Helping Foster and Adoptive Families Cope With Trauma

June 19, 2013
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Questions

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• Questions will be answered at the end of the webinar, time permitting

• Today’s webinar will be recorded and posted online at www.aap.org/fostercare

• Any other questions or comments, please email Jonathan Faletti jfaletti@aap.org
1. Childhood Adversity & Toxic Stress  
Andrew S. Garner, MD, PhD, FAAP  

2. How to Identify Traumatized Children  
Heather C. Forkey, MD, FAAP  

3. Anticipatory Guidance  
John Stirling, MD, FAAP  

Thank You!  
Dave Thomas Foundation for Adoption  
Jockey Being Family  

Authors  
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Childhood Adversity & Toxic Stress

Andrew S. Garner, MD, PhD, FAAP
Children in Foster Care

• Significant early life trauma & adversity
  – Prenatal substance exposures
  – Inadequate parenting
    • Mental health conditions
    • Drug or alcohol addictions
    • Neglect
  – Being the victim of and/or witness to violence
    • Physical, sexual, emotional abuse
  – Multiple losses, separations, & major life changes

• Removal from home is traumatic

• What do we know about the impact?
ACE Study

- Adverse Childhood Experiences (ACE) Study
- 1995-1997
- > 17,000 middle-aged, middle class Americans in San Diego
- Retrospective assessment of childhood adversity (3 categories of abuse, 2 categories of neglect, 5 categories of household dysfunction)
- Associations with current physical, behavioral, and mental health status
# ACE Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Women (n=9,367)</th>
<th>Men (n=7,970)</th>
<th>Total (17,337)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>13.1%</td>
<td>7.6%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Physical</td>
<td>27.0%</td>
<td>29.9%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Sexual</td>
<td>24.7%</td>
<td>16.0%</td>
<td>20.7%</td>
</tr>
<tr>
<td><strong>Household Dysfunction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Treated Violently</td>
<td>13.7%</td>
<td>11.5%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Household Substance Abuse</td>
<td>29.5%</td>
<td>23.8%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Household Mental Illness</td>
<td>23.3%</td>
<td>14.8%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Parental Separation or Divorce</td>
<td>24.5%</td>
<td>21.8%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Incarcerated Household Member</td>
<td>5.2%</td>
<td>4.1%</td>
<td>4.7%</td>
</tr>
<tr>
<td><strong>Neglect</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>16.7%</td>
<td>12.4%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Physical</td>
<td>9.2%</td>
<td>10.7%</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

* Wave 2 data only (n=8,667)  
Data from [www.cdc.gov/nccdphp/ace/demographics](http://www.cdc.gov/nccdphp/ace/demographics)
ACEs Impact Multiple Outcomes

**Risk Factors for Common Diseases**
- Smoking
- Alcoholism
- Promiscuity
- Obesity
- High Perceived Risk of HIV
- Poor Perceived Health
- Illicit Drugs
- IV Drugs
- Multiple Somatic Symptoms

**Prevalent Diseases**
- Cancer
- Skeletal Fractures
- Liver Disease
- Chronic Lung Disease
- Ischemic Heart Disease
- Sexually Transmitted Diseases

**General Health and Social Functioning**
- Relationship Problems
- High perceived stress
- Married to an Alcoholic
- Difficulty in job performance

**Mental Health**
- Depression
- Anxiety
- Panic Reactions
- Poor Anger Control
- Memory Disturbances
- Sleep Disturbances

**Sexual Health**
- Teen Paternity
- Fetal Death
- Unintended Pregnancy
- Early Age of First Intercourse
- Sexual Dissatisfaction

**Poor Self-Rated Health**
- Hallucinations
- Difficulty in job performance
- High perceived stress
- Married to an Alcoholic

**ACEs**

- Smoking
- Alcoholism
- Promiscuity
- Obesity
- High Perceived Risk of HIV
- Poor Perceived Health
- Illicit Drugs
- IV Drugs
- Multiple Somatic Symptoms

- Cancer
- Skeletal Fractures
- Liver Disease
- Chronic Lung Disease
- Ischemic Heart Disease
- Sexually Transmitted Diseases
Linking Childhood Experiences and Adult Outcomes
Defining **Adversity or Stress**

- How do you define/measure adversity?
- Huge **individual variability**
  - Perception of adversity or stress (subjective)
  - Reaction to adversity or stress (objective)

- National Scientific Council on the Developing Child (Dr. Jack Shonkoff and colleagues)
  - **Positive** Stress
  - **Tolerable** Stress
  - **Toxic** Stress

Based on the **REACTION**
(objective physiologic responses)
Defining Adversity or Stress

**Positive Stress**
- Brief, infrequent, mild to moderate intensity
- Most normative childhood stress
  - Inability of the 15 month old to express their desires
  - The 2 year old who stumbles while running
  - Beginning school or daycare
  - The big project in middle school

- **Social-emotional buffers** allow a return to **baseline**
  (responding to non-verbal clues, consolation, reassurance, assistance in planning)

- **Builds motivation and resiliency**

- Positive Stress is **NOT** the **ABSENCE** of stress
Defining Adversity or Stress

- **Toxic Stress**
  - Long lasting, frequent, or strong intensity
  - More extreme precipitants of childhood stress (ACEs)
    - Physical, sexual, emotional abuse
    - Physical, emotional neglect
    - Household dysfunction

- **Insufficient social-emotional buffering**
  (Deficient levels of emotion coaching, re-processing, reassurance and support)
  - Potentially permanent changes and long-term effects
    - **Epigenetics** (there are life long / intergenerational changes in how the genetic program is turned **ON** or **OFF**)
    - **Brain architecture** (the mediators of stress impact upon the mechanisms of brain development / connectivity)
Development results from an ongoing, re-iterative, and cumulative dance between nurture and nature.
**Physiologic STRESS in Childhood**

<table>
<thead>
<tr>
<th>STRESS RESPONSE</th>
<th>Positive</th>
<th>Tolerable</th>
<th>Toxic</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURATION</td>
<td>Brief</td>
<td>Sustained</td>
<td>Sustained</td>
</tr>
<tr>
<td>SEVERITY</td>
<td>Mild/moderate</td>
<td>Moderate/severe</td>
<td>Severe</td>
</tr>
<tr>
<td>SOCIAL-EMOTIONAL BUFFERING</td>
<td>Sufficient</td>
<td>Sufficient</td>
<td>Insufficient</td>
</tr>
<tr>
<td>LONG-TERM Effect on Stress Response System</td>
<td>Return to baseline</td>
<td>Return to baseline</td>
<td>Changes to baseline</td>
</tr>
</tbody>
</table>

*Sources of resilience and other vulnerabilities are able to mitigate or exacerbate the physiologic stress response.*

**TRAUMATIC ALTERATIONS**

- Epigenetic modifications
- Changes in brain structure and function
- Behavioral attempts to cope
  - May be maladaptive in other contexts
Linking Childhood Experiences and Adult Outcomes

Childhood Adversity → Toxic Stress → Behavioral Allostasis → Poor Adult Outcomes

Toxic Stress
- Epigenetic Modifications
- Disruptions in Brain Architecture

Behavioral Allostasis
- Maladaptive behaviors
- Non-communicable Diseases

Improve caregiver/community capacity to prevent or minimize toxic stress (e.g. – efforts to promote the safe, stable and nurturing relationships that turn off the physiologic stress response)

Improve caregiver/community capacity to promote healthy, adaptive coping skills (e.g. - efforts to encourage rudimentary but foundational SE, language, and cognitive skills)
Pediatricians’ Role

Pediatricians are uniquely positioned to intervene through their:

• Regular interactions.
• Appreciation for the important roles played by families and communities.
• Developmental approach to health.
• Understanding of the advantages of prevention over remediation.
• Connections with the local resources/service providers.
• Awareness of the critical importance of effective advocacy.
Asking Families

Asking families about exposure to stress and potential associated symptoms:

• Communicates that it is a common problem.
• Begins to reduce the isolation and frustration associated with troublesome behaviors.
• Communicates that there are solutions ... but they may take time.
• Conveys that past trauma is threat to the healthy growth and development of children.
How to Identify Traumatized Children

Heather C. Forkey, MD, FAAP
What Trauma Looks Like
What Trauma Looks Like
What Trauma Looks Like
What Trauma Looks Like
How Do You Identify a Child Impacted by Trauma?
Trauma

• Stress and the tiger
  – Bodies designed to respond to stress
  – Adrenaline and cortisol help us run from tiger or hide
  – Threat of short duration
Trauma happens when the tiger lives in your home, neighborhood, or life
Assume that all children who have been adopted or fostered have experienced trauma.
Neurobiology of Trauma

Amygdala

- Input from sensory, memory and attention centers
  - Emotional memory system = The brain’s alarm system
Neurobiology of Trauma

Hippocampus

- Interface between cortex and lower brain areas.
- Major role in memory and learning.
  - The brain’s file cabinet or search engine.
Neurobiology of Trauma

- Frontal cortex
  - Executive function
    - Impulse control
    - Working memory
    - Cognitive flexibility

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MORE COMMON WITH</th>
<th>RESPONSE</th>
<th>MISIDENTIFIED AS AND/OR COMORBID WITH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociation (Dopaminergic)</td>
<td>● Females</td>
<td>● Detachment</td>
<td>● Depression</td>
</tr>
<tr>
<td></td>
<td>● Young children</td>
<td>● Numbing</td>
<td>● ADHD inattentive type</td>
</tr>
<tr>
<td></td>
<td>● Ongoing trauma/pain</td>
<td>● Compliance</td>
<td>● Developmental delay</td>
</tr>
<tr>
<td></td>
<td>● Inability to defend self</td>
<td>● Fantasy</td>
<td></td>
</tr>
<tr>
<td>Arousal (Adrenergic)</td>
<td>● Males</td>
<td>● Hypervigilance</td>
<td>● ADHD</td>
</tr>
<tr>
<td></td>
<td>● Older children</td>
<td>● Aggression</td>
<td>● ODD</td>
</tr>
<tr>
<td></td>
<td>● Witness to violence</td>
<td>● Anxiety</td>
<td>● Conduct disorder</td>
</tr>
<tr>
<td></td>
<td>● Inability to fight or flee</td>
<td>● Exaggerated response</td>
<td>● Bipolar disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>● Anger management difficulties</td>
</tr>
</tbody>
</table>
35 Month Old Was Kicked Out of Preschool

- Severe tantrums
- Hurts other kids, damages furniture
- Very short attention span
- BMI >95%
  - Eats all the time
  - Obese
- Not toilet trained
- Insomnia
<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>CENTRAL CAUSE</th>
<th>SYMPTOM(S)</th>
</tr>
</thead>
</table>
| Sleep      | Stimulation of reticular activating system        | 1. Difficulty falling asleep  
2. Difficulty staying asleep  
3. Nightmares |
| Eating     | Inhibition of satiety center, anxiety              | 1. Rapid eating  
2. Lack of satiety  
3. Food hoarding  
4. Loss of appetite |
| Toileting  | Increased sympathetic tone, increased catecholamines | 1. Constipation  
2. Encopresis  
3. Enuresis  
4. Regression of toileting skills |
Overeating

http://www.vivo.colostate.edu/hbooks/pathphys/digestion/pregastric/foodintake.html
Angie Just Can’t Get to Sleep
Not Sleeping

https://www.meducation.net/encyclopedia/reticular%20formation
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MORE COMMON WITH</th>
<th>RESPONSE</th>
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- Aggression  
- Anxiety  
- Exaggerated response | - ADHD  
- ODD  
- Conduct disorder  
- Bipolar disorder  
- Anger management difficulties |
The Baby is Fine

• 22 month old
• Very quiet, never cries, hides in every corner during exam
• Stays where put – not getting into everything
• Serious looking baby
Dissociative Continuum

- Infants & young children not capable of fighting or fleeing
  - Early stress: infants manifest precursor form of hyperarousal
    - Limited way to express distress to caretaker
Dissociative Continuum

• Defeat response
  – Dissociation describes mental mechanisms of
    • disengaging from the external world
    • attending to stimuli of the internal world
Trauma Responses: Adaptive and Protective When in Threatening Situation

- Same bodily functions and behaviors may be maladaptive when children are removed from the stressor
- When not examined within the context of past traumas can be misinterpreted as pathologic
ADHD – Really??
Neurobiology of Trauma

- Frontal cortex
  - Executive function
    - Impulse control
    - Working memory
    - Cognitive flexibility

## Response to Trauma: Development and Learning

<table>
<thead>
<tr>
<th>AGE</th>
<th>IMPACT ON WORKING MEMORY</th>
<th>IMPACT ON INHIBITORY CONTROL</th>
<th>IMPACT ON COGNITIVE FLEXIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant / toddler / pre-schooler</td>
<td>Difficulty acquiring developmental milestones</td>
<td>Frequent severe tantrums</td>
<td>Easily frustrated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aggressive with other children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attachment may be impacted</td>
<td></td>
</tr>
<tr>
<td>School-aged child</td>
<td>Difficulty with school skill acquisition</td>
<td>Frequently in trouble at school and with peers for fighting and disrupting</td>
<td>Organizational difficulties</td>
</tr>
<tr>
<td></td>
<td>Losing details can lead to confabulation, viewed by others as lying</td>
<td></td>
<td>Can look like learning problems or ADHD</td>
</tr>
<tr>
<td>Adolescent</td>
<td>Difficulty keeping up with material as academics advance</td>
<td>Impulsive actions which can threaten health and well-being</td>
<td>Difficulty assuming tasks of young adulthood which require rapid interpretation of information: ie, driving, functioning in workforce</td>
</tr>
<tr>
<td></td>
<td>Trouble keeping school work and home life organized</td>
<td>Actions can lead to involvement with law enforcement and increasingly serious consequences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confabulation increasingly interpreted by others as integrity issue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Screening for Trauma

• Questions
  – Since the last time I saw you (your child) has anything really scary or upsetting happened to you (your child) or anyone in your family?
  
  – You have told me that your child is having difficulty with aggression, attention and sleep. Just as fever is an indication the body is dealing with an infection, when these behavioral symptoms are present, they indicate that the brain and body are responding to a stress or threat. Do you have any concerns that your child is being exposed to threat?”
Screening for Trauma

“The behaviors you describe and the trouble she is having with school and learning are often warning signs that the brain is trying to manage stress or threat. Sometimes children respond this way if they are being harmed, or if they are witnessing others they care about being harmed. Do you know of any violence exposure at school, with friends, or at home?”
<table>
<thead>
<tr>
<th>TOOL</th>
<th>DESCRIPTION</th>
<th>NUMBER OF ITEMS AND FORMAT</th>
<th>AGE GROUP</th>
<th>ADMIN AND SCORING TIME</th>
<th>CULTURAL CONSIDERATIONS</th>
<th>COST AND DEVELOPER</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLA PTSD - RI: Post Traumatic Stress Disorder Reaction Index*</td>
<td>Assesses exposure to trauma and impact of events</td>
<td>20-22 items depending on child, parent, or youth version</td>
<td>Child and Parent: 7-12 years; Youth 13+</td>
<td>20-30 min to administer 5-10 min to score</td>
<td>English, Spanish</td>
<td>Available to International Society for Traumatic Stress Studies members</td>
</tr>
<tr>
<td>Abbreviated UCLA PTSD RI</td>
<td>Elicits trauma-related symptoms</td>
<td>9 items for child 6 items for adult</td>
<td>8-16 years 3-12 years</td>
<td>2-5 min</td>
<td>English, Spanish</td>
<td>Available to International Society for Traumatic Stress Studies members</td>
</tr>
<tr>
<td>TSC-C Trauma Symptom Checklist for Children</td>
<td>Elicits trauma-related symptoms</td>
<td>TSC-C: 54 items TSC-YC: 90 items, caregiver report for young children</td>
<td>8-16 years 3-12 years</td>
<td>15-20 min</td>
<td>English, Spanish</td>
<td>Proprietary ($172-$230 per kit)</td>
</tr>
</tbody>
</table>
## Therapies for the Traumatized Child

<table>
<thead>
<tr>
<th>AGE</th>
<th>THERAPY</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young child 0-5 years</td>
<td>• PCIT – Parent Child Interactive Therapy</td>
<td>Works with caregivers and children to address child behaviors observed during play.</td>
</tr>
<tr>
<td></td>
<td>• CPP – Child Parent Psychotherapy</td>
<td>A dyadic intervention that targets the impact of trauma on the child-parent relationship and how the parent can provide emotional safety for the child.</td>
</tr>
<tr>
<td>Older children</td>
<td>• TF-CBT – Trauma Focused Cognitive Behavioral Therapy (for children 5 and older)</td>
<td>Trains children and families in:</td>
</tr>
<tr>
<td></td>
<td>• CBITS – Cognitive Behavioral Intervention for Trauma In Schools (for high school-aged youth)</td>
<td>• relaxation techniques</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• skills and language to access emotion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• psychoeducation</td>
</tr>
<tr>
<td>Both older and younger children</td>
<td>• ARC – Attachment, Self-Regulation, and Competency</td>
<td>Then, child is guided to create a trauma narrative. Child develops/writes a story about what happened to him or her.</td>
</tr>
<tr>
<td>with complex trauma/attachment</td>
<td></td>
<td>When the child is able to tell or read this story to the caregiver, it indicates the trauma no longer defines the child, but is instead a story of what happened, having lost its power to continue to harm.</td>
</tr>
<tr>
<td>concerns</td>
<td></td>
<td>To support healthy relationships between children and their caregiving systems to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• support resources and safety for adult members of the family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• build all family members’ ability to manage feelings, body sensations, and behaviors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• improve problem solving skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• support healthy development of identity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• support the child in processing/integrating stressful life experiences</td>
</tr>
</tbody>
</table>
Trauma Treatments

– Child Parent Psychotherapy (CPP)

• Observing child behavior or play with therapist
• Facilitates interactions/understanding behaviors
• Caregiver guided to identify trauma narrative and triggers for caregiver and child
Therapy for Older Children

• Trains children and families in:
  – Relaxation techniques.
  – Skills and language to access emotion.
  – Psychoeducation.

• Child is guided to create a trauma narrative.
  – Child develops a story about what happened to them.

• Final goal: Child is able to tell or read story
  – Trauma no longer has capacity to hurt child
Attachment, Self Regulation and Competency (ARC)

- **Attachment:**
  - Caregiver Affect Mgt
  - Attunement
  - Consistent Response
  - Routines and Rituals

- **Self-Regulation**
  - Affect Identification
  - Modulation
  - Expression

- **Competency:**
  - Executive Functions
  - Self and Identity

- **Trauma Experience Integration**

For more info on ARC see: http://nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf
Visit with family who has a child in foster care or a child who has been adopted

Identification of trauma:
- Review existing diagnosis (p8)
- Review symptoms (p8)
- Use screening questions and / or instrument (p10)

Are concerns identified?

YES
- Guide, advise, assist:
  - Use script (p11)
  - Anticipatory guidance (p12)
  - Referral for evidence-based intervention (EBI) (p13)
  - Provide discharge plan (pocket)

NO
- Is the child new to the family?

YES
- Rescreen for trauma in 1–3 months

NO
- Rescreen for trauma in 6–12 months

Follow-up (visit / phone 2–4 wks):
- Did child receive EBI?
- Child’s status (home, school, intervention)
- Caregiver status / needs
- Case management: Contact with mental health provider
Anticipatory Guidance

John Stirling, MD, FAAP
What’s Our Job?
Children in Foster Care Are Children With Special Health Care Needs

- Medical needs
- Developmental delays
- History of toxic stress: trauma, neglect, grief
- Attachment difficulties
- Maladaptive behaviors
What’s a Maladaptive Behavior?

- One that brings about negative results,
- Usually learned in a different setting, where it worked, and
- Which persists because of some gain.
- AKA: “mental health needs,” diagnosed as:
  - Attention Deficit Hyperactivity Disorder
  - Oppositional Defiant Disorder
  - Bipolar disorder
What Do Parents Need to Know?

Kids who have lived with toxic stress may have:

• “Hair trigger” emotional responses
• Difficulty regulating their arousal
• Reluctance to turn to others for help (trust)
• Inability to discuss their emotional feelings
• Insecurity over food, safety, or relationships
What Do You Need to Know?

• What do the parents see as the problem?
  – Preconceptions, fears

• What kind of experiences have they had?
  – Strengths, weaknesses

• Who will be there to help them?
  – Sources of support

Begin by listening!
What’s a Parent’s Job?

• Parents are teachers
  – Show the kids what’s important
  – Show them what works

• Good teachers are:
  – Responsive
  – Consistent
  – Predictable
Changing Behavior

• Changing learned behaviors takes time
  – The more the child sees a behavior as protective, the harder it is to change

• Keep the lesson simple, and logical

• Discipline is not the same as punishment

• Anger
  – Can trigger the threat/safety response
  – Which makes learning difficult
Tips to Teach

• Learn to notice and avoid emotional “triggers”
• Allow control: Keep to a routine, give choices
• Don’t take behaviors personally
• Remain as calm, patient, logical as possible
• Acknowledge (and respect) the child’s feelings
• Don’t expect quick results!
Children Are Doing the Best They Can!

- Parents’ job is to teach them how to adapt to our world
- Our job is to support them as teachers
- If we’re both patient and persistent, and listen to each other, we can help make the transition successful.
can I have the life I always dreamed of?
Using the Discharge Form

- Summarizes findings
  - Trauma reactions
  - Developmental, medical issues
- Directs next steps
Pediatrics subscribers will receive a complimentary hard copy of the trauma materials in the November issue!
Questions?

To ask a question, please type your question in the box on the right.

www.aap.org/traumaguide