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www.reachmd.com
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(866) 423-7849

Understanding and Treating Trauma in Pediatric Patients: Key Management Strategies

Mr. Quigley:
Welcome to *Clinician's Roundtable* on ReachMD. I'm Ryan Quigley, and joining me to discuss the challenges of treating trauma in children and adolescents are Drs. Heather Forkey and Wynne Morgan, who presented on this topic at the 2025 American Academy of Pediatrics National Conference and Exhibition. Dr. Forkey is a Professor of Pediatrics and Vice Chair of Pediatrics at UMass Chan Medical School in Worcester, Massachusetts.

Dr. Forkey, thank you for being with us today.

Dr. Forkey:
Thank you. It's such a pleasure to be with you.

Mr. Quigley:
And Dr. Morgan is an Assistant Professor in the Departments of Psychiatry and Behavioral Sciences, also at UMass Chan Medical School.

Dr. Morgan, it's great to have you with us as well.

Dr. Morgan:
Thanks. I'm happy to be here.

Mr. Quigley:
So if we start off with some background, Dr. Forkey, how are children and adolescents impacted by trauma, and how is it different from how adults are impacted by trauma?

Dr. Forkey:
That's such a great question. I think where you want to start is sort of what all humans have in common, which is how we respond to stress. And most people have heard about the freeze response. So a threat comes at you; you can just stay still. For humans, that's not so useful, right? We're big. We get noticed. We're not a mouse or opossum. So we evolved to have fight or flight. It's much more effective if you can run away or fight, but children are not going to be really effective at that. And humans in general, we don't have claws, we can't hide underwater, so again, from an evolutionary standpoint, not our best bet.

So humans evolved to have a stress response, which we use most often, called the affiliate response. It's also kind of colloquially called tend and befriend. And what it means is that in most instances of threat or danger, we look to others and we say, "Hey, can you help me with this?" And it's mediated by oxytocin. We look and we sort of see, "Will you help me or won't you help me?" And if we find support, we gather that support to us, we deal with the threat, and all of that stress calms right down. If you think about it, kids are using this all the time. A baby cries for a bottle. A toddler says, "Pick me up." You know, all of the stressors of life are usually addressed through this affiliate response.

When kids experience trauma, though, they can't use affiliate. By the very definition of trauma, they've looked around for support, and they haven't been able to find it in the people or the surroundings around them, and so they're shoved over to fight or flight. And here's the difference between kids and adults, because that happens to all of us. But for kids, there's a developing brain and body. And that's different than an adult. So a human is born well before the brain and body are really ready to be outside, so the womb, because you have to get a human head through a female pelvis, and nine months is the max you can kind of keep it inside. So we actually have a

whole system by which an external brain externally regulates the human baby to kind of get them to an age where they can manage on their own. And that process of an adult supporting the child involves things like the adult attuning to the child, being in sync with that child, and co-regulating the child—sort of helping that child to manage the world.

A huge part of that process is that continued affiliate support, and if a child doesn't continue to get that affiliate support because the caregiver has their own challenges with mental illness or substance misuse, or the adult is overwhelmed and they can't provide it, the child winds up with only fight or flight at their disposal. And overuse of fight or flight floods this developing brain and body with cortisol and adrenaline, which has consequences for how that brain and body develop. It alters the trajectory of how we develop so that the child stays safe in the short term, but there are consequences for later life.

When an adult is under threat and they get shoved to fight or flight, the brain and the body is already developed, so the consequences are not as profound.

Mr. Quigley:
Thank you for that detailed breakdown, Dr. Forkey.

Now, turning to you, Dr. Morgan, when a child presents with tantrums, inattention, or hyperactivity, how can clinicians begin to distinguish trauma responses from ADHD or other behavioral diagnoses?

Dr. Morgan:
That's a really great question. And as a child and adolescent psychiatrist, that's one of the most common referral questions that I get in my clinic. Is this trauma-related symptoms, or is this ADHD? And what I can tell you is that in the moment when I'm first seeing that child, I really can't tell if the inattentiveness, temper tantrums, or oppositional behaviors are more related to the trauma-reactive symptoms or more related to ADHD or another disorder, like anxiety or depression. What's really important when we're first seeing children is identifying if they've experienced trauma or if there's been a traumatic event. When we're working with higher-risk populations, such as youth in the child welfare system or juvenile justice system, there's an assumption that there's been more chronic and cumulative trauma that they've experienced, so we always definitely want to have trauma on the differential for those populations.

The other really important piece when we're seeing children and trying to differentiate trauma-related symptoms versus ADHD or other comorbid systems is that developmental picture, so we really want to be able to get a good developmental history for these kiddos. So when did this behavior start? Did it start in relation to when that traumatic experience happened, or was it more of a chronic developmental picture? This gets complicated when there's also a developmental trauma picture as well that you can see with some of our children that are child-welfare involved.

The other really important piece is, where are these behaviors happening? So are these behaviors happening just at home, at school, or in both places? So making sure that we're getting collateral information, both listening to the caregiver in the family who's with the child, but then also making sure that we're talking with school teachers, therapists who are also involved with the child, or the child welfare system if they're involved in the child welfare system.

Mr. Quigley:
And now turning back to you, Dr. Forkey, what are some common diagnostic pitfalls that pediatricians encounter when assessing children with behavioral dysregulation tied to trauma?

Dr. Forkey:
So I think Dr. Morgan pointed out that that can be a really difficult challenge, and for the pediatrician, it's really important for them to ask the question, not just "What's wrong with you?" but "What happened to you?" And one of the biggest innovations in this area is that we now have excellent screening tools where we can ask families or kids themselves, "What experiences did you have?" but more importantly, "What symptoms are related to those experiences?" And that allows us to pair those screening tools for trauma with screening tools for ADHD, anxiety, and depression, so that put together, we begin to get a more full picture about what's going on. I think the problem in pediatrics is that sometimes we jump to what we're more familiar with seeing, like ADHD or anxiety, and we forget to ask that question, not "What's wrong with you?" but "What happened to you?"

Mr. Quigley:
That makes a lot of sense. Thank you, Dr. Forkey.

For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Ryan Quigley, and I'm speaking with Drs. Heather Forkey and Wynne Morgan about key considerations in managing children and adolescents experiencing trauma responses.

So, Dr. Morgan, back to you. Once you identify that a child or adolescent has experienced trauma, what are the key elements of building an effective treatment plan?

Dr. Morgan:
Yeah, so one of the most important pieces of an effective treatment plan for children who have experienced trauma is going to be safety. We want to ensure that where they are and where they're living is safe and that they have a sense of safety, and so it's really important to talk with the caregiver, parent, foster parent, or guardian to provide that reassurance to the child so that they know that they're in a safe environment. In pediatrics, we talk a lot about the safe, stable, and nurturing relationships, and so it's really important to build that connection with the caregiver who's caring for the child. So we want to provide that reassurance around safety to the child.

It's also important that children have routines. So when you've gone through a really stressful situation, we want to decrease that fight-or-flight response and ensure that the child feels safe. And part of feeling safe is having a routine, so knowing what's going to happen next. And so we want kids to have an effective routine, which means having a consistent bedtime, knowing when dinner is going to happen, knowing when school is going to happen. Knowing what's going to happen next is really reassuring to children, especially children who've experienced trauma and adversity.

The other key piece to the treatment plan for kiddos is relaxation and regulation—helping them be able to have some relaxation skills and regulate their emotions. So that might be some deep breathing, belly breathing, yoga, or long walks in nature—these are all really great things for children.

It's important to note that every child who experiences something bad—a trauma response—doesn't necessarily have a trauma disorder. So they don't necessarily have trauma-related symptoms, but if these symptoms of stress persist, there may be a place also for trauma-related therapy. And so it's really important that children that do have persistent trauma symptoms access trauma-based therapeutic supports, such as trauma-focused CBT.

Mr. Quigley:
Yeah, those are all very good things to implement, not even just for children, but for adults too. I mean, we could use myself as an example: having a nice routine, it feels comfortable. It's familiar. As Dr. Forkey mentioned earlier, how a child's brain is still developing, for them it's even more important, so that is very, very good advice.

And now, Dr. Forkey, how do you guide parents and caregivers in supporting children with trauma-related behaviors?

Dr. Forkey:
I think the first thing that we're doing is we're recognizing that the parents themselves are often overwhelmed by these behaviors and frightened for their child, so we want to promote affiliate support to the parent. "We're here for you; we're working on this together," so the parent's not in fight or flight. We're also doing psychoeducation with that parent to help them understand, why are you seeing these behaviors in the child? We use a phrase that was coined by another provider, which is "Children do well if they can." And when kids have experienced trauma, their reactions are actually appropriate given what's happened to them. And what we want to do is retrain the brain now that things are calmer or safer to calm down and sort of have responses that you would typically see outside of trauma.

So many of the tools that Dr. Morgan talked about are what we use as part of that psychoeducation of the parent. We're also giving them some practical tips of things to do at home, reminding them that kids who've experienced trauma often act younger than they are in age. So when they respond to the child, try to think about how would you respond to a child that was younger than your child. You wouldn't ask of a three-year-old the same things you ask of a nine-year-old, but your child may be behaving more like a three-year-old.

And then finally, we talk about, what are the supports that are going to need to happen, not just in your home but outside the home? What can we link you to in terms of community supports—not just therapeutic—but what other supports for that caregiver so that they don't feel so very alone in this process? One of the biggest things we're doing is providing a sense of hope that there's a way to solve this problem. It's not going to be this way forever.

Mr. Quigley:
Now, as we approach the end of our program, I have one last question for you, and this is for you, Dr. Morgan. What are some key practical takeaways that you want clinicians to remember when it comes to effectively identifying and treating trauma responses?

Dr. Morgan:
I think one of the most important takeaways is understanding the importance of relational health, and like Heather mentioned, trying to build that caregiver capacity. We really want to focus on supporting the caregiver to then be able to provide that safe and reassuring environment for the child. When children are having temper tantrums, it can be really, really difficult, and so one intervention that I use often, especially for my younger kids—my preschool or school-aged kiddos, but a child of any age—is something called time in or special time. And so that's ensuring that once a week there's one-on-one time that's with the child and the parent or caregiver, and that 20 minutes once a week is scheduled and always happens. Whether it's the worst week in the world, you're always going to have your

special time. And what that does over time is it reassures the child that that parent is always going to be there no matter what, and so it's consistent, it's predictively available, and you're building that relationship. And so then a lot of the negative attention-seeking behaviors, like those outbursts and temper tantrums that are so hard, over time will diminish.

Treating trauma is really a journey. There'll be ups and downs for parents, and so I think for pediatricians, it's really being that support for the caregiver in listening and helping them through that journey, and like Heather said, providing that hope that things will get better, that with that building that relational health and that consistency and predictive availability, that the child and the family will move forward and do better and recover from trauma.

Mr. Quigley:
And with those key takeaways in mind, I want to thank my guests, Drs. Heather Forkey and Wynne Morgan, for joining me to discuss how we can identify and treat trauma in children and adolescents. Dr. Forkey, it was great having you on the program today.

Dr. Forkey:
Thank you so much, Ryan. This was really fun to have a conversation with you.

Mr. Quigley:
Absolutely, likewise. And, Dr. Morgan, it was great having you on the program as well. It was a pleasure.

Dr. Morgan:
Thanks so much.

Mr. Quigley:
For ReachMD, my name is Ryan Quigley. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.