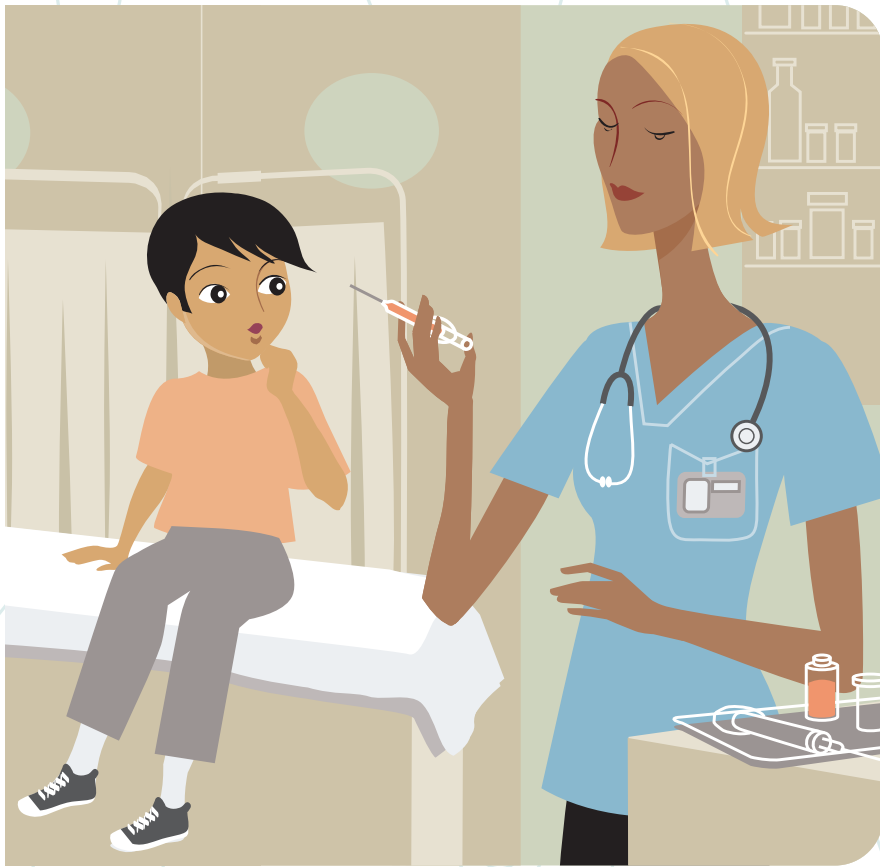




Pediatric Medical Traumatic Stress Toolkit

Your Guide to Using the Toolkit Effectively



Introduction

Some children and families experience medical traumatic stress at the moment of the traumatic injury or at the time of diagnosis. But they and others can experience traumatic stress at many points along the diagnostic and treatment continuum, and even after treatment ends.

All health care providers encountering children, regardless of discipline, should be “trauma-informed.” This means that it is important to incorporate an understanding of traumatic stress and related responses into routine encounters with children and families. Additionally, it is important that all health care professionals learn to provide basic interventions to children and families that will minimize the potential for ongoing trauma and maximize continuity of care. The D-E-F protocol provides a straightforward method for identifying, preventing, and treating traumatic stress responses at the time of your patient’s need and within your scope of practice.

To demonstrate how the D-E-F protocol can be effective, the stories of two children, Tommy — a school-aged boy struck by a car, and Maria — an adolescent girl newly diagnosed with cancer, are presented throughout this guide. These composite case stories are used to bring to life common issues about medical traumatic stress and to illustrate different approaches that health care providers can take to assessment and intervention using the D-E-F protocol.

Maria’s story pauses at several critical junctures — time of admission, diagnosis and treatment planning, inpatient treatment, treatment setback, discharge planning and outpatient treatment to address traumatic stress issues that are common to life-threatening illness and to recommend interventions that are specific to each care point. Tommy’s story demonstrates how a range of health care providers — from first responders, to emergency and trauma, general hospital, rehabilitation, discharge planning, and general pediatric providers — can effectively intervene with children and their families at multiple junctures central to traumatic injury.

Regardless of your discipline, we hope that the stories of Tommy and Maria will raise your awareness about the importance of responding to children and families experiencing medical traumatic stress and in incorporating the D-E-F protocol into your routine care.



Toolkit for Health Care Providers Treating Children with a Life-Threatening Illness

General Information:

- Having a life-threatening illness can be traumatic for children and families at many points along the diagnosis and treatment continuum (including survivorship,) and can be impacted by perception of life-threat.
- Perception of life threat is often unrelated to (objective) prognosis. Parents who believe that their child might die or children who believe that they could die can be at increased risk for persistent posttraumatic stress.
- Parents and siblings can also be affected, even after treatment ends. Some parents become hypervigilant for signs and symptoms that the illness has returned. Siblings may worry in private about their brother or sister.
- Treatment can be painful and emotionally difficult at times. Treatment setbacks sometimes occur, in addition to physical changes and limitations. Parents often feel helpless when they see their child in pain, and a child in pain can feel angry, frustrated or depressed. In addition to pharmacologic and behavioral interventions, emotional support and family resources are vital to helping children and families cope with the painful and emotional aspects of treatment.

Universal Interventions for Providers:

1. Educate yourself about traumatic stress responses in children and families in medical settings (see brochure.)
2. Actively assess and treat pain, using your hospital's protocol.
3. Take steps to minimize additional exposure to traumatic elements within the hospital environment (e.g. scary sights and sounds, painful procedures, etc.)
4. Provide information to parents on coping with traumatic stress responses. See parent handouts:
 - At The Hospital: Helping My Child Cope
 - At The Hospital: Helping My Teen Cope
 - After The Hospital: Helping My Child Cope

Maria is a typical 13 year-old girl — active, social, and friendly. One day, she complains to her mother of “not feeling quite right.” A few days later, Maria looks pale and complains of being tired all the time. She begins missing school and after school activities...

Maria’s mother becomes concerned and takes Maria to her pediatrician, thinking that she might have the flu or be anemic. The doctor examines Maria and does some blood tests. The next day, the doctor recommends that Maria and her mother see a specialist at the hospital for further evaluation for cancer.

More tests are done. Maria’s father leaves work early to join them at the hospital. The doctor tells mom and dad that they think Maria may have cancer, but he wants to admit her and do more tests to be sure. Mom and Dad become very worried. They arrange for their 15 year-old son, Anthony, to stay overnight with his grandmother.

Maria feels sick, but also feels scared and worried when she realizes that she may have cancer. She tells her mom that she wants to go home. Mom agrees to stay with Maria at the hospital and reassures her that the doctors have a lot of experience in treating patients with all kinds of illnesses.

Two days later, a team of oncologists tells Maria’s mom and dad that Maria has Leukemia — a common form of cancer in children. They give them comprehensive information regarding diagnosis and treatment, which includes chemotherapy. The doctors seem very hopeful. Maria’s parents can’t believe that Maria has cancer, and feel empty and numb at the news. Mom keeps thinking: “but she was fine two weeks ago...”

Maria’s parents and medical team tell Maria that she has cancer, and that it can often be treated with good success. However, she will need to stay in the hospital for awhile for treatment. Maria’s mother promises to stay with her. Maria gets upset and cries — she wonders to herself whether she will die. Maria’s parents try to be reassuring, even though they are unsure of how they feel themselves.

Maria begins meeting a lot of people — doctors, nurses, a social worker, and a teacher who will help her keep up with her schoolwork. The nurse also tells her about other teens on the floor with cancer. Even though she thinks that everyone is nice, Maria doesn’t want to say much to them. She gets upset when her mom leaves the room for just a few minutes.



Intervention Point: #1: ADMISSION

D E Providers and staff admitting Maria should understand that:

1. Unexpected hospitalization is associated with increased risk for posttraumatic stress for children and parents.
2. Like other families in their situation, Maria and her parents feel very anxious due to unexpected admission and uncertain diagnosis/prognosis.

Intervention Point #2: DIAGNOSIS & TREATMENT PLANNING

D E F Providers treating Maria should be aware that:

1. Time of diagnosis can be especially traumatic for children and families, and can be impacted by their perception of life-threat.
2. Perception of life threat can be unrelated to (objective) prognosis. Parents who believe that their child might die or children who believe that they will die can be at increased risk for posttraumatic stress.
3. As is the case with Maria and her parents, most initial responses to diagnosis, including shock and disbelief; crying; feeling worried or overwhelmed are common and often temporary.
4. Recent losses within the family or other family stressors can increase risk of posttraumatic stress responses.

See page 7 for recommended assessments and interventions for Maria and her family.

Maria's father brings in a package with cards and letters from Maria's friends and teachers at school. Maria is happy to hear from her friends. Her mother and the social worker help her decorate her room with the cards. Maria's mom suggests that she write a thank you letter to the school. The social worker recommends that Maria keep a journal of her hospital experience, as other teens have found this helpful. The social worker also suggests that she may be able to share parts of her journal with her friends and teachers after she returns to school.

Finally, with some encouragement, Maria begins to leave her room on a regular basis. She likes going to the group room for school lessons and the recreation room with the computers, books, and games. She begins meeting other patients with cancer, including some who have no hair and who look sick. Maria thinks she has little in common with them, and at first, doesn't want to make friends with them.

Maria's treatment is painful at times. Some of the medicines make her sick; she doesn't want to eat, and at times, she throws up. While she writes in her journal periodically, most days she says she "doesn't have anything to say." Her dad comes every night, and her brother frequently visits on weekends, along with her aunt. One night, Maria asks her mom: "Am I going to die?" Mom reassures Maria that both they and her doctors believe her cancer is treatable, and because of the chemo, she is going to feel sick sometimes. But privately, Mom is upset at seeing her daughter so ill, and wonders about whether she will die.



Intervention Point #3:

ADJUSTING TO INPATIENT TREATMENT

E Providers treating Maria while inpatient should be aware that:

1. Like Maria, children can initially feel isolated, alone, and self-conscious during a hospital stay. As a result they may withdraw from family and friends or feel depressed. These initial responses are often temporary, and improve with support.
2. During an initial hospital stay, children and parents often don't know what to expect. What may seem "routine" to providers, staff, and experienced families can seem unfamiliar, awkward, and sometimes frightening to newly admitted children and families. It is helpful to spend extra time with children and families initially, and to explain routines and procedures to them in advance.

Intervention Point # 4:

D E F COPING WITH PAINFUL TREATMENT

Providers treating Maria should be aware that:

1. Children who experience significant pain or painful treatment can experience traumatic stress reactions during treatment and are at increased risk for persistent posttraumatic stress.
2. In dealing with painful treatment, children and families sometimes feel helpless. It is often difficult for parents to see their children in pain. Combining the use of pharmacologic and behavioral interventions (e.g., teaching relaxation or distraction techniques) for pain management is often helpful.

See page 7 for recommended assessments and interventions for Maria and her family.



Maria's doctors decide she can go home for two weeks during a down cycle. At first, Maria feels very excited and happy to be home. Then, as the family tries to readjust to normal routines and expectations, Maria feels irritable because things don't feel the same to her. She and Tony fight a lot. After a week, Maria begins to feel very tired. She doesn't want to eat. She begins to have a fever one evening.

Maria's mother calls the doctor. They tell her to take Maria to the emergency department and she is readmitted. Maria begins to cry — she wants to go back home. The nurses stop by to say “Hi” and to tell her that they've missed her — but she doesn't want to talk to them. Mom suggests that they re-decorate Maria's new room, but she doesn't want to. Maria feels very angry to be back so soon.

Maria's treatment resumes. After a few days, clumps of Maria's hair begin to fall out. The social worker talks with Maria and her mother about how other patients have coped with having their hair fall out. Maria doesn't like the idea of wearing a wig, and she doesn't want a lot of other people to see her. She cries a lot and seems to withdraw from the staff and other patients at the hospital.

Slowly, with support from her family and treatment team, Maria begins to cope with the changes in her appearance. Thanks to her friends, she has a new collection of cool hats to wear. Still, she has good days and bad days. She begins to interact with other teens and staff on the floor again. She develops a pen-pal relationship with an older girl who had the same type of cancer a few years earlier and is now finished with treatment.

A few weeks later, Maria gets excited when the doctors say that she will soon be ready for treatment at the outpatient clinic. But, she worries about going home too; she's not sure how her friends will react, or if they will understand what she's been through. Mom is worried about how she will cope with all of Maria's medical needs at home, without the medical team around. She thinks to herself — “What if something happens to Maria and I'm not able to help her in time?”

Intervention Point #5: TREATMENT SETBACKS & EMOTIONAL REACTIONS

D E Providers treating Maria should be aware that:

1. Like Maria, common emotional responses to treatment and setbacks can include feeling sad, depressed, irritable, angry, scared, or withdrawing from others. These responses are often transient and improve with patience, understanding, and support.
2. Some children and parents experience treatment setbacks as failures, rather than as a “bump” in the treatment road. Setbacks can also trigger earlier distress and emotional reactions.
3. Emotional support and family resources are vital to helping children and families deal with emotional effects and treatment setbacks.

Intervention Point #6: DISCHARGE PLANNING

E F Providers treating Maria should be aware that:

1. Some families experience discharge as a time when they lose medical support and a sense of safety. They can worry about coping with medical and treatment issues at home, without frequent support. Providers can help families anticipate challenges they will face and problem-solve with them in advance, as well as provide reassurance.

See page 7 for recommended assessments and interventions for Maria and her family.

Maria finally goes home. The re-adjustment is difficult at first. Mom is anxious about letting Maria do the things she did before, while dad thinks the family should be getting back to normal. Maria's brother, Tony, is mad that Maria is getting "special treatment" at home, too. Maria has brief visits with friends, but she still feels different from them. Once a week, she gets a knot in her stomach when she has to go back to the outpatient clinic for treatment. There is talk of going back to school, but Maria is not sure if she's ready to go back. She worries that other kids at school might make fun of her or say things about her.

Maria *begins to adjust to outpatient treatment and life at home. Mom is less anxious about letting Maria do things on her own and has been giving her small chores to do around the house. Dad seems more relaxed, too. Tony, is more sympathetic and recently asked Maria a lot of questions about being in the hospital and having cancer. Maria's friends are visiting more often and she was able to attend an art show at her school where one of her drawings was displayed. Her parents and doctor have begun making plans for Maria to go back to school part-time. She is writing in her journal again.*



Intervention Point # 7:

OUTPATIENT TREATMENT

E

F

Outpatient providers treating Maria should be aware that:

1. Having a life-threatening illness can be traumatic for children and families, and can be impacted by perception of life-threat. Parents who believe that their child might die or children who believe that they could die can be at increased risk for persistent posttraumatic stress.
2. As in Maria's case, the transition from hospital to home can be difficult. Families can feel isolated from social and medical supports. Parents, children, and siblings may become irritable and anxious while trying to reestablish normal routines and expectations. Children may look and feel different and worry about how friends will react. These reactions are common, but can improve with understanding, support, and advance planning.
3. Recent losses within family or other family stressors can increase risk of posttraumatic stress during and after treatment.
4. Parents and siblings can also be affected, even after treatment ends. Some parents become hypervigilant for signs and symptoms that the illness has returned. Siblings may worry in private about their brother or sister. They may also feel jealous of the special attention their sibling is getting.

See page 7 for recommended assessments and interventions for Maria and her family.

How can I help Maria (and others like her) within the scope of my job?

ADMISSION:

- Provide simple explanations about what is happening and realistic expectations about what will happen next to reduce fears and worries.

DIAGNOSIS AND TREATMENT PLANNING:

- Acknowledge common emotional reactions to trauma and traumatic stress.
- Ask about fears and worries.
- Connect parents to family support resources in the hospital.
- Provide simple explanations about medical procedures and treatment to the child and family to reduce fears and worries.
- Provide child with as much age-appropriate involvement as possible in treatment planning.

ADJUSTING TO INPATIENT TREATMENT:

- Connect children and parents to supportive resources in the hospital.
- Provide simple explanations for medical routines and procedures to the child and family to reduce fears and worries.
- Help families establish daily routines and behavioral expectations, when possible.
- Identify family strengths and resources. Gauge family distress and other stressors.

COPING WITH PAINFUL TREATMENT, EMOTIONAL EFFECTS, AND TREATMENT SETBACKS:

- Acknowledge common emotional reactions to pain, painful treatment, and setbacks.
- Encourage and promote a stepped approach to confront emotionally painful thoughts, fears, worries and avoidant reactions.
- Combine pharmacologic and behavioral interventions (e.g., relaxation and distraction techniques) for pain management.
- Involve psychosocial staff in a team-based approach to helping the child and family experiencing setbacks or difficulties in treatment.

DISCHARGE PLANNING:

- Anticipate challenges in returning to the home environment and help families plan accordingly.
- Support child's physical and emotional transition to the home environment.

OUTPATIENT TREATMENT:

- Monitor child and family's physical and emotional recovery.
- Connect parents to family support resources in the community.
- Make referrals to mental health resources for children and families with symptoms of traumatic stress and those who are at increased risk. (See QUICK SCREEN.)

D-E-F Protocol for Assessing and Treating Children and Families with Traumatic Stress

D **DISTRESS** - Use brief assessment and indicated interventions for distress (see pocket card,) including:

- Provide child with as much information about what is happening and choices in decisions as possible.
- Listen carefully for child's understanding and clarify any misconceptions.
- Ask about fears and worries.
- Provide reassurance and realistic hope.

E **EMOTIONAL SUPPORT** - Use brief assessment and indicated interventions for emotional support (see pocket card,) including:

- Encourage parents to be with their child as much as possible and to talk with their child about worries and fears.
- Empower parents to comfort and help their child.
- Encourage child involvement in age-appropriate activities when possible.

F **FAMILY** - Use brief assessment and indicated interventions for family needs (see pocket card,) including:

- Gauge family distress, coping resources, and other stressors.
- Encourage parents to use own coping resources or resources available at the hospital or in the community.

D E F Use **QUICK SCREEN** (see pocket card,) to identify those who have traumatic stress symptoms or who are at greater risk for traumatic stress.

- Involve psychosocial staff in a team-based approach for those at higher risk.
- Make referrals to mental health resources when appropriate.



Toolkit for Health Care Providers Treating Children with a Traumatic Injury

General Information:

- Having a serious injury can be traumatic for children and families, and can be impacted by perception of life-threat.
- Perception of life threat is often unrelated to (objective) prognosis. Parents who believe that their child might die or children who believe that they might have died during the trauma event can be at increased risk for persistent posttraumatic stress.
- Parents and siblings can also be affected even after treatment ends. Some parents become hypervigilant regarding safety. Siblings may worry in private about their brother or sister.
- With injuries, acute pain is often involved, and children sometimes require painful treatment or experience chronic pain or physical limitations as a result. Parents often feel helpless when they see their child in pain, or unable to do things, and children can feel angry, frustrated, or depressed. In addition to pharmacologic and behavioral interventions, emotional support and family resources are vital to helping children and families cope with painful treatment or physical limitations, and their emotional effects.
- Recent losses, including those related to the trauma event, and other stressors within the family can increase risk of posttraumatic stress.

Universal Interventions for Providers:

1. Educate yourself about traumatic stress responses in children and families in medical settings (see brochure.)
2. Actively assess and treat pain, following your hospital's protocol.
3. Take steps to minimize additional exposure to traumatic elements within the hospital environment (e.g., scary sights and sounds, painful procedures, etc.)
4. Provide information to parents on coping with traumatic stress responses. See handouts:
 - At The Hospital: Helping My Child Cope
 - At The Hospital: Helping My Teen Cope
 - After The Hospital: Helping My Child Cope



Tommy is a typical 9 year-old boy playing soccer at the local recreation center. While playing one afternoon, Tommy runs after a loose ball into the street and is hit by a car...

A crowd of friends gathers around Tommy while waiting for the ambulance to come. Tommy appears awake, but he is dazed and not talking to anyone.

Tommy is rushed by ambulance to the emergency department. He is awake, disoriented, and crying to see his parents, who have not yet arrived. He tells a nurse that he is in pain and very scared. The nurse does her best to reassure Tommy and she spends a lot of time talking to him.

Tommy's parents arrive and he seems calmer. Tommy has surgery for internal injuries and a leg fracture and is admitted to the hospital for follow-up care.

Tommy's parents are very anxious and upset as they wait for news of his condition. They are dealing with a lot of forms to fill out, questions from strangers, and feelings of uncertainty. They also have to arrange for a relative take care of their other two children at home. People from the recreation center are calling and asking about Tommy. A social worker takes the time to talk with Tommy's parents.

Intervention Point #1: PREHOSPITAL AND FIRST RESPONSE

D Providers treating Tommy should be aware that:

1. The sights and sounds of an ambulance can be very frightening for children, who may overestimate life threat or seriousness of their condition.
2. A child's perception of life threat can be unrelated to actual injury severity; therefore, provider's medical impressions can be different from what the child is thinking or feeling.
3. Like many other children who may be in his situation, Tommy is in pain, separated from his parents, and feels alone and scared. All of these factors can contribute to current traumatic stress reactions in children and potential persistent posttraumatic stress.

Intervention Point #2: EMERGENCY AND TRAUMA

D E Providers treating Tommy should be aware that:

1. Tommy is in pain and initially separated from his parents, which are potential risk factors for persistent posttraumatic stress.
2. The sights and sounds of the emergency department and hospital can be very frightening for children, who may overestimate life threat and the seriousness of their condition.
3. A child's perception or impressions of life threat can be unrelated to actual injury severity; therefore providers' medical impressions can be different from what the child is thinking and feeling. All of these factors can contribute to current traumatic stress reactions in children and potential persistent posttraumatic stress.

See page 12 for recommended assessments and interventions for Tommy and his family.

Tommy's internal injuries are quite extensive. He is in critical condition for the first two days. Tommy's parents are very anxious and upset during this time. They are having a difficult time sorting through all of the medical information. A lot of friends and relatives are calling and they don't know what to tell them. Tommy's younger brother comes to the hospital and asks "Is Tommy going to die?"

Finally, Tommy begins to stabilize. He is talking and aware of his surroundings but still very confused about what happened. He cries a lot and is afraid to be left alone. Tommy's injuries are extensive enough to keep him in the hospital. He will need rehabilitation and physical therapy to help him walk correctly again.



Being in rehabilitation and having physical therapy is very difficult for Tommy at first. He cries and gets angry when he has a difficult time walking, and has nightmares about being chased by a car. He reports having flashbacks of being in the ambulance, alone, and scared. Tommy tells his parents "I never want to play soccer again!"



Intervention Point #3: INPATIENT CARE

E F Providers treating Tommy should be aware that:

1. Like other families in their situation, Tommy's parents feel anxious and upset due to unexpected hospitalization and uncertain prognosis, which are associated with increased traumatic stress responses.
2. Traumatic stress responses can be unrelated to injury severity. Parents who are afraid that their child might die, or children who are afraid that they might die at some point during the trauma can have more significant traumatic stress responses.
3. During initial hospitalization, children and parents often don't know what to expect. What may seem "routine" to providers, staff, and experienced families can seem unfamiliar, awkward, and sometimes frightening to newly admitted children and families. It is helpful to spend extra time with patients and families initially, and to explain routines and procedures to them in advance.

Intervention Point #4: REHABILITATION

D E F Providers treating Tommy should be aware that:

1. Children and families can become more anxious or upset as a result of changes in the medical environment, such as the transition to rehabilitation. They sometimes experience these transitions as losses, especially when it involves changes in providers or the treatment team.
2. Children can experience significant pain, emotional loss, anger or frustration when challenged to do something that once came naturally, but is now more difficult because of the injury. In addition, traumatic reminders of the event can be triggered during rehabilitation.
3. Children with significant physical injuries can often feel different from their peers. They might withdraw from friends and family or feel depressed as a result.

See page 12 for recommended assessments and interventions for Tommy and his family.

Tommy has made a lot of progress physically and has made some new friends at the rehabilitation center. Soon, it will be time for him to return home. He is anxious about leaving the hospital and says he never wants to go back to the recreation center again.

Tommy has returned home and things seem to go well the first few days. However, when it's time for Tommy to get in the car and return for outpatient physical therapy, he becomes irritable and refuses to leave the house. With Dad's encouragement, he finally gets into the car, but he is very quiet and withdrawn, even when he sees familiar staff there.



Over the next few days, Tommy complains of feeling sick, and not wanting to go anywhere. Mom arranges to have a few of Tommy's friends from the recreation center visit Tommy at home. They play some video games and Tommy seems to have fun.

The next day, Tommy has to go to his doctor. His mother drives near the recreation center on the way. Tommy begins to cry as they get near it, and mom feels a pit in her stomach and tears up, but doesn't say anything.

Tommy's doctor asks Tommy and his mother about how they and the rest of the family are coping with the accident. Tommy talks about how he still doesn't want to play soccer or go too far from home. Mom tells the doctor privately about Tommy's avoidance and other behaviors, and about her reaction to driving near the recreation center.

Tommy's doctor gives mom a handout about typical traumatic stress reactions and tips for coping. The doctor also gives mom a list of local counseling agencies, and asks mom to think about having Tommy and the family meet with a counselor for additional support.

Intervention Point #5: DISCHARGE PLANNING

E F Providers treating Tommy should be aware that:

1. Children and families can become anxious or agitated as a result of the transition from hospital to the home environment, and sometimes experience it as a loss of safety or security. Parents can initially worry about how they and their children will cope on their own, without frequent support.
2. Like many other children, Tommy displays some traumatic stress symptoms — including nightmares and flashbacks. Also, instead of returning to his usual activities, Tommy states that he never wants to play soccer again, a potential sign of avoidance. While avoidance can be common initially after a trauma, it may also signal ongoing traumatic stress responses.

Intervention Point #6: OUTPATIENT AND GENERAL PEDIATRICS

D E F Providers treating Tommy should be aware that:

1. Unexpected hospitalization, pain, and separation from parents are associated with increased risk for posttraumatic stress.
2. Traumatic stress responses can be unrelated to injury severity. Parents who are afraid that their child might die, or children who are afraid that they might die at some point during the trauma event can have more significant traumatic stress responses.
3. Parents and siblings can also be affected. Some parents become hypervigilant or avoidant. Siblings may worry in private about their brother or sister, and may also feel jealous of the special attention their sibling is getting.
4. Tommy has shown some avoidant symptoms — not wanting to get in the car; or go to outpatient appointments; not wanting to play soccer or drive near the recreation center. In addition, Tommy reported nightmares and flashbacks while at the hospital, all of which signal the potential for persistent posttraumatic stress.

See page 12 for recommended assessments and interventions for Tommy and his family.

How can I help Tommy (and others like him) within the scope of my job?

PREHOSPITAL PROVIDERS AND FIRST RESPONDERS:

- Minimize additional exposure to traumatic elements at the scene and during transport.
- Encourage parent presence, when possible.
- Provide simple explanations to child about what is happening and what is about to happen, when possible.

EMERGENCY AND TRAUMA PROVIDERS:

- Acknowledge common emotional reactions to trauma and traumatic stress.
- Ask about fears and worries and provide simple explanations for medical procedures to child and parents to reduce anxiety.
- Encourage parent presence and support parents in comforting.

INPATIENT HOSPITAL PROVIDERS:

- Connect child and parents to supportive resources in the hospital.
- Help families establish daily routines and behavioral expectations, when possible.
- Provide child with as much age-appropriate involvement as possible in daily care and decision-making.
- Identify family strengths and coping resources, and gauge family distress and other stressors.

REHABILITATION PROVIDERS:

- Support child's transition to the rehabilitation environment.
- Provide simple explanations for therapies or procedures to reduce the child's fears and worries.
- Encourage and promote a stepped approach to confront emotionally painful thoughts, fears, worries, and avoidant reactions.
- Involve psychosocial staff in a team-based approach to helping the child or family experiencing significant distress.

DISCHARGE PLANNING:

- Anticipate challenges in returning to the home environment and help families plan accordingly.
- Support child's physical and emotional transition to the home environment.

OUTPATIENT AND GENERAL PEDIATRICS:

- Monitor child and family's physical and emotional recovery.
- Connect parents to family support resources in the community.
- Make referrals to mental health resources for those with symptoms of traumatic stress and those at increased risk. (See QUICK SCREEN.)

D-E-F Protocol for Assessing and Treating Children and Families with Traumatic Stress

D **DISTRESS** - Use brief assessment and indicated interventions for distress (see pocket card,) including:

- Provide child with as much information about what is happening and choices in decisions as possible.
- Listen carefully for child's understanding and clarify any misconceptions.
- Provide reassurance and realistic hope.

E **EMOTIONAL SUPPORT** - Use brief assessment and indicated interventions for emotional support (see pocket card,) including:

- Encourage parents to be with their child as much as possible and to talk with their child about worries and fears.
- Empower parents to comfort and help their child.
- Encourage child involvement in age-appropriate activities when possible.

F **FAMILY** - Use brief assessment and indicated interventions for family needs (see pocket card,) including:

- Gauge family distress, coping resources, and other stressors.
- Encourage parents to use own coping resources or resources available at the hospital or in the community.

D E F Use **QUICK SCREEN** (see pocket card,) to identify those who have traumatic stress symptoms or who are at greater risk for traumatic stress.

- Involve psychosocial staff in a team-based approach for those at higher risk.
- Make referrals to mental health resources when appropriate.

NCTSN

The National Child
Traumatic Stress

www.NCTSN.net

