Trauma-Informed Care (TIC) in Dietetics: How to Apply in Clinical Practice

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Learning Objectives

At the end of this CPE activity, the learner will be able to:

- Recognize when a patient may have a history of trauma.
- Describe the effects of trauma on the brain.
- Understand the framework and key principles of Trauma-Informed Care.
- Apply trauma-informed care strategies in clinical dietetics practice to enhance patient trust, safety, and outcomes.

Anticipated Outcomes

An opportunity to demonstrate understanding of the concepts presented in this CPE activity will be provided at the end to ensure learners have met the learning objectives and gained proficient knowledge

Disclosure

- No conflicts of interest to disclose.
- No commercial support has been provided.
- No funding from non-CPE revenue for CPE planning, development, review, and/or presentation has been provided.

WHAT IS TRAUMA?

Substance Abuse and Mental Health Services (SAMHSA) defines trauma as:

"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 adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

WHO IS AFFECTED BY TRAUMA?

Trauma is inclusive and does not discriminate.

Those at Risk:

- Children and Adults
- All Genders
- All Socioeconomic Levels
- All Races/Ethnicities/Sexual Orientation
- Mental Health Disorders
- Substance Use Disorders

SYMPTOMS OF TRAUMA

- GUARDED/UNTRUSTING
- CONFUSED OR MEMORY LOSS
- INTRUSIVE THOUGHTS MIXED WITH NUMBNESS
- AVOIDANCE OF TRIGGERS/FEAR OF TRAUMATIC MEMORIES
- EXTREME AWARNESS OF SURROUNDINGS
- AGGRESSION
- EAGER TO PLEASE – KNOWS WHAT PEOPLE WANT TO HEAR

3 E'S OF TRAUMA

- **EVENT**
  - Single event, series of events, or circumstances
- **EXPERIENCE**
  - Harmful or life-threatening physical /emotional experiences
- **EFFECTS**
  - Long-term effects on function and well-being

THE EFFECTS OF TRAUMA ON THE BRAIN:
3 Key Neurological Changes

1. Threat-Perception of Danger Changes

- Trauma-Brain = **"Fear-Driven Brain"** seeing situations as **DANGER** vs **MANAGEABLE**

2. Filtering System Increases

- Difficult to focus on **ORDINARY** and **PRESENT** situations

3. Self-Sensing System/Perception of Your Experiences Gets Blunted

- Brain in a state of constant **"terror"** = need to dampen negative feelings

TRAUMA-INFORMED CARE (TIC)

A framework in healthcare that works to understand the

widespread impact of trauma on individuals and improving recovery outcomes.

The emphasis is on shifting current culture away from **"What is wrong with you?"** to **"What happened to you?"**

By recognizing signs and symptoms of trauma, we actively avoid retraumatizing the patient

FRAMEWORK OF TRAUMA-INFORMED CARE

5 KEY PRINCIPLES

1. Safety
2. Trustworthy & Transparency
3. Empowerment/Autonomy
4. Cultural Sensitivity
5. Collaboration

SAFETY

Patients need an environment that feels:

- **SAFE**
- **CALM**
- **COMFORTABLE**

TRUSTWORTHY & TRANSPARENCY

Clinicians need to provide clear

and consistent information

EMPOWERMENT/AUTONOMY

- **Involve** patients in their care plan and treatment
- Speak **“to”** them not **“at”** them
- **Reassure** patients they have control over their situation – you as the clinician are to offer guidance and support

CULTURAL SENSITIVITY

Each person is uniquely shaped by their culture, heritage, and personal life-experiences.

- *There is no **"ONE-SIZE"** fits all for trauma-informed care.*
- *Trauma is processed differently for each patient*

COLLABORATION

GET EVERYONE INVOLVED to MAXIMIZE TREATMENT PLANNING of the PATIENT

- ***Healthcare staff***
- ***Patient***
- ***Families***
- ***Organizations***
- ***Community Resources***

THE 4 R’s of TIC

REALIZE

All people at every level have a basic realization regarding trauma, and how it can affect individuals, families, and communities

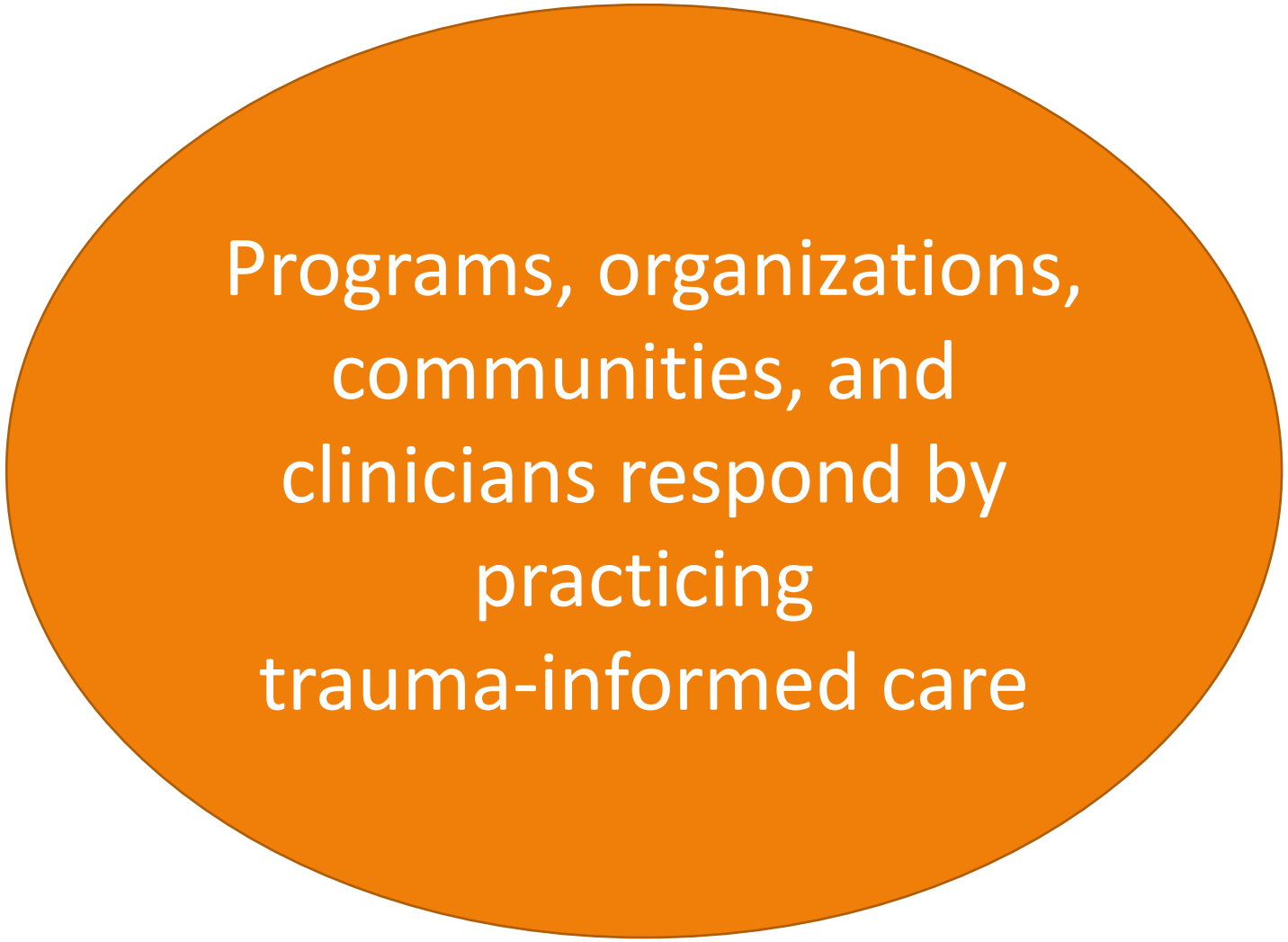
RECOGNIZE


People within organizations are able to recognize the signs of trauma

RESIST RETRAUMATIZING

Organizational practices may compound trauma unintentionally. Trauma-informed organizations and clinicians avoid this.

RESPOND


Programs, organizations, communities, and clinicians respond by practicing trauma-informed care

WORDS AND TONE MATTER

- Patients/clients with past trauma are hyper-aware of people, expressions, and **"intentions."** This goes back to the **"fear-driven"** brain response

- Introduce yourself and **REASSURE** the patients/or clients you are not there to "tell" them what to do or what is best for them…they have autonomy over their care

- Speak in calm tones using open-ended questions to allow patients/clients to feel seen and heard

- Never tell patients/clients you "understand" what they are going through if you have never been through their experience

Comparison of Standard Practice Language vs Trauma-Informed Language

Standard Language

- Do you know much you weigh or if you've lost weight?
- I see you aren't eating very much.
- I am recommending a nutrition supplement for increased kcals/protein

Trauma-Informed Language

- Do you mind if I ask about your weight history?
- How is your appetite, any changes you've noticed – it's okay, no judgment.
- Would you be open to a supplement to help meet your nutritional needs?

Retraumatization
WHAT HURTS?

SYSTEM *(Policies, Procedures, Structural and Institutional Racism and Oppression)*	RELATIONSHIP *(Power, Control, Subversiveness, Interpersonal Racism and Oppression)*
HAVING TO CONTINUALLY RETELL THEIR STORY	NOT BEING SEEN/HEARD
BEING TREATED AS A NUMBER	NON-TRANSPARENCY AND VEILED TRUTHS
BEING SEEN AS A LABEL (I.E. ADDICT, SCHIZOPHRENIC)	DOES THINGS FOR RATHER THAN WITH
NO CHOICE IN SERVICE OR TREATMENT	USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE
NON-ACKNOWLEDGEMENT OF WORK RELATED STRESS	RACIAL PROFILING
NO ACCESS TO SERVICES	BEING NON-COLLABORATIVE
PRACTICES WITHOUT ACCESSIBILITY CONSIDERATIONS	VICTIM BLAMING
ISOLATION OR EXCLUSION PRACTICES	NON-ACKNOWLEDGEMENT OF HISTORICAL NARRATIVES
MARGINALIZING PRACTICES	MICROAGGRESSIONS
PRACTICES WITHOUT CULTURAL CONSIDERATIONS	NON-INCLUSIVE LANGUAGE AND MESSAGING
"ISMS" AND PHOBIAS	NON-ACKNOWLEDGEMENT OF POWER DYNAMICS

CASE STUDY

- Female adult 24 years of age
- Presents to behavioral health's chemical dependency unit for medically supervised withdrawal from Opioids
- Decreased appetite prior to admission
- Reported weight loss prior to admission – amount and time frame unknown
- Patient is paraplegic and wheelchair bound
- Low BMI: <18 kg/m^2

CONSULT ORDERED FOR DIETITIAN

- Patient triggered for consult due to:
- Reported weight loss PTA
- Decreased appetite PTA
- Non-healing wounds: Stage IV x 2 on Coccyx

Standard Clinical Practices to Address Consult

1. Stage IV wounds: need increased kcals/protein
2. Obtain weight hx to see if weight loss is significant for time frame
3. Ask patient about usual body weight and/or discuss low BMI
4. Ask about PO intake and appetite
5. **Initial Intervention:** Oral nutrition supplement for increased kcals/protein to aid in wound healing, weight stability, and support PO intake – protein additive.

Trauma-Informed Care Practices to Address Consult

1. Stage IV wounds: need increased kcals/protein: priority
2. Obtain weight hx to see if weight loss is significant for time frame: electronic medical record if available
3. Ask patient about usual body weight and/or discuss low BMI: NO – this is harmful and triggering
4. Ask about PO intake and appetite: this is normal with detox
5. Oral nutrition supplement offered: patient immediately asked – "Will it make me fat."

BARRIERS TO TRAUMA-INFORMED CARE

1. **STIGMA:** Mental Health & Substance Use Disorders
2. **LIMITED UNDERSTANDING:** How trauma impacts patients/patient care
3. **“CHECK-the-BOX” MENTALITY:** Treating the disease, not the person
4. **TIME:** Unable to provide patient-focused time and attention
5. **PATIENTS:** Trauma history = how reactionary vs how receptive

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Discussion, Question & Answer

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