Graham Swanson MD, MSc, CCFP, FCFP.
Associate clinical professor McMaster Department of Family Medicine
An ounce of prevention is worth a pound of cure.

- Benjamin Franklin

Facebook.com/AFineParent
Disclosure:

Graham Swanson is a researcher in private family practice.

He has no monetary connection to Hamilton Children Aid Society (CAS). He taught residents who benefited from experiencing the special clinic designed for foster children. He was very upset that the great learning experience closed due to funding re-allocation.

He has no financial conflicts.

He is a member of the Regional Palliative Care Network for HNHB
ACEs in children

- Felitte reported >50% of all respondents (Kaiser Permanente) had one ACE
- 25% had more than one [Felitte 1999]

Which children will be impacted adults?

- Joseph >70% of foster children had more than one type of maltreatment at intake [Joseph 2017]
Who to look for?

- parental divorce or separation
- parental death
- parental incarceration
- parental abuse
- violence exposure
- house hold person with mental illness
- household member with substance abuse
Who to look for?

Treat them all
Children with ACEs: Resiliences that helped

A Patient’s Medical Home  Fisher 2008, College of Family Physicians of Canada

Strong relationships to a Participatory Practice  [Swanson 2016, Macauley 1999, Ramsden 2010]

“The kids feel they are listened to or respected or supported ..its not so much that it’s a he

”Strong teacher relationship protective against non-medicinal use of prescription drugs”  Forster M. Addictive Behaviors 68(2017) 30-34
Foster Children: Resiliences that helped

Continuity, Continuity, Continuity
Foster Children: Resiliences that helped

- higher education
- income (not worrying about the cost of next meal)
- physical activity
- good coping skills
- good quality relationship with friends and family
- guidance
- reliable alliance
- social integration
- reassurance of worth  [Afifi 2016]
Did Participatory Practice work?

“You have actually made a difference in my CAS life. It’s something that's kept pushing me forward and pretty much the only thing that has kept me going.” [FC]

“There is no comparable services for these children within our community.” [CAS staff]

“They give me peace to know I can talk to someone at the Clinic and know

Swanson, Ramsden, Mills, Davis, Kittler. Paper under development
References: Foster community and ACEs


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College of Family Physicians of Canada. A visions for Canada. Family Practice : the patients’s medical home Sept 2011

A novel treatment for adults who were traumatized as children: New frontiers in primary care

Keith S. Dobson, University of Calgary
Dennis Pusch, Southport Psychological Services
Family Medicine Forum
November 8, 2017  Montréal, Québec
Neither Dr. Pusch nor Dr. Dobson have a conflict of interest in this presentation.

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Acknowledgements

- Work in adult mental health, focus on depression, cognitive behavioral therapy, and evidence-based practice more generally
- Working in partnership with colleagues from Alberta Health Services (AHS), and the Primary Care Networks within Calgary area
- Representatives from mental health, primary care, government, justice, AHS leadership
- Have a long standing patient advisory group
- Sponsored by Palix Foundation
The ACEs-Alberta Research Program

- Project Purpose and Goals: To identify and treat adults with high ACE childhoods in primary care settings

- Four Phase Implementation
  - Phase 1: Develop and validate an ACEs measure
  - Phase 2: Large scale replication of the first ACEs study
    - The hunt for moderators and modifiers
  - Phase 3: Develop and test an intervention for people with high ACE scores in primary care
  - Phase 4: Test the intervention in an RCT
Purpose: Large scale replication of the ACEs study in Primary Care in Alberta

Process:
- 4007 patients in primary care completed a revised ACEs measure
- Patients also completed “life experience” questionnaires
- Examined health care usage in the past year (acute care and primary care), as well as in the year following the completion of the questionnaires
- Examined “resilience” “emotional regulation” and “interpersonal problems” as moderating and mediating variables
Phase 2 Results

ACE Scores for Sample (%) N = 4,007

- Females
- Males
ACEs and Clinical Depression & Suicidal Ideation

- Major Clinical Depression
- Suicidal Ideation

Bar chart showing the relationship between ACEs and clinical depression/suicidal ideation.
Phase 2 Results

- Our research examined emotion dysregulation and interpersonal problems as mechanisms by which ACEs may be associated with anxiety and depression, and resilience as a buffer of these associations.
- All of these variables have been shown to be **modifiable** treatment targets.
- Treatment initiatives for ACE-related depression should address emotion dysregulation, interpersonal problems, and resilience as treatment targets.
- We are conducting analyses with other physical health conditions as criteria.
An ACE-informed Adult Treatment Program

Understand your past. Embrace your future.
Treatment Development Group

• Experienced mental health clinicians in primary care settings
  • Training and knowledge of developmental trauma factors
  • Experience in clinical work within primary care

• Met over the course of about a year to develop the treatment model
• Reviewed literature, clinical models, relevant factors

• Consensus and feedback!
  • embrACE Research Group
  • Advisory Group
The Treatment Development Process

1. Multi-disciplinary, collaborative approach

2. Consultation with experts: Anda, Briere, Cloitre, Strosahl, Robinson

3. Role of the patient Advisory Group

4. Pilot groups and focus groups
<table>
<thead>
<tr>
<th>Issue</th>
<th>Our decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content- Toolbox and skill development versus “digging into the past”?</td>
<td>A recognition of the past, but a focus on current functioning, and tools</td>
</tr>
<tr>
<td>Format- Individual versus group?</td>
<td>Group- provides normalization, social support and possible cost efficiency</td>
</tr>
<tr>
<td>Length- How much treatment is enough?</td>
<td>Six meetings- not too long, but enough for meaningful content</td>
</tr>
<tr>
<td>Outcomes- What are the treatment targets?</td>
<td>Modifiable risk factors: resilience, coping strategies, interpersonal relationships</td>
</tr>
</tbody>
</table>
1. Intro to ACEs

2. Body

3. Thoughts

4. Emotions

5. Relationships

6. Past and Future

ACEs

Process

✓ Initial ACE screening
✓ Meeting with GP and Clinician
✓ Inclusion/ exclusion criteria
✓ Invited to join the skills-based group
✓ Follow up at 3 & 6 months to assess health outcomes
Format of Each Meeting

1. Today’s topic
2. Review of homework
3. Relaxation exercise
4. Skill building, discussion, practice
5. Check out and homework
Development of a Self-Care Plan

- List of all the skills taught in the 6 sessions

- Participants indicate their favourite skills

- Participants make a plan for using those skills in the future

- Participants share their plan with GP and/or clinician after the end of the group
Phase 3- Open Trial

Goal was to develop and provide “Proof of Concept” data for embrACE, an ACEs-informed treatment for patients in primary care

Inclusion criteria:
- An ACE score of 3 or more
- A presenting chronic health problem (mental or physical)
- Physician referral

N = 107
### Pre- and Post-Treatment Scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre- test</th>
<th>Post- test</th>
<th>t- test</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Anxiety- GAD- 7</strong></td>
<td>11.42</td>
<td>5.89</td>
<td>8.73</td>
<td>5.63</td>
</tr>
<tr>
<td><strong>Depression- PHQ- 9</strong></td>
<td>13.47</td>
<td>6.63</td>
<td>9.88</td>
<td>6.57</td>
</tr>
<tr>
<td><strong>Emotion Regulation</strong></td>
<td>102.80</td>
<td>29.07</td>
<td>94.2</td>
<td>27.29</td>
</tr>
<tr>
<td><strong>DERS-Total</strong></td>
<td>16.90</td>
<td>6.64</td>
<td>15.22</td>
<td>6.16</td>
</tr>
<tr>
<td><strong>- Non-acceptance</strong></td>
<td>16.22</td>
<td>4.76</td>
<td>15.29</td>
<td>4.89</td>
</tr>
<tr>
<td><strong>- Goals</strong></td>
<td>13.82</td>
<td>5.70</td>
<td>12.56</td>
<td>5.25</td>
</tr>
<tr>
<td><strong>- Impulse</strong></td>
<td>19.46</td>
<td>5.65</td>
<td>18.11</td>
<td>5.31</td>
</tr>
<tr>
<td><strong>- Awareness</strong></td>
<td>21.81</td>
<td>8.08</td>
<td>19.42</td>
<td>7.21</td>
</tr>
<tr>
<td><strong>- Strategies</strong></td>
<td>13.82</td>
<td>4.59</td>
<td>12.82</td>
<td>5.85</td>
</tr>
<tr>
<td><strong>- Clarity</strong></td>
<td>53.60</td>
<td>15.34</td>
<td>58.28</td>
<td>13.36</td>
</tr>
<tr>
<td><strong>Resilience CD-RISC</strong></td>
<td>53.60</td>
<td>15.34</td>
<td>58.28</td>
<td>13.36</td>
</tr>
</tbody>
</table>
Recent and Next Steps

- Complete data collection of Phase 3 trial (October, 2017)
- Conduct analyses of pilot data, estimate effect sizes and required sample size (October, 2017)
- Conduct focus groups of participants and leaders (May, 2017)
- Finalize revisions to manuals (September, 2017)
- Conduct literature review on possible biomarkers (September, 2017)

- **Randomized Clinical Trial** to begin in Spring, 2018
- Likely design is 2 armed:
  1. The embrACE Program in group format
  2. Treatment as Usual
- Thank you

- Comments and Questions....
The Trauma-Informed Receptionist
5 things to remember about the distressed caller

1. Under stress! May be upset, irritable, teary
2. May be struggling to retain some sense of control in their life
3. May need affirmation of worth
4. May not be able to articulate needs, fears, vulnerabilities, or triggers
5. May not be able to hear what you say
When A Caller Truly Believes You Understand, They Can Begin To Hear You
How to show that you Understand and Care

1. Validation (empathy)
2. Solution-focused interaction
Validating (empathic) statements

1. “That sounds very upsetting...”
2. “I can understand how that worries you”
3. “I’m really glad you called”
4. “I really want to help”
5. “I care”
Solution-focused statements

1. “Let’s find some good options”
2. “I’m sure we can find something that will help”
3. “Is there anything else I can do to help you?” “Can you tell me a little more to help me find the best options?”
4. “Hmmm, can I put you on hold for a couple of minutes while I (check with my team supervisor to) look for options that might be helpful for you?”
When Conflict Occurs

1. Express regret and start over
   “I’m really sorry that the way I said that upset you. I really want to help, can we try again?”

2. Blame isn’t helpful

3. If a patient is yelling/abusive
   “I am sorry, I do not think we will find a solution while you are so upset. Would you like to call back when you are feeling a little less upset/better?”
   If that does not work, do not hang up, let them know that you will be putting them on hold, take a breath, seek help from peer/team supervisor/doc
Devaluing or obstructing statements

- “There’s nothing I can do for you”
- “The doctor is too busy”
- “You’re not listening”
- “It’s not my fault”
- “That’s not part of my job”
So... Why Offer the ACE Questionnaire?
STIGMA
▪ So that explains...

▪ ...and I’m not alone
Awareness

An opportunity for growth
An Ounce of prevention...

The *compounding* benefit of helping the parents of future generations
My doc cares enough to ask
Genuine Empathy

Transforming the “difficult” patient into the “suffering” patient
How can we ignore the evidence?
Screening for Adverse Childhood Experiences to Build Resiliency and Improve Mental Health Outcomes

Sanjeev Bhatla, MDCM, CCFP, FCFP
Clinical Associate Professor
Department of Family Medicine
Cumming School of Medicine, University of Calgary

Family Medicine Forum
November 10, 2017
Faculty/Presenter Disclosure

- Faculty/Presenter: Dr. Sanjeev Bhatla

- Relationships with commercial interests: None
  - Grants/Research Support: None
  - Speakers Bureau/Honoraria: None
  - Consulting Fees: None
  - Other: None
Objectives

1. How to take a history for Adverse Childhood Experiences (ACEs)
2. How to provide Trauma-Informed Care to Patients
3. How to build Healthy Therapeutic Boundaries with Your Patients
TRAUMA INFORMED CARE DEMYSTIFIED

Dr. Lydia Hatcher
Faculty/Presenter Disclosure

Dr. Lydia Hatcher

Faculty: Associate Clinical Professor – McMaster University

○ FOR PROFITS: Speakers Bureau/Honoraria/Consulting Fees: Purdue Pharma, Eli Lilly, MdBriefcase, Tilray, Mettrum, Knight Therapeutics, CMEaway;
  ○ Advisory Boards: Purdue Pharma, Astra Zeneca, Eli Lilly, Tilray

○ NON PROFIT: College of Physicians and Surgeons of Ontario-Peer Assessor; Alliance for Best Practice in Health Education- treasurer; Canadian Medical Association- Planning and reviewer for Joule CMA, Chief of Family Medicine St Josephs Healthcare Hamilton

○ NON FINANCIAL: NOUGG expert panel member; CFPC Community of Practice for Chronic Pain
My ACE Experiences

- My ACE Score 2/10
- Worked over 10 years with youth <18 in closed custody and open custody corrections centres
- Psychotherapy all ages >11; many victims of ACE
- CNCP pts of which abuse/ACE is correlated*

“As a consequence, abused children are at increased risk for a wide range of physical health conditions including obesity, heart disease, and cancer, as well as psychiatric conditions such as depression, suicide, drug and alcohol abuse, high risk behaviours, and violence.”

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

https://www.cdc.gov/violenceprevention/acestudy/about.html
Childhood Experiences Underlie Chronic Depression

ACE Score

% With a Lifetime History of Depression

https://www.cdc.gov/violenceprevention/acestudy/about.html
“Now that we have defined the problem. What else could go wrong?”
Preparing for a Trauma-informed Practice

- The personal level
  - Self-awareness and self-compassion on the part of practitioners

- The practice level
  - Interactions with clients

- Organizational level
  - Staff training and policy development
Principles and Practices of Trauma-Informed Approaches

- Trauma awareness
- Emphasis on safety and trustworthiness
  - For patients
  - For yourself
- Strengths based
- Skill building
  - Develop resiliency and coping skills
Trauma Awareness:

- Use appropriate language that matches the patients level of understanding/culture and education.
- Don’t use jargon.
- Acknowledge non-verbal communication as much as verbal communication
  - Keep cultural differences in mind
- Acknowledge silence
- Clarify anything you do not understand or are confused about
- Some people will speak indirectly about trauma
  - “bothering me” may mean “abusing me.”
- Use non-judgmental language
Examples

“How do you connect your experience (as a child, when you were younger, while in combat, in your home country, with the accident, etc.) with how you are feeling/managing/coping now?”

“Would you want your own child to have the experiences you had?”
What can you do in your practice to ensure awareness?
Emphasis: Safety - Red Flags

- No prenatal care
- Single parent/broken home
- Substance abuse
- Exposure to violence/neglect
  - physical and emotional
- Incarceration – self or family
- Others?
Emphasis: Safety- normalize

“Because the things we have experienced in our lives can often impact our health—even if they happened a long time ago—we ask the following questions of all people.”

“Some people want to talk about very personal or difficult topics. If you do, I am open to listening. I don’t need to know all of the details, only what you think would be helpful.”
Emphasis: Trustworthiness

“You do not have to answer questions you don’t want to.”

“If there are any questions you are not comfortable answering, that’s no problem. You can just tell me to pass and we’ll move on.”
How do you approach asking, safety and trustworthiness with your patients?
Strengths based: Working with the patient

- ‘I’d like to understand your perspective.’
- ‘Let’s look at this together.’
- ‘Let’s figure out the plan that will work best for you.’
- ‘What is most important for you that we should start with?’
- ‘It is important to have your feedback every step of the way.’
- ‘This may or may not work for you. You know yourself best.’
Skill building: Resilience and Coping

- Encourage physical activity
- Improve coping skills
- Support strong social integration
- Build self esteem
- Assist with continuity of care
  - Medical
  - School
  - Peers
Skill building

How do you learn these skills?
- Practice
- Empowering patients
- Using the internet
- Local resources
We Can’t Fix Everyone

- ‘Normal’ ACE’s
- Humanity is full of emotional turmoil
  - This is the norm
- How much DYS in your function?
Thank You

References:


CARE & COMPASSION
THE FOUNDATION FOR COLLABORATION:
"MAKING A CASE FOR THE THERAPEUTIC ROLE OF COMPASSION"

DR. MARIA PATRIQUIN MD CCFP
FOUNDER LIVING WELL INTEGRATIVE HEALTH CENTER
FOUNDING & BOARD MEMBER ASSOCIATION FOR POSITIVE PSYCHIATRY OF CANADA
MENTAL HEALTH COMMITTEE CFPC ATLANTIC CANADA REPRESENTATIVE
EDITORIAL ADVISORY BOARD CANADIAN FAMILY PHYSICIAN
PMH 60/20 CARE & COMPASSION GRANT CFPC 2016
ASSISTANT PROFESSOR DALHOUSIE UNIVERSITY, HALIFAX NS

"PROMOTION COMPASSION, COMMUNICATION AND COLLABORATION IN HEALTH CARE"
A Curriculum of Care
"Brought to You by the Letter C"

- Care
- Character
- Compassion
- Conscience
- Communication
- Courage
- Competency
- Contribution
- Collaboration
- Conscience
And we thought “C” was for cookie!
Compassion Defined

From Latin “co-suffering”

Awareness and understanding of the suffering of another accompanied by the desire to help
THE COMPASSION INSTINCT:
ALTRUISM, EMPATHY, AWARENESS, UNDERSTANDING, AND DESIRE TO HELP
The Evidence for Compassion

- Accelerated Healing
- Enhanced Immune Function
- Decreased Inflammatory Markers
- Positive emotions
- Increased awareness
- Greater sense of social support
- More purpose
- Greater life satisfaction
- Fewer illness and depression symptoms
Healing Connections
Patient-Centered Care

- IS compassionate care.
- Patients want to be seen, heard and understood and if we can’t quite understand we convey we are trying to.
- Patients want to feel cared for. This is how they build trust.
- Seeing patients for who they are NOT for what happened to them or what ails them. Seeing the WHOLE person
Through an ACE lens people, circumstances, illness, and health behavior are not what they once seemed.

Consider the:

- “Difficult patient”. 15-30% of all encounters.
- “Frequent flyer”
- “Borderline”
- “Sensitive patient”

- “Personality”
- “Non-compliant”
- “Self-sabotage”
- “Hysterical”
- “Medically Unexplained symptoms/syndromes”
Compassion Communicates via the:

**Verbal:**
Language, Meaning & Tone (Attitude)

**Nonverbal:**
Body Language, Environment

VERBAL 35%

NONVERBAL 65%
Facial Expressions
Tone of Voice
Movement
Appearance
Eye Contact
Gestures
Posture
Healing Words and the Positive Reframe:

UNDERSTOOD + CARED FOR = CONFESSION A SENSE OF OK + Safety

NON-VIOLENT COMMUNICATION

REFRAME OF WORDS/TERMINOLOGY
From Mindfulness: Attitudinal Factors that Promote Healing and Wellbeing

Non-judging: being an impartial witness to your own experience. Things just are. They are neither good nor bad.

Patience: for the wisdom as all things unfold with time.

Beginner’s Mind: As if seeing it for the first time

Trust: in the inner wisdom of our feelings and body.

Non-striving: Grasping, wanting, goal directed e.g. “fix-it”

Acceptance: Not fighting but allowing things to be as they are so we can choose what’s healthiest

Letting go: Changing our attachment to things having to be a certain way, usually ideal or perfect person
Body Language: What patients perceive as empathic, open, non-threatening

- Boundaries
- Space
- Posture
- Pose
- Eye contact
- Touch
- Not touching
RESILIENCE, OPTIMISM AND NEUROPLASTICITY
A CIRCLE OF CARE

Teamwork

- Compatibility
- Confidence
- Communication
- Coordination
- Commitment
The true cost versus the value to the system

- Office Visit ...................... $31.46
- Flu vaccine ....................... $14.52
- Tray fee .......................... $3.63
- Geriatric Visit .................... $39.93
- Pap Smear ......................... $21.00
- Counsel 30 min $25.40 MSU

Compassion = PRICELESS
Self-compassion is when we notice our own suffering and respond to it with kindness and care. At this time of reform this is more relevant than ever.

It is critical to living and working healthy as physicians. Doctors have ACEs too and also experience vicarious trauma when caring for patients.

Critical to being able to have clarity and see patients for who they are otherwise we run the risk of projecting, stereotyping, making mistakes, crossing boundaries which are neither healthy for ourselves or patients.

Holding others pain is a privilege and its important to show up for that experience having cared for ourselves and this enables us to be more compassionate of others.

Understanding and sharing life’s joys, sorrows, failures, imperfections and suffering connects us. Holding our shared sense of humanity is healing.