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Trauma-Informed Care Across the Lifespan: A Clinical Framework for Practice

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ABSTRACT

Background: Trauma-informed care (TIC) is increasingly recognized as essential in rehabilitation settings, where patients frequently present with complex medical, neurologic, and psychosocial histories. Despite this, integration within physical medicine and rehabilitation (PM&R) remains inconsistent.

Objective: To provide a clinically applicable framework for implementing TIC across the lifespan within PM&R contexts.

Methods: This narrative review synthesizes guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA) with rehabilitation-focused clinical practices and case-based application.

Results: TIC implementation in PM&R is supported through universal precautions, the triad of consent (adversity, distress, strengths), and alignment with SAMHSA's Four R's. Application of these principles improves therapeutic alliance, reduces behavioral escalation, and enhances engagement, particularly in populations with neurologic injury and co-occurring trauma.

Conclusion: TIC is a foundational component of high-quality rehabilitation care. Standardization of training and integration into interdisciplinary practice models are necessary to improve patient outcomes and reduce disparities.

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Introduction

Physical medicine and rehabilitation (PM&R) clinicians routinely manage patients with complex functional impairments shaped not only by injury or disease, but also by prior trauma exposure. Trauma-informed care (TIC) reframes clinical practice by emphasizing safety, trust, autonomy, and contextualized understanding of patient behavior.

In rehabilitation environments, where care often involves physical contact, vulnerability, and prolonged engagement, failure to incorporate TIC principles may result in reduced adherence, behavioral dysregulation, and suboptimal outcomes. This manuscript outlines a structured approach to TIC tailored for PM&R professionals [1-5].

Defining Trauma

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

"An event, series of events, or set of circumstances experienced as physically or emotionally harmful or life-threatening, with lasting adverse effects on functioning and well-being."

Trauma exposure includes direct experience, witnessing events, secondary exposure (e.g., healthcare providers, first responders), and relational or media-based exposure. This broad definition is particularly relevant in rehabilitation populations, where trauma histories are often under-identified.

Epidemiology and Relevance to PM&R

Trauma exposure affects approximately 70% of adults and is disproportionately prevalent among populations commonly served in rehabilitation settings, including:

- Individuals with neurologic injury (e.g., TBI, stroke)
- Veterans
- Individuals with disabilities
- Socioeconomically marginalized populations

These overlapping risk factors necessitate routine integration of TIC into PM&R workflows. Trauma is the #1 cause of death ages 1-46.

SAMHSA Framework Applied to Rehabilitation

SAMHSA's Four R's provide a structure for TIC implementation:

- **Realization** – Acknowledging trauma's prevalence in rehabilitation populations
- **Recognition** – Identifying trauma-related behaviors (e.g., agitation, avoidance)
- **Response** – Embedding TIC into evaluation and treatment

planning
- **Resistance to re-traumatization** – Modifying environments and interactions to prevent harm

Core principles, including safety, trust, collaboration, empowerment, and cultural responsiveness, should be operationalized within interdisciplinary teams. This is accomplished through initial hire training initiatives as well as regular interval "refresher" training. Concepts such as role-playing, scenario evaluations, training with first responders to enhance community awareness, and ongoing program evaluation reinforce the 4 R's.

The Triad of Consent in Clinical Practice

The triad of consent provides a structured, patient-centered approach:
- **Adversity (Screening):** Incorporating trauma screening into intake processes
- **Distress (Assessment):** Linking symptoms to potential trauma triggers
- **Strengths (Resources):** Identifying resilience factors to guide goal setting

In PM&R, this triad supports individualized care planning and improves patient engagement. There are free and low-cost training programs available online nationwide and cover cross-practice settings such as schools, healthcare, long-term care, and correctional facilities. Training such as the grant-funded, Virginia Heals was developed to accomplish the following, "Virginia HEALS started as part of a national demonstration project called Linking Systems of Care for Children and Youth. It was supported by the United States Department of Justice, Office for Victims of Crime." The program is organized under three main components, including a Trauma-Informed Model of Service Delivery, Healing Centered Organizations, and Lived Experience Engagement. The information available includes toolkits, online training, and a tool for identifying available community resources [6-9].

Clinical Impact of Trauma

Physical Health

Trauma is associated with increased risk of chronic disease, including cardiovascular conditions, autoimmune disorders, and reduced life expectancy.

Cognitive and Emotional Functioning

Patients may demonstrate impaired attention, executive dysfunction, emotional lability, and reduced frustration tolerance, all of these are factors that directly impact rehabilitation participation.

Behavioral Considerations

Trauma-related behaviors may include non-adherence, avoidance, aggression, or withdrawal. Within TIC, these are interpreted as adaptive responses rather than noncompliance.

Barriers to Rehabilitation Engagement

Common barriers include:
- Distrust of healthcare providers
- Fear of re-traumatization
- Stigma and self-blame
- Difficulty tolerating emotionally or physically demanding interventions

Recognition of these barriers is critical for accurate clinical interpretation and treatment planning [10-12].

Universal Precautions in PM&R Settings

Universal precautions assume all patients may have a trauma history. Key practices include:
- Clear role identification and communication
- Explicit consent prior to physical contact
- Stepwise explanation of procedures
- Environmental modifications to reduce overstimulation
- Incorporation of patient choice and control

These strategies are particularly relevant during bedside care, therapy sessions, and procedural interventions. Professions that do NOT require TIC training for licensure or for renewal (at least not in my locale):

- Chiropractors
- Massage therapists
- Skin estheticians
- Cosmetic/plastic surgeons
- Physical therapists
- Mental health state hospital workers

Case Application

Severe Traumatic Brain Injury with Co-Occurring PTSD

A 27-year-old active-duty male with severe traumatic brain injury (GCS = 6) presents with agitation and combative behavior in acute care. History is significant for prior blast injuries, alcohol use disorder, and PTSD.

TIC Implementation in PM&R:
- Use of consistent staff and structured routines
- Minimization of sensory triggers (noise, lighting, too many people)
- Trauma-informed behavioral interpretation
- Family engagement in care delivery
- Interdisciplinary coordination across medical and therapy teams

Outcome Implications: Improved participation across rehab disciplines, reduced agitation, and enhanced therapeutic alliance. Integration of caregiver support and education supported short and long-term goals and outcomes. Also supported were long-term outcomes including return-to-work, return to hobbies, decreased alcohol use, and continued self-advocacy [13-16].

Training and Systems-Level Gaps

Despite its relevance, TIC is not universally required in PM&R training or continuing education. This gap contributes to variability in patient experience and outcomes.

Recommended system-level actions include:
- Integration of TIC into residency and continuing education
- Development of interdisciplinary care protocols
- Organizational policies supporting trauma-informed environments
- Provider support to address secondary traumatic stress

Discussion

TIC aligns closely with the biopsychosocial model central to PM&R. Its integration enhances clinical reasoning by contextualizing patient behavior and improving therapeutic relationships. For patients with neurologic injury, TIC may directly influence recovery trajectories by improving engagement and reducing barriers to participation.

Future directions include development of standardized outcome measures and evaluation of TIC-specific interventions within rehabilitation populations.

Clinical Implications

- **Assume Trauma Exposure:** Use universal precautions with ALL patients to reduce risk of re-traumatization during rehabilitation encounters.
- **Prioritize Consent and Control:** Incorporate the triad of consent (adversity, distress, strengths) to guide evaluation and treatment planning.
- **Reframe "Noncompliance":** Interpret resistance, agitation, or avoidance as potential trauma responses rather than willful behavior.
- **Modify the Environment:** Reduce sensory overload and unpredictability, particularly for patients with neurologic injury or PTSD.
- **Strengthen the Therapeutic Alliance:** Consistent communication, transparency, and patient choice improve engagement and functional outcomes.
- **Leverage Interdisciplinary Care:** Coordinate TIC principles across physicians, therapists, nursing, and support staff for consistency.
- **Address Disparities:** Recognize populations at higher risk for trauma and adapt care to be culturally and contextually responsive.
- **Support Clinician Well-Being:** Implement strategies to mitigate secondary traumatic stress and burnout within rehabilitation teams.

Conclusion

Trauma-informed care is not an adjunct to PM&R practice; it is a core clinical competency that directly shapes patient safety, engagement, and functional outcomes. Within this framework, SAMHSA's six principles-safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender responsiveness-serve as an operational scaffold for both individual encounters and system-level design. When consistently applied, these principles recalibrate the therapeutic environment from one that risks re-traumatization to one that actively supports neurologic and psychosocial recovery.

The triad of consent-typically conceptualized as informed, ongoing, and voluntary-functions as the actionable interface between these principles and day-to-day clinical care. In PM&R settings, where patients frequently experience diminished autonomy due to physical, cognitive, or communicative impairments, consent must be dynamically assessed and explicitly supported. This includes adapting communication modalities, verifying comprehension, incorporating surrogate decision-makers when appropriate, and recognizing nonverbal indicators of assent or distress. Embedding consent processes into routine interventions (e.g., positioning, manual therapy, swallowing assessments, cognitive-linguistic tasks) reinforces patient agency while reducing the likelihood of procedural distress or disengagement [17,18].

Operationalizing this framework requires attention at multiple levels. At the clinician level, it involves deliberate communication strategies, reflective practice, and vigilance for trauma cues that may manifest as behavioral, cognitive, or physiological responses. At the team level, it necessitates interdisciplinary alignment to ensure consistency in language, expectations, and care delivery. At the systems level, it calls for policies that prioritize psychological safety, flexible care pathways, caregiver inclusion, and equitable access to resources. Importantly, trauma-informed care must be responsive to the cumulative effects of structural inequities and adverse experiences that disproportionately impact marginalized populations, thereby advancing health equity within rehabilitation contexts.

In practice, integrating trauma-informed principles with structured consent processes enhances therapeutic alliance, improves adherence, and supports more accurate assessment of patient capacity and goals. It also positions clinicians to better address the complex interplay between neurologic injury, identity, and lived experience that characterizes many PM&R populations. Ultimately, a trauma-informed clinical framework is not defined by isolated techniques, but by a sustained commitment to centering dignity, autonomy, and partnership throughout the rehabilitation continuum.

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