Trauma-Informed Care

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With content adapted from presentation with Katharine Barnard, MD
Questions we will look at today

• What is trauma and how does it affect people’s development, their brains and their behavior?

• How does a trauma history “show up” in medical settings?

• How do we respond to it?

• How do we take care of ourselves when working with people who have had traumatic experiences?
Definitions

**Trauma**: Events that cause intense physical and psychological stress reactions. These events may include combat exposure, sexual or physical abuse, serious accidents, natural disasters, and terrorist attacks.

**Posttraumatic stress disorder**: Exposure to actual or threatened death, serious injury, or sexual violence that produces significant distress and impairment for more than four weeks. The DSM-5 (APA, 2013a) identifies four symptom clusters: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity.

**Trauma-informed care**: A service delivery approach “grounded in an understanding and responsiveness to the impact of trauma” (Hopper, Bassuk, & Olivet, 2010, p. 82). It emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and environment. It also involves vigilance in anticipating and avoid institutional processes and individual practices that are likely to re-traumatize individuals with a history of trauma (SAMHSA, 2014).

**Vicarious trauma**: The process of change that happens to providers over time as they witness and engage with other people’s suffering and need.
WHAT ARE ACES?

AND HOW DO THEY RELATE TO TOXIC STRESS?

“ACEs” stands for “Adverse Childhood Experiences.” These experiences can include things like physical and emotional abuse, neglect, caregiver mental illness, and household violence.

The more ACEs a child experiences, the more likely he or she is to suffer from things like heart disease and diabetes, poor academic achievement, and substance abuse later in life.

https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/
TOXIC STRESS Explains How Aces “GET UNDER THE SKIN.”

Experiencing many ACEs, as well as things like racism and community violence, without supportive adults, can cause what’s known as toxic stress. This excessive activation of the stress-response system can lead to long-lasting wear-and-tear on the body and brain.

The effect would be similar to revving a car engine for days or weeks at a time.

https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/
Three Types of ACEs

ABUSE
- Physical
- Emotional
- Sexual

NEGLECT
- Physical
- Emotional
- Divorce

HOUSEHOLD DYSFUNCTION
- Mental Illness
- Mother treated violently
- Substance Abuse
- Incarcerated Relative

https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean
ACEs increase health risks:

**Behavior**
- Lack of physical activity
- Smoking
- Alcoholism
- Drug use
- Missed work

**Physical & Mental Health**
- Severe obesity
- Diabetes
- Depression
- Suicide attempts
- STDs
- Heart disease
- Cancer
- Stroke
- COPD
- Broken bones

https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean
Allostatic Load

"the wear and tear on the body" that accumulates as an individual is exposed to repeated or chronic stress, and fluctuating or heightened neural or neuroendocrine response

HOMEOSTASIS is about balance
ALLOSTASIS is about adjusting to stress
ALLOSTATIC LOAD means coping with chronic stress but experiencing slow breakdown
THE NORMAL STRESS RESPONSE:
- Amygdala > hypothalamus > adrenals release adrenaline to activate the sympathetic nervous system
- Pro-inflammatory cytokines are released, “fight or flight” mechanism activated
- For short term stress there is a feedback loop that shuts it down.

VERSUS TRAUMATIC TOXIC STRESS (allostatic load):
- Sustained activation of stress response: at first excess cortisol and later relative lack of cortisol.
- Disruption of immune and neuroendocrine systems
- Leads to chronic disease
So what do we do?
Core Principles of Trauma-informed care

1. Realizing the widespread impact of trauma
2. Recognizing signs and symptoms of trauma, including in patients and their families and in staff and clinical team members
3. Responding by fully integrating knowledge about trauma into policies, procedures, and practices
4. Seeking to actively resist retraumatization

<table>
<thead>
<tr>
<th>Trauma Informed Principles</th>
<th>Relationship-Centered Care (what we do in Family Medicine!)</th>
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<tbody>
<tr>
<td>Safety</td>
<td>Reliability &amp; Consistency</td>
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<tr>
<td>Trustworthiness</td>
<td>Commitment</td>
</tr>
<tr>
<td>Empowerment, Voice &amp; Choice</td>
<td>Continuity</td>
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<tr>
<td>Collaboration &amp; Mutuality</td>
<td>Connectedness &amp; Reciprocity</td>
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<tr>
<td>Peer Support</td>
<td>Caring &amp; Affinity</td>
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<td>Cultural, Historic &amp; Gender Issues</td>
<td>Whole-person care</td>
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## Strategies to help patients with trauma-related behaviors

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Anger + irritability</td>
<td>Try to de-escalate. Be calm, listen. Try not to take it personally.</td>
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<td>Discomfort</td>
<td>Understand patients may want to be near an exit, have a clear view of the entire waiting room, or wait away from others.</td>
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<tr>
<td>Trust</td>
<td>Patients may insist on only seeing their regular provider.</td>
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<tr>
<td>Startle</td>
<td>Avoid loud sounds or approaching a patient from behind.</td>
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<tr>
<td>Avoidance</td>
<td>Don’t use touch or an overly cheerful attitude to coax someone out of his/her shell.</td>
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<td>Traumatic reminders</td>
<td>Work with the patient to learn cues he/she associates with past trauma (e.g., physical examination by a professional of the same sex as a perpetrator of abuse).</td>
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<tr>
<td>Sleep problems</td>
<td>Understand patients may be tired or irritable because of poor sleep.</td>
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<tr>
<td>Trouble concentrating</td>
<td>Try repeating information and/or writing it down.</td>
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<tr>
<td>Feelings of powerlessness</td>
<td>Actively involve patients in treatment decisions.</td>
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### Table 2. Trauma-Informed Care Actions for Physicians

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<thead>
<tr>
<th>Previsit</th>
<th>Invasive examinations and procedures</th>
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<tbody>
<tr>
<td>Review the patient’s chart for trauma-related documentation to avoid asking the patient to repeat this history and to improve visit preparation</td>
<td>Determine whether alternate measures can be taken for certain examinations (e.g., offering self-insertion of swabs for vaginitis workup instead of speculum examination)</td>
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<tr>
<td>Be seated to decrease the existing power differential between physicians and patients; encourage residents, students, or other present staff to also be seated</td>
<td>Ask whether the patient would like to have another person in the room for support</td>
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<td>Offer options for the patient to be interviewed alone (e.g., have support staff care for accompanying children)</td>
<td>Describe the entire procedure, obtain consent, and set up the appropriate equipment (e.g., remove packaging from swabs and papanicolaou smear containers, and apply lubrication on scopes or speculum) before the patient removes clothing</td>
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<tr>
<td>Emphasize confidentiality as the encounter begins</td>
<td>Describe ways in which the examination may interact with senses (e.g., “You may hear clicks when the speculum is opened”; “The lubrication on the speculum/anoscope may feel cool”; or “You may experience a gagging sensation with the throat swab”)</td>
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<tr>
<td>Prepare the patient for what to expect with regard to history, examination, and any procedures</td>
<td>Discuss in advance that the patient can dictate the pace of the examination and can signal to you (through verbal or nonverbal signals) if there is any discomfort or a break is needed</td>
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<tr>
<td>Make the patient aware that you may be taking notes during the encounter to ensure thoroughness in addressing all questions and concerns</td>
<td>Offer speculum self-insertion</td>
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<tr>
<td>Explain the rationale for sensitive questions, such as when eliciting substance use and sexual history</td>
<td>Practice suggestive instead of instructive language (e.g., replace the phrase “Take a deep breath and relax” with “Some people find it helpful to take a deep breath during this part of the examination”)</td>
</tr>
<tr>
<td>If a language interpreter is being used, when possible, ask if the patient has a gender and/or cultural preference for the interpreter</td>
<td>Have postprocedure supplies ready to provide to patient (e.g., tissues or wipes following speculum examination or anoscope)</td>
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#### Physical examination

| Ask patients if there are any parts of the physical examination that they feel anxious about, and if there is anything you can do to help make the physical examination feel more comfortable | Imaging |
| Ask the patient to shift his or her clothing out of the way instead of doing it yourself (e.g., lifting his or her own shirt for an abdominal examination) | Alert the patient in advance if imaging may be invasive (e.g., transvaginal or scrotal ultrasonography), constrictive (e.g., magnetic resonance imaging), or weighted (e.g., lead aprons for chest radiography) |
| Ask the patient for permission before conducting each section of physical examination (e.g., when moving from heart to lung examination) | Referrals |
| | Notify referrals in advance regarding relevant trauma history so colleagues are appropriately prepared |

#### Postvisit

| Provide written after-care instructions and follow-up plan in case patients experience dissociation or distracting anxiety during the visit | Choose sensitive language for diagnoses in visit summaries that are provided to patients and in documentation |

Information from references 3, 4, and 11 through 13.
Vicarious Trauma

“Vicarious trauma is a process of change resulting from empathetic engagement with trauma survivors.

Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals.”

Signs of vicarious trauma

- experiencing lingering feelings of anger, rage and sadness about patient's victimization
- becoming overly involved emotionally with the patient
- experiencing bystander guilt, shame, feelings of self-doubt
- being preoccupied with thoughts of patients outside of the work situation
- over identification with the patient (having horror and rescue fantasies)
- loss of hope, pessimism, cynicism
- distancing, numbing, detachment, cutting patients off, staying busy. Avoiding listening to client's story of traumatic experiences
- difficulty in maintaining professional boundaries with the client, such as overextending self (trying to do more than is in the role to help the patient).

Strategies to help cope with vicarious trauma

• Increase your self-observation - recognize and chart your signs of stress, vicarious trauma and burnout.
• Take care of yourself emotionally - engage in relaxing and self-soothing activities, nurture self-care.
• Look after your physical and mental wellbeing.
• Maintain a healthy work/life balance - have outside interests.
• Be realistic about what you can accomplish - avoid wishful thinking.
• Don't take on responsibility for your patients' wellbeing but supply them with tools to look after themselves.

Strategies to help cope with vicarious trauma

• Take regular breaks, take time off when you need to.
• Seek social support from colleagues, family members.
• Use a buddy system - particularly important for less experienced doctors.
• Use peer support and opportunities to debrief.
• Take up training opportunities.
• If you need it, take up time-limited group or individual therapy.
• There are also significant organizational factors that can increase the risk of a person being vicariously traumatized, which should be assessed and addressed.