Trauma-informed care

Better care for everyone

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Without realizing that the past is constantly determining their present actions, they avoid learning anything about their history. They continue to live in their repressed childhood situation, ignoring the fact that it no longer exists. They are continuing to fear and avoid dangers that, although once real, have not been real for a long time.

Alice Miller[1]

Although physicians are adept at seeing the illnesses that emerge, we often fail to consider how external forces shape what hides inside the body. Among the most common and yet least visible of these are adverse childhood experiences (ACEs), particularly childhood neglect and abuse. Adverse childhood experiences work their way into the physical body, increasing allostatic load, inflammation, dysfunction, and ultimately disease.

Max is a burly, tattooed man. He visits frequently complaining of pain and claims you are doing nothing for him. When he appears at the office your heart sinks.

Max has 2 kids and he is very close to one son. This relationship motivated him to end his criminal activities. Unfortunately, he has chronic pain that started in his back, spread to his arms and legs, and now is everywhere. No treatment has been effective. He has become a loner, experiences anxiety and insomnia, and cannot maintain functional relationships.

After struggling with his care for months, you finally take the time to ask him about his life. He is surprised, as he has never been asked about his upbringing. He was abused as a child, left home at age 14, lived on the streets, and worked as a labourer before joining street gangs.

After this conversation, your rapport changes dramatically. You start to talk about the link between chronic pain and childhood trauma. He is open to this conversation and gradually visits less often, although you still see him regularly. When he visits, you listen to him with care, and when you discuss the need to wean him off the narcotics he has been prescribed, he is willing to participate despite his persistent pain. Now you both smile when you greet each other, and you are surprised to discover that you look forward to seeing him.

Evidence for the long-term effects of ACEs is convincing and extensive. For some, childhood experiences marked by abuse lead to addiction, mental health challenges, cardiovascular disease, respiratory disease, and cancer.[2-4] Others adapt and even thrive. We cannot rewrite the histories of patients, but as health care providers, we might be able to help them develop resiliency, improving function and well-being.

Imagine 3 patients, each with a limp. One has a splinter in his foot, the second has sciatica, and the third had a knee replacement 6 weeks ago. Without identifying the cause of each limp there will be no cure. Even if there is no cure, physicians look for the cause, recognizing that we can help with improving function only by understanding the cause. In the same fashion, we should look for causes of anxiety, addiction, chronic pain, teen pregnancy, and cardiovascular disease. Many of the conditions we treat and screen for routinely can be linked to remote ACEs. In our research article in this issue of *Canadian Family Physician* on **page 204**—in which we examine the primary care experiences of women who have a history of traumatic childhood experiences and chronic disease—we propose that it is critical that family physicians ask their patients about childhood experiences in the same way they ask about other risk factors for ill health (eg, family history, substance abuse).[5] Although one's past cannot be changed, we can read the script to identify causes, understand patients' experiences, and intervene appropriately.

What does "reading the script" mean? This brings us to applying trauma-informed care to family medicine. The 5 principles of trauma-informed care guide clinicians in caring for complex patients who are often survivors of ACEs, who are neglected or shunned, and who might be labeled as *difficult, borderline,* or *chronic pain patients*. The trauma-informed care model offers a clear, compassionate, and rewarding approach.

Applying the principles

The relevant literature explains that trauma-informed care has 5 principles.[6-11] Ideally, delivering such care involves the entire health care system, from receptionists to nurses, from physicians to learners and other allied health professionals. Trauma-informed care is not trauma-specific care; it does not propose to heal the trauma nor even to address it directly. It does not imply that family doctors need to be trauma specialists. Here we present the principles of trauma-informed care followed by a description of how to apply them.

Trauma awareness and acknowledgment

Step 1. Bear witness to the patient's experience of trauma: This is a fundamental step and can be therapeutic on its own. In some ways, it is the easiest step, and in some ways, it is the one that most deeply threatens to

undermine the physician's worldview. This step involves bearing witness to the patient's experience of trauma, not in all its terrible detail but in its general outlines, while acknowledging the persistent and ongoing effect of this trauma on all facets of the person's life. It involves identifying for the patient that the violence and abuse they had experienced led to coping strategies that might have once been necessary for survival, but that are often maladaptive once these threats no longer exist. Bearing witness offers an opportunity for clinicians to ensure that patients do not feel responsible for their neglect or abuse. Adverse childhood experiences are not their fault. The guilt and shame that often accompany these experiences need to be acknowledged and, most important, validated as relevant to current health and coping strategies. Understanding the connection between these past experiences and current functioning can be life changing.

Safety and trustworthiness

Step 2. Help patients feel they are in a safe space and recognize their need for physical and emotional safety: This step has 2 components, and although the step appears straightforward it is often hard to achieve. The first component is fundamental to the structure and delivery of care. Consistency and predictability in the procedure of care is essential. Consider that anxiety might easily be triggered in a patient living with ACEs. Perhaps appointments could be scheduled for this patient at times when the waiting room is not full, which would minimize time spent in the waiting room and accommodate last-minute cancellations. A survivor of ACEs is supremely sensitive to nonverbal communication. A rushed, harried, or patronizing physician can undo a great deal of progress toward regaining a sense of safety. A safe and predictable relationship with a health care provider can be a critical component of this step.

The second component involves recognizing the need for the physical and emotional safety of a person with a history of ACEs. There are many factors that can affect one's sense of safety, such as financial instability, involvement with child protection agencies, and insecure housing issues. These circumstances all diminish one's ability to feel calm, secure, and safe. For example, if a patient living with anxiety had a father who was an abusive alcoholic, that patient's anxiety might be triggered by a drunk partner even if he or she is never abusive; living with this current partner is not a safe space for this patient and will undermine treatment of anxiety.

Choice, control, and collaboration

Step 3. Include patients in the healing process: Here we are seeking to actively involve patients in their own healing process using informed choice. By presenting both positive and negative choices (including the option to not engage in care), we can begin to override the passivity or deferral to authority that is typically used as a means of self-preservation by survivors of trauma. Physicians should seek to develop truly collaborative relationships with such patients, despite the initial added time required to do so. This will encourage the patient to move toward more active engagement in health care, rather than passivity or dependence. This step helps overcome the "no-show" problem (ie, the patient who habitually misses specialist appointments; the one who has no intention of going but does not dare to disagree with the proposed referral) or, similarly, the "failure-to-change" dilemma (ie, the patient who does not modify behaviour despite his or her apparent repeated commitments to do so). Active involvement helps patients avoid feeling they have failed yet again. A more collaborative approach might also elicit the reasons behind their reticence, resulting in better and more effective care.

Strengths-based and skills-building care

Step 4. Believe in the patient's strength and resilience: Here the physician is called upon to shift from seeing the patient as a victim with symptoms and pathology, to a person with tremendous strength and resilience who has survived serious ACEs. Supporting a patient's evolution from passive victim to active, motivated participant is one the most rewarding aspects of a health care provider's work. This might be the first time someone has highlighted these strengths to a patient. One of the fundamental experiences of abuse is disempowerment, and even the most benevolent paternalism (often inherent in the medical system) recreates a cycle of helplessness from which a person must emerge. If a physician truly believes in a patient's strength and resilience, then this belief can be conveyed, and the patient will be encouraged to move on, albeit slowly and with setbacks at times.

Cultural, historical, and gender issues

Step 5. Incorporate processes that are sensitive to a patient's culture, ethnicity, and personal and social identity: Understandably, in addition to the issues of ACEs, there are groups who have experienced and continue to experience more systemic abuse based on their race, culture, gender identity, biological sex, or sexual orientation. This sometimes leads to intergenerational transmission of both trauma and shame that must be recognized. Demonstrating a sensitivity to group marginalization will augment the effectiveness of a trauma-informed care approach.

Conclusion

Trauma-informed care has already been accepted in fields such as addiction and mental health, child protection, and the penal system. However, this approach is essential for family medicine given our breadth of practice and connection to community. As family physicians, we already recognize that the relationship between

physician and patient is a key component of care. The principles of trauma-informed care provide guidance for physicians who might be unsure of how to approach the difficult topics of ACEs that are central to a person's health and identity. Physicians are susceptible to our society's collective denial of child abuse and neglect. As physicians we are morally called to provide compassionate and healing care to the survivors of such trauma. We propose that ACEs are a key determinant—a root cause—of many of the pathologic conditions we treat on a daily basis. Viewing patients through a trauma-informed lens can lead to considerable patient healing and much greater professional satisfaction.

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Competing interests
None declared

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This article has been peer reviewed. *Can Fam Physician* 2018;64:170-2

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