# Creating a Trauma-Informed Care Curriculum

Anthony Brine, PsyD

Director of Behavioral Health

Lisa Weiss, MD, M.Ed., FAAFP

Associate Program Director

BSMH St. Elizabeth Boardman Family Medicine

# Please check-in to this session

You can use the QR code to the right which should also be available in written form at the entrance to the room.

You can also use this code in your app.

**PTZBU**

# Disclosures

- We have no financial interests or relationships to disclose
- We have no actual or potential conflict of interest in relation to this program/presentation

# Goals and Objectives

| Inform | Display | Engage |
| --- | --- | --- |
| Provide brief overview of Trauma Informed Care (TIC) and the importance within Family Medicine Residency | Demonstrate a framework for a longitudinal curriculum involving didactic presentations, problem-based workshops, and direct observation | Provide a discussion for the purpose of generating creative ideas for programs to be able to develop or edit their own TIC curriculum |

# Case Presentation

- Mr. A is a 58-year-old male admitted to the hospital for a myocardial infarction. He lives alone and is currently unemployed. Since the start of his admission, he has been frequently argumentative with staff. He complains about the noises outside his room, having a room close to the nurse's station, and being woken up early for labs. While he has improved medically, he repeatedly expresses distrust and dissatisfaction with his doctors. He accuses his treatment team of being "in this for the money." Further, he claims his nurses of "not caring about the patients" and "only wanting to gossip to each other" when he feels his needs are not being met. He has been described as "verbally aggressive" and has been seen cursing at staff. Finally, he has been refusing a physical therapy consult and states adamantly that he needs to be discharged home.

# Sound Familiar?

- How will this patient be described during morning report by the resident physician?
- Are your residents ready to:
  - Manage patients with similar characteristics and needs as Mr. A?
  - Establish or build trust with this patient?
  - Create a safe environment for this patient?

Let's talk about trauma

# Trauma

- Estimated that 50 to 75% of general population experiences substantial exposure to traumatic events
- Trauma has been linked to mental health diagnoses such as PTSD, depression, and anxiety, as well as interpersonal difficulties
- Also linked to increased health care costs and negative health outcomes, including chronic cardiac and pulmonary diseases

Green, et al 2015

# Trauma Informed Care (TIC)

- Taking a patient's experiences of trauma into account during clinical care delivery
- Involves creating a safe and trusting environment, allows the patient to have choice and collaboration in treatment, focuses on patient's strengths and promotes resiliency
- Substance Abuse and Mental Health Services Administration (SAMHSA) four key elements of TIC
  - *Realizing* widespread impact of trauma
  - *Recognizing* how trauma affects children, families, staff, and others involved within the system
  - *Responding* by integrating TIC knowledge into policies, procedures, and practices
  - Preventing *Retraumatization*
- Improving a resident's therapeutic relationship, attitude, and empathy toward a vulnerable population

Ditcher, et al 2018

Schiff, et al 2017

# TIC in FM Residency

- Dichter and colleagues (2018) surveyed 503 US family medicine residency program directors
- 52.3% response rate (263)
  - Of the 263, 71 (27%) reported having TIC in the curriculum
  - Majority devoted less than 5 hours annually to core content
    - Content most commonly addressed recognizing signs of trauma
    - Most frequently using didactic format
- 48.5% reported curriculum met patient's TIC needs "somewhat" and 4.6% met needs "a great deal"
- Most common barrier to integrating TIC curriculum included lack of a champion followed by lack of time

Ditcher, et al 2018

# Longitudinal Curriculum

## Didactics

- Four sessions each academic year
  - First lecture is divided into two lectures
    - 1st half is an intro to TIC for 1st year residents and review for 2nd and 3rd year residents
    - 2nd half is a lecture topic that is new for all residents
  - 1 full workshop
  - 1 hybrid session involving lecture and workshop
  - 1 full lecture

## Patient Centered Observation Form

- Directly observing residents and giving feedback on care delivery to ensure universal TIC protocols are used for patients

# Lecture Series

- Introduction to Trauma Informed Care
- Understanding Trauma
- Patient Centered Care Communication
- The Role of the Physician
- Assessment of Trauma and Anxiety-Related Disorders
- DSM-5 Trauma- and Stressor-Related Disorders
- How to Coordinate Care for Your Patient with Trauma
- Biological Connections to Trauma
- Trauma and Substance Use Disorders
- Vicarious Trauma and Secondary PTSD

# Lecture Series

- Introduction to Trauma Informed Care
  - Defining TIC
  - Exploring statics related to Primary Care
  - Focusing of the importance of TIC in Family Medicine
- Understanding Trauma
  - Defining stress and trauma
  - Identifying common symptoms and reactions to trauma
  - Facilitating discussions related to working with this population
- Patient Centered Care Communication
  - Identifying the lack of control for patients in medical settings
  - Universal trauma precautions for providing safety and comfort
  - Adjusting the physical examination to patient needs
  - Creating a collaborative atmosphere for your patient

# Lecture Series

- The Role of the Physician
  - How to normalize symptom presentation
  - How to education your patient on trauma reactions
  - Providing practical assistance
    - Collaborative approach on identifying immediate needs, creating an action plan, and adjusting to what the patient is able to work on right now
  - How to provide empathy and instill hope for patients
- Assessment of Trauma and Anxiety-Related Disorders
  - Screeners vs assessment
  - Avoiding retraumatization
  - Identifying risk and protective factors
  - Engaging in risk assessment and management clinic protocol when needed
- DSM-5 Trauma- and Stressor-Related Disorders
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder
  - Acute Stress Disorder
  - PTSD
  - Adjustment Disorders

# Lecture Series

- How to Coordinate Care for Your Patient with Trauma
  - Reviewing clinic protocol
  - How to coordinate care
  - Identifying resources for after graduation
- Biological Connections to Trauma
  - Adverse Childhood Experiences Study and other notable studies
  - Biology of Stress
  - Toxic Stress on the Developing Brain
- Trauma and Substance Use Disorders
  - Defining addiction
  - Identifying connections to trauma
  - Recognizing stigmas
  - Reviewing Motivational Interviewing techniques and Patient Centered Care Communication

# Lecture Series

- Vicarious Trauma and Secondary PTSD
  - Defining vicarious trauma and Secondary PTSD
  - Identifying risk factors and normalizing symptoms
  - Exploring management and prevention
  - Facilitating discussions on the changes within ourselves from medical school to today

# Workshop Series

- Identifying Trauma
- Patient Centered Care Communication
- The Difficult Conversation
  - Assessment of trauma, normalizing symptoms, educating patients, building empathy, avoiding retraumatization
- Assessment of Substance Use Disorders
- Assessment of DSM-5 disorders
- Practicing Grounding Techniques, Coping Skills, and CBT

# Workshop Series

- Identifying Trauma
  - Role playing exercise run by Dr. Weiss as narrator and Dr. Koprucki as patient
    - Psychologist not involved to avoid suspicion of it being a mental health diagnosis
  - New patient with no chart and known history
  - The "patient" has a simulated narrative response sheet given prior to study
    - Also has personality characteristics, as well as social, medical, substance use, and trauma history
  - Narrator informs the residents of the chief compliant of migraines and wanting a new neurologist referral
  - Volunteer resident provides introduction and agenda setting
    - Explore physician-patient interaction, patient centered care communication, and patient provides nonverbal information
  - Volunteer resident completes a brief neurological exam
    - Identify patient centered care communication and patient provides nonverbal information
  - Narrator provides information from record release days after leaving the session, phone calls to the office before next appointment, and follow-up appointment
    - Narrator guides residents who are given options in how to respond and provide appropriate care for the patient while exploring differentials

## Crystal Jones

**Diagnoses**

- Fibromyalgia
- Moderate persistent asthma without complications
- Migraines
- Dysuria
- Irritable Bowel Syndrome with diarrhea

**Medications**

- IMITREX 50 MG tablet
- ANUSOL-HC 25 MG
- DULERA inhaler
- ZANAFLEX 2 MG tablet
- ibuprofen (ADVIL;MOTRIN) 600 MG tablet
- TOPAMAX 25 MG tablet
- EMGALITY 120 MG/ML
- MYRBETRIQ 50 MG
- albuterol sulfate inhaler
- Cymbalta 30 MG

**Doctors**

- Dr. Dennis Tallis, Neurology
- Dr. Ted Grameriou, OB-GYN
- Dr. Lucy Steele, Urology
- Dr. Mariel Bird, Gastroenterology
- Dr. Scott Petrallo, Pulmonology
- Dr. Thomas Geisler, Rheumatology
- Dr. Amy Cooke, Dermatology

**Simulated Patient Narrative:**

| Topic/Question | *Narrative Response* |
|---|---|
| **Depression?** | *I don't feel sad or anything. Just stressed.*<br><br>*It's been tough planning for the wedding. I was a lot more excited before but now I am almost over it. I have to return calls to a caterer and a photographer, but I just haven't done it for over a week now. I guess I've been putting it off.*<br><br>*I have always had trouble sleeping. I toss and turn all the time. It drives Johnny crazy. It takes me forever to finally fall asleep.*<br><br>*I don't want to get out of bed in the mornings. I feel so tired and usually my kids are the ones pulling me out of bed.*<br><br>*I am so exhausted during the day. My Johnny says I move slower than Frankenstein.*<br><br>*To be honest, I used to have those thoughts. I was always told I was worthless and all kinds of nasty stuff. But since I met Johnny, I don't even think about it as much as I used to.*<br><br>*I know I have lost some weight. Probably about 15 pounds in the last year. I just don't want to eat. My stomach is all messed up. I hate constantly feeling like I need to be around a bathroom at all times.*<br><br>*I'm not suicidal. I guess my last thoughts were probably like nine months ago. I hate to think this, but I would just think about how I wanted to die. I don't even want to talk about it.*<br><br>*It's stupid but I used to cut my legs and sometimes my stomach in high school. I totally stopped though when I was like 22. God, I was so stupid.* |

# Identifying Trauma

# Timeline of the Curriculum

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| • Lecture:<br>  • Introduction to TIC – Understanding Trauma<br>• Hybrid:<br>  • Patient Centered Care Communication<br>• Workshop:<br>  • Identifying Trauma<br>• Lecture:<br>  • Assessment of Trauma and Anxiety-Related Disorders | • Lecture:<br>  • Introduction to TIC – The Role of the Physician<br>• Workshop:<br>  • The Difficult Conversation<br>• Hybrid:<br>  • DSM-5 Trauma- and Stressor-Related Disorders – Assessment of DSM-5 Disorders<br>• Lecture:<br>  • Vicarious Trauma and Secondary PTSD | • Lecture:<br>  • Introduction to TIC – How to Coordinate Care<br>• Workshop:<br>  • Practicing Grounding Techniques, Coping Skills, and CBT<br>• Hybrid:<br>  • Trauma and Substance Use Disorders – Assessment of Substance Use Disorders<br>• Lecture:<br>  • Biological Connections to Trauma |

# Patient Centered Observation Form

- Directly observing residents and giving feedback on care delivery to ensure universal TIC protocols are used for patients
- Applied throughout the year
  - Interns: Three times in the year
  - 2nd years: Two times in the year
  - 3rd years: One time in the year

| INTERPERSONAL COMMUNICATION SKILLS | Yes | Missed Opportunity | Not Applicable | Comments |
|---|---|---|---|---|
| **Establishes rapport** | | | | |
| -introduces self / warm greeting (ICS1:1/1) | | | | |
| -acknowledges others in the room (ICS1: 1/1) | | | | |
| -uses appropriate eye contact and body language throughout visit (ICS1:1/2) | | | | |
| -adjust style and approach to patient based on patient needs (ICS1:2/2) | | | | |
| | | | | |
| **Maintains relationship** | | | | |
| -uses verbal or non-verbal empathy during discussions | | | | |
| -repeats important verbal content | | | | |
| Demonstrates mindfulness through presence, curiosity, intent focus, not seeming "rushed" or acknowledging distractions | | | | |
| -manages family/individual conflict (ICS1:1/3) | | | | |
| -creates non-judgmental safe environment for patient/family to share information (ICS1:2/4) | | | | |
| -respects patient's autonomy in health care decisions (ICS1:3/3) | | | | |
| -recognizes and uses verbal/nonverbal communication skills (ICS1:1/1) | | | | |
| -organizes and clarifies information (ICS1:3/2) | | | | |
| -educates and counsels patient and families avoiding medical jargon (ICS1:2/2) | | | | |
| -communicates difficult information effectively (ICS1:3/3) | | | | |
| | | | | |
| **Maintains Efficiency using transparent thinking and respectful interruption** | | | | |
| -talks about visit time use/visit organization | | | | |
| -talks about problem priorities | | | | |
| -talks about problem solving strategies | | | | |
| -respectful interruption/redirection using EEE: Excuse yourself, Empathize/validate issues being interrupted, Explain the reason for interruption | | | | |
| | | | | |
| **Collaborative Agenda Setting** | | | | |
| -negotiates visits agenda and guides the visit (ICS1:3/2) | | | | |
| -additional elicitation – "something else?" | | | | |
| -acknowledges agenda items from another team member or from EMR | | | | |
| -asks or confirms what is most important to patient | | | | |

# Discussion – Break into Groups

- Identifying barriers to implementing a TIC curriculum
- Creating alternative learning activities for residents
- Locating and coordinating with your local trauma resources
- Recognizing and addressing the challenges in addressing a patient population with significant mental health needs that can lead to vicarious traumatization and professional burnout

# Questions?



ANTHONY BRINE, PSYD

ABRINE@MERCY.COM

# Relevant References


1. Davis, S. M., Whitworth, J. D., & Rickett, K. (2009). Clinical inquiries. What are the most practical primary care screens for post-traumatic stress disorder?. *The Journal of family practice*, *58*(2), 100–101.
2. Dichter, M. E., Teitelman, A., Klusaritz, H., Maurer, D. M., Cronholm, P. F., & Doubeni, C. A. (2018). Trauma-Informed Care Training in Family Medicine Residency Programs Results From a CERA Survey. *Family medicine*, *50*(8), 617–622. https://doi.org/10.22454/FamMed.2018.505481
3. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8
4. Green, B. L., Saunders, P. A., Power, E., Dass-Brailsford, P., Schelbert, K. B., Giller, E., Wissow, L., Hurtado-de-Mendoza, A., & Mete, M. (2015). Trauma-informed medical care: CME communication training for primary care providers. *Family medicine*, *47*(1), 7–14.
5. Kavan, M. G., Elsasser, G. N., & Barone, E. J. (2012). The physician's role in managing acute stress disorder. *American family physician*, *86*(7), 643–649.
6. Martín-Higarza, Y., Fontanil, Y., Méndez, M. D., & Ezama, E. (2020). The Direct and Indirect Influences of Adverse Childhood Experiences on Physical Health: A Cross-Sectional Study. *International journal of environmental research and public health*, *17*(22), 8507. https://doi.org/10.3390/ijerph17228507
7. Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., & Rajagopalan, C. (2015). Trauma informed care in medicine: current knowledge and future research directions. *Family & community health*, *38*(3), 216–226. https://doi.org/10.1097/FCH.0000000000000071
8. Ravi, A., Gorelick, J., & Pal, H. (2021). Identifying and Addressing Vicarious Trauma. *American family physician*, *103*(9), 570–572.
9. Schmitz, A., Light, S., Barry, C., & Hodges, K. (2019). Adverse Childhood Experiences and Trauma-Informed Care: An Online Module for Pediatricians. *MedEdPORTAL : the journal of teaching and learning resources*, *15*, 10851. https://doi.org/10.15766/mep_2374-8265.10851
10. Warner, C. H., Warner, C. M., Appenzeller, G. N., & Hoge, C. W. (2013). Identifying and managing posttraumatic stress disorder. *American family physician*, *88*(12), 827–834.

# Session Evaluation link

- https://mcwisc.co1.qualtrics.com/jfe/form/SV_bBGUQCI5AMbHc4C
- Please complete an evaluation of this session. There should be a direct link in your conference app. You can also use this QR code.