Trauma-Informed Care

Position Statement

Women's Health Task Force

MARCH 2023 |

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Note: **this document includes information about and descriptions of trauma and the effects of trauma. Some of this information may be heavy to read. Consider this while navigating the document.**

Goal: Trauma-Informed Care as *standard of care* in all areas of perinatal medicine

Section 1: Overview – What is Trauma-Informed Care?

3-min You tube video: What is Trauma-Informed Care? - YouTube

Trauma-informed care (TIC) is a whole-person approach to health care that acknowledges the impact of trauma on health and is inherently *patient-centered*. A trauma-informed framework assumes that trauma is pervasive and that medical evaluation and treatment themselves are potentially traumatizing. TIC practices seek to create physical and emotional safety for those who have experienced trauma and rebuild their sense of control and empowerment during interactions. It also emphasizes the need to resist re-traumatization and/or the creation of new trauma through the healthcare experience. As health care providers grow aware of trauma's impact, they are realizing the value of trauma-informed approaches to care. Trauma-informed care acknowledges that a patient's life experiences will impact their perspectives when engaging in healthcare and that awareness of these experiences has the potential to improve patient engagement, treatment adherence, health outcomes, and even provider and staff wellness. Disclosure of past traumas is not a requirement to provide Trauma-Informed Care. Rather, the assumption that *all people* carry past traumas is the foundation of Trauma-Informed Care. Implementation of a TIC approach in medicine has shown improvements in all categories, including less depression, less behavioral or emotional problems, and even less caregiver strain[1].

According to the Substance Abuse and Mental Health Services Administration, a **Trauma-Informed Approach** is one 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.
- **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and
- seeks to actively **resist** re-traumatization.

Section 2: Why does this matter?

Experiencing trauma can lead to a cascade of adverse health outcomes. According to the Kaiser Permanente's (1998) Adverse Childhood Experiences (ACE) study, adults who experience 4 or more adverse childhood events have: a 1.4-1.6-fold increased risk for physical inactivity and severe obesity, a 2-4-fold increase in smoking, poor self-rated health, and STIs, and 4-12-fold increased risk for alcoholism, drug abuse, depression, and suicide attempt. As the number of ACEs a person experienced increased, the likelihood of cardiovascular disease, cancer, AIDS, pulmonary disease,

[1] *Rog DJ, Holupka CS, Mccombsthornton KL. Implementation of the Homeless Families Program.1. Service Models and Preliminary Outcomes. Am J Orthopsychiatry 1995; 65: 502-13. Retrieved May 28, 2017, from http://dx.doi.org/10.1037/h0085057.*

skeletal fractures, and liver disease increased as well. A recent study looking at ACEs in Connecticut found that a reduction in ACEs could save the state's Medicaid program $1.1-1.9 billion between 2021-2030.[2] In 2019, the CDC found that at least five of the top 10 leading causes of death, including respiratory and heart disease, cancer and suicide, are associated with ACEs.[3]

Higher ACE scores were associated with a higher risk of hypertensive disorders in pregnancy, pregnancy loss, preterm birth, and low birth weight as well as peripartum depression in some studies.[4] In Indiana, three of the top causes of pregnancy-associated deaths are linked to higher ACE scores, including accidental overdose which was the #1 cause of pregnancy-associated deaths in 2018, according to the Indiana Maternal Mortality Review Committee Annual Review 2020[5]

Perinatal care, given its intimate and somewhat invasive nature, has the potential to traumatize or cause re-traumatization.[6] As many as 20% to 48% of all women who give birth meet some diagnostic criteria for PTSD related to their birth.[7] Implementing trauma-informed care (TIC) as the universal standard of care in the perinatal period can both reduce traumatization and re-traumatization of pregnant patients and through this possibly reduce the incidence of ACEs their children experience.[8]

Benefits of Trauma-Informed Care

Financial

A study looking at ACEs in Connecticut found that a reduction in ACEs could save the state's Medicaid program $1.1-1.9 billion between 2021-2030. Research has found that certain patient behaviors can cost the health care system both time and money. Examples include high no-show rates to appointments, noncompliance with medical recommendations, and underutilization of preventive resources. Implementing trauma-informed approaches to care may help health care providers engage their patients more effectively, thereby offering the potential to improve outcomes and reduce avoidable costs for both health care and social services. TIC can decrease demand for crisis services, which can cost the state less money. TIC also increases consumer

[2] *Ashby, B.D., Ehmer, A.C., & Scott, S.M. (2019). Trauma-informed care in a patient-centered medical home for adolescent mothers and their children. Psychological Services, 67-74. https://doi.org/10.1037/ser0000315*

[3] *Dexler, Kathleen et al. Intimate partner violence and trauma-informed care in pregnancy. AJOG MFM Volume 4, Issue 2, March 22, 2022, 10542*

[4] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2560-8#:~:text=The%20current%20study%20adds%20to,preterm%20birth%2C%20and%20low%20birthweight.
https://www.sciencedirect.com/science/article/abs/pii/S0165032719324553
https://pubmed.ncbi.nlm.nih.gov/34619717/
https://pubmed.ncbi.nlm.nih.gov/33079811/

[5] https://www.in.gov/health/cfr/files/Maternal-Mortality-Report_December-2020-Final.pdf

[6] https://pubmed.ncbi.nlm.nih.gov/34619717/
https://www.sciencedirect.com/science/article/abs/pii/S0272735805000991
https://www.scirp.org/journal/paperinformation.aspx?paperid=104116

[7] *Singh N, Barber J, Van Sant S. (2016). Handbook of Recovery in Inpatient Psychiatry. Series: Evidence-Based Practices in Behavioral Health. Publisher: Springer International Publishing. doi: 10.1007/978-3- 319-40537-7.*

[8] https://www.ingentaconnect.com/content/wk/jpn/2020/00000034/00000004/art00003
https://pubmed.ncbi.nlm.nih.gov/29193613/

participation, which is better for addiction recovery and cost effective, since missed appointments result in millions of dollars annually in wasted staff time. [9]

<u>Improved health/outcomes</u>

(1) **More likely to attend their appointments:** Pregnant patients are more likely to attend prenatal appointments with TIC. This was noted in a study looking at adolescent mothers in Colorado through an obstetric and pediatric medical home. Programmatic and operational changes to clinical care were made using the Substance Abuse and Mental Health Services Administration's six key principles of a trauma-informed approach. Following the inclusion of trauma-informed principles, patients had significantly higher rates of attendance at prenatal appointments
($p<.001$).

(2) **Lower incidence of low-birth-weight babies:** Pregnant patients who experience TIC in their healthcare have lower incidence of low-birth-weight babies, which can save the states in NICU costs and other financial burdens of low-birth-weight babies. In the study noted above, they also experienced significantly lower rates of low birthweight babies ($p=.02$)[10]

(3) **Reduction in maternal mortality related to Intimate Partner Violence:** People who experience intimate partner violence during pregnancy may be about *3 times more likely* to suffer perinatal death compared with those who do not experience intimate partner violence. A meta-analysis of qualitative studies involving survivors of IPV, and their perceptions of the healthcare system response demonstrated that patients want caregivers to be nonjudgmental, compassionate, and confidential, rather than critical of their choices or encouraging them to leave their situation. A TIC approach to patients who experience IPV could decrease perinatal deaths related to IPV by providing such an environment.[11,12]

(4) **Improvement in long-term health outcomes:** Working towards reducing ACEs, which TIC helps to accomplish, can significantly improve long-term health outcomes.[13] The graphic that follows shows three tables on the potential reduction of negative outcomes in adulthood. The first table shows *adverse health conditions* that could be reduced by the following amounts with adverse childhood experiences prevention: depressive disorder (44%), Chronic Obstructive Pulmonary Disease (27%), Asthma (24%), Kidney Disease (16%), Stroke (15%), Coronary Heart Disease (13%), Cancer (6%), Diabetes (6%), and Overweight/Obesity (2%).

The second table shows *health risk behaviors.* The potential reduction of negative outcomes in adulthood for current smoking is 33% and heavy drinking is 24%.

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[9] *SAMHSA (2014). SAMHSA's Concept of Trauma op. cit*

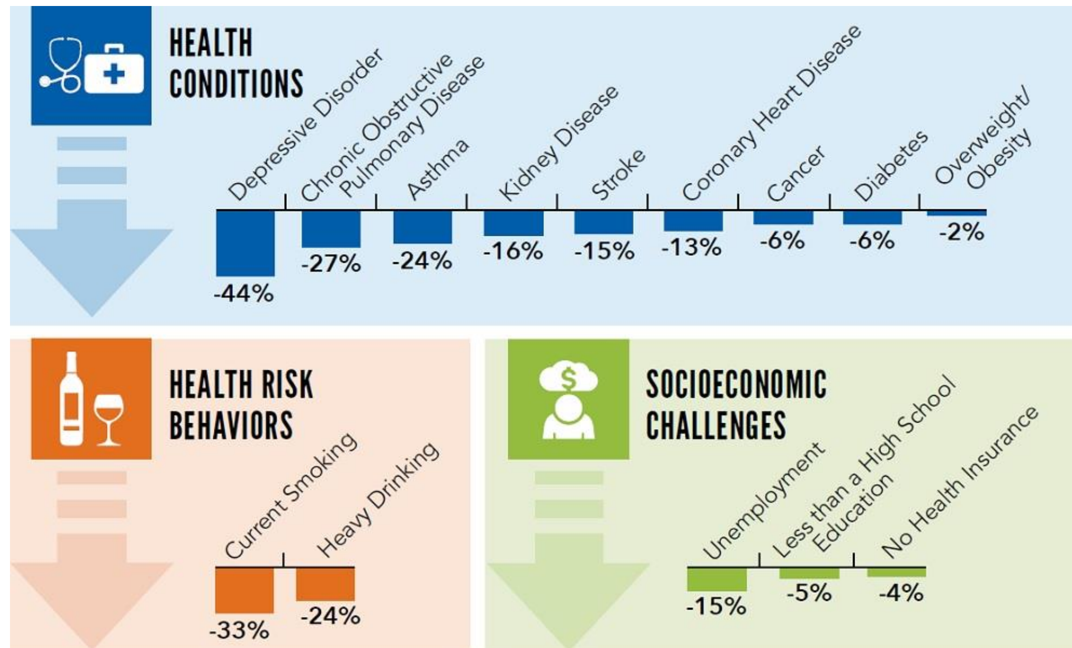
[10] *Ashby, B. D., Ehmer, A. C., & Scott, S. M. (2019). Trauma-informed care in a patient-centered medical home for adolescent mothers and their children.* Psychological Services, 16*(1), 67–74.* https://doi.org/10.1037/ser0000315

[11] *Dexler, Kathleen et al. Intimate partner violence and trauma-informed care in pregnancy. AJOG MFM Volume 4, Issue2, March 2022, 100542*

[12] *G Pastor-Moreno et al. Intimate partner violence during pregnancy and risk of fetal and neonatal death: a meta-analysis with socioeconomic context indicators. Am J Obstet Gynecol. 2020 Feb, 222(2):123-133. e.5.*

[13] *https://pubmed.ncbi.nlm.nih.gov/30475045/*

The third table shows *socioeconomic challenges*. The potential reduction of negative outcomes in adulthood for unemployment is 15%, earning less than a high school education is 5%, and not having health insurance is 4%.[14]



(5) Improved housing stability: TIC has a positive effect on housing stability, which can improve health outcomes and decrease ACEs. A multi-site TIC study of homeless families discovered that, at 18 months of TIC, most participants (88%) had remained in Section 8 housing or moved to permanent housing.[15] Additionally, housing stability increased when a TIC approach was utilized in an outreach and care coordination program for homeless mothers in Massachusetts.[16]

(6) **Better newborn care/bonding:** Skin-to-skin or Kangaroo Care. This is an evidence-based best practice of trauma-informed care to promote parent-infant connection, lessen stress of both members of the dyad, and enhance parental confidence In their landmark study, Feldman and Eidelman showed that skin-to-skin care improves autonomic function, attenuates stress, improves maternal attachment behavior, reduces maternal anxiety, and enhances child cognitive developmental outcomes from 6 months to 10 years of age. Additional studies of skin-to-skin care have shown lower maternal depression and improved

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[14] *CDC: Adverse Childhood Experiences: Preventing Early Trauma to Improve Adult Health. BRFSS 2015-2017, 25 states, CDC Vital Signs, November 2019.*

[15] *Rog DJ, Holupka CS, Mccombsthornton KL. Implementation of the Homeless Families Program.1. Service Models and Preliminary Outcomes. Am J Orthopsychiatry 1995; 65: 502-13. Retrieved May 28, 2017, from http://dx.doi.org/10.1037/h0085057.*

[16] *Marra JV. Final evaluation report: Evaluation of the trauma center of excellence initiative. Unpublished program evaluation. Storrs, CT: University of Connecticut Department of Psychology and the CT Department of Mental Health and Addiction Services Research Division 2006.; Hopper, E. K., Bassuk, E. L., and Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3, 80-100. http://www.homelesshub.ca/sites/default/files/cenfdthy.pdf.*

maternal confidence, as well as lower infant salivary cortisol, accelerated functional brain maturity and improved cognitive and communication performance of infants at 6 and 12 months of age.[17] [18] [19] [20] [21] To remain trauma-informed, this practice must be a choice for the patient and not done without consent as body fluids or close skin contact could be activating/re-traumatizing for some patients.

Provider-patient relationship/Patient experience

Cultivating a setting in which it is routine to screen patients for trauma exposure can confer several benefits. This line of inquiry can enhance patients' perceptions of practitioners and strengthen the bond between patients and practitioners.[22] In a recent study, patients of primary care physicians who were trained in TIC were compared to patients of providers who did not receive the training. Using a 21-item questionnaire through which patients rated their primary care physicians on rapport, information, and partnership, the study found that patients of trained physicians rated their providers more highly in terms of partnership, such as taking patient concerns into account when making treatment decisions. This approach can enhance adherence to treatment recommendations and increase patient satisfaction scores.[23]

Decreased secondary trauma and burnout for health care teams

Secondary trauma occurs when caregivers bear witness to and engage empathically with others' trauma. It can result in physical, cognitive, and emotional changes like those experienced by the people directly impacted by trauma. Concepts related to secondary trauma include secondary traumatic stress, vicarious trauma, compassion fatigue, moral injury, and burnout. In addition to understanding that the ubiquity of trauma implies a high likelihood of primary trauma among the healthcare workforce, as in any other environment, the healthcare workforce has many opportunities to experience secondary trauma through their caregiving. This makes implementing a trauma-informed approach even more important. TIC leads to increased staff confidence and satisfaction, better relationships between service providers and consumers, and increased self-esteem and satisfaction with services among consumers. The latter occurs because TIC considers an individual's experience in a non-judgmental way.[24]

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[17] *Hall S, Hynan M, Phillips R, Lassen S, Craig J, Goyer E et al. The neonatal intensive parenting unit (NIPU): an introduction. J Perinatol 2017; e-pub ahead of print 10 August 2017; doi:10.1038/jp.2017.108*

[18] *Johnson A. The maternal experience of kangaroo holding. J Obstet Gynecol Neonatal Nurs 2007; 36 (6):568-573.*

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[21] *Gonya J, Ray W, Rumpf R, Brock G. Investigating skin-to-skin care patterns with extremely preterm infants in the NICU and their effect on early cognitive and communication performance: a retrospective cohort study. BMJ Open 2017; 7 (3): e012985.*

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[23] *German, Miguelina, et al. Measuring the Impact of Trauma-Informed Primary Care: Are We Missing the Forest for the Trees? Feb 2020. Montefiore Medical Group.*

[24] *https://www.nasmhpd.org/sites/default/files/2022-08/TAC.Paper_.5.Quantitative_Benefits_TraumaInformedCare_Final.pdf*

A Special Note on Obstetric Violence

Obstetric violence refers to harm inflicted during or in relation to pregnancy, childbearing, and the post-partum period. Such violence can be both *interpersonal* and *structural*, arising from the actions of health-care providers and from broader political and economic arrangements that disproportionately harm marginalized populations.

The practice of Trauma-Informed Care is uniquely appropriate for peripartum care and can minimize obstetric violence. There are multiple forms of potentially trauma-inducing events in obstetrical care including but not limited to:

- Separation of mom and baby
- Repeated vaginal exams
- Having genitalia exposed
- Reproductive coercion (including legal and systemic restrictions on reproductive freedom and justice)
- Unwanted cesareans
- Shackled incarcerated pregnant individuals
- Pain management disparities
- Patients' concerns being minimized or dismissed
- Lack of explanation during emergencies (e.g. postpartum hemorrhage with manual intrauterine sweep, shoulder dystocia with McRobert's position without explaining first)

Ultimately, trauma, and being reactivated into a past trauma, is defined by the person who is experiencing it. It can be as obvious as fetal loss or emergency surgery, as personal as feeling a loss of control of your body, or as subtle as having a call-light unanswered in a timely fashion.

Section 3: Recommendations – How do we implement this?

Due to the ubiquity of trauma and the desire to not create new trauma in a perinatal or any healthcare setting, a trauma-informed approach should be viewed through the lens of a universal precautions model. All patients deserve and will benefit from trauma-informed care regardless of a known history of trauma or any other designation as a special or high-risk population. Patients do not owe providers or others they encounter throughout the healthcare system a disclosure of their history of trauma. Patients may not be aware of elements of their histories or past traumas that may be activated or triggered during a healthcare encounter or increase the likelihood of re-traumatization in the healthcare setting. Similarly, coworkers and colleagues do not owe each other personal disclosures. As such, a trauma-informed approach should be the *standard of care* for all patients as well as the foundation of *all interactions* in the healthcare work environment.

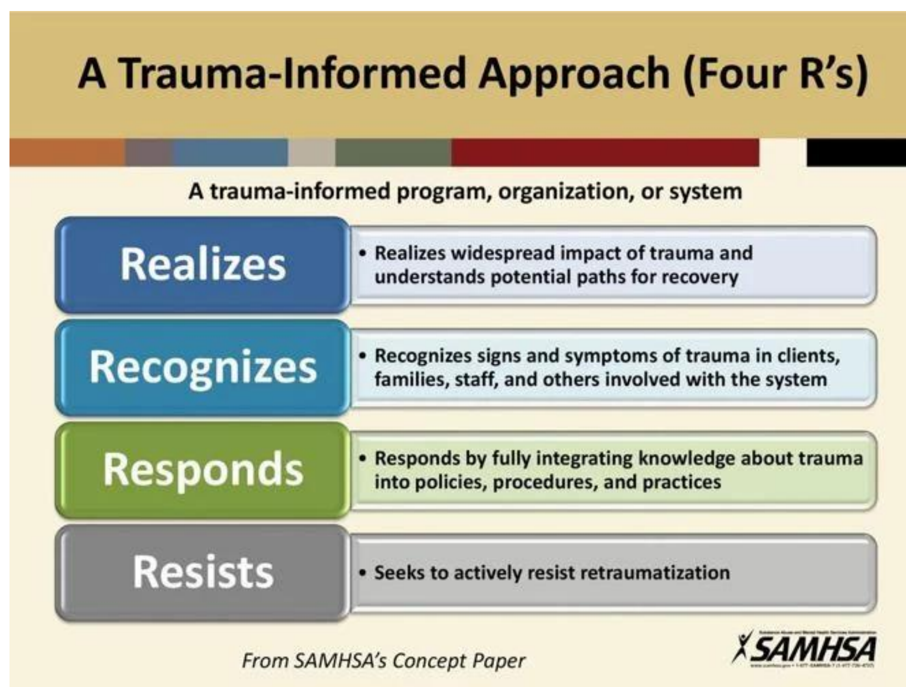
It is important to note that a trauma-informed approach to service delivery is not the same as providing trauma-specific services. TIC practices seek to create **physical and emotional safety** for survivors and **rebuild their sense of control and empowerment** during interactions. This approach also emphasizes the need to resist re-traumatization or the creation of new trauma

through the healthcare experience. This is important in any healthcare interaction but is especially salient in a perinatal context where care is intimate and personal and patients can be particularly vulnerable. Trauma can be created or reactivated through any number of events and interactions, some that may seem obvious and some that are entirely unpredictable and unique to the experience of the individual. Adopting a trauma-informed approach is not accomplished through any single technique or checklist. It requires *constant attention*, caring awareness, sensitivity, and often a cultural change at an organizational level.[25] TIC transforms the fundamental questions in medical care from "What is wrong with you?" to "What happened to you?" Effective TIC includes recognition of the effects of **indirect trauma exposure** on the workforce and safeguards to protect caregivers as well.

The Substance Abuse and Mental Health Services' (SAMHSA) conceptualization of trauma-informed care is based on four assumptions (*The 4 Rs)* and S*ix Key Principles.*[26]

<u>The 4 Rs of Trauma-Informed Care</u>:

- **Realize** the widespread impact of trauma and understands potential paths for recovery
- **Recognize** the signs and symptoms of trauma in clients, families, staff, and others
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practices, and
- seek to actively **Resist** re-traumatization

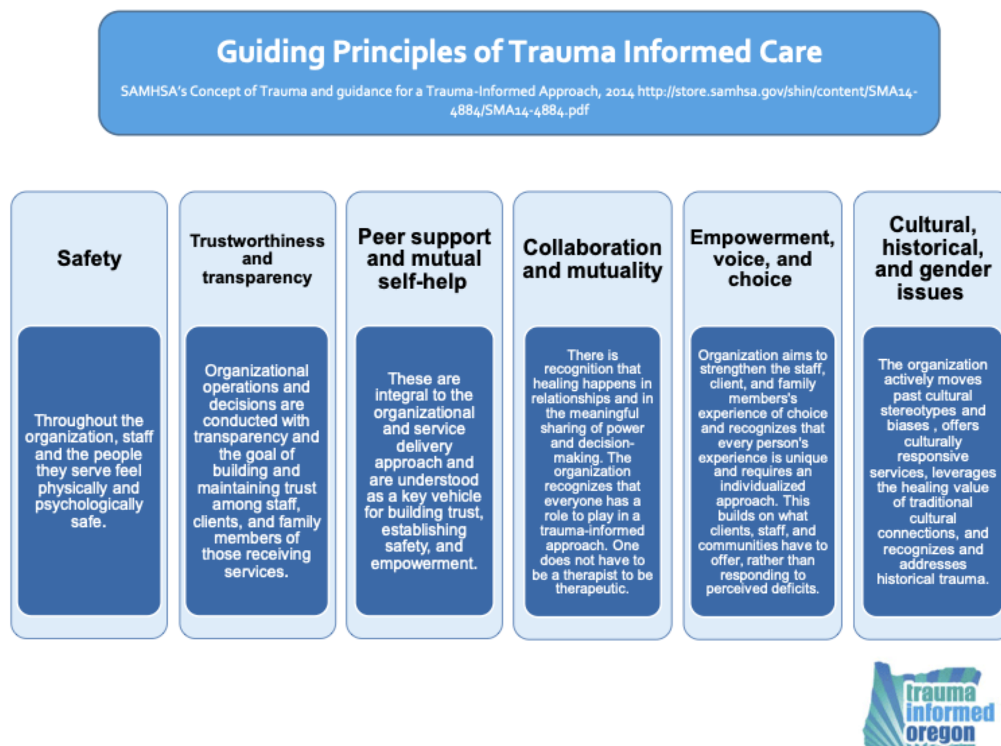


[25] https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
[26] https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

Six Key Principles of Trauma-Informed Care[27]

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice
- Cultural, Historical, and Gender Issues

Note: For more information on the key principles, see Appendix B.



Patient Centered Care/Patient Led Care/Shared Decision Making

Many providers and healthcare systems are familiar with the concepts of shared decision making, patient centered, and patient led care. These models of care emphasize that while a provider brings extensive training and medical knowledge to the encounter, the patient brings knowledge of their own background, preferences, and lifestyle that is equally important to creating the best care plan for the individual. The goal of **shared decision making** is to collaborate to arrive at a decision and plan informed by evidence and consistent with the patient's values and priorities. **Patient centered care** must be individualized and reflect the patient as a whole person including social, psychological, emotional, lifestyle and financial priorities, in addition to clinical priorities. **Patient**

[27] https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

led care extends this further, emphasizing that patients are the ultimate experts of their own lives, are empowered to take control of their own health, and with accurate and complete information are in the best position to make choices about their own care.

There is significant overlap between these approaches to care and a trauma-informed approach. Not feeling heard, believed, or taken seriously can take someone back to a traumatic event and make them feel retraumatized. It is not possible to provide trauma-informed care without committing to many of the elements of shared decision making, patient centered, and patient led care. Trauma-informed care brings unique perspective and additional components that enhance and expand on these approaches to best serve patients and minimize re-traumatization and/or the creation of new trauma. [28]

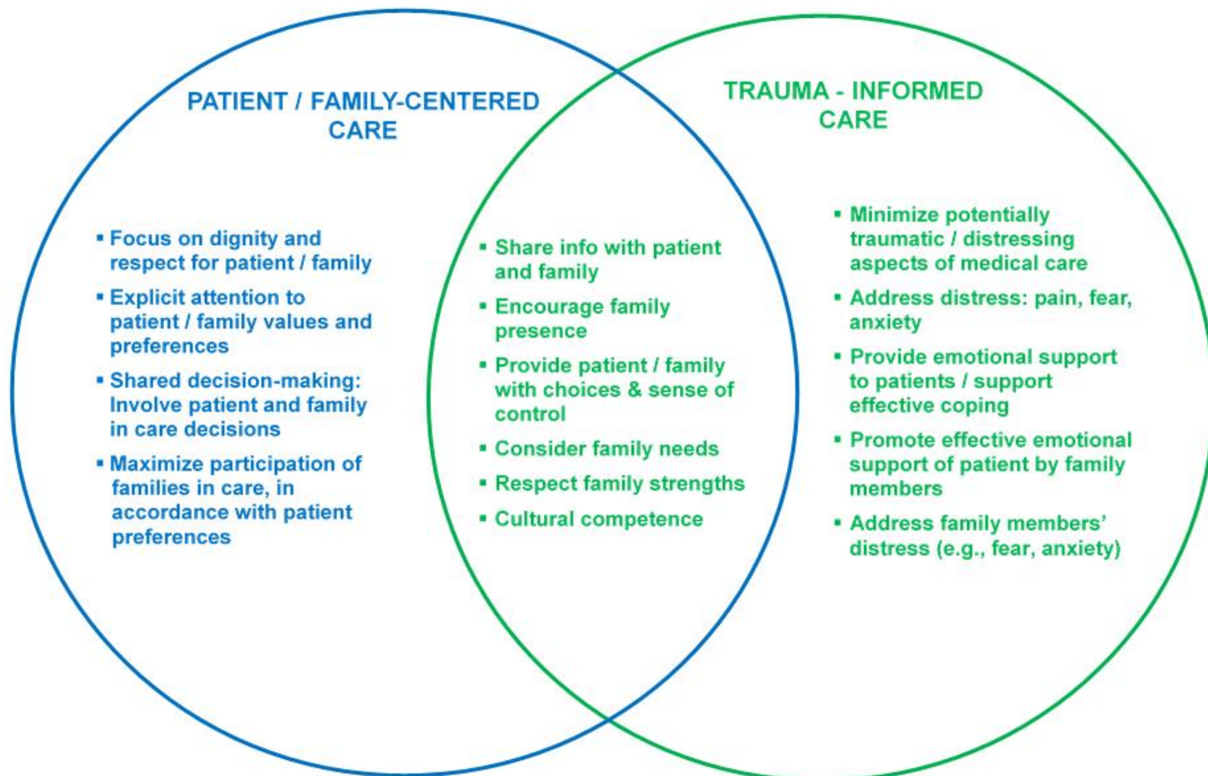


Image used with permission from healthcaretoolbox.org, authored by the Center for Pediatric Traumatic Stress"

Consent is essential to providing trauma-informed, patient centered care. Consent is agreement or permission expressed through affirmative, voluntary, uncoerced words or actions that are mutually understandable to all parties involved, to engage in a specific act at a specific time. The American Medical Association states “informed consent to medical treatment is fundamental both in ethics and law. Patients have the right to receive information and ask questions about recommended

[28] https://www.healthcaretoolbox.org/trauma-informed-care-the-basics

treatments so that they can make well-considered decisions about care ."[29] They state that this process and communication should build trust and support shared decision making.

Organizational Planning

"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 Model

Creation of a stakeholder committee. This should include individuals who have experienced trauma. These individuals can provide valuable first-hand perspectives to inform organizational changes by serving alongside staff, patient advisory boards, and boards of trustees. Health care organizations should consider compensating patients and community members for their time as they would with other highly valued consultants.

Providing trauma-informed training is critical for not only clinical, but also for non-clinical employees. Providers should be well-versed in how to create a trusting, non-threatening environment while interacting with patients and staff. Likewise, non-clinical staff, who often interact with patients before and more frequently than clinical staff, play an important role in trauma-informed settings. Personnel such as front-desk workers, security guards, and drivers have often overlooked roles in patient engagement and in setting the tone of the environment. For example, greeting people in a welcoming manner when they first walk into the building may help foster feelings of safety and acceptance, initiate positive relationships, and increase the likelihood that they will engage in treatment and return for future appointments.

INFORMED DECLINATION/REFUSAL

Consent also includes the right to informed declination/refusal – the right to informed declination is as important as the right to informed consent. Consent is an ongoing process that is fully reversible and can be revoked at any time. Consent should be obtained with every aspect of care – from entry into the room, taking of vitals, talking about various topics with patients, and any examination including any procedures. Consent should never be assumed simply because someone is seeking care. Patients do not owe providers their trauma histories, nor access to their bodies. Consider the difference between telling a patient "I am going to begin the exam now" and "Tell me when you are ready for me to begin the exam."

PHYSICAL SPACE

Feeling physically, socially, or emotionally unsafe may cause extreme anxiety in a person who has experienced trauma, potentially causing re-traumatization. Therefore, creating a safe environment is fundamental to successfully engaging patients in their care.

Examples of creating a safe environment include:

[29] https://www.ama-assn.org/delivering-care/ethics/informed-consent

Physical Environment

- Keeping parking lots, common areas, bathrooms, entrances, and exits well lit
- Ensuring that people are not allowed to smoke, loiter, or congregate outside entrances and exits
- Monitoring who is coming in and out of the building
- Keeping noise levels in waiting rooms low
- Using welcoming language on all signage
- Making sure patients have clear access to the door in exam rooms and can easily exit if desired

Social-Emotional Environment

- Welcoming patients and ensuring that they feel respected and supported
- Ensuring staff maintain healthy interpersonal boundaries and can manage conflict appropriately
- Keeping consistent schedules and procedures
- Offering sufficient notice and preparation when changes are necessary
- Maintaining communication that is consistent, open, respectful, and compassionate
- Being aware of how an individual's culture affects how they perceive trauma, safety, and privacy

STAFF AWARENESS

Minimizing and mitigating effects of secondary traumatic stress can increase staff morale, allow staff to function optimally, and reduce the expense of frequently hiring and training new employees. Strategies to prevent secondary traumatic stress in staff include:

- Providing trainings that raise awareness of secondary traumatic stress
- Offering opportunities, such as EAPs, for staff to explore their own trauma histories.
- Supporting reflective supervision, in which a service provider and supervisor meet regularly to address feelings regarding patient interactions
- Encouraging and incentivizing physical activity, yoga, and meditation
- Allowing "mental health days" for staff

One study that surveyed staff recommended support for dealing with complex patients, formal mechanisms for feedback, and time for self-care. Administrators recognized the need for more support, acknowledged that opportunities for employees to voice concerns were lacking, and felt that implementing multi-disciplinary team meetings could improve morale and reduce stress and burnout.[30]

When hiring new staff, hiring managers can use behavioral interviewing, a technique that relies on candidates' past behavior as a predictor of future behavior, to screen for empathy, non-judgment, and

[30] *Sales JM, Piper K, Riddick C, Getachew B, Colasanti J, Kalokhe A. Low provider and staff self-care in a large safety-net HIV clinic in the Southern United States: Implications for the adoption of trauma-informed care. SAGE Open Medicine. 2019;7. doi:10.1177/2050312119871417*

collaboration. This method can identify viable candidates who may not have had formalized training in trauma-informed care.[31]

Consider peer counselors. One promising engagement strategy uses peer support workers — individuals with lived trauma experiences who receive special training — to be part of the care team. Based on their similar experiences and shared understanding, patients may develop trust with their peer support worker and be more willing to engage in treatment. Peer engagement is a powerful tool to help overcome the isolation common among individuals who have experienced trauma.[32]

[31] *L. Lockert. "Building a Trauma-Informed Mindset: Lessons from CareOregon's Health Resilience Program." Center for Health Care Strategies. June 2015. Available at: http://www.chcs.org/building-trauma-informed-mindset-lessons-careoregons-health-resilience-program/.*

[32] *SAMHSA (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, op. cit.*

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- https://www.ama-assn.org/delivering-care/ethics/informed-consent

Appendix A: Definitions

Term	Definition/Framework
Adverse childhood experiences (ACEs)	**Adverse childhood experiences**, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example: psychological, physical, or sexual abuse, physical or emotional neglect, living with violence in the home, a family member with mental illness or a substance use disorder, parental divorce or other loss of a parent, or a family member being incarcerated. *Dose response relationship:* The more ACEs a person experiences, the more likely they are to experience adverse health outcomes. Adults who experienced ***4 or more*** categories of ACEs had the following increase for negative health behaviors and outcomes: • 1.4 to 1.6-fold increase in physical inactivity and severe obesity • 2- to 4-fold increase in smoking, poor self-rated health, multiple sexual partners (> 50) and STIs • 4- to 12-fold increased risk for alcoholism, drug abuse, depression, and suicide attempt As the number of ACEs a person experienced increased, the likelihood of cardiovascular disease, cancer, AIDS and other STIs, pulmonary disease, skeletal fractures and liver disease increased as well. • A reduction in adverse childhood experiences (ACEs) could save Connecticut's Medicaid program $1.1 to 1.9 billion between 2021 – 2030. **What can be done?** • ***Prevention***: cdc.gov/violenceprevention/aces/prevention.html • ***Resilience & Protective Factors***: https://pacesconnection.libguides.com/resourcecenter/pacesscience • https://www.pacesconnection.com/blog/aces-101-faqs • ***Intervention:*** https://www.cdc.gov/violenceprevention/aces/help-youth-at-risk.html CDC-Kaiser Study: https://www.cdc.gov/violenceprevention/aces/about.html BRFSS (Behavioral Risk Factor Surveillance System) survey: https://www.cdc.gov/brfss/ Philadelphia survey: https://www.philadelphiaaces.org/philadelphia-ace-survey
Burnout (BO)	The term **"burnout" (BO)** was coined in the 1970s by the American psychologist Herbert Freudenberger. He used it to describe the consequences of severe stress and high ideals in "helping" professions. Burn-out is included in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. It is ***not*** classified as a medical condition.

Term	Definition/Framework
	Burn-out is a syndrome conceptualized as resulting from *chronic workplace stress* that has not been successfully managed. It is **characterized by three dimensions**: • Feelings of energy depletion or exhaustion • Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job • Reduced professional efficacy. Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life. **What can be done?** • ***Assessment*:** Maslach Burnout Inventory: MBI-Human Services Survey for Medical Personnel • ***Prevention & Intervention***: Acknowledgement, peer-to-peer counseling, mental health resources page on department websites for anonymous psychological health support, training on supervising with empathy to foster genuine dialogue with trainees about burnout and wellness, culture change (shift from managing acute mental health issues to promotion of wellness), provider wellness committees https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases https://www.ncbi.nlm.nih.gov/books/NBK279286/ https://www.aamc.org/news-insights/medical-burnout-breaking-bad
Compassion Fatigue (CF)/Empathic Distress Fatigue	**Compassion fatigue (CF)** is stress resulting from exposure to a traumatized individual. CF has been described as the convergence of secondary traumatic stress (STS) and cumulative burnout (BO), a state of physical and mental exhaustion caused by a depleted ability to cope with one's work environment. **CF = STS + BO**. Some suggest that the term empathic fatigue or empathic distress fatigue may be more accurate than compassion fatigue. Empathy is rooted in feeling, sharing, and understanding the feelings of another person. Compassion is rooted in being aware of someone else's distress and wanting to help alleviate it. Compassion can be protective against burnout, where empathic distress is not. **What can be done?** • ***Expand research on prevalence and effective interventions***. There is a lack of information and evidence about effective interventions designed to reduce CF • ***Utilize assessment tools***: Compassion Fatigue Self-Test (CFST) • ***Invest in programs such as the Accelerated Program for Compassion Fatigue (ARP)***

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	ARP is a five-session model for the treatment of the deleterious effects caregivers experience as a result of their care giving work through the promotion of resilience and self-efficacy. Participants in the ARP not only report a reduction in CF symptoms, but they also feel more empowered, more energetic, and have a stronger sense of self-worth. Designed to reduce the intensity, frequency and duration of symptoms associated with Compassion Fatigue, ARP aims to help at-risk workers identify symptoms of CF, recognize CF activators, identify and utilize existing available resources, review personal and professional history to the present day to identify those at increased risk, master arousal reduction methods, resolve any impediments to efficacy, initiate conflict resolution, and initiate a supportive aftercare plan in collaboration with their employer or supervisor. ***Note:*** *Many terms are used to describe the effects of secondary trauma including secondary traumatic stress (STS), compassion fatigue (CF), and vicarious trauma (VT). They are often incorrectly used interchangeably.* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4924075/ (*Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review*) https://psycnet.apa.org/record/2002-17425-006 (The Accelerated Recovery Program for Compassion Fatigue) Klimecki, Olga, and Tania Singer, 'Empathic Distress Fatigue Rather Than Compassion Fatigue? Integrating Findings from Empathy Research in Psychology and Social Neuroscience', in Barbara Oakley and others (eds), *Pathological Altruism* (2011; online edn, Oxford Academic, 19 Jan. 2012), https://doi.org/10.1093/acprof:oso/9780199738571.003.0253, accessed 19 Oct. 2022.
Consent	**Consent** is when a person voluntarily and willfully agrees to undertake an action that another person suggests. The consenting person must possess sufficient mental capacity. Consent is agreement or permission expressed through affirmative, voluntary, uncoerced words or actions that are mutually understandable to all parties involved, to engage in a specific act at a specific time. Consent should be freely given, reversible, informed, and specific. Consent also includes the right to **informed declination/refusal** – the right to informed declination/refusal is as important as the right to informed consent. Consent should never be assumed simply because someone is seeking care. **<u>What can be done</u>?** • ***Teach explicit consent****:* greet patients fully clothed, ask before you touch instead of telling before you touch, check in during exam, offer chaperone, ask permission for learner to be present AND/OR participate in exam

Term	Definition/Framework
	before learner is in room, tell patients they may ask to stop at any time, explicitly state who will touch them/get consent for exams under anesthesia https://stopsexualviolence.iu.edu/policies-terms/consent.html https://www.plannedparenthood.org/learn/relationships/sexual-consent https://www.law.cornell.edu/wex/consent https://providers.bedsider.org/articles/why-and-how-providers-should-get-consent-in-the-exam-room
Moral Injury	**Moral injury** is the distressing psychological, behavioral, social, and sometimes spiritual aftermath of acting on or witnessing behaviors that go against an individual's values and moral beliefs. Guilt, shame, disgust, and anger are some of the hallmark reactions of moral injury. ***Potentially Morally Injurious Events (PMIEs):*** Events that place healthcare workers at risk may include the following: Loss of a vulnerable person (e.g. an elder or child) • Situations where death may have been the result of insufficient resources or staffing, particularly when these issues are perceived to have been preventable • Having to save one patient over another due to limited equipment or resources • Following clinical, institutional, or political directives that the worker feels are immoral • Issuing directions that result in the death of a patient **What can be done?** • ***Multifactorial prevention & intervention***: Address resource shortages, leadership can provide social and psychological support, develop personal stress management plans, refer to Compassion Fatigue and Burnout strategies above https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury_hcw.asp#:~:text=Moral%20injury%20can%20occur%20when,lead%20to%20a%20negative%20outcome https://files.asprtracie.hhs.gov/documents/bh-addressing-moral-injury-for-healthcare-workers.pdf
Obstetric Violence	**Obstetric violence** refers to harm inflicted during or in relation to pregnancy, childbearing, and the postpartum period. Such violence can be both *interpersonal* and *structural*, arising from the actions of healthcare providers and from broader political and economic arrangements that disproportionately harm marginalized populations. According to Venezuelan Law, which was the first to define this type of violence, obstetric violence is the "*appropriation of a woman's body and reproductive processes by health staff, in the form of dehumanizing treatment, abusive*

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	medicalization and pathologizing of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life." In their 2010 framework, Diana Bowser and Kathleen Hill identified 7 categories of disrespect and abuse in childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in facilities. **Historical/Examples**: **Separation of mom and baby:** In 16th-century papal Rome, for instance, Roman Catholic authorities in houses of catechumens (institutions for non-Christians) sequestered Jewish women's babies unless they consented to Christianization via baptism. **Forced cesareans**: In the late 18th-century viceroyalties of New Spain and Peru, priests performed forced caesarean sections on some women who struggled to give birth. Crown officials made the operations obligatory and emphasized that the priority was to save the souls of fetuses and not the lives of their mothers. **Reproductive coercion of enslaved women:** Obstetric violence lay at the heart of slavery in the Americas, which relied on the exploitation of Black women's reproductive labor for economic profit: women faced violent punishment and abuse for failing to conceive and give birth to healthy offspring. J. Marion Sims, considered the father of gynecology, created the speculum by experimenting and operating on enslaved women, sometimes up to 30 times, without anesthesia. **Shackling/mistreatment of incarcerated women**: forcing people in labor to remain shackled to the bed, ignoring/lack of care in prisons (example: woman died from ruptured ectopic in prison while spending all day asking for help; another woman gave birth in jail because the staff thought she was 'faking it'). **Forced sterilization:** In the early 20th century, eugenics movements in multiple countries promoted the involuntary sterilization of those deemed hereditarily "unfit", which disproportionately impacted disabled, impoverished, and racially marginalized populations. Even after laws were in place to prevent this, as recently as the 1970s Native American women were forced to be sterilized (a study estimated ¼ of Native American women were sterilized during this time). **Pain management disparities**: 9th-century physicians in multiple regions claimed that middle-class and upper-class white women experienced more pain in childbirth, and they focused their efforts of pain relief on this subset of patients. Even today racial disparities persist in obstetric pain management, with practitioners in the United States providing less pain treatment to Black and Latinx obstetric patients than to their white counterparts. **Denial or obstruction of access to legal abortion**: results in medical harms, such as increased rates of preventable death from sepsis and hemorrhage. Economic and political harms related to exclusion and loss of autonomy bolsters patriarchal norms that punish women for rejecting motherhood.

<table>
<tr><th>Term</th><th>Definition/Framework</th></tr>
<tr><td></td><td><u>What can be done</u>?
Culture change: teach patient-centered, empathic care where patients' choices are held first
Operationalizing the terms: to create pathways for studying prevalence, and creating accountability and restitution
Hospital/clinic policies: for zero tolerance; involvement of patient in decisions regarding childbirth policies and practices
Join groups for change: Make Mothers Matter, the Borgen Project, etc.
Birth Issues in Perinatal Care (Wiley)
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)01022-4/fulltext (Obstetric Violence in Historical Perspective)
https://borgenproject.org/obstetric-violence/
https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf (Bowser and Hill reference above)
https://makemothersmatter.org/?s=obstetric+violence</td></tr>
<tr><td>Patient-centered care</td><td>Patient-Centered Care: An individual's specific health needs and desired health outcomes become a driving force behind all healthcare decisions and quality measurements. Patients are partners with their healthcare providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective. The provider is the expert in medical knowledge and the patient is the expert of their own circumstances.

Benefits:
Improved satisfaction scores
Enhanced reputation of providers
Better morale and productivity among clinicians and ancillary staff
Improved resource allocation
Reduced expenses and increased financial margins
<u>What can be done</u>?
NEJM has 7 steps to create this model:
(1) Mission and values align with patient goals, (2) Care is collaborative, coordinated and accessible, (3) Physical comfort and emotional well-being are top priorities, (4) Patient and family viewpoints respected and valued, (5) Patient</td></tr>
</table>

<table>
<tr><th>Term</th><th>Definition/Framework</th></tr>
<tr><td></td><td>and family always included in decisions, (6) Family welcome in care setting, (7) Full transparency and fast delivery of information

https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559#:~:text=Under%20patient%2Dcentered%20care%2C%20care,in%20patient%2Dfocused%20care%20models (What is Patient Centered Care?)</td></tr>
<tr><td>Secondary Traumatic Stress (STS)</td><td>Secondary Traumatic Stress: STS is the impact on caregivers when they help and/or bear witness to people with injury and trauma. This can affect anyone whose job calls them to empathize with someone else’s trauma and distress.
• STS involves behavioral symptoms based on DSM criteria of PTSD (e.g. avoidance, hyperarousal/hypervigilance) resulting from hearing about or helping to treat another’s trauma. Can occur with just one exposure & with rapid onset or cumulatively over time.

<u>STS Data</u>:
• In a study of 300 educators, 75% reported symptoms of secondary traumatic stress and more than 30% said they had symptoms of moderate depression
• A 2007 study showed that 34% of child welfare workers met the criteria for PTSD due to STS
• 89% of emergency room nurses had high levels of burnout and 86% had high levels of compassion fatigue
• 37% of first responders had contemplated suicide, compared with 3.7% national average

<u>What can be done</u>?
• Intervention & Prevention: Policy makers, workplaces and individuals can act to buffer, reduce, and prevent STS, building a culture in which all of us care for each other. Creating and prioritizing a trauma-informed approach to patient care and work environment supports this.

Note: Many terms are used to describe the effects of secondary trauma including secondary traumatic stress (STS), compassion fatigue (CF), and vicarious trauma (VT). They are often incorrectly used interchangeably.

https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress
https://www.philadelphiaaces.org/sts/what-is-sts</td></tr>
<tr><td>Toxic Stress Response (TSR)</td><td>Toxic Stress Response (TSR): can occur when someone experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems</td></tr>
</table>

Term	Definition/Framework
	and increase the risk for stress-related disease and cognitive impairment. ***Think of this as the long-term outcome of experiencing ACEs.*** **<u>What can be done</u>?** • ***Supportive, responsive relationships*** with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response. • ***JPB Network on Toxic Stress*** is creating an assessment tool based on five principles: (1) attention to both environmental and genetic factors; (2) assessment at multiple levels, including molecular, cellular, physiological, and behavioral assays; (3) reliable information on both risk factors and assets in the family and community context; (4) the need for data collection to be logistically, ethically, and financially acceptable within community settings; and (5) the imperative that findings are accessible and empowering for parents as well as clinicians. ***When fully validated, the final battery will make it possible to identify child stress effects and resilience, family assets and stressors, and key behavioral indicators in children as young as two months of age, target preventive services before overt problems emerge, and measure short-term impacts of interventions on learning, behavior, social-emotional development, and health indicators to facilitate rapid-cycle learning and iteration.*** https://pubmed.ncbi.nlm.nih.gov/31855338/ (National Academies of Sciences, Engineering, and Medicine. Vibrant and healthy kids: Aligning science, practice, and policy to advance health equity. Washington, DC: National Academies Press, 2019.) https://developingchild.harvard.edu/science/key-concepts/toxic-stress/ JPB Network on Toxic Stress
Trauma	Per the Substance Abuse and Mental Health Services Administration (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 effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.” **https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf**
Trauma-Informed Care (TIC)	Per the Substance Abuse and Mental Health Services Administration (SAMHSA), a **Trauma-Informed Approach** is one 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 • **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and

Term	Definition/Framework
	• seeks to actively **resist** re-traumatization. **Trauma-informed care (TIC)** is a whole-person approach to health care that acknowledges the impact of trauma on health and is inherently ***patient-centered***. TIC practices seek to create **physical and emotional safety** for survivors and **rebuild their sense of control and empowerment** during interactions. Adopting a trauma-informed approach is not accomplished through any single technique or checklist. It requires *constant attention*, caring awareness, sensitivity, and a cultural change at an organizational level. TIC transforms the fundamental questions in medical care from "What is wrong with you?" to "What happened to you?". Effective TIC includes recognition of the effect of **indirect trauma exposure** on the workforce and safeguards to protect caregivers as well. Providing TIC *does not require individuals to disclose* their specific trauma history. A trauma-informed approach to service delivery is not the same as providing trauma-specific services. TIC-based services seek to recognize the ubiquity of trauma in peoples' lives – what is traumatizing to one individual might not be traumatizing to another. TIC requires a **universal precautions approach with all individuals** rather than selectively applying this approach with special populations or only in the presence of disclosure of trauma. **<u>Benefits</u>** For patients, trauma-informed care creates the opportunity to **engage more fully in their health care,** develop a trusting relationship with their provider, and improve long-term health outcomes. Trauma-informed care can also help **reduce burnout among health care providers**, potentially reducing staff turnover. TIC can be conceptualized in a <u>public health stratification</u>: • *Primary prevention* of trauma and promotion of resilience • *Secondary prevention* and intervention for those exposed to potentially traumatic experiences, including parents, siblings, guardians/caregivers, and healthcare workers • *Tertiary care* for ALL who display symptoms related to traumatic experiences **<u>What can be done</u>?** ***Organizations*** can develop policies and practices that promote safety, trust, transparency, collaboration, mutuality, empowerment, and choice among staff members and people seeking care. Input is needed from a range of stakeholders, including trauma survivors. A universal precautions approach is recommended. Strategies may include: • a warm and welcoming waiting room • clear communication of expectations and procedures

Term	Definition/Framework
	• providing choices whenever possible (e.g. do you want blood pressure taken on your right arm or your left?) • Being mindful of *trauma activators* (events that might activate conscious and unconscious memories of and defenses against the effects of trauma) https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care https://traumatransformed.org/ https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf https://case.edu/socialwork/begun/consultation-and-training/center-innovative-practices-cip/evidence-based-interventions/trauma-informed-care https://www.aafp.org/about/policies/all/trauma-informed-care.html https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/04/caring-for-patients-who-have-experienced-trauma https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm https://publications.aap.org/pediatrics/article/148/2/e2021052580/179745/Trauma-Informed-Care?_ga=2.214904983.1232586874.1653664968-1125946638.1653664968?autologincheck=redirected
Vicarious Trauma (VT)	**Vicarious Trauma (VT)** was first defined in the 1980's. and is sometimes incorrectly used interchangeably with compassion fatigue (CF). Vicarious trauma occurs when individuals are exposed *indirectly* to the *direct* trauma experienced by others and causes changes in cognition and world view. This indirect exposure can produce symptoms of distress that fall on a continuum of mild to severe. It is the consequence of long-term or cumulative exposure to indirect trauma. These changes are not pathological but their sequelae can be damaging both personally and professionally. **What can be done?** • ***Utilize assessment tools***: TSI Belief Scale (TSI-BSL) is the most common measure of VT • ***De-stigmatize*** the reactions of first responders and reinforce the need for ***wellness training*** and ***post-exposure care*** • ***"Duty to Train"*** – educate helping professions about the potential negative effects of the work and how to cope ○ ***Recognize risk factors*** (see NASWWV reference, presentation page 22) • ***Vicarious resilience/Vicarious post-traumatic growth*** • ***Create strong professional relationships/support***

Term	Definition/Framework
	Note: Many terms are used to describe the effects of secondary trauma including secondary traumatic stress (STS), compassion fatigue (CF), and vicarious trauma (VT). They are often incorrectly used interchangeably. https://www.oxfordbibliographies.com/view/document/obo-9780195389678/obo-9780195389678-0267.xml Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-V), American Psychiatric Association, 2013 https://naswwv.socialworkers.org/LinkClick.aspx?fileticket=Bj2s9-H4Brw%3D&portalid=13

Appendix B: Six Key Principles

Six Key Principles of Trauma-Informed Care[1] [2]

- **Safety:** includes both physical and psychological safety. Not only built environment and policies/procedures but interpersonal relationships as well. Includes safety for staff and those they serve. Safety should be defined by those we serve.
  - Examples:
    - Bed rails vs being constrained
    - Waiting rooms should have ample space for individuals that may be re-traumatized by sitting in close contact with strangers
    - Parking lots and walkways should be well lit
    - Orienting the patient and family to a room to ensure they know how to turn on the lights, call for help, get water
    - All staff should introduce self by name and role
- **Trustworthiness and Transparency:** Building and maintaining trust is key. A victim of abuse might reason that if someone they trust can hurt them, so too could anyone. People who have experienced trauma may have more difficulty creating trusting relationships.
  - Examples:
    - Discuss what information you will review with the patient before beginning and why
    - Let patients know why a procedure is recommended
    - Provide staff information on rationale behind policy change before it happens
    - Explain every part of the exam before it happens
- **Peer Support:** assists in building hope, trust, and safety and promotes healing. Peers are those who have shared experiences or traumatic experiences.
  - Examples:
    - Peer counseling in substance treatment or HIV care
    - Support groups for infertility or infant loss
    - Creating space for staff/team debriefs and processing after a loss or negative patient experience
- **Collaboration and Mutuality:** focus on leveling power differentials between staff and patients as well as between staff roles. Strive to develop partnerships between staff and patients as well as among staff teams.
  - Examples:
    - *Leveling power dynamics*: meet the patient while they are dressed (whenever possible); ask patients to let the provider know when they are ready to begin the exam rather than the provider telling the patient they are going to begin the exam.
    - *Patient led care:* A patient with newly diagnosed diabetes meets with providers to go over all treatment options to find out what works best with the demands of their life.
    - *Shared decision making:* Postmenopausal bleeding: discussing in office procedure vs surgical procedure under anesthesia vs pelvic ultrasound and allowing patient to choose based on their own priorities.

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[1] https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/
[2] https://www.cdc.gov/orr/infographics/6_principles_trauma_info.htm

        - *Collaborative goal setting* prioritizes patient-defined goals. Ex: A patient with sickle cell anemia and pulmonary embolism on anti-coagulation and heavy periods. Patient's goals are to decrease periods and avoid surgery.
- **Empowerment, Voice and Choice:** Recognize and build on strength and resilience of patients and staff. Promote shared decision making and patient led care. Focus on areas where choices are present and what we can control. Emphasize to the patient they are in the driver's seat, and we are here to guide them with their goals.
    - Examples:
        - What elements of care can/should be deferred?
        - What are the lights like in the room?
        - Who is in the room?
        - Position choices?
        - STI testing via urine, self-swab, or provider collected swab?
- **Cultural, Historical, and Gender Issues:** TIC cannot exist without a focus on diversity, equity, inclusion and accessibility (DEIA). Recognize and address historical trauma. Try to avoid cultural stereotypes and biases or at least be aware of them, offer gender responsive services, support the healing value of traditional cultural connections and traditions.
    - Examples:
        - Be aware of historical and generational trauma that may impact someone's relationship with systems in general, healthcare in particular, and especially gynecologic health-care and the way this may play into your interactions. This may be especially true for communities of color and those in the LGBTQ+ community.
        - Gender pronouns. Offer your own, ask patients and use them correctly.
        - Modesty differences with various cultures. Ask if unsure.
        - Request for female provider. Honor when able, and when not, explain while honoring their priorities, offer female chaperone.
        - A provider may interpret a patient's refusal to make eye contact as a lack of interest, embarrassment, or even depression. However, a Chinese patient may be showing the provider respect. If the patient is female and from a Muslim country, and the provider is male, she may be trying to avoid sexual impropriety. A Navaho patient may be trying to avoid soul loss or theft.[1]
        - We are often taught the importance of touch. Yet, for some cultures, for example in the Orthodox Jewish community, contact outside of hands-on care maybe prohibited between members of the opposite sex.[3]

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[3] Galanti GA. An introduction to cultural differences. West J Med. 2000 May;172(5):335-6. doi: 10.1136/ewjm.172.5.335. PMID: 10832428; PMCID: PMC1070887.

Appendix C: Communication Examples

Examples of Trauma-Informed Communication in Action	
Examples of Commonly Used Language	**Examples of Trauma-Informed Language**
"Step on the scale so we can get your weight."	**"We typically weigh people at the start of their visits. Would it be okay if we weigh you today?"**
"I'm going to take your blood pressure now."	**"Would it be okay if I take your blood pressure now? Do you have a preference for your left arm or your right arm?"**
"I'm going to examine you now."	**"This is what I recommend for the exam (describe every step of the exam). Is any of that *not* okay with you? What questions do you have about that?"**
"Hold out your arm so I can draw your blood."	**"Do you have a preference for where I draw your blood?"**
"It's time to check your cervix."	**"Would it okay to check your cervix now?"**
"I'm going to begin the pelvic exam now."	**"Let me know when you are ready to begin the pelvic exam/exam of your vulva and vagina."**
Focusing on typing in the HER, looking down to take notes, or placing back to patient to look at computer while the patient is talking.	**"It is important to me that your concerns are heard and that I take in the details of everything you tell me. If it's okay with you, I will be taking notes during the visit" Follow up with a summary of concerns/notes to ensure understanding.**