

What EMS Needs to Know About Trauma-Informed Care

In EMS, “trauma care” conjures up bleeding or broken bones. But there’s another type of trauma care that has little to do with blood and guts.

It’s called “trauma-informed care,” and it’s provoking changes to the way that healthcare providers treat and communicate with patients.

Trauma-informed care acknowledges that most people have had one or more traumatic experiences. The goal of trauma-informed care is to speak to, interact with and care for patients in a way that avoids re-traumatizing them.

“Trauma-informed care is a strategic framework for how to support people who have survived various forms of trauma. It could be physical, sexual, psychological or even historical and structural trauma, like the kind of trauma that gets passed down in gender and racial minorities,” explained Dr. Sadie Elisseou, a clinical instructor of medicine at Harvard Medical School and a physician with the VA Boston Healthcare System.

SAMHSA: What is trauma?

SAMHSA defines trauma as “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.”

- Individual, such as a car accident or death of a loved one.
- Interpersonal, such as domestic violence, discrimination, or abuse.
- Societal, such as natural disasters, pandemics, or terrorist attacks.
- Newer definitions include structural trauma, such as racism and sexism.

Studies show trauma is very common. One national sample of U.S. adults¹ found that nearly 90% had at least one traumatic event during their lifetimes, and most had been exposed to more than one. Trauma exposure is particularly common among patients in emergency departments², above and beyond the injury or illness that brought them there.

“We are very familiar with trauma-focused care. ‘I’m going to see a psychologist to talk about the details of my childhood trauma.’ Or, ‘I need to get seen right now by a paramedic because I am at the site of a motor vehicle accident,’” Elisseou said. “Trauma-informed is different. It’s simply a manner of approaching someone in a way that is sensitive to their prior trauma.”

Elisseou developed a curriculum³ for medical students on conducting a trauma-informed physical exam. She spoke with *NAEMT News* about how EMS practitioners can practice trauma-informed care in the field.

When did you first realize that past trauma could affect how patients reacted or behaved during exams or in healthcare settings?

The majority of my patients are trauma-exposed. About one-third have PTSD. Pretty soon after I started seeing patients it became clear that the standard physical exam procedures I had learned in med school were making my patients uncomfortable.

One vivid example I’ll never forget is I swung my stethoscope off my neck and the patient jumped. Effectively, I



had just swung a rope near his neck. Or I remember approaching someone to check their thyroid in the traditional way, where you are behind the patient, outside of their field of vision and you wrap your hands around their neck, and he flinched to get away from me.

I thought, “I had taken an oath to do no harm, what am I doing?” I started adjusting how I spoke, where I stood, and how I moved in the room, purely in an effort to make these trauma-exposed vets who were hurting feel safe and comfortable with me.

I started teaching these techniques to medical students at Brown University. Eventually, it led to a formal framework for a trauma-informed physical exam. It’s now being taught at medical schools across the U.S.

I’ve been privileged to be invited to teach this across the country. This generation of healthcare professionals is demanding this material. They are aware that we are not called as healthcare professionals only to treat physical disease, but also social illness and injustice.

How does past trauma act as a social determinant of health?

When we are exposed to trauma, particularly at a young age, it changes the brain. It affects our neurobiology and brain development. It can release stress hormones and inflammatory markers that promote chronic disease, impaired immunity and the development of things

¹Kilpatrick, Dean G et al. “National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria.” *Journal of Traumatic Stress* vol. 26,5 (2013): 537-47. doi:10.1002/jts.21848

²Brown, Taylor et al. “Trauma-informed Care Interventions in Emergency Medicine: A Systematic Review.” *The Western Journal of Emergency Medicine* vol. 23,3 334-344. 13 Apr. 2022, doi:10.5811/westjem.2022.1.53674

³Elisseou, Sadie, et al. “A Novel, Trauma-Informed Physical Examination Curriculum for First-Year Medical Students.” *MedEdPORTAL*, 2019, https://doi.org/10.15766/mep_2374-8265.10799.

like heart disease, diabetes, cancer and even shortened lifespans. Populations who are more exposed than others to adversity end up getting sicker. And in a society with depleted psychosocial resources for these populations, we are perpetuating a cycle of sickness.

Who developed the concept of trauma-informed care?

The group that really defined trauma-informed care is the Substance Abuse and Mental Health Services Administration (SAMHSA). They are pioneers and leaders in trauma-informed approaches. Everything draws from their six principals.

What are these principals?

1 Safety, which means that everyone in the encounter should feel physically, psychologically and emotionally safe.

2 Trustworthiness and transparency, with the goal of building trust with the patient. Even if you only have a couple of seconds, you can explain what you're about to do and why. "I need to put this IV in your arm, so that we can give you fluids because your blood pressure is low. Is that OK?"

3 Peer support. That could be asking, "Would you like anyone else to be present? Is there someone you'd like to sit with you?" Or it could be giving a list of peer support groups for this issue, such as AA or NA meetings. Peer support is also making sure EMS practitioners who witness trauma are supported. Isolation only perpetuates psychological trauma. Connection is crucial to psychological healing.

4 Collaboration. There should be a meaningful sharing of power in decision-making between providers and patients. Typically, when patients call EMS, there is already a power differential. There is the healthcare professional who has a degree, or a license, and a white coat or uniform. Then there is a patient who is vulnerable, or in pain. They feel

What can EMS do to put trauma-informed care into practice?

On time-sensitive responses where a life hangs in the balance, the priority is on saving the life. But for all other calls, here are Dr. Elisseou's tips for practicing trauma-informed care.

Pay attention to non-verbal cues. Model calmness. Wind down the stress level. Try not to speak too loudly or too quickly.

Set an agenda. Introduce yourself. Look your patient in the eye, and let them know you are here to help. When possible, use phrases that give people a sense of autonomy, such as "We can pause if you need a break," or "You are in control of the pace."

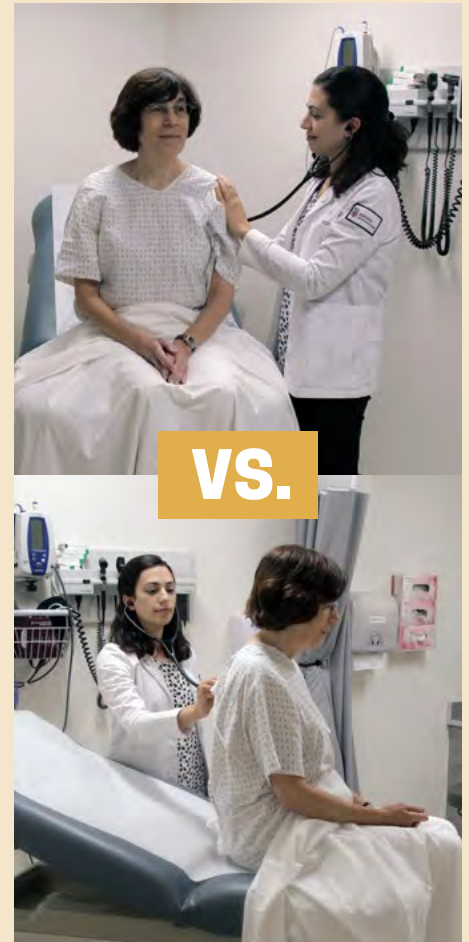
Be mindful of language choices. "One of the phrases I hear consistently throughout healthcare is 'for me,' which can enhance the power differential and even be sexually suggestive," Elisseou said. "Take off your shirt for me.' 'Hop on the bed for me.' It's just not a necessary phrase. Omit that all together."

She gives similar advice for checking reflexes/doing neuro exams. "We use adversarial language like 'Push me away' or 'Put up your arms like you're going to fight.' Instead say, 'Resist this motion,' 'Keep your arms up strong,' or 'Push forward' so they are in control of their own body parts."

Help patients maintain a sense of control. Allow them to adjust their privacy draping, or to lift their own shirt. Ask permission to touch them. Instead of saying "I want to," ask "Would it be OK if I?" Or instead of saying "I'm going to look at, feel, touch," say "Is it OK if I examine, evaluate, or check." These are more clinical words.

Stay within their vision. When listening to their lungs, try to stand at the patient's side in their peripheral vision, not behind them.

Alert patients to what they might feel during an exam. For example, when checking their blood pressure, you might tell them that it will feel like a tight squeeze.



Dr. Elisseou recommends staying in the patient's view when checking heart and lung sounds. Photographer: Jared DiChiara. Courtesy of Dr. Elisseou.

Conduct an efficient exam. Try to avoid keeping the mouth in an open position for longer than absolutely necessary, or other positions that can make patients feel vulnerable or trigger unwanted memories.

Be careful with suggesting specific imagery. When health professionals are trying to get people to calm down, they may suggest imagery, such as, "Pretend you're at the beach." Elisseou recalled one patient whose traumatic experience occurred at the beach. Instead, ask patients to take a deep, relaxing breath. "We don't necessarily know what experiences they've had before," she said.

a lack of control, or they are wounded, or maybe they are undressed. Whatever measures you can take to level the playing field of power and help patients feel a sense of control is important, such as sitting or standing at eye level and not looming over them.

5 Empowerment, voice and choice.

Trauma can strip away feelings of control and autonomy. When we encounter patients who are trauma-exposed, do whatever you can to make them feel like they have autonomy. It can be a really tiny choice. "Would you like to sit in the wheelchair or on the exam table?" When you listen to their lungs with the stethoscope, a lot of the time the examiner raises the patient's shirt. Instead, I ask the patients to raise their own shirt, from the back, and explain that's so I can get a more accurate listen to their lungs.

6 Cultural issues.

The final principal is attending to cultural, historical and gender issues. Being mindful of structural trauma and racism and the ways that it affects people's experiences with healthcare, and doing whatever we can do to create an inclusive environment, is really key.

How does trauma affect EMS practitioners?

As health workers, we are not immune from trauma. Thinking you can take care of trauma cases in EMS and not be affected is an antiquated way of thinking. It's like thinking you can walk into water and not get wet. It's just part of it.

There is vicarious trauma, and secondary traumatization. We are more aware now of mental health concerns and that healthcare workers are trauma survivors themselves, not only perhaps from childhood but also just plain on the job.

One thing that was very eye-opening for me is that anything sensory that is similar to your previous trauma experience can bring back feelings in the body that can make us feel unsafe again, as if we were reliving that

trauma. I could just be working, and I can smell something and... Woah. I can feel agitated. You may need to take a moment and calm yourself down.

Or what if some dude on a Zoom call reminds me of a perpetrator when I was 12. Just going through our typical workday, we can be activated to feel symptoms of trauma. We need to know how to recognize that in ourselves and take care of ourselves.

From a trauma-informed standpoint, as healthcare providers, we are moving beyond the accusatory, "What is wrong with you?" to "What has happened to you that has affected you in this way?"

The most famous influential study⁴ in the trauma world was from the 1990s. It found that over half of adults surveyed had experienced at least one ACE, or Adverse Childhood Experience – abuse, neglect or household dysfunction. Health workers have the same rates of ACEs as those not in healthcare.

How could interacting with emergency responders trigger a trauma-response in patients who've experienced ACEs?

One of the things that happens often in EMS scenarios is people are in the fight or flight response. They are no longer grounded in their current circumstances. They are hyperaroused, on edge and the rational thinking part of their brain goes offline.

If people are touching them, quickly, or firmly, they may think they are continuing to be abused. As much as possible, we should give people cues to let them know that that they are in control and this is an exam for medical purposes, for their own benefit.

If someone is being combative, think trauma. There is a concept called the "window of tolerance." We try to stay in this middle zone of optimal arousal where we can think and act clearly. But

sometimes something activates us to go out of that window into hyperarousal, where we are tense, on guard and agitated. These are the patients you see in the ER. The majority of them have ACEs. The majority of them have trauma, both chronic and acute so it can be the teensiest little "boop" that throws them into hyperarousal. They are all ready to blow.

From a trauma-informed standpoint, as healthcare providers, we are moving beyond the accusatory, "What is wrong with you?" to "What has happened to you that has affected you in this way?"

This has revolutionized my own practice. If I see somebody who is angry and agitated, I know that person is doing the best they can today. That person is not intentionally trying to ruin my day. They are coming from a place of pain. If I go in modeling calmness, I am at eye level. I sit with an open posture, not with my face in the computer. I am role modeling empathy and helping people feel heard, it can change that patient's experience.

To practice trauma-informed care, what do all healthcare providers need to know?

With trauma-informed care, you don't screen first. It's a universal precaution. It's like handwashing. You assume people have lived through difficult things. We are all carrying some difficult things in our backpacks. Some rocks in those backpacks are heavier than others, and the last thing we want to do is to add to the weight of that backpack.

What is your message for EMS?

We live in a world of sorrows and joys. The aim of trauma-informed care is to cultivate a practice that is compassionate, both for the healing and benefit of patients, as well as for ourselves. Because neither trauma nor healing happen in isolation. We are in this together.

⁴Felitti, VJ et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine* vol. 14,4 (1998): 245-58. doi:10.1016/s0749-3797(98)00017-8