FUNDAMENTALS of TRAUMA (AND VIOLENCE) INFORMED CARE

For Adolescents

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Safety First!

- How I became more interested in TIC…
- Trauma is subjective, personal, experiential so is TIC
- Presentation may contain triggering content and conversations
- Self Care
- We can learn together ☺

Objectives:

1. Be familiar with concept of TIC/ TVIC
2. List various types of trauma and be familiar with prevalence of trauma
3. Describe how trauma impacts health
4. Have an understanding of Trauma Informed Care Clinical Implementation
   -framework for trauma-informed universal precautions
   - integrate a trauma-sensitive approach to PE
5. List some challenges of TIC Implementation

ADOLESCENT CASES – Discuss ways to implement TIC principles

What is Trauma-Informed Care?

A strengths based delivery approach grounded in an understand of and responsiveness to the effect of trauma; emphasizes physical, psychological and emotional safety for both providers and survivors; and creates opportunities for survivors to rebuild a sense of control and empowerment *NATIONAL CENTER FOR TIC*

TIC involves recognizing and planning for detecting and treating the disorders that result after traumatic events.
DR. ROBERT URSANO, MD – TIC FOR PRIMARY CARE: LESSONS OF WAR

TIC includes minimizing the potential for medical care to trigger or to serve as traumatic events addressing distress, providing emotion support for the family, encouraging coping, resources, and providing anticipatory guidance regarding recovery.
DR. MEGHAN MARSAC PHD IN IMPLEMENTING TI APPROACH IN PEDS HC NETWORKS

A program, organization or system that is TI:
1. realizes the widespread impact of trauma and understands potential paths for recovery
2. Recognizes the signals and symptoms of trauma in clients, families, staff, and other involved with the system
3. responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4 seeks to actively resist re-traumatization. A TI approach adheres to 6 key principles. *SAMHSA*

What is TIC?

Strengths-based care delivery approach that fosters recovery and healing through safe and collaborative relationships

TIC functions as a form of **universal precautions**

Trauma survivors have had their trust violated, especially in health care situations so the goal is to **avoid inadvertently retraumatizing patients** while fostering collaborative and trusting care (Gerber et al, 2019)

Trauma and Violence-Informed Care (TVIC)

Expands this concept to acknowledge the *broader social and structural conditions* impacting people's health, including **structural violence** and **inequities, discriminatory systems**, and ongoing **experiences of violence.**

SAMHSA's 4Rs of Trauma-Informed Care

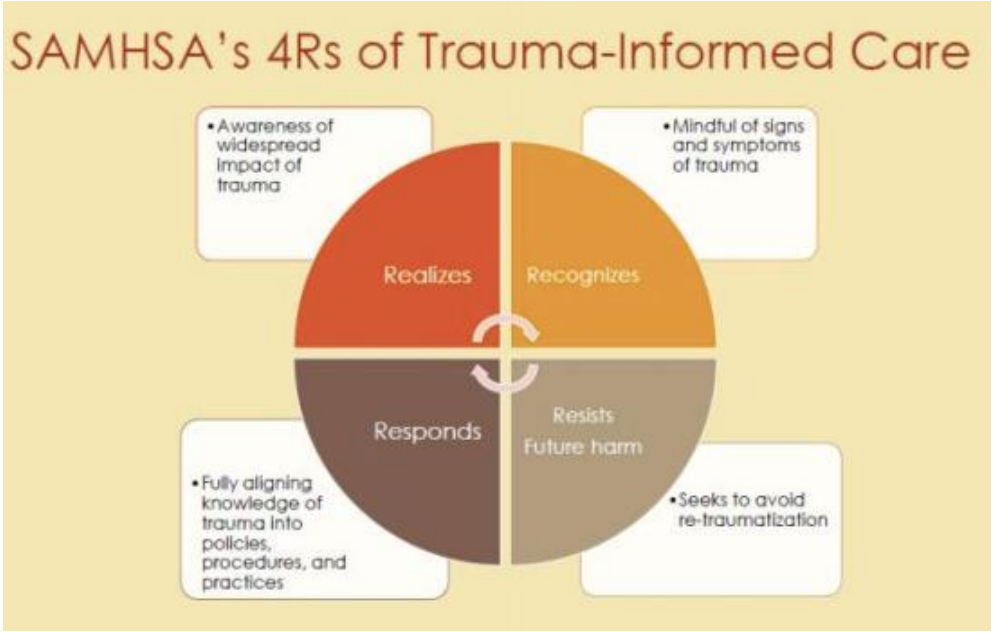
A program, organization, or system that:

Realizes the widespread impact of trauma and understands potential paths for recovery;

Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

Responds by fully integrating knowledge about trauma into policies, procedures, and practices;

Seeks to actively **Resist** re-traumatization



What is Trauma? Realize

- **No Universal Definition of Trauma**
- Experts create def based on clinical experiences – most comm ref def is from SAMHSA
- *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*
- **TYPES:**
- **Potentially traumatic events** (PTEs) = experiences or witnesses actual or threatened death or serious injury to oneself or others. Many childhood PTEs involve lower-profile events such as accidental injury, motor vehicle crashes, and exacerbation of chronic illnesses
- **Complex Trauma** = exposure to multiple or chronic traumatic experiences and the cumulative effects of that trauma
- **Racial Trauma** = experiences of ongoing prejudicial treatment, which may include violence, threats, shaming and ostracizing experiences. It can be considered as a type of complex trauma

Examples of Trauma (not limited to): Realize

- Experiencing or observing physical, sexual, and emotional abuse (adult or child)
- Family member with a MH or SUD
- Experiencing or witnessing violence in the community / serving in the military
- Poverty and systemic discrimination
- sudden/violent loss of loved one
- racism, discrimination, and oppression
- school shooting
- witnessing violence
- medical interventions
- accidents and natural disasters

Trauma Prevalence Realize

- ~50-75% exposed to traumatic experiences lifetimes
- PH data from 23 states ~61 percent of adults at least one ACE, 25 % experienced 3+ ACEs
- 2/3 exposed to at least one traumatic event during their childhood
- ¼ girls and 1/6 boys report a hx of sexual abuse
- All populations are affected by trauma but certain groups experience trauma at higher rate including;
  -Black, Hispanic or multiracial;
  -incomes of less than $15,000 per year; and unemployed
  -youth who (LGBTQ)
  -Urban populations show higher rates of trauma

Landmark ACES study – 1998 Realize

- Conducted as Kaiser thru CDC – looked at association bw ACEs and adult health outcomes
- Survey 17,000 white middle class adults in CALIFORNIA 1995-1997
- 64% reported at least 1 ACE, 17% reported 4 or more
- 28% females reported childhood sexual abuse
- Results showed a **20-year life expectancy gap** between individuals with high and low ACE scores demonstrating the profound impact trauma has on morbidity and mortality
- 2x rate of lung dz and liver dz
- 3x rate depression and ETOH
- 11x rate of IVDU
- 14x rate of SA
- = Pathophysiology of Disease is Causative
- ***Most compelling reasons to implement a trauma informed approach***

ADVERSE CHILDHOOD EXPERIENCES Realize

- **1. ABUSE** -Emotional, Physical, Sexual
- **2. NEGLECT**- Emotional or Physical
- **3. HOUSEHOLD CHALLENGES-**

  Mother treated violently

  Household substance abuse

  Mental illness in household

  Parental separation or divorce

  Criminal household member

PTSD IN DSM-5 Recognize

Traumatic event, followed by:

-*Intrusion* -Flashbacks, nightmares, involuntary memories

-*Avoidance* - Avoid thoughts, feelings, people, places, things associated with event; dissociation

-*Negative change in mood and thoughts* - Exaggerated negatives beliefs about self/others, feelings of guilt/shame, feelings of detachment

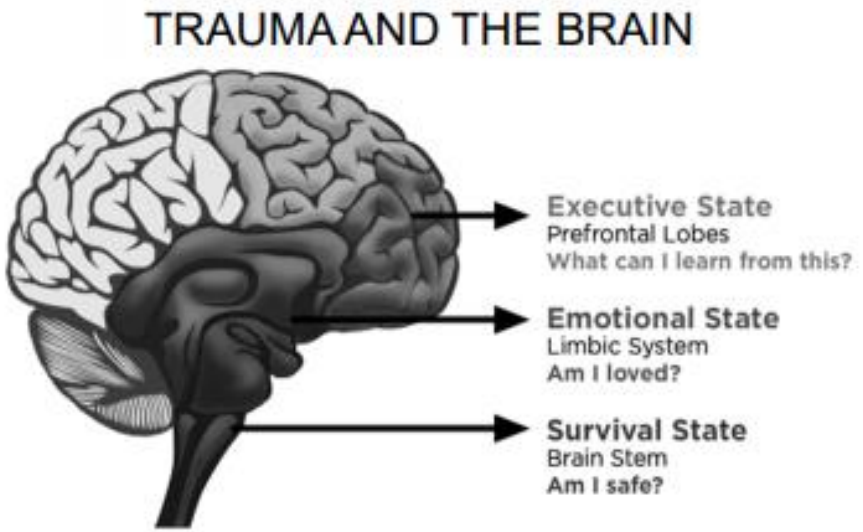
-*Change in arousal and reactivity* -Hypervigilance, aggressive outbursts, exaggerated startle response

-*Lasts more than 1 month*

-*Disrupts functioning*

Toxic Stress Derails Healthy Development Recognize

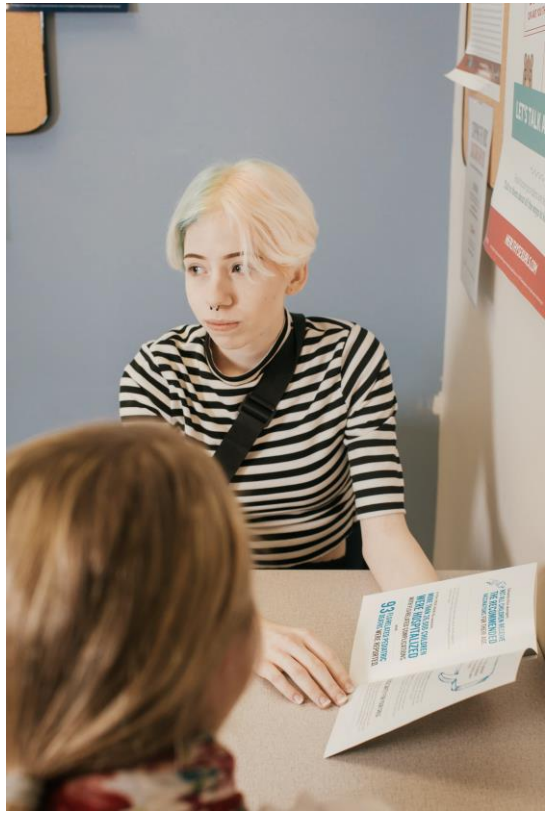
- Trauma = direct physiologic changes , act. (HPA) axis and stress hormones, which may play a role in chronic inflammation and disease development (Gerber et al, 2019)
- Cortisol levels increased across generations (Yehuda, 2008)
- Verbal abuse causes cellular damage makes verbal expression physically more difficult (Teicher, 2006)
- Changes in brain structures, cells = hypervigilant and numb simultaneously and more likely to misinterpret safety/danger = retraumatization (Van der Kolk, 2014)
- Traumatic states become biological traits (Perry 1995)



ADOLESCENT DEVELOPMENT Recognize

Unique physical, psychological, and social changes occur during adolescent period

- Increased focus on peer group
- More independence from parents
- Increase of risky behaviors; prefrontal cortex not fully developed
- Heightened emotional reactivity and sensitivity; onset of many mental health disorders occurs during adolescence



What aspects of our clinic/ visit may be traumatizing to Adolescents?

Aspects of Visit Potentially Traumatic for Adolescents Recognize

- Fear of being touched, in close proximity to a provider
- Fear of being unconscious
- Fear of objects inserted into their bodies
- Fear of not being able to swallow or breathe during exam
- Fear of having a flashback
- Anxiety- lack of being in control, new dx
- Procedures – painful, frightening, and unfamiliar
- Experiences can reoccur if chronic illness, repeat visits
- Our practices may seem coercive and feel involuntary
- These may be compounded by racial trauma, racism and medical mistrust = further traumatize minority populations

GOAL – minimize triggering these reactions by incorporating TIC

Trauma of Racism & Impact on Adolescent Health? Recognize

- **Education:** less likely ID for special needs educational services or receive them at an early age
- **Absenteeism:** Chronic absenteeism (missing 10% of school days in an academic year) disproportionately affects children of color = predicts poorer educational achievement
- **School Discipline:** AA & AI students are overrepresented in students experiencing suspension, more harshly punished/discipline = long-term consequences for student educational outcomes
- **Youth Incarceration:** AA, HIS and AI youth are disproportionately represented in youth incarceration rates. Experiences like solitary confinement and abuse while incarcerated can adversely impact developmental outcomes
- **Immigration:** HIS & AA immigrant students may face fear of immigration enforcement = dec. school attendance and worsen inequalities in educational achievement
- **Socioeconomic Status:** AA, HIS and AI children have statistically significantly lower household wealth compared to white children in the United States & have higher rates of parental unemployment

Trauma of Racism and Medical Mistrust Recognize

- Hx the medical system has been constructed on structurally racist premises
- Important us to understand the historical racism our system has engaged in, as well as our own implicit biases
- E.g. Tuskegee Syphilis Study, the case of Henrietta Lacks, and forced sterilizations of minority populations
- Currently - false medical teachings continue to perpetuate harmful falsehoods. A 2016 study demonstrated that 50% of white medical students and residents have false beliefs about biological differences between races (i.e., that black people's skin is thicker; black people's blood coagulates more quickly; that black people feel less pain)
- =inadequate care given to AA and they are systematically undertreated for pain
- 2015 study = disparities in pain management for pediatric patients suffering from appendicitis, with black children less likely to receive any pain management for moderate pain

Why Implement a Trauma-Informed Approach in Primary Care Settings *Respond

- In HC, more aware of trauma = avalanche of long-term negative consequences = serious public health crisis
- Know that early adversity has lasting effects on a child's brain
- TI primary care = establish more appropriate and effective care utilization
- Pts feel safer = safer spaces for staff, improve clinical decision-making
- If we are able to ID and respond to trauma = build collaborative care networks address holistic needs
- Engage our patients more effectively = improve outcomes and reduce avoidable costs for both HC and SW

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:

1. SAFETY
2. TRUSTWORTHINESS & TRANSPARENCY
3. PEER SUPPORT
4. COLLABORATION & MUTUALITY
5. EMPOWERMENT VOICE & CHOICE
6. CULTURAL, HISTORICAL, & GENDER ISSUES

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

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

PRINCIPLE	DEFINITION	EXAMPLES IN PRACTICE
Safety	Ensuring physical and emotional safety among patients and staff.	• Allow patients to define safety and ensure it is a high priority of the organization. • Create calm waiting areas and exam spaces that are safe and welcoming. • Respect privacy in all interactions.
Trustworthiness and Transparency	Conduct operations and decisions with transparency with the goal of building and maintaining trust with patients, family members and staff.	• Provide clear information on services. • Ensure informed consent. • Schedule appointments consistently.
Peer Support and Mutual Self-help	Promote recovery and healing by valuing and applying lived experience of peers and individuals with trauma histories.	• Facilitate group and partner interactions for sharing recovery and healing from lived experiences. • Include peer supporters in health teams as navigators.

Collaboration and Mutuality	Make decisions in partnership with patients and encourage shared power between patient and provider.	• Give patients a significant role in planning and evaluating services.
Empowerment, Voice and Choice	Patients retain choice and control during decision-making and patient empowerment with a priority on skill building.	• Create an atmosphere that allows patients to feel validated and affirmed with each contact. • Provide clear and appropriate messages about patients' rights, responsibilities and service options.
Cultural, Historical and Gender Issues	The organization embeds principles of diversity, equity and inclusion to deliberately move past cultural stereotypes and biases and incorporate policies, protocols and processes that are responsive to the racial, ethnic, cultural and gender needs of patients served.	• Ensure access to services that address specific needs of individuals from diverse cultural backgrounds. • Display messages in multiple languages to ensure everyone feels welcome. • Provide gender responsive services. • View every policy, practice, procedure and interaction through a lens of diversity, equity and inclusion.

Universal Trauma Precautions Respond

- Need to treat *every* patient as if they have experienced trauma
- **ASK** – ask every pt what can be don't to make them more comfortable during appt
- **NON- JUDGEMENT-** negative coping behaviors may be related to trauma, non-blaming, adolescents disengage if provider is judgmental
- **DISCUSS**- concerns and help them develop coping techniques if high anxiety
- **CONTROL-** often taken away with trauma hx – give as much control as possible during interview and exam

What can we do in clinic? Respond

Multi-pronged approach

- **EDUCATION** – every member of staff – training on TIC and racial justice (learn how racism, power and oppression are their own forms of trauma)
- **WAITING ROOMS** – have info about local resources/hotlines, display PP slides about trauma
- **CLINICAL POLICIES AND GUIDELINES-** prioritize pt choice, support safety in exam rooms, meet with provider alone (one on one screening), ask preference for who should be in exam room
- *ADOLESCENTS may feel more comfortable with a friend in the room with them ☺*

Sample Notice to patients and family Members

Respond

“The confidentiality of the patient-doctor relationship is important to us. That’s why we ask family members and friends to remain in the waiting area during patient examinations. Afterward, you may invited family or friends into the exam room, at the patient’s request.”

Shift Focus - “What’s wrong with you?” → “What happened to you?”

Quick Tips for Greetings and Intake Respond

- In transit →ASK walk ahead of, behind or beside the staff member

= inc pt. empowerment, voice, choice and safety

- Inform patients of every step in the initial intake and offer them a choice about whether to proceed

=inc sense of automony, mutuality in their relationship provider

- Arranging exam room to fit patients' general preferences and comfort *=reinforces physical and emotional safety*
- Ask patients their preference on who should be in the examination room with them and **Always allow them an opportunity to meet one-on-one with their provider**

Collaborative Documentation Respond

- With trauma hx – uncomfortable not knowing what is being documented
- “Usually I take notes during these conversations, would that be okay with you”
- = provider and pt document together
- = high pt satisfaction, improved engagement and clinical outcomes

TRAUMA-INFORMED PHYSICAL EXAMINATION BASICS Respond

Goal = level the power differential, infuse TI principles

- Using universal principles of trauma-informed care throughout exam

"I know these questions may feel very personal. I ask all my patients about their sex hx so I can provider the best care possible"

- Use tell-show- modeling, ?s

"Before we proceed, is there anything else you think I should know?"

- Ask if there is anything you can do to help them feel more comfortable
- Tell them what will happen during the exam and why
- Always ask for permission to conduct the components of the exam using simple, clinical language

BEFORE THE EXAMINATION Respond

CHECK NON-VERBALS

calmly, appear engaged, eye contact, sit/stand at eye level with the patient, avoid sudden movements, and be aware of patient cues

(i.e. tensing muscles, fidgeting, breathing quickly, appearing distracted, crying)

SET AN AGENDA

“I’d like to transition now to the physical exam. I recommend that we do a pelvic exam, which should only take about 5 minutes. How does that sound to you?” “When we’re finished, you can head to the laboratory for bloodwork. We will be doing routine screening blood tests for HIV, hepatitis, and syphilis.”

MAKE IT STANDARD

“This is something that we do with all of our patients who come in with symptoms of a sexually transmitted infection

CONSENT, CONSENT, CONSENT – for all parts of the exam

BEFORE THE EXAMINATION Respond

IDENTIFY CONCERNS

“What questions do you have before the exam?”

“Do you have any concerns you would like me to be aware of?”

ASK ABOUT COMFORT

“Is there anything we can do to make you more comfortable during the exam? Please tell me if ever you feel uncomfortable and we can pause the exam–you are in control of the pace.”

OFFER SUPPORT PERSON

“Would you like anyone else to be present for the exam?”

DURING THE EXAMINATION Respond

ATTEND TO DRAPING AND MODESTY

-Give clear, specific directions of what clothing can be removed / on and how to wear/position the gown or drape

-Only expose areas examined (dont assume patients ok to bear parts of their body e.g., chest, legs)

-“I’m going to exit the room and allow you to change, please remove **the** pants and underwear. You may leave **the** socks and shoes on, if you’d like. Once you’re ready, you can have a seat on the exam table. Here’s a drape for you to place over **the** lap. I’ll be back in a few minutes. I’ll knock before I come in.”

DURING THE EXAMINATION Respond

INTRODUCE EXAM COMPONENTS

"To do a pelvic exam, we start by first **inspecting** the genitals and then doing an internal vaginal exam, using this speculum."

"Inspect", "examine", and "check" are recommended over "look at", "feel", and "touch"

EXPLAIN WHY

Use plain language and provide translator services as appropriate

"This exam is important because we need to see if you have any signs of a sexually transmitted infection. Our goal is to keep you healthy."

DURING THE EXAMINATION Respond

STAY WITHIN EYESIGHT

“We’ll keep the head of the exam table elevated slightly, so that you can see what I’m doing. Would you like to hold a mirror?”

ASK PERMISSION

“Please move the buttocks all the way down to the edge of the exam table, and place the feet in these foot rests. You can allow the legs to fall to the side. Then I will need to lift the drape slightly, in order to inspect the external area. Is that alright?”

Be mindful of word choice—consider “buttocks” instead of “butt”, “exam table” instead of “bed”, “foot rests” instead of “stirrups”, “allow the knees to fall to the side” instead of “open your legs”, and “healthy” instead of “normal”

CHECK IN TO ENSURE PATIENT COMFORT

“How are you doing?”

“Some find it helpful to take a deep, relaxing breath”

Be cautious when giving suggestions to calm or comfort patients, as traumatic experiences could be associated with a variety of places, people, objects etc.

DURING THE EXAMINATION Respond

USE PROFESSIONAL TOUCH

“First, you are going to feel my hand on the buttock. Next you’ll feel some pressure in the rectum. Is it alright to proceed?”

BE EFFICIENT /Reduce the time procedures take when possible

Ask the patient to show you a genital lesion, rather than taking time to find it yourself

“You mentioned feeling a lump a few days ago—can you show me where it is?”

“That concludes the exam. We’ll help you sit up. I’m now going to step out so that you can get dressed. Here are some tissues if you need them to wipe off. I’ll be back in a few minutes so that we can come up with a plan for next steps together. I’ll knock before I come in.”

AFTER THE EXAMINATION Respond

EXPRESS THANKS

“Thanks very much for coming to this appointment and for helping me perform a physical exam.”

DISCUSS RESULTS

“Your exam showed no abnormalities, which is good news. We will still send off a sample for lab testing, just to be sure. We’ll be in touch over the next few days with results.”

PROVIDE AN OPPORTUNITY FOR QUESTIONS

“What questions do you have?"

Screening *Resist

- U.S. Preventive Services Task Force (USPSTF) recommends screening women of reproductive age for intimate partner violence (IPV) but does not recommend screening for adverse childhood experiences (ACEs) or sexual assault

Many approaches to screen for trauma:

- Asking open-ended questions about trauma
- Screening for specific types of trauma
- Conducting universal education in the practice
- Developing an environment with patient cues (such as pamphlets and posters) that indicate the office is safe space for trauma discussions

Screening and Mandatory Reporting Resist

- Decision to screen for trauma is multifaceted
- Resources in place to adequately address positive results or refer patients to outside resources
- Face to face vs. self report
- Need to ensure they elicit only the information necessary to determine a hx of trauma
- Requesting that patients describe their trauma can actually be re-traumatizing= best left to mental health professionals

How to Ask (Screening) Resist

An open-ended question like:

"Have you experienced anything that makes seeing a doctor difficult or scary for you?" (Millstein, 2020)

"Have you ever been in a setting where your life was in danger?"

Stem/intro question to the PC-PTSD-5 (*full stem below*)

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

"Since the last time I saw you, has anything really scary or upsetting happened to you or your family?"

Mandatory Reporting Resist

- Any practice that is considering screening for trauma also needs to be aware of practitioner roles as mandatory reporters, especially among minors
- Adolescent patients may have misconceptions about mandatory reporting, so it is especially important to discuss confidentiality

Navigating Resources After Disclosure Resist

- Clarify confidentiality, normalizing the experience by expressing prevalence of abuse, validation, addressing any time limitations, offering reassurance, and collaborating with the patient on an immediate self care plan
- **Provide Validation and Empathy**

"Thank you for sharing this with me. This information can help me understand how best to care for you. I'm sorry that this happened to you."

- **Assess if this is First Disclosure/ Social Support**

"Have you been able to talk to others in your life about this? What support do you have or have you had?"

- **Assess Current Difficulties in Life** (Ex: relationship difficulties, nightmares, trouble leaving house, etc.)

"How much does this continue to affect your daily life today? In what ways?"

- **Assess Implications for Care**

"Do you feel like this experience affects your health or well-being?"

- They may not want or need anything other than to be heard and your support/validation
- Open door policy
- Providers need to be careful about delving into the trauma unless they have specific training

Sample Script

"I am sorry this happened to you. Thank you for sharing this with me. This information can help me understand how best to care for you. Trauma can continue to affect our lives and health. Do you feel like this experience affects your health or well-being?"

Sample Script

"In light of what you've shared today, is there anything I can do to make you feel more comfortable during our appointments together?[72] Do you have any concerns we should address before moving forward? I will note it in the record for future appointments and you can always change or add to it later."

Responding to Disclosures of Trauma Resist

Refer to Available Resources

-maintain a list of resources for patients who disclose trauma

Arrange Follow-up

-Patients with trauma are less likely to utilize preventive care = establishing a longitudinal relationship to create trust and improve health outcomes

Sample Script

"Difficult life experiences, like growing up in a family where you were hurt or there was mental illness, drug or alcohol issues, or witnessing violence can affect our health. How do you think your past experiences have affected your physical or emotional health? Trauma can continue to affect our health. If you would like, we can talk more about services that are available that can help."

Identify Patients' Resilience Factors Resist

- ?positive strengths and resiliency factors
- Use conversational & open-ended questions + formalized instruments
- Ask about positive supports / ways they have successfully coped in the past
- ***Examples of a formalized instrument :***
- *Devereux Resilience Scale*
- *Connor-Davidson Resiliency Scale (CD-RISC) available in 2, 10 or 25-item versions*

Sample Script

"In the past, which of your strengths have you relied on to 'bounce back' after difficult experiences?"

Creating Anti-Racist Clinics Resist

- Train staff in culturally and linguistically appropriate care- language services, signs in multiple languages
- Infuse racial and ethnic diversity into images in clinic
- Educate staff and providers on hx of medical mistrust and abuse in black and brown communities
- Post a Non discrimination policy
- Hire staff representative of pt pop (esp security guards)
- Provider that speaks preferred language
- Resources – medial legal partnerships/ civil rights agencies

Challenges of TIC Implementation

- TIC is good for us but more needs to be done
- develop an integrated, comprehensive approach, screening patients →measuring quality outcomes
- Q?'s ~ to conceptualize trauma & develop payment strategies to support this approach

Clinical and Organizational Cultural Shift

Clinically we can:

- Involve patients in the treatment process
- Screen for trauma
- Train staff in trauma-specific treatment approaches
- Engage referral sources and partnering organizations
- Need Organizational Policy and Cultural Change - to Lead Communication, Organizational planning, Training all staff, create safe environments, prevent secondary traumatic stress in staff, hire TI workforce
- *Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land.* Sandra Bloom, MD, Creator of the Sanctuary Mode
- "Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today." - Dr. Robert Block, former President of the American Academy of Pediatrics

Trauma-Informed Care Pearls

- Never exclude trauma from your differential (even in young people)
- In addition to personal trauma, people may come from a community that experiences discrimination, racism, or other forms of structural and historical violence
- We should be less afraid to inquire about trauma = NOT necessary to elicit a highly-detailed trauma history
- Conversations with patients to facilitate open dialogue and builds trust
- Pts w/ trauma hx are more likely to reveal underlying causes of other conditions if they feel heard and respected
- Ask for questions and feedback

Case 1

Audrey 15 yo F who comes in for fu on depression, you use the screening question- “Since the last time I saw you has anything scary or upsetting happened to you or your family?”

She tells u that while working at Little Ceasars she was held at gunpoint and robbed. Since this event she has been feeling more anxious and having issues sleeping. She is still working there because she needs the money to pay for her car and phone.

What should you do next?

Case 2

Alexis is a 15 yo F who comes into Atrisco for STI testing. She tells you that she went to a party and woke up naked a few weeks ago. She is not sure what happened. She does not remember who was around her at the time and tells you that she is “kind of glad that I don’t remember anything”

What should you do next?

Case 3

James is a 16 yo M that you are seeing at YSC. He is having problems sleeping and talks to you about how heroin has helped him calm down for years. He has been using this regularly for 2 years. He tells you he also has PTSD.

What should you do next?

Sample Script

"You mentioned that heroin makes you feel calm when you are very stressed and that you have a goal to stop using but are not ready to now. So, let's talk about how you can stay safe when you use heroin. What ideas do you have? Are you familiar with steps to prevent and respond to an overdose, such as using with a friend and carrying naloxone?"

Resources and References:

- Adverse Childhood Experiences Study: http://acestoohigh.com/ and https://www.cdc.gov/violenceprevention/acestudy/index.html https://cdn.ymaws.com/www.fadaa.org/resource/resmgr/files/Webinar_Handouts/Handout_TIC_for_Adolescents_.pdf
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