Trauma Informed Care

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The Fenway Institute
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?
“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.”
Trauma is Ubiquitous

Occurs at Multiple Levels

ADVERSE CHILDHOOD EXPERIENCES
ISMS AND PHOBIAS
MICRO-AGGRESSIONS
ABUSE AND VIOLENCE
HISTORIAL AND STRUCTURAL TRAUMA
ABUSES AND VIOLENCE
MEDICAL DIAGNOSIS AND TREATMENT
POLITICAL AND ECONOMIC TRAUMA
WAR AND TERRORISM
COMMUNITY VIOLENCE
NATURAL DISASTERS
ACCIDENTS AND INJURIES
HISTORICAL AND STRUCTURAL TRAUMA
LEAVES
BETRAYAL
MAJOR LIFE TRANSITIONS
ADVERSE CHILDHOOD EXPERIENCES
WITNESSING
POVERTY
MEDICAL DIAGNOSIS AND TREATMENT
LOSS
VARIOUS AGENTS OF INJURY
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

Adverse Childhood Experiences (ACEs)

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce
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**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
ACEs are Common

- 0 ACEs: 38%
- 1 ACE: 24%
- 2 ACEs: 13%
- 3 ACEs: 9%
- 4+ ACEs: 16%

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

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

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

Dose-Response Relationship with Health Outcomes

0 ACEs  1 ACE  2 ACEs  3 ACEs  4+ ACEs
<table>
<thead>
<tr>
<th><strong>BEHAVIOR</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of physical activity</td>
<td>Smoking</td>
</tr>
<tr>
<td>Smoking</td>
<td>Alcoholism</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Drug use</td>
</tr>
<tr>
<td>Drug use</td>
<td>Missed work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PHYSICAL &amp; MENTAL HEALTH</strong></th>
<th></th>
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<tbody>
<tr>
<td>Severe obesity</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Depression</td>
</tr>
<tr>
<td>Depression</td>
<td>Suicide attempts</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>STDs</td>
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<tr>
<td>STDs</td>
<td></td>
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<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>Heart disease</td>
<td>Cancer</td>
</tr>
<tr>
<td>Cancer</td>
<td>Stroke</td>
</tr>
<tr>
<td>Stroke</td>
<td>COPD</td>
</tr>
<tr>
<td>COPD</td>
<td>Broken bones</td>
</tr>
</tbody>
</table>
Stress
Environmental stressors, major life events, trauma, abuse

Development 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
Pathophysiology

Adaptation
Mechanisms by which ACEs Influence Health and Wellbeing

- Early Death
- Disease, Disability, and Social Problems
- Adoption of Health-Risk Behaviors
- Social, Emotional, and Cognitive Impairment
- Disrupted Neurodevelopment
- Adverse Childhood Experiences

Death

Conception

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
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

Schools are unsafe and unwelcoming for the majority of LGBT students.

- 65% heard homophobic remarks like “fag” or “dyke” frequently or often
- 30% missed at least one day of school in the past month because they felt unsafe or uncomfortable
- 85% were verbally harassed in the past year

Learn more in GLSEN’s latest National School Climate Survey at GLSEN.org/NSCS

LGBTQ Youth Incarcerated in the Juvenile Justice System

- 95% are youth of color

LGBTQ Youth in Juvenile Justice Facilities

- Inadequate Health Care
- Inappropriate Placement
- Abuse by Other Youth
- Little Oversight of Facilities
- Lack of Supportive Services
- Challenging Us with Family Visitation

The Facts

- OF ALL YOUTH NATIONWIDE
- OF ALL YOUTH IN JUVENILE FACILITIES
- OF BOYS IN JUVENILE FACILITIES
- OF GIRLS IN JUVENILE FACILITIES

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

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

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

Higher Unemployment Rates for LGBT People of Color

General Population: 8%
Asian/Pacific Islander LGBT Adults: 11%
Latino LGBT Adults: 14%
African American LGBT Adults: 15%

Don’t Be a Statistic

Queer People Uninsured: 17%
Trans People Uninsured: 25%
Bisexual People Uninsured: 19%

Learn about your health insurance options now at www.healthcare.gov

#GetCovered  #BeOutBeHealthy

Source: Center for American Progress, Why Repealing the Affordable Care Act is Bad Medicine for LGBT Communities, 2017
LGBTQ & Domestic Violence

The facts about LGBTQ 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 LGBTQ domestic violence is mutual, and that there are no significant differences between heterosexual domestic violence and same-sex 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% of women
61% of bisexual women
35% of lesbian women

There are many similarities between how abusers control their victims regardless of sexual preference. In LGBTQ relationships, the abuser may use the additional tactic of threatening to "out" their victims to work colleagues, family, and friends.

26% of gay men
37% of bisexual men

Nearly Half

29% of medication users
5% of food
9% of water

Anti-LGBTQH Murders

2009
2010
2011

22
27
30

HIGHEST EVER

30% increase over the last 3 years.

87% of anti-LGBTQH murder victims in 2011 were PEOPLE of COLOR

45% of reported hate murders were WOMEN

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
Internalized Homo/Bi/Transphobia

- Early occurrence
- Being silenced or not believed
- Blaming or shaming
- Perpetrator is a trusted caregiver
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

What it looks like

- 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

- I can't do it
- I'm not worthy
- I must not make a mistake
- I'm not good enough
- Nobody loves me
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 (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

Health Risk Behaviors
- Identity concealment
- Social disengagement
- Avoidance of routine healthcare

Health Promoting Behaviors
- Identity management
- Learned coping strategies
- Connection to community
- Participation in routine healthcare

Positive and Adverse Health Outcomes
- Physical Health
- Mental Health
- Overall Wellbeing
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?

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:*

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

* A score of 3 or higher should prompt additional evaluation.
### Responding to Disclosure

#### Acknowledging Injustice

<table>
<thead>
<tr>
<th><strong>Listen</strong></th>
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</table>

<table>
<thead>
<tr>
<th><strong>Communicate belief</strong></th>
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</thead>
<tbody>
<tr>
<td>“That must have been frightening for you”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Validate the decision to disclose</strong></th>
</tr>
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<tbody>
<tr>
<td>“I understand it could be very difficult for you to talk about this”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emphasize the unacceptability of violence</strong></th>
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<tbody>
<tr>
<td>“Violence is unacceptable. I’m sorry that happened, that should not have happened”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Be clear that the patient is not to blame</strong></th>
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<tbody>
<tr>
<td>“What happened is not your fault”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Make a safety plan/Provide resources</strong></th>
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<tr>
<td>Preferably a “warm”, on-site referral</td>
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**ADVANCING EXCELLENCE IN TRANSGENDER HEALTH**
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?
ASK FIRST

Trauma-Informed Physical Exams and Procedures
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

These terms may be uncomfortable or distressing for trans men to hear.

Breasts
Vulva
Vagina
Uterus, Ovaries
Pap smear
Bra, Panties
Period, Menstruation

LESS GENDERED TERMS

Try your best to use neutral and inclusive terminology to avoid patient discomfort. If you are unsure, ask what terms your client prefers.

Chest
External Pelvic Area
Genital Opening, Frontal Pelvic Opening, Internal Canal
Internal Organs
Cancer screening
Underwear
Bleeding

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

TOP TIPS FOR STAYING SAFE AND GETTING THE MOST OUT OF YOUR BINDER

- Don’t try to put on a wet binder
- Don’t wear a size too small
- Don’t ever sleep in your binder
- Don’t ever wear your binder for more than 8 hours
- Don’t ever exercise in your binder
- Don’t use ace bandages or duct tape
- Don’t pull your binder over your hips
- Take breaks, listen to your body and stay safe

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

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

<table>
<thead>
<tr>
<th>Phrases to Avoid</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Don’t be scared, everything will be fine.</td>
<td>• What are you most afraid of? • How can we help you through this?</td>
</tr>
<tr>
<td>• Stirrups</td>
<td>• Footrests</td>
</tr>
<tr>
<td>• Avoid unnecessary touching of the patient (e.g., “Scoot down on the table until your bottom touches my hand”)</td>
<td>• 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.</td>
</tr>
<tr>
<td>• I’m going to insert the speculum.</td>
<td>• I’m going to place the speculum now. • It’s normal to feel a little pressure.</td>
</tr>
<tr>
<td>• I’m going to come into you now.</td>
<td></td>
</tr>
<tr>
<td>• I’m going to open the blades of the speculum.</td>
<td>• I’m going to open the speculum.</td>
</tr>
<tr>
<td>• I’m going to take the sample now... you may feel a “poke” [“prick”].</td>
<td>• You may feel a little discomfort or cramping.</td>
</tr>
<tr>
<td>• Hold still</td>
<td>• If you need to move, wiggle your toes/squeeze your hands.</td>
</tr>
<tr>
<td>• Relax</td>
<td>• Try to keep your pelvis resting on the table.</td>
</tr>
</tbody>
</table>
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

Breathe in and out slowly 3x

Name 3 things
- you see
- you smell
- you hear
- you feel

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
What you see
- BEHAVIORS

The rest of the story
- THOUGHTS
- FEELINGS
- BELIEFS
Reframe What You See

FIGHT

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

FLIGHT

“Disengaged or nonadherent” → Avoiding or escaping from those in power

FREEZE

“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?**

<table>
<thead>
<tr>
<th>MEDICATION OPTIONS</th>
<th>TALK THERAPY OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION:</strong> Continuous</td>
<td><strong>DURATION:</strong> Usually 8-15 sessions with long-lasting effects</td>
</tr>
<tr>
<td>Antidepressant Medications</td>
<td>Cognitive Processing Therapy</td>
</tr>
<tr>
<td>HOW IT WORKS</td>
<td>HOW IT WORKS</td>
</tr>
<tr>
<td>Treats sadness, anger, and numb feelings that contribute to your PTSD symptoms.</td>
<td>You learn balanced ways to think about your trauma.</td>
</tr>
<tr>
<td></td>
<td>Prolonged Exposure</td>
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<tr>
<td></td>
<td>Eye Movement Desensitization and Reprocessing</td>
</tr>
<tr>
<td></td>
<td>HOW IT WORKS</td>
</tr>
<tr>
<td></td>
<td>You focus on hand movements while thinking about your trauma and change your reactions to it.</td>
</tr>
</tbody>
</table>

**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**

- **Medications:** 0.43
- **Talk Therapy:** 0.28

*What do the numbers mean?*

The greater the effect size, the more noticeable a change in symptoms.

**Next steps? Talk to your health care provider.**

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

For more information about PTSD treatment options, visit [www.PTSD.va.gov](http://www.PTSD.va.gov).

References