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Commentary

From Treatment to Healing: The Promise of Trauma-Informed Primary Care

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In August 2013, a national strategy group convened in Washington, DC to clarify a framework for trauma-informed primary care (TIPC) for women. The group was motivated by an increasing body of research and experience revealing that people from all races, ethnicities, and socioeconomic backgrounds come to primary care with common conditions (e.g., heart, lung, and liver diseases, obesity, diabetes, depression, substance use, and sexually transmitted infections) that can be traced to recent and past trauma. These conditions are often stubbornly refractory to treatment, in part because we are not addressing the trauma and posttraumatic stress disorder (PTSD) that underlie and perpetuate them. The purpose of the strategy group was to review the evidence linking trauma to health and provide practical guidance to clinicians, researchers, and policymakers about the core components of an effective response to recent and past trauma in the setting of primary care. We describe the results of this work and advocate for the adoption of TIPC as a practical and ethical imperative for women's health and well-being.

An Unrecognized Opportunity

Janice[1] is a 45-year-old woman with poorly controlled diabetes, obesity, and alcoholism. She feels ashamed about her alcohol use and about her body. She fears that her clinician will be angry with her for not checking her blood sugar, not losing weight, and for missing multiple gynecology appointments. Janice's clinician has worked with her for over a year and is frustrated by their inability to make progress together on her health issues. Janice has never revealed to any of her clinicians that she was sexually abused during childhood nor that she is currently experiencing severe emotional abuse by her husband.

For many people like Janice and her provider, understanding the connection between traumatic experiences and health can be transformative and healing. When patients understand that childhood and adult trauma underlie many illnesses and unhealthy behaviors, they often stop blaming themselves, feel more self-acceptance, and make progress toward health and well-being. Providers who understand this connection are able to create clinical environments that are less triggering for both patients and staff, identify referrals to appropriate trauma-specific services, and develop more effective therapeutic alliances and treatment plans with their patients.

Our strategy group worked to clarify a practical framework for TIPC, a patient-centered approach that acknowledges and addresses the broad impact of both recent and lifetime trauma on health behaviors and outcomes. The goal of TIPC is to improve the efficacy and experience of primary care for both patients and providers by integrating an evidence-based response to this key social determinant of health.

The Link between Trauma and Poor Health

The Substance Abuse and Mental Health Services Administration defines trauma as "an event, series of events, or set of circumstances [e.g., childhood and adult physical, sexual, and emotional abuse; neglect; loss; community violence; structural violence] that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse

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[1] Janice represents a composite of cases seen in our clinics.

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effects" (Substance Abuse and Mental Health Services Administration, 2014b).

Childhood and adult trauma have been shown to be major risk factors for the most common causes of adult illness, death, and disability in the United States. The seminal Adverse Childhood Experiences (ACE) study found remarkably high rates of childhood physical and sexual abuse, neglect, and household dysfunction among 17,000 predominately white, middle-class adults (Centers for Disease Control and Prevention Division of Violence Prevention, 2014a; ACE Study–Health Presentations, 2014). The study calculated an ACE Score (0–10) based on how many categories of childhood abuse individuals had experienced: 64% reported at least one ACE category, and one in six reported four or more. Women were 50% more likely than men to have experienced six or more categories of ACEs. Notably, 25% of women and 16% of men reported having experienced childhood sexual abuse. The study also revealed a strong dose–response relationship between childhood trauma and adult heart, lung, and liver disease, obesity, diabetes, depression, substance abuse, sexually transmitted infection risk, and intimate partner violence (IPV). For example, individuals who reported four or more ACE categories had twice the rates of lung and liver disease, 3 times the rate of depression, at least 3 times the rate of alcoholism, 11 times the rate of intravenous drug use, and 14 times the rate of attempting suicide than those who reported ACE scores of 0.

Similarly, trauma in adulthood is common, linked with poor health, and often undiagnosed. More than one-third of U.S. women experience stalking, physical violence, and/or rape from an intimate partner during their lifetime (Black et al., 2011). Work over the course of many years has demonstrated that both IPV and PTSD are correlated strongly with most of the same illnesses and unhealthy coping strategies as childhood trauma (Centers for Disease Control and Prevention Division of Violence Prevention, 2014b; U.S. Department of Veterans Affairs National Center for PTSD, 2014).

The mechanisms by which trauma affects adult health are still being studied, but likely include 1) neuroendocrine, inflammatory, and epigenetic changes that affect the brain and body, 2) psychological and social factors such as persistent anxiety and stigma, and 3) adaptive but unhealthy coping behaviors (Bowes & Jaffee, 2013; Moffitt & The Klaus-Grawe 2012 Think Tank, 2013; Substance Abuse and Mental Health Services Administration, 2014b). In fact, many people experience prolonged, repeated episodes of childhood and adult trauma. Such complex trauma can lead to complex PTSD (Cloitre et al., 2012; Herman, 1997), which has a profound effect on emotional regulation, self-perception, and relationships with others and helps to explain many of the reactions and coping behaviors seen among trauma survivors.

Many prominent stakeholders have called for a trauma-informed approach to primary care. The American Medical Association called for addressing domestic violence as early as 1992 (American Medical Association, 1992). More recently, the U.S. Preventive Services Task Force found that screening for IPV increases its identification, is not harmful, and that effective interventions exist to reduce repeat victimization. They now call for clinicians to screen women for IPV and "provide or refer women who screen positive to intervention services" (Nelson, Bougatsos, & Blazina, 2012). The Institute of Medicine and the Agency for Healthcare Research and Quality have also called for the integration and evaluation of a response to trauma in primary care (Carey et al., 2010; Institute of Medicine Committee on Preventive Services for Women, 2011).

Recent calls for trauma-informed services have been particularly eloquent from clinicians, researchers, and advocates working with women living with human immunodeficiency virus (HIV), among whom rates of IPV and PTSD are estimated to be 55% and 30%, respectively (Machtinger, Wilson, Haberer, & Weiss, 2012b). Participants in a 2010 forum sponsored by the U.S. Office on Women's Health and the Joint United Nations Programme on HIV/AIDS identified practical opportunities to integrate services for HIV and gender-based violence and described this integration as fundamental to achieving and building on the goals of the National HIV/AIDS Strategy (Forbes, Bowers, Langhorne, Yakovchenko, & Taylor, 2011; Wyatt et al., 2011). In 2013, a presidential working group that was convened to address the intersection of violence and HIV among women found that childhood and adult trauma are key drivers of HIV infection and poor health outcomes among women living with HIV, and called for organizations to "develop, implement, and evaluate models that integrate trauma-informed care into services for women living with HIV" (White House Interagency Federal Working Group, 2013).

A number of effective interventions exist to address trauma (Substance Abuse and Mental Health Services Administration, 2014a, 2014b). However, a practical approach to incorporating interventions for both IPV and the impacts of lifelong trauma into primary care is needed.

A Practical Approach to Trauma-informed Primary Care

Our efforts to respond to trauma in a more comprehensive way began after more fully clarifying the devastating impact of trauma on the lives of women living with HIV (Machtinger, Haberer, Wilson, & Weiss, 2012a; Machtinger et al., 2012b). A review of patient deaths at the Women's HIV Program (WHP) at the University of California, San Francisco, revealed that most were not from HIV, but rather from trauma—directly through murders and indirectly through depression, suicide, and addiction. These deaths occurred in a clinic that already had integrated physical, mental health and social services. Positive Women's Network—USA (PWN-USA) had also noted the pervasive impact of trauma among its national network of women living with HIV. Together, we looked for ways to address trauma in a clinic setting and found that, despite national calls to action, there was a lack of guidance about the core components of a practical approach to addressing recent and past traumatic experiences within adult primary health care settings.

To address this gap, WHP and PWN-USA convened a strategy group of 27 leading policymakers, trauma experts, and advocates from the government, military, academia, clinics, and community organizations (National Strategy Group to Develop a Model of Trauma-informed Primary Care for Women Living with HIV, 2013). The group identified existing evidence-based strategies and frameworks to use as building blocks for an approach to TIPC. These frameworks and strategies included the patient-centered medical home (Agency for Healthcare Research and Quality, n.d.), trauma-informed care (Bloom, 2013; Harris & Fallot, 2001; Substance Abuse and Mental Health Services Administration, 2014b), longstanding and effective efforts to address IPV (Bair-Merritt et al., 2014; García-Moreno et al., 2014; Ghandour, Campbell, & Lloyd, 2014; MacMillan et al., 2009; Miller et al., 2011; Ramsay, Rivas, & Feder, 2005); successful treatments for PTSD and complex PTSD (Cloitre et al., 2012; Engel et al., 2008; U.S. Department of Veterans Affairs National Center for PTSD, 2015; van der Kolk et al., 2014); interventions with adults to ameliorate the impact of adverse childhood experiences (Sikkema et al.,