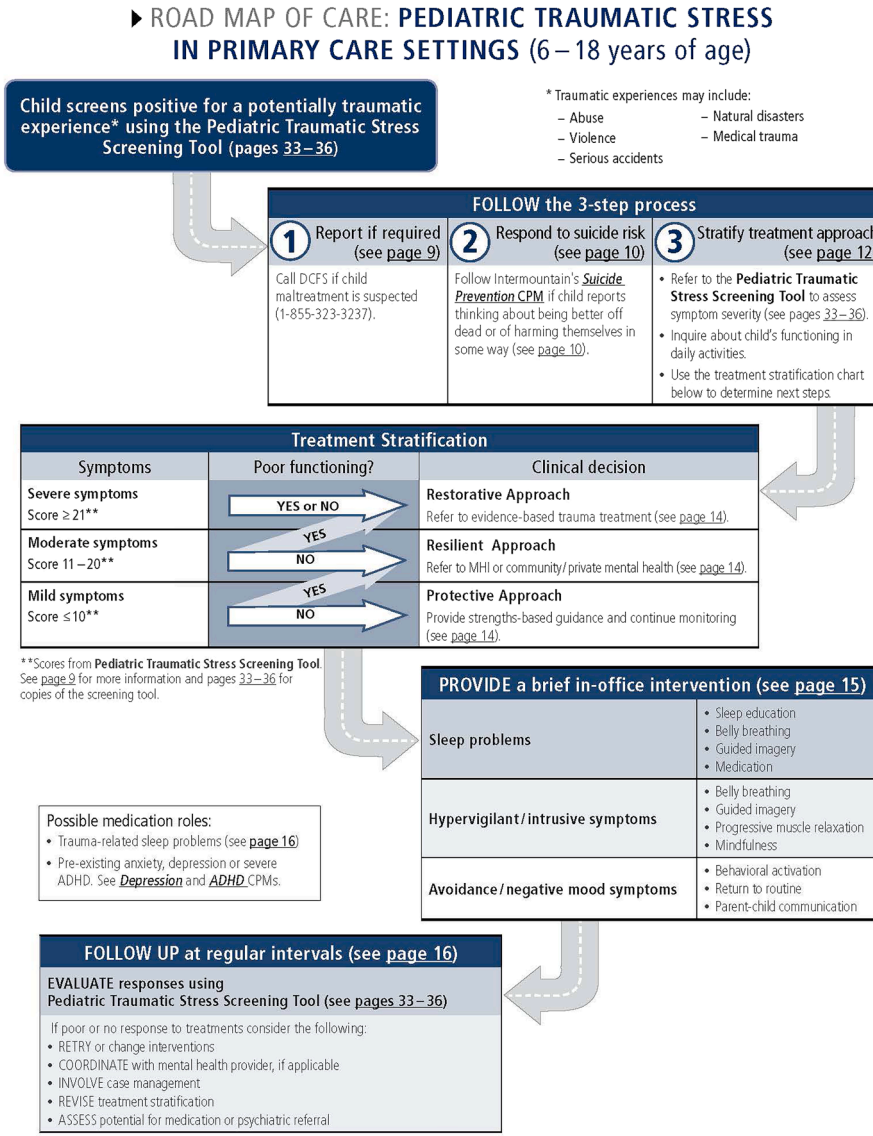


**Fig. 3.** Care process model for pediatric traumatic stress. (With permission from Behavioral Health Innovations (BHI). Retrieved from Intermountain Healthcare: https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906. The suite of UCLA PTSD Reaction Index for DSM-5 instruments are available at www.reactionindex.com.)

screening at well-child visits is effective at identifying children who have had potentially traumatic experiences and are experiencing traumatic stress symptoms.[18] It also highlights that, when screening for depression alone in pediatric primary care settings using the Patient Health Questionnaire for Adolescents (PHQ-A), more than half of children with moderate to severe traumatic stress symptoms will go undetected.[18]

For those children who are identified by other mental health screening tools like the PHQ-A, the addition of trauma screening may help clinicians more accurately

characterize and contextualize their symptoms.[18] Across well-child visits among older children and adolescents in the Intermountain Health System, half of all those with PHQ-A scores of 19 and above had trauma symptoms consistent with PTSD, suggesting that symptoms of depression may often be explained by traumatic stress rather than indicative of a primary depressive disorder and, thus, better addressed by evidence-based interventions for traumatic stress.[18,19] Furthermore, certain psychopharmacologic agents commonly prescribed in primary care, such as antidepressants, have little evidence to support their use in pediatric traumatic stress symptoms/pediatric PTSD.[20] Clinician misattribution of symptoms of traumatic stress to other psychiatric diagnoses, such as depression, may help explain the frequency of polypharmacy and high-dose prescribing of psychiatric medications to children with high rates of trauma such as in settings like the foster care system.[19,20] Thus, incorporating screening for trauma and traumatic stress symptoms into routine mental health screening practices is critical to ensuring children receive the evidence-based interventions that are most likely to help them.

### *Responding to Trauma and Traumatic Stress Symptoms*

It is important to note that simply identifying trauma and traumatic stress symptoms and then referring children and families to specialized mental health services is not the only goal of providing trauma-informed care. Not all youth with experiences of trauma need a therapy referral, and, even among those who would benefit from evidence-based assessment and treatment, many will never make it to therapy. Therefore, primary care pediatricians have an important role to play in discussing the results of screening with children and their families and providing them with accurate information about trauma, traumatic stress, and its potential short- and long-term effects.[10] Additionally, a trauma-informed response includes assessing identified events' impact on the child and family's functioning, supporting the child's and family's strengths and resiliency, and responding to concerns that are raised.[10] While responses must be tailored to the needs of each individual child and their family, there are some concepts that should always be included in a trauma-informed response, such as the capacity to take urgent or emergent steps to ensure the safety of the child in cases of ongoing child maltreatment, suicidality, or other safety risks.[2] For children who are currently symptomatic and suffering, in addition to possible referrals, the ability to provide brief, targeted in-office interventions to address prominent traumatic stress symptoms is also critical for a comprehensive trauma-informed response.[2]

The CPM-PTS provides an example of a structured, step-by-step trauma-informed approach to responding to positive trauma screens.[2] Following screening, the model prompts clinicians to follow a three-step process: (1) Report if required, (2) Respond to suicide risk, and (3) Stratify treatment approach.[17] Through this process, clinicians address any safety issues first before considering symptoms and therapy referrals, including reporting any cases of suspected child maltreatment or family violence to child protective services in accordance with local legal requirements, as well as responding to reported suicidality by completing a suicide risk assessment when indicated.[2] After addressing safety issues, the clinician is then prompted to respond to the child's traumatic stress symptoms with a brief, in-office intervention tailored to the severity and categories of reported traumatic stress symptoms (ie, sleep problems, hypervigilance or intrusive symptoms, avoidance or negative mood symptoms), as well as provide appropriate mental health referrals.[2]

Recognizing that each clinical setting is unique, trauma screening must be flexible and easily adapted to individual clinics' resources and needs. For example, in addition to primary care settings, the CPM-PTS has also been studied in child advocacy

centers that care exclusively for children who may have been maltreated or exposed to violence, where it has been shown to be feasible, acceptable, and effective at identifying youth with traumatic stress symptoms, as well as empowering both clinician and nonclinician staff to appropriately respond to issues of trauma, traumatic stress, and suicidality.[21–23]

The inclusion of suicide screening and response when screening for trauma is critically important. Trauma and traumatic stress symptoms are established risk factors for suicidality.[24,25] Studies conducted in child advocacy centers and pediatric primary care clinics have found high rates of comorbid traumatic stress symptoms and suicidality among adolescents.[18,22] Given these risks, pediatric primary care clinics that screen for trauma must have processes in place to respond to issues of suicidality that may arise while completing routine trauma screening. As an example, the CPM-PTS uses a two-step approach: initial identification of suicidal ideation risk by using question #9 from the PHQ-A followed by a follow-up screen using the Columbia Suicide Severity Rating Scale (C-SSRS) for any positives.[2,26] Use of tools like the C-SSRS helps guide clinicians in assessing the severity and urgency of an individual's suicide risk and inform appropriate responses, including safety planning, referral to outpatient mental health resources, and/or referral to emergency services.[22] Other approaches to suicide screening, such as the Ask Suicide Screening Questions followed by the Brief Suicide Safety Assessment when indicated, are also an effective means for detecting and stratifying suicide risk.[27]

Critical to the successful implementation of trauma and traumatic stress screening is the need for clinicians to have a comprehensive understanding of the mental health resources available in their communities. When incorporated into general mental health screening or assessment in primary care, trauma screening creates 2 distinct populations of children that may benefit from ongoing mental health services: those without histories of trauma and/or without significant traumatic stress who have mental health concerns and those with histories of trauma and experiencing traumatic stress. Those children who have distress and are traumatic stress can generally be referred to community-based or other general outpatient child mental health services. However, the research is clear that youth with significant and persistent traumatic stress best respond to evidence-based trauma treatments.[28]

To effectively ensure that youth with trauma and traumatic stress are going to be assessed by professionals or clinics that will be of greatest benefit, pediatricians need to know where they can refer families to connect them with age-appropriate, evidence-based, trauma-focused, and trauma-informed assessment and treatments for childhood traumatic stress, such as TF-CBT and CPP, as these therapies are not universally offered at all outpatient mental health practices.[2,10,29] Online databases are available to help clinicians and families identify providers that are certified in these therapies at www.tfcbt.org and www.childparentpsychotherapy.com, respectively. However, quite often phone calls and in-person visits by members of the primary care team to different mental health sites are necessary to truly understand the approaches and capacity of different settings to accept and work with trauma-exposed youth. Primary care pediatricians may find it helpful to develop and maintain resource lists that can be readily provided to families when indicated.

### *Populations at Risk of Trauma and Traumatic Stress*

Certain populations of children face a heightened risk of exposure to potentially traumatic events and subsequent traumatic stress symptoms due to systematic factors and other anticipated adversities.[10] Examples include children who are medically complex, identify as LGBTQ, have intellectual or developmental disabilities, are

involved in the child welfare system, have experienced homelessness or street involvement, or belong to military or veteran families or refugee or immigrant populations.[10,30] While it is important for pediatricians and child and adolescent psychiatrists to maintain a heightened awareness of the risks faced by children in these populations, it is important to note that many children who have adversity or are part of an "at risk" group do not experience significant trauma, and conversely many children exposed to potentially traumatic events do not belong to an "at risk" group. Thus, it is overly simplistic to think that all at-risk groups are traumatized or that primary care initiatives that solely target children belonging to at-risk populations for trauma and traumatic stress screening are sufficient, as both approaches will miss a large number of children who have experienced trauma. Instead, universal screening of all children presenting for routine pediatric visits provides the greatest opportunity to identify the most children experiencing traumatic stress symptoms and intervene.

It is also important to note that many children who have had a potentially traumatic experience will not have traumatic stress symptoms and/or require specialized mental health services. Integral to any trauma-informed practice is an awareness that simply knowing a child belongs to an at-risk group or has had a certain potentially traumatic experience does not tell the clinician how the child is functioning.[2] Pediatricians and child and adolescent psychiatrists should avoid making hasty judgements as to how any given experience may have impacted a particular child or family and identify opportunities to support children's and family's strengths and recovery efforts in addition to assessing for mental health or other concerns.

### *Role of the Child and Adolescent Psychiatrist in Pediatric Primary Care*

Regardless of their model of collaboration, child and adolescent psychiatrists have an important role to play in working with primary care pediatricians to provide care to children affected by trauma. As mental health experts, it is critical that child and adolescents psychiatrists have a thorough understanding of the multitude of ways in which trauma may contribute to a broad range of developmental and mental health problems, as they may be called upon to provide education and training, help clarify children's psychiatric diagnoses, and provide guidance on medication management to pediatricians treating children's mental health concerns in the primary care setting.[20]

Making a psychiatric diagnosis in the setting of trauma can be challenging, even for the most experienced mental health specialists. Children's traumatic stress symptoms are often consistent with symptoms of other common psychiatric disorders, such as depression, anxiety, and ADHD, due to the significant overlap in symptoms between psychiatric disorders.[20] Alternatively, these disorders may also be comorbid with one another.[10] In addition, children's presentations vary depending on the age at which the child was exposed to the potentially traumatic event(s).[20] Complex histories of multiple and/or sustained exposures to trauma may also further complicate clinicians' diagnostic assessments, leading children to accumulate numerous psychiatric diagnoses as their clinician(s) seek to explain important aspects of their clinical presentation.[20]

Misdiagnosis and the accumulation of multiple psychiatric diagnoses can lead pediatricians to recommend ineffective treatments and delay children's connection to the evidence-based interventions that are most likely to help them. Unlike for childhood depression and anxiety or adult PTSD, there is insufficient evidence to suggest that antidepressants are effective at treating childhood traumatic stress symptoms or PTSD.[20] Thus, guidelines recommend providing evidence-based psychotherapies before considering the use of any psychotropic medications in children with PTSD.[20] Likewise, children with traumatic stress symptoms often have significant

issues with sleep, which should be first addressed with appropriate psychoeducation and sleep hygiene counseling before considering the use of medications.[20]

However, it is not uncommon to find children with significant trauma histories who have been prescribed multiple psychotropic medications, including antipsychotics and benzodiazepines, which do not effectively address their traumatic stress symptoms but instead expose them to potential side effects and complications from polypharmacy.[20] Child and adolescent psychiatrists have an important role to play in advocating for and guiding the deprescribing of psychotropic medications when appropriate. Guidelines for the deprescribing of psychotropic medications in pediatric primary care were recently outlined in a 2020 clinical report from the AAP.[20,31]

Given the challenges of making an accurate psychiatric diagnosis in the setting of untreated or partially treated traumatic stress symptoms, clinicians should be wary of concluding that children are "treatment resistant" for diagnosed comorbidities that have not responded to interventions. Failure to respond to a particular psychotropic medication in a traumatized youth should prompt a thorough reevaluation of the child's psychiatric diagnosis and reconsideration of trauma/traumatic stress as the primary driver of distress prior to moving down a treatment-resistant pathway, such as considering the addition of a second or third psychiatric medication or continued titration of existing medications to supratherapeutic doses. It may be that traumatic stress symptoms better explain the child's current presentation or that the child's environment is perpetuating the child's distress, and they would be better served by an evidence-based psychotherapy for traumatic stress symptoms or other case management strategies rather than pursuing a treatment-resistant clinical pathway. It is also important to consider whether the child is facing continued exposure to trauma, such as through ongoing child maltreatment, as the child's symptoms may represent an appropriate response to ongoing danger rather than a diagnosable psychiatric issue that should be addressed by a psychotropic medication.[20]

## SUMMARY

Pediatricians have a critical role to play in providing trauma-informed care to the children and families that they serve. This includes leading efforts to prevent childhood trauma and bolster children's and families' resilience, identifying children who have experienced trauma and are suffering from traumatic stress symptoms, and intervening to address children's traumatic stress symptoms and promote children's and families' recovery after trauma. In this article, we have outlined how trauma screening, with structured protocol-based responses, can be used in pediatric primary care to aid pediatricians in identifying and appropriately responding to childhood traumatic stress in their practices. Child and adolescent psychiatrists can play an important role in supporting pediatricians by serving as a resource for accurate information on the impact of childhood trauma on child mental health and development and using this knowledge to provide informed guidance on the psychiatric diagnosis and treatment of children impacted by traumatic stress.

## CLINICS CARE POINTS

- Pediatricians and child and adolescent psychiatrists should provide trauma-informed care to the children and families that they serve and maintain awareness of the evidence-based trauma treatment resources available in their communities.
- Routine screening for trauma and traumatic stress symptoms in pediatric primary care—rather than ACEs screening—provides pediatricians with actionable information to support

the early identification of children affected by traumatic stress who may benefit from evidence-based trauma interventions.

- The Pediatric Traumatic Stress Screening Tool and accompanying Care Process Model for Pediatric Traumatic Stress are examples of flexible, evidence-based tools that have been specifically designed and studied for the outpatient pediatric setting to support clinicians in identifying and responding to childhood traumatic stress.
- Clinician responses to childhood traumatic stress in pediatric primary care must be tailored to the needs of the individual and family and should include addressing any ongoing safety issues (eg, child maltreatment and suicidality), providing psychoeducation and interventions for prominent traumatic stress symptoms, and offering any indicated referrals to external resources.
- While certain populations face heightened risk for exposure to traumatic stress, it is important to note that most children impacted by trauma do not belong to an "at risk" group and that many children exposed to potentially traumatic events do not experience functionally impairing traumatic stress symptoms.
- Child and adolescent psychiatrists can play an important role in supporting pediatricians' assessment and treatment of children with traumatic stress, as well as advocating for the dediagnosing and deprescribing of children affected by trauma when indicated.

## DISCLOSURES

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