Trauma Informed Care in Primary Care Settings

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Workshop Goals

Part One:

- How Does Trauma Negatively Impact Health?
- What is Trauma Informed Care in Primary Care?
- How Can I Provide Trauma Informed Care?
- Several Providers Reflect

Part Two

- Secondary Traumatic Stress, Empathy Fatigue, and Burnout
- Self Care is Self Preservation: Building Resiliency
- A Provider Reflection

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Fostering Resiliency Toolkit

The conversation

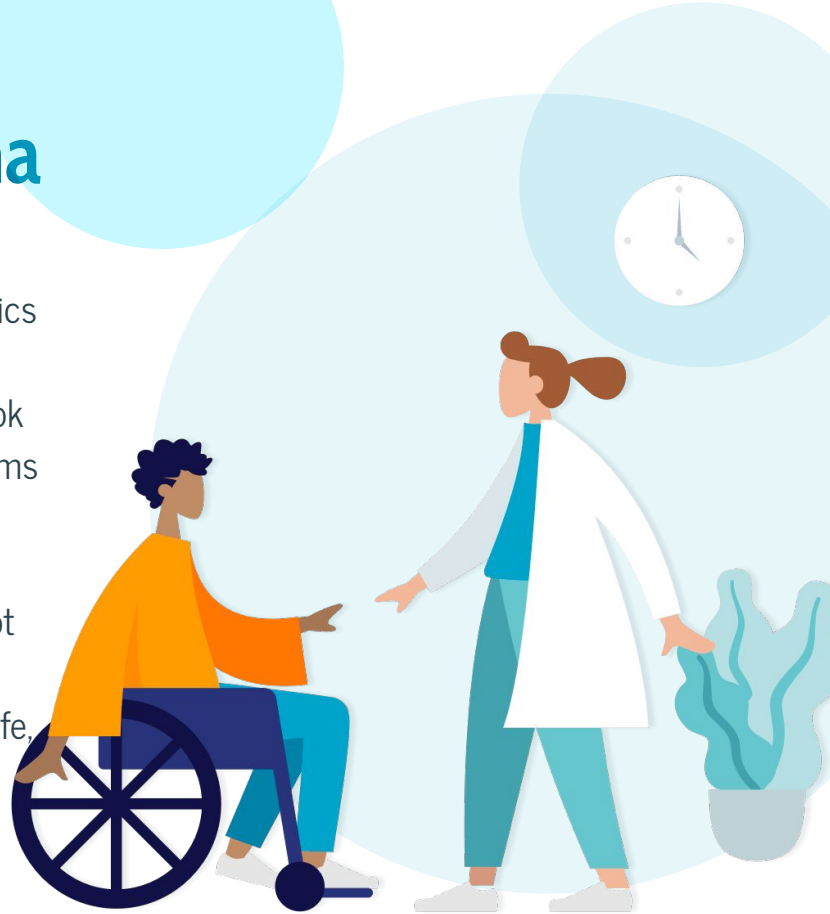
What is Trauma

- Trauma occurs when a person experiences a serious injury, threat of death and/or violation of personal integrity OR witnesses a serious injury, threat of death or actual death AND the experience evokes strong feelings of fear, helplessness or horror.
- Extreme stress that overwhelms a person's ability to cope.

Source: American Psychiatric Association. (2007). Diagnostic and statistical manual of mental disorders (5th ed..). Washington, DC: Author.

What We Know About Trauma

- Over 90% of patients who are seen in public behavioral health clinics have experienced trauma
- Many trauma survivors do not seek mental health services, but look for help in primary care settings, presenting with physical symptoms
- Neither provider or patient may be aware that current physical complaints may be connected to trauma
- Research suggests that most patients with a trauma history do not object to being asked about their trauma history in a primary care setting BUT will not typically disclose unless asked directly in a safe, supportive manner



Sources: http://www.publichealth.va.gov/docs/vhi/posttraumatic.pdf
Schumann, L. and Miller, J. L. (2000), Post-Traumatic Stress Disorder in Primary Care Practice. Journal of the American Academy of Nurse Practitioners, 12: 475–482.

Trauma in Primary Care Settings

- It is important to understand that "problem behaviors" may actually be manifestations or symptoms of trauma, or coping skills that served them when surviving their trauma.
- What happens when someone is triggered, retraumatized or their trauma is not accounted for?
  - Frequent missed appointments
  - Disengagement from care
- Viewing patient behavior through a trauma informed lens helps providers understand their patients, and provide the care needed to truly treat them.

A Provider's Reflection

Christopher J. Pezzullo, DO

Clinical Director, MPCA

Implementing trauma-informed approaches within primary care marks a fundamental shift in care delivery that supports improved utilization of services, improved patient outcomes, increased staff satisfaction and healthier work environments.

Source: Fostering Resilience and Recovery: A Change Package

Table 1. Six Principles of a Trauma-Informed Approach[26,27]

PRINCIPLE	DEFINITION	EXAMPLES IN PRACTICE
Safety	Ensuring physical and emotional safety among patients and staff.	• Allow patients to define safety and ensure it is a high priority of the organization. • Create calm waiting areas and exam spaces that are safe and welcoming. • Respect privacy in all interactions.
Trustworthiness and Transparency	Conduct operations and decisions with transparency with the goal of building and maintaining trust with patients, family members and staff.	• Provide clear information on services. • Ensure informed consent. • Schedule appointments consistently.
Peer Support and Mutual Self-help	Promote recovery and healing by valuing and applying lived experience of peers and individuals with trauma histories.	• Facilitate group and partner interactions for sharing recovery and healing from lived experiences. • Include peer supporters in health teams as navigators.
Collaboration and Mutuality	Make decisions in partnership with patients and encourage shared power between patient and provider.	• Give patients a significant role in planning and evaluating services.
Empowerment, Voice and Choice	Patients retain choice and control during decision-making and patient empowerment with a priority on skill building.	• Create an atmosphere that allows patients to feel validated and affirmed with each contact. • Provide clear and appropriate messages about patients' rights, responsibilities and service options.
Cultural, Historical and Gender Issues	The organization embeds principles of diversity, equity and inclusion to deliberately move past cultural stereotypes and biases and incorporate policies, protocols and processes that are responsive to the racial, ethnic, cultural and gender needs of patients served.	• Ensure access to services that address specific needs of individuals from diverse cultural backgrounds. • Display messages in multiple languages to ensure everyone feels welcome. • Provide gender responsive services. • View every policy, practice, procedure and interaction through a lens of diversity, equity and inclusion.

Source: Fostering Resilience and Recovery: A Change Package

Change Concepts

CHANGE CONCEPT 1: Help All Individuals Feel Safe, Secure and Establish Trust

CHANGE CONCEPT 2: Develop a Trauma-Informed Workforce

CHANGE CONCEPT 3: Build Compassion Resilience in the Workforce

CHANGE CONCEPT 4: Identify and Respond to Trauma and Toxic Stress Among Staff

CHANGE CONCEPT 5: Finance and Sustain Trauma-Informed Approaches in Primary Care

Source: Fostering Resilience and Recovery: A Change Package

What Helps

Round table conversation with MPCA staff:

- Trauma Informed Supervision
  - Hillary Colcord, BPHC Program Manager
- Organizational Trauma
  - Maureen O'Connor, MA, Director of Resource & Member Development

Building Compassion and Resiliency in Providers

Creating Space for Inquiry

- Why do you do this work?
- How do you measure success in your work?
- What can you control in your work?
- What are the costs and rewards of this work and how are you personally changing?

Empathy Fatigue

- Compassion builds on Empathy
- Empathy without Compassion may lead to Burnout
- Over-identification leads to Burnout
- Compassion is a teachable skill

Secondary Traumatic Stress

- STS/ Caregiver fatigue:
  - Also called "vicarious traumatization" (Figley, 1995).
- The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events.
- It differs from burn-out, but can co-exist.
- How is it different from Burnout?
  - *There is a high correlation between burnout and STS.*
  - *Burnout can be a predictor of STS.*

Burnout

- Burnout is a state of chronic stress that leads to physical and emotional exhaustion, cynicism and detachment and feelings of ineffectiveness and lack of accomplishment.

- In 2019 the World Health Organization classified burnout in the International Classification of Diseases (ICD-11) as an occupational phenomenon or "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed."

Characteristics of Burnout

- Reduced professional efficacy
- Increased mental distance from one's job
- Feelings of negativism and cynicism related to the work
- Joy of work is lost
- Progresses gradually as a result of emotional exhaustion, cynicism, and feelings of inefficacy.
- Does NOT lead to changes in trust, feelings of control, issues of intimacy, safety concerns, and intrusive traumatic imagery that are foundational to Vicarious/Secondary Trauma.

Risk Factors for Secondary Trauma

Understanding risk factors:

- Personality and coping style
- Personal trauma history
- Current life circumstances
- Social support
- Spiritual resources
- Work style – work/life boundaries
- Professional role/work setting/degree of exposure
- Work support
- Affected populations response or reaction
- Cultural styles of expressing distress and extending and receiving assistance

Signs and Symptoms

- Feeling frustration or anger about a patient's choice(s)
- Thinking about a patient outside of work more than you want to
- Feeling anxious about working with a patient
- Feeling dread when you anticipate seeing a patient
- Feeling more worried than you think is necessary about a patient
- Feeling angry at a patient
- Feeling de-skilled or incompetent when you meet with a patient
- Taking on too much responsibility- difficulty leaving work at end of day – stepping in to control other's lives

Secondary Trauma and PTSD

- A - Stressor – The traumatic material
- B- Re-experiencing traumatic event
  - Intrusive recollections of traumatized patient (TP)
  - Dreams about TP patient
  - Reminders of TP's traumatic event
- C- Avoidance/Numbing
  - Efforts to avoid thoughts/feelings or patient
  - Efforts to avoid activities/situations
  - Detachment, estrangement from others, diminished affect
- D- Persistent Arousal
  - Sleep disturbance
  - Problems concentrating
  - Exaggerated startle response
  - Irritability/outbursts of anger
  - Response to triggers – physiologic reactivity to cues

Key Considerations for Building a Culture of Compassion Resilience[62]

- What is your vision of the most positive work environment to be your best self in your job?
- What staff behaviors and attitudes would lead to such an environment?
- Which of these are you top five-to-eight priorities for the culture you desire?
- What are your strengths in regard to these behaviors?
- Where would you like to see growth in your ability to think and act in these ways?
- What might help you with that?
- How has what happened in your life impacted your ability to contribute to a positive work culture?
- What practices/activities work best for you to enhance connections with your colleagues within these behavior boundaries?

A Provider's Reflection

Sarah Morrill, RN, BSN, HNB-BC

- Quality Improvement Program Manager

Questions!

References

American Psychiatric Association. (2007). Diagnostic and statistical manual of mental disorders (5th ed..). Washington, DC: Author.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators

Kaiser Permanente and the National Council for Behavioral Health (2018). The Trauma-Informed Care Primary Care: Fostering Resilience and Recovery initiative

Machtinger, E. L., Cuca, Y. P., Khanna, N., Rose, C. D., & Kimberg, L. S. (2015). From treatment to healing: the promise of trauma-informed primary care. Women's health issues : official publication of the Jacobs Institute of Women's Health, 25(3), 193–197.

Singer T, Seymour B, O'Doherty J, Kaube H, Dolan RJ, Frith CD. (2004). Empathy for pain involves the affective but not sensory components of pain. Science. 303:1157–1162.

Singer T, Klimecki OM. (2014). Empathy and compassion. Curr Biol. ;24:R875–R878.

Substance Abuse and Mental Health Services Administration. (2014, Spring). Guiding principles of trauma-informed care. SAMHSA News, 22(2).