uchealth

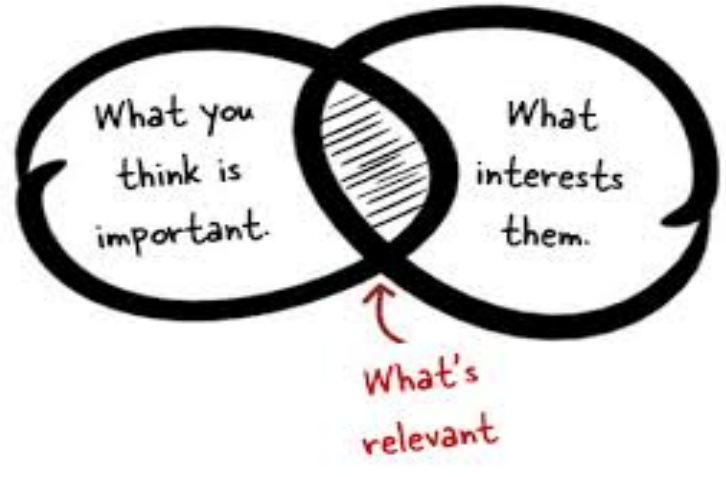
Trauma Informed Care in Physical Therapy Settings

American Physical Therapy Association
Colorado Chapter
2019 APTA Rocky Mountain Annual Conference

Felicia Greher, Ph.D.
Licensed Psychologist, Integrative Medicine
University of Colorado Hospital Denver Anschutz Medical Campus

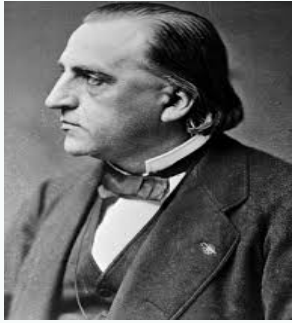
Learning Objectives

1. Define the basic principles of trauma and trauma-informed care and its' relevance to physical therapy
2. Identify signs and symptoms of trauma
3. Identify tools to more effectively treat these patients to maximize benefits of physical therapy

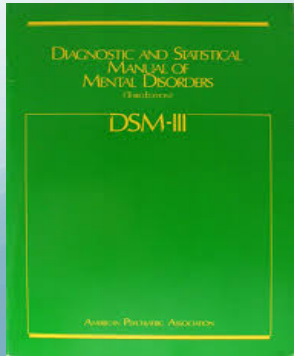


History Lesson

(Ringel & Brandell, 2012)



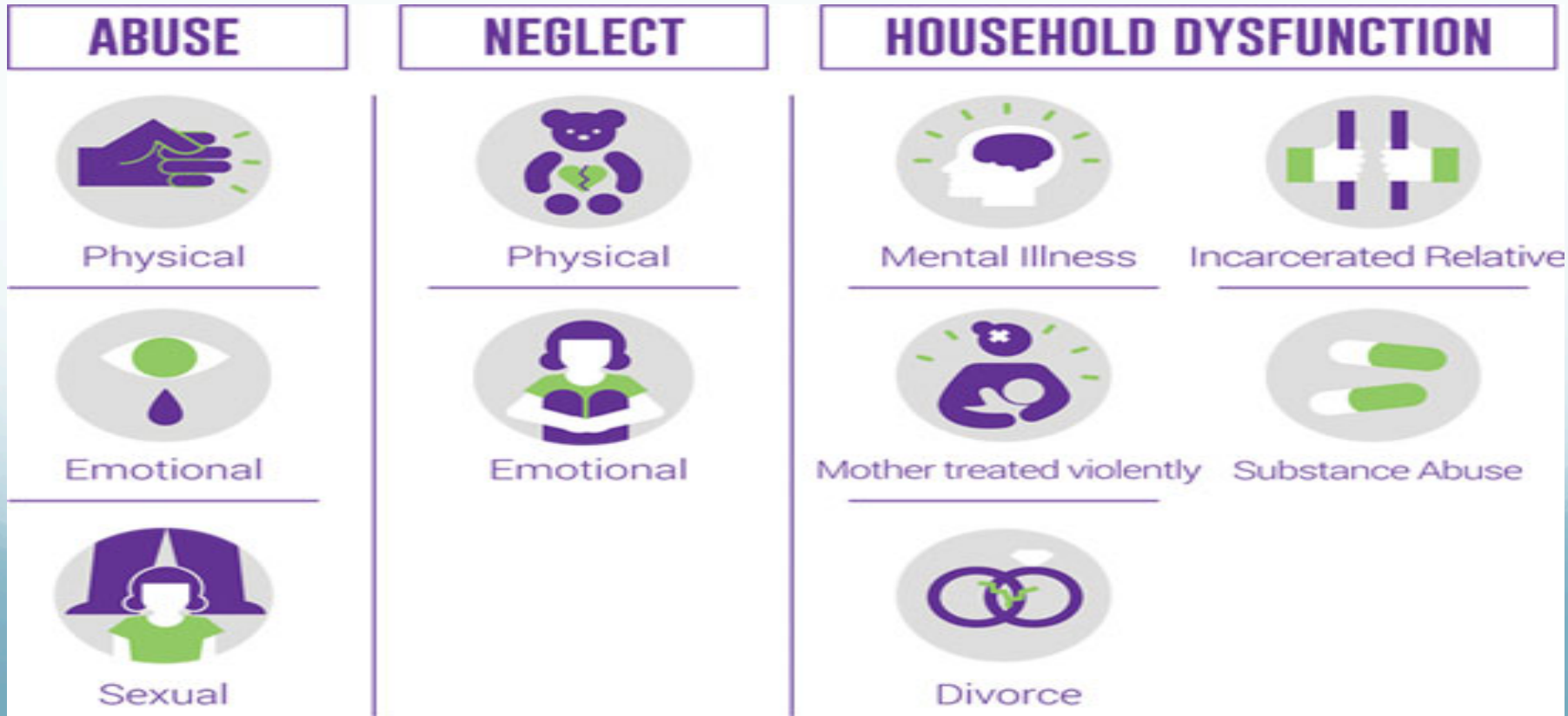
- Late 19th century- Jean Charcot
  - Origin of hysterical symptoms was not physiological but rather psychological
- 1880s- Freud, Breuer, and Janet
  - Psychological trauma caused hysteria
- World War I veterans -"shell shock" syndrome
  - Reenactment : "the subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion"
- 1942 Coconut Grove fire in Boston
  - Civilian crisis reactions such as disorganization, guilt, somatic complaints, and overwhelmed coping capacities
- 1970s- increased awareness of trauma in Vietnam veterans and women
- 1980s- DSM-III inclusion of PTSD



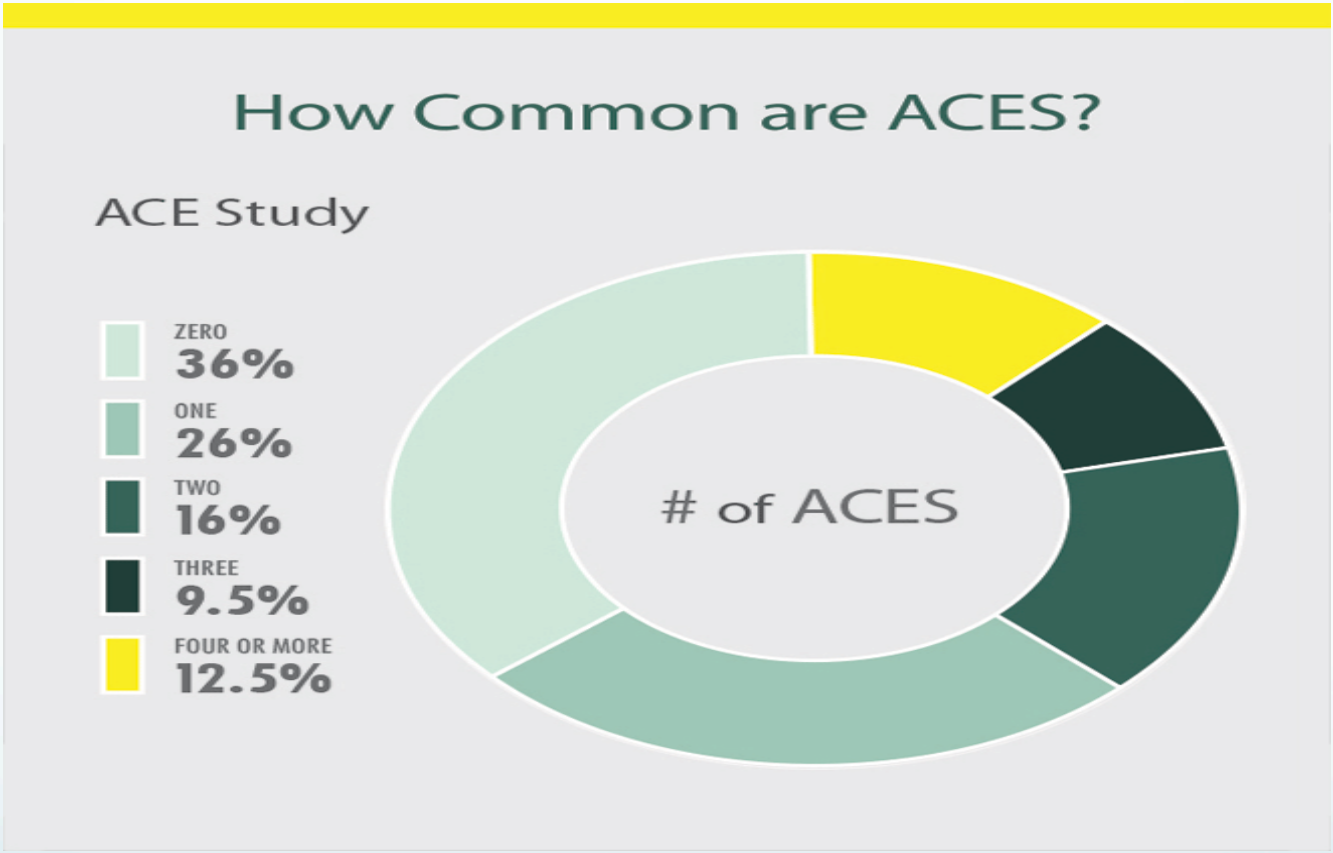
- Any event or experience that overwhelms the brain's ability to cope and shapes our beliefs or behaviors going forward.
- Trauma is less about *what happened*, and more about one's *subjective experience* of it
- Does not discriminate
- Generally over-whelms coping resources and ignites the survival response "fight, flight, or freeze"
- Produces a sense of fear, vulnerability, helplessness, powerlessness, and loss of control

Prevalence of Trauma

- Adverse Childhood Experiences Study (ACEs)
  - (Kaiser and Center for Disease Control and Prevention, 95-97') was a large epidemiological study involving more than 17,000 individuals from U.S.; it analyzed the long-term effects of childhood and adolescent traumatic experiences (before age 18) on adult health risks, mental health, healthcare costs, and life expectancy.



How Common are ACEs?



Note: Research papers that use Wave 1 and/or Wave 2 data may contain slightly different prevalence estimates. Source: Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

Early Adversity has Lasting Impacts

Lifetime Trauma Prevalence

- US Sample - Kilpatrick et al., (2013)
  - 89.7% exposed to traumatic event
  - 8.3 % lifetime PTSD prevalence
    - higher among women
    - greater for interpersonal violence and military combat
- Netherlands Sample- deVries & Olff (2009)
  - 80.7% exposed to traumatic event
  - 7.4% lifetime PTSD prevalence

SAMHSA'S Trauma Definition

Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

SAMHSA
Substance Abuse and Mental Health Services Administration

EVENT

Traumatic Events and circumstances include:

(1) Exposure to actual or extreme threat of physical or psychological harm

(2) Single traumatic event or repeated

Types of Trauma

- Physical, sexual, and emotional abuse and/or assault
- Childhood neglect
- Living with a family member with mental health or substance use disorders
- Sudden, unexplained separation from a loved one
- Serious medical illness or disease (disabling conditions, loss of function, invasive and distressing procedures)
- War, combat, civil unrest conditions, violence in the community or terrorism
- Catastrophic losses of one's home, livelihood, people, pets due to natural disasters
- Involved in or witnessing horrific events involving violence, gruesome accidents or death/ serious injury (i.e., first responders)
- Poverty and discrimination
- Medical Trauma

BIG T vs. little t

- **“BIG T” Trauma**
  - Life threatening; impact our sense of safety; powerlessness and helplessness
  - Readily identified as acutely traumatic
  - Ex: disasters, terrorism, abuse, assault, car accidents, combat

- **“little t” Trauma**
  - Attack on self-efficacy; exceed coping capacity and disrupt emotional functioning
  - May not appear acutely traumatic, but distressing and impair functioning.
  - Can build over time; easily overlooked or dismissed
  - Ex: family conflict, infidelity, divorce, job loss, abrupt life changes, minor medical procedures, repeated criticism/neglect

EXPERIENCE

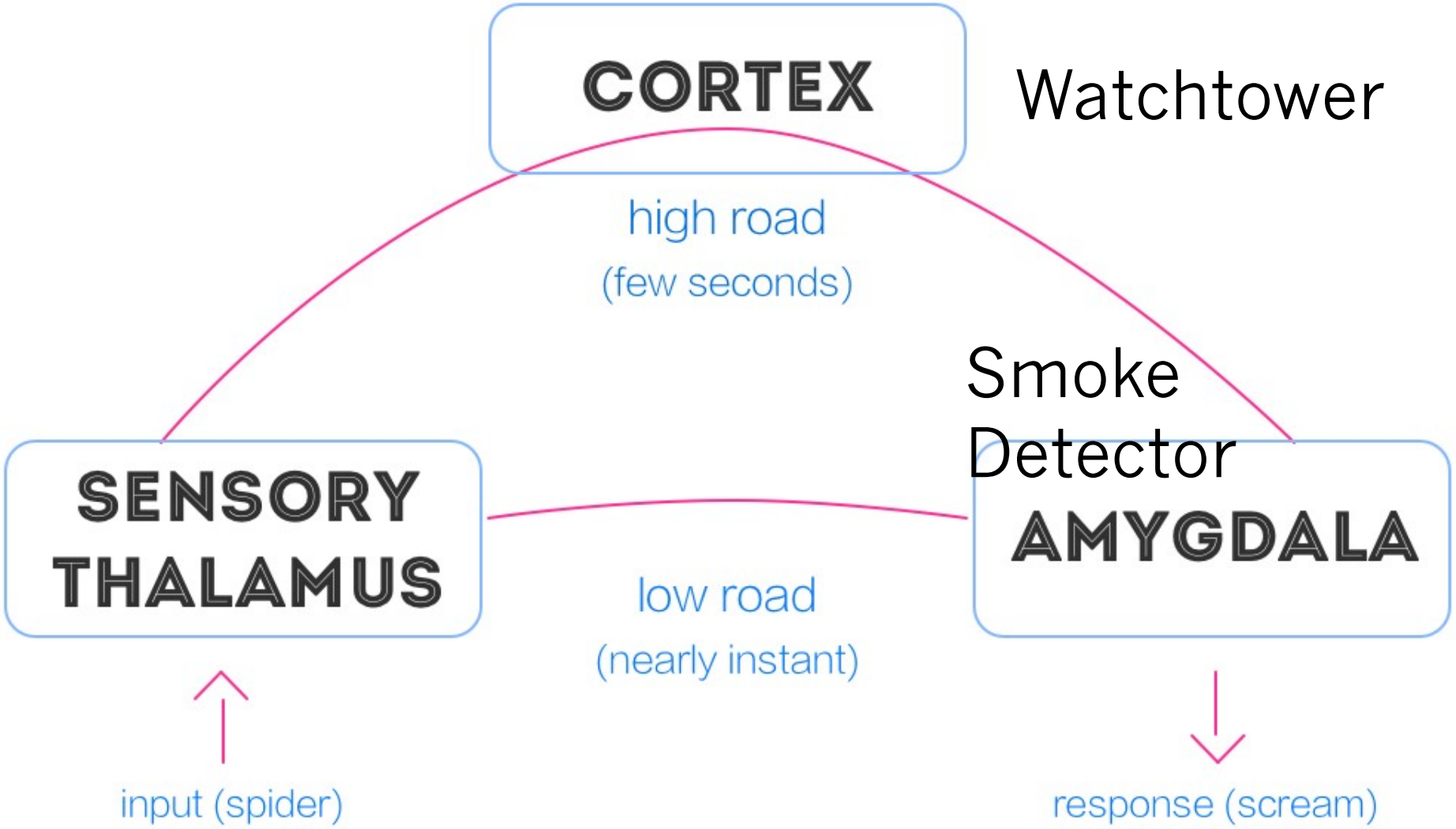
- How the *individual labels, assigns meaning to, and is disrupted* physically and psychologically by an event will contribute to whether or not it is experienced as traumatic.
- The meaning of the trauma continues to evolve well after the event itself
- Feelings of powerlessness, humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event.
- How the event is experienced may be linked to a range of factors including the individual's cultural beliefs, availability of social supports, the developmental stage of the individual, past trauma, etc.
- Experience of and expression of trauma is situation and person specific

EFFECTS

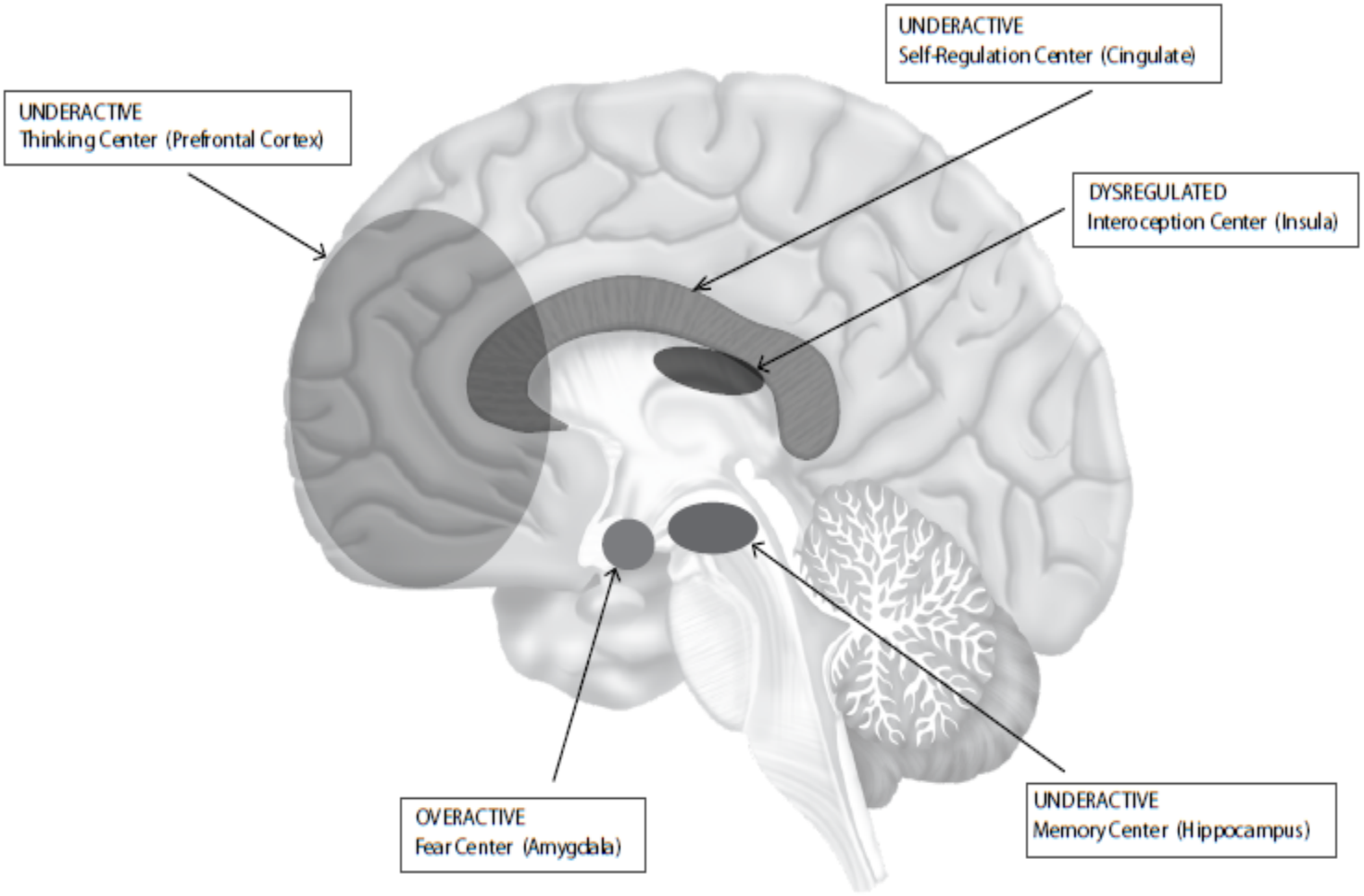
- Neurological, biological, psychological and social in nature.
- Immediate or delayed onset
- Short to long term

HOW THE BRAIN PROCESSES FEAR

(the high and low road)



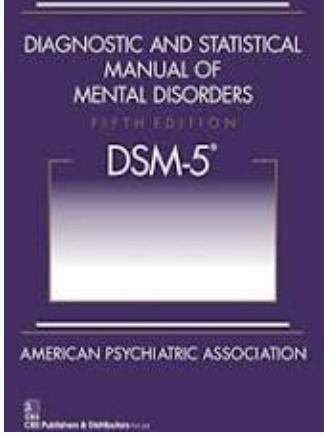
The Brain On Trauma



Trauma Sequelae

(examples include but are not limited to)

- Hypervigilance
- Hyperarousal
- Hypoarousal
- Emotional Numbing
- Intrusive thoughts, images, and body memories
- Avoiding people, places and things that are similar to or reminders of the traumatic event(s)
- Coping with stress
- Trust
- Sense of Safety
- Cognitive deficits
- Behavioral dysregulation
- Emotional dysregulation
- Alterations in spiritual beliefs
- Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self harm, sexual promiscuity, violence)
- Anxiety and fear
- Depression
- Physical health problems
- Somatization
- "Body Memories"
- Sleep problems
- Flashbacks
- Relationship issues
- Engagement in healthcare
- PTSD

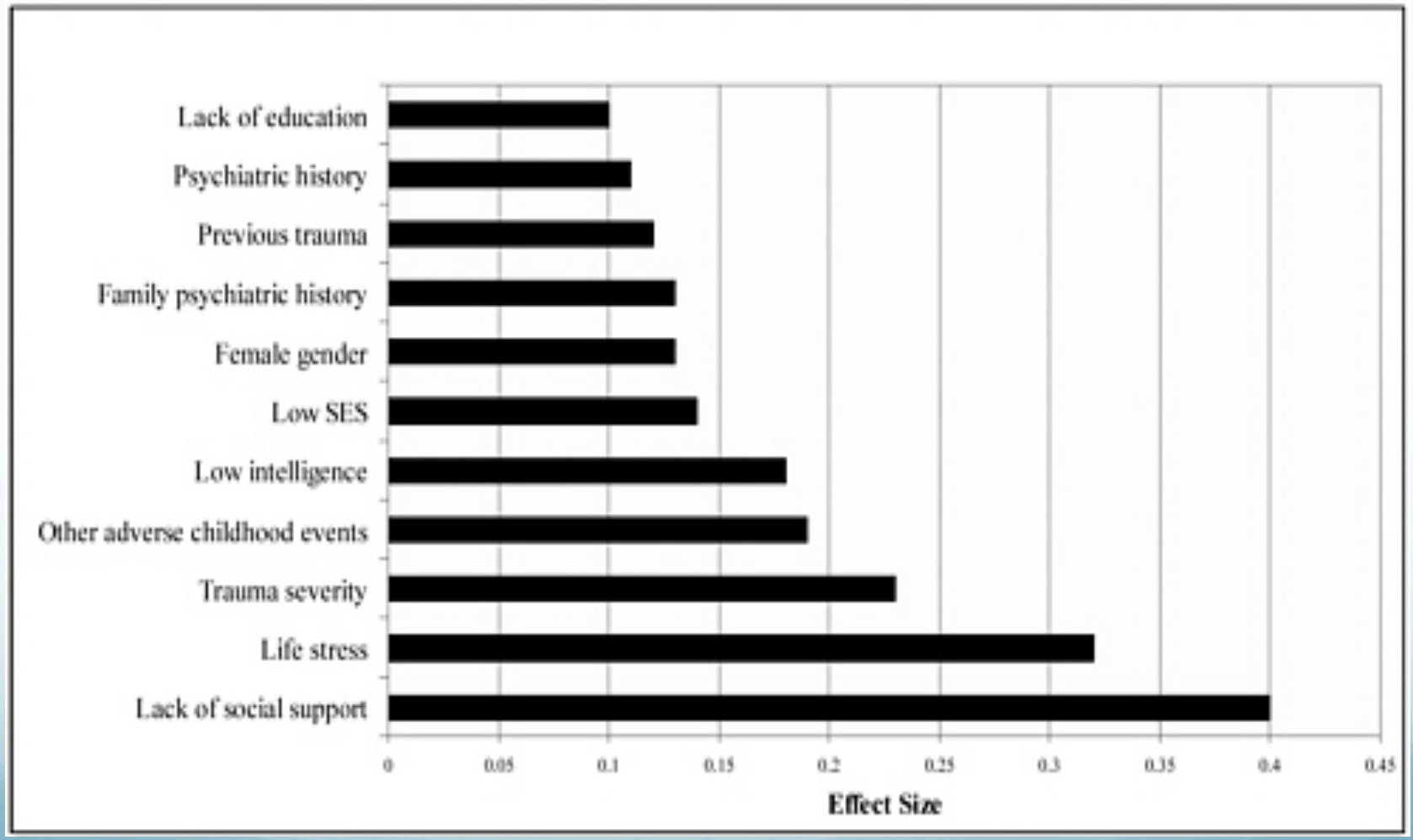


PTSD (DSM V, 2013)

A. Exposure
B. Intrusive Symptoms
C. Persistent Avoidance of stimuli associated with trauma
D. Negative Alterations in Cognitions & Mood
E. Marked Elevations in Arousal & Reactivity
F. Duration > 1 month
G. Clinically significant functional impairment
H. Not attributable to substances or medical condition

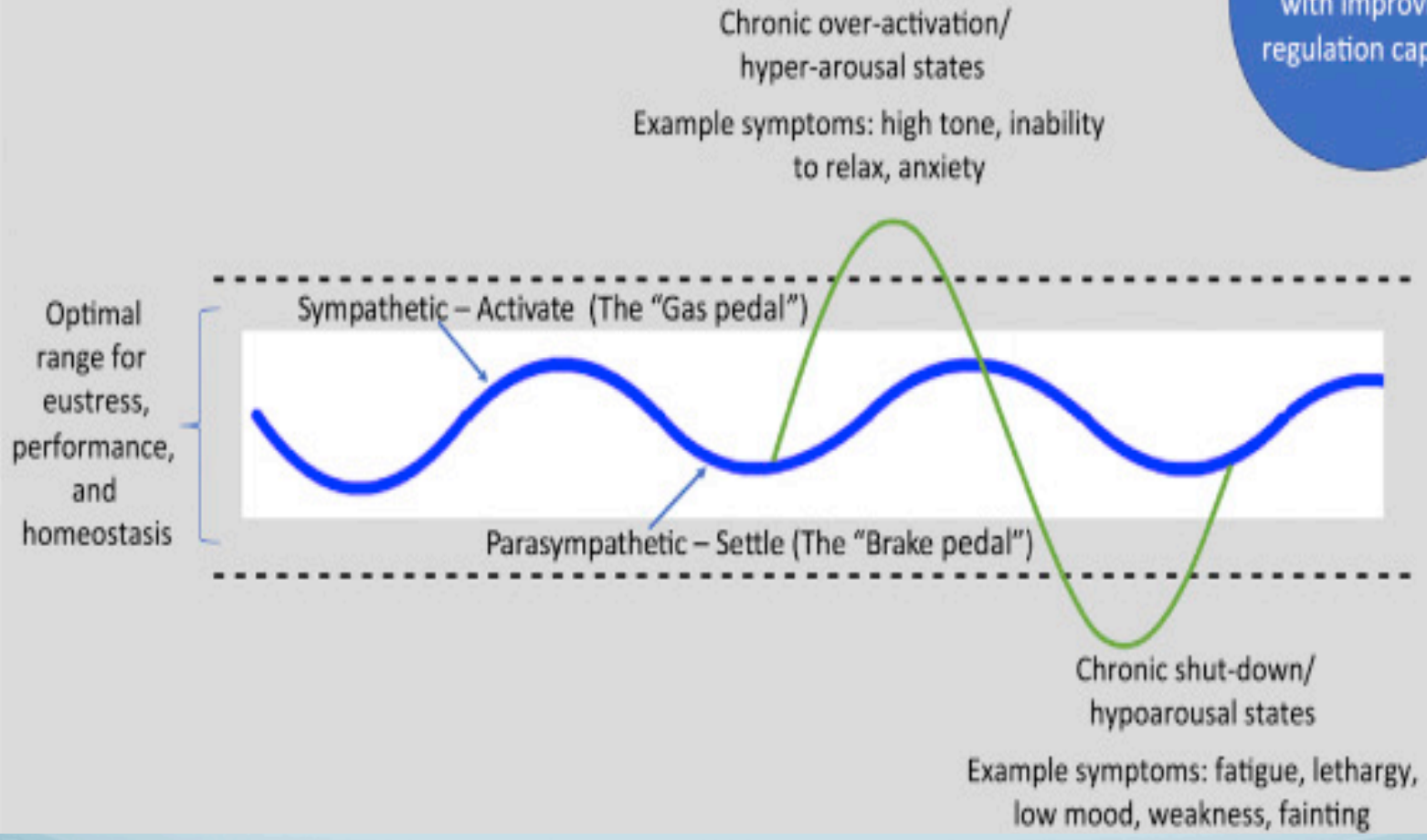
Risk Factors for PTSD

(Brewin et al., 2000)

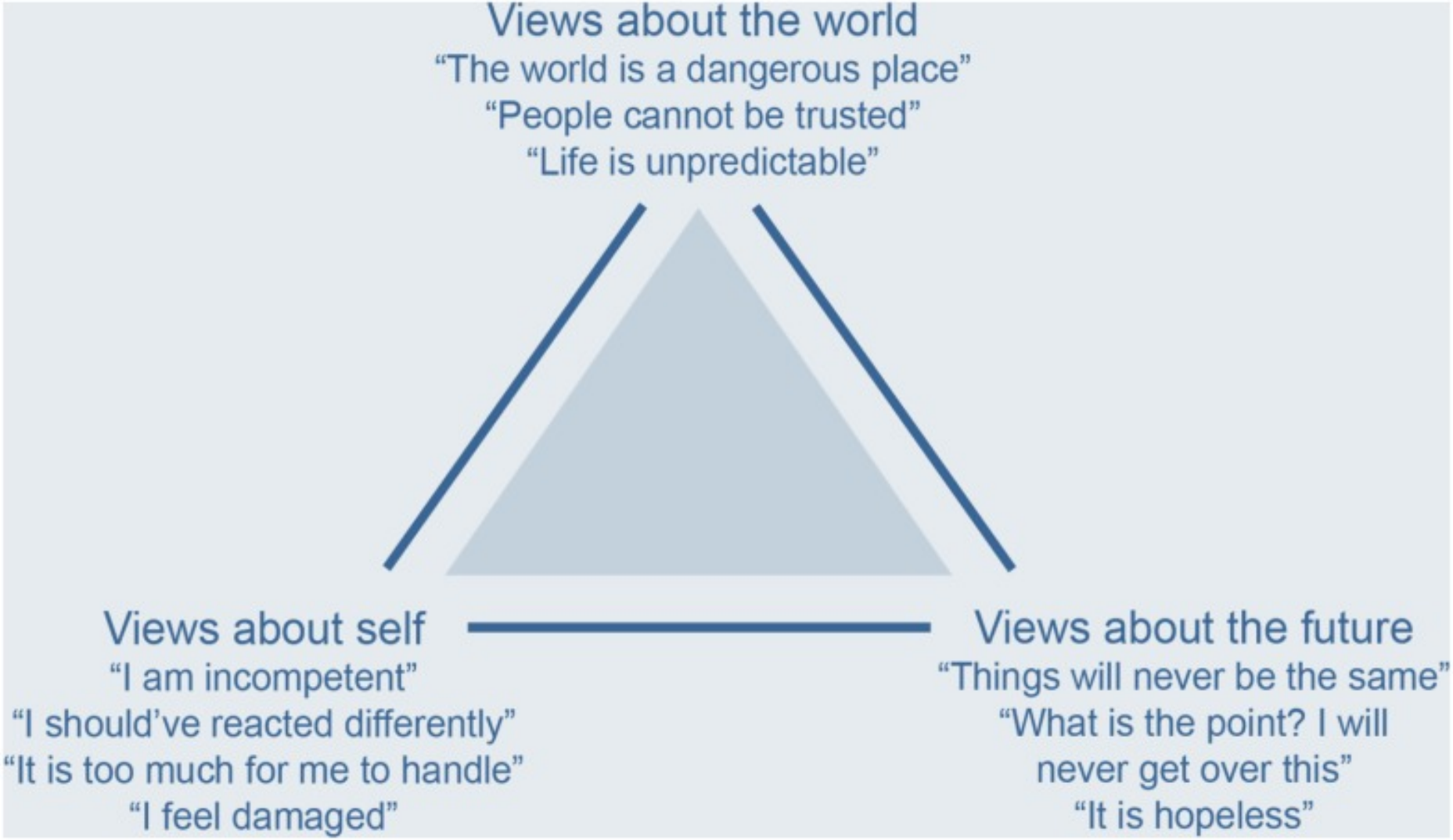


ACEs, chronic stress, and/or trauma
may affect autonomic nervous system physiology

Mind-body skills training can assist with improving regulation capacity



Cognitive Triad of Traumatic Stress



Restoring Balance

Top down regulation

The mind is engaged to change the brain

Help clients think differently

Examples:

- Talk therapy
- CBT
- Trauma-focused interventions that emphasize discussing traumatic events in detail
- Mindfulness

Bottom up regulation

Body sensations are engaged to change the brain

Help clients cope with raw emotions and defense reactions

Examples:

- EMDR
- Breathing exercises
- Body scan
- Progressive muscle relaxation
- Biofeedback
- Yoga
- Exercise
- Tai chi
- Mindfulness

Relevance to PT

- Barriers to treatment (patient engagement, repeatedly missed or cancelled appointments, poor adherence to recommendations)
- High needs patients
- Drain providers
- Unconscious bias by provider (ex. patient viewed as noncompliant)

What feelings, beliefs and biases come up for you?

Trauma-Informed Care

- Universal Precautions
  - We don't know what kinds of experiences our clients have had when they present for services, so we need to approach them in a universally sensitive manner
  - If we assume that their presenting issues are not related to trauma, then we miss a great opportunity to help
  - If we assume trauma may be playing a role, then we begin to pay attention to signs of trauma and ask the right questions
- Acknowledges the need to have a complete picture of a patient's life — past and present — in order to provide effective health care services
- Highlights adaptation over symptoms and resilience over pathology (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467)
- **Shifts the focus from *"What's wrong with you?"* to *"What happened to you?"***
- Improves patient engagement, treatment adherence, health outcomes, and provider and staff wellness and reduces burnout
- Relies on basic tenets of good care, like respect, professionalism, and communication.

The Four Rs of Trauma-Informed Care

Realize the widespread impact of trauma and understand potential paths for recovery

Recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system

Respond by fully integrating knowledge about trauma into policies, procedures, and practices

Resist re-traumatization of children, as well as the adults who care for them

This figure is adapted from: Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and Guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

6 KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

- **Safety**: *How can we ensure physical and emotional safety for clients throughout our system of care?*
- **Trustworthiness & Transparency**: *How can we maximize trustworthiness and be transparent with decisions and procedures?*
- **Empowerment, Voice , & Choice**: *How can we enhance client choice and control* (i.e., recognizing and building on individuals' strengths, skill building, honoring their preferences, shared decision-making and goal setting)?
- **Collaboration & Mutuality**: *How can we maximize collaboration and sharing of power?*
- **Cultural, Historical, & Gender Issues**: *How can we incorporate policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served?*
- **Peer Support**: *How do we include peer support and mutual self-help to enhance collaboration and utilize their lived experience to promote recovery and healing?*

Revictimization

- A situation, attitude, interaction, or environments that replicates the events and dynamics of the original trauma and triggers the overwhelming feelings and reactions associated with them
- Interferes with treatment
- Usually unintentional and may/may not be obvious to provider or client
- Idiosyncratic
- Inability to consistently predict

Ways Medical Care Can Activate Patients with Trauma History

- Loss of and lack of privacy (disrobing)
- Asked personal questions
- Invasive procedures
- Physical touch
- Vulnerable physical position
- Relationship dynamics between patient and provider (power, gender)
- Demand Characteristics

Adapted from: www.integration.samhsa.govTrauma_Informed_Care_Webinar_Slides__072715.pdf

Signs of Distress

- Emotional
  - anxiety, fear, powerlessness, helplessness, worry, anger
- Physical
  - nausea, light headedness, increase in BP, headaches, stomach aches, increase in heart rate and respiration or holding breath
- Behavioral
  - crying, uncooperative, argumentative, unresponsive, restlessness
- Cognitive –
  - confused, forgetfulness, inability to give adequate history

Resist Revictimization

- Not about getting it right all the time, but rather how consistently and forthrightly you handle situations when feelings of vulnerability and lack of safety arise
- Maintain vigilance and curiosity and collaboration
- Encourage ongoing dialog
- Work with client to learn cues
- Be responsive and adaptive
- Create a sense of safety

Creating Safety

"The ability to feel relaxed in one's body requires the emotional experience of safety."
- Bessel van der Kolk, "The Body Keeps the Score"

- **Establish and maintain positive rapport and trust**
  - Communicate clearly
  - Validate
  - Attend to provider and client body language
  - "Connect" with client
  - Listening. Be present in the moment.

- **Language Matters**
  - *How* we say something has the greatest impact
  - Be mindful of your words, tone, and how statements and questions are phrased
  - Slow down, relaxed/soft tone
  - Convey dignity, respect, and validation
  - Avoid using language that is judgmental, subtly disapproving, or reveals assumptions and biases ("Just relax and let go" "Non-compliant, "Uncooperative," "Resistant," "No show," "Manipulative," "Controlling," "Paranoid")

Creating Safety

- **Language Matters**
  - Clarify things you don't understand
  - Respond carefully to disclosures
  - Normalize and avoid apologizing, clarifying beliefs, etc.
    - *"We are learning more about these issues all the time."*
    - *"Would you like me to connect you with someone you could talk to about this?"*
    - *"Let me know how I can make you more comfortable as I take care of your medical needs."*
    - *"Please tell me if there is anything that doesn't feel right to you."*
    - *"Thank you for trusting me with such an important and private experience."*
  - Look back but don't stare. Avoid probing for specific content
    - Avoid assumptions about relevance or meaning ascribed to content shared or utilize your hypotheses about the relevance or meaning ascribed to these events to guide treatment decisions

To Screen or Not to Screen

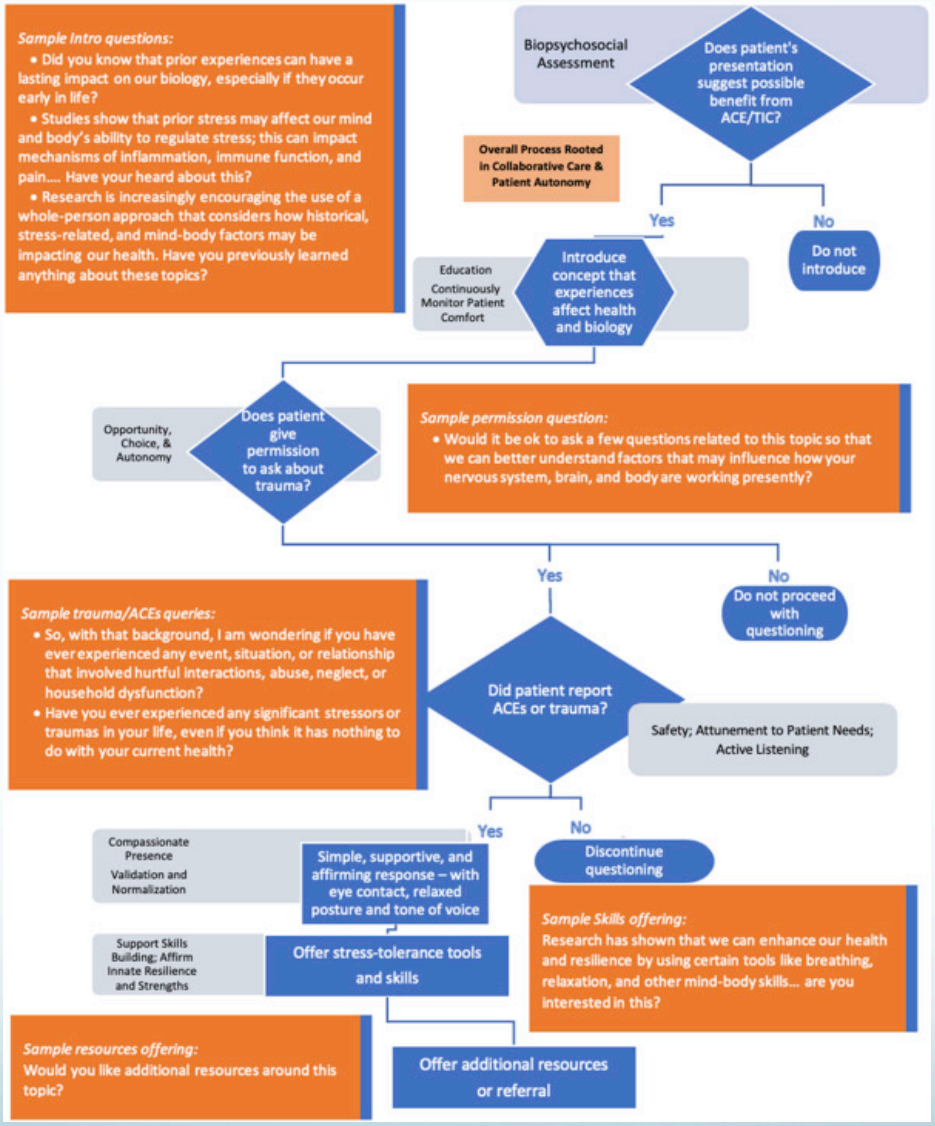
- **Treatment setting and patient population should guide screening**.
  - Upfront, universal screening may be more effective in primary care settings and later screening more appropriate in behavioral health settings to allow relationships to form.
  - Variations in the frequency and type of screening might also exist between adult and pediatric populations.

- **Screening should benefit the patient**.
  - Providers must have a clear strategy for utilizing the information in a way that supports patients' health, including an established referral network.

- **Care coordination should be employed to avoid rescreening**
  - Sharing results across treatment settings with appropriate privacy protections may help reduce re-screening and the potential for re-traumatization.

- **Provider training should precede screening**.
  - Health care professionals should be proficient in trauma screening and conducting patient follow-up and resourcing in a manner that is sensitive to cultural and ethnic characteristics. Trauma Assessment Tools: http://www.istss.org/assessing-trauma.aspx

Ranjbar & Erb Schema (June 2019)



Creating Safety

(Schachter et al., 1999)

- **Partner with and empower client**
  - Share control and obtain consent for each component (permission to say no)
  - Be transparent. Share information and invite them to give you feedback
  - Collaborate and actively engage patients in their care and utilize their feedback to direct the treatment plan
  - Giving them control and autonomy
  - Explain movements and touch
- **Convey understanding and work with attitudes about body**
  - Education about mind-body relationship
- **Work with client on triggers**
  - Remember that defenses serve a function
  - Honor their pace
  - Graded exposure
  - Seek alternatives (i.e., therapist preferences, privacy, touch, body positioning)
  - Minimize retraumatization
- Practice holistic healthcare and facilitate links with other supports

Refer Out

- Seek consultation and/or supervision
- Recognize when the needs of patients are beyond your scope of practice and make appropriate referrals to other behavioral health professionals
- Refer patient to PT with advanced training in trauma-informed practices

Examples of **Patient** Self-Care Strategies

- 54321 Technique (see, hear, feel with breath)
- STOP Technique
- Box Breathing Exercise (4 seconds breathe in, 4 seconds hold, 4 seconds breathe out)
- “Take 5 Breath” with Hand and Fingers

Secondary Traumatic Stress

Hypervigilance
Hyperarousal
Hopelessness
Inability to embrace complexity
Inability to listen
Avoidance of clients or avoidance behavors during client interactions
Anger and cynicism
Negative thinking
Depressed Mood
Sleeplessness
Fear
Chronic exhaustion
Limited range of emotional expression/domished affect
Physical ailments
Minimizing
Guilt
Social withdrawal

Provider Self-Care Strategies

*More to come on this later in day

- Peer and Social Support
- Supervision and consultation
- Training
- Setting clear limits and boundaries with clients
- Personal therapy
- Maintaining balance and self-care

Final Reflection

One thing you will **continue** doing…….

One thing you will **change** moving forward to apply a trauma-informed lens to your practice…….

Questions and comments?

Sources

- https://www.traumainformedcare.chcs.org/
- https://www.ncbi.nlm.nih.gov/books/NBK207205/
- https://store.samhsa.gov/system/files/sma14-4884.pdf
- https://www.integration.samhsa.gov/Trauma_Informed_Care_Webinar_Slides__072715.pdf
- https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html
- Brewin CR, Andrews B, Valentine JD. (2000) Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology* 68(5):748–766.
- de Vries, G. and Olff, M. (2009), The lifetime prevalence of traumatic events and posttraumatic stress disorder in the Netherlands. *Journal of Traumatic Stress*, 22: 259-267.
- Elliott, D, Bjelajac, P, Fallot, R, Markoff, L, & Reed, B (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33: 461 - 477.
- Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of traumatic stress*, *26*(5), 537–547.
- Ringel, S., & Brandell, J. R. (2012). *Trauma: Contemporary Directions in Theory, Practice and Research.* Sage Publications, California.
- Ranjbar, N, & Erb, M (2019). Adverse Childhood Experiences and Trauma-Informed Care in Rehabilitation Clinical Practice. *Archives of Rehabilitation Research and Clinical Translation*, Volume 1, Issues 1-2, https://doi.org/10.1016/j.arrct.2019.100003
- Schachter, C, Stalker, C, & Teram, E. (1999). Toward Sensitive Practice: Issues for Physical Therapists Working With Survivors of Childhood Sexual Abuse, *Physical Therapy*, Volume 79, Issue 3, 248–261, https://doi.org/10.1093/ptj/79.3.248
- Substance Abuse and Mental Health Services Administration. (2014). *Concept of Trauma and Guidance for a Trauma-Informed Care Approach.* U.S. Department of Health and Human Services.
- Substance Abuse and Mental Health Services Administration (2014). *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services, Tip 57*. U.S. Department of Health and Human Services, 14-4816
- Van der Kolk, Bessel (2014). *The Body Keeps the Score: Brain, mind, and body in the healing of trauma.* New York, NY.