

# Trauma Informed Healthcare: From Theory to Practice

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# Goals

- Review prevalence of traumatic events, including sexual assault, domestic violence, elder abuse, child abuse, combat, community violence, and refugee trauma
- Understand how trauma is processed behaviorally, emotionally, and physiologically
- Discuss how traumatic events are related to negative ways of coping and disease outcomes
- Communicate effectively with trauma survivors through universal trauma precautions
- Provide practical suggestions for providing trauma-informed care for family planning services
- Utilize screening as appropriate



# Defining Trauma



# DSM-V PTEs

- Based on the DSM V: The person has been exposed to a traumatic event where they experience, witness, or are confronted with death (or threatened death), serious injury, or threat to physical integrity
- Motor Vehicle Accidents, Natural Disasters, Sexual Assault, Childhood Sexual Abuse, Domestic Violence, Community Violence, Combat, Elder Abuse, Homicide, Suicide of Loved One



# What is Stress?

- Positive stress
  - Normal, essential for healthy development
  - Brief elevations in heart rate, hormone levels
  - Everyday stressors of childhood



Source: [Center on the Developing Child \(Harvard\)](#)



# What is Stress?

- Tolerable stress
  - Longer lasting activation of stress response
  - Loss of a loved one, natural disasters, caregiver illness, chronic illness
  - Social support is a key to buffering



Source: [Center on the Developing Child \(Harvard\)](#)

# Toxic Stress

- Strong, frequent or prolonged stressors
- Abuse, neglect, caregiver mental illness or incarceration, poverty
- Lack of adult support
- Disrupts brain & body functioning
  - Leaves child vulnerable to future physical, emotional and cognitive disruptions

Source: [Center on the Developing Child \(Harvard\)](#)



# What is PTSD?

- Reliving the event (re-experiencing symptoms)
- Avoiding situational reminders
- An increase in negative beliefs (about yourself, others, and the world)
- Feeling keyed up (hyperarousal)





# What is Trauma? A Practical Definition

- Non-consensual
- Victim is in discomfort, fear, feels intimidated
- Bodily integrity (or that of someone else is threatened)

Source: <http://www.ncvc.org>



# Why Focus on Trauma?

- Unaddressed trauma affects individuals, families and communities
- Unaddressed trauma impacts the overall health and economy of nations

Source: A Federal Intergovernmental Partnership on Mental Health Transformation. "Report of the Federal Partners Committee on Women and Trauma." *A Working Document*. (June 2011).





# Prevalence of Trauma in the United States



# Childhood



# Child Abuse

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation OR
- An act or failure to act which presents an imminent risk of serious harm



# Childhood Violence

- Acts of commission
  - Physical abuse
  - Sexual abuse
  - Emotional abuse
- Acts of omission
  - Witnessing verbal abuse or physical family violence.
  - Neglect (lack of adequate food, clothing, shelter, and/or general care.

Source: Tsavoussis, A., Stawicki, S. P. A., Stoicea, N., & Papadimos, T. J. (2014).



# Child Abuse

- More than 5 children die every day as a result of child abuse
- ~80% of children that die from abuse are under the age of 4
- Children with special needs are vulnerable
- Makes people vulnerable to future abuse

Sources: USDHHS, ACF, (2011). *Child Maltreatment 2010*.

Available from [http://www.acf.hhs.gov/programs/cb/stats\\_research/index.htm#can](http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can)

United States Government Accountability Office, 2011. Child maltreatment: strengthening national data on child fatalities could aid in prevention (GAO-11-599). Retrieved from <http://www.gao.gov/new.items/d11599.pdf>





# Child Abuse

- Child protection services
  - 3 million cases/year, 5.5 million children
  - About 30% have “proof”
  - Youngest are the most vulnerable
    - 1/3 of substantiated reports are < 5 years old
    - 77% of children killed due to maltreatment are under the age of 3 years
  - Consider how involvement in foster care, past, or ongoing abuse may affect adolescents

Source: [National Center for PTSD](#)





# Investigations of Abuse

- Of the Child Protective Services Cases that are pursued:
  - 65% neglect
  - 18% physical abuse
  - 10% sexual abuse
  - 7% psychological abuse

Sources: USDHHS, ACF, (2011). *Child Maltreatment 2010*.

Available from [http://www.acf.hhs.gov/programs/cb/stats\\_research/index.htm#can](http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can)

United States Government Accountability Office, 2011. Child maltreatment: strengthening national data on child fatalities could aid in prevention (GAO-11-599). Retrieved from <http://www.gao.gov/new.items/d11599.pdf>



# Child Sexual Abuse

- 1 out of 4 girls and 1 out of 6 boys report a history of childhood sexual abuse
- Educational efforts in the last decades have helped, but more is needed

Source: [https://www.nsvrc.org/sites/default/files/publications\\_nsvrc\\_factsheet\\_media-packet\\_statistics-about-sexual-violence\\_0.pdf](https://www.nsvrc.org/sites/default/files/publications_nsvrc_factsheet_media-packet_statistics-about-sexual-violence_0.pdf)



# Childhood Abuse & Vulnerability

- Childhood abuse increases the odds of adult sexual assault
  - If you were abused before the age of 18, you have approximately 1/5 chance of being abused after the age of 18
  - If you were not abused before age 18, you have a 1/10 chance of being abused after the age of 18
- WHY?

Source: U.S. Department of Justice, 1998



# Rape and Sexual Assault

A statutory offense where the offender knowingly causes another person to engage in unwanted sexual acts by force or threat of force



# Rape and Sexual Assault

- National random sample of US adult population: 18% of women and 1.5% of men experience adult sexual assault
- Other studies are close to this estimate
- Vastly under-reported (especially non-stranger assaults and men)

Source: <https://www.cdc.gov/ViolencePrevention/pdf/SV-DataSheet-a.pdf>



# Who Seeks Medical Care?

- Injured victims are more likely to report the crime and more likely to seek medical attention (National Crime Victims Survey)
- Approximately 1/3 of victims are injured in SA, and 1/3 of those victims seek medical services
- Women are more likely to be injured in SA
  - 32% of women vs. 16% of men

Source: Bureau of Justice Statistics; U.S. Department of Justice, 1998; Tjaden & Thoennes, 2000



# Intimate Partner Violence

- A violent confrontation between family or household members involving physical harm, sexual assault, or fear of physical harm
  - Family members included spouses, former spouses, those in dating (or formerly) dating relationships, adults related by blood or marriage, and those who have a biological or legal parent-child relationship



# Intimate Partner Violence

- **Nearly 1/4 women in the US reports experiencing violence by a current/former spouse or boyfriend in her lifetime.**
- On average >3 women/ day are murdered by their husbands or boyfriends in the US
- Men who have witnessed their parents' domestic violence are 2x more likely to abuse their own partners
- Girls who have witnessed domestic violence are more likely to stay in an abusive relationship as an adult
- More than 50% of batterers also abuse their children or their victim's children

Sources: [www.enabuse.org](http://www.enabuse.org); <https://ncadv.org/statistics>





# Elder Abuse

- The physical, sexual, or emotional abuse of an elderly person, usually one who is disabled and frail
  - Physical, Sexual abuse, Emotional, Financial/material, Neglect
- 1 in 10 seniors report experiencing elder abuse
- Estimates that only 1 in 14 cases are reported

Source: Cooper, Selwood, & Livingston, 2008



# Combat Exposure

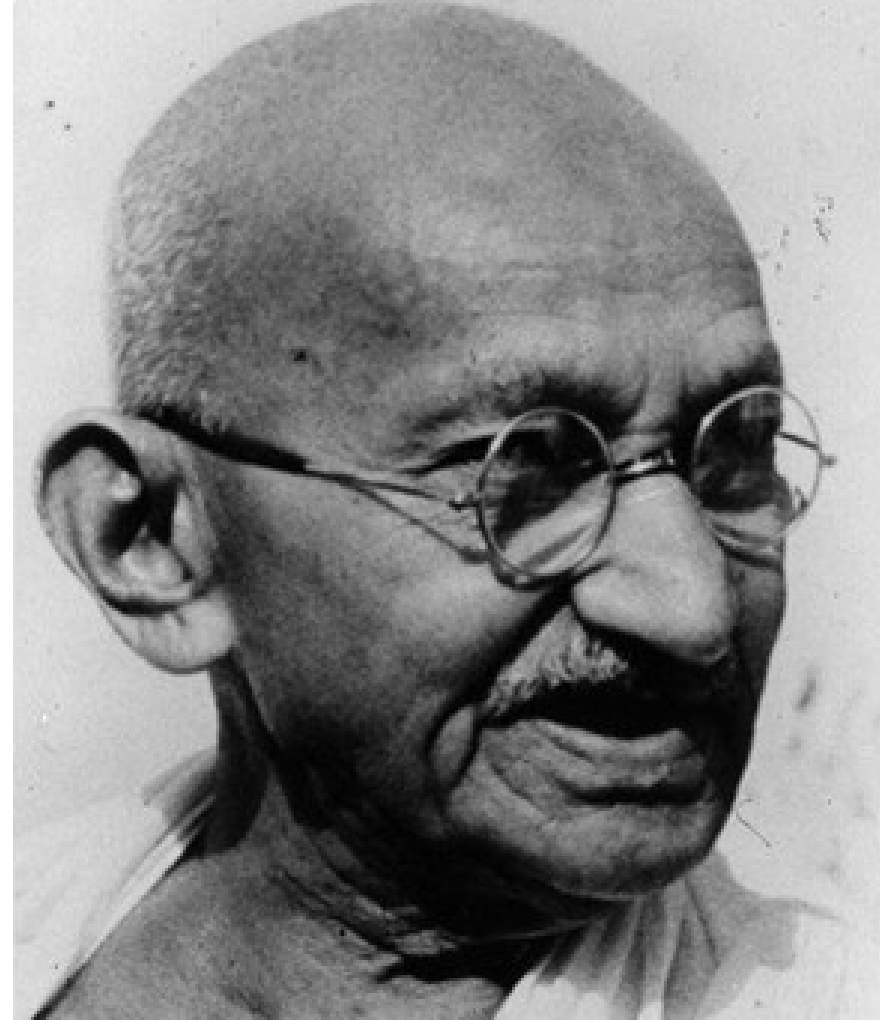
- 7% of US population (either as soldiers or immigrants/refugees)
- Military sexual trauma and harassment among female veterans
  - 4% of men, 39% of women report harassment or assault

Source: Wilson, 2016;  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4096796/>



# Vulnerable Populations

- Homeless Individuals
- Patients with HIV/AIDS
- Refugees



The true measure of any society can be found in how it treats its most vulnerable members

— *Mahatma Gandhi* —

# Homelessness

- Lifetime and 1-year prevalence of homelessness in the US population was found to be 4.2% and 1.5%
- Suicide attempt and substance abuse are predictors
- Sexual, psychological, and physical violence as stressors

Source: <https://www.ncbi.nlm.nih.gov/pubmed/28335013>



# HIV/AIDS

- HIV+ individuals more likely to have a history of childhood physical and sexual abuse, as well as interpersonal violence.
- Women living with HIV/AIDS in violent relationships may be less likely to negotiate condom use

Source: <https://www.apa.org/international/united-nations/trauma-hiv.pdf>



# Refugees

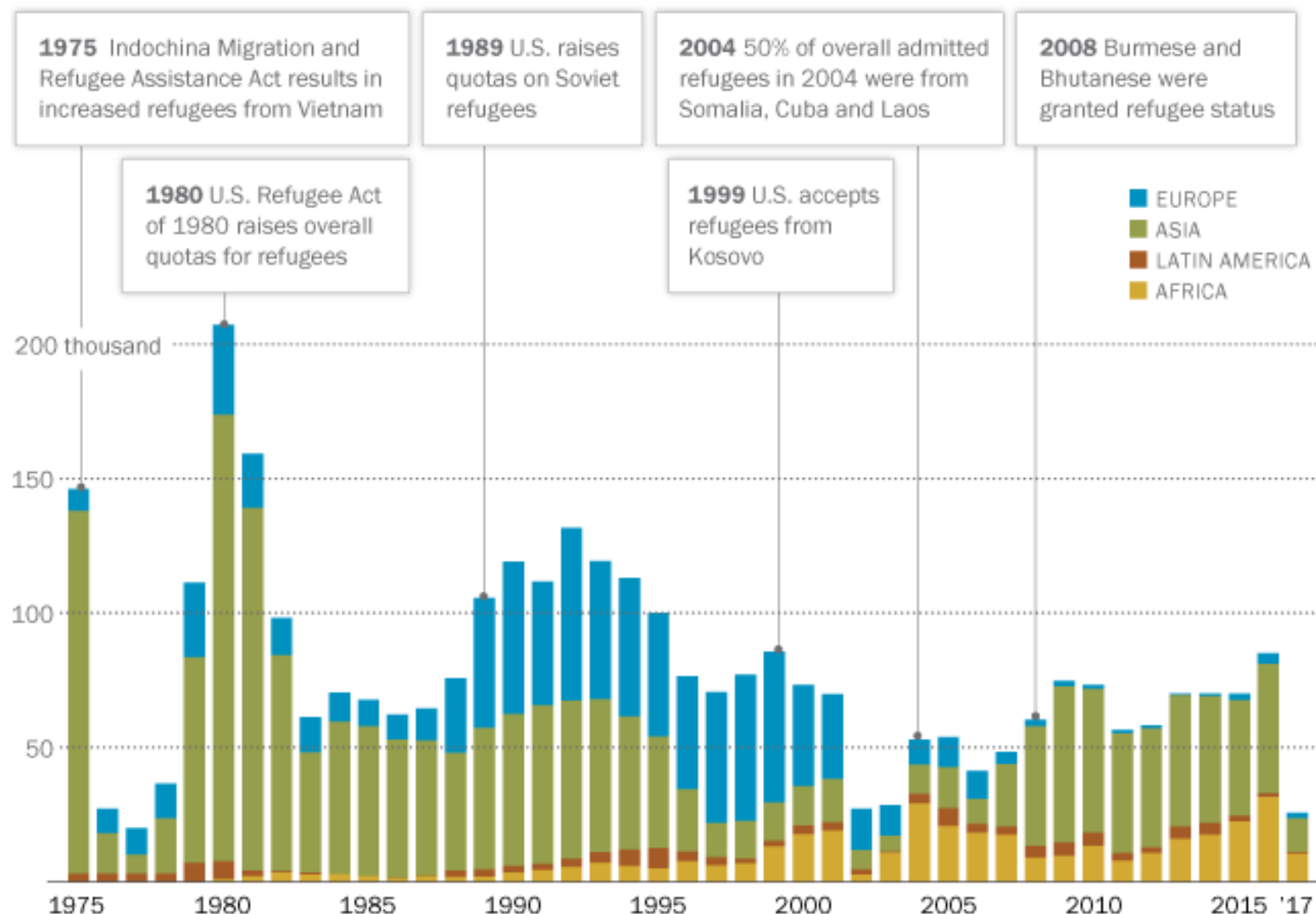
- ~3 million refugees have come the US since the Refugee Resettlement Act of 1980
- ~39,000 Muslims refugee in 2016 (highest number on record)

Source: US Census; Pew Research



## The shifting origins of refugees to the U.S. over time

*Number of refugees admitted to the U.S., by region of origin of principal applicant and fiscal year*



# Refugees

- Each group is different, but may have been exposed to multiple traumas prior to leaving country of origin
  - Ranging from discrimination, financial problems, to warfare, sexual assault, and torture
- Discrimination and stigma when moving to the US (as well as forcible separation of families)
- Depression, Social Isolation, Anxiety

Source: <https://www.apa.org/international/united-nations/trauma-hiv.pdf>







**Toxic Stress, Violent  
Interpersonal Relationships  
and Communities at War**

# Trauma Is a Public Health Crisis



# Community Violence/Firearms

- Approximately 12,000 firearm homicides per year (greater than any other industrialized nation)
- US is 5% of the world's population and has over 30% of the world's mass shootings
- The CDC now reports that the rate of firearms and MVA death are not equal in the US (~30,000 from each cause/year; includes suicides)
- PTSD rates in some neighborhoods may be the same as for war veterans

Source: <https://www.cdc.gov/nchs/fastats/injury.htm>



# Gun Violence & Interpersonal Violence

- Guns in the home:
  - 2x more likely to die of homicide
  - Males are 10x more likely to die from suicide
  - Of those who attempt suicide, those who attempt with a firearm are 30x more likely to die
  - In domestic violence situations, 5x more likely the woman will be killed

Sources: Dahlberg et. al., 2004; [Futures Without Violence](#)



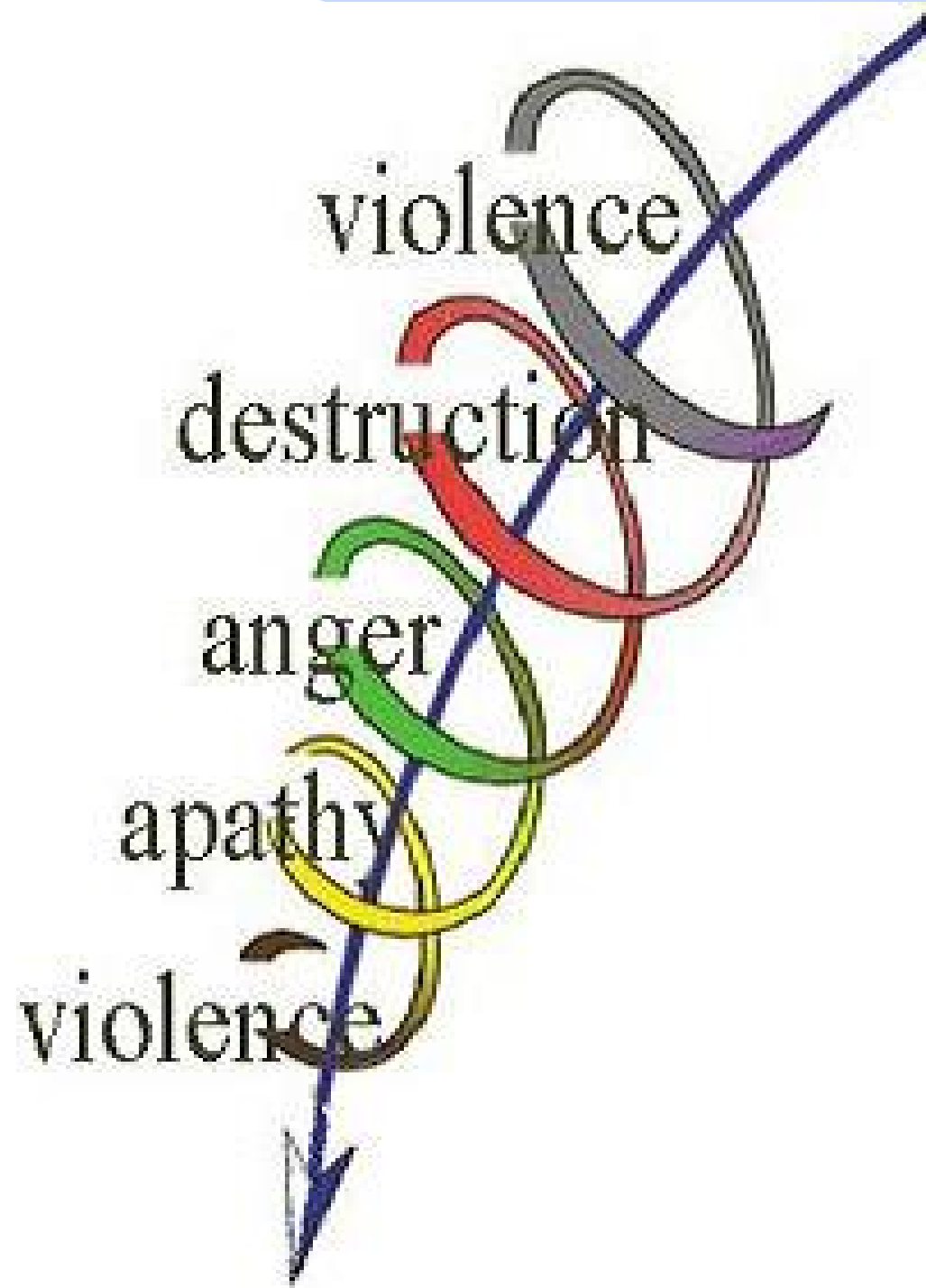
# Gun Violence and Children

- According the American Academy of Pediatrics
  - About 7,500 pediatric admissions for gunshot wounds every year
- Firearm deaths in children and young people:
  - 2x cancer
  - 5x heart disease
  - 15x infection

Source: Source: [American Academy of Pediatrics](#)



# Violence is Connected



# Case Discussion #1





# Short Term Consequences



# The Immediate Aftermath

## **Psychological:**

- Disbelief, numbness, shame, guilt, anxiety, anger, confusion, difficulty concentrating

## **Physical:**

- Appetite/sleep changes, bodily aches/pains

## **Behavioral:**

- Difficulty trusting others, not keeping up with responsibilities, using alcohol or drugs as a way to cope



# Prevalence of PTSD

- 60% of women and 50% of men experience at least one trauma (lifetime)
- 7-8% of the population will have PTSD in their lifetime
- Most people who experience trauma do not develop PTSD
  - 10% of women have PTSD in their lifetime
  - 4% of men have PTSD in their lifetime

Source: [www.ncptsd.org](http://www.ncptsd.org)



# Risk Factors for PTSD

- Severity of traumatic event
- In children: Parental reaction (support & their own processing)
- Proximity to the event
- Number of traumatic events
- Ethnicity—unclear (may be more exposure)

Source: [National Center for PTSD](#)



# What Leads to Acute Stress Becoming Chronic?





# How is Trauma Processed

- Cognitive
- Dual Representation
- Emotional Processing

# Cognitive Models

- Individuals have preexisting beliefs and models of the world
- Trauma experiences are both highly salient and incompatible with preexisting models
- Success = When new info is integrated into the preexisting models (so the model changes).
- PTSD = When the information isn't processed



New, Horrible, Awful,  
Threatening Information!



Pre-existing Schemas

# Too Simple

- Basic assumptions about the world that are shattered
  - Personal invulnerability, the world as meaningful or comprehensible, positive view of self
- Problem: Many studies find that people with pre-existing psychiatric issues are more vulnerable to PTSD
  - Already feel personally vulnerable and may have negative views of the self





# Information-Processing Theories

- Focus on trauma-related threat and how it is processed (Foa and colleagues)
  - A fear network is formed in in memory
    - Stimulus information about the traumatic event
    - Information about cognitive, behavioral, and physiological reactions to the trauma
    - Interoceptive information linking stimulus to response
- Problem: what about triggers that are outside of accessible memory--numbing, and psychogenic amnesia, or feelings of guilt, depression, self-blame?



# Dual Representation Models

- Influenced by cognitive, social, clinical and neuropsychology
- Sensory input undergoes conscious and nonconscious information processing
- Nonconscious processing
  - Extreme rapidity, parallel processing of multiple inputs
  - More detailed and extensive computations than conscious processing
- These different forms of processing are stored in different locations or different codes (LeDoux, 1992)



# Dual Representation of PTSD

- Conscious processing
  - Verbally accessible memories (VAMs)
  - Info on sensory features, emotional and physiological reactions, and perceived meaning
- Nonconscious processing
  - Situationally accessible memory (SAM)
  - Extremely rapid, detailed, parallel processing of multiple inputs
  - Cannot be deliberately accessed but can be triggered



# Traumatic Memories

```
graph TD; TM([Traumatic Memories]) --> VAM[Verbally Accessible Memories]; TM --> SAM[Situationally Accessible Memories];
```

## Verbally Accessible Memories

- Conscious
- Contain facts and information about the event
- Easily recalled

## Situationally Accessible Memories

- Less conscious control
- Triggered by reminders of the event
- Very detailed

# Applications

How might this “dual processing” influence a patient’s physical health or their experiences in sexual and reproductive healthcare?



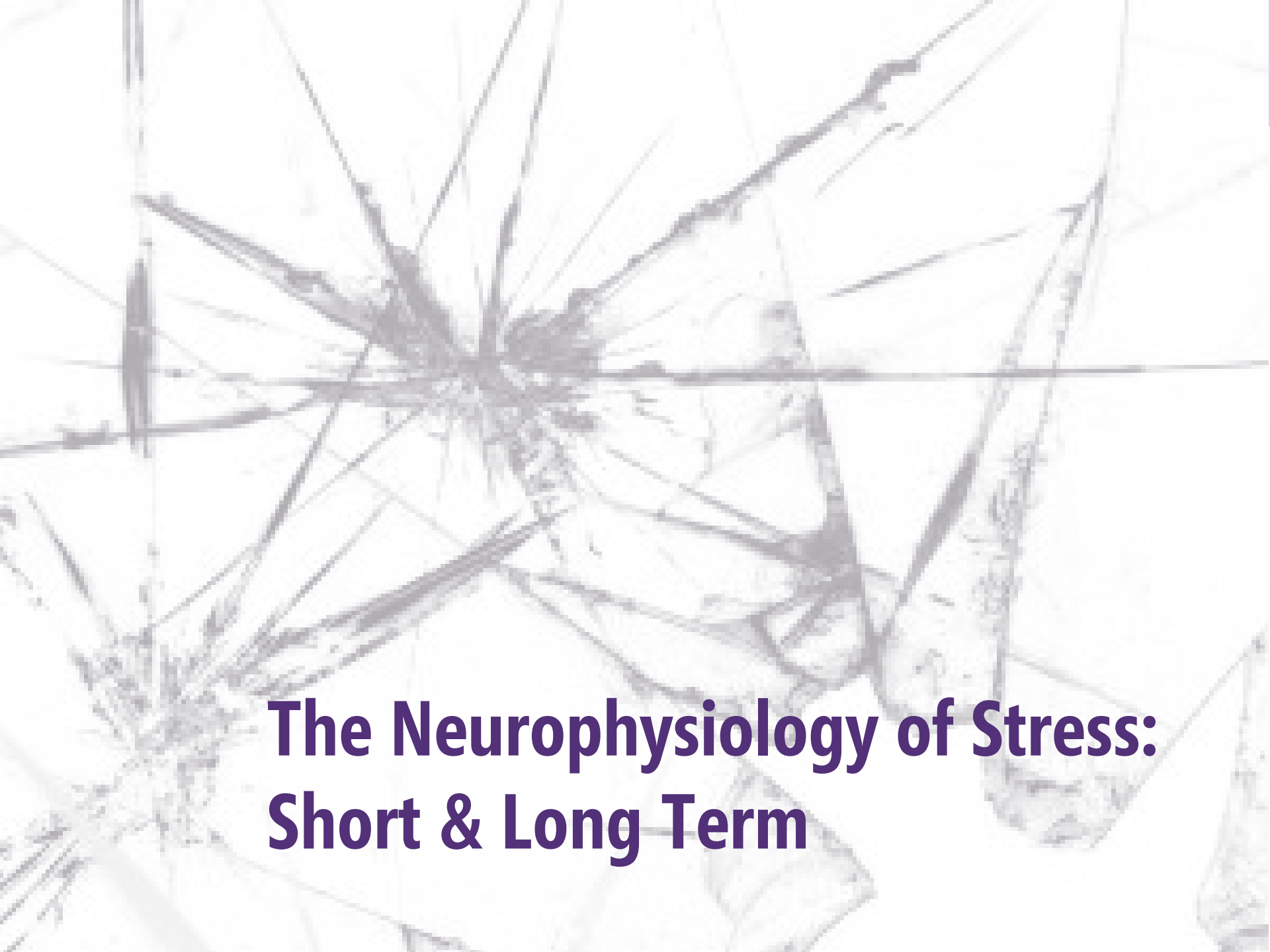
# Case Discussion #2



# Mindfulness Exercise

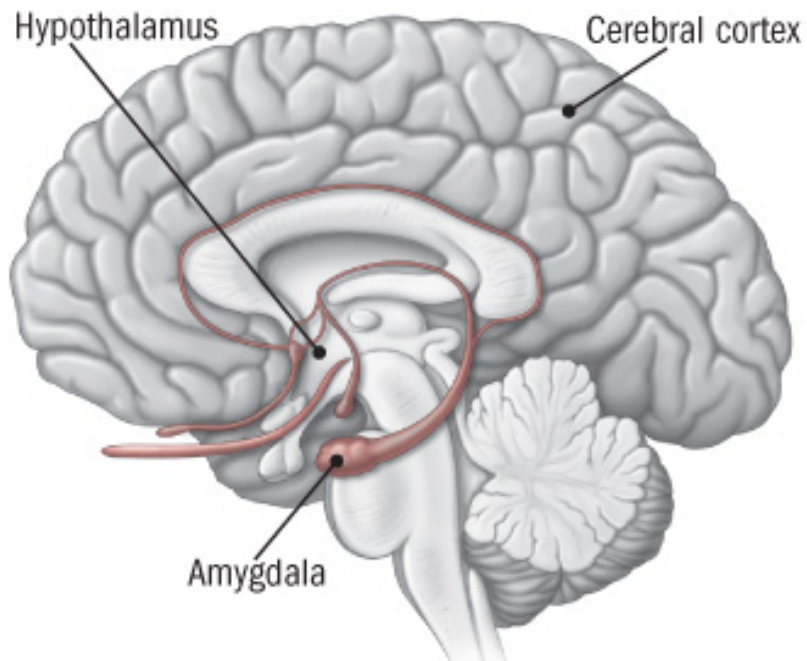


<https://www.youtube.com/watch?v=Eqyj6Rp2Q1w>

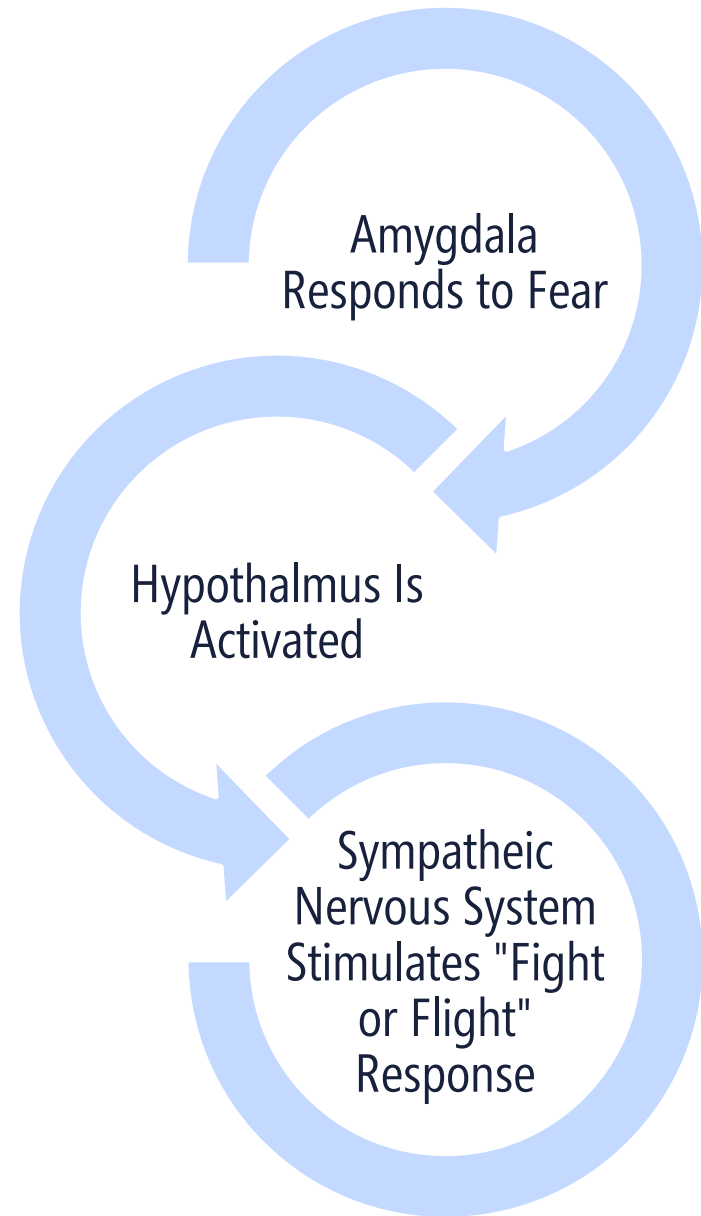


# **The Neurophysiology of Stress: Short & Long Term**



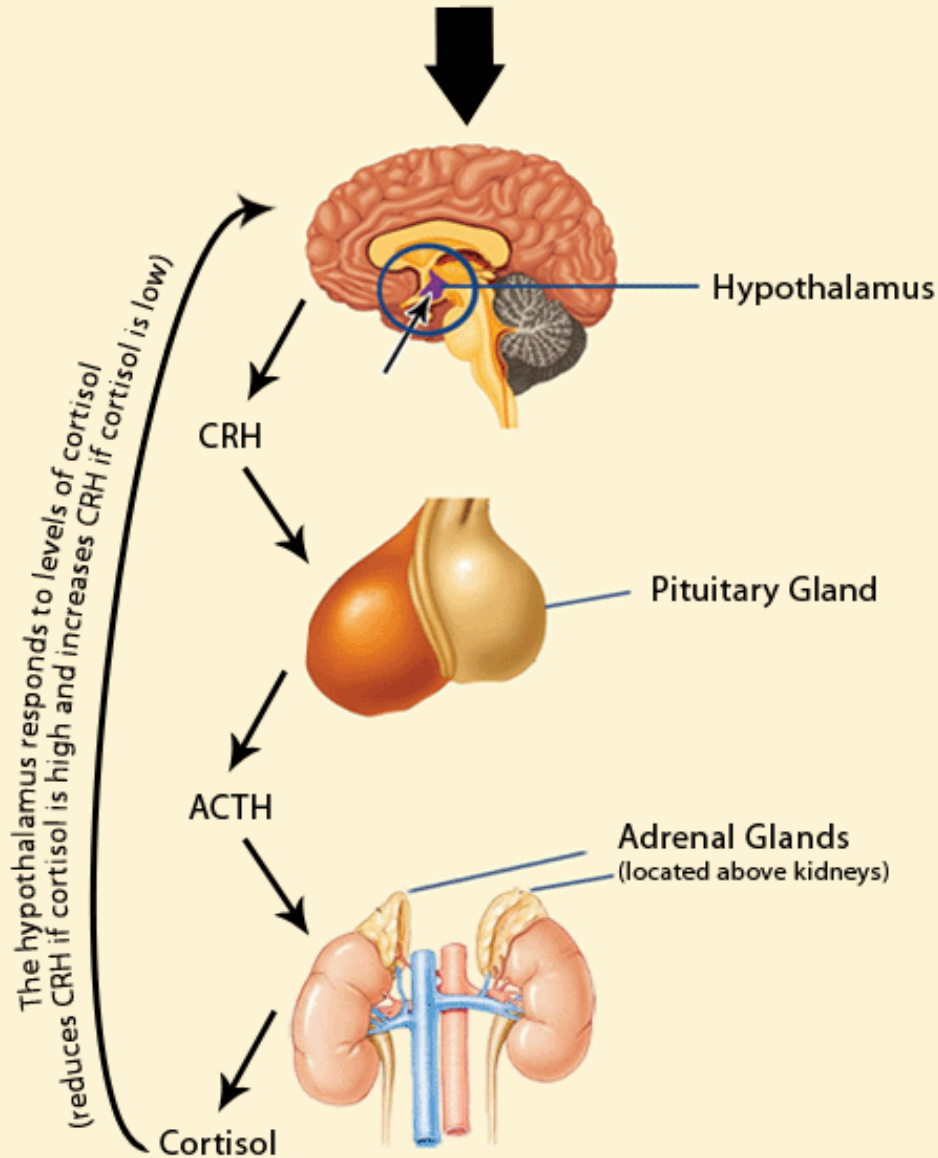


Source: <http://sites.bu.edu/ombs>



# Stress

Physical, psychological or environmental



Source: <http://stress.about.com>

## Amydala

- Senses Threat

## Hypothalamus

- Releases corticotropin releasing hormone

## Pituitary

- Releases adrenocorticotrophic releasing hormone

## Adrenal Cortex

- Releases glucocorticoids (including cortisol)

# Dissociative Freeze (Tonic Immobility)

- Seen in both animals and humans
- Occurs in the face of an inescapable danger, when fight or flight response is unsuccessful
- Body may respond by releasing analgesics, stopping movement (freezing) and reducing cognitive activity
- Allows survivor to localize sound and develop a clear image of the possible threat, time for cognitive processing about how to proceed

Source: Briere, Scott & Weathers, 2005; Perry, Pollard, Blakley, Baker, & Vigilante, (1995)



# The Neurophysiology of Stress

- Bodily responses to stress are ideal for short-term, discrete threats
- In PTSD, individuals begin to generalize their fear responses to situations that once felt safe
- The amygdala can no longer discern threatening from safe stimuli
- The SNS and HPA axis become chronically activated



# The Neurophysiology of Stress

- Over reactivity is damaging to the body
- Chronic increase in blood pressure can lead to damaged blood vessels and heart disease
- Chronic increases in blood sugar may lead to increased insulin production, and eventually, insulin resistance



# Biological Vulnerability in Childhood

- Neural development
- Toxic stress influences
  - Arousal
  - Stress hormones
  - Emotion regulation circuits
- Impact is long lasting

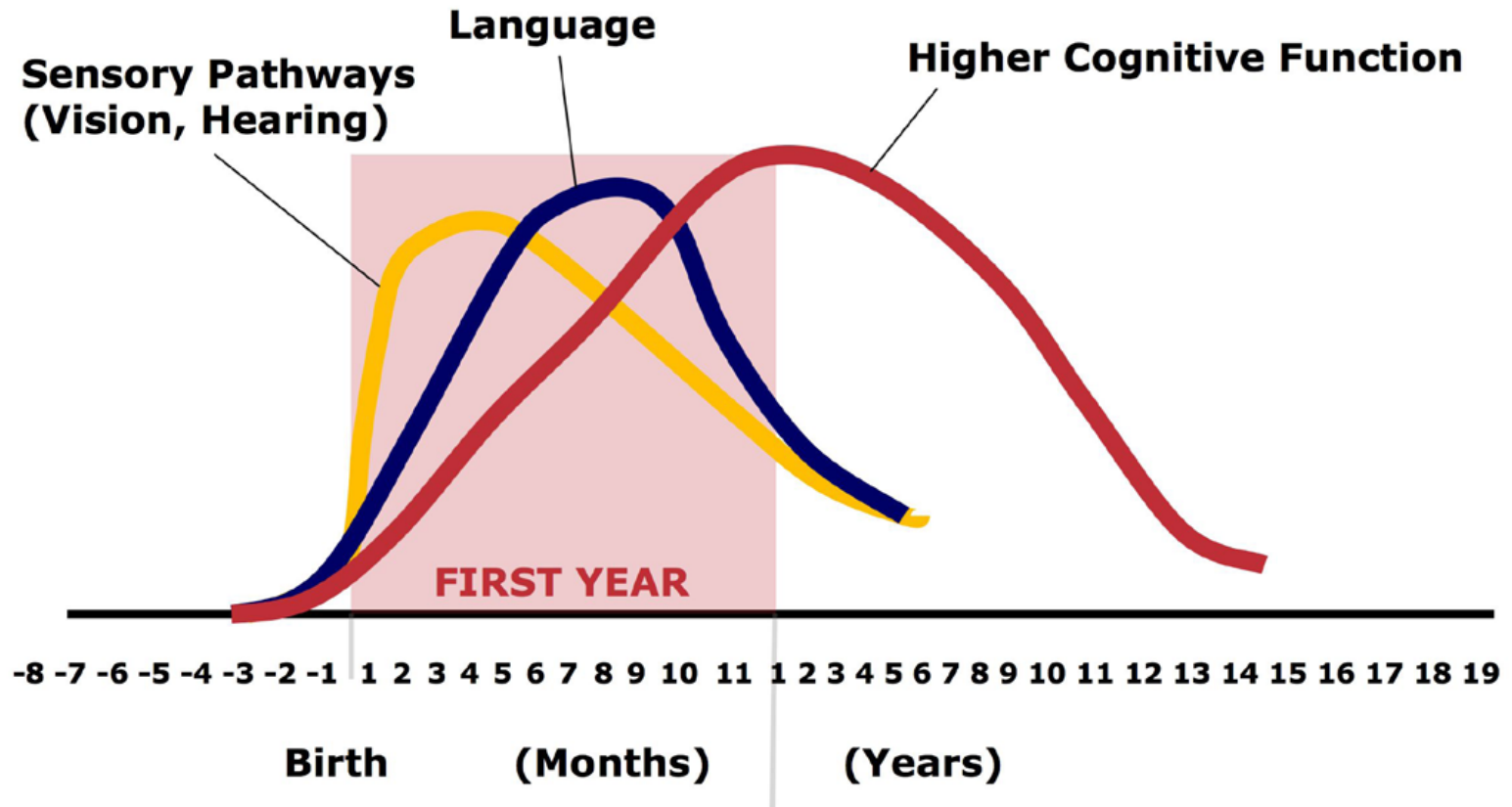
Source: [National Center for PTSD](#)





# Human Brain Development

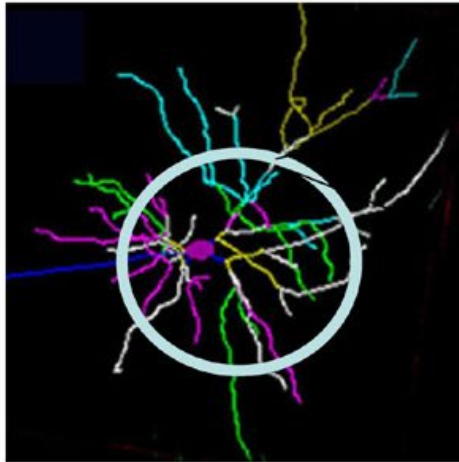
Neural Connections for Different Functions Develop Sequentially



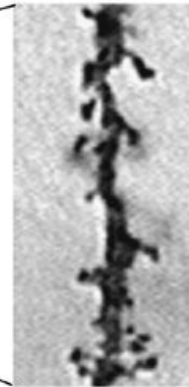


# Persistent Stress Changes Brain Architecture

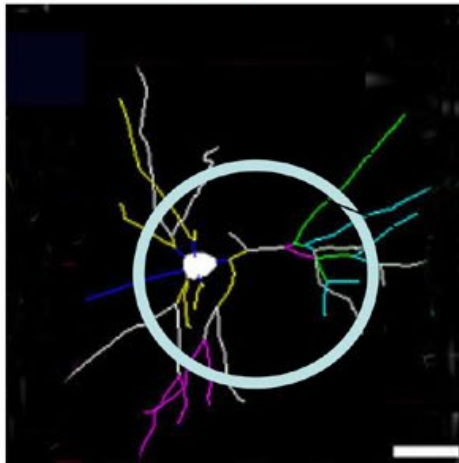
Normal



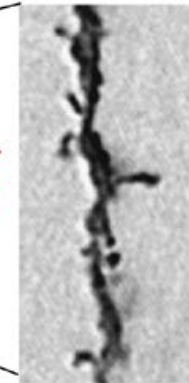
Typical neuron—  
many connections



Toxic  
stress



Damaged neuron—  
fewer connections

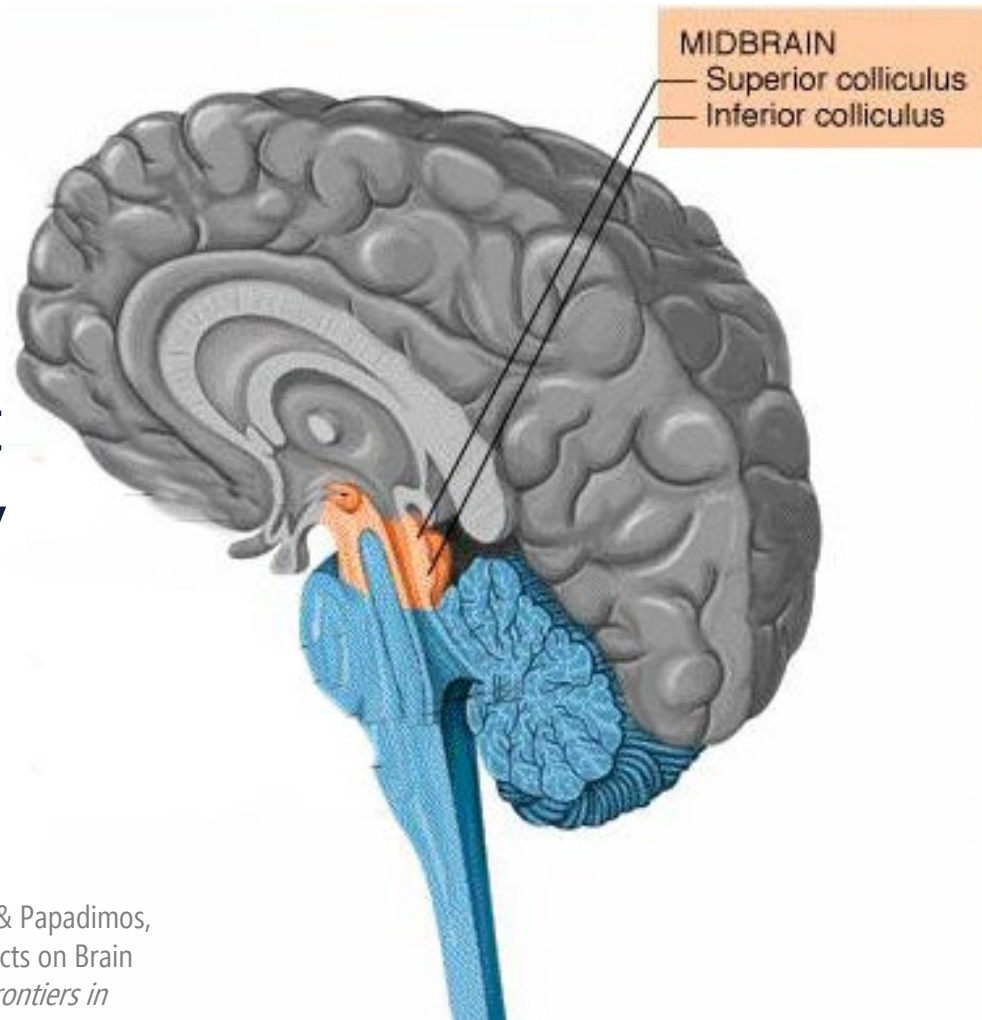


Prefrontal Cortex and  
Hippocampus



# Witnessing Violence

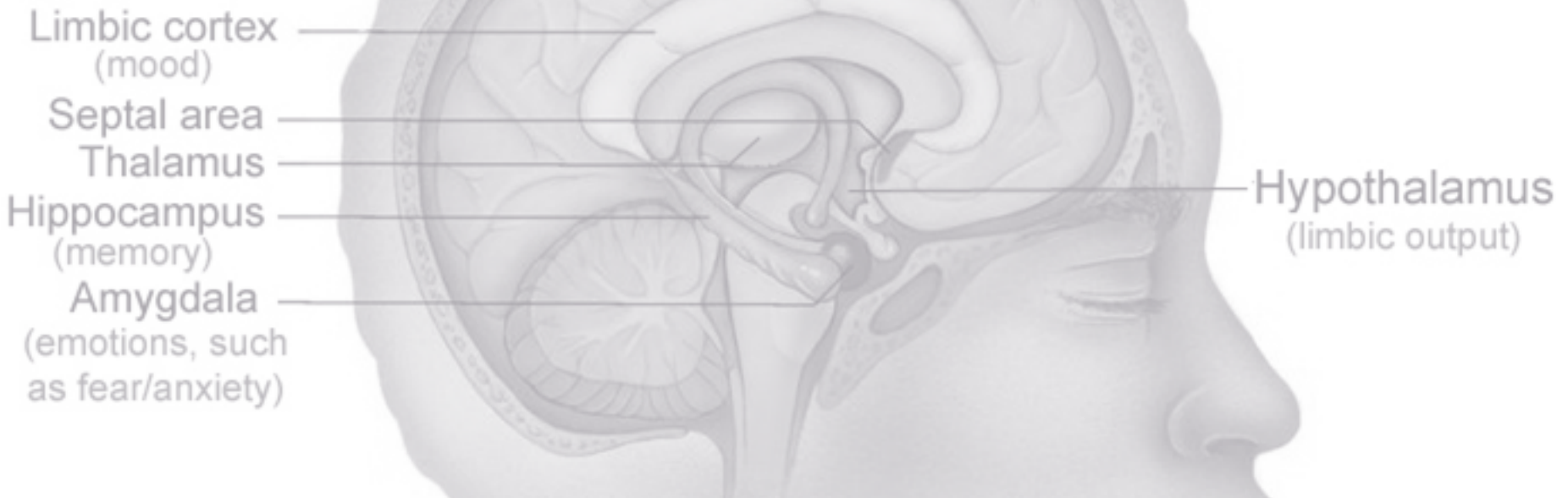
- Midbrain serves to relay visual and auditory messages.
- Under-development leads to being easily distracted (ADHD) and difficulty with attachment



Source for slides 69-73: Tsavoussis, A., Stawicki, S. P. A., Stoicea, N., & Papadimos, T. J. (2014). Child-Witnessed Domestic Violence and its Adverse Effects on Brain Development: A Call for Societal Self-Examination and Awareness. *Frontiers in Public Health*, 2, 178. <http://doi.org/10.3389/fpubh.2014.00178>

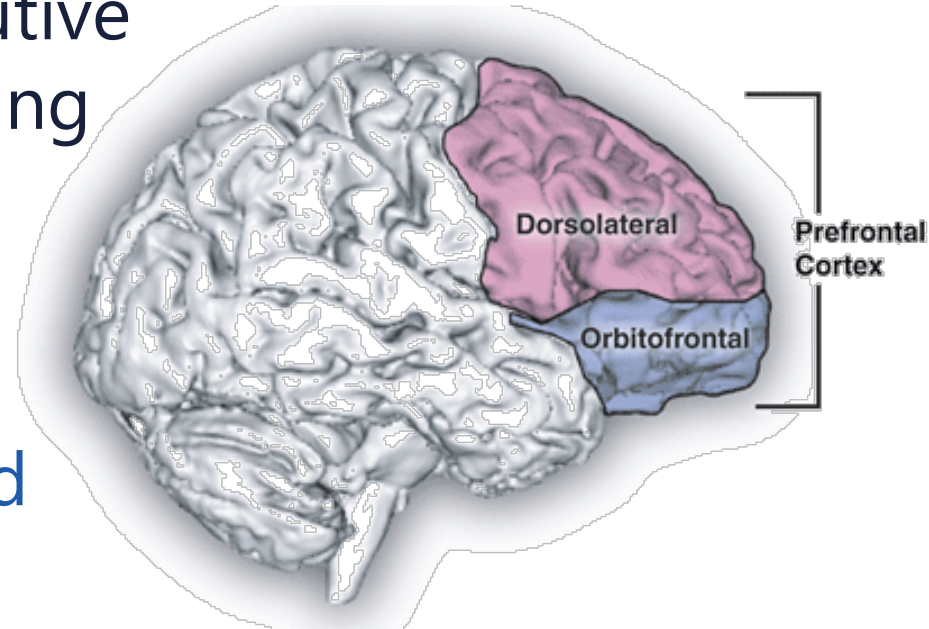
# Witnessing Violence

- The limbic system (amygdala, hippocampus, hypothalamus)
  - Controls primitive emotions like fear, anger, and pleasure, including sex
  - Plays a role in encoding memories and storing information
  - Helps control “magnitude” of an emotional response
- May lead to hippocampal atrophy over time



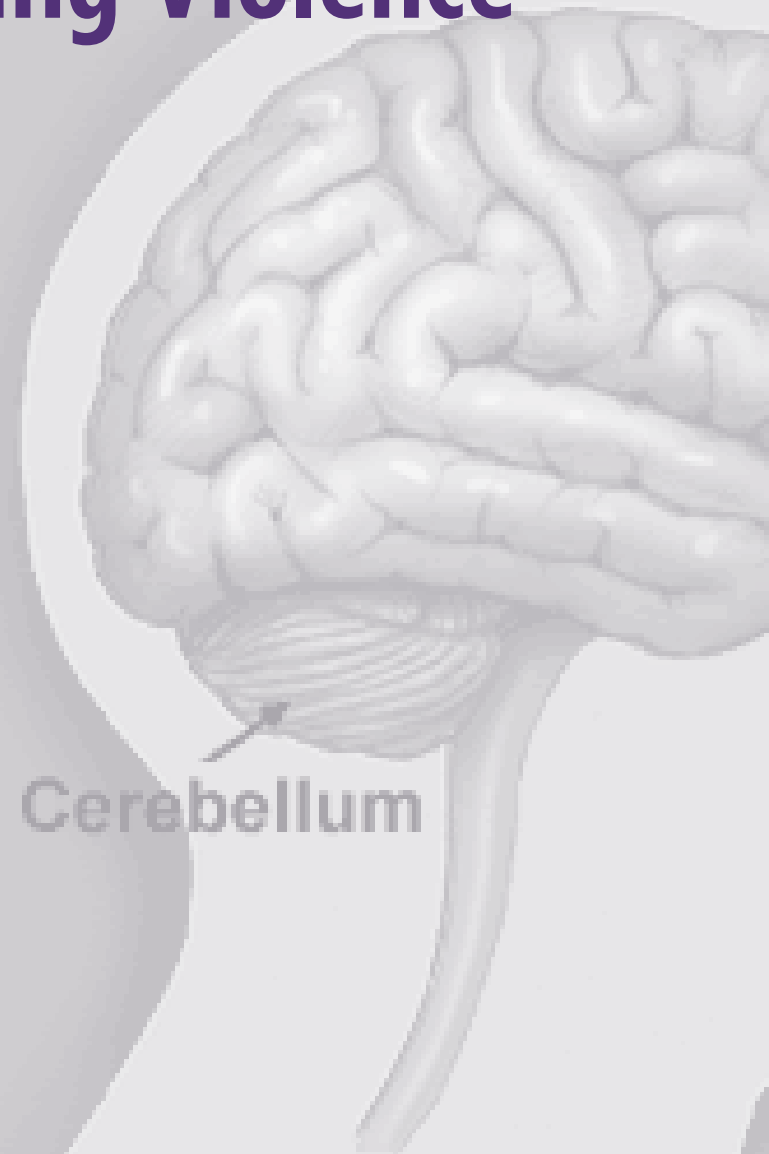
# Witnessing Violence

- The cortex controls executive function and understanding consequences
  - Mature adult behavior (particularly inhibition, moderation or “learned social behavior”)
- Kids who witness violence may have smaller prefrontal cortex (PFC) and gray matter volume.



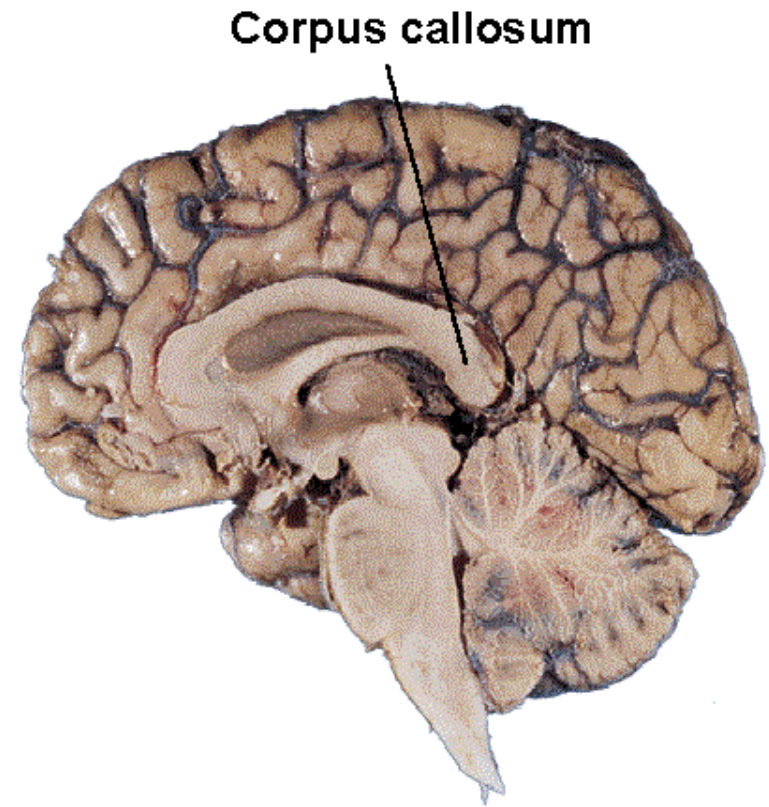
# Witnessing & Experiencing Violence

- The cerebellum is involved in emotion and cognitive development and balance.
  - Connections to the frontal lobes help modulates behavior
  - Kids who experience abuse show smaller volume.
- Smaller volume is associated with earlier onset of PTSD.
- This area may also play a role in vulnerability to other anxiety disorders and substance abuse.



# Witnessing Violence

- The corpus callosum connects the right and left cerebral hemispheres and facilitates their communication (auditory, visual, and cognitive messages).
  - Kids who witness violence have a smaller volume

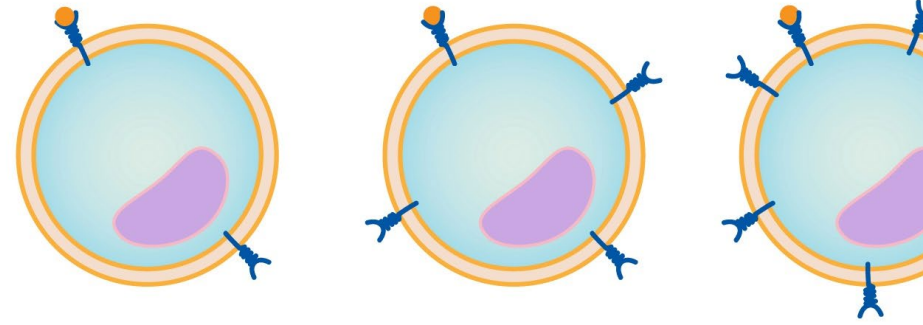




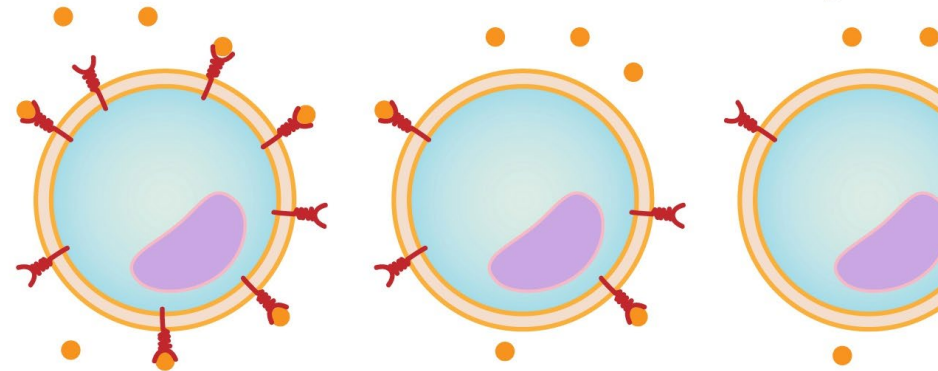
# Physiology Though the Lifespan

- Children who witness and experience violence may have elevated basal cortisol levels
- Adults who were maltreated as children may exhibit low basal cortisol levels and elevated ACTH levels when stressed.

**upregulation**



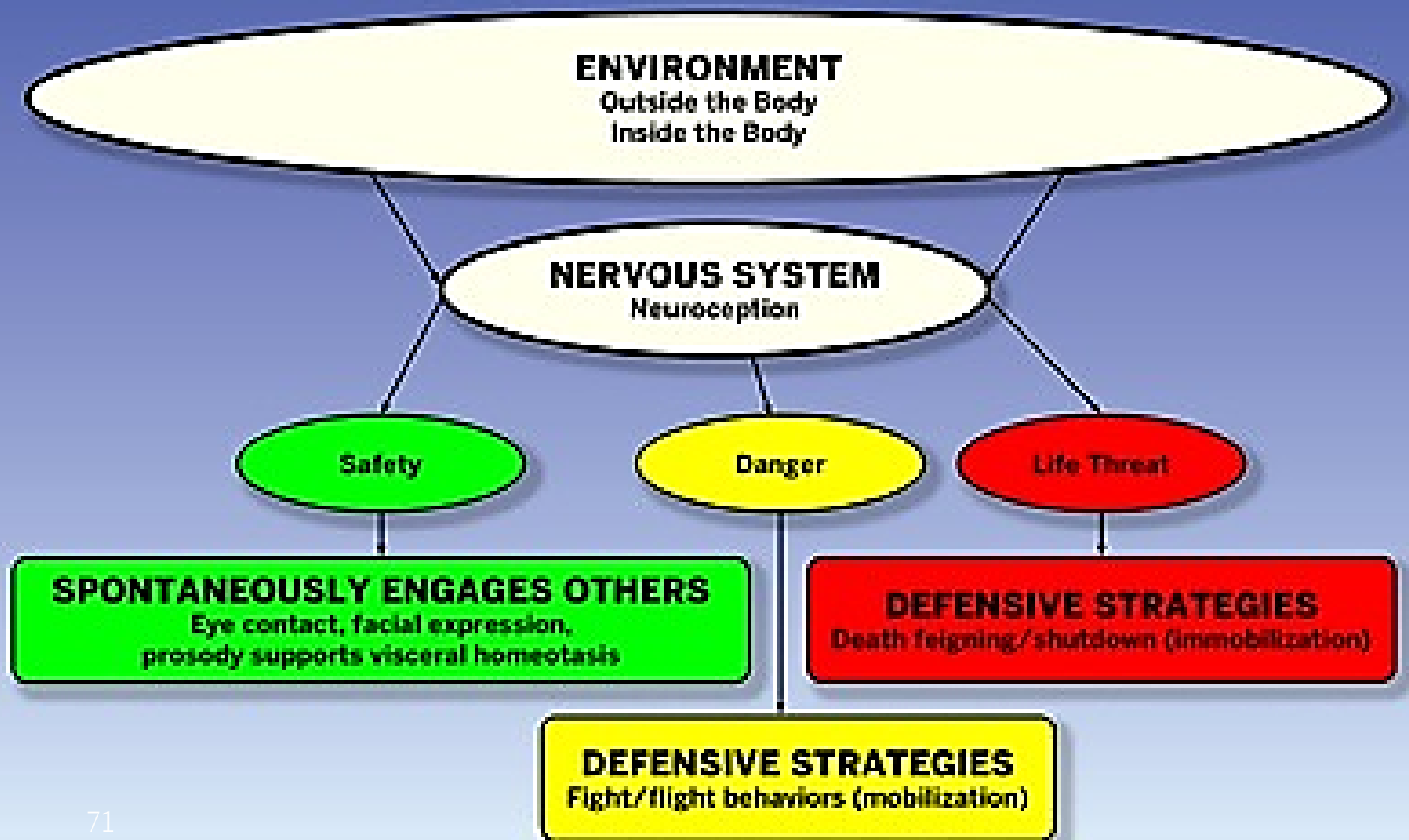
**time** →



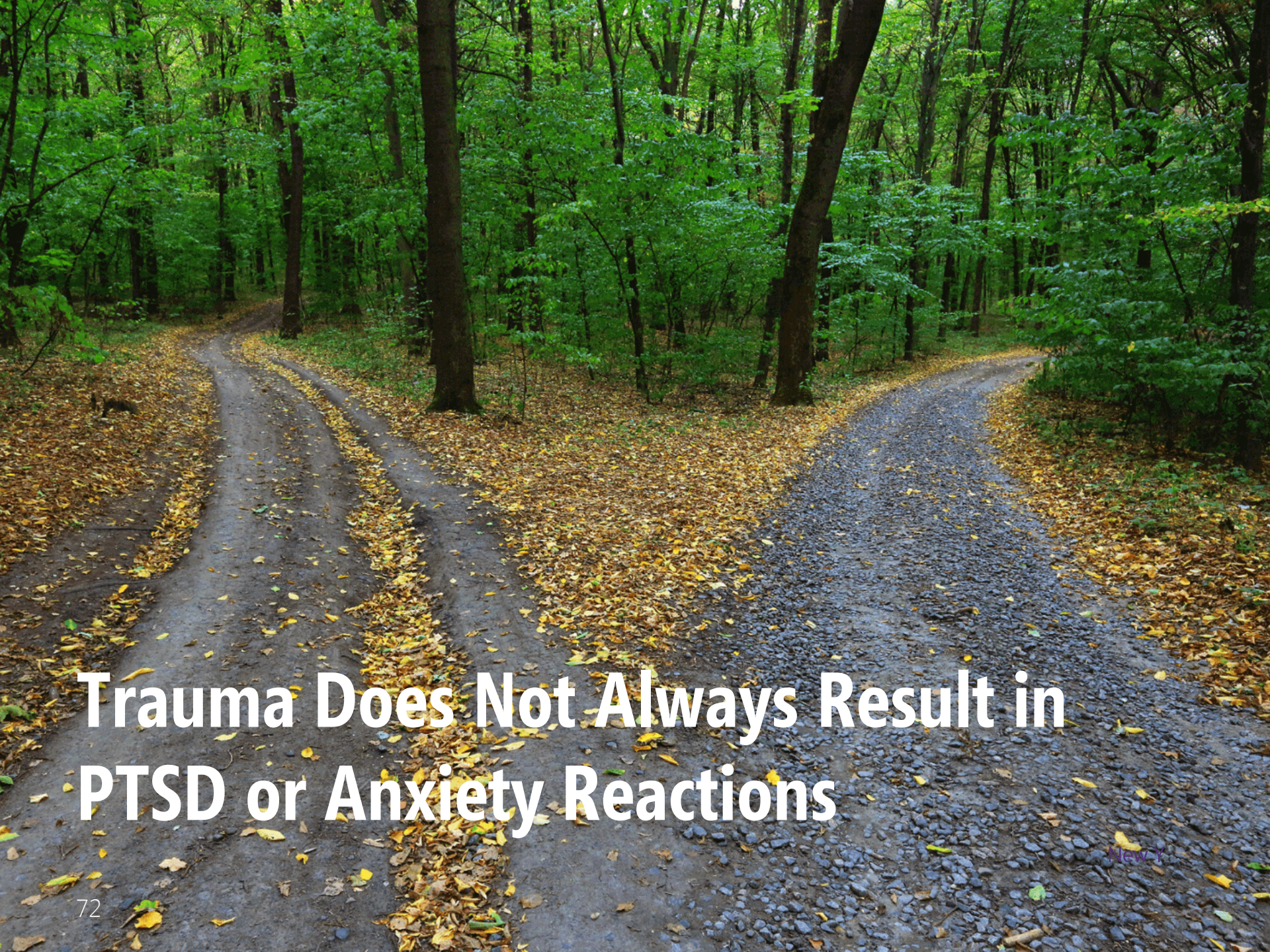
**downregulation**

# The Quest for Safety:

## Emergent Properties of Physiological State







**Trauma Does Not Always Result in  
PTSD or Anxiety Reactions**



# Acute Stress and Grief Reactions

- Acute stress disorder--many of the symptoms of PTSD for a period of several weeks
  - Usually resolves on its own
- Grief reactions--extreme sadness, difficulty maintaining a routine, difficulty concentrating, and problems with guilt and anger.
  - Often associated with unexpected death of a loved or sudden illness or injury.



# Depression

- Varies based on trauma type and social support
- Extreme sadness
- Weight loss or weight gain
- Difficulty concentrating
- Loss of interest in previous activities
- Guilt
- Hopelessness
- Irritability or anger



A close-up photograph of medical instruments. A silver stethoscope with two white earpieces is positioned diagonally across the frame. Below it, a black reflex hammer is partially visible. The instruments are resting on a textured blue surface. The background is a solid, slightly darker blue.

# Trauma and Health

# The Adverse Childhood Experience (ACE) Study

- Over 17,000 Kaiser patients participating in routine health screening participated
- Underscores the health, social, and economic risks that result from childhood trauma

Source: Felitti & Anda, 1998



# What is an ACE?

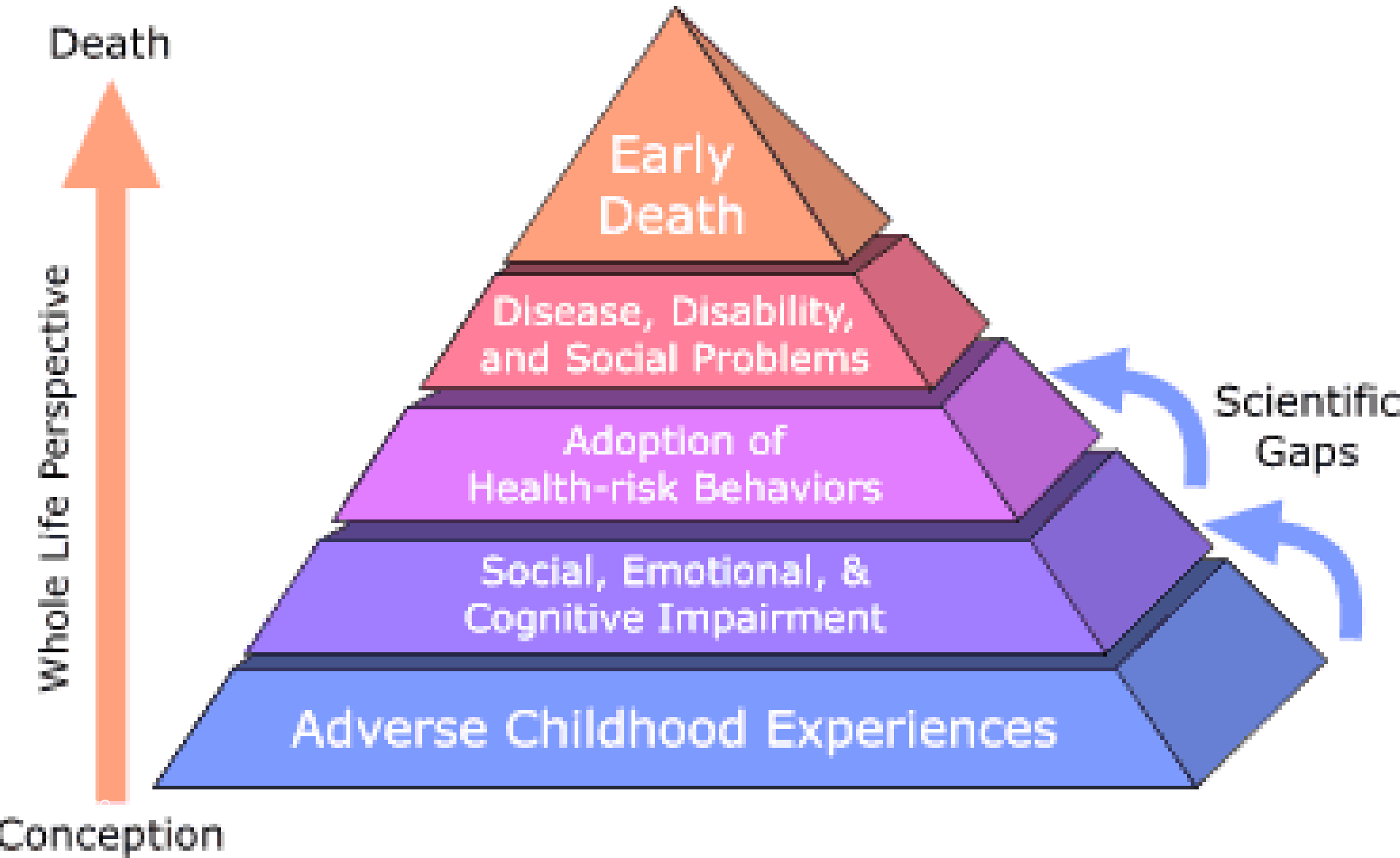
Growing up experiencing any of the following conditions in the household prior to age 18

- Recurrent physical abuse
  - Recurrent emotional abuse
  - Contact sexual abuse
  - An alcohol/and or drug abuser in the household
  - An incarcerated household member
  - Someone who is chronically depressed, mentally ill, institutionalized or suicidal
  - Mother is treated violently
  - One or no parents
  - Emotional or physical neglect
- Philadelphia study added:
- discrimination
  - community violence
  - food insecurity
  - bullying

<http://www.cestudy.org/>



# The ACE Pyramid



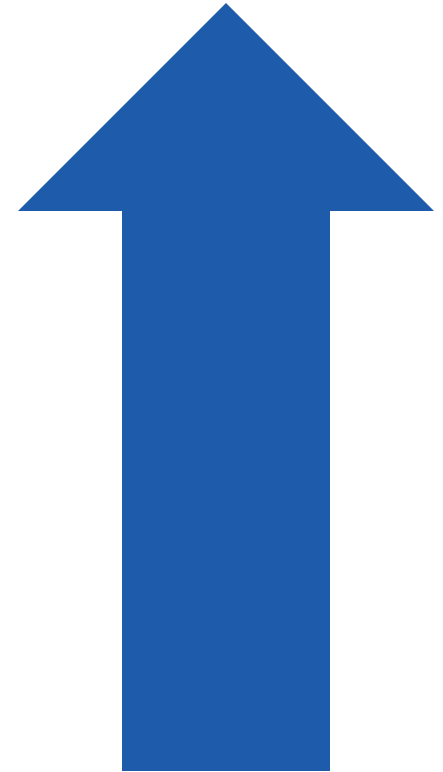
# ACE Study Findings

- If ACE >4 (compared to a score of 0)
  - 250% greater odds of having a sexually transmitted infection
  - 260% more likely to have COPD
  - 460% more likely to be suffering from depression
- If ACE >6 (compared to a score of 0)
  - Men had a 4600% increased odds of using IV drugs



# ACE Study Findings

As the number of ACEs increase, the risk for health problems including chronic diseases such as autoimmune disease, COPD, frequent headaches, health-related quality of life, ischemic heart disease, liver disease and lung cancer, increase in a strong and graded fashion





# Limitations

- Retrospective, Cross-Sectional
- Equivalency of ACEs
- Failure to measure dosage of each ACE
- Physiology is implied, not measured



# Physical Health & Trauma

- Ways of Coping
  - Overeating, Alcohol and Drug Use, Smoking, High Risk Sexual Behavior
- Disease Burden
  - Chronic pain, GI disorders, Gynecological problems, Fibromyalgia
- Multiple traumas are associated with a higher disease burden

Sources: Gawronski et al., 2014; Kartha et al., 2008; Lesserman, et al., 2006; Letourneau, Holmes, & Chasendunn-Roark, 1999; Nicolaidis, et al., 2004; Sadler, et al, 2000; Sansone, Jordan Bohinc, & Wiederman, 2014; Sledjeski, Speisman & Dierker, 2008



# Utilization of Medical Services

- Survivors have higher utilization of medical services (and report a greater # of physical health problems)
  - Higher levels of inpatient days and sick visits
  - PTSD may be a particularly important predictor of medical utilization
- Results are similar for self-report, physician report, or lab/chart review

Sources: Gawronski et al., 2014; Kartha et al., 2008; Lesserman, et al., 2006; Letourneau, Holmes, & Chasendunn-Roark, 1999; Nicolaidis, et al., 2004; Sadler, et al, 2000; Sansone, Jordan Bohinc, & Wiederman, 2014; Sledjeski, Speisman & Dierker, 2008



# Example: IPV and Healthcare Cost

Of over 3300 women aged 18 to 64 years from large HMO

- ~50% reported IPV in their lifetime
- IPV had ceased in 87% of women—average of 16 years ago
- Compared to women without IPV:
  - Healthcare utilization higher for all categories of service during IPV & decreased over time after cessation of IPV
  - Healthcare utilization was still 20% higher 5 years after women's abuse ceased compared to women without IPV.
  - Adjusted annual total healthcare costs 19% higher in women with a history of IPV (amounting to \$439 annually) compared to women without IPV

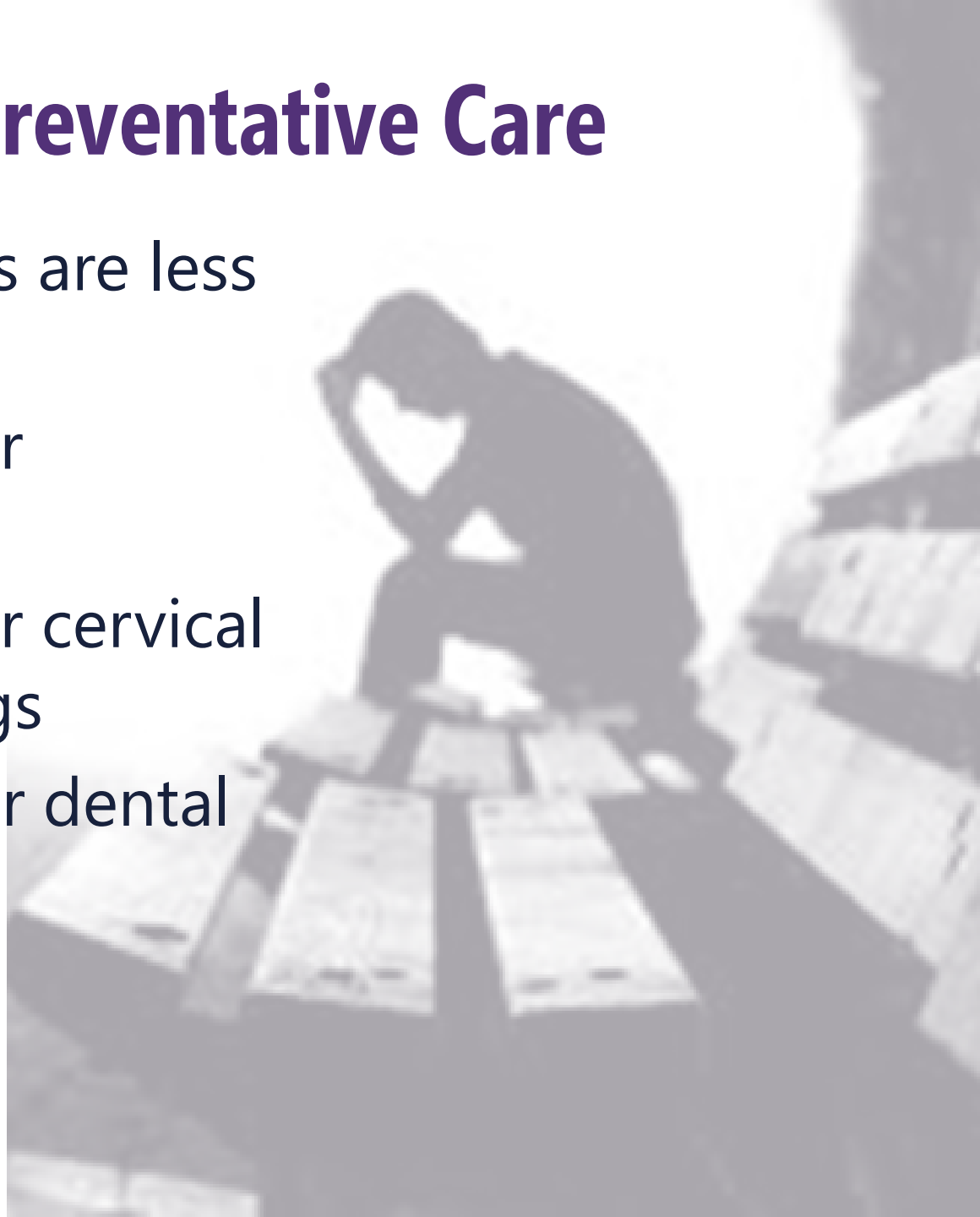
Sources: Rivara et al., 2007



# Utilization of Preventative Care

- Trauma survivors are less likely:
- To obtain regular mammograms
- To obtain regular cervical cancer screenings
- To attend regular dental appointments

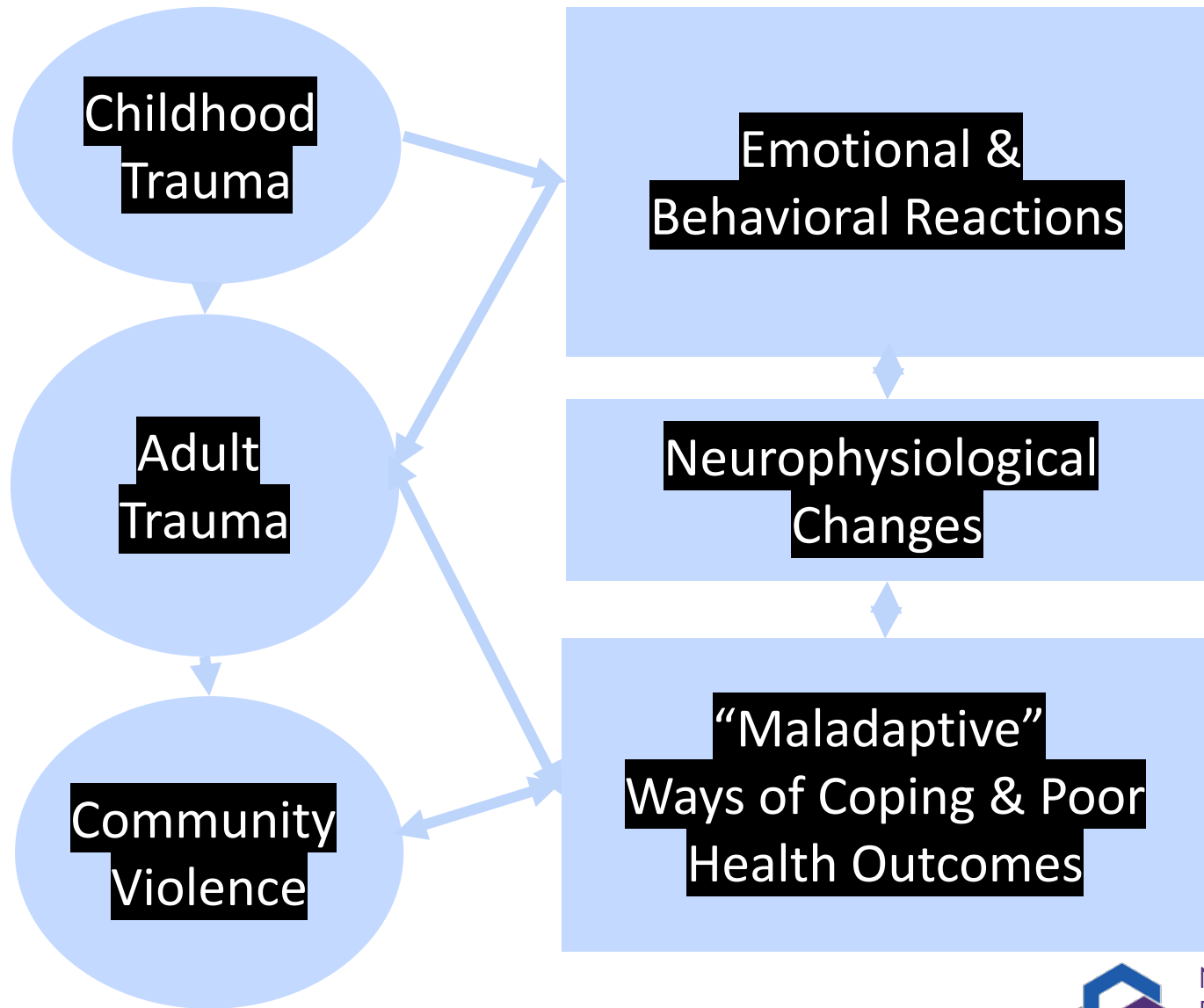
Sources: Farley, Golding, & Minkoff (2002); Farley, Minkoff, & Barkan (2001); Farley & Patsalides (2001)



# Case Discussion #3



# Summary



# Break





# Group Questions

- How might family planning appointments be difficult for trauma survivors?
- Is the healthcare system responsive to the needs of survivors of trauma and violence? What works well and what needs to be improved?
- How might traumatized patients experience common procedures such as mammograms and pelvic exams? How might traumatized patients respond to conversations about sexual history, sexual health, and behavioral coping strategies?



# Trauma Survivors in Healthcare

- Having to lie down for treatment
- Objects used during exams
- Fear of flashbacks
- Fear of authority
- Fear of being touched
- Fear of pain
- Anxiety regarding potential diagnoses

Source: Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C., Danilkewich, A. (2008)





Courtesy: Oregon Parks and Recreation Department

# Who is Resilient?

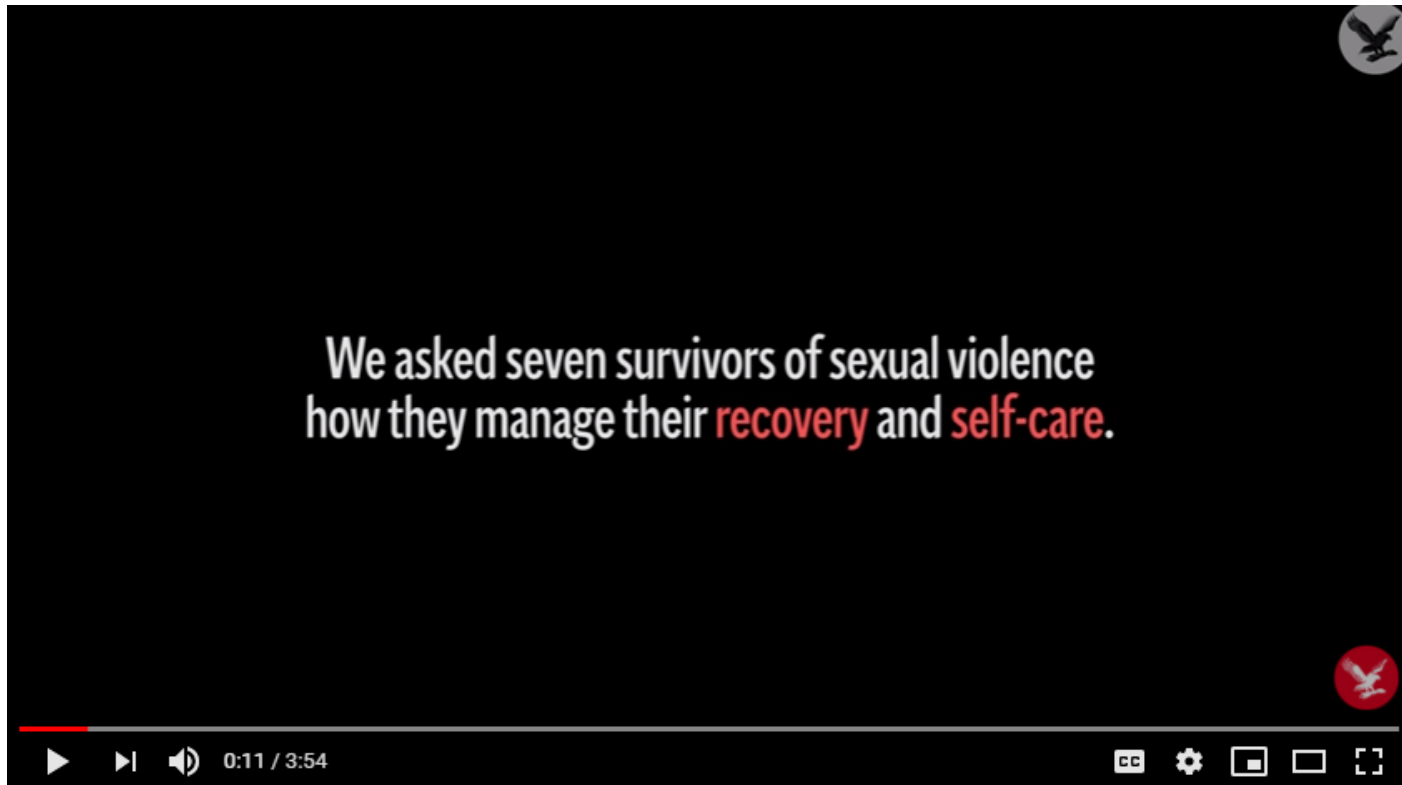
- No prior trauma history
- Non-intentional trauma
- Higher social support
- Active coping (approach vs. avoidance)
- Cognitive reappraisal (potentially even during the event)
- Exercise or physical activity
- Altruism/moral purpose

Source: Lebens ML, Lauth GW (2016);

Wu, G., Feder, A., Cohen, H., Kim, J. J., Calderon, S., Charney, D. S., & Mathé, A. A. (2013)



# Video: Resilience



[https://www.youtube.com/watch?v=\\_D47RWYytYE](https://www.youtube.com/watch?v=_D47RWYytYE)

# Trauma-Informed Care



# Trauma-Informed Care

- Your words, actions, and policies have the ability to hurt or heal
- Patients remember and truly value what you say and do



# Specific Suggestions: What is Trauma-Informed Care?

Every part of an agency or institution (from front desk staff, administrators, to care providers) understand the effects of traumatic events, sensitively interact with trauma survivors, avoid re-traumatization, and engage in trauma screening and prevention as appropriate





# Re-Traumatizing Care

- Refusal to recognize experiences as criminal victimization
- Intrusive/inappropriate conduct and victim blaming attitudes
- Medical processes that don't include the victim's perspective

Sources: Campbell & Wasco (2005); Campbell & Raja (2005); Campbell, Wasco, Ahrens, et.al, (2001); Ullman & Filipas, 2001



# Trauma and Prenatal Care

- Women with childhood sexual abuse histories
- Prenatal care
  - More discomfort in pregnancy
  - More abuse experiences during pregnancy
  - More nonscheduled medical contacts
  - More ultrasounds (in 1st pregnancies)

Source: Leeners et al., 2006



New York State  
Family Planning  
Training Center  
[nysfptraining.org](http://nysfptraining.org)

# Trauma and Prenatal Care

- Women with childhood sexual abuse histories
- Prenatal Psychological Concerns
  - Increased rates of depression
  - Fear of being “retriggered” during exams
  - Fear of “relaxing” in childbirth classes (among strangers)

Source: Leeners et al., 2006



New York State  
Family Planning  
Training Center  
[nysfptraining.org](http://nysfptraining.org)

# Trauma and Prenatal Care

- Women with childhood sexual abuse histories
- Postpartum Concerns
  - CSA memories resurfacing during labor
  - Higher levels of subjective pain during delivery
  - Increased risk of postpartum depression
  - Higher intent to breastfeed (with some women having difficulty)

Source: Leeners et al., 2006



New York State  
Family Planning  
Training Center  
[nysfptraining.org](http://nysfptraining.org)

# The Trauma-Informed Care Pyramid

Screening

Understanding  
Your Own  
History

Collaboration &  
Understanding Your  
Professional Role

Understanding the Health  
Effects of Trauma

Patient-Centered Communication  
Skills

# Universal Trauma Precautions

- Patient-centered communication skills
- Explain generally that stress can influence coping and physiology
- Collaboration
- Professional Self-Care



# Patient-Centered Communication Skills

## Behavioral Strategies

- Ask your patient if there is anything you can do to make them more comfortable.
- If the patient seems worried or anxious about a specific procedure, ask them to think about what has helped them with a stressful situation in the past.
- Use tell-show-do modeling to let the patient know what you are going to do in advance—give them an overview of the whole appointment.
- Let the patient know that they can raise their hand (or another signal) and you will stop the procedure, if it is medically safe to do so.
- Don't just rely on distraction techniques (use PMR, guided imagery, etc.)



# Patient-Centered Communication Skills

## Sample Communication Skills

- “What can I do to make you more comfortable during this pelvic exam?”
- “Before we proceed, is there anything else you think I should know?”
- “Just to let you know, this is generally how a pelvic exam is done. First I will get a history, then we will do the exam, where you will feel some pressure. And then I will call you in a week to go over the results. Let me know if you have questions along the way.”
- “I know that questions about our sexual health history may feel very personal. Please know this is confidential and we ask these questions to take the best care of you.”



# Understanding the Health Effects of Trauma

- Does not involve the provider delving into trauma history
- Awareness of the health-related effects of traumatic events
  - Negative coping behaviors (e.g., smoking, drinking, overeating, high risk sexual behavior) may be related to stressful life experiences
  - Consistent with patient-centered communication skills and the principles of Motivational Interviewing



# Case Discussion



# Collaboration & Understanding Your Professional Role

- Maintain a list of referral sources for patients who do disclose a trauma history
- Keep information readily available to all patients in the waiting room
  - The National Center for Trauma Informed Care's website ([www.samhsa.gov/nctic](http://www.samhsa.gov/nctic))
  - Local referral sources (behavioral health, dentists, specialists) who have the excellent communication and behavioral skills needed to care for traumatized patients.



# Collaboration & Understanding Your Professional Role

- Understanding your mandated reporting & inform patients when confidentiality needs to be breached (in most states, in the case of child and elder abuse)
- Respect the wishes of survivors to report (or not report) abuse when mandated reporting is not required (for example, in some states domestic violence does not need to be reported)



# Reporting

## Child Abuse Reporting

- <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/mandatory-reporting/>

## Domestic/Interpersonal Violence

- [https://www.acf.hhs.gov/sites/default/files/fysb/state\\_compendium.pdf](https://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf)



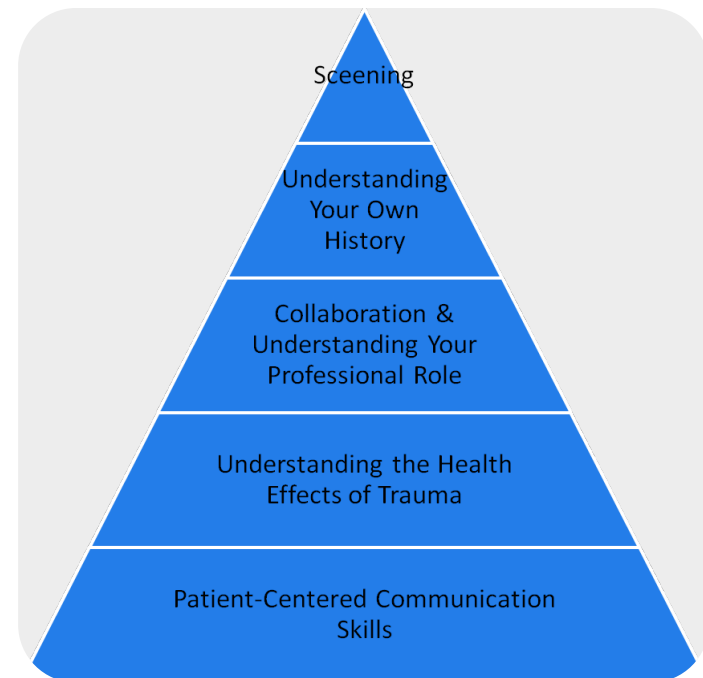
# Understanding Your Own History

- Providers are human beings too
- Your own history may interfere with your ability to ask questions or be empathic to a survivor
- You should not delve into trauma history
  - Learn communication techniques that are empathic and present focused
  - Learn to say “I am not the expert on this...” but have referrals.
- Support good self-care for your staff (guard against compassion fatigue, vicarious trauma and burnout)



# Most the Trauma-Informed Pyramid

- Does not require screening, asking, delving...
- Just Universal Trauma Precautions!



# Case Discussion #4





# Screen When Appropriate

- High risk environments
  - Ongoing, long-term relationships
  - Settings with integrated care
  - Acute injuries (not really screening)
- 
- How do you ask the questions?
  - What kinds of trauma do you ask about?
  - Do you screen for trauma, problem behaviors, or coping skills?



# Patient Attitudes Toward Screening

- Most comfortable with demographics and medical information
- Less comfortable discussing mental health, violence/trauma history, housing and food insecurity and other household variables

Source: Raja, da Fonseca, Rabinowitz, study in progress



# IPV: Assessment and/or Screening

- Patients are not being screened
  - 13% in the ED
  - 1.5-12% in Primary Care (consistent over decades, despite ACA)
  - Depends on population
- Many patients want to be screened
  - About half of the women surveyed favored routine screenings (review of 4 studies)
  - Most patients are not in favor of mandatory reporting of DV

Sources: Tavrow, Bloom, & Withers, 2018; Ramsay, et al. 2002; Sullivan & Hagen, 2005; Waalen, 2000



# Barriers to Screening

- Fear of offending patients
- Unsure how to respond to disclosure
- Limited time to conduct screening
- Lack of effective interventions once identified
- Where to refer

Sources: Green et al., 2011; Waalen, et al., 2000



# Assessment

## Indirect:

- Is everything alright at home?
- Do you get along well with your partner?

## Direct:

- Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?

# Suggestions for addressing IPV

"AVDR"

- Ask
- Validate
- Document
- Refer



# Child Abuse & Neglect

Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm

Source: [childwelfare.gov](http://childwelfare.gov)



# Screening

## Child Questions—no leading questions

- Does any place on your body hurt?
- What happens when you do something your parents don't like?
- What happens at your house when people get angry?
- Do people ever hit? Who do they hit? What do they hit with? How often does it happen? Is it scary?
- Are you afraid of anyone?
- What happens when you take a bath? (younger kids)
- Where do you sleep? What happens when you go to sleep?
- Has anyone touched you in a way you didn't like?

Source: Stanford.edu





# Child Abuse: Mandated Reporting/Acute Injuries

- Open-ended questions to avoid accusatory implications
  - Are the accounts of the injuries given by the child and the parent the same?
  - Are they reasonable and consistent with the type of injury observed?
- Suspicious injuries documented in the patient's chart
  - Include photographs and relevant xrays, etc of the structures involved. (use a ruler by the injury to record injury size)
  - Location, appearance, severity and distribution of the injuries

Source: Tsang, 1999



# Sexual Abuse In the Past

- Assessment?
- Recommendation is to allow the patient to disclose when they are ready
- Screen for coping skills and triggers, not trauma



# Suggested questions

- Victims usually don't want to be asked directly

Instead:

- Are there any parts this appointment that are particularly difficult for you? (for example, before a pelvic exam)
- Is there anything we can do to help you feel more comfortable?

Source: Stalker, 2005; Raja et al., 2015



# Responding to Disclosure

- Provide validation and empathy: *"I'm sorry that happened to you."*
- Provide education and normalization: *"Many patients have had experiences like yours and for some, it can continue to affect them even many years later. People can recover."*
- Assess current difficulties: *"How much does this continue to affect your daily life today? In what ways?"*
- Assess social support: *"Have you been able to talk to others in you life about this?"*

Source: Amy Street, PhD



# Responses to Disclosure: Current Appointment and Referrals

- Assess implications for care: *"Do you think this might affect your healthcare?"*
- Share information about referral for mental health care: *"Some of the women I've met with have found it helpful to talk with someone about their experiences. Would you like to know more about the services available? "*
  - Not everyone needs counseling: *"If you ever change your mind and want to speak to someone, just let me know."*

Source: Amy Street, PhD



# Screening Instruments



# Life Events Checklist - 5

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						

Source: Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013).



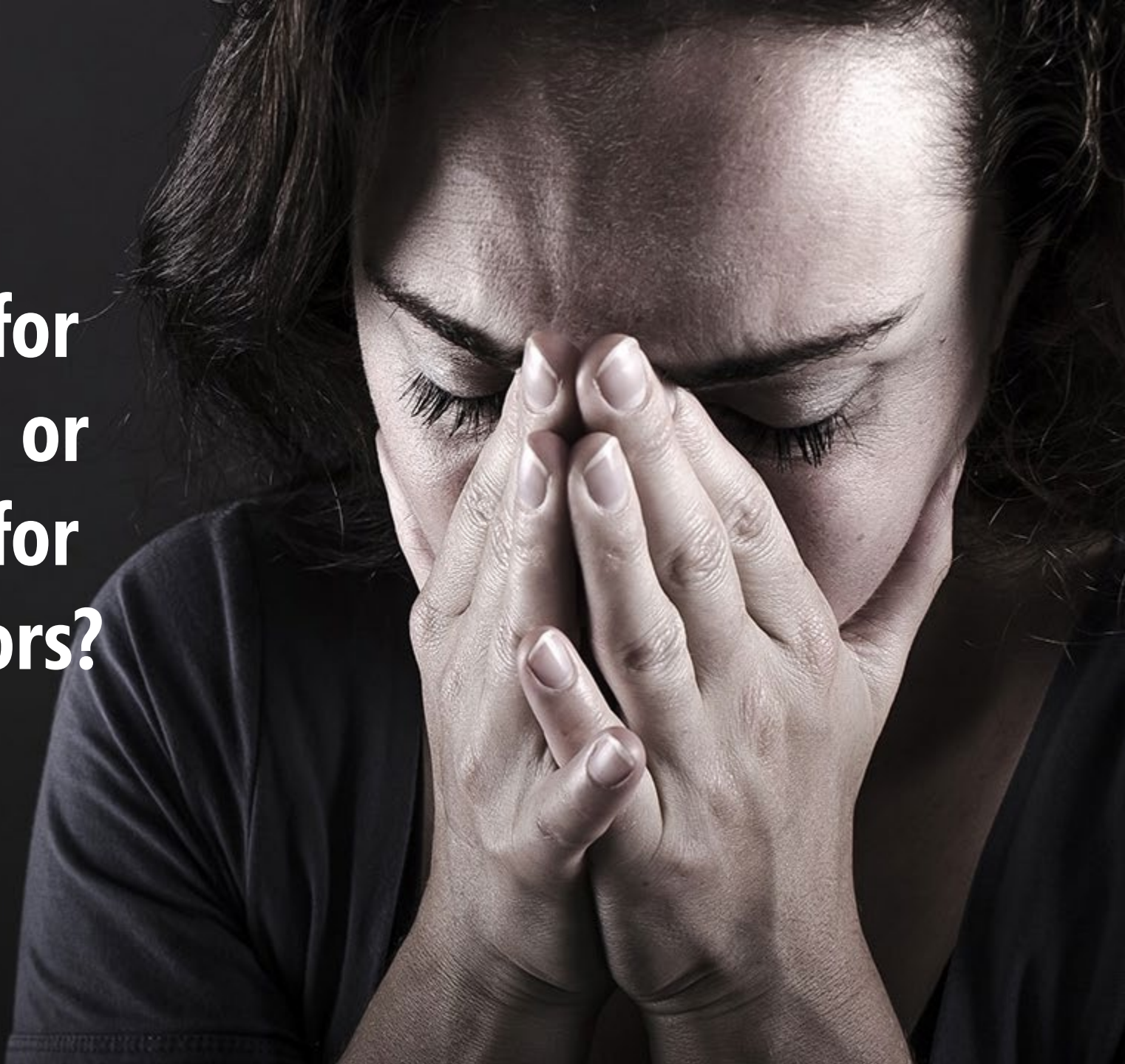
# Primary Care PTSD Screen – 5 (PC-PTSD)

- In your life have you ever had an experience that was so frightening, horrible, or upsetting that, in the past month you:
  - had nightmares about the event(s) or thought about the event(s) when you did not want to?
  - tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
  - been constantly on guard, watchful, or easily startled?
  - felt numb or detached from people, activities, or your surroundings?
  - felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?





# **Screen for Trauma or Screen for Behaviors?**



# Presentation in Teens

- Impulsivity & aggression may be present
- Self-harm
- Anxiety, worry
- Difficulty concentrating
- Anger
- Sadness
- High risk behavior
- Trust issues
- Substance use/abuse
- Appetite/sleep changes
- Physical health complaints

Source: [National Center for PTSD](#)



# Child Behavior Checklist

- Social withdrawal
- Somatic complaints
- Anxiety/depression
- Social problems
- Thought problems
- Attention problems
- Delinquent behavior
- Aggressive behavior

Source: Achenbach & Rescorla, 2001

# Brief COPE Instrument--Adults

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.

Source: Carver, C. S. (1997)



# Brief COPE Instrument--Adults

15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

Source: Carver, C. S. (1997)



# Summary

- Traumatic events are prevalent
- Trauma effects the way people cope, their neurophysiology and physical health
- The Trauma-Informed Pyramid can be used to sensitively engage patients in healthcare
- Screening can take many forms and can play a role in healing

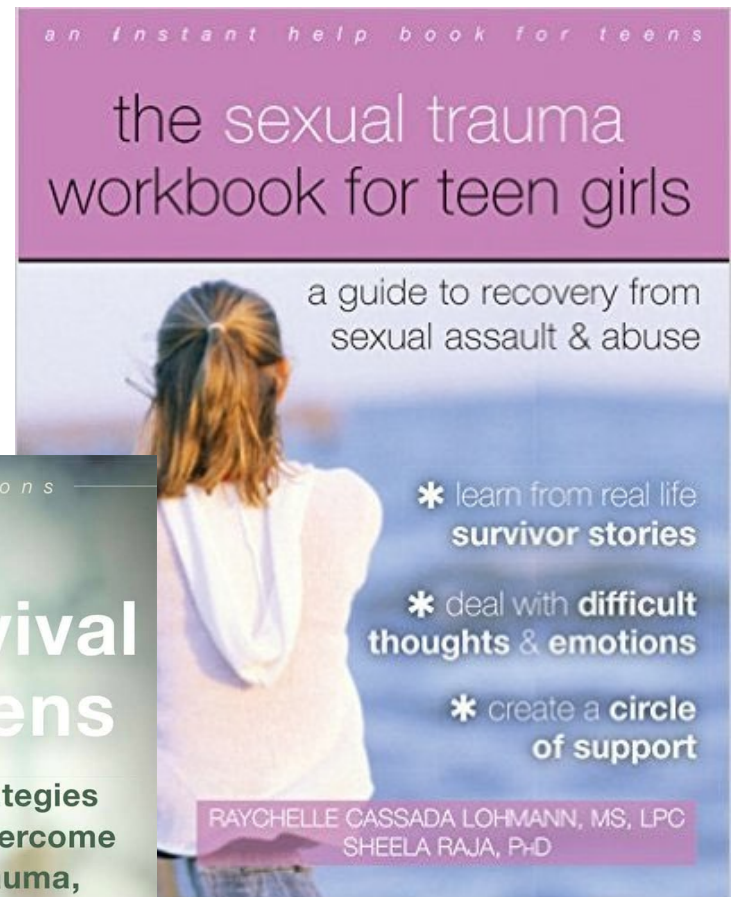
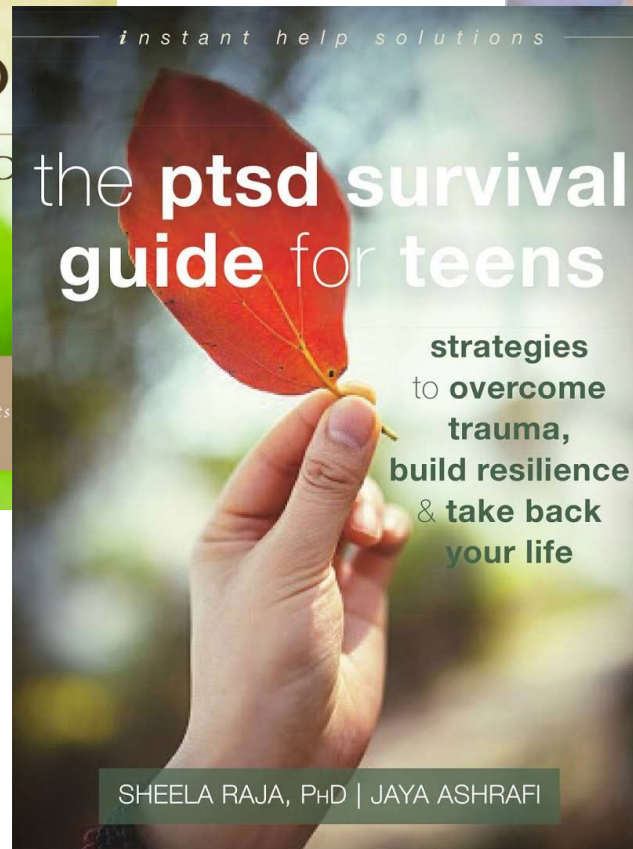
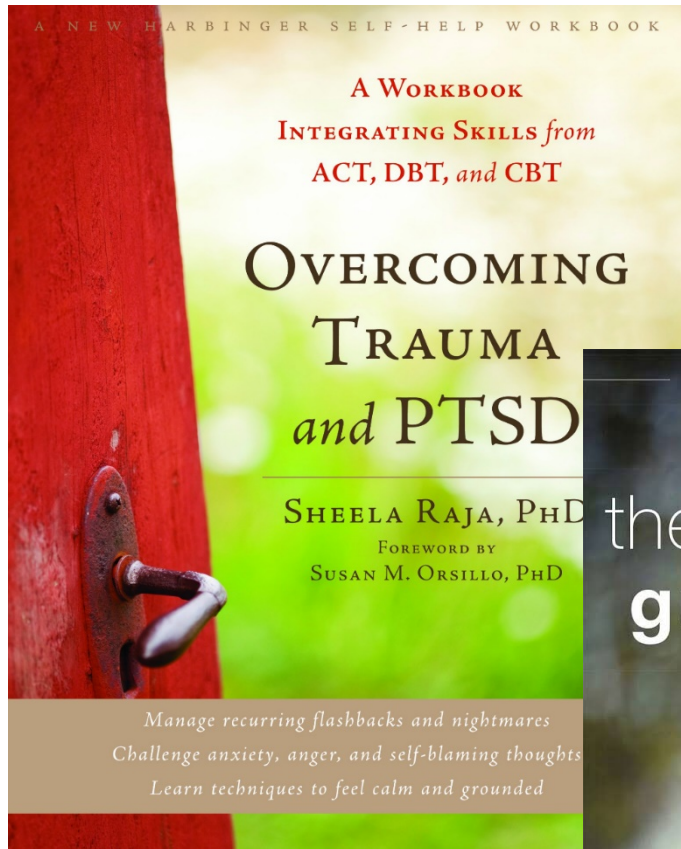




# Another Summary

- By getting someone into care, you might save a life—directly or indirectly
- All it takes is ONE person to believe you







# For More Practice

## Cases Online:

<https://www.aquifer.org/courses/aquifer-trauma-informed-care/>



# Thank you!

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