

## Safe Place

### Introduction

The National Center on Safe Supportive Learning Environments, on behalf of the White House Task Force to Protect Students from Sexual Assault, presents Safe Place.

Trauma-Sensitive Practice for Health Centers Serving Students. The Trauma-Sensitive Clinical Encounter

### Learning Objectives

Upon completing this lesson, you will be able to summarize neurological structures involved in mediating stress, identify the neurologically damaging hormone predominantly associated with trauma, articulate various means of dispelling challenges to the clinical encounter, explain the benefits of task-specific inquiry, and identify essential elements for de-escalating an agitated patient in crisis.

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being

Physical and sexual assault are the most frequently trauma-inducing events in the United States.

Trauma at different stages in life and among different individuals differentially affects the brain. Whether a recent trauma produces long-term effects on a student in higher education or develops into post-traumatic stress disorder depends on such factors as the survivor's history, genetic makeup, age, and culture; the nature of the event; and the timing and amount of medical and emotional support.

### Neurobiology of Trauma

It is beyond the scope of this training to address the effect of trauma on early brain development. But a simplified sketch of neurological function under stress will inform your understanding of trauma's effects.

Visual and auditory stimuli are first processed by the thalamus (located in the forebrain), which activates the amygdala, which then passes information to the medial prefrontal cortex for interpretation.

The cortex returns the results of its assessment to the limbic system, in particular the amygdala and the hippocampus. When the perception of a threat is gone, signals

activate inhibitory neurons in the amygdala, which in turn activates the parasympathetic nervous system and causes the person to relax.

*An image of a brain labeling the amygdala and the hippocampus is shown. Each term has the following description:*

*The amygdala assigns and records emotional meaning.*

*The hippocampus records spatial and temporal dimensions of experience.*

### **Fight-Flight-Freeze**

As long as threat is perceived, however, signals to the limbic system invoke the familiar survival response—fight, flight, or freeze—by the sympathetic nervous system. Heart rate accelerates, digestion slows, blood vessels constrict, pupils dilate, muscles energize, saliva dries up, and breathing becomes panting.

(sound of panting and heartbeat)

### **Hypothalamic-Pituitary-Adrenal Axis (HPA Axis)**

The excited amygdala activates the hypothalamic-pituitary-adrenal (HPA) axis deeper in the brain by stimulating the hypothalamus to release corticotropin-releasing hormone (CRH) and vasopressin, which cause the anterior pituitary to secrete adrenocorticotropic hormone (ACTH). ACTH stimulates the adrenal gland to release a surge of hormones, notably glucocorticoids (mainly cortisol) and the catecholamines adrenalin and noradrenalin.

CRH also triggers noradrenergic neurons in the locus coeruleus in the brainstem to release noradrenalin and other neurotransmitters associated with increased alertness and vigilance behavior critical to surviving an acute threat.

Cortisol provides negative feedback on the HPA axis, which also is regulated by the hippocampus and prefrontal cortex. The limbic structures generally inhibit stress-induced HPA activation, though the amygdala excites it.

### **Cortisol**

Also subject to normal circadian rhythms, cortisol contributes to homeostasis by regulating serum glucose. But also it propagates the stress response by overriding insulin to raise glucose levels, dampening the immune system and promoting emotional memory, among other effects. At the same time, high levels of circulating cortisol have a significant negative effect on memory, which, over time, can cause hippocampal atrophy.

### **Neurological Impact of Trauma**

Mechanisms involved in trauma's lingering neurological and psychiatric effects have yet to be fully articulated. Some scientists believe that chronic high stress disrupts inhibitory HPA feedback. Certainly, traumatic stress can alter neurological pathways linking the medial prefrontal cortex, hippocampus, and amygdala. It can specifically keep the amygdala in a super-vigilant state, decrease cortical function, and damage neurons in the hippocampus.

Human studies show that the hormonal interactions vary with the stressor so that HPA dysfunction produces hyper- or hyposecretion of cortisol and other glucocorticoids.

### **Chronic and Persistent Stress**

Whereas reasoning by the prefrontal cortex normally contributes to fear extinction, chronic and persistent stress such as that caused by unaddressed trauma—also known as fear conditioning—can hijack the process and contribute to the long-term, debilitating disorder known as PTSD. In fact, patients diagnosed with PTSD have been found to have a 7%–8% reduction in hippocampus volume.

Fortunately, the human hippocampus demonstrates an unusual capacity for plasticity and revitalization with improvements in the survivor's environment, including physical exercise and psychotherapy.

Until the survivor has obtained the necessary support and progressed through a healing process, heightened sensations associated with the survival response—fear, anxiety, agitation, and fragmented memory—continue to dominate.

From the practitioner's standpoint, however, a patient may only seem to be excessively modest, timid, eccentric, sullen, or crabby. At a busy clinic, anything that delays or disrupts the schedule can be frustrating, and it can be a challenge to avoid making assumptions.

Although adopting trauma-sensitive practices may seem likely to cause delays, the prevalence of trauma in the general population, among some immigrant cultures, and in LGBT individuals justifies the extra effort to help all patients feel safe, respected, and empowered. The benefits to the encounter include enhanced cooperation and compliance as well as reduced distress.

Knowing that medical appointments cause anxiety for many people anyway, clinics do what they can to ease the encounter. Adopting a trauma-sensitive approach emphasizes issues concerning intake, time, clothing, and touch.

### **Intake**

During the intake clinicians can ask the patient about preferences, experiences, and difficulties with the exam or procedure and request suggestions for increasing their

comfort. Even after the topic seems to be exhausted, you can open the door to new information by asking if there is anything else you should know. Should the situation seem to warrant it, you can invite the patient to request examination by a person of the same gender or to have a friend or other person present for support. Encourage the patient to ask questions throughout the appointment.

## Time

Time affects everyone's sense of control, but a person affected by trauma can seem excessively sensitive to it. To circumvent rising anxiety, tell patients at the outset how much time you are scheduled to spend with them and negotiate how best to use it.

Information to reduce patient anxiety:

- Currently scheduled length of appointment
- Options for best use of time
- Events that could affect available time

Different female voice: "Your appointment is scheduled to last 15 minutes. What do we need to focus on?"

Or

Different female voice: "The doctor has been delayed by an emergency. It may take an hour or more. Can you wait that long?"

## Clothing

Attending to issues of clothing and touch reinforces a trauma survivor's fragile sense of safety. The trauma-sensitive approach leaves patients fully clothed to meet all staff, including clinicians. They remain clothed throughout the taking of vitals and history and throughout discussions about the content of the appointment. They are again clothed when taking leave of the examining clinician.

If the encounter warrants clothing removal, the reasons for doing so need to be made clear and arrangements worked out to the patient's satisfaction. Stick to simple straightforward language and consider the words you use for their potential to cause anxiety.

Problematic term:

Undress

Bed

Panties

Better option:

Change

Exam table

Underwear

Provide a gown that fits the person's body, or even double-gown as needed to enclose the patient's backside. Have the patient remove the minimum clothing necessary, leave the room while the patient changes, and minimize the amount of time he or she must remain disrobed. Again, knock and receive an answer before returning to the examination room. Later, leave the room and wait until the patient is again clothed before you say good-bye.

## **Touch**

Touch being another especially difficult issue, you may need to talk about it specifically. Besides the sensitivity of traumatized persons, some cultural mores make touch tricky. Some persons may perceive gentle touch as sexually suggestive while others find it soothing. You may need to explain palpation and other touch required in a health care setting.

## **Managing Encounters**

As for the procedure or examination itself, the following recommendations are probably familiar but bear repeating in the context of patients affected by trauma. For example, some persons startle easily, so try to avoid quick, unexpected movements. And when at all possible, avoid standing behind the patient or approaching him or her from behind.

## **Narrate the Process**

In a similar vein, you'll probably find it facilitates the exam to develop your narrative skills so that you can explain what you are about to do and why, seek consent before you proceed, describe what you are doing as you do it, and prepare the patient for the next step.

Be sure to tell the patient when you are shifting focus from one body part to another. Explain why you may need to examine a site other than the one initially specified.

## **Task-Specific Inquiry**

Along with narration, you may find that employing task-specific inquiry also keeps the encounter on track. This means asking questions specific to the procedure, such as,

“Have you ever had difficulty with this process?” If the patient says yes, ask, “What can I do to make it easier for you?”

It also means periodically requesting feedback with the simple question, “How are you doing?” Address the response.

If the patient tenses at some point, task-specific inquiry ties your observation to the procedure. “I noticed that you flinched when I shifted the gown to perform a breast examination. Do you have difficulty with this part?” Again, if the patient says yes, ask how you can make it easier.

Some survivors will deny what their body language is saying. By keeping the focus on the task, you can explain that a relaxed state eases the process and gets the patient’s help in finding an approach to make it more comfortable.

“Would it help if I gave you a mirror so that you can see what I’m doing?”

Remind patients that it’s okay if they need to withdraw consent, have the process slow down, or take a break. If time runs out, tell them that they can make another appointment or you can make some other arrangement.

Documenting patient responses to the exam can alleviate difficulty in subsequent health care encounters.

### **Convey Interest**

Busy practitioners struggling to complete required documentation during the appointment often find they need to make an effort to maintain eye contact with the patient. But nonverbal and verbal communication convey interest and attention, so it’s important to look at the person with whom one is conversing.

Also, talking with one hand on the doorknob indicates an eagerness to leave. Abruptly leaving to take a call without an explanation or promise to return immediately suggests that the person in the exam room is unimportant.

Interruptions do the same thing. And the presence of students in training can make the patient feel like an object. If yours is a teaching practice, get permission to include other persons in the room.

### **Remain Culturally Aware**

For some people, particularly from non-Western cultures, physical ailments and pain rather than emotional expression are the primary way of manifesting psychological trauma. Symptoms cover the gamut of somatoform disorders associated with mental illness, stress, and PTSD. Thus, what appears to be a disproportionate amount of pain

can indicate traumatic stress. Genital and rectal examinations, particularly, can be fraught with anxiety.

### **Minimize Patient Anxiety**

To recap, minimize the patient's anxiety and pain, acknowledge any discomfort, keep explaining what you are doing, limit the time the patient must remain in a prone or subordinate position, and drape parts of the body not under examination. Keep encouraging the patient to tell you if he or she needs to pause, slow down, or stop.

### **Managing Triggered Patients**

Even under the most nonthreatening circumstances, a sound or an odor can trigger acute distress associated with trauma. The trigger may elicit a sudden memory, feeling, or flashback. The distress can run the gamut from a relatively mild, increased heart rate to severe dissociation. Though distress symptoms are highly variable, the experience is always upsetting. When you perceive a sudden negative shift in mood, it's important to ask if the person wants to talk about what is happening to them. Remember the SAVE protocol.

Stop what you're doing and focus on the situation.

Appreciate and understand the person's state.

Validate the person's experience.

Explore resolutions.

### **Dissociation**

In a dissociative state, patients may stare blankly into space or even try to hide. Upon return to normal consciousness, they're often vague, bewildered, and frightened. It's not uncommon for them to ask, "What just happened?" or "Where am I?"

Orient patients to the present by reminding them where they are and what you were doing when they began to seem distressed.

Tell patients to open their eyes if they keep closing them. Remind them to feel the floor through their feet or the chair against their back and the temperature of the room.

Encourage slow rhythmic breathing. "Count to four while you breathe in and count to six while you breathe out."

Offer water and assurance, but don't touch the person at this time. Keep questions simple and focused on reconnecting. "Are you with me?" "Do you understand what I'm saying?" "Can I do anything for you?"

## Reassurance

Even if you don't know exactly what set off their reaction, let them know that it is normal and lots of people get anxious at the doctor's office. If you do know the cause, remind the patient that clinical procedures can trigger strong emotional responses.

Without pressing the patient for an explanation, suggest that it might be helpful to talk about the experience with someone.

"Exams like the one we are doing can be scary and bring up all sorts of feelings. It can help to talk about it with someone. Is there anyone I can call for you?"

And depending on the response, "Would you like a referral to a counselor?"

To close the discussion, repeat all instructions for the patient and write them down in simple terms.

## De-Escalating Patients

Perhaps more commonly identified as an issue with male survivors, angry feelings can suddenly well up in females as well. Though patients who don't feel well can certainly present as irritable, some patients affected by trauma can be triggered into a highly agitated state that calls for considerable skill assessing and managing the situation. Always, the primary goal is everyone's safety and, after that, to help the patient regain control without having to use restraints or coercion such as threats to call the police.

When dealing with a highly agitated or angry patient, respect everyone's personal space. Stay two arm lengths back. Avoid provocation. Keep your hands in sight and unclenched. Keep your face calm. Stand at an angle to eliminate the appearance of confrontation. One person should speak politely with the patient. Avoid having voices come from all directions. Be concise. Keep it simple. Agitated or triggered patients have difficulty tracking and processing verbal information. Ask what the patient wants. Listen closely to what the patient says and verify it. Agree or agree to disagree. You can usually find something to agree with in the words of an upset person. If you can't, just admit that you haven't had the same experience or ask if it's okay to disagree. Staying neutral and respectful, set boundaries by stating what is and is not acceptable behavior. Help the patient find a way to regain control. Offer choices. Provide alternatives to violence and offer food or water or a blanket, something the patient will recognize as a kindness. When it's all over, debrief all parties. Talk with the patient about what happened, explore other ways to deal with the feelings, and discuss referrals. With the staff, let everyone talk it over. What worked? What didn't? What might be done to improve the response? And what are some ways that all involved can take care of themselves?



## Managing Disclosure

The final issue to be addressed in this overview of the trauma-sensitive clinical encounter is disclosure. Though primary care may offer such services as STD testing, physical examinations, and occasionally the services of a sexual assault nurse examiner, most student health centers are not equipped to treat traumatic stress. A likely scenario contains a revelation of trauma that emerges from an appointment made for another reason.

Practitioners help the patient feel safe when they follow protocol and explain confidentiality, make appropriate referrals, supply support contacts and stress-relief handouts, and convey accurate information about what happens next.

A revelation of abuse, intimate partner violence, or some other traumatic event can be disconcerting for everyone. The patient is likely to feel particularly vulnerable, perhaps even fearful of your reaction. Your immediate response can be significant.

Accept the information without asking for more and express empathy. Validate the disclosure and assure the patient that he or she is not to blame and that you believe they can recover from the experience.

Don't be too effusive with reassurance, though, because it can be perceived as negating the patient's pain. Listen, recognizing that action is not always required. Sometimes a traumatized person is just ready to talk.

## Staff Self Care

As in the discussion about triggering, disclosure is an opportunity to collaborate with the patient on a plan for self-care. You can use the [Stress Relief Tips](#) handout as a starting point and ask if there's someone they want to call. This should serve as a reminder to the clinician to monitor his or her own need for self-care. The [Staff Self-Care Plan](#) can be a useful tool for professionals to restore equanimity.

Practitioners adopting trauma-sensitive practice as their standard of care are encouraged to explore the wealth of information now available. As your awareness and skill develop, you can take encouragement from the words of a relieved patient about their practitioner: "He said, 'You know, I'm really sorry this happened to you.' And that was the best thing he could have said."

Please note that this training offers no information regarding therapeutic modalities. The ongoing care of persons displaying symptoms of trauma should be managed by a professional trauma practitioner. Treatment outcomes literature attests to complex interactions among symptoms of trauma and apparent mood disorders, making diagnosis and treatment problematic for primary care providers.

As you consider your conduct in service to a trauma-sensitive patient encounter, the [Safe Place Encounter Checklist](#) can direct your reflection.

## References

Bremner, J. D. (2006). Traumatic stress: Effects on the brain. *Dialogues in Clinical Neuroscience*, 8(4), 445–461.

Clervil, R., Guarino, K., DeCandia, C. J., & Beach, C. A. (2013). *Trauma-informed care for displaced populations: A guide for community-based service providers*. Waltham, MA: The National Center on Family Homelessness.

Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P., Rifai, M. A., & Ng, A. T. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1), 17–25.

Schachter, C. L., Stalker, C. A., Teram, E., Lasiuk, G. C., & Danilkewich, A. (2008). *Handbook on sensitive practice for health care practitioners*. Ottawa, Ontario: Public Health Agency of Canada.

Wilson, J. P., & Tang, C. S. (2007). *Cross-cultural assessment of psychological trauma and PTSD*. New York, NY: Springer Publishing.

Wright, A. (1997–present). *Chapter 6: Limbic system: Amygdala*. *Neuroscience Online*. The University of Texas Medical School at Houston. Retrieved from <http://neuroscience.uth.tmc.edu/s4/chapter06.html>

## Conclusion

This resource is produced on behalf of the White House Task Force to Protect Students from Sexual Assault by the National Center on Safe Supportive Learning Environments, which is funded by the Office of Safe and Healthy Students in the Office of Elementary and Secondary Education at the U.S. Department of Education.

That brings to a close our exploration of trauma-sensitive encounters.

Go to [http://airhsdlearning.airws.org/safeplaceassets/Certificate\\_4.pdf](http://airhsdlearning.airws.org/safeplaceassets/Certificate_4.pdf) to obtain a certificate of completion.

## (Additional) Test Your Knowledge

Thank you for completing this learning module. We hope that by participating, you are making a commitment to offering a trauma-sensitive standard of care and to keep learning more. Thank you.

The next few slides will take you through a short quiz to gauge your understanding of the concepts you just learned.

1. Task-specific inquiry helps keep a patient encounter on track by asking questions... (Consider all that apply.)
  - a. About other parts of the patient's life.
  - b. Aimed at relaxing the patient.
  - c. Specific to the procedure being performed.
  - d. That keep the patient's mind off being touched.
  - e. That elicit feedback from the patient.

*The correct answers are c and e.*

2. Which hormone subject to normal circadian rhythm can cause the hippocampus to atrophy when high levels circulate for an extended period of time? (Select one option.)
  - a. Cortisol
  - b. Noradrenaline
  - c. Corticotropin-releasing hormone (CRH)
  - d. Adrenocorticotrophic hormone (ACTH)
  - e. Vasopressin

*The correct answer is a.*

3. Which of the factors listed does **not** affect the development of long-term traumatic stress or PTSD? (Select one option.)
  - a. Age
  - b. Culture
  - c. Gender
  - d. Support
  - e. History
  - f. Genetic makeup
  - g. Nature of the trauma-causing event

*The correct answer is c.*

4. When the medial prefrontal cortex notifies the limbic system that a threat exists, which structure activates the hypothalamic-pituitary-adrenal axis to release a cascade of hormones associated with increased alertness and vigilance behavior? (Select one option.)
- Amygdala
  - Hippocampus
  - Thalamus
  - Locus coeruleus
  - Corpus callosum

*The correct answer is a.*

5. Match the anxiety-reducing strategy with the issue it addresses. (Check all that apply.)

### **Anxiety-reducing Strategies**

Clothing

Touch

Time

Intake

### **Issues the Strategies Address**

- Explain the scheduled length of the appointment, provide options for best sticking to the schedule, and update the patient as to delays and allow rescheduling.
- Explain palpation when performed, narrate the process, explaining what you are about to do and why, obtain consent before you proceed with an exam or procedure, and acknowledge any discomfort.
- Provide a gown that fits, have the patient disrobe to the minimum extent necessary for the procedure, leave the room while the patient changes, and clearly explain the reasons why any street clothing needs to be removed.
- Seek suggestions regarding preferences, experiences, and difficulties with the procedure, encourage the patient to ask questions throughout the appointment, ask if there is anything else you should know, if warranted, invite the patient to request examination by a person of the same gender or have support present.

*The correct answers are as follows: clothing goes with c, touch goes with b, time goes with a, and intake goes with d.*

6. When something triggers acute traumatic stress in a patient, you will need to help her regain composure. What is the proper sequence for the following steps? (Decide the proper sequence.)

- a. Explore resolutions.
- b. Stop what you're doing and focus on the situation.
- c. Validate the person's experience.
- d. Appreciate and understand the person's emotional state.

*The correct sequence is b, d, c, a.*

7. Match the de-escalation techniques to the steps they address for highly agitated or angry patients.

### **De-Escalation Techniques**

Respect personal space

Avoid provocation

Speak politely

Keep it simple

Ask what the patient wants

Listen to what the patient says and verify it

Agree or agree to disagree

Set boundaries

Offer choices

Debrief all parties

### **Steps to Address a Highly Agitated or Angry Patient**

- a. Have only one person speaking politely with the patient.
- b. Keep your hands in sight and unclenched, face calm.
- c. Agitated patients have difficulty tracking and processing what they hear, so be concise and clear.
- d. Stay two arm lengths back.
- e. When the incident has ended, talk over the feelings and possible alternatives with the patient and then with the staff.
- f. Pay attention and validate what the patient says.
- g. "Can you tell me what you need?"
- h. If you don't share their experience, admit it and ask if it's okay to differ.
- i. State what is and what is not acceptable behavior.
- j. Provide alternatives to violence and offer food, water, or a blanket.

*The correct answers are as follows: "respect personal space" goes with d- Stay two arm lengths back; "avoid provocation" goes with b- Keep your hands in sight and unclenched, face calm; "speak politely" goes with a- Have only one person speaking politely with the patient; "keep it simple" goes with c- Agitated patients have difficulty*

*tracking and processing what they hear, so be concise and clear; “ask what the patient wants” goes with g- “Can you tell me what you need?”; “listen to what the patient says and verify it” goes with f- Pay attention and validate what the patient says; “agree or agree to disagree” goes with h- If you don’t share their experience, admit it and ask if it’s okay to differ; “set boundaries” goes with i- State what is and what is not acceptable behavior; “offer choices” goes with j- Provide alternatives to violence and offer food, water, or a blanket; and “debrief all parties” goes with e- When the incident has ended, talk over the feelings and possible alternatives with the patient and then with the staff.*

8. Rather than express emotion, what is a common means of manifesting psychological trauma in some, especially non-Western, cultures? (Select one option.)
- a. Screaming
  - b. Staring blankly
  - c. Paralysis
  - d. Physical ailments and pain
  - e. Itching

*The correct answer is d.*