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Commentary

From Treatment to Healing: Inquiry and Response to Recent and Past Trauma in Adult Health Care

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In 2015, a national working group developed and published a conceptual framework for trauma-informed primary care (Machtinger, Cuca, Khanna, Dawson-Rose, & Kimberg, 2015). Since that publication, there has been increasing recognition that childhood and adult trauma underlie and perpetuate many physical and behavioral health conditions seen in health care settings and that addressing trauma could fundamentally improve the experience and efficacy of care for both patients and providers. A number of high-level efforts are currently under way to translate trauma-informed principles and frameworks into practical guidance for health care providers and practices (e.g., clinics and offices), including comprehensive endeavors by the Substance Abuse and Mental Health Services Administration and the National Council for Behavioral Health.

The original 2015 conceptual framework focused on adult primary care. Since that time, it has become clear that the model applies equally well to a wide variety of other adult health care specialties in which trauma is known to affect the experiences and outcomes of care. These include obstetrics and gynecology, rheumatology, neurology, infectious disease, geriatrics, palliative care, and many other medical and surgical specialties. As such, the framework is now referred to as trauma-informed health care (Figure 1).

Trauma-informed health care has five core components: a foundation grounded in trauma-informed principles and a team approach; an environment that is calm, safe, and empowering; education about the impacts of current and past trauma on health; and inquiry about and response to recent and past trauma that includes onsite or community-based resources and treatments. A more detailed description of each of these components can be found in the original article (Machtinger, Cuca et al., 2015). Herein, we provide guidance for adult health care providers and practices about how to inquire about and respond

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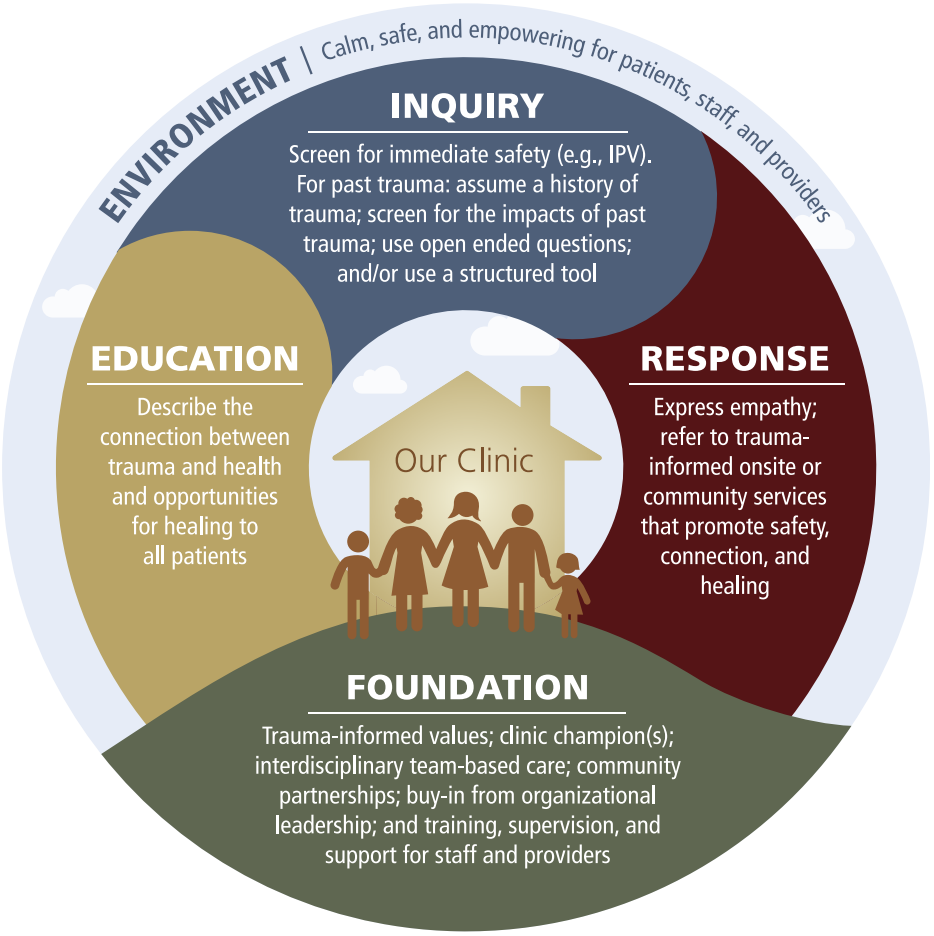

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Figure 1. A framework for trauma-informed health care.

to recent and past trauma as a way of more effectively addressing many common health problems. Although these two components of trauma-informed health care are the focus of this article, we also recommend that providers and practices take certain key preparatory steps that are necessary to lay the foundation for trauma inquiry and response.

Key Preparatory Steps for Trauma Inquiry and Response

Practice Preparation

First, recognize that trauma is common. Many people have experienced childhood and/or adult trauma that has a lasting impact on their mental and physical health (Black et al., 2011; Felitti et al., 1998). Understanding this impact helps to clarify why some conditions remain refractory to traditional therapies and why some patients seem to be hard to engage, defensive, demanding, or "on edge." This understanding informs a fundamental shift in the way each person on the health care team (providers and staff) thinks about patients, from "What is wrong with you?" to "What has happened to you?" Ultimately, this trauma-informed perspective helps the health care team to sustain a compassionate and patient-centered approach and develop more satisfying relationships and more effective treatment plans with patients.

Next, adopt trauma-informed principles. Trauma can damage a person's sense of safety and trust and can adversely affect relationships. To provide a healing environment for both patients and the health care team, integrate trauma-informed principles into your practice (safety, trustworthiness, collaboration, peer support, empowerment, and cultural humility and responsiveness; Reyes, 2017; Substance Abuse and Mental Health Services Administration, 2014).

Then, offer education and resources for patients, staff, and providers. Educate all patients, staff and providers about the

connections between trauma, health, and health-related behaviors. Understand that patients may not disclose trauma for many reasons, including shame and fear. Recognize that health care staff and providers may also have suffered traumatic life experiences and can experience vicarious trauma. Supportive responses for staff and providers include regular interdisciplinary team meetings to decrease isolation, supporting opportunities for self-care, and facilitating access to employee support services available in many institutions.

Thereafter, establish referral processes for patients wanting further service and/or treatment. Having referral processes in place increases provider comfort when asking about trauma and facilitates referrals to onsite or community-based services that are trauma-informed and that match the patient's needs, desires, and readiness. Integrating behavioral health providers into primary care and medical subspecialties greatly facilitates this process. Establishing referrals to address other social determinants of health such as housing and food insecurity can also contribute to reducing the incidence and adverse impacts of trauma.

Personal Preparation

Providers and staff can embrace techniques that greatly facilitate inquiry about and response to trauma. We suggest using the "4 Cs" (Kimberg, 2016).

Be calm

Your ability to stay calm and grounded when caring for a patient who has experienced trauma is emotionally regulating for the patient and can make your visits more productive and healing.

Contain the interaction

You do not need to elicit a detailed trauma history to be compassionate and offer help. Providing information, resources, and referrals to address a patient's trauma facilitates an interaction that is emotionally manageable for you and the patient.

Care for the patient and yourself

Emphasize good self-care and compassion for both the patient and yourself. Guilt and shame are very common feelings for survivors of interpersonal violence. A nonjudgmental attitude is extremely helpful. Destigmatize the adverse consequences of trauma such as substance use, overeating, and depression.

Focus on coping

Emphasize resilience and strengths. Solicit and incorporate the skills and strategies the patient has used in the past to overcome difficulties.

Inquiry and Response About Current Trauma

After these preparatory steps, providers and practices can move toward a more consistent approach to inquiring and responding to current and past trauma.

Inquiry About Current Trauma

Trauma inquiry is guided by a hierarchy of needs in which immediate safety is the top priority. As such, it is essential that practices are prepared to address current abuse or violence, such as intimate partner violence (IPV). IPV is a particularly common form of violence that has a strong evidence base for effective screening and response (U.S. Preventive Health Services Task Force, 2018). Whether inquiring about IPV as part of history taking or with standardized screening tools, it should be done in private. If there are language barriers, professional (not family) interpreters should always be used. Some settings may choose to emphasize universal education, in which providers use informational materials to educate patients about IPV, provide resources, and facilitate discussion before direct inquiry.

Response to Current Trauma

An appropriate response when a patient discloses IPV or another form of recent violence is to affirm that she or he does not deserve to be treated that way; express concern for the patient's safety and that there are many helpful resources; and offer a warm handoff to an onsite social worker or to a local or national domestic violence agency to provide ongoing support services, preferably while the patient is still on site. A domestic violence hotline (e.g., National Domestic Violence Hotline 1-800-799-SAFE (7233)) accessed by telephone from the clinic can provide emotional support, do safety planning, assess for lethality risk, and provide practical resources such as shelter or legal assistance. Many resources and tools are available to help clinics provide or link to more robust IPV services (http://ipvhealth.org/).

Inquiry and Response About Past Trauma

Inquiry About Past Trauma

There are fewer evidence-based health care protocols for how to inquire about past trauma. Herein, we describe four general approaches (Figure 2).

Option 1: assume a history of trauma instead of asking

All patients can be approached using a "trauma lens" that assumes that difficult life experiences may have contributed to current illnesses and coping behaviors. Universal education can be provided about the connection between trauma and physical and emotional health. Regardless of whether or not a patient chooses to disclose their trauma history, referrals can be offered to onsite or community-based interventions that address experiences and consequences of past trauma.

Option 2: screen for the impacts of past trauma instead of for the trauma itself

Another promising way to inquire about trauma that does not require patients to describe details of past traumatic experiences is to screen for symptoms of common conditions that are highly correlated with traumatic experiences, such as anxiety, posttraumatic stress disorder, depression and suicidality, substance use disorder, chronic pain, and morbid obesity (U.S. Department of Veterans Affairs National Center for PTSD, 2018). These conditions are often markers for past trauma and are themselves often highly stigmatized. A patient experiencing any of these conditions would benefit greatly from having them addressed in a nonjudgmental, compassionate, trauma-informed manner. Treatments for these conditions are most effective when onsite or community-based services are trauma-informed and offer evidence-based trauma-specific interventions.

Option 3: inquire about trauma using open-ended questions

In contrast with structured tools, open-ended questions included in routine history taking allow patients to disclose any

Inquiry About Past Trauma

OPTION 1

Assume a History of Trauma Without Asking

Referrals can be offered to onsite or community-based interventions that address experiences and consequences of past trauma regardless of whether a patient chooses to disclose their trauma history.

OPTION 2

Screen for the Impacts of Past Trauma Instead of for the Trauma Itself

Common conditions highly correlated with trauma, such as anxiety, depression, posttraumatic stress disorder, chronic pain and substance use disorders, can be more effectively addressed when services are trauma-informed and offer evidence-based trauma-specific interventions.

OPTION 3

Inquire About Past Trauma Using Open-ended Questions

Open-ended questions about past trauma sensitively included in a routine history allow patients to disclose any form of trauma they feel is relevant to their health and well-being.

OPTION 4

Use a Structured Tool to Explore Past Traumatic Experiences

Multiple validated scales exist to screen for past trauma. Carefully consider why, when, how, and by whom it will be administered, as well as who will have access to the information.

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Figure 2. Four options to inquire about past trauma.

form of trauma they feel is relevant to their well-being. For example, an open-ended script can be: "Difficult life experiences, like growing up in a family where you were hurt, or where there was mental illness or drug/alcohol issues, or witnessing violence, can affect our health. Do you feel like any of your past experiences affect your physical or emotional health?" [If yes] "I am so sorry that happened to you. Past traumas can sometimes continue to affect our health. If you would like, we can talk more about services that are available that can help." It is important for providers to know that there are many different types of traumatic experiences that may have had a significant impact on patients' health, including childhood and adult physical and sexual abuse; bullying; community violence; war; serious accidents or illnesses; structural violence such as racism, sexism, xenophobia, homophobia, and transphobia; and experiences in the foster care, criminal justice, or immigration systems.

Option 4: use a structured tool to explore past traumatic experiences

If a structured screening tool or process is used, carefully consider when, how, and by whom it will be administered, as well as who will have access to the information. Some clinics use a previsit screening tool administered via electronic tablet, paper, or small wipe-off board. In other settings, nonclinical staff administer the tool, or medical providers conduct the standardized screening in the examination room. Regardless of what tool is used and how it is administered, it is essential that the patient be able to discuss their responses with the provider in private. Multiple validated scales exist to screen for past trauma (https://www.ptsd.va.gov/professional/assessment/te-measures/index.asp). One such tool is the Adverse Childhood Experiences (ACE) Questionnaire, which was designed as a research instrument to measure the rate of childhood trauma in a clinic population. The clinical benefits of screening for ACEs in adult primary care are being actively investigated (link to more ACEs information: https://acestoohigh.com/aces-101/).

The choice of approach to inquiring about past trauma depends on the resources, expertise, and patient population of individual providers and practices. It is important to note that for patients who have experienced severe and/or cumulative trauma (i.e., complex trauma) and are experiencing negative physical or emotional health consequences, it will be helpful for the provider or behavioral health clinician to know the general nature of their traumatic experiences (e.g., childhood sexual abuse, abusive parents with serious mental illness, combat-related exposure) to make the most effective referral to trauma-specific treatments.

Response to Past Trauma: Immediate Steps

Disclosures of past trauma do not typically require detailed discussion or urgent intervention. Rather, responses to such disclosures are often best limited to a statement of empathy, an offer of available referrals to overcome the impacts of trauma, and an opportunity to follow-up with you. Providers should first acknowledge the patient's disclosure with a simple statement of nonjudgmental compassion like, "I am sorry this happened to you. Thank you for sharing this with me. This information can help me understand how best to care for you." This can be followed up with a question like "Past traumas can sometimes continue to affect our lives and health. Do you feel like this experience continues to affect your health or well-being?"

Understanding a patient's past trauma can explain how coping techniques like substance use or disordered eating may have been adaptive in the past (Felitti, Jakstis, Pepper, & Ray, 2010), but are currently causing health problems. This understanding can often facilitate a more effective treatment plan. For example, treatments for substance use disorder have been shown to be significantly more effective if co-occurring trauma and/or posttraumatic stress disorder are addressed as part of the treatment (Dass-Brailsford and Amie, 2010). Using a harm reduction framework can be a good first step. This can include a brief conversation about how a substance-using patient can stay safe while still using. "You mentioned that alcohol makes you feel calm when you are very stressed and that you have a goal to stop drinking, but are not ready to now. So let's talk about how you can stay safe when you do drink. What ideas do you have? Have you considered limiting the number of drinks you drink each time you drink?"

Depending on the desires and readiness of the patient, providers may offer referrals for further evaluation or treatment. This could include a referral to onsite behavioral health providers or community-based programs that are trauma-informed and offer trauma-specific therapies. Patients and providers can find local mental health and substance abuse services at the Substance Abuse and Mental Health Services Administration website or National Help Line (www.samhsa.gov/find-help/national-helpline or National Helpline 1-800-662-HELP (4357)).

Response to Past Trauma: Longer Term Healing

There are many evidence-based trauma-specific techniques and mental health interventions to help patients heal from the impacts of past trauma and cope more healthfully and safely with persistent symptoms and persistent traumas, such as racism or xenophobia. Medical providers are not typically resourced or trained to lead these interventions. Nonetheless, they have a crucial role to play in linking patients to trauma-informed treatments in the community or to onsite psychosocial staff members who are skilled in providing them.

Most important, providers can communicate hope to patients that it is possible to heal from even the deepest wounds of trauma and that it is possible to gradually adopt healthier coping strategies. Learning more about trauma-specific interventions can help providers to identify what may be most useful for each patient. Trauma-specific interventions include 1) individual and/or group therapies that help patients to manage trauma symptoms, process traumatic experiences, and reduce isolation, 2) trauma-informed somatic interventions like mindfulness, yoga, somatic experiencing, and acupuncture, and 3) medicines to reduce posttraumatic symptoms like insomnia, anxiety, and depression. Often, it is a combination of such interventions that leads to genuine healing. It is important to recognize that helping an adult to heal from trauma can benefit both the patient and their families and children, helping to disrupt intergenerational cycles of trauma. Practical tips about how adults can help children to overcome the impacts of trauma can be found here: https://changingmindsnow.org/.

Although some patients may not feel ready to engage in deeper trauma-specific interventions, there are many approaches that do not involve directly processing trauma. These trauma-specific services can start the healing process by helping patients to connect with others and develop healthier coping skills. These services include drop-in peer support groups, trauma-informed behavioral health counseling and psychiatry, group therapy that addresses trauma and substance use (e.g., Seeking Safety; Najavits, Weiss, Shaw, & Muenz, 1998), Wellness Recovery Action Plan groups (Copeland, 2002), mindfulness-based stress reduction, trauma-informed somatic therapies (e.g., yoga), and various forms of expressive and art-based therapies (Machtinger, Lavin, Hilliard, Jones, Haberer, Capito, & Dawson-Rose, 2015). Providers can also support patients who do not want any trauma-specific referrals begin healing through faith and spirituality, exercise, nature, work, caring for people and pets, and other practices in which they find connection, comfort, and meaning.

Conclusions

Providers and clinics that adopt a trauma-informed approach, inquire about trauma, and provide linkages to trauma-specific services will offer new pathways to support more satisfying and effective relationships for both patients and providers. Moving toward trauma-informed health care has the potential to transform the experience and efficacy of health care from treatment to genuine healing for both patients and providers.

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