ADVANCING EXCELLENCE IN TRANSGENDER HEALTH

Trauma Informed Care

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The Fenway Institute

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

HARVARD MEDICAL SCHOOL

Massachusetts League of Community Health Centers

Acknowledgments

- The National Trauma-Informed Health Care Education and Research Group
- Harvard Medical School's Trauma-Informed Care Curriculum Steering Committee
- Conall O'Cleirigh, who presented with me at last year's conference


LISTEN
TO YOUR
BODY.
ITS SMARTER THAN YOU.

Learning Objectives

- Portray the range of stressors experienced disproportionately across the life course by SGM individuals.
- Analyze how a lived experience of trauma can interfere with formation of therapeutic SGM patient-provider relationships.
- Describe how to use a trauma-informed approach to enhance SGM patients' engagement and retention in care.

Dino *(Part 1)*

Dino is a 42-year-old trans man (AFAB, on testosterone, no gender affirming surgeries, pronouns he/him) who is brought in by his partner for evaluation of several months of irregular frontal bleeding after having had no bleeding for a number of years. He has not had a pelvic exam in >10 years.

Questions:

- What factors might explain Dino's delay in seeking care?

Definition of Trauma - SAHMSA (2012)

"Trauma results from an ***event***, series of events, or set of circumstances that is ***experienced*** by an individual as physically or emotionally harmful or threatening, and has lasting ***effects*** on the person's functioning and physical, social, emotional, and spiritual wellbeing."

ADVERSE CHILDHOOD EXPERIENCES

SOCIAL AND BEHAVIORAL DETERMINANTS OF HEALTH

LOSS

HISTORIAL AND STRUCTURAL TRAUMA

COMMUNITY VIOLENCE

BETRAYAL

ISMS AND PHOBIAS

Trauma is Ubiquitous

MAJOR LIFE TRANSITIONS

MICRO-AGGRESSIONS

Occurs at Multiple Levels

NATURAL DISASTERS

ABUSE AND VIOLENCE

POLITICAL AND ECONOMIC TRAUMA

WAR AND TERRORISM

WITNESSING

ACCIDENTS AND INJURIES

MEDICAL DIAGNOSIS AND TREATMENT

Health impact

- Adverse Childhood Experiences (ACEs) Study conducted in 1997
  - 17,500 middle class, predominantly white, medically insured Americans
  - Assessed the relationship between trauma and health outcomes
- Subsequent studies of ACEs have shown remarkably consistent results

Am J Prev Med 1998;14: 245-258.

Adverse Childhood Experiences (ACEs)

ABUSE

Physical

Emotional

Sexual

NEGLECT

Physical

Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness

Incarcerated Relative

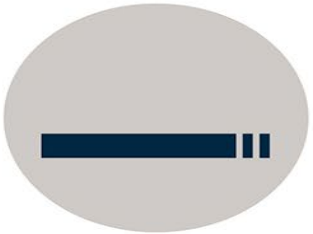
Mother treated violently

Substance Abuse

Divorce

BEHAVIOR

Lack of physical activity



Smoking

Alcoholism

Drug use

Missed work

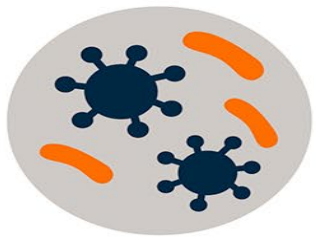
PHYSICAL & MENTAL HEALTH

Severe obesity

Diabetes

Depression

Suicide attempts

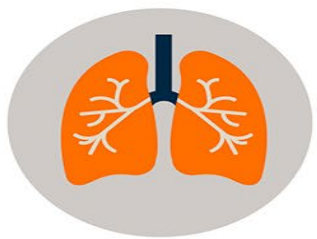


STDs

Heart disease

Cancer

Stroke



COPD

Broken bones

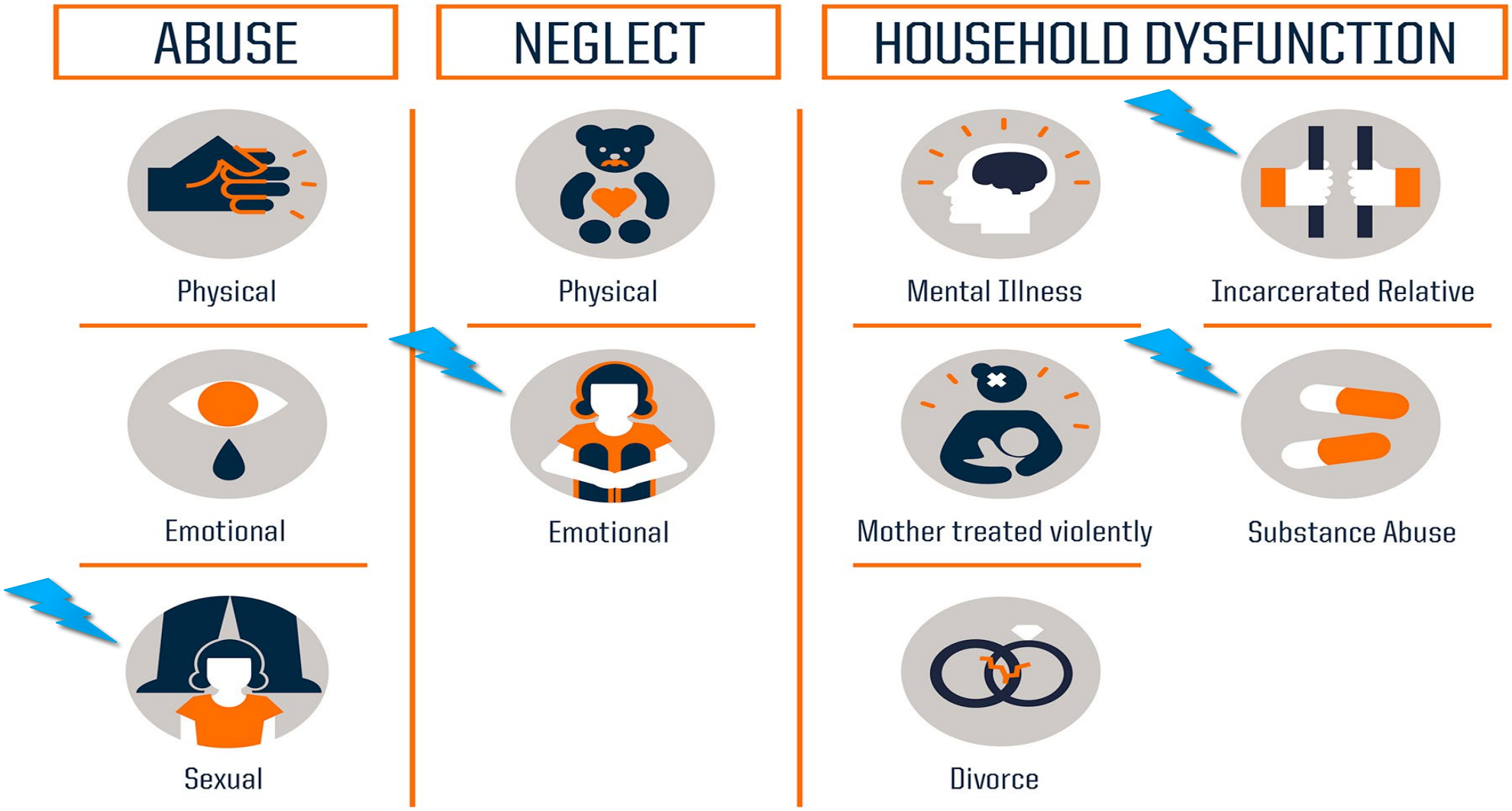
Dino *(Part 2)*

Dino was raised by a single mother who frequently left him alone at night when she went to work. They were evicted several times because there wasn't enough money to pay the rent. Dino moved in with his aunt and uncle at age 10, after his mother was convicted of a drug-related offense. Shortly after puberty, Dino's uncle began abusing Dino by forcing him to perform oral sex when his aunt wasn't home.

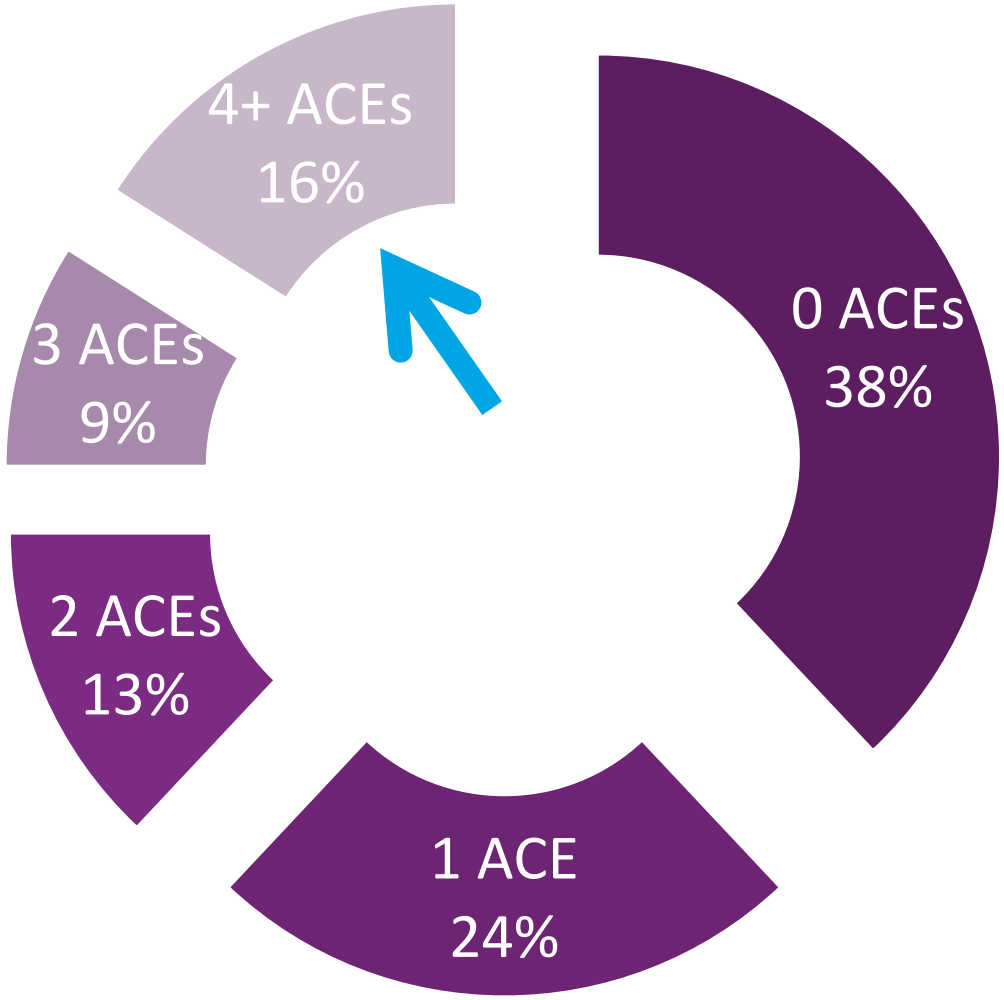
Questions:

- What is Dino's ACE score?
- Is Dino's story unusual?
- What are the implications?

Dino's ACEs


ABUSE
NEGLECT
HOUSEHOLD DYSFUNCTION
Physical
Emotional
Sexual
Physical
Emotional
Mental Illness
Incarcerated Relative
Mother treated violently
Substance Abuse
Divorce

ACEs are Common



n=200,000 adults in the 2011-2014 BRFSS

Merrick et al. JAMA Pediatrics 2018.

Prevalence of ACEs by Socio-Demographic Group From the 2011-2014 BRFSS in 23 States

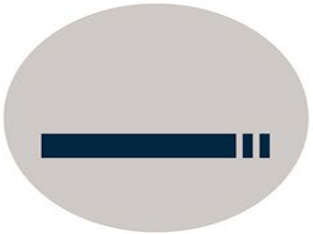
Socio-Demographic Group	Mean ACE Score (95% CI)
Bisexual	3.14 (2.82-3.46)
Lesbian/gay	2.19 (1.95-2.43)
Straight	1.60 (1.57-1.63)
Multiracial	2.52 (2.36-2.67)
Hispanic	1.80 (1.70-1.91)
Black	1.69 (1.62-1.76)
White	1.52 (1.50-1.54)

JAMA Pediatrics. doi:10.1001/jamapediatrics.2018.2537

Dose-Response Relationship with Health Outcomes

BEHAVIOR

Lack of physical activity



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PHYSICAL & MENTAL HEALTH

Severe obesity

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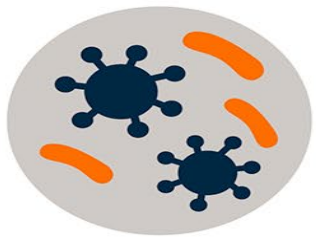
Suicide attempts



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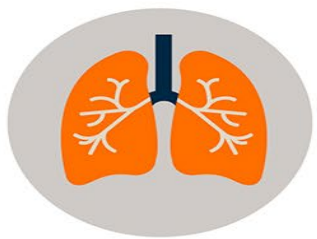
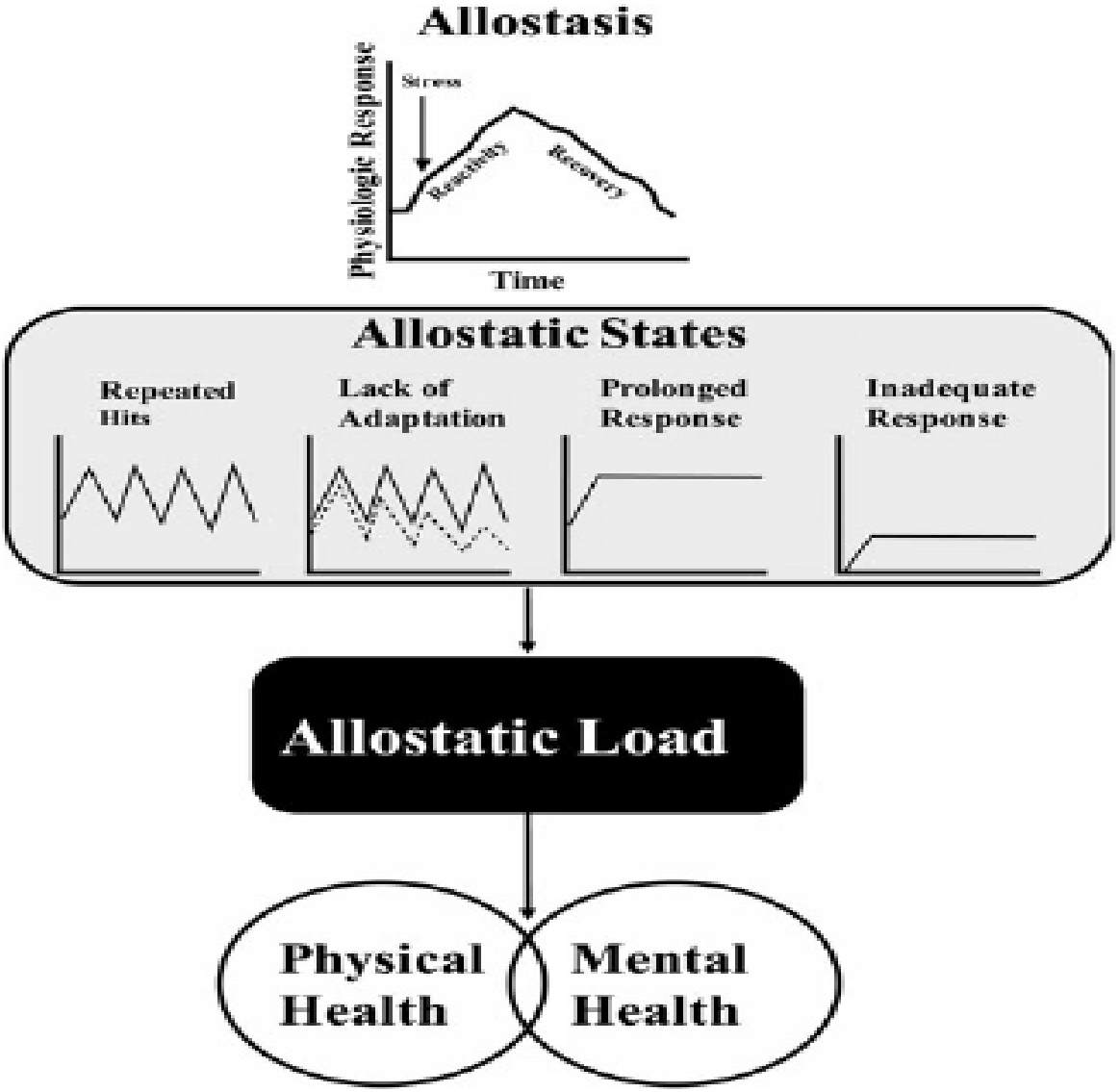


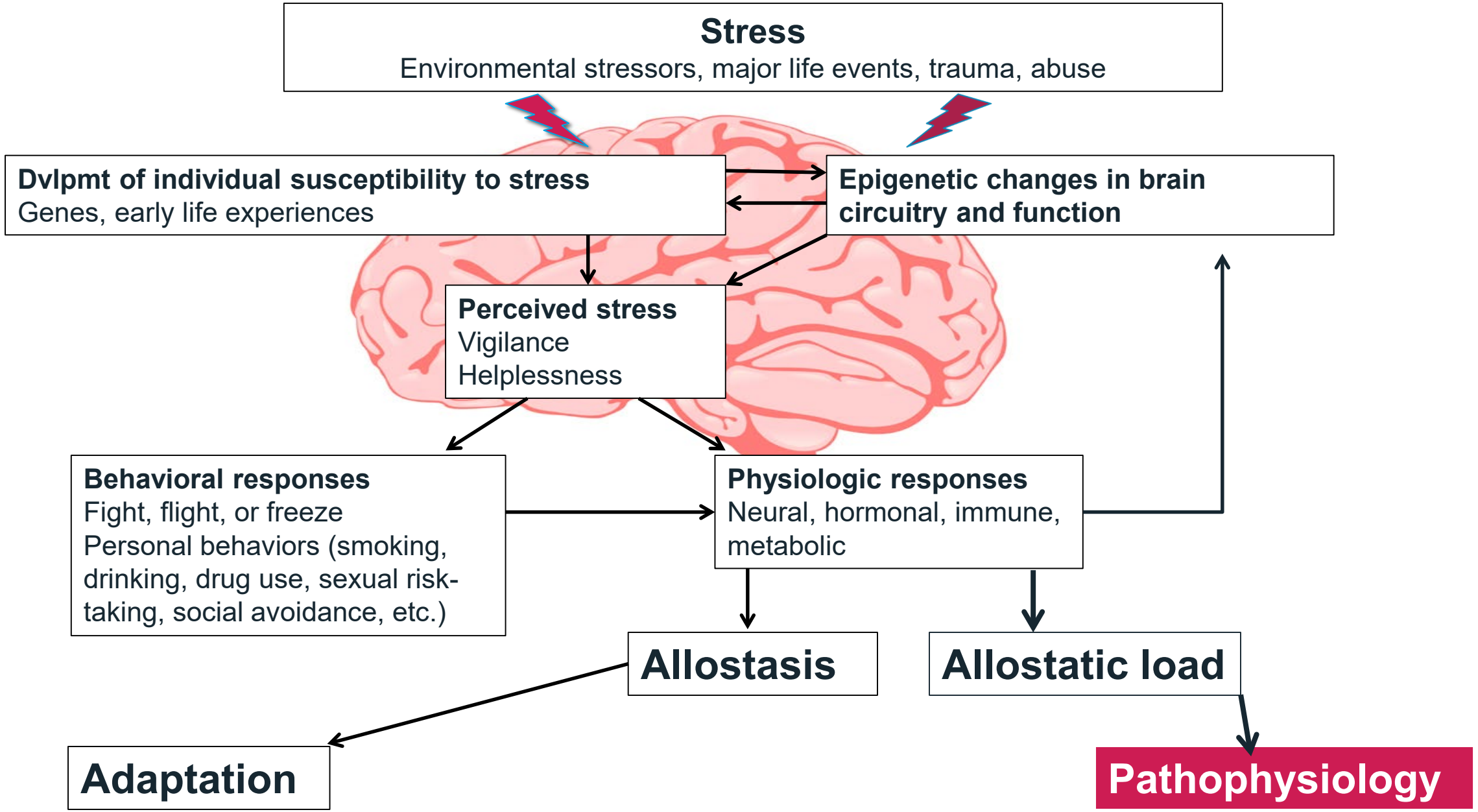
COPD

Broken bones

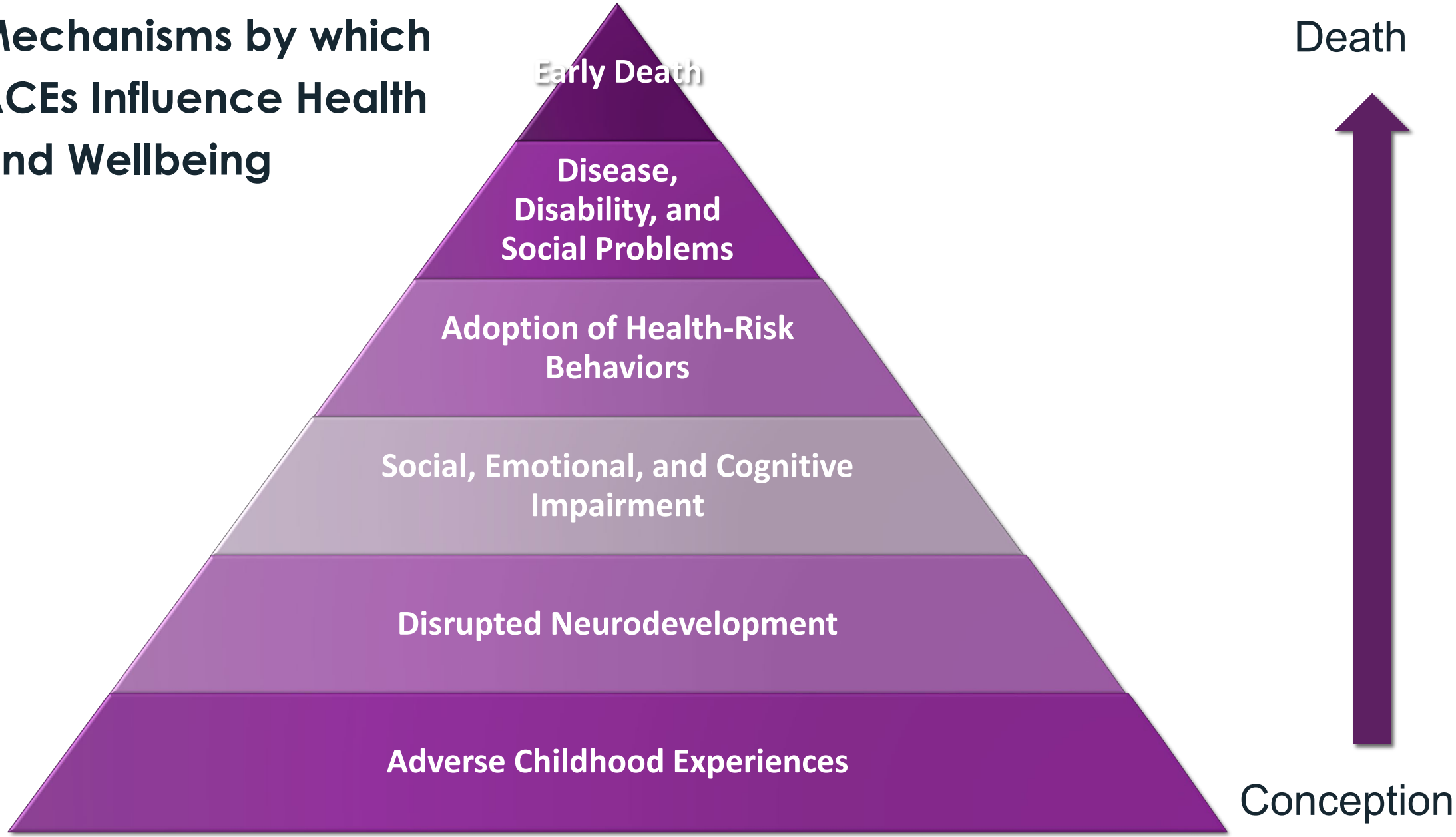
https://blog.cloudhq.net/tag/creativity/



McEwen BS. NEJM 1998;338:171-9.
McEwen. JAMA Psychiatry. 2017.


Stress
Environmental stressors, major life events, trauma, abuse
Dvlpmt of individual susceptibility to stress
Genes, early life experiences
Epigenetic changes in brain circuitry and function
Perceived stress
Vigilance
Helplessness
Behavioral responses
Fight, flight, or freeze
Personal behaviors (smoking, drinking, drug use, sexual risk-taking, social avoidance, etc.)
Physiologic responses
Neural, hormonal, immune, metabolic
Allostasis
Allostatic load
Adaptation
Pathophysiology

Mechanisms by which ACEs Influence Health and Wellbeing



Dino *(Part 3)*

During middle school, Dino was bullied because he didn't "act like a girl is supposed to act." He started smoking (cigarettes and marijuana), binge drinking, and having unprotected sex with peers of diverse genders. At age 13, Dino went to a clinic because of heavy bleeding, and was told he was having a miscarriage. The provider was abrupt, rough, and gave him a prescription for the pill, saying, "Be a smart girl and don't let this happen again." Soon after, Dino spent time in juvenile detention after repeated episodes of shoplifting and truancy. At 16, he dropped out of school.

Question:

- What traumatic experiences besides ACEs did Dino have to endure?

LGBTQ Youth: Bullying & Incarceration

Negative Experiences When Seeing a Health Care Provider in the Past Year (2015 Trans Health Survey)

Negative Experience	%
Had to teach HCP about transgender people in order to get appropriate care	24%
HCP asked unnecessary or invasive questions about their transgender status that were not related to the reason for the visit	15%
HCP refused to give them transition-related care	8%
Verbally harassed in a healthcare setting	6%
HCP used harsh or abusive language when treating them	5%
HCP refused to give them routine care unrelated to gender transition	3%
HCP was physically rough or abusive when treating them	2%
Physically attacked by someone during their visit in a healthcare setting	1%
Sexually assaulted in a healthcare setting	1%
One or more negative experiences listed	**33%**

What Hurts?

Systems Level ("Way Things Are Done")	Relationship Level (Who Has Power/Control)
Being treated as a number	Not being seen or heard
Being seen as one's label (i.e., "addict")	Violating trust
Having to continually retell one's story	Failing to ensure emotional safety
Procedures that require disrobing	Failure to ensure physical safety
No choice in service or treatment	Does things "to", "on", or "for" rather than "with"
No opportunity to give feedback about service delivery	Use of punitive treatment, coercive practices, or oppressive language

Dino *(Part 4)*

From 16-19, Dino continued to get high a lot and had a hard time holding down a job. He got involved with a series of partners of diverse genders. One of them got mad if Dino wanted to see his friends and tracked where he went electronically. Luckily, that relationship ended when the partner moved away, but by then Dino was isolated and miserable. Because of his previous healthcare experience, he was too scared to seek help. At age 20, Dino overdosed on acetaminophen.

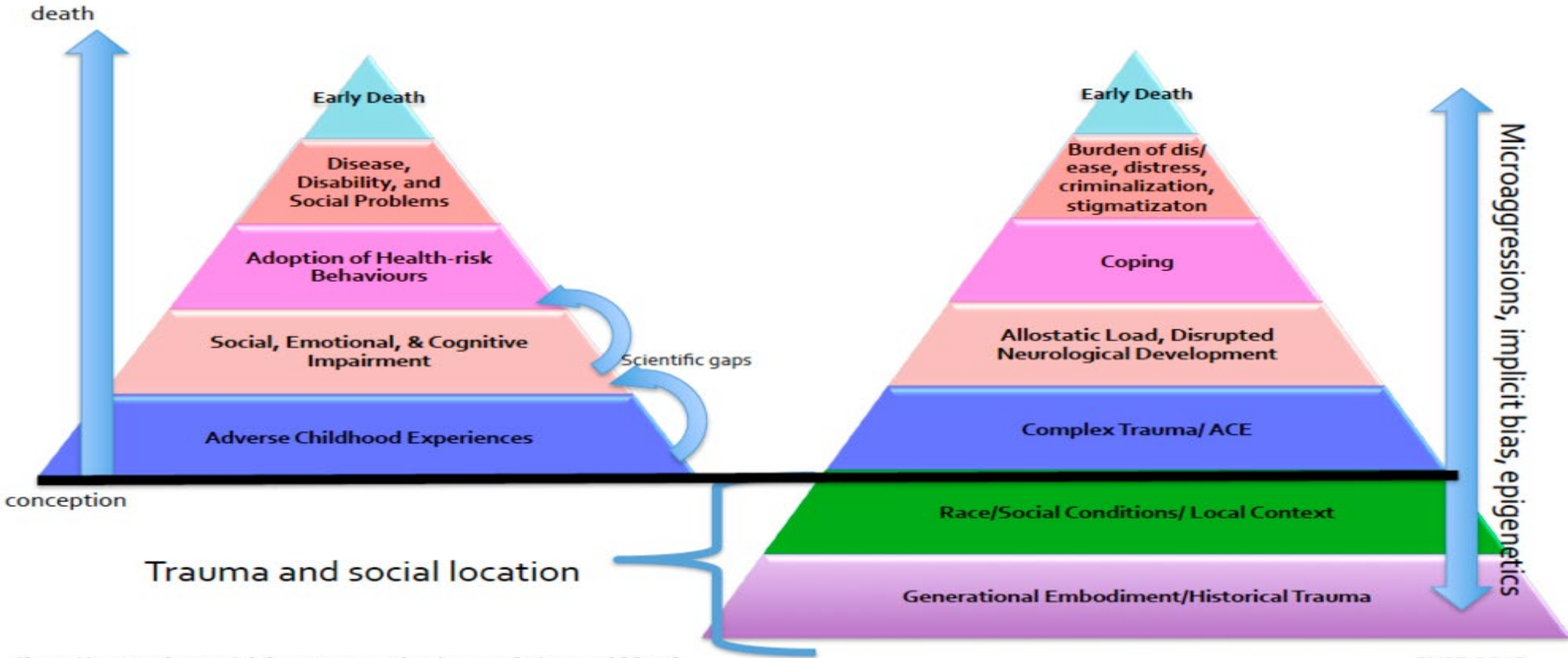
Question:

- Why didn't Dino seek mental health care sooner?

Trauma and Social Location

Adverse Childhood Experiences*

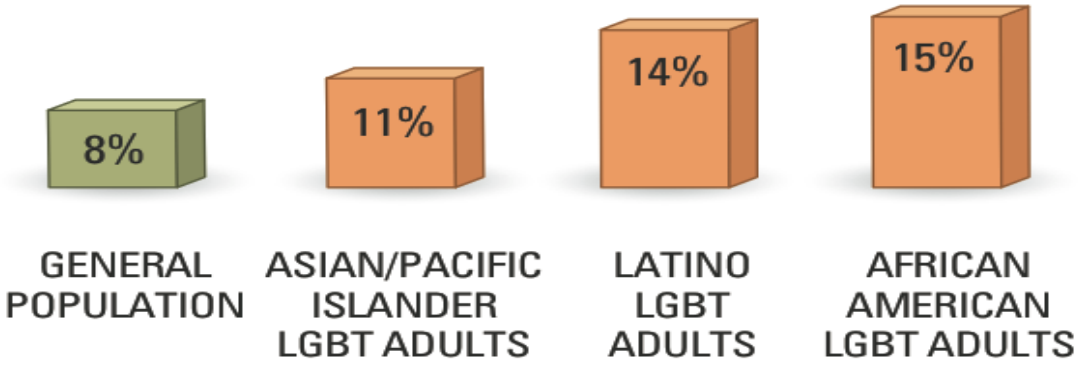
Historical Trauma/Embodiment

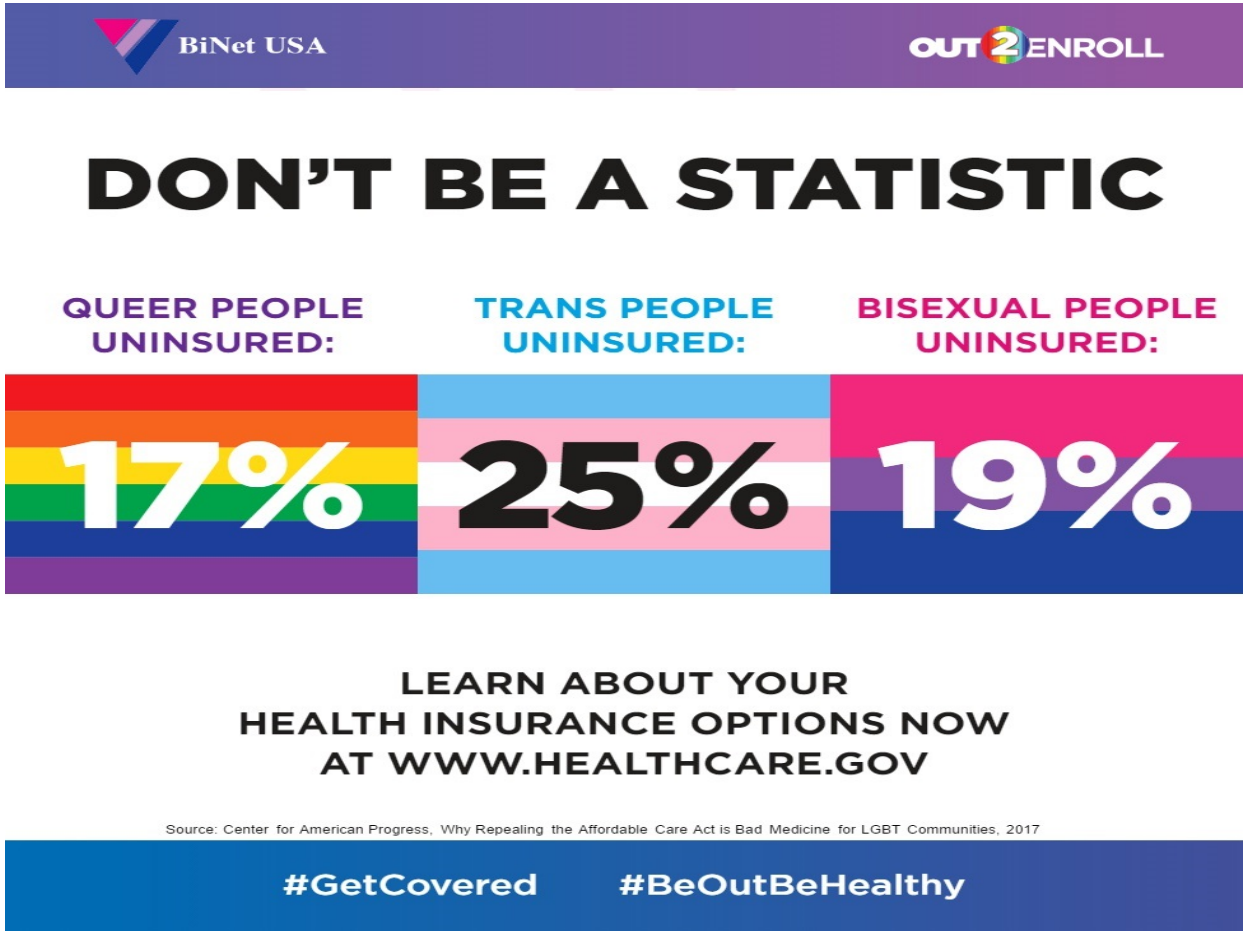


*http://www.cdc.gov/violenceprevention/acestudy/pyramid.html

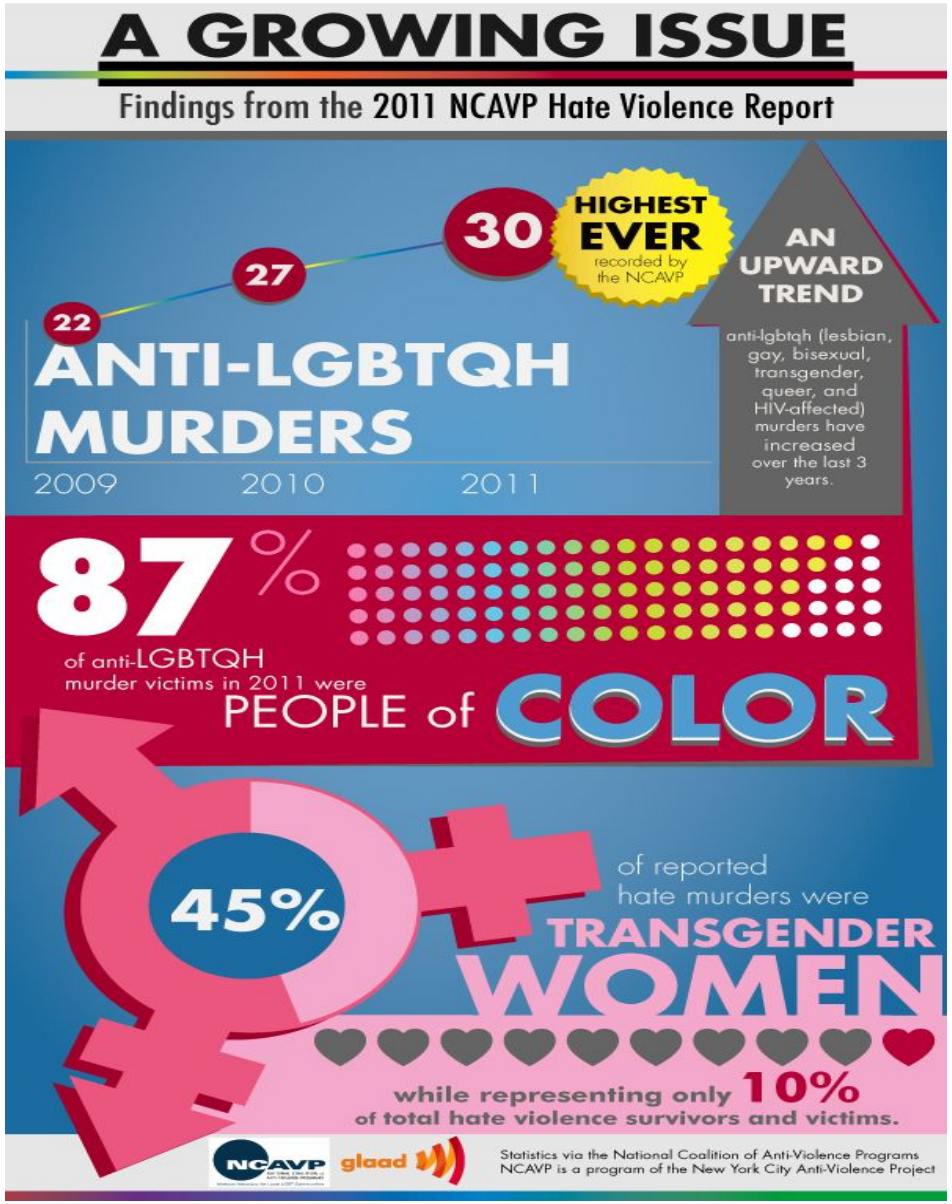
Unemployed, Uninsured, Living in Poverty

HIGHER UNEMPLOYMENT RATES FOR LGBT PEOPLE OF COLOR

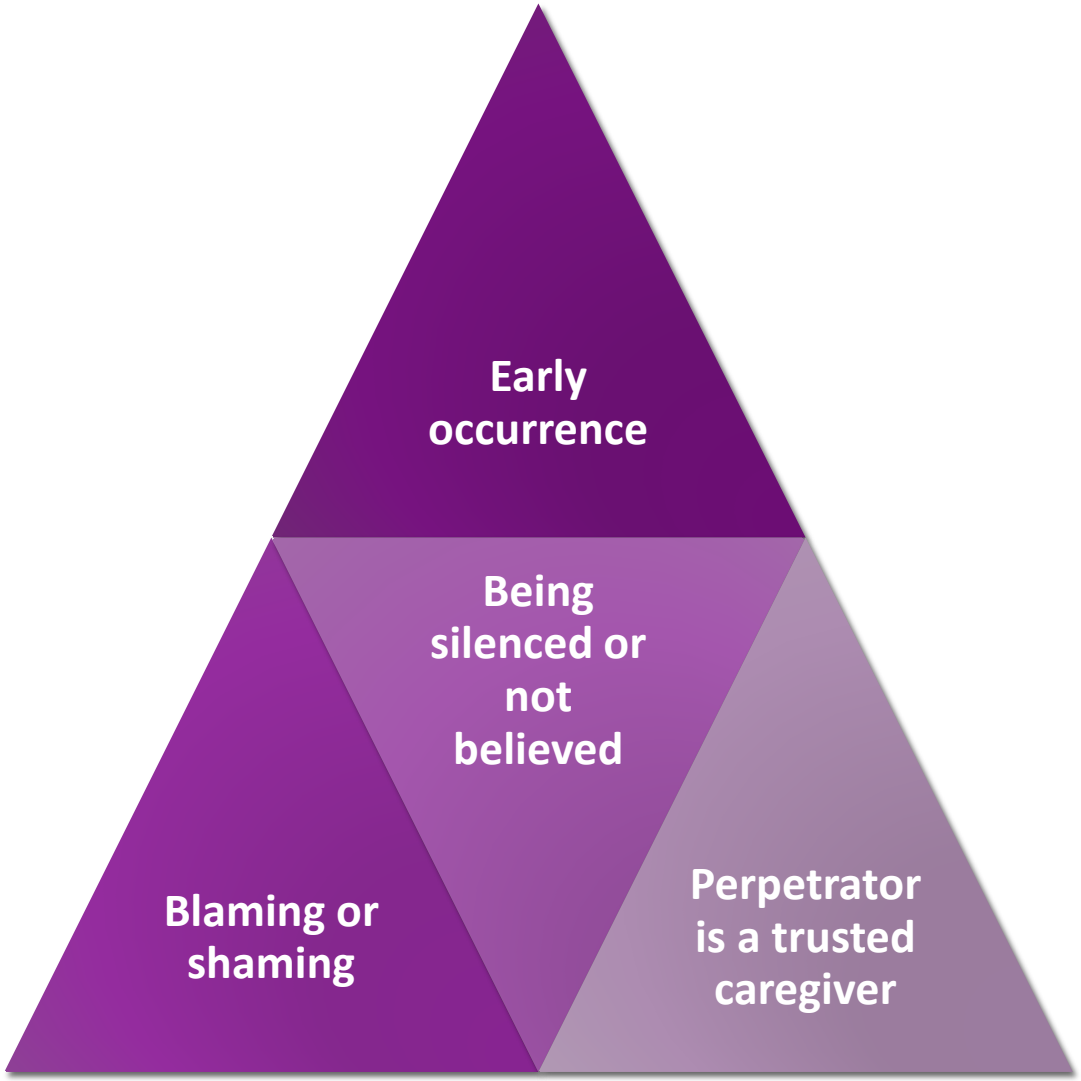





LGBTQ &
Domestic Violence
from DomesticShelters.org
The facts about LGBT partner abuse/domestic violence are often hidden by numerous myths and misconceptions. Common myths and misconceptions include the belief that women are not violent, that men are not commonly victims, that LGBT domestic violence is mutual, and that there are no significant differences between heterosexual domestic violence and same-gender domestic violence. However, people who are lesbian, gay and bisexual have an equal or higher prevalence of experiencing intimate partner violence, sexual violence and stalking as compared to heterosexuals.
44%
61%
35%
26%
37%
29%
experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
NEARLY HALF
There are many similarities between how abusers control their victims regardless of sexual preference.
domesticshelters.org


A GROWING ISSUE
Findings from the 2011 NCAVP Hate Violence Report
22
27
30
HIGHEST EVER recorded by the NCAVP
AN UPWARD TREND
ANTI-LGBTQH MURDERS
2009
2010
2011
anti-lgbtqh (lesbian, gay, bisexual, transgender, queer, and HIV-affected) murders have increased over the last 3 years.
87%
of anti-LGBTQH murder victims in 2011 were PEOPLE of COLOR
45%
of reported hate murders were TRANSGENDER WOMEN
while representing only 10% of total hate violence survivors and victims.
NCAVP
glaad
Statistics via the National Coalition of Anti-Violence Programs
NCAVP is a program of the New York City Anti-Violence Project

Internalized Homo/Bi/Transphobia



Dino *(Part 5)*

After the overdose, a friend took Dino to the ER, where he underwent a painful gastric lavage procedure and was admitted for observation. A psychiatrist performed an evaluation and noted that Dino was “disengaged” and “withdrawn” but no longer actively suicidal. He was discharged with the phone number of a local mental health clinic.

Question:

- What do you make of Dino's "disengagement" and "withdrawal"?

What is PTSD?

4 symptom clusters

- Avoidance
- Hyperarousal
- Reexperiencing
- Negative thoughts and emotions

Clinically significant distress and impairment

Avoidance

Major mechanism by which PTSD does its damage

- General avoidance
- Emotional avoidance
- Drug and alcohol use
- Avoidance in healthcare settings

Hyperarousal

<u>What it looks like</u>

- Anxious
- Irritable
- Angry
- Impatient
- Easily startled
- Restless
- Scattered
- Terrified
- Fight or flight

Risk Appraisals and Safety Appraisals

- I am not a good judge of when I am safe or when I am at risk
- I don’t feel safe therefore I am at risk
- I can’t evaluate novel situations reliably for safety

Trauma Cognitions about Self

Dino *(Part 6)*

After being discharged from the hospital, Dino's friend took him to a local LGBTQ health center, where he started seeing a primary care provider and a therapist specializing in trauma-informed care. Dino also joined a transgender support group and started taking testosterone. One year later, he felt dramatically better and was starting to make plans for his future.

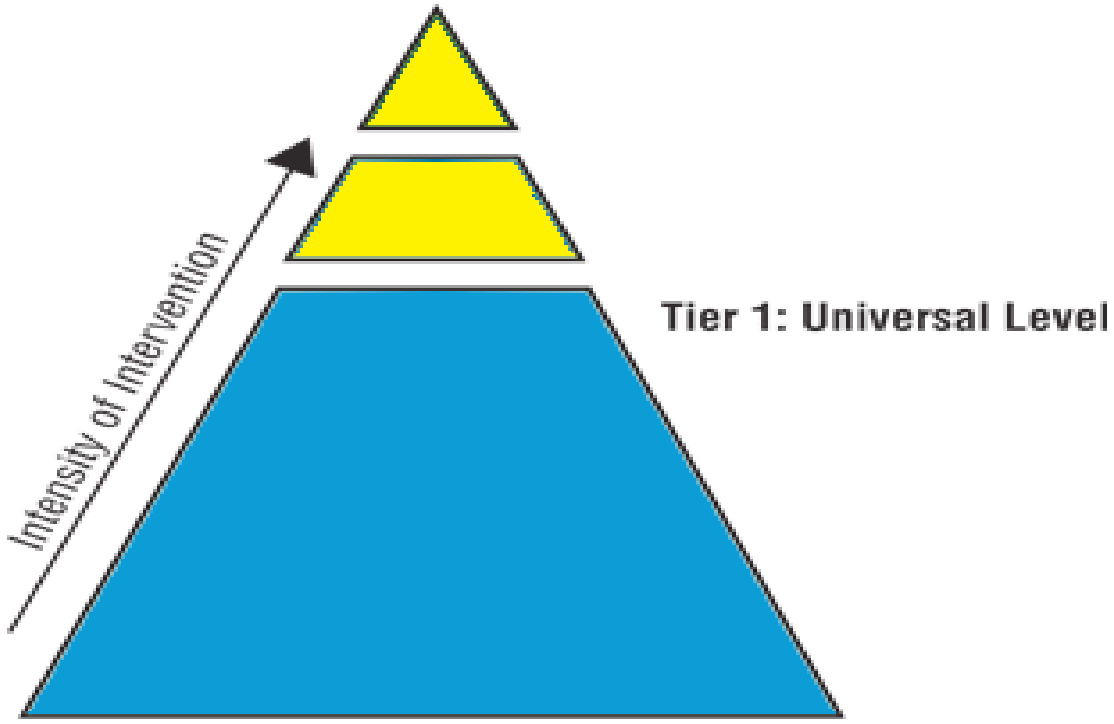
Question:

- What is trauma-informed care?

Trauma-Informed Care: Key Features

- **Universal precautions for all patients**.

- **Trauma-specific interventions for patients with a known trauma history**.



Trauma Informed Care

Trauma Informed Care (TIC) recognizes that traumatic experiences ***terrify, overwhelm and violate*** the individual. TIC is a commitment not to repeat these experiences and, in whatever way possible, to **restore a sense of safety, power and worth**.

The Foundations of Trauma Informed Care

Commitment to Trauma Awareness

Understanding the Impact of Historical Trauma and Oppression

Agencies Demonstrate Trauma Informed Care with Policies, Procedures and Practices that:

Create Safe Context through:

- Physical safety
- Trustworthiness
- Clear and consistent boundaries
- Transparency
- Predictability
- Choice

Restore Power through:

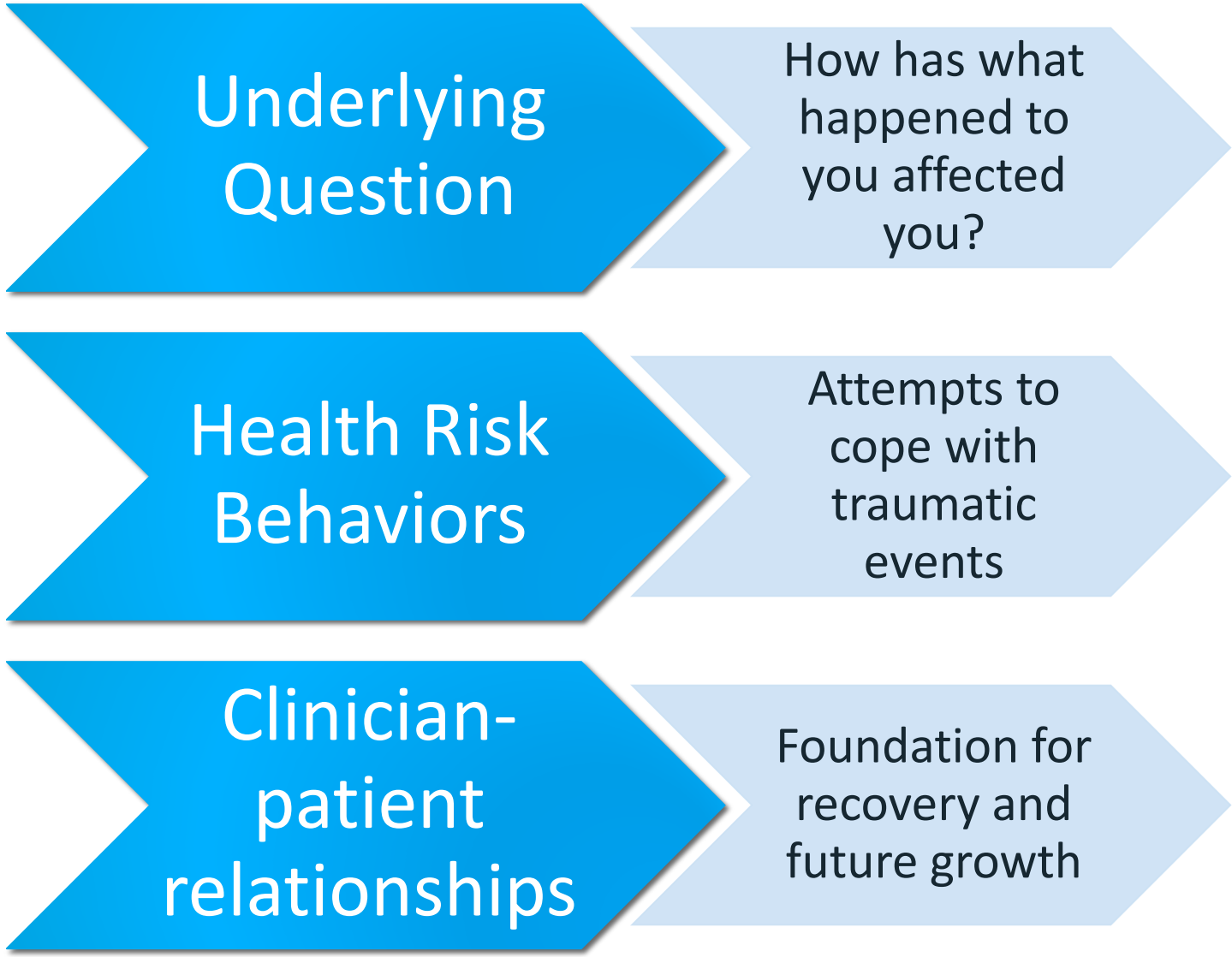
- Choice
- Empowerment
- Strengths perspective
- Skill building

Build Self-Worth through:

- Relationship
- Respect
- Compassion
- Acceptance and Nonjudgment
- Mutuality
- Collaboration

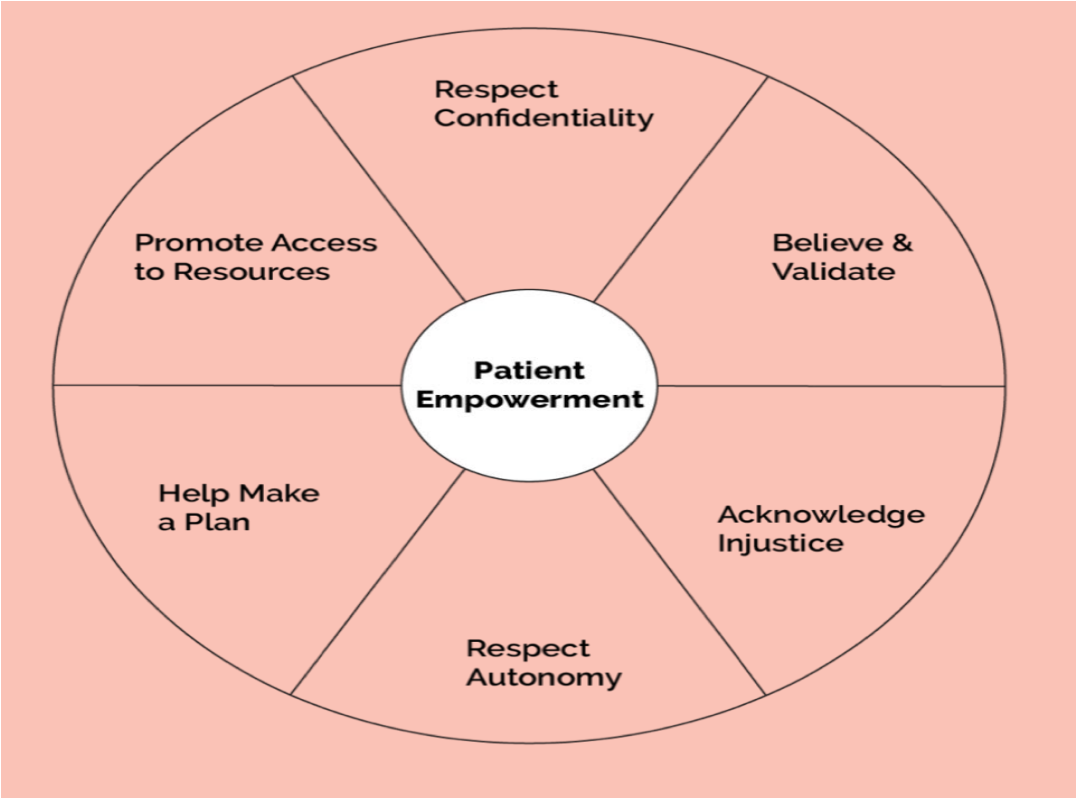
Image Credit: Trauma Informed Oregon, 2014

"WITH", rather than "ON", "TO", or "FOR"


Underlying Question
How has what happened to you affected you?
Health Risk Behaviors
Attempts to cope with traumatic events
Clinician-patient relationships
Foundation for recovery and future growth

General Approach

- Establish and use name and pronouns.
- Sit at eye level.
- Conduct the interview with the patient clothed.
- Speak slowly and clearly.
- Develop a shared agenda.
- Offer treatment choices.
- Locus of control with the patient at all times.



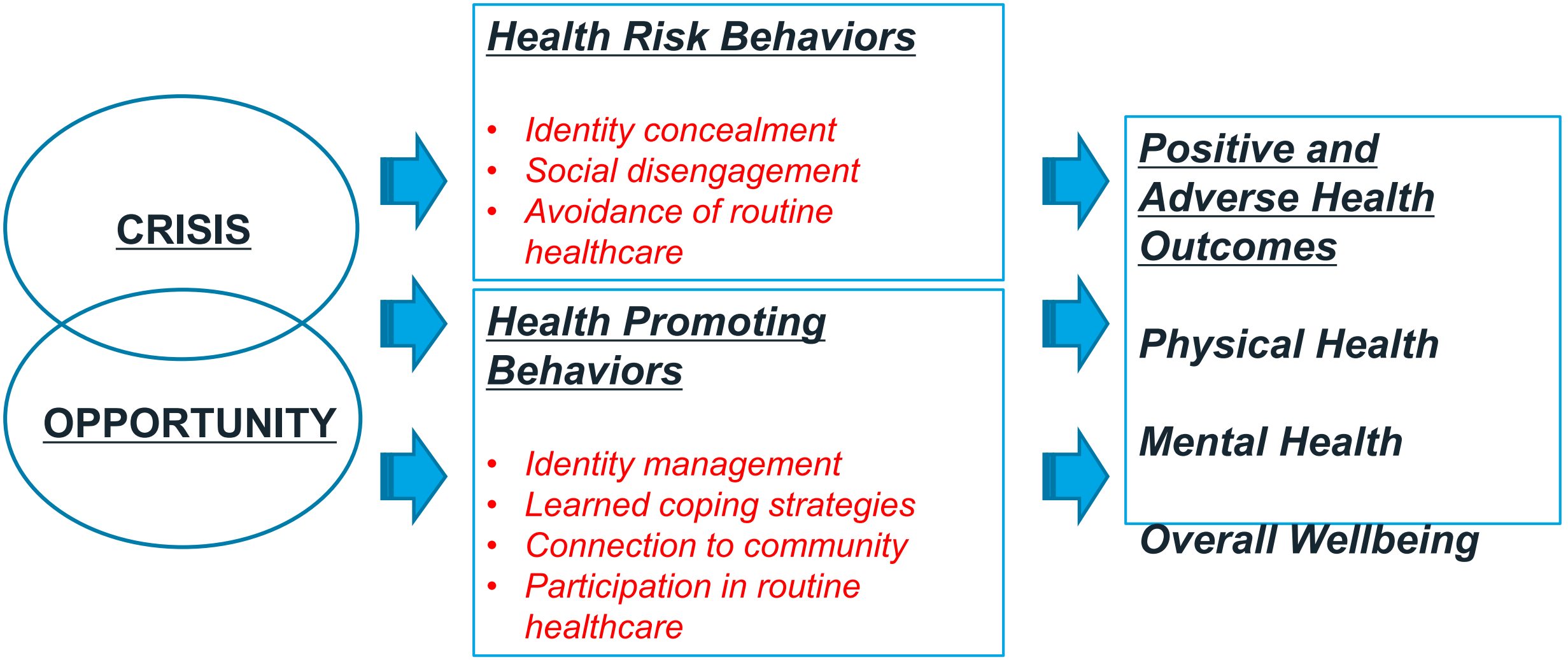
General Questions

- Have you had any significant or traumatic life experiences that you think it would be helpful for me to know about?
- How comfortable do you feel navigating the world with the identities you've told me about?
- Have you ever experienced discrimination or harassment because of any of your identities?
- How often do you find yourself concealing your [identities]?

Questions about Coping/Resilience

- How do you cope with [stressful experiences][the fact that life can be unfair]?
- Sometimes people are deeply affected by stressful experiences, and may feel depressed, anxious, or use drugs/ alcohol to feel better. Has this ever happened to you?
- Who do you turn to when you need support [family][friends][the community]?
- What brings you joy?

Minority Stress and Adaptive Coping



Screening for Trauma

Considerations

- Trained staff
- Screener administered in private, without companion or partner present
- Opt out option provided
- Clinician sees and discusses result at the visit
- Referral resources available, preferably on-site

IPV Screener
Adapted from the Abuse Assessment Screener*

In the past year, did a current or former partner…

1) Make you feel cut off from others, trapped, or controlled in a way you did not like?
2) Make you feel afraid that they might try to hurt you in some way?
3) Pressure or force you to do something sexual that you didn't want to do?
4) Hit, kick, punch, slap, shove, or otherwise physically hurt you?

McFarlane et al. JAMA 1992;267:3176-8.

Primary Care-PTSD Screener

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:*

1. Have had nightmares about it or thought about it when you did not want to?	Yes or No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes or No
3. Were constantly on guard, watchful, or easily startled?	Yes or No
4. Felt numb or detached from others, activities, or your surroundings?	Yes or No

*A score of 3 or higher should prompt additional evaluation.
Source: Prins A et al. *Prim Care Psychiatry*. 2003.[18]

Responding to Disclosure

Acknowledging Injustice

Listen
Communicate belief
“That must have been frightening for you”
Validate the decision to disclose
“I understand it could be very difficult for you to talk about this”
Emphasize the unacceptability of violence
“Violence is unacceptable. I’m sorry that happened, that should not have happened”
Be clear that the patient is not to blame
“What happened is not your fault”
Make a safety plan/Provide resources
Preferably a “warm”, on-site referral

Dino *(Part 7)*

Fast forward to 2019. Dino is now 42 years old and presents with several months of irregular frontal bleeding. His partner tells you she's been trying to convince him to come in to clinic, but "the last time he had one of those exams it was so bad, he is terrified."

Question:

- How would you proceed?

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH

Trauma-Informed Physical Exams and Procedures

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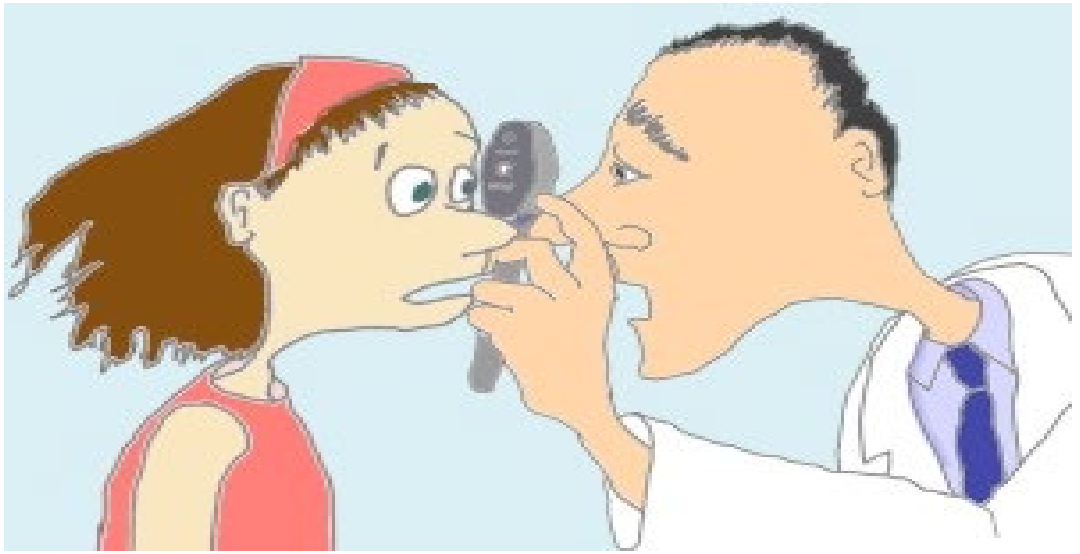
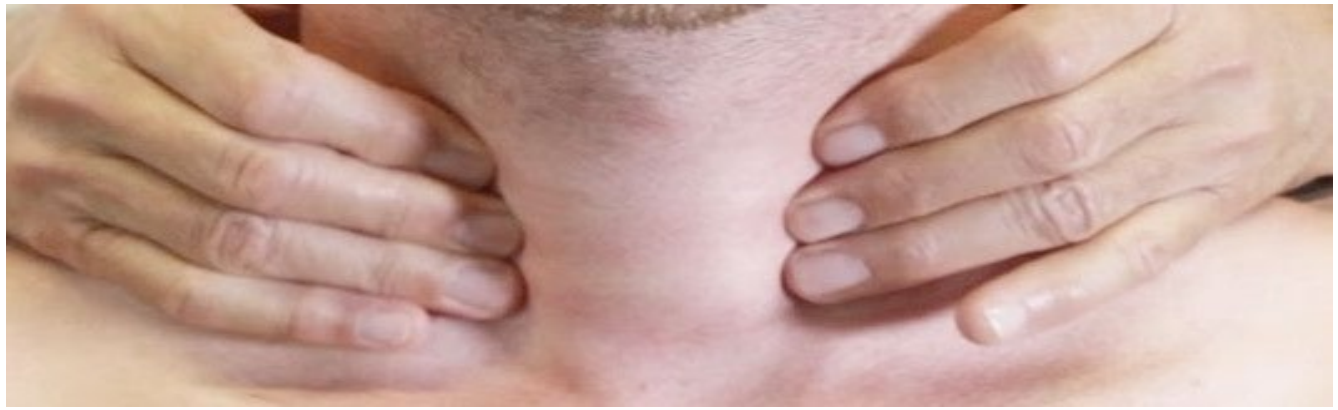
Any exam or procedure has the potential to be traumatizing

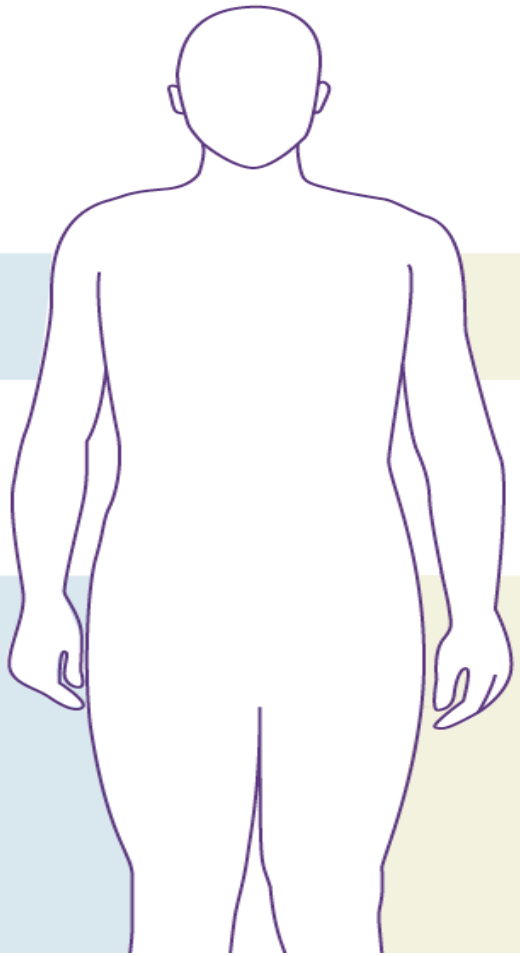




More common with ‘vulnerable’ (i.e., chest, genital, rectal) exams

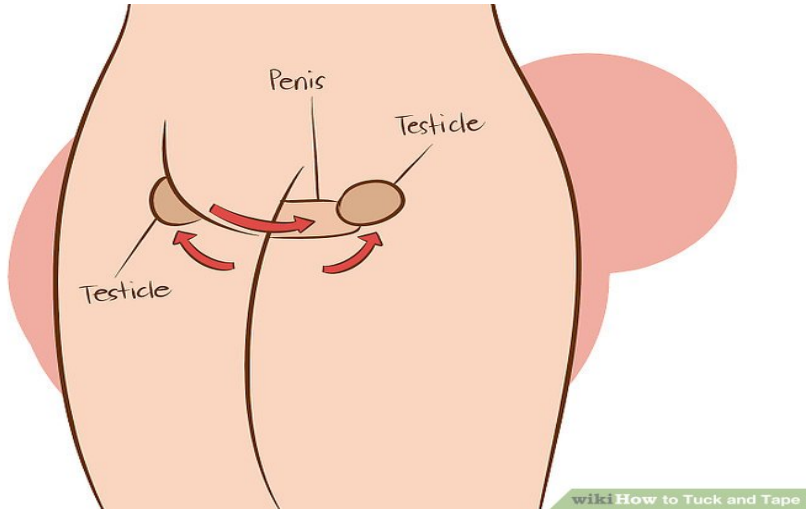
Trans/NB/Intersex Patients

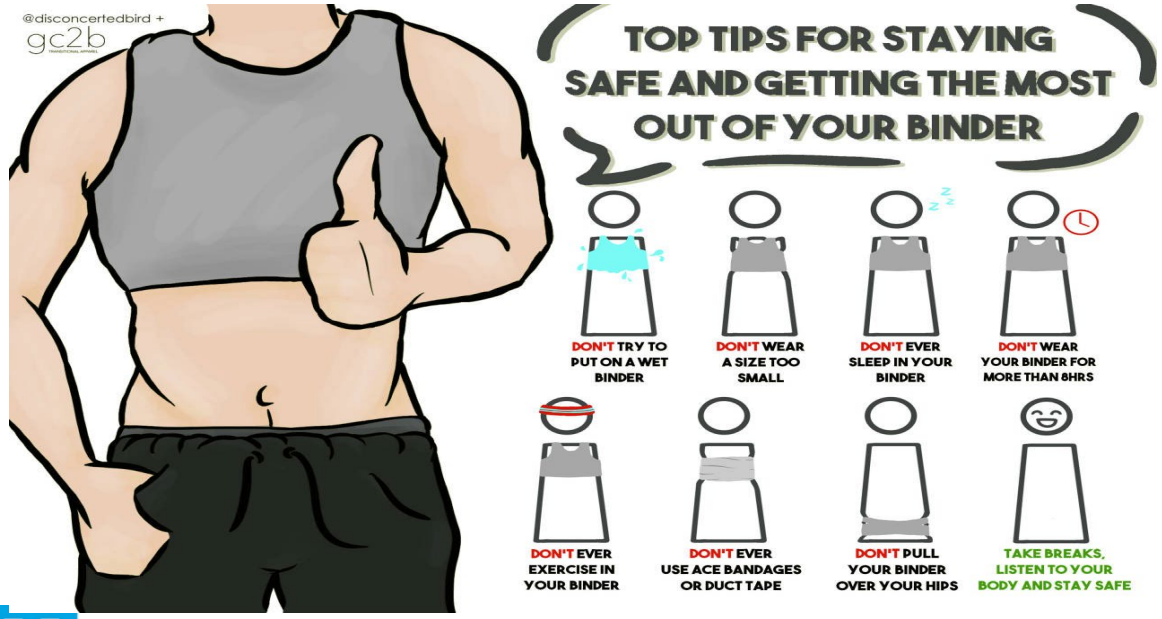
- Prior exposure to traumatic/voyeuristic exams
- Historical tendency to inappropriately gender certain exams (pelvic = “well-woman exam”)
- Dysphoria during examination of body parts that are discordant with one’s gender
- Dysphoria if provider uses triggering terms to refer to body parts

GENDERED TERMS		LESS GENDERED TERMS
These terms may be uncomfortable or distressing for trans men to hear.		Try your best to use neutral and inclusive terminology to avoid patient discomfort. If you are unsure, ask what terms your client prefers.
Breasts		Chest
Vulva		External Pelvic Area
Vagina		Genital Opening, Frontal Pelvic Opening, Internal Canal
Uterus, Ovaries		Internal Organs
Pap smear		Cancer screening
Bra, Panties		Underwear
Period, Menstruation		Bleeding

*Language may be adapted to male external genital, anorectal, prostate exams. JGIM 2015;30:1857-64.

Binding/Tucking





Tucking Tips:

- Using a gaff is the safest route.
- Never use duct tape.
- If it hurts; stop. Give your body a break.
- A tight pair of panties or shape-wear work great.
- High waisted bottoms work best, they help keep everything in place.

Padding/Packing

Evidence-Based Exams

- Avoid exams that are not supported by reliable and consistent evidence (e.g., routine screening CBE, BME, testicular exam).
- Consider less intrusive ways to obtain needed data (e.g., vaginal self-swab for gonorrhea/chlamydia).
- Utilize shared decision-making in the face of uncertain evidence or conflicting guidelines.

Before the Exam

- Review the patient's prior experiences with the exam.
- Explain the purpose and offer to talk through the steps of the exam.
- Ask what you can do to make the experience more comfortable.
- "You're in control here. If you want me to stop at any point, please let me know."

Exam Modifications

Exam Element or Technique	Modification Options
Chaperone	Patient's choice of support person
Positioning for exam	Feet on table rather than 'footrests'
Speculum selection	Pedersen long narrow or pediatric speculum
Lubricant use	• Non-carbomer-containing water-based • Consider use of topical lidocaine
Speculum insertion	Self-insertion
Cervical sampling	Trans male with prior unsat cytology: pretreat with 2 weeks of vaginal estrogen

J Gen Intern Med 2015; 30: 1857-64.

Phrases to Avoid	Use Instead
• Don't be scared, everything will be fine.	• What are you most afraid of? • How can we help you through this?
• Stirrups	• Footrests
• Avoid unnecessary touching of the patient (e.g., "Scoot down on the table until your bottom touches my hand")	• Please move your body down until you're almost hanging off the edge of the table. • Allow your knees to fall to the sides as much as you can.
• I'm going to insert the speculum. • I'm going to come into you now.	• I'm going to place the speculum now. • It's normal to feel a little pressure.
• I'm going to open the blades of the speculum.	• I'm going to open the speculum.
• I'm going to take the sample now… you may feel a "poke" ["prick"].	• You may feel a little discomfort or cramping.
• Hold still	• If you need to move, wiggle your toes/squeeze your hands.
• Relax	• Try to keep your pelvis resting on the table.

Adapted from: J Gen Intern Med 2015; 30: 1857-64.

Dino *(Part 8)*

- Dino agrees to be examined if his partner inserts the speculum and lidocaine gel is used to enhance comfort. The exam is unremarkable. Dino then agrees to a pelvic ultrasound that shows a thickened endometrial lining. After considering various options, Dino chooses to have a complete hysterectomy, which he had been thinking about for some time. He recovers well post-op. Pathology shows endometrial polyps. No further treatment is indicated.

- Question:
  - What would you have done if Dino had become distressed during the exam?
  - What additional resources could you provide to support Dino's recovery?

How to Handle Patient Distress

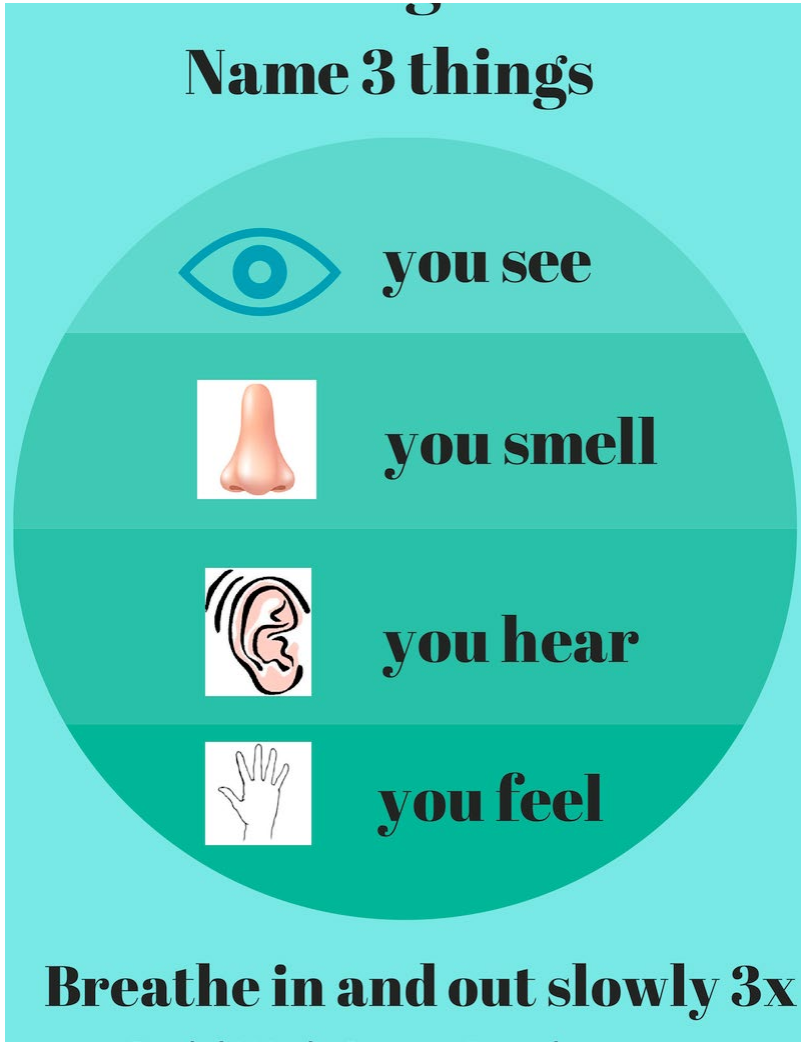
General DOs and DON'Ts

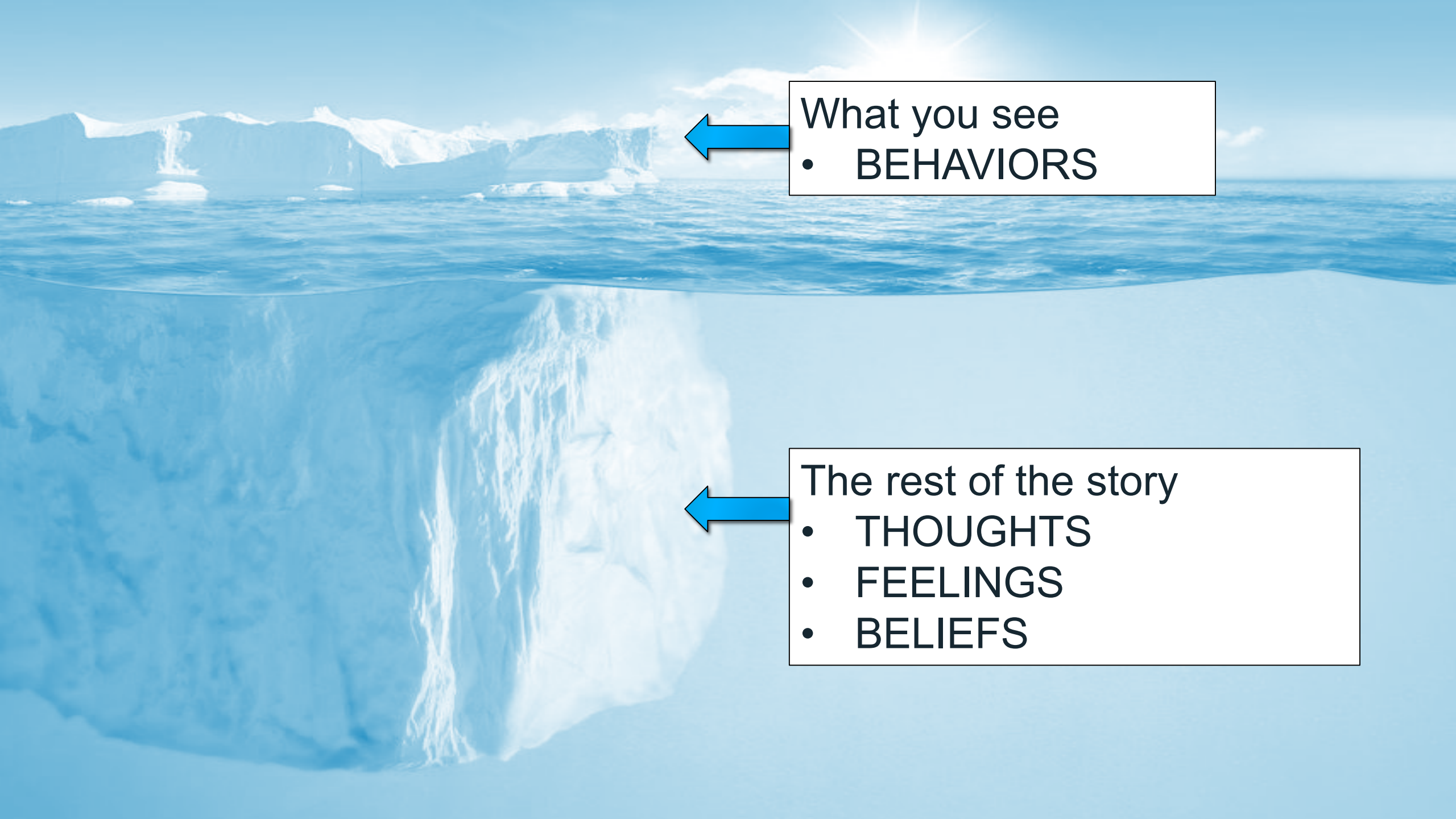
Do:

- Stay calm
- Stop the exam
- Provide reassurance
- Use grounding techniques
- Make a self-care plan

Do not:

- Engage in the trauma
- Bombard with questions




What you see
• BEHAVIORS
The rest of the story
• THOUGHTS
• FEELINGS
• BELIEFS

Reframe What You See

"Angry, aggressive" → Struggling to regain or hold onto personal power

"Disengaged or nonadherent" →

Avoiding or escaping from those in power

"Passive, withdrawn" → Giving in to those in power

If the Patient is Passive / Withdrawn

- Be sensitive to self-worth
  - A patient who doesn't feel worthy of care cannot advocate for themselves.
- Depression is 80% concurrent with PTSD
  - Patient could be experiencing depression-related withdrawal in addition to anxiety-related avoidance.
- Simply making it into your office is a show of strength.

If the Patient is Dissociated

- In a traumatized patient, dissociation can be a withdrawal response to high levels of acute distress.
- Dissociation can be a sign of serious mental health problems.
- Help the patient to reconnect with their immediate surroundings
  - Withdraw task demands
  - Provide simple, reassuring statements
  - Orient the patient to the present time, place, and situation.

If the Patient is Angry / Aggressive

- Finding a therapeutic stance can be challenging.
- Recognize that anger is rooted in hyperarousal-driven anxiety and fear that they are not safe.
- Provide reassurances/prepare for multiple angry responses.
- Ending the appointment may be the best solution.
- Be prepared to enact your own safety plan.

Trauma-Specific Treatment

PTSD Treatment Works

There are more options than ever for successful PTSD treatment

What are my treatment options?

MEDICATION OPTIONS

DURATION: Continuous

Antidepressant Medications

HOW IT WORKS

Treats sadness, anger, and numb feelings that contribute to your PTSD symptoms.

TALK THERAPY OPTIONS

DURATION: Usually 8-15 sessions with long-lasting effects

Cognitive Processing Therapy

HOW IT WORKS

You learn balanced ways to think about your trauma.

Prolonged Exposure

HOW IT WORKS

You talk about your trauma and approach the situations you've been avoiding.

Eye Movement Desensitization and Reprocessing

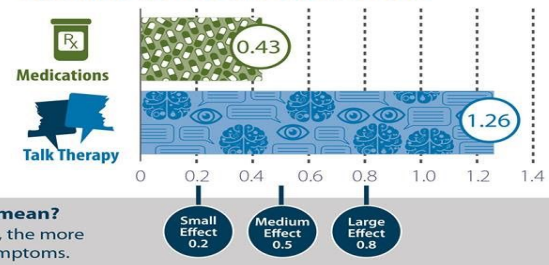
HOW IT WORKS

You focus on hand movements while thinking about your trauma and change your reactions to it.

How effective are these treatments?

Both medication and talk therapy can help to treat your symptoms. Your customized treatment plan may include one or more of these options.

TREATMENT EFFECTS ON PTSD SYMPTOMS



What do the numbers mean?
The greater the effect size, the more noticeable a change in symptoms.

Small Effect 0.2 | Medium Effect 0.5 | Large Effect 0.8

Next steps? Talk to your health care provider.

- Which treatments are right for me?
- How long will I need treatment?
- How soon will I start to feel better?
- **When can I start?**

For more information about PTSD treatment options, visit **www.PTSD.va.gov**

August 2015 | **SOURCE** Watts, B. V., Schnurr, P. P., Mayo, L., Young-Zu, Y., Weeks, B. B., & Friedman, M. J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. The Journal of Clinical Psychiatry, 74(6), pp. e541-50.

The National Domestic Violence
HOTLINE
1.800.799.SAFE (7233) • 1.800.787.3224 (TTY)

NCAVP
NATIONAL COALITION *of* ANTI-VIOLENCE PROGRAMS
National Advocacy for Local LGBTQ Communities

love is respect org
National Teen Dating Abuse Helpline

FORGE
Trauma, Transgender, and Aging
www.forge-forward.org

National Sexual Assault Hotline
800.656.HOPE
online.rainn.org
Free. Confidential. 24/7
RAINN

theNetworkLaRed
Survivor-led organizing to end partner abuse
Dirigida por sobrevivientes • Movilizando para acabar con el abuso de pareja

IN TRANSGENDER HEALTH

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