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Understanding and Applying Trauma-Informed Approaches Across Occupational Therapy Settings

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ABSTRACT

Trauma and adverse childhood experiences can have lifelong effects on emotional, behavioral, and physical health. Health providers, along with state and federal policy makers, are calling for increasing trauma-informed care and trauma-informed approaches across health, social service, and education sectors. Occupational therapy practitioners are likely to work with individuals with a history of trauma across many settings, and it is imperative to have a working knowledge of ways to support these individuals. This article outlines basic principles related to trauma, trauma-informed approaches, and research that may assist practitioners in understanding how trauma-informed approaches align with core tenets of occupational therapy and how to facilitate best care for those they serve across all settings and environments.

LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Define basic principles of trauma and trauma-informed approaches
2. Identify research-based outcomes of trauma-informed approaches across practice settings
3. Identify application of trauma-informed approaches in occupational therapy

INTRODUCTION TO TRAUMA AND TRAUMA-INFORMED APPROACHES

Formal recognition of trauma and its associated implications can be traced back to the American Civil War, when the effects of war on soldiers was described by terms such as *soldier's heart* and *nostalgia*. Terms such as *shell shock* and *battle fatigue* were used to describe a similar phenomenon during World War I and World War II. The term *posttraumatic stress* took hold after the Vietnam War, when interest in developing more targeted interventions for returning soldiers burgeoned. The third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-III) was released in 1980 and, for the first time, trauma was officially recognized as a significant event or series of events that could potentially have long-standing implications for occupational functioning (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Since that time, definitions of trauma and ways to care for individuals who have experienced it have continued to evolve.

Currently, *trauma* is defined as singular or cumulative experiences that result in adverse effects on functioning and mental, physical, emotional, or spiritual well-being (SAMHSA, 2018). Examples of trauma include exposure to violence, natural disasters, bullying, displacement, food insecurity, abuse, neglect, sexual assault, terrorism, motor vehicle accidents, and life-threatening military incidences. The original Centers for Disease Control and Prevention (CDC)–Kaiser Permanente Adverse Childhood Experiences (ACEs) Study was the first to ask a large number of people (17,000) about their history of traumatic experiences in childhood, and it found that childhood trauma is common (CDC, n.d.). Two thirds of adults reported experiencing least one ACE, and 1 in 5 reported three or more (Pardee et al., 2017).

Because the original ACEs study was a retrospective survey of adults, the National Survey of Children's Exposure to Violence was conducted in 2008 to collect data during childhood. Finkelhor and colleagues (2013) highlighted the cumulative harm experienced when children are exposed to multiple forms of

childhood victimization. They conducted a regression analysis and added ACE items based on the 2008 survey, including peer victimization, property victimization, parents always arguing, having no good friends, having someone close with a bad illness or accident, low socioeconomic status, and exposure to community violence.

The Office of Juvenile Justice and Delinquency Prevention and the CDC conducted a national telephone survey of 3,392 school-aged children aged 5 to 17 years old regarding victimization and violence exposure at school, and 74% reported exposure to some form of victimization (Finkelhor et al., 2016; Perfect et al., 2016). Finkelhor and colleagues (2016) stated that 48% of those victimized reported at least one incident at school. Furthermore, victimization at school increased the likelihood that children would also be victimized elsewhere. Children with disabilities reported higher rates of assault and bullying.

Trauma contributes to mental health and functional difficulties. Individuals with multiple ACEs are more likely to engage in health risk behaviors and are more likely to be obese, and have higher rates of heart disease, stroke, liver disease, lung cancer, chronic obstructive pulmonary disease, and autoimmune disorders than the general population (Oral et al., 2016).

People with posttraumatic stress disorder (PTSD) may also present with disassociation and increased autonomic reactivity and/or emotional under engagement, which causes difficulty in relationships. Oral and colleagues (2016) also reported a relationship between the number of ACEs and learning and behavioral problems in children and adolescents, and in somatic disorders, hallucinations, anxiety and obsessive compulsive disorders, depression, and suicide attempts in adults. Although trauma-informed approaches (TIAs) had their initial development and implementation in mental health settings, the current understanding of the effect that trauma has on all body systems, in addition to the notion that the vast majority of people have potentially experienced trauma, have made TIAs necessary best practice in all settings.

SAMHSA (2018) states that a trauma-informed program, organization, or system:

1. Realizes the widespread effect of trauma and understands potential paths for recovery
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices
4. Seeks to actively resist re-traumatization

SAMHSA (2018) put forth six core trauma-informed principles:

1. Safety
2. Trustworthiness and transparency
3. Peer support and mutual self-help
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues.

TIAS AND THE PUBLIC HEALTH MODEL

Researchers have called for all health care providers and staff working with children, youth, and adults to apply TIAs and interventions (Perfect et al., 2016; Soleimanpour et al., 2017). Given the long-term effects of adverse experiences in childhood, it is particularly important that all disciplines working in health care assess trauma; address safety in schools and the community; build strengths and resilience; and provide opportunities for educational, economic, and social successes (Shonkoff et al., 2012).

Because trauma is widespread, a public health model is useful in conceptualizing TIAs at various levels and across different practice settings. A public health model divides care and health initiatives into three tiers: universal, targeted, and intensive. In the public health framework, *universal* (Tier 1) services are geared toward universal promotion and prevention among large groups of people. *Targeted* (Tier 2) services are directed at individuals whose experiences place them at risk for developing mental, emotional, and behavioral difficulties. Last, *intensive* (Tier 3) services focus on intensive interventions for individuals with identified disorders that notably affect function and participation.

A public health model seeks to efficiently allocate resources by effectively addressing as much as possible at the lowest level of care, beginning with trauma-informed "universal precautions" applied at a whole population level. At a universal level, occupational therapy practitioners can use person-centered care practices, such as telling clients what is going to happen, asking about their concerns, giving as much control as possible, and asking what can be done to make them more comfortable (Raja et al., 2015). All health care providers need to create safe environments, recognize common symptoms of traumatic stress, and shift their responses to better support individuals who are in distress.

Next, targeted supports are provided to populations who are at increased risk for behavioral and mental health difficulties, such as those with disabilities, physical injuries, and chronic life stressors. Bassuk and colleagues (2017) stated that within systems serving high-risk, low-income populations, such as people involved in child welfare and/or homelessness, traumatic stress may be nearly universal. They proposed that trauma-informed care (TIC) be implemented in health care systems serving these populations and recommended the following guidelines:

1. Establish and disseminate a person-centered standard of care.
2. Establish collaborative healing relationships between the provider and the service user.
3. Establish SAMHSA's six TIC principles as a foundation.
4. Respect all forms of diversity.
5. Understand the effects of trauma, mental health, and substance abuse conditions.
6. Promote belief that recovery is possible for all.
7. Ensure person-centered care is individualized and transparent, and be accountable.
8. Form collaborative, interdisciplinary teams that include peer-to-peer roles.

The third and highest level of care within a public health model is intensive interventions. At this level, individuals with histories of trauma may require expansive and interdisciplinary care, much of which uses trauma-specific interventions by professionals with advanced trauma skills. See Figure 1 for a list of TIC do's, don'ts, and related principles in action.

Raja and colleagues (2015) stated the importance of understanding the health effects of trauma, including coping styles and behaviors, and the need to respectfully and collaboratively discuss negative coping behaviors. They also stressed the importance of knowing your own history and reactions, being aware of the potential for secondary trauma, and knowing how to care for yourself and practice "trauma stewardship," which is caring for patients without taking on their trauma yourself.

Standard occupational therapy interventions that focus on improving function, well-being, and health can support individuals with intensive needs. However, it is essential that practitioners know the limits of their personal knowledge and skills and be ready to refer when needed by maintaining collaborative relationships with colleagues who have advanced trauma-specific skills.

REVIEW OF TIC LITERATURE ACROSS TREATMENT SETTINGS

Infancy and Early Childhood Settings

Sanders and Hall (2018) asserted the importance of the neuroception of safety provided by a well-regulated nervous system, beginning in the newborn intensive care unit. They emphasized the importance of social engagement and shifting from "what is wrong" with the infant and family to "what happened to them," and aligning with SAMHSA's six TIC principles: safety, trustworthiness, peer support, collaboration, empowerment, and cultural competence.

Figure 1. Trauma-Informed Care (TIC) in Action: Do's, Don'ts, and Associated Principles

Do	Don't	Associated TIC Principle(s)
Ask, "What happened to you?"	Ask, "What's wrong with you?"	Safety
Always ask preferred pronouns.	Assume pronoun based on name or appearance.	Cultural, historical, and gender issues
Ask permission for everything.	Assume that individuals will be willing to say or do anything you ask them to do.	• Safety • Collaboration and mutuality • Empowerment, voice, and choice
Provide TIC training for all providers and support staff.	Provide training only for certain staff, based on title or role.	• Safety • Trustworthiness and transparency • Peer support • Collaboration and mutuality • Empowerment, voice, and choice • Cultural, historical, and gender issues
Administer an Adverse Childhood Experiences screening to all clients.	Ignore the pervasiveness of trauma in all areas of practice.	• Collaboration and mutuality • Safety • Trustworthiness and transparency • Cultural, historical, and gender issues
Assess and follow up with trauma-related needs.	Ignore trauma-related needs.	• Collaboration and mutuality • Safety • Trustworthiness and transparency
Acknowledge that there may be aspects of the environment that you cannot change to support well-being, such as loud noises from machines.	Ignore those things over which you have no control.	Trustworthiness and transparency
Recognize that trauma manifests in many different ways, including flat affect, defensiveness, and aggressiveness, and that the individual is likely trying to communicate with you.	Automatically attribute challenging behaviors to static personality traits.	Safety
Recognize historical trauma.	Dismiss the historical context in which a client is potentially embedded.	Cultural, historical, and gender issues
Be cognizant of the type of information you are trying to gather.	Forget that people may be re-traumatized by telling their story and/or providing information.	• Safety • Cultural, historical, and gender issues • Trustworthiness, and transparency
Foster growth and positivity.	Assume that individuals cannot change once they have experienced trauma.	• Safety • Empowerment, voice, and choice

All health care providers must recognize the psychosocial challenges that family members may face and collaborate with them to build self-efficacy through positive caregiving experiences and opportunities for independent decision making. Practices to build infant and family adaptive responses include making sure the mother sees the baby within 3 hours of birth, skin-to-skin contact or kangaroo care, private rooms, and parents as primary caregivers.

An essential component of trauma-informed practice is collaboration with all key stakeholders. Watt (2017) stated that caregivers avoid child welfare systems when those systems fail to address trauma. Watt (2017) also cited that a trauma perspective is not congruent with the current system's reliance on diagnosis through the DSM and accompanying problem-oriented focus. When working with children, collaboration means involving families in making decisions about their children's care and the services, systems, policies, and practices that will affect that care (Dayton et al., 2016).

Dayton and colleagues (2016) also cited training, confidentiality concerns, scheduling, power imbalances, lack of family-advocate role clarity, and role imbalances as barriers. Clinicians reported barriers to collaborating through family involvement as recruiting families that represent patient demographics, sustaining engagement, leadership buy in, and concerns about re-traumatizing those families with a trauma history. Additionally, families stated concerns related to the costs incurred, lack of confidence, and logistics as barriers to collaboration.

Suggestions offered to prepare for successful family engagement include:

1. Identify champions
2. Adopt a vision and specific goals
3. Deliberately build buy in with staff and management
4. Create the family-advocate role description
5. Orient staff
6. Identify a staff mentor and develop their role description
7. Establish compensation for family advocates

Dayton and colleagues (2016) also stressed the importance of ongoing recruitment and support for family voice, ensuring that family input is heard, creating meaningful roles, training the whole team, mentoring and monitoring workloads, holding meetings at convenient times, avoiding jargon, and recognizing and celebrating family advocates at team and organizational levels.

School Settings

Occupational therapy practitioners need to put on their "trauma glasses" and frame what they see in the classroom from a perspective that recognizes common trauma-based responses in children and youth to recognize potential triggers, so they can help students feel safe and cope effectively. Perfect and colleagues (2016) asserted that all school staff need to be trauma informed, and schools should use trauma-informed interventions. They stated that prolonged or repeated exposure to trauma has negative effects on learning and behavior and reported that common traumatic stress reactions include intrusive thoughts, irritability, arousal, anxiety, fear, difficulty concentrating, dysregulation, aggression against self and others, dissociative symptoms, somatization, and character issues.

Wong and colleagues (2007) discussed the effects of trauma on development and learning and their development of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) intervention, which is an established, evidence-based intervention designed to reduce the negative effect of violence on students. They reported exposure to violence can result in psychological, behavioral, and academic problems. Students exposed to trauma may demonstrate decreased concentration, irritability and worry, avoidance behaviors, conduct problems, and/or substance abuse. Chronic traumatic stressors may cause developmental cognitive changes that reduce students' ability to focus, organize, and process information.

CBITS is a school-based individual and group intervention and training program to support children exposed to community violence (Wong, 2018). It aims to reduce PTSD symptoms, depression, and behavioral problems, and to facilitate better overall functioning, grades, attendance, support, and coping skills (https://cbitsprogram.org).

The online Trauma Sensitive Schools Training package is another recent addition to the resources available to support-trauma informed practice in schools (Guarino & Chagnon, 2018). Its resources walk through what trauma is, the stress response system, the effect of trauma exposure, and how schools can meet the needs of students (https://safesupportivelearning.ed.gov/trauma-sensitive-schools-training-package).

After Hurricane Katrina, Cohen and colleagues (2009) randomly assigned New Orleans students to test two types of interventions, CBITS or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), during the next school year. They reported both CBITS and TF-CBT were effective at reducing trauma symptoms but suggested using CBITS as a Tier 2 or targeted intervention, and using TF-CBT at Tier 3 with the students and their families participating in collaboration with community mental health providers.

Whiting (2018) highlighted the distinct knowledge and skills that occupational therapy practitioners can contribute to working with children who have been affected by ACEs. Using a trauma-informed, sensory, relationship-based approach, school-based practitioners can help educate school staff on trauma and its effect on children's academic performance, and collaborate with teachers and other school behavioral health team members. Their role is to facilitate participation in childhood occupations, such as education, social interaction, and play. They can identify problem areas and support self-regulation strategies, and contribute their skill in analysis of environment, tasks, and routines.

At a Tier 1 level, first author Claudette Fette facilitated district-wide training using the Trauma Sensitive Schools Package to frame a Trauma 101 session in a local in-service course in preparation for the 2018–2019 school year. Participants included all of that district's occupational therapists (OTs) as well as many speech-language pathologists, school psychologists, and teachers. Next steps will be to reach out to schools that did not have staff at the training, and to seek to support trauma-sensitive teams

on individual campuses. At a Tier 2 level, therapists can provide specific supports to classrooms or groups of children who are at an elevated risk of having experienced trauma.

Primary Care Settings

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses, and is carried out in various settings, including emergency care facilities, physician offices, and the home (American Academy of Family Physicians, n.d.). Primary care settings have begun to explore the tenets of trauma, train staff, and address the potential for both the physical and social environments to traumatize or re-traumatize individuals in these settings.

Most recently, the National Council for Behavioral Health (2017) launched a 3-year initiative titled, "Trauma-Informed Primary Care: Fostering Resilience and Recovery" to better support primary care settings in developing best practices for using TIAs with their clients. Although still in its pilot stage, this initiative includes developing screenings, evidence-based interventions, trainings, and policy changes at the institutional level if necessary. Literature in this area is growing as individuals, teams, and systems attempt to balance the need to be trauma informed and provide a trauma-sensitive environment with the need to streamline services and maintain productivity standards, both of which can depersonalize the health care experience.

In a study by Bruce and colleagues (2018), 147 medical personnel in physical trauma–related roles completed a 38-item survey related to their knowledge of TIC and injury-related trauma, opinions of and competency with TIC, recent use of TIC, and perceived barriers to TIC implementation. Although most participants reported understanding aspects of injury-related trauma, most also indicated the greatest barriers to using a TIA included decreased competence surrounding TIC execution, being fearful of re-traumatizing individuals, time constraints, and needing more training in TIC.

In another study, Green and colleagues (2016) recruited 30 primary care providers (PCPs) who then engaged in a 6-hour continuing education program on trauma-informed medical care. A total of 400 patients saw these PCPs either before or after they received the training and completed a survey related to perceptions of the patient–provider relationship. Those respondents who saw the PCP after the training reported improved partnerships with their PCP.

Additionally, training related to TIC was the central concept of an elective course offered to first-year medical students attending the Warren Alpert Medical School at Brown University. In a survey completed by 11 students at the conclusion of the course, participants indicated that TIC should be a part of medical education, with most indicating that TIC is important to patient care (mean 4.91 on a 5-point Likert scale) and all reporting moderate to high levels of competence in their ability to manage their own vicarious trauma (Nandi et al., 2018).

Finally, another study highlighted the need for an efficient tool that would enable identification of risk factors and adverse experiences in the context of a young person's life (Pardee et al., 2017). They proposed using the event history calendar and an expanded ACEs survey and stated the need to recognize the effect of trauma on health and development when working with young people in primary care.

Psychiatric Hospitals and Residential Settings

Hodgdon and colleagues (2013) asserted the need for applying trauma-informed frameworks across staff roles and contexts (e.g., schools, treatment milieu, individual treatment sessions), and spoke to their development of trauma-informed capacity in residential treatment for youth. They focused on teaching self-regulation and building staff attunement skills to help them shift from a behavioral orientation to trauma-focused interactions that reset everyone to focus on building effective self-regulation.

Even though it was not a focus of the intervention, restraints were dramatically decreased. Outcomes included decreased re-experiencing and hyperarousal, aggression and rule breaking, anxiety, thought-disorder symptoms, somatic complaints; and increased attention.

Although TIC effectively reduces restraint and seclusion in inpatient psychiatric hospital settings, knowledge transfer and implementation of training across entire systems can present challenges. McEvedy and colleagues (2017) used a train-the-trainer model to extend TIC and sensory modulation strategies statewide. They reported that end users still wanted more experiential training components.

Azeem and colleagues (2017) specifically cited occupational therapy techniques in their discussion of restraint and seclusion reduction tools in their implementation of the National Association of State Mental Health Program Directors (NASMHPD) six core strategies based on TIC.

The six strategies recommended by NASMHPD are:

1. Foster leadership to initiate and sustain focus, allocate resources for change, and encourage role modeling.
2. Collect data on restraint and seclusion incidents and share with staff.
3. Develop the workforce, using principles of recovery-oriented care, person-centered care, respect, partnership, and self-management.
4. Reduce restraint and seclusion through awareness of trauma, safety plans, comfort rooms, occupational therapy techniques, and de-escalation.
5. Involve patients and their families in safety plans.
6. Debrief in the moment with emotional support; include patients and staff, and conduct formal problem-solving debriefings to look for root causes.

Azeem and colleagues (2017) dramatically reduced restraint/seclusion incidents in the pediatric unit of a state hospital from 79 patients in 278 restraint/seclusion incidents at baseline to 31 restraint/seclusion incidents during the final 6 months of the study.

Community

Hopper and colleagues (2010) asserted the need for TIC in homeless shelters and completed a literature review in which they found the following themes as components of TIC: trauma awareness, emphasis on safety, opportunities to rebuild control, and use of strengths-based practices. They found that using TIC with people experiencing homelessness resulted in increased self-esteem and relationships, safety for children, cost effectiveness, housing stability, and consumer satisfaction.

Halasz (2017) asserted the need for a trauma-informed lens in primary care, especially when working with children in foster care, to prevent confusing trauma symptoms with other behavioral disorders and to limit inappropriate prescribing.

People who are homeless are more likely to have a history of ACEs, and homelessness itself can involve trauma, such as physical violence, sexual assault, and neglect in the form of social exclusion. People who are homeless are at greater risk for re-traumatization, but providers seeking to work with this population can facilitate supportive community connections and opportunities to begin healing (Hopper et al., 2010).

In Canada, OTs work as part of a three-phase interdisciplinary traumatic stress program in community mental health (Snedden, 2012). In the first phase, they facilitate safety planning, build coping skills, and develop a Safety and Wellness Recovery Action Plan. In the second phase, trauma therapists work with survivors on losses, boundaries, self-esteem, guilt, and forgiveness. The third phase focuses on engagement in meaningful occupation and posttraumatic growth and resilience (Snedden, 2012).

Acceptance and commitment therapy focuses on building psychological flexibility, which is understood as being present and open to experience, and taking action guided by one's values (Harris, 2009). It has been used effectively to reduce symptoms of PTSD in veterans (Shipherd & Salters-Pedneault, 2018) and persons who have experienced domestic violence, and in loosening the connection between traumatic events and the person's identity (Boals & Murrell, 2016).

Foster Care Populations

According to the Administration for Children and Families (n.d.), nearly 500,000 children and youth are currently in the foster care system in the United States. Nineteen percent of these individuals self-identify as members of the lesbian-gay-bisexual-transgender-queer (LGBTQ) community (Wilson et al., 2014). Forge and colleagues (2018) researched the concerns facing young adults experiencing homelessness who had prior experiences with the child welfare system. Two-thirds of the LGBTQ study participants reported having experienced child abuse, and 95% of all study participants reported experiencing some form of trauma, including sex trafficking, sexual violence, and being robbed.

Caretakers, staff, and all professionals who work with children in foster care systems need to have a firm understanding of TIAs.

As an example of a successful approach, the Atlas Project focused on youth with intensive behavioral health needs in New York City's Treatment Family Foster Care and building trauma knowledge and skills in caregivers and staff (Tullberg et al., 2017). The Atlas Project developed a partnership between foster care and a mental health provider, identified a lead champion, and created a joint organizational plan. They used the Pediatric Symptom Checklist (Jellinek et al., 1988) and the Child Stress Disorder Checklist (Saxe et al., 2003) to screen children within 30 days of coming into foster care, then they implemented trauma systems therapy as a phased treatment, beginning with a focus on safety, then regulation, and finally maintenance. Outcomes were increased staff and foster parent understanding of trauma-related behavior, and their report of having the tools to respond effectively.

TIAS AND OCCUPATIONAL THERAPY

As occupational therapy practitioners, we can begin by refining and highlighting areas of our practice that closely align with TIAs. These include taking a non-pathological view of the people we serve through respecting the person, seeing their humanity, and empathizing with their experiences with pain.

Additionally, taking time and care in obtaining the occupational profile is essential when working from a TIA. Not only is the profile a highlight of our professional identity and one that allows us to deeply connect, but it also aligns with the principles of TIAs, as occupational profiles allow us to build trust, collaborate with and empower our clients, and get to personal issues that are unique to each person we work with.

CASE EXAMPLE: GEORGE

George was adopted into a supportive family in preschool, but his early years were marked by extreme violence and neglect. Chronic trauma in his early life changed the wiring of his brain so that he was hardwired for fight-or-flight responses, which had enabled his early survival. Even though George was in a supportive, loving home, those neurological efficiencies that helped him survive persisted.

Fast forward to middle school. George was educated in a behavioral adjustment classroom, where, at the beginning of the school year, he was mouthing off in class and an aide jokingly threatened to physically assault him. The remark triggered a trauma response in George, who became verbally aggressive and got into the aide's face. This response prompted a restraint, which acted as another trigger for George's trauma.

After several days of multiple restraints per day, George was suspended from school. He went into homebound education and began wraparound care with the local mental health center. His wraparound team included an OT, who functioned as a natural support for George and his family and worked to support fidelity to wraparound principles and practices on the team. After a few months, George began attending a couple of classes in the school building. He added a couple more at a time until a year later, at the start of the next school year, he was back in school full time.

Although not a school district employee, the OT served on the school team, planning accommodations, and providing trauma-informed resources and encouraging their application. All

this work supported George, his parents, and the wraparound team, which met in the school setting.

For children like George, whose needs for intensive, individualized supports present at the Tier 3 level, Whiting (2018) suggested specific contributions that occupational therapy can offer as part of a multidisciplinary school-based team. Therapists can use task analysis to enable environmental accommodations, teach self-regulation strategies and serve as a resource to model regulation management strategies during instruction, and facilitate the development of habits and routines. Whiting (2018) advocated a sensory, relationship-based approach that includes body-based interactive activities such as rhythmic, patterned, repetitive activities that support self-regulation. Such activities include mindful breathing, listening to music and singing, humming, doing yoga and other types of physical activity, and playing circle games.

CONCLUSION

TIC and TIAs should cross the life span and environments. Given the prevalence of ACEs, an understanding of trauma and the capacity to respond appropriately is critical across practice settings and populations. As occupational therapy practitioners who adhere to holistic care and person-centered interventions, we have a duty to understand the widespread nature and effects of trauma that are likely to be part of the fabric of most clients we serve. Using TIAs will make us better and more caring practitioners.

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A. To get pricing information and to register to take the exam online for the article **Understanding and Applying Trauma-Informed Approaches Across Occupational Therapy Settings,** go to http://store.aota.org, or call toll-free 800-729-2682.

B. Once registered and payment received, you will receive instant email confirmation.

C. Answer the questions to the final exam found on pages CE-8 & CE-9 by **May 31, 2021**.

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Final Exam

Article Code CEA0519

Understanding and Applying Trauma-Informed Approaches Across Occupational Therapy Settings

To receive CE credit, exam must be completed by May 31, 2021.

Learning Level: Beginner

Target Audience: Occupational Therapists and Occupational Therapy Assistants

Content Focus: Domain: Client Factors; mental health; Occupational Therapy Process: Occupational Therapy Evaluation and Interventions

1. A client is admitted to the emergency department complaining of shortness of breath, feeling dizzy, and self-described feelings of "nervousness." Which of the following questions by the attending physician would be most in concert with the core principles of trauma-informed care (TIC)?

- A. "What is wrong?"
- B. "What is happening for you right now?"
- C. "Why aren't you feeling well?"
- D. "What makes you think this is a physical problem?"

2. Which one of the following is *not* typically considered traumatic?

- A. Witnessing death on the battlefield
- B. Emotional neglect by a primary caregiver
- C. Intimate partner violence
- D. Caregiver arrives late to day care for pick up

3. A trauma-informed approach (TIA) should:

- A. Be used with all clients, because anyone has potentially experienced trauma
- B. Be used only when you suspect the client has a history of trauma
- C. Be used in isolation and not combined with other models or frames of reference
- D. Not be used with client unless certification in TIC is obtained

4. Administering an Adverse Childhood Experiences (ACEs) screen yields which one of the following?

- A. Sufficient information for the individual to be diagnosed with a trauma-related disorder
- B. Correlation between the score and potential risk level for mental and physical health challenges
- C. Information regarding the specific trauma-related incidences
- D. Nothing, because occupational therapy practitioners are not qualified to administer the ACEs screen

5. A patient was admitted to your hospital floor after being sexually assaulted in a dark corner of a bustling subway tunnel. You read the electronic medical records and recognize that she is at risk for being re-traumatized by the excessive sounds and noises associated with a hectic hospital floor. Which of the following would you do on first meeting her, given you are a trauma-informed practitioner?

- A. Nothing—she needs time and space to heal mentally and physically
- B. Ask her what aspects of the social and/or physical environment might be re-traumatizing
- C. Turn the lights off and put a sign on the door to whisper when people enter the room
- D. Develop trust by being with her and supporting her to control the development of the therapeutic relationship

6. Members of the lesbian-gay-bisexual-transgender-queer (LGBTQ) community are at greater risk for being traumatized in the health care system than are their non-LGBTQ counterparts. Which of the following actions taken by a health care professional would conform with TIC principles?

- A. Make no assumptions and ask all individuals their preferred pronoun
- B. Use pronouns based on how an individual looks and/or dresses
- C. Do not broach the subject of pronouns, as that is a private matter
- D. Use the pronoun "they" to reflect inclusivity

7. Which one of the following is *not* true of trauma?

- A. Trauma has the potential to remodel the brain.
- B. Trauma can be passed from one generation to another.
- C. Trauma typically manifests as extreme emotionality.
- D. Not all trauma is abuse, but all abuse is traumatic.

8. The hospital where you work has hired an individual with a trauma history to inform development of policies and procedures for the organization. This individual will also be on call for patients when indicated. This reflects which of the following TIC principles?

- A. Cultural, historical, and gender issues
- B. Safety
- C. Peer support
- D. Trustworthiness and transparency

9. An occupational therapist provides training for all staff at a local community center regarding trauma and principles of using a TIA. This would be considered what tier of intervention?

- A. 1
- B. 2
- C. 3
- D. Population

10. Which of the following was a finding of the original ACEs Study?

- A. Trauma is uncommon.
- B. Sixty percent of adults reported three or more ACEs in childhood.
- C. Twenty percent of adults reported three or more ACEs in childhood.
- D. Ten percent of adults reported three or more ACEs in childhood.

11. You are retrieving a student from his classroom to take him to the occupational therapy treatment room. Which is the best thing to say or do if using a TIA?

- A. "It's time for our fun in the OT room! Let's go!"
- B. Inform the teacher you need to pull the student out and then do so.
- C. "You know if you go to therapy now, you won't have to keep missing class"
- D. "Is it all right with you if we go to the OT room to work on our goals together?

12. Trauma is not a new phenomenon, but the first official acknowledgement of the experience came in the context of:

- A. DSM-I
- B. DSM-III
- C. DSM-IV-TR
- D. DSM-V

Now that you have selected your answers, you are only one step away from earning your CE credit.

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