Webinar: Providing Trauma-Informed Care in Family Planning Clinics: From Theory to Practice
June 2, 2020

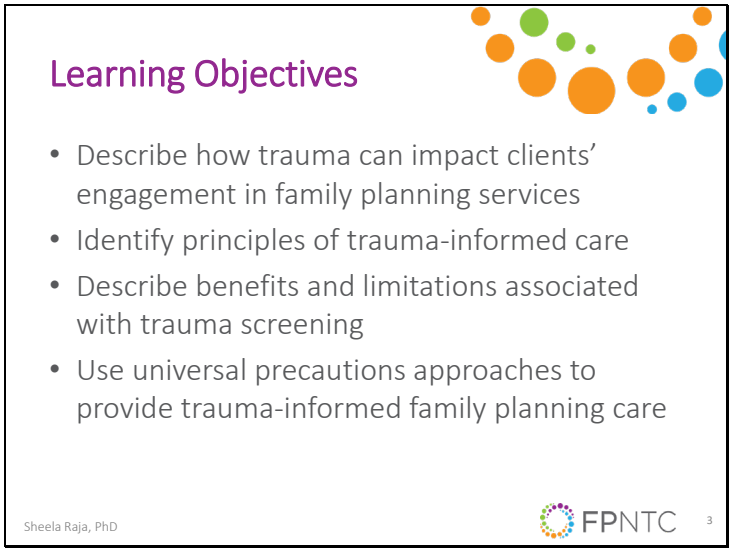
Slide 1

Katie Quimby: Hello, everyone. This is Katie Quimby from the Title X Family Planning National Training Center, and I am pleased to welcome you all to today's webinar, where we will discuss providing trauma-informed care in family planning clinics. As a few announcements before we begin, first, everyone on the webinar today is muted, given the large number of participants, but we do want your participation. We plan to have time for questions at the end of the webinar today. You can ask your questions using the Q&A pod on the side of your screen. We'll also be asking for your input at a few points during the webinar. You can respond in the audience chat pod, which is green and can be found at the bottom of your screen. A recording of today's webinar, the slide deck, and a transcript will be available on fpntc.org within the next few days. This activity has been approved for one continuing nursing education or CNE contact hour. To receive your credit, you'll please complete the evaluation, which will appear at the end of the webinar. Finally, this presentation was supported by the Office of Population Affairs. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Slide 2

I'd now like to briefly introduce our speaker for today's webinar. We are joined today by Dr. Sheela Raja. Dr. Raja is a licensed clinical psychologist, associate professor, and director of clinical behavior services at the University of Illinois at Chicago. She is experienced in evidence-based treatments for post-traumatic stress, trauma, and anxiety disorders in adolescents and adults, and her research interests include understanding the role of traumatic and toxic stress on health behaviors, and examining the outcomes of trauma-informed trainings in healthcare settings. With that, I will now turn it over to you, Dr. Raja.

Slide 3

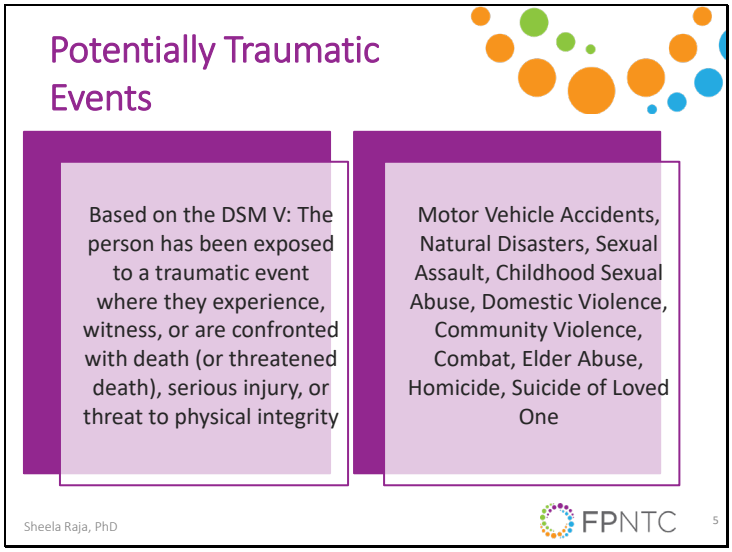


Dr. Sheela Raja: Thank you so much, Katie. I really appreciate the opportunity to be with you all today and talk about this really important topic of trauma-informed healthcare, and I should just say to begin with that this is, of course, an evergreen topic, meaning that we know that things like trauma, which we'll get more into in the next few minutes, but we know that this affects people all the time, but certainly in terms of everything that we're experiencing in our world and in our country, both in terms of everything going on right now. This is a timely topic. It's also a topic that we need to know about all the time, and so my hope is that in the next half an hour to 40 minutes or so, and then we'll have time for discussion, that you can all leave here understanding more about how trauma can impact clients' engagement in family planning services, identify the principles of trauma-informed care, describe some of the benefits and the limitations associated with trauma screening, and then really get into sort of what is universal trauma precautions, especially as it applies to trauma-informed family planning and care.

Slide 4

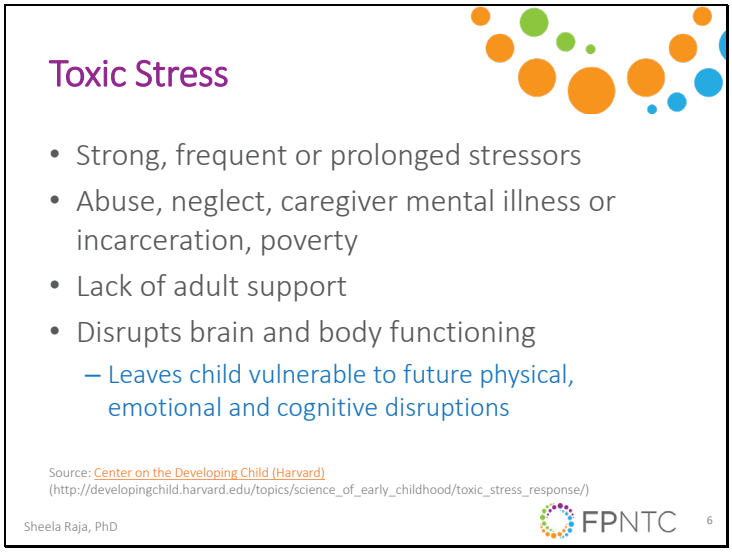
So, first of all, let's think about how we define trauma.

Slide 5



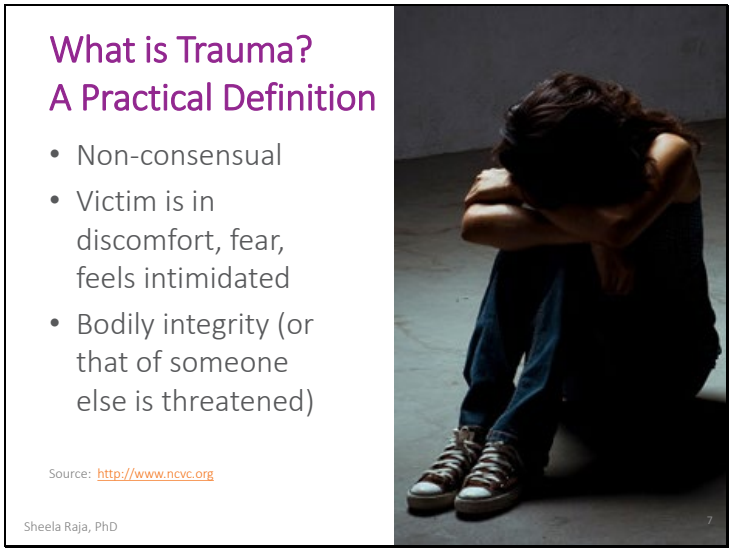
In psychology we, of course, use the DSM as one of our guides of how do we define traumatic events, and that involves things that could be potential traumatizing for people. That often involves things where maybe they are confronted with a serious illness or the potential of death or injury, so often things like motor vehicle accidents, natural disasters, sexual assault, childhood sexual abuse, domestic violence, other abuse, combat, homicide, suicide of a loved one. Those are all things that are potentially traumatic to the individual.

Slide 6



Now, toxic stress is also a term that you will see that's used fairly often, and toxic stress refers to strong, frequent, or prolonged stressors, things like abuse, neglect, caregiver mental illness, incarceration, poverty, and that's particularly when you're young and you don't have adult support, potentially, you don't have a buffer. And we know that toxic stress can actually lead to disruptions in brain and body functioning. It leaves an individual very vulnerable later on to both mental health and physical effect issues.

Slide 7



So, trauma and toxic stress are, of course, serious things, and as we're out there educating the public as healthcare providers about what does it mean, it's often something that you can educate your clients by saying trauma is not consensual. We don't ask for it to happen to us. It means that we feel like we're in discomfort, or we feel intimidated or fear, and then our bodily integrity or somebody that we love is threatened, or somebody close to us.

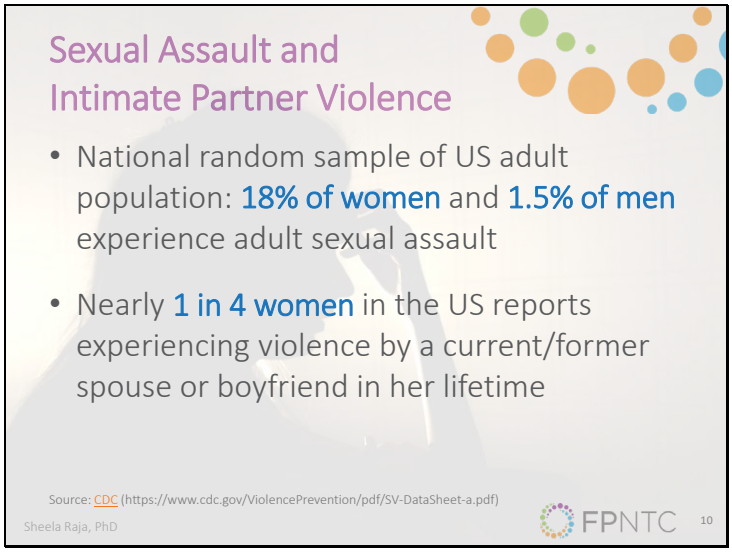
Slide 8

So, that's sort of a practical definition of trauma, and when we start looking at the prevalence of various traumatic events, unfortunately, we see that these things are very common in the United States.

Slide 9

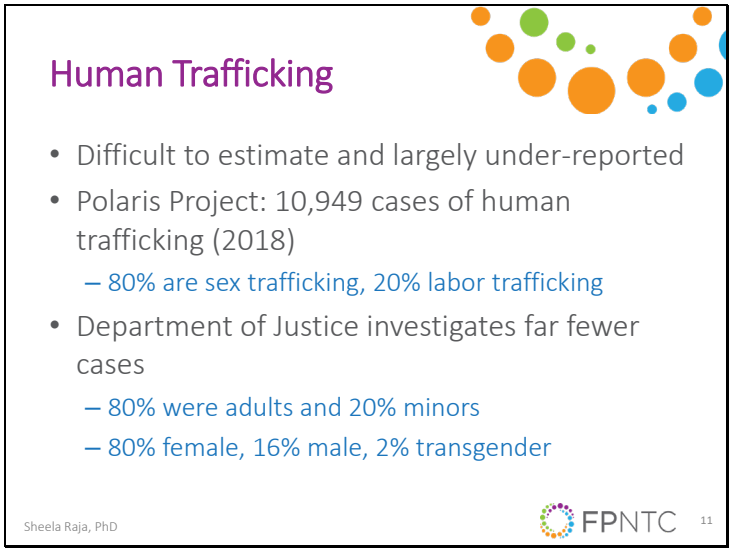
So, in the US, more than five kids every day die from the result of child abuse. One out of four girls and one out of six boys report a history of childhood sexual abuse. These are large epidemiological studies, also. I mean, these are not studies of small, clinical populations. These are large epidemiological studies where we're getting some of these numbers, and we also know that younger kids, kids with special needs are often the most vulnerable to both physical and sexual abuse.

Slide 10



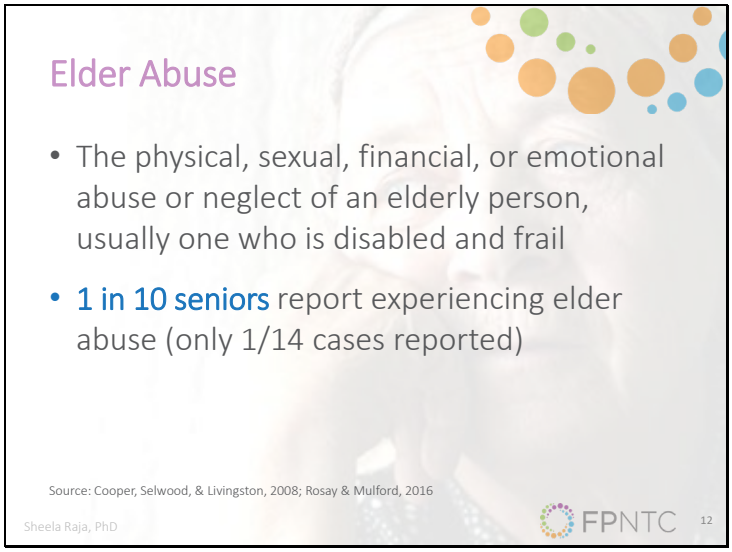
Also, sexual assault, interpersonal and intimate partner violence as adults. National random samples of the adult population, about 18% of women and 1.5% of men report some kind of sexual assault as adults. You may be looking at that number with men and wonder where that's coming from, or you may know where that's coming from. We have a very large population of incarceration in our country, and so sometimes we have sexual assault that's happening in our prison population that's not being reported nearly enough.

Slide 11



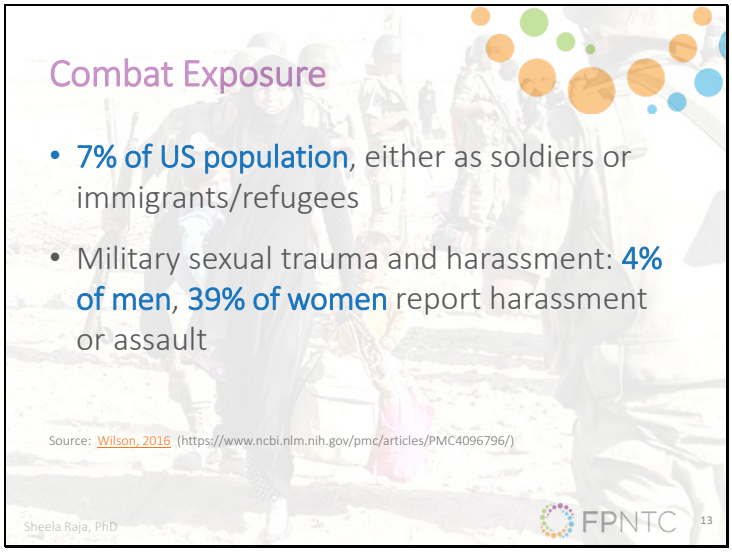
While one in four women in the United States report experiencing some kind of intimate partner violence by either a current or former partner, human trafficking is also an issue that we are starting to pay more and more attention to. The Polaris Project, which does a lot of work in this issue, reports in 2018 over 10,000 cases, mostly sex trafficking, but also labor trafficking, and labor trafficking... I mean, all these issues intersect with each other. Labor trafficking is probably under-reported because people are afraid to come forward. They may feel like they lack documentation, or they've broken rules or laws. So, a lot of what the Department of Justice is investigating has to do with adults, but we may not be detecting everything going on with minors as well.

Slide 12



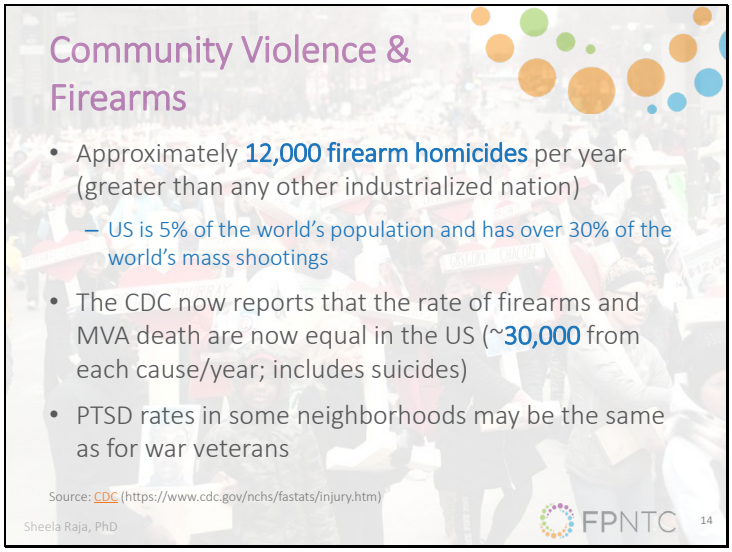
Elder abuse is also an issue in our country and is also probably vastly under-reported. Elder abuse takes a lot of different forms: physical, sexual, financial, emotional abuse. About 1 in 10 seniors report experiencing something in terms of elder abuse, and the other issue is that with seniors, sometimes we don't trust their reporting because we say, "Well, did that really happen?" So, we need a lot more supports in place in order to protect our seniors from elder abuse.

Slide 13



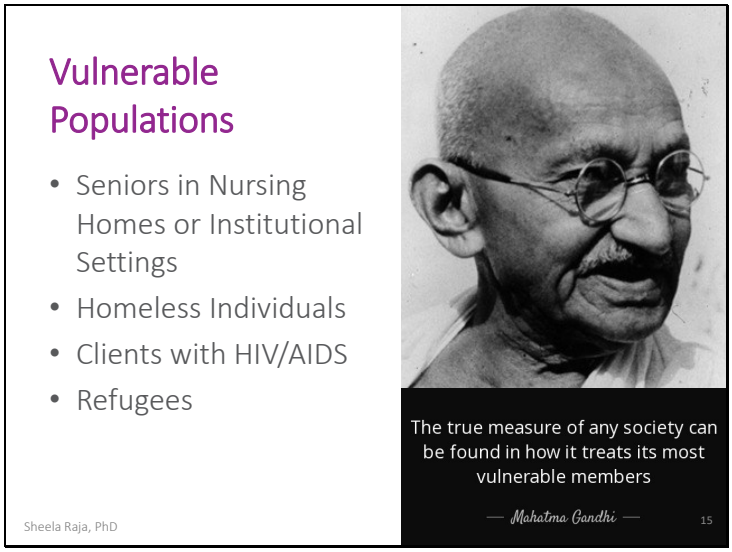
Combat exposure. About 7% of the US population, either as soldiers or immigrants or refugees from somewhere that was war-torn has witnessed combat in their lives, and military sexual trauma. If any of you work with military populations or work with populations that have served, there is a large number of women who have experienced military sexual trauma.

Slide 14



Also, the issue of community violence, which, again, we're sort of seeing as a backdrop, but firearms, 12,000 firearm homicides. The rates of motor vehicle accidents and the rate of somebody dying in firearm gunshot wounds, including self-inflicted, dying by suicide is approximately equal these days, which, for my healthcare providers, they often find that to be somewhat of a stunning and very sad statistic, that we really need to do something about community violence. The PTSD rates in some neighborhoods might actually be the same as what we're seeing in our veterans of foreign wars.

Slide 15

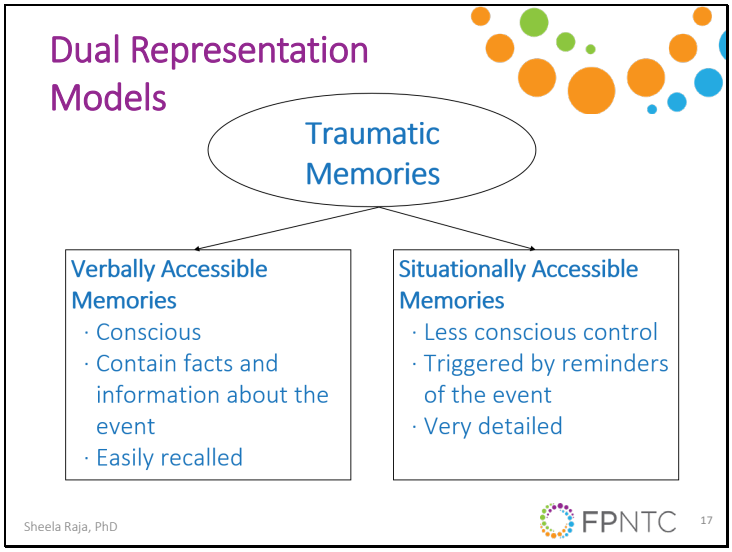


Vulnerable populations include people who are seniors, especially those who are in nursing homes or institutional settings. We've seen that again and again. We see homeless individuals who are always unfortunately on the front lines of trauma, people who might have HIV or AIDS or other sexually transmitted infections, and refugees are all populations that carry with them high levels of trauma.

Slide 16

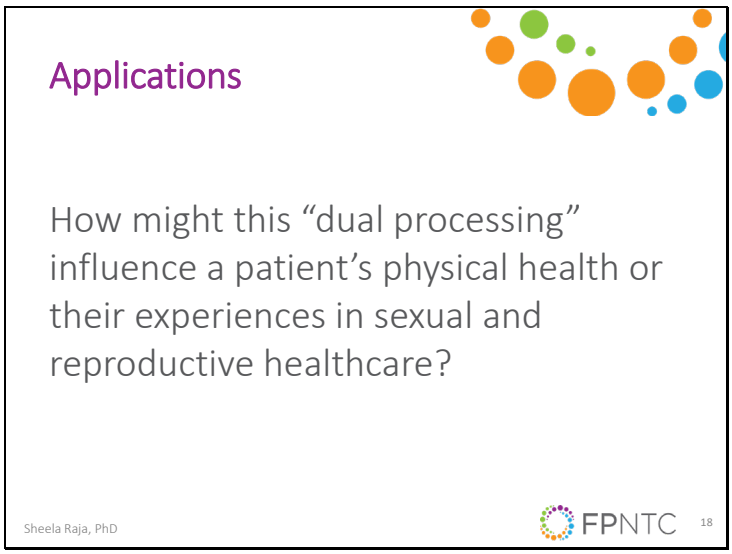
How is trauma processed?

Slide 17



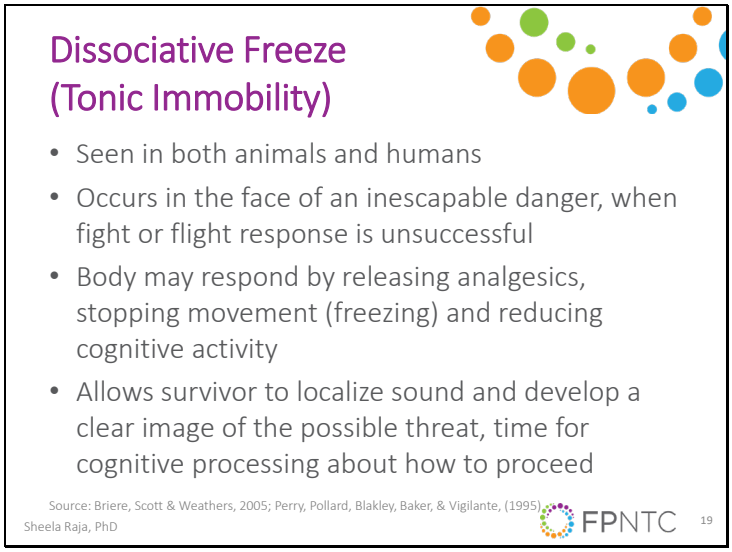
You might want to think about, at least for a second, as we're working to think about how this applies to family planning, how trauma is processed. There were many, many theories for years about how does an individual process something that's very frightening and overwhelming, and these days in psychology, a model that has received a lot of attention and empirical support has to do with the dual representation model, which is this idea that when we are encoding something traumatic that we encode verbally accessible memories. That's what we tell. That's what we tell other people. It's conscious, it usually has the facts about what happened, where was it. It's pretty easily recalled. There's also something that is simultaneously encoded, but is usually situationally accessible. In common language we often call these triggers. These are less consciously controlled. They're triggered by reminders of an event, and sometimes they're very, very detailed. Sometimes they contain a lot of sensory memories, but something has to happen to remind us of the traumatic memory, so it's not something we're walking around with all the time, but it's something that might trigger us.

Slide 18



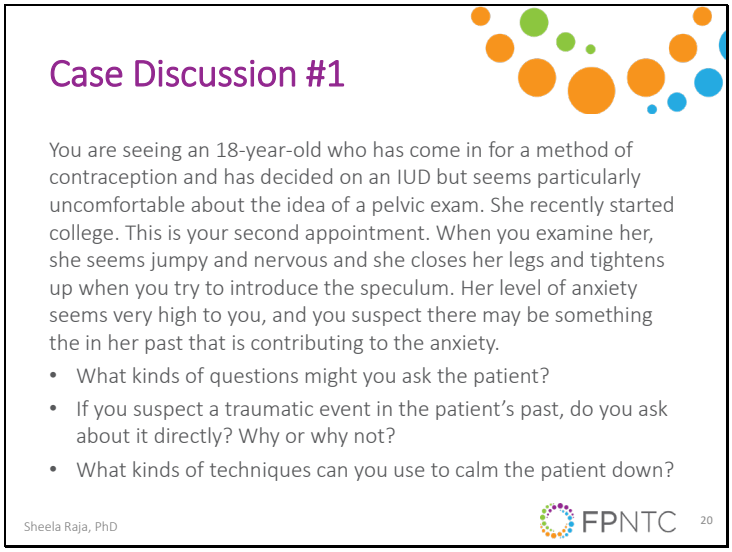
So, how do you all think that that dual processing might influence a patient's physical health or their experience in sexual and reproductive healthcare? I'm just going to open that up to the chat for just a second, and then we can move on from this slide. I'll give you my ideas about that as well, but I'd like to see what you all have to say about that. I will wait for the audience chat for a second here. How do you all think that this dual processing might be influencing people's experience in sexual and reproductive healthcare? Yes, exactly. Getting in some answers here. A physical exam that might trigger a memory of rape. They may have inadvertently be in denial about what their healthcare needs are, sure. You may not want to go in. You may be triggered because something physically is triggering a memory, yes, and I think all of those things are true.

Slide 19



So, if we move to the next slide, I also want to call your attention to the fact that in addition to sort of the fight-or-flight response, which is the idea that when we are in inescapable danger, either our bodies get ready to react to that danger, or we get ready to run away. We also notice something in human beings called the dissociative freeze, or also called tonic immobility. Sometimes when we have inescapable danger, we actually... Our bodies may actually just stop, start releasing analgesics, freeze our movement, reduce our cognitive activity, and really, in the short-term, this is very beneficial because a survivor can localize what's going on, they can try to figure out how to get away, but it's also something that you may see your clients experiencing.

Slide 20

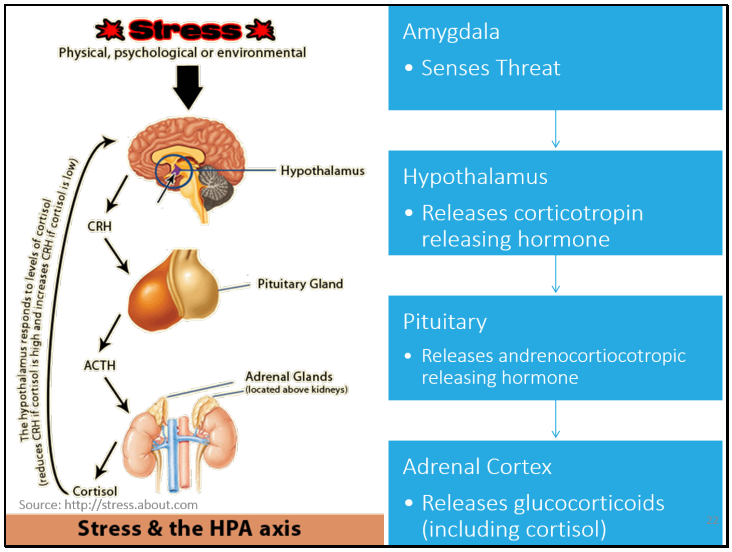


I want to open this up really, really briefly to us being able to interact around this material with a couple of cases, and we can use the chat box to do that, but let's say that you are seeing an 18-year-old client who's come in for a method of contraception and has decided on an IUD, but she seems particularly uncomfortable about the idea of a pelvic exam. She recently started college. It's your second appointment, and when you examine her, she seems really jumpy and nervous. She closes her legs, she tightens up when you try to introduce the speculum, and her level of anxiety seems really high to you, and you think there might be something in her past. So, sort of my general question for the audience is what do you think you might ask this person? Do you feel like you would ask directly about her past at this point? Why or why not? Or what kinds of techniques might you use to calm her down? Maybe we could just take a minute or so to talk about this. You can use the chat box, the green chat box. Do you feel like you would ask directly about this at this time, or would you use some other techniques to calm her down? What might you do? Okay, great. I'm seeing here, "Is there anything I could do to make you more comfortable and supported right now?" A number of you are saying that. Let her know beforehand what are you going to do next. Absolutely. Can I ask you how you're feeling right now? Building some more rapport with the patient. Yes, telling her in advance so that she doesn't feel surprised or shocked, asking her more about how she's doing, what is she thinking. So, it seems like most of you, I agree, are saying you wouldn't ask directly at this point, but you would use various techniques to make her feel more in control and more empowered about what to expect next. I think that that's exactly right in terms of some of the techniques we're going to be using, and what is trauma-informed healthcare.

Slide 21

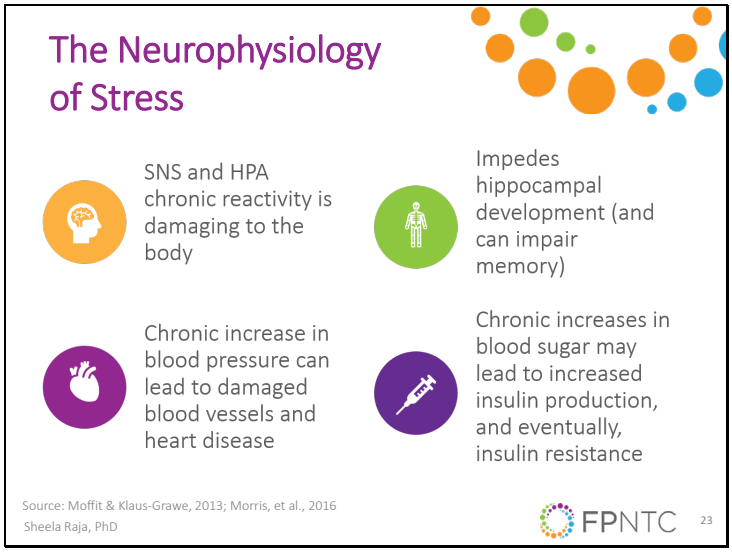
I think there's sometimes a metaphor that's really useful as we educate our clients about what is trauma, is that trauma really affects us starting from the neighborhood and all the way into our neurons, and I believe that's the name of the book, actually, From Neurons to Neighborhoods. So, I think that often our clients may not understand that what's happening to them in the world is really affecting them on a deep level.

Slide 22



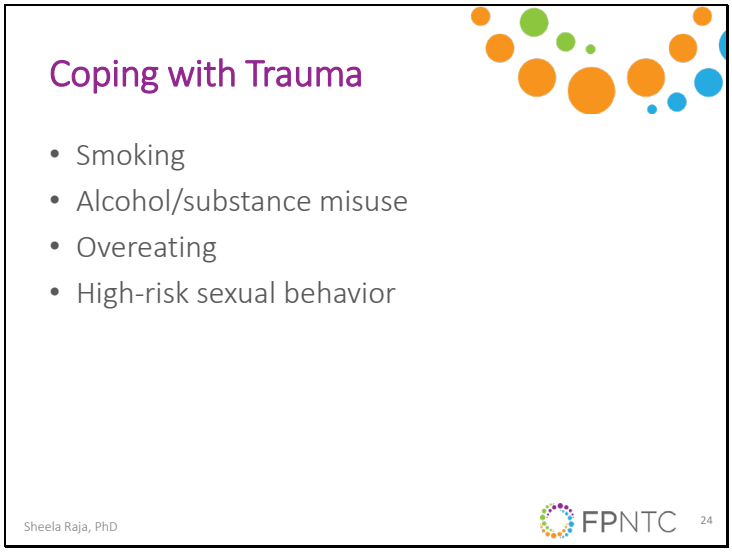
So, I think that often our clients may not understand that what's happening to them in the world is really affecting them on a deep level. I know that you all as providers already know about the fight-or-flight response, the HPA axis, the hypothalamus, the pituitary, the adrenal gland, and I think the next step is for us to be able to educate our clients about what is happening in their own bodies. When they're traumatized or they're startled or they're upset, what is happening to them?

Slide 23



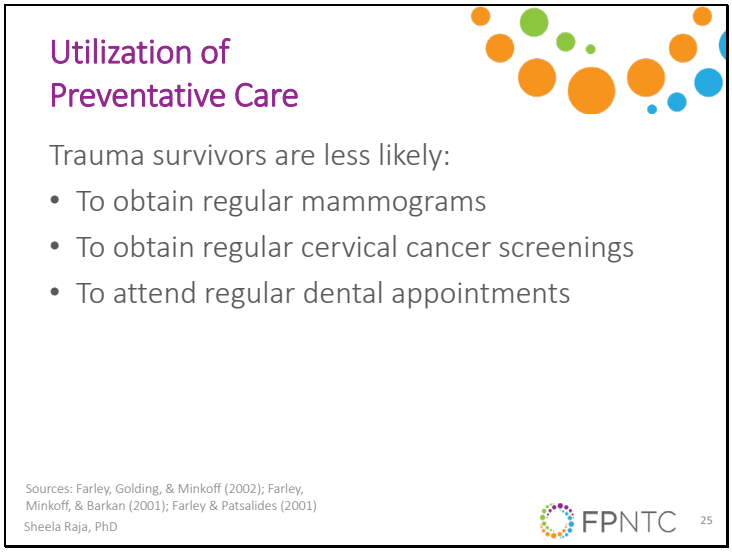
I think that educating them about the neurophysiology of stress, that teaching our clients that chronic reactivity is damaging for the body, and that it can impair us, the way we think, the way we concentrate, our memory, that HPA axis, the end result of cortisol, and that chronic inflammation of the body is not good for us. It can lead to high blood pressure, it can lead to damaged blood vessels, it can lead to higher blood sugar, which, of course, is related to diabetes.

Slide 24



So, there's a lot of education, I think, that can take place around trauma-informed care, particularly in your settings, that trauma is associated with the way people cope. Smoking, alcohol, overeating, high risk sexual behavior. I'm sure around the country right now we're seeing lots of people cope with things in ways that may not be healthy for us, and sometimes when I do trainings around the country, I'll ask people, "How do you cope with stress?" Sometimes somebody will raise their hand and say, "Well, I do yoga," and you think, wow, that's amazing, that's great. And more often people will say, "Well, I eat too much cake, or maybe I have a glass of wine, or I sit on the couch and watch too much TV." So we, I think, understand that sometimes it's very difficult to cope with stressful life events.

Slide 25



When we look at the literature, there's also some indication that people who survive traumatic events are also less likely to obtain things like regular mammograms, regular cervical cancer screenings, and go in for regular dental appointments, all these sort of preventive care types of activities they may not be engaging in.

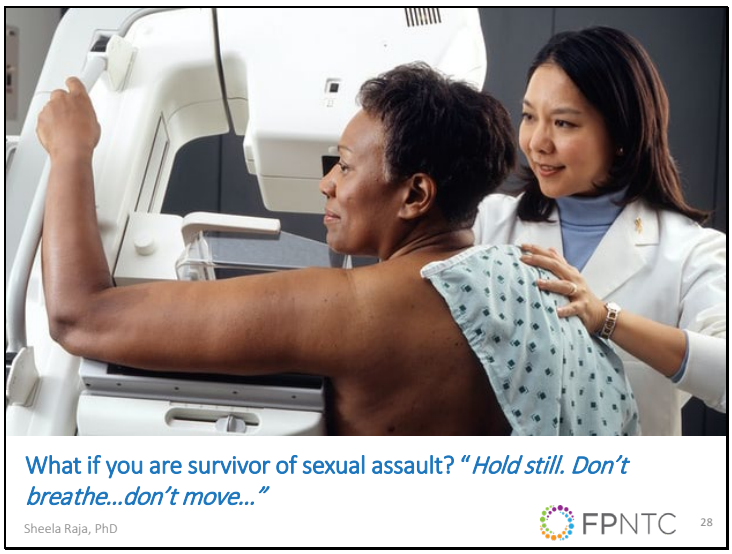
Slide 26

I think that the next couple of slides here probably give us an idea of why that is, so for example here, if you're a survivor of intimate partner violence, and then your provider's like, "Well, let me just come closer and take a look," suddenly this interaction, which is sort of just a regular, everyday interaction in the office looks different.

Slide 27

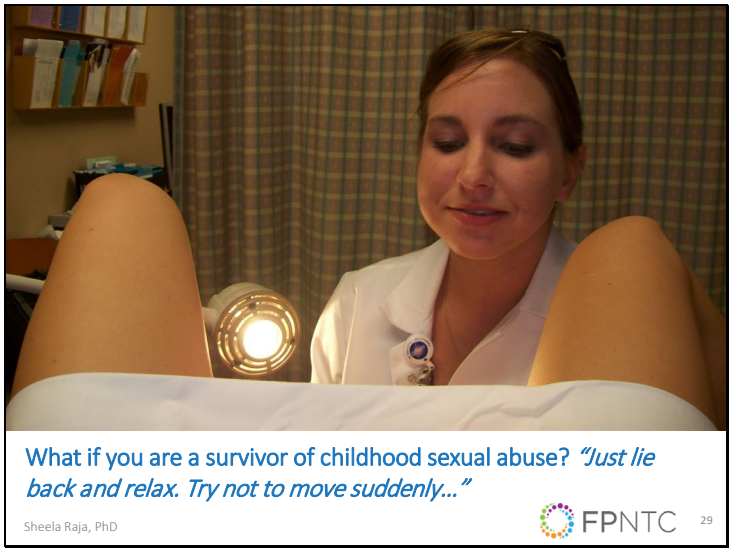
Similarly, this is a regular interaction, but what if you're a survivor of human trafficking and you're being told, "Hold still, this is only going to hurt a little bit." Something's that regular day-to-day in the office takes on a whole different tone when you've survived trauma.

Slide 28



Similarly, you're going in for a regular checkup here, and what if you're a survivor of sexual assault and you're told, "Hold still, don't breathe, don't move," and that is what you're instructed to do during these times, but again, this is really different.

Slide 29

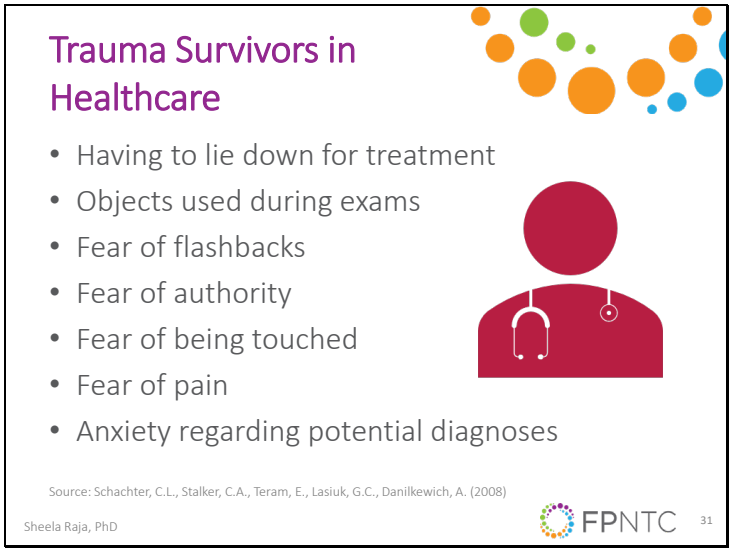


Again, what if you're a survivor of childhood sexual abuse and you're told, "Just lie back and relax. Try not to move suddenly." That can be very re-triggering.

Slide 30

Again, you're having just a regular discussion with your provider, but what if you live in a community with violence, that experiences violence on a daily basis, and you know you need to stop smoking and eat better, but you've got all these other things? Is there room for discussion with your provider about these things?

Slide 31

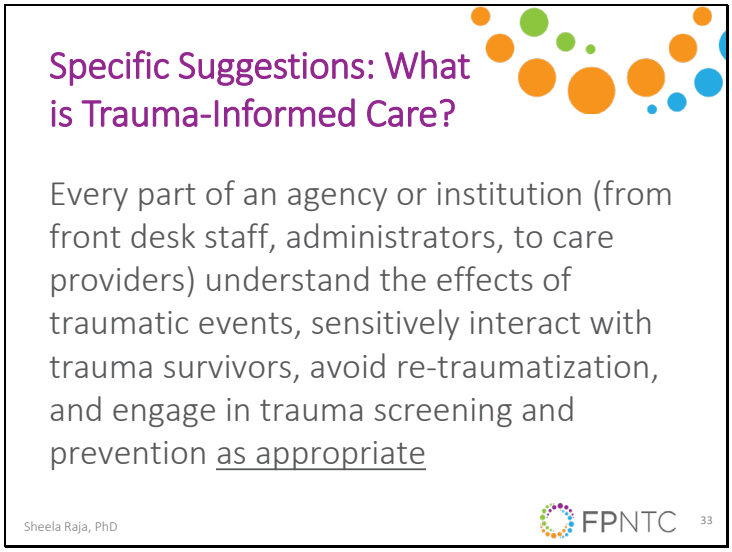


So, we do know that trauma survivors in healthcare have a lot of issues that sometimes they talk about, that it's difficult to lie down for treatment, have objects used during exams. They are worried about flashbacks. Some people talk about feeling worried about authority and that they feel like they can't ask questions, or that they can't collaborate because they're afraid. Fear of being touched, fear of being in pain, anxiety about what the diagnosis is going to be. Maybe if you've had a lot of stressful experiences in your life, you always go in kind of worrying and fearing the worst.

Slide 32

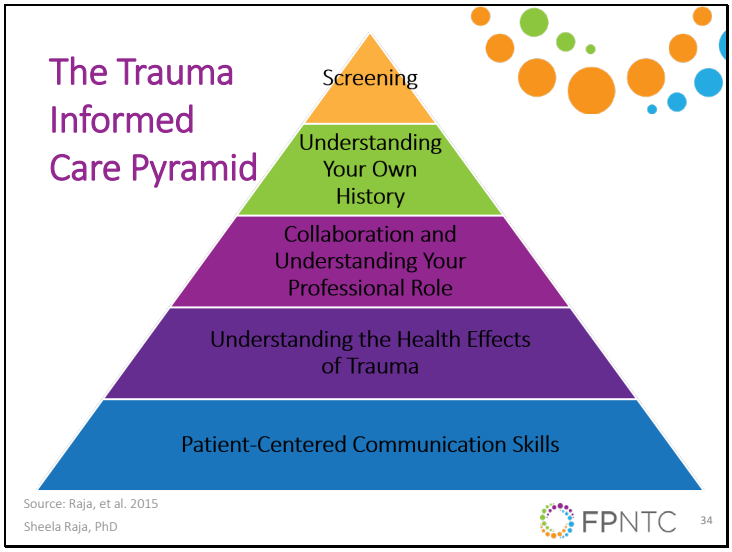
Trauma-informed care

Slide 33



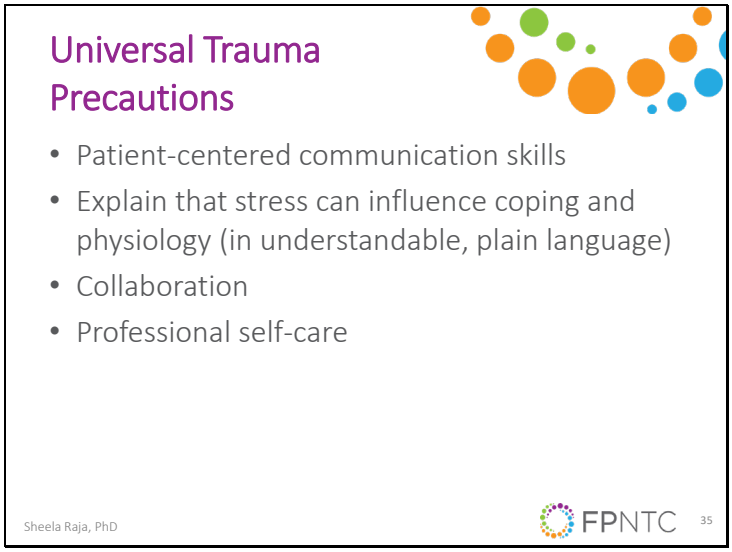
So, this all leads us up to the idea of how can we be trauma-informed? What does it mean? SAMHSA has a wonderful definition of trauma-informed... And what does it mean to try to bring that into specifically a healthcare realm? Every part of an agency or institution, from the front desk staff to care providers, and everyone in between really does need to understand the effects of traumatic events, be able to sensitively interact with trauma survivors, avoid re-traumatizing, and engage in trauma screening, but only as appropriate.

Slide 34



But what does that really mean? What does that mean in terms of all of us and the day-to-day work we do, and how can we bring this in to a reality? We have developed, sort of based on the literature and based on clinical interacts, this idea of a trauma-informed pyramid, which my team and I published about five years ago, suggesting that healthcare providers can really kind of use this as a tool to operationalize what does trauma-informed healthcare look like. So, I'll go through it with you over just the next few minutes, and then we'll have more of a chance to talk what each one of these levels of the pyramid look like.

Slide 35

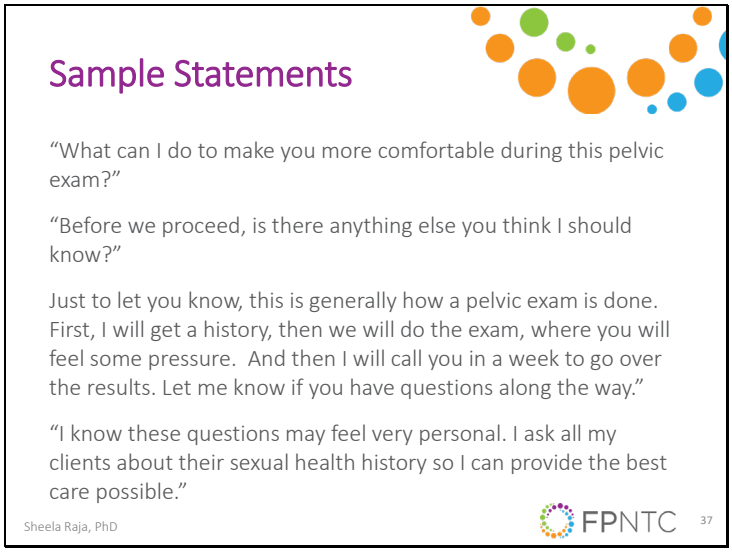


So, I want to point out that the majority of this pyramid is actually what we would call universal trauma precautions, which means that really, they're things that we can do with every patient every time. It doesn't matter whether we know their history or not. It doesn't matter how much detail we know about their trauma history, these are just things we can do in everyday practice, and that's really the majority of this pyramid.

Slide 36

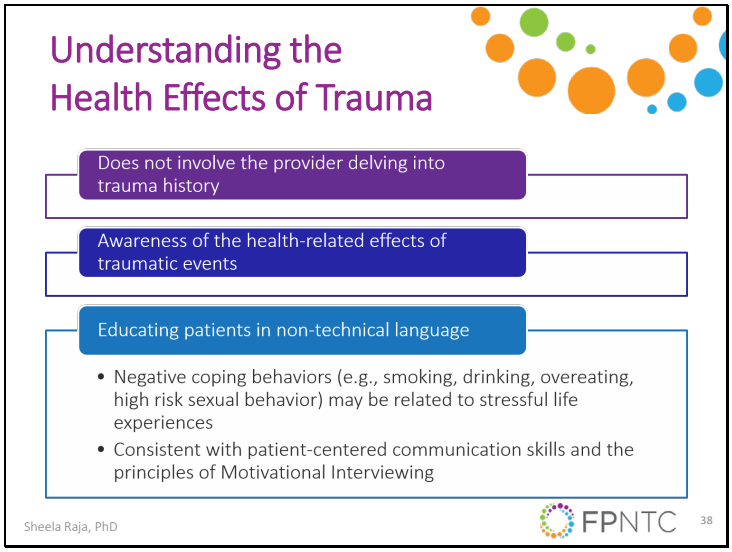
So, patient-centered communication skills is everything you guys already talked about. When you responded to the chat, so many of you brought up these specific strategies, asking your patient, "What can I do to make you more comfortable?“ If they seem worried or anxious, ask them what's helped them in the past. Use what we call tell-show-do, which is telling them what you're going to do, maybe showing them on a model to give them an overview of what that appointment is going to be like, because many of you used the word try to give control back to your client, and I think that's exactly it. Start and stop signals, raise your hand if you feel like you want me to stop, or just give me a signal. Sometimes if the person feels like they verbally don't want to speak up, they can raise their hand and say, "I'm in discomfort." It's also important for us to not overly rely on distraction. I think in healthcare we do a lot of just chatting with our patient or our client, and that's wonderful. I think we need to do that, but sometimes when somebody is higher in their anxiety level, we need to think about other things, progressive muscle relaxation, guided imagery. There's a lot of other types of things that we can do to help with anxiety.

Slide 37



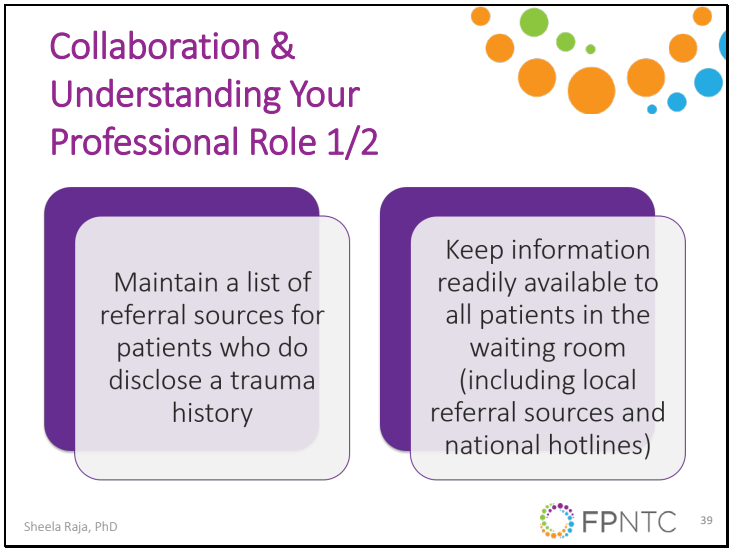
So, these are just some sample communication skills for you all to look at. What can I do to make you more comfortable? Is there anything else you think I should know? In general, this is how a pelvic exam is done. First I'm going to get your history, then you're going to feel some pressure. So, again, giving that control back. If you're asking really personal questions, letting them know ahead of time, sort of an anchoring statement, "I know these questions are going to feel personal, but I ask all my clients about their sexual health history so I can provide the best care." These are probably things you're all doing already.

Slide 38



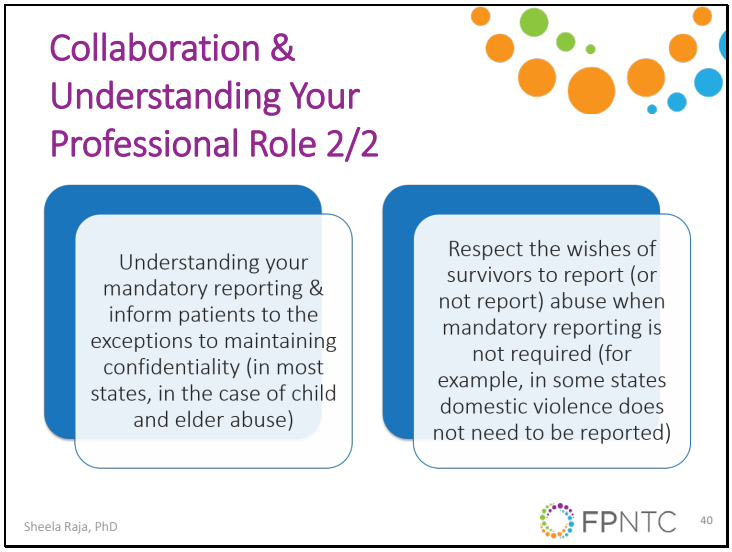
The second step is really understanding the health effects of trauma. Again, it doesn't involve the provider needing to delve into the trauma history. It's really a global awareness that trauma impacts our health, and so educating patients in non-technical language that things like smoking, drinking, overeating... You can let your patients know if they're doing those types of things that they may be related to stressful life events. Sometimes people haven't even made those links yet, so think about, well, what's going on in the environment is affecting how I cope, and how I cope is affecting both my mental health, but also my physical health. All of this is really consistent. Some of you may have been trained in motivational interviewing techniques where it's really based on your patient's goals and respecting your patient or your client, and so I think that this is really pretty consistent with motivational interviewing as well.

Slide 39



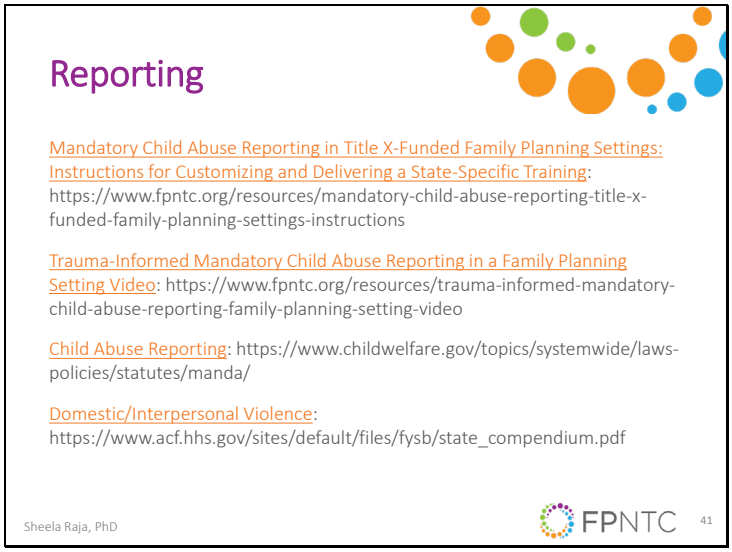
The next step in that pyramid is the idea of collaborating and understanding your own professional role. So, none of us can do trauma-informed healthcare and do it well and do it alone, so we really do all need to work to maintain a list of referral sources, whether that's behavioral health, any other kind of specialized service to really think through who are the providers that you know in your community who are trauma-informed, whether they know it or not. Are these the people that are explaining procedures? Are they collaborative with their patients and clients? Those are the people that you want to be able to refer to. Also, I think you... We also have a huge opportunity for education just in our waiting rooms. Having information about local referral sources, national hotlines, just having some of that information readily available raises the bar on education around these issues.

Slide 40



Another aspect of this pyramid is understanding your own professional role in collaboration, so being comfortable with what is your mandatory reporting requirements, informing patients about exceptions to maintaining confidentiality. In most states that's child abuse and elder abuse, not in every state. But again, being upfront about what you can keep confidential, and then, when you need to involve other people in order to keep that person safe, and respecting the wishes of survivors as much as possible in terms of also respecting your mandated reporting requirements, but respecting the wishes of survivors of whether they want to report something or not report something. For example, in some states, domestic violence does not need to be reported, in which case it's important for us to respect our clients in terms of what they want to do.

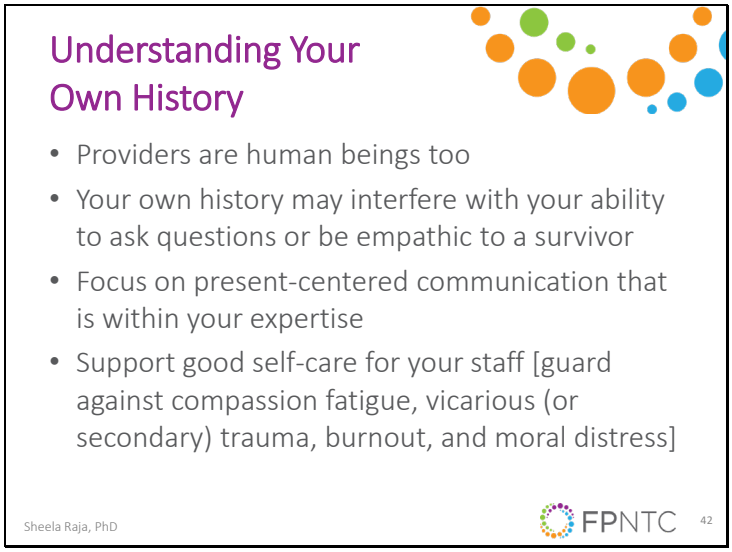
Slide 41



So, here are some suggestions for you all in terms of reporting. These are some really good references for you all in terms of where you can get more information about mandated reporting and trauma-informed mandatory reporting of child abuse, interpersonal violence. So, there is more information for those of you who may not quite feel comfortable with that yet.

Mandatory Child Abuse Reporting in Title X-Funded Family Planning Settings: Instructions for Customizing and Delivering a State-Specific Training:
https://www.fpntc.org/resources/mandatory-child-abuse-reporting-title-x-funded-family-planning-settings-instructions
Trauma-Informed Mandatory Child Abuse Reporting in a Family Planning Setting Video:
https://www.fpntc.org/resources/trauma-informed-mandatory-child-abuse-reporting-family-planning-setting-video
Child Abuse Reporting: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/
Domestic/Interpersonal Violence:
https://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf

Slide 42



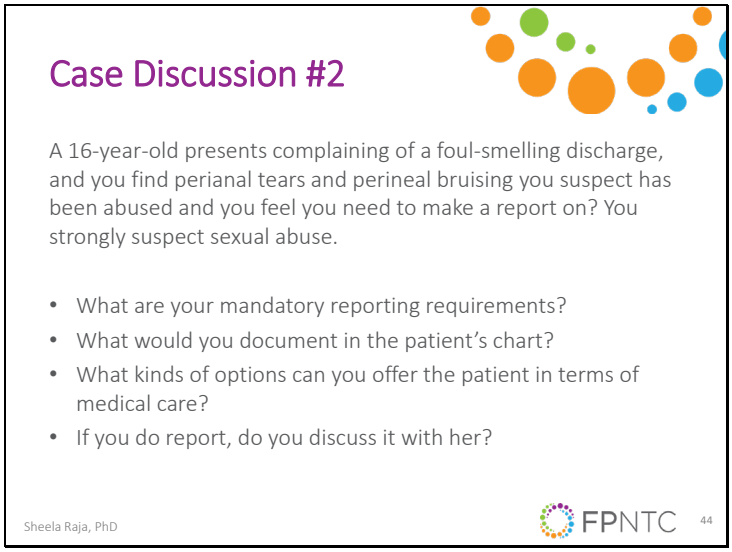
The next part of this pyramid also involves... Again, doesn't involve us knowing much more about the patient's specific trauma history. It really has to do with understanding your own history as a human being and in the world. We are all human beings too, and we all bring to the table things that we've experienced in our own lives that sometimes might interfere with our ability to ask questions or be empathetic on a particular day, and so I've had many, many providers come up to me over the years and say, "Well, I have my own trauma history of something, and I don't know if I'm ready to hear a lot of trauma from somebody." My advice for that person... I mean, if they're not working in behavioral health or mental health and it's not necessarily part of their job to hear 45 minutes of a trauma story, I think there's a lot of ways that providers can still be empathetic, but focus on the present. So, really, the idea of how do you say, "I really appreciate that you've disclosed this to me. How can I make you more comfortable at today's appointment? I have a really good provider that I work closely with that gives a lot of support to survivors. If that's something you're interested in, let me know." So it's, again, forming those linkages, but also in a way that doesn't feel dismissive, that feels present-centered, collaborative, and respectful. I think that that's a process. We also, as institutions, have to support good self-care for ourselves and our staff. There's basically sort of a lot of words, I think, that we need to be educated on. Compassion fatigue, which is the idea that emotionally, we're giving so much and we may have our own emotional reactions to our clients. Vicarious or secondary trauma is when we start seeing the world through our client's eyes, and that can become overwhelming for us sometimes, which then, eventually, all of the... Compassion fatigue and vicarious trauma can make you what we call burnout, which is the feeling that you just feel like you cannot emotionally renew yourself anymore, and you may be actually experiencing problems in your physical health and coming home and not experiencing

any joy in your day-to-day life, and that's a problem. Burnout you can change by changing your job, but if you're experiencing things like compassion fatigue and vicarious trauma, you have to address that because you need to be able to figure out how you can take care of yourself while you're still taking care of other people. There's also a term that's being used quite a bit these days called moral distress, which is the idea that you want to do the right thing in your practice, but you may feel like organizational constraints or practical considerations are getting in the way, so a very modern example of that right now, maybe the providers that want to do certain things, but they're experiencing shortages of PPE, for example, so that creates an internal sense of moral distress because ethically and morally they know what they want to do, but they're not able to do it on a day-to-day basis, and this is where we need to start talking about these issues, and organizations have to work to address these issues.

Slide 43

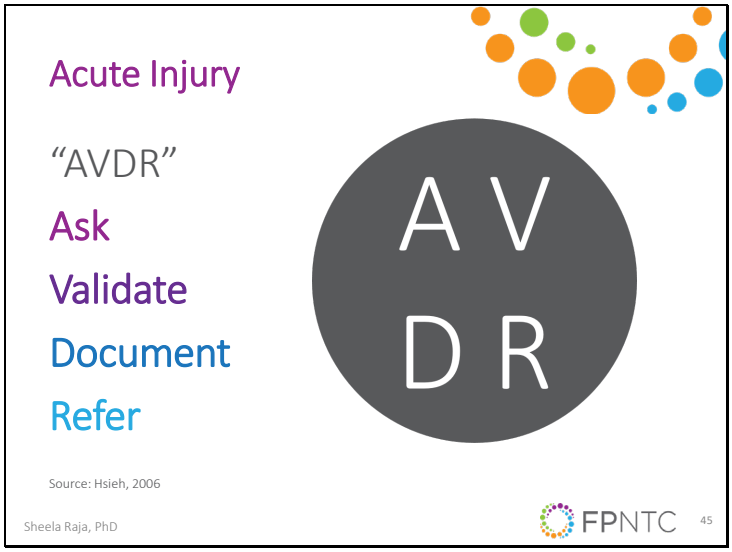
So, as you see, a large portion of this pyramid that we've talked about so far, the bottom four levels really don't require us screening or asking or delving heavily into a person's trauma history. It really involves universal trauma precautions, and by that I mean assuming that every person you encounter in your practice may have a history of trauma. I mean, we went over those statistics, and added together, it's a lot. It's highly likely that somebody in front of you has experienced something traumatic in their life, maybe multiple things that are traumatic. So, a lot of the trauma-informed pyramid really just involves good education and a way of approaching people.

Slide 44



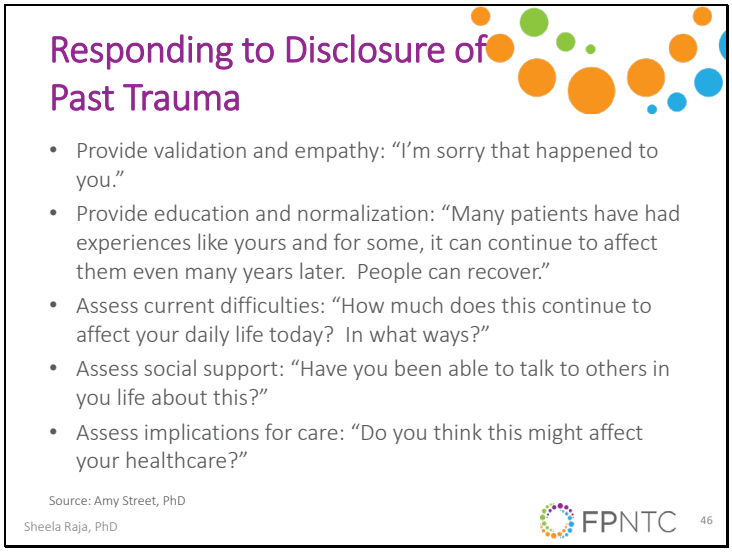
Here's a case discussion, so I would encourage you all to use the chat box, the audience chat box to respond to this. A 16-year-old presents complaining of foul-smelling discharge, and you find perianal tears and bruising, and you suspect that she's been abused, and you feel a need to make a report. You strongly suspect sexual abuse. So, what are your mandated reporting requirements? There's a lot of questions here. If you want to respond to just one of them, that's fine, but do you have to report this? If you do, what would you document in the patient's chart? What kinds of options do you offer her from here, and if you do report that, do you discuss that with her? So, that's a lot of questions, but maybe we can at least scratch the surface of that. So, I'm just going to give you all a second to respond and let some of those answers come on. Okay. All right, so someone says, well, there may not be any... A 16-year-old can consent to anal sex, so there is no claim of abuse, so there may be nothing to report. The patient should be offered the opportunity to report herself. Right, you may suspect something, but there may not be anything. Okay. Discuss with her about her sexual history. I'm just waiting for a couple more to come in. Sometimes there's a little bit of a lag. It appears that most of you in what's coming in in terms of the audience chat are... I agree with you. I think that we should be in favor of asking more questions. I mean, we may suspect certain things, but that may not be the case. Sort of developing that rapport, asking more questions, giving the client a choice and options about what to do next, but not making assumptions, and I think that's really important.

Slide 45



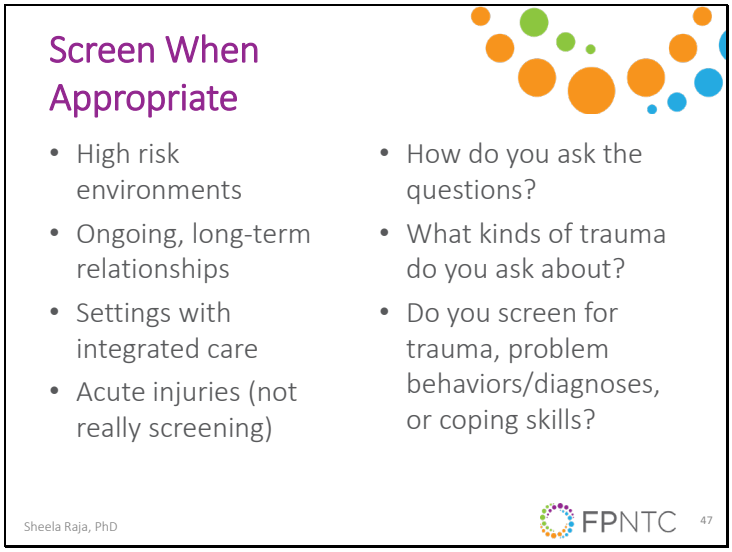
I think that you're actually alluding to sort of a nice protocol that has been developed around domestic violence and how it can be applied in... If a healthcare provider suspects domestic violence, what are the things that you can do? And I think this applies widely to trauma as well, it's something we can start thinking about, is asking just generally, well, how did this happen? Always tying it back to the clinical findings. Validating, which is if they do tell you that something traumatic has happened to them, that validating statement makes a huge difference. I'm sorry this happened to you. Nobody deserves to be treated like this, or I don't believe that this is ever right to be treated like this. That validation can go a long way. Documenting those things, and then referring. Again, it doesn't mean you're just referring and saying, "Okay, bye, this is a behavioral health issue." It means I'm collaborating, I have a team that I work with, and it's really hard. Some of you may work in more integrated teams, and I think that's wonderful.

Slide 46



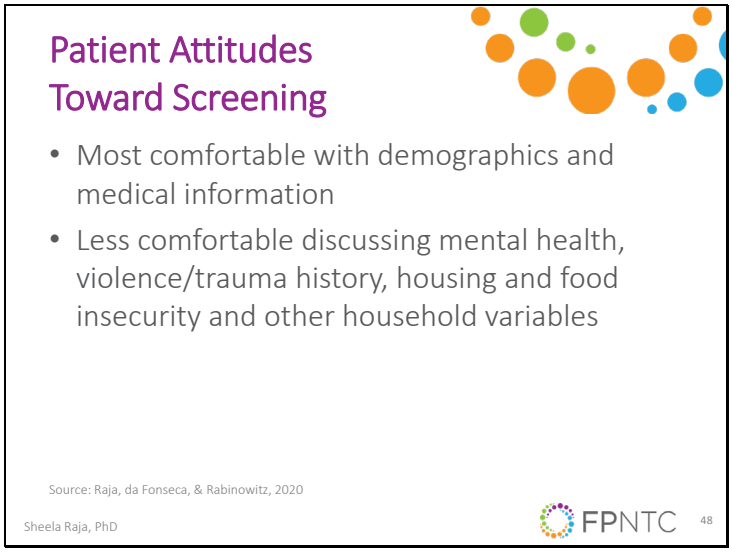
I think if you don't work in an integrated team, you also need to kind of work on creating those referral linkages for yourself. If somebody does disclose trauma to you, some suggestions are providing validation. I'm sorry that happened to you. Providing education. Many patients have had experiences like yours, and for some, it can continue to affect you, but people can recover. You also need to offer hope. Assessing their current difficulties. How much does this affect your daily life, and in what way? Assessing their social support. Have you been able to talk to other people about this? And then, how do you feel that this might affect your healthcare? So, doing some assessments, bringing it back to the current appointment and how you can help as well.

Slide 47



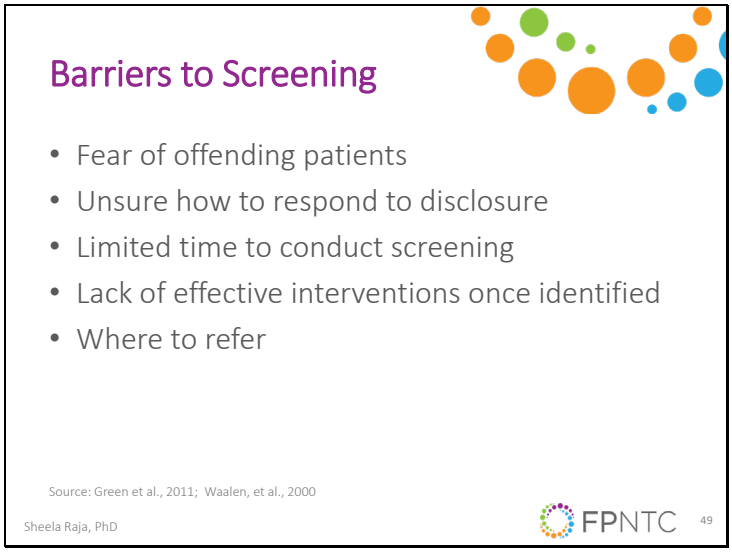
Now, there may be times where you do all of these things, and sometimes people are disclosing things, and sometimes they're not. You may be in a situation where you decide your organization as a whole wants to screen for traumatic events. You want to ask everybody every time whether they've experienced things like sexual trauma or interpersonal violence, or other types of things. That's particularly true, I think, depending on the setting you work in. I think that in reproductive health you certainly work in a setting where that can be triggering for many people, so it may be perfectly appropriate to be screening people for this. You may work in a high risk environment, so people that might be working in juvenile justice settings, for example, or other types of settings where they feel like there's a high level of trauma. When you have an ongoing or long-term relationship with your client, then screening may be very appropriate because you can continue on with that patient and with that client and see what's happening next when you have integrated care and you can have the hand out to behavioral health and primary care, all the other things that that person needs. Of course, when somebody has an acute injury, you always have to ask about it. I don't really consider that screening. I think that that's just good clinical care. But you also really have to consider these following questions: how do you ask about the trauma? What kind of trauma do you ask about? Or do you just look for current functioning?

Slide 48



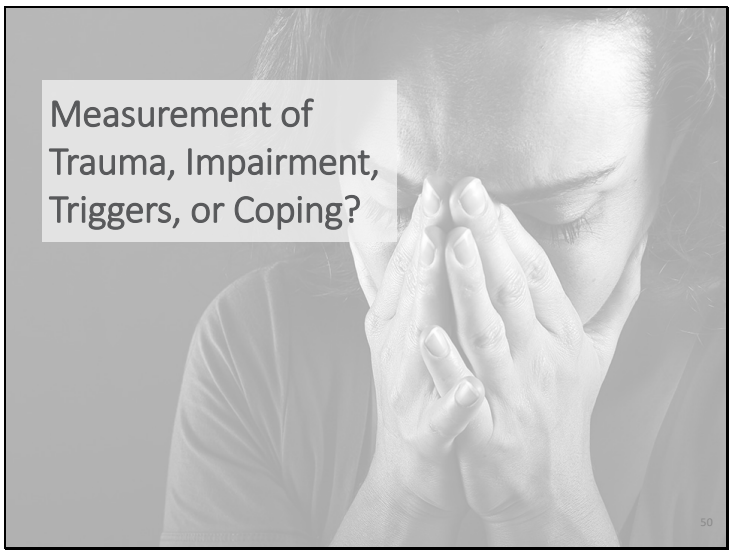
So, we really have to think about what are our clients' attitudes towards screening? Recently, my team and I did a survey with our clients at the University of Illinois in our clinics about how comfortable people are, and it's interesting. People are most comfortable talking about their demographics, their medical information, and not surprisingly, they are less comfortable talking about mental health, violence and trauma history, housing and food insecurity, and other sort of household variables that they perceive as very personal and we perceive as being very relevant to their overall health, and I think this is where that education piece comes in. We can't miss an opportunity to be educating our clients at large about why these things are important.

Slide 49



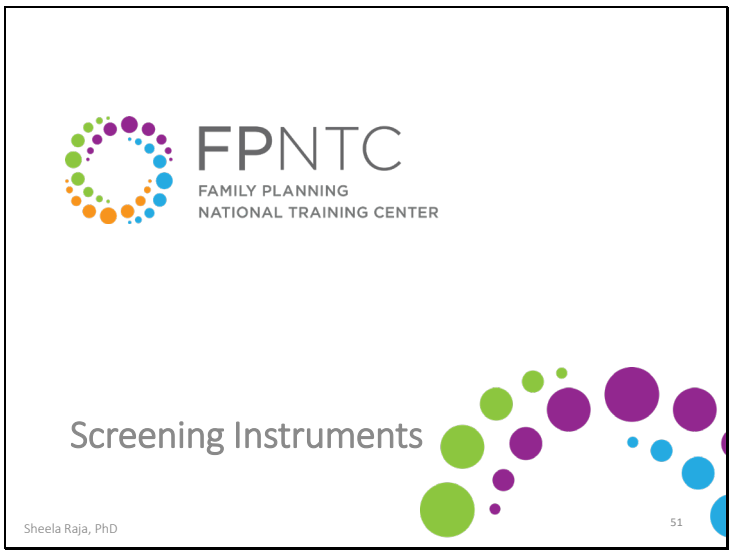
Providers sometimes talk about their own fears of offending patients. They're not sure how to respond if someone talks about it, but again, today we've talked about at least a few tools about how to respond to a disclosure. There's the time issue. That's an organizational constraint. Sometimes maybe we feel like we've identified something, but if you work in a setting that's more rural, for example, maybe that person has to drive so far for services that they're really not able to obtain them, or maybe the waiting list is so long. So, there's also actual barriers involved when you implement large scale screening programs.

Slide 50



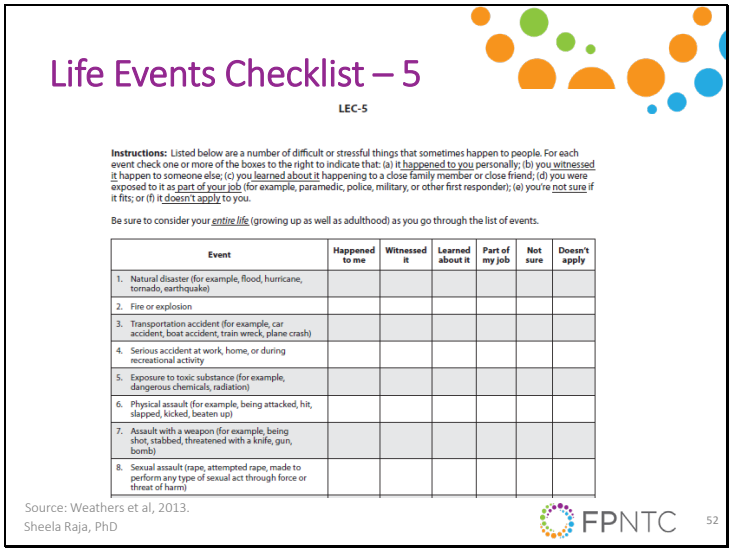
So, because of that, I think a lot of people are thinking now around, well, if we do implement these large screening programs, what should we be measuring? Should we be measuring trauma exposure? Should we be measuring current impairment? Should we be measuring triggers in the healthcare environment, or should we be measuring the way someone's coping?

Slide 51



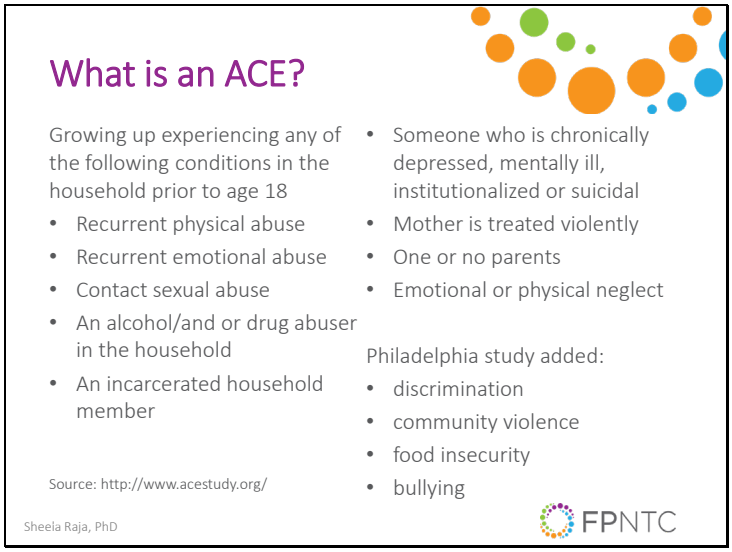
So, based on that, you might choose different screening instruments, and I'm just introducing you to a few of these. You may be familiar.

Slide 52



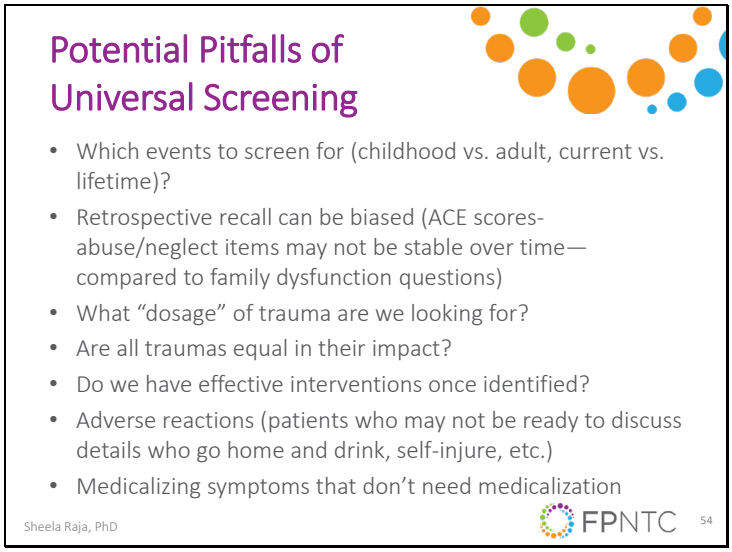
So, for example, if you're going to screen for trauma, there's the life events checklist. These are sort of... These are a list of some really difficult things, and did any of these happen to you, or did you witness any of these things? It ranges, as you can see, from things like a natural disaster all the way down to a sexual trauma or a physical assault.

Slide 53



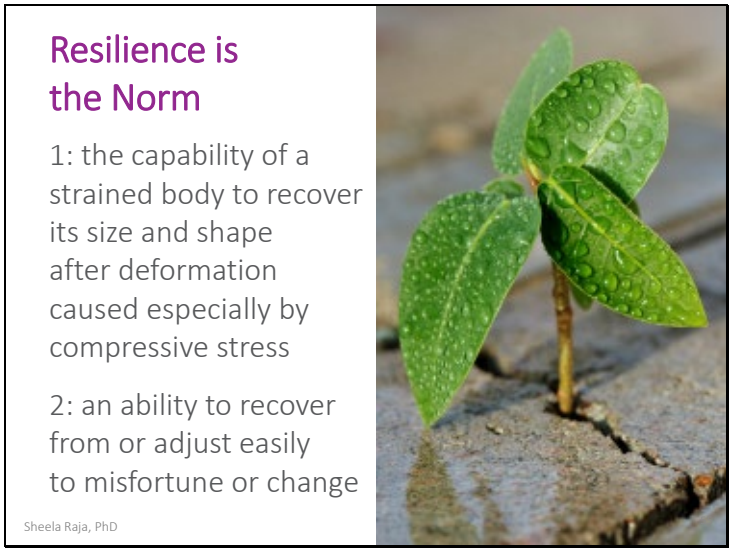
There's the ACE measure that's being pretty widely implemented into primary care around the country, but it focuses only on childhood trauma. The Philadelphia portion of the ACE study actually added on things like exposure to discrimination, community violence, food insecurity, bullying.

Slide 54



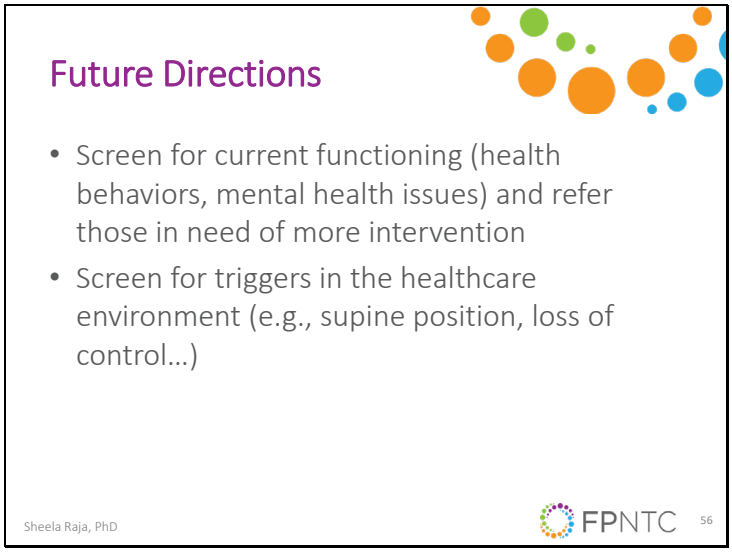
There are potential pitfalls associated with universal screenings. Again, I sort of alluded to the fact that... Do we only focus on childhood, or do we focus on adult trauma as well? Because we know that a sexual trauma as an adult can be devastating, and maybe an ACE screening won't pick that up. What dosage of trauma are we looking for? For example, do we just tally it up when we're kind of screening our clients for these things, or are we having them in clinical discussion? So, there's a lot of potential issues when we're trying to implement large scale screenings, and people may have adverse reactions, and if so, do we have linkages within to behavioral health or social work, or if people want to talk more, do they have a place to go do that, both immediately and in the long term?

Slide 55



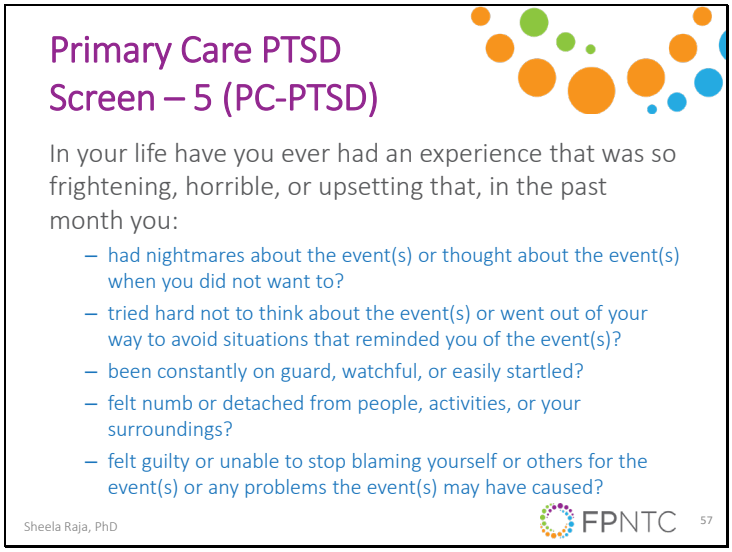
We also know that a lot of people are quite resilient. It's incredible the number of people who have experienced many, many difficult things and are able to go back to their communities and heal within their own communities, their own social support networks, and so I think in healthcare, we also need to figure out ways to bolster people's natural coping abilities, things they're already doing in their communities, and our first instinct shouldn't necessarily be that we just identify it and then refer them over, because they potentially maybe don't have a behavioral health issue. They may be able to regain their current functioning if they stay within their current community and bolster their social support.

Slide 56



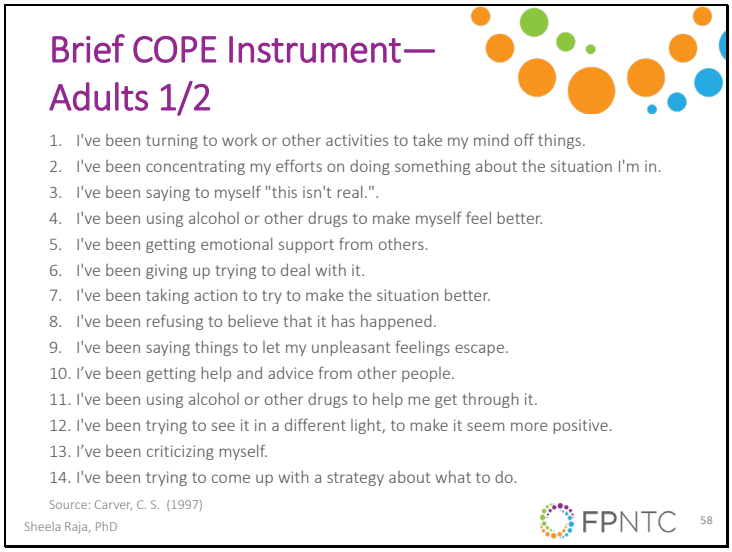
So, in terms of future directions, maybe we're going to decide on a longer scale that we need to screen for current functioning. How are people doing now in terms of their health behaviors and their mental health? Maybe we're going to screen for triggers in the healthcare environment.

Slide 57



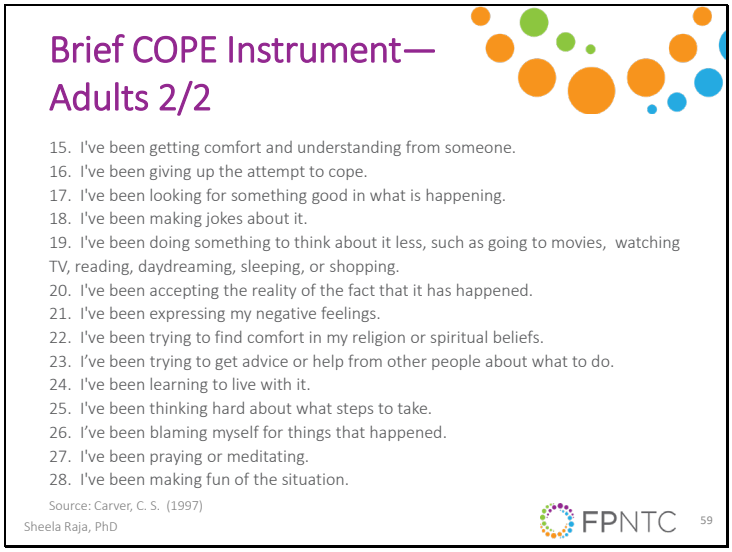
I've just given you some examples here. You can screen for PTSD in a primary care type of environment in a pretty short way.

Slide 58



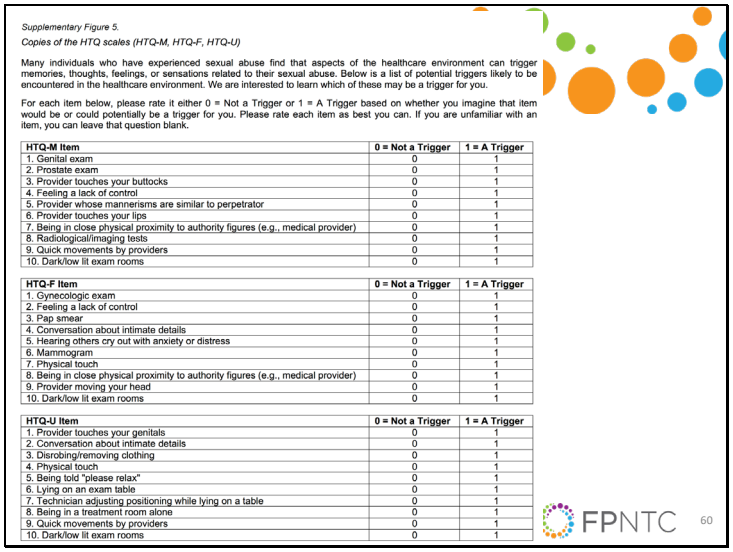
You can screen for how people are coping in a fairly short way, so for example, are people coping by accessing social support?

Slide 59



Are they coping through alcohol? Are they coping through avoiding difficult thoughts? Then, that can be sort of a springboard for discussion.

Slide 60



Supplementary Figure 5.

Copies of the HTQ scales (HTQ-M, HTQ-F, HTQ-U)

Many individuals who have experienced sexual abuse find that aspects of the healthcare environment can trigger memories, thoughts, feelings, or sensations related to their sexual abuse. Below is a list of potential triggers likely to be encountered in the healthcare environment. We are interested to learn which of these may be a trigger for you.

For each item below, please rate it either 0 = Not a Trigger or 1 = A Trigger based on whether you imagine that item would be or could potentially be a trigger for you. Please rate each item as best you can. If you are unfamiliar with an item, you can leave that question blank.

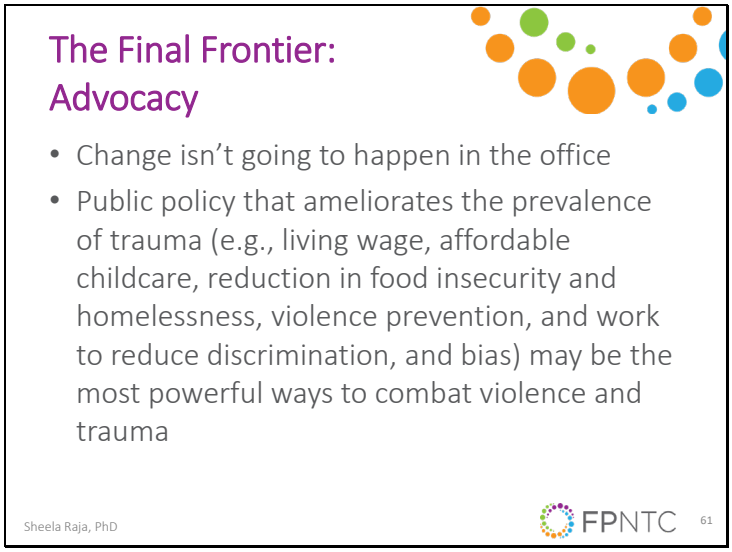
HTQ-M Item	0 = Not a Trigger	1 = A Trigger
1. Genital exam	0	1
2. Prostate exam	0	1
3. Provider touches your buttocks	0	1
4. Feeling a lack of control	0	1
5. Provider whose mannerisms are similar to perpetrator	0	1
6. Provider touches your lips	0	1
7. Being in close physical proximity to authority figures (e.g., medical provider)	0	1
8. Radiological/imaging tests	0	1
9. Quick movements by providers	0	1
10. Dark/low lit exam rooms	0	1

HTQ-F Item	0 = Not a Trigger	1 = A Trigger
1. Gynecologic exam	0	1
2. Feeling a lack of control	0	1
3. Pap smear	0	1
4. Conversation about intimate details	0	1
5. Hearing others cry out with anxiety or distress	0	1
6. Mammogram	0	1
7. Physical touch	0	1
8. Being in close physical proximity to authority figures (e.g., medical provider)	0	1
9. Provider moving your head	0	1
10. Dark/low lit exam rooms	0	1

HTQ-U Item	0 = Not a Trigger	1 = A Trigger
1. Provider touches your genitals	0	1
2. Conversation about intimate details	0	1
3. Disrobing/removing clothing	0	1
4. Physical touch	0	1
5. Being told "please relax"	0	1
6. Lying on an exam table	0	1
7. Technician adjusting positioning while lying on a table	0	1
8. Being in a treatment room alone	0	1
9. Quick movements by providers	0	1
10. Dark/low lit exam rooms	0	1

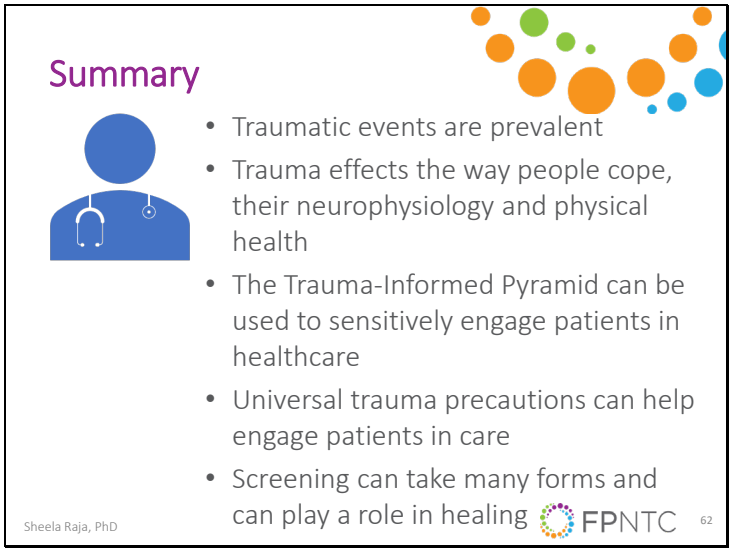
We can also screen for triggers. This is a really interesting piece of work that came out recently that involves, for example, asking clients when you're going through a gynecological exam, is that a trigger? Is dark lighting a trigger for you? Is physical touch a trigger for you? Being told, "Please relax," is that a trigger for you? So, again, somebody may go through this and say, "No, none of these things are triggers for me," and this is great information for a clinician to have.

Slide 61



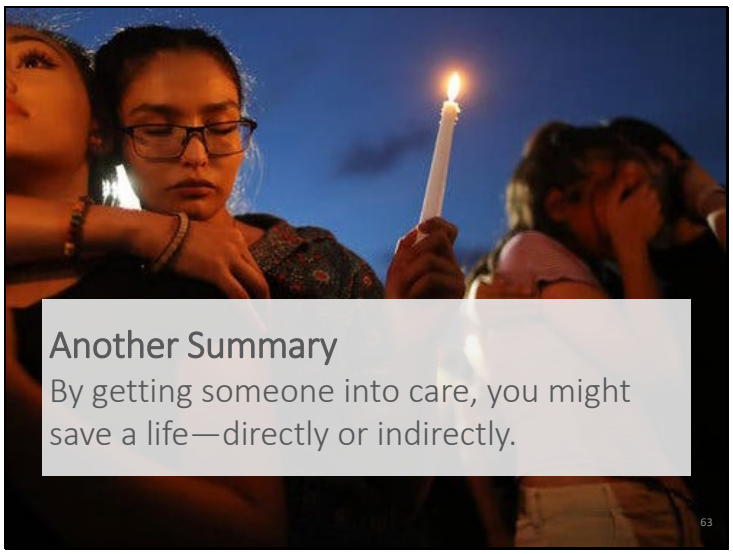
I also think that as we approach thinking about what a trauma-informed system looks like. A trauma-informed healthcare system can't do it alone. I don't really think change is going to happen just in our office. We know more and more that public policy... That we have to work hand-in-hand with public policy that helps to sort of reduce the overall prevalence of trauma, things like a living wage, affordable childcare, reduction in food insecurity and homelessness, violence prevention, working to reduce discrimination, bias. They also may be really important ways to combat violence and trauma before they even build up.

Slide 62



So, the summary, I think, of today is really all of these types of traumatic events are prevalent. They impact the way people cope and their neurophysiology, their health. Hopefully this sort of pyramid structure has given you a way to think about a lot of the things that you're already doing to engage people who have been traumatized in healthcare, and that universal trauma precautions can be used almost with every patient every time, and then, if you do do screenings, how do you be thoughtful about some of those things and put it in in a way that really plays a role in healing and your clinical discussions?

Slide 63



The shorter summary, I would say, from this is really... If I was going to summarize it in a tweet, I would say by getting somebody into care and really developing that rapport with somebody, you might really save a life, directly or indirectly.

Slide 64

So, at this point, I'm going to open it up for questions, so we'll monitor the audience chat here. Thank you all for joining. I really appreciate it.

Slide 65

Katie Quimby: Thank you so much, Dr. Raja. That was wonderful. As Dr. Raja said, we have some time for questions and we are open for questions now. You can chat those in, or you can enter them in through the Q&A pod. We already have received quite a few, so I'm going to start us off. The first question is related to secondary trauma, and the question is what are some signs, perhaps subtle signs of secondary trauma or compassion fatigue?

Dr. Sheela Raja: Yeah, that's a really good question, and I think that the subtle signs of secondary trauma are... The things you can watch for are, I think, irritability. That's one that we miss a lot. Are we getting frustrated with our clients more? Are we getting frustrated with the people around us at home more often? Are we just sort of on edge? When we come home, are we less able to let the day go and engage in watching that movie with our kids, for example, or somebody, our friend? Those are all signs that something is going on either in our life or in our work life that might be building up. I think that as we sort of build more trauma-informed healthcare systems as a whole, we really need to educate everybody in our system about that, and also de-stigmatize it. There's a lot of stigma associated with talking about that you're having reactions, and we need to say, "Well, everyone's going to go through a period where they have some of these things, and it's okay." How do you come to me and say, "I've had a really hard week and I would like a half a day off this morning just to chill out?" I would love to see us become that trauma-informed at some point.

Katie Quimby: Yeah. Yeah, great. Okay, our next question is around time, and the question is do you have tangible ways of navigating the very real limitations of time constraints to still provide thorough and compassionate trauma-informed care?

Dr. Sheela Raja: Yeah, this is the number one question I get around... I mean, for years, and around the country, and it's so legitimate, right? It's that, depending on your setting, you have a certain number of people that you have to see, and you have to move towards a diagnosis and treatments, and all of those things, and then you add all of this on top and we say build rapport. So, this trauma-informed pyramid is really the idea... There's certain things that I think are really important in terms of rapport-building that don't take a lot of time. What can I do to make you more comfortable? This is the way that this kind of exam runs. It's almost like you know this because you're doing it every day, and maybe you're already doing this, but I think those are really trauma-informed, the idea of giving the roadmap. This is what we're doing. This is what to expect. This is what you can do if you're feeling upset or distressed. I think that those small, little ways that don't cost us a lot of time and don't go deep, necessarily, into the person's experience are probably some of the best ways under our current system of how we can implement this.

Katie Quimby: The next question is about balancing, so the question is how do we gauge how to ask questions about trauma with our clients and balancing the concern that asking too many questions or asking certain questions might push them away, and thus risk them not returning for much-needed care?

Dr. Sheela Raja: Yeah, so it's a question of balance, right, and I think this is where, again, focusing on what do you need to know to make that person comfortable at this particular appointment or procedure, and let that rapport grow over time. But I also think letting your clients know, "I'm going to ask you a couple of questions, because it's not uncommon in our setting for people to have experiences that sometimes make this a difficult experience, but maybe, maybe not. Some of this may or may not apply to you." I mean, I think sometimes by letting clients know, "We're asking these questions of everybody. Some of these things may or may not apply. Feel free to not answer any of these questions. You don't actually have to answer them in any great detail if you don't want to, but it's really the idea of what could we do to make you more comfortable. That's what we're trying to get at.“ I mean, I think sometimes we have all of these things in our minds, and just sharing our thought process with our clients helps them feel so much more at ease in terms of that, and we know this. You're not doing this to pry or anything like that, but just letting them know, "My goal is to make you feel more comfortable, so you can share as much as this or as little of this as you want," and so they may go, "Oh, well, to make me feel more comfortable, this is all I need to tell you." And I think it gives them more control.

Katie Quimby: All right, okay, so the next question here is around telemedicine. In light of the public health emergency, many providers have transitioned to using telemedicine, and the question is what recommendations do you have about ensuring you're providing trauma-informed care in that context, or how is providing trauma-informed care different when providing care virtually?

Dr. Sheela Raja: Yeah, this is such a good, important question, and I thank you for bringing it up.

In fact, this is something that I've been transitioning with my healthcare students in terms of them having more conversations, practice conversations with standardized patients just to practice some of these conversations that are going to be happening much more, either on the phone or through Zoom, or whatever, and I think... Well, first of all, if I think trauma-informed, the first thing I'm thinking is SAMHSA's definition. We need safety, so you have to make sure that you're under a confidential, safe spot to talk. Very important. And I think you still have to do all of the same things that you're doing in the office. Of course, you can't... Because you don't have as much of the non-verbal behavior, it is really important that you try to convey as much of that positive attitude and trust as you can, whether it's talking to the person on the phone, or whether it's through a video link. I also kind of think right now that telemedicine is trauma-informed, because explaining to people it can be very stressful for people to come into the clinic, and sometimes people now just want to come in and they want to leave, understandably. Again, I think part of being trauma-informed is to let them know, "You may have anxiety, and that's normal, and so if you have questions afterwards, we can talk afterwards and debrief when you're not in the office," or, "I can answer your questions before you come in," safe to say. I mean, I think that that is going to be extremely important in the months to come, for us to establish that rapport, because we really relied on that first five minutes of the appointment or whatever it might be to create that rapport, but we don't have it anymore, and so to let our patients know, "This is really important for us to be able to chat ahead of time. We can definitely talk afterwards. I'm here." I think that's really trauma-informed, so that's a great question. Were there other questions?

Katie Quimby: Yes. Great point, and yes, we have time for one more question, and it seems to be an appropriate question to end on. You started by saying this is an evergreen topic, but maybe particularly relevant right now, and I wonder if you can close by talking about implications of current events the current public health emergency on levels of anxiety, and what does that mean for providing trauma-informed care?

Dr. Sheela Raja: I'm sure I'm not the only one thinking this, but part of trauma-informed care involves collaboration across silos and across disciplines, and if we have ever seen the need for that, it is now. It is now when we are seeing sort of this perfect storm of unemployment, which leads, of course, to food insecurity and housing instability, differences in access to healthcare, all of these types of things that, on a larger level, we have to be able to make better. So, sometimes when I'm talking about this topic in person with folks, I'll talk about the fact that a lot of us who have been doing PTSD and violence therapy, per se, when we, the clinicians for years... Often, people start to change and become advocates for prevention, because we don't want our offices full of people anymore. We want to prevent, and I think in the healthcare system, we're all on the same side. We want to stop this from happening, and the only way we can is to create linkages where people feel more supported so there's less trauma, there's less toxic stress, and that will trickle all the way down to people coping better, taking better care of themselves. It's going to flow all the way down to physiology, and I think we just have to keep on educating and keep on creating linkages. That was a long answer to a short question.

Katie Quimby: Not a short question, and really appreciate the answer. I hope the rest of you will join me in thanking Dr. Raja for a wonderful presentation. Just a few closing announcements, we will have the materials from today's session posted within the next few days, and Dr. Raja had mentioned a few FPNTC resources about trauma-informed mandatory reporting, which are currently available on fpntc.org in our mandatory reporting training package. Our final ask is that you please complete the evaluation today. You'll receive the evaluation by email after the webinar, and we do really love getting your feedback and use your feedback to inform future sessions. Additionally, if you are seeking CNEs, you must complete the evaluation to receive your certificate. If you have any additional questions, don't hesitate to reach out to us or Dr. Raja, and thank you all again for joining us for a wonderful presentation. That concludes today's webinar.

Email fpntc@jsi.org and sraja1@uic.edu

Subscribe at www.fpntc.org/enewsletter