

## Clinical Commentary

# A Physical Therapist's Role in Providing a Trauma-Informed, Whole-Body, Holistic Approach to Address the Spiritual and Mental Health of Patients

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## Abstract:

It is well documented that patient outcomes improve when providers address the patient's mental and spiritual needs in addition to their physical needs. There is currently a shift from the biomedical model to the biopsychosocial model and now a focus on the dynamic biopsychosocial model. Trauma is known to have spiritual, cultural, mental and physical implications, and people that have experienced trauma want their providers to address it. Transitioning to a biopsychosocial model can be challenging, but the physical therapist is in a unique position to provide quality care within their scope of practice, while addressing the complexity of the whole person. Physical therapists must look introspectively at their own beliefs and practices to provide improved holistic, trauma-informed care. Through personal experience and literature reviews, a case is made for addressing both spiritual beliefs and mental health needs in the clinical setting. (SDC call-out)

Keywords: trauma, spirituality, healthcare, domestic violence, biopsychosocial

## **1)INTRODUCTION**

In 1977 Engel introduced the biopsychosocial model of healthcare which shifts the focus of patient care from a purely biomedical view to incorporation of psychological and social factors, such as culture or religion, that may also influence a patient's health.<sup>(1-3)</sup> Since its introduction, many facilities have tried to implement strategies to treat holistically, with little success or standardization of care.<sup>(2)</sup> The emergence of trauma-informed care, combined with a shift toward inclusion of cultural sensitivity and Interfaith perspectives, is important and is timely for review in physical therapy practice.

## **2)DEFINING TRAUMA**

The Substance Abuse and Mental Health Services Administration defines "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."<sup>(3)</sup> Trauma is experienced by an individual, family or community, and can be caused by another individual, community, workplace, or from legislation.<sup>(4)</sup>

Physical therapists have a duty to identify trauma responses in their patients and provide compassionate, consensual care.<sup>(5)</sup> The women's and pelvic health physical therapist has a unique opportunity to care for mothers throughout pregnancy and

delivery by combining education, hands on techniques, and encouragement, thus empowering the birthing mother in making autonomous decisions.<sup>(5-6)</sup>

### **3)TRAUMA DURING BIRTH EXPERIENCE**

Traumatic birth experiences are known to cause both physical and psychological trauma.<sup>(7)</sup> A previous history of post-traumatic stress disorder (PTSD) or mental health disorder combined with negative interactions with the birthing staff are reported as the leading cause of postnatal PTSD.<sup>(7)</sup> These poor interactions have led to terms such as obstetric violence and obstetric rape becoming popular in the literature.<sup>(8)</sup> Common medical practices such as limiting food or activity during parts of labor, frequent cervical checks, restraint via continuous monitoring, episiotomy without consent, and lack of information or uninformed consent are associated with increased trauma scores.<sup>(8)</sup> This is a type of gender-based trauma that is directly related to birthing mothers.<sup>(8)</sup>

Physical therapists should be included in the healthcare team throughout the pregnancy and postpartum phases to provide education, functionally prepare, and rehabilitate women. Many hospitals around the world include physical therapists in the birthing room as pain and movement experts.<sup>(9-10)</sup>

### **4) TRAUMA WITH SEXUAL ASSAULT**

Despite the progression in the utilization of women's and pelvic health physical therapists in the birth process, there continues to be a lack of knowledge regarding the role physical therapy plays in improving the birth experience outcomes.<sup>(9)</sup> Sexual harassment or assault was reported by 81% percent of women during the #MeToo Movement.<sup>(11)</sup> The CDC reports that 50% of all women have experienced sexual violence involving physical contact, and one in five women in the US will report a history

of sexual assault (SA) or rape, with estimates reaching up to 30% in women in racial and ethnic minority groups.<sup>(4,12,13)</sup> Working with people who have experienced SA, rape, or intimate partner violence (IPV) can be challenging. The experience of each person must be understood as an individual and unique response, with triggers and subsequent responses being drastically different from person to person.<sup>(14-15)</sup> For example, some people are aware immediately they have been through a traumatic experience, while others, especially those who have experienced childhood trauma, may not realize for years the full extent of the trauma they have endured or continue to experience.<sup>(14-15)</sup> The physical therapist may meet them at any point on their journey to this realization.<sup>(14-15)</sup>

Ninety-three percent of women that have been killed by a partner sought medical treatment for their injuries prior to their death.<sup>(16)</sup> Women with chronic disabilities are at an even higher risk for IPV, and are frequently seen in physical therapy clinics, thus placing physical therapists on the front line to recognize women in IPV situations and provide trauma-informed care.<sup>(17)</sup>

Coping strategies often used by survivors of sexual violence, include: substance abuse, increased promiscuity, risky physical behaviors, feelings of sadness or hopelessness, suicidal thoughts or actions, and disordered eating.<sup>(12-14)</sup> Teens with SA experience mental health decline and require care for up to 10 years after initial SA report.<sup>(12)</sup>

Among women referred to pelvic floor physical therapy for chronic pelvic pain, 50% have a history of abuse.<sup>(18)</sup> A pelvic floor physical therapist treats conditions related to chronic pain and pelvic floor dysfunction and may encounter patients with

unresolved trauma, triggering general feeling of illness, pelvic pain, unintended pregnancy, and obstructive defecation syndrome.<sup>(14,18)</sup>

## **5) IMPLICATIONS OF TRAUMA**

“All too often, society is horrified with trauma survivors; their symptoms; and the burdens it places on the health care, child welfare, criminal justice, and educational systems—and insufficiently horrified by the systems of oppression that underlie so much trauma, violence, and abuse.”<sup>(19)</sup> In order to address trauma, the underlying systemic issues of violence must be first addressed at all levels.<sup>(3-4,20)</sup>

Unfortunately, trauma survivors are often misjudged by clinicians and the general public. Agitation, irritability, anxiety, depression, inappropriate outbursts, startling easily, sudden sweating, dissociation, inability to concentrate, difficulty trusting, self blame, guilt, shame, and feeling numb are all mental health manifestations of unresolved trauma.<sup>(3, 14-15)</sup>

Patients living with trauma may have difficulty regulating their emotions and this may show through sudden outbursts or complete withdrawal from social contact. This may also show up, clinically, through an inconsistent report of the subjective history of the patient. Physical therapists, wrongly, place judgment on patients and label them as “noncompliant” or “difficult”. However, physical therapists must begin to recognize these behaviors as signs of underlying trauma that must be addressed. <sup>(19)</sup> Patients from religiously, culturally and language divers backgrounds may be especially vulnerable to this type of projected and harmful labeling. <sup>(4,12,20)</sup>

Unresolved trauma can also lead to physical postural changes, such as “submissive posturing”. Submissive posturing is a posture similar to the fetal position

with thoracic kyphosis, knee and hip flexion. Over time, this positioning can lead to muscle asymmetry and pain. Physical therapists can help the trauma survivor out of these postures.<sup>(21)</sup>

## **6) DEFINING SPIRITUAL CARE**

Trauma affects a person's spirituality, especially if the person relates closeness to their god with decreased suffering.<sup>(22)</sup> For the purpose of this paper, we will focus on the broader topic of spirituality which can include religion, but is not limited to religious beliefs or doctrine.<sup>(23)</sup> Spirituality is a universal set of Interfaith values that encompasses individual beliefs as they pertain to the meaning of life and how an individual holds the parts of their world sacred.<sup>(23-26)</sup>

## **7) INTERFAITH SPIRITUALITY**

The US is home to almost all of the world's religions due to its consistent immigration.<sup>(27)</sup> The relationship between religion and healthcare has been intertwined for centuries, only seeing a major shift away from this practice in the 20th Century with the emergence of corporate hospitals.<sup>(25-26)</sup>

During the pandemic people increased their time spent in spiritual or religious practices in order to cope with the psychological distress caused by the uncertainty of the times.<sup>(28-29)</sup> Religious and spiritual leaders influence their followers' medical practices through integration and promotion of spiritual rituals and practices such as forgiveness, prayers, and community engagement to help people improve mental health.<sup>(30-31)</sup> Likewise, when medical providers address spirituality, health outcomes improve.<sup>(22)</sup> Patients want their spiritual needs met by their healthcare provider, but they can be fearful of rejection because of a difference in religious or spiritual perspectives,

especially if they are from a religious, cultural or language diverse background different from their provider.<sup>(22, 32-33)</sup>

Many cultures around the world continue to have healing ceremonies that provide comfort and resilience to the participant.<sup>(26)</sup> Some cultures and religions may view mental health struggles as a “curse” or consider “demonic possession” as a cause that cannot be cured with modern medicine.<sup>(26)</sup> It is important for physical therapists to be open to understanding the diverse spiritual, social and medical beliefs of their patients and to recognize any provider bias that may produce a barrier to the healing process for people from diverse religious, cultural, and language backgrounds.<sup>(26)</sup> The city of Detroit recognized the multiple health disparities experienced by Indigenous populations, and through a multi-organizational collaboration set up a health center that combines traditional Western medicine with Indigenous cultural healing rituals.<sup>(34)</sup> These programs allow for patient-led experiences, while also providing evidence-based medicine and education, contributing to a cohesive treatment plan. Patients are more willing to participate in Western medicine when they feel their spiritual and cultural values are respected.

With the uniqueness of each person’s spirituality, more focus is being drawn to Interfaith systems.<sup>(25-26)</sup> Interfaith systems build relationships between people of different faith identities focusing on empathy and collaboration, therefore improving compassion and health outcomes.<sup>(25-26)</sup> Interfaith practices are defined by inclusivity which naturally supports universal human rights, regardless of religion or belief in a god, while still acknowledging we can be spiritual beings.<sup>(24,26)</sup> Practicing spiritual strategies can give meaning to individual beliefs, increase faith, purpose of life, and create peace within

suffering.<sup>(35)</sup> The most common spiritual practices universally are mindfulness, meditation and prayer.<sup>(35)</sup>

## **8) BARRIERS TO INTEGRATION**

Medical providers, including physical therapists, report a gap in education training in trauma which is inadequate to care for people that have experienced IPV or SA.<sup>(16,36)</sup> Those that do feel they are more equipped to handle trauma often have experienced trauma themselves or observed close friends or family handle traumatic situations.<sup>(36)</sup> In the state of Oklahoma there are no continuing education requirements for trauma training, cultural sensitivity training or addressing spirituality for physical therapists.<sup>(37)</sup> Agencies such as the Department of Human Services recognize the importance of trauma training, and require 12 hours of trauma training yearly for all foster parents.<sup>(38)</sup> One of the essential parts of understanding trauma is understanding that every single person has had traumatic experiences, so trauma should be assumed prior to treatment, not only when disclosed by the patient.

Providers are responsible for educating patients on all treatment options, but then allowing the patient the autonomy to make informed decisions about their care.<sup>(27)</sup> Providers must be aware of their own biases, and respect when a patient chooses a different treatment option, whether it is for spiritual reasons or possibly to reduce the risk of re-traumatization.<sup>(14,27)</sup> Policy changes combined with education of upcoming clinicians can help, but a work environment that does not burden the clinician when additional time or documentation is needed should be prioritized.<sup>(14,16)</sup>

Retraumatization may happen when working with people who have experienced trauma. It can stem from a loss of power, control or felt safety.<sup>(14)</sup> Physical therapists

must educate themselves on retraumatization triggers and intentionally integrate ways to avoid retraumatization. Examples of how physical therapists may avoid retraumatization of patients includes: (1) asking consent from patients for each step of the evaluation and intervention, (2) not asking patients to retell their story, (3) asking patients their preference for provider (gender), clinical environment (door open or closed), and specific use of restrictive equipment.<sup>(14,39)</sup> Something as simple as how a clinic is decorated can be a trigger for someone who has experienced medical trauma.<sup>(19,39)</sup> Trauma and PTSD symptoms of hyperarousal, avoidance, flash-backs and hypervigilance can be recognized by the physical therapist.<sup>(39)</sup> Physical therapists should ask patients prior to physical examination for consent to touch, and follow their physical and emotional cues to avoid retraumatization.

Past trauma and religious customs may dictate the need for a specific gender of provider, and gender of the provider is the number one reason why a patient will choose one provider over another.<sup>(15,27,40)</sup> A simple way to address both mental health and spirituality is to comply with a patient's request of a gender specific provider.

Patients seek providers that share similar values to their own.<sup>(40)</sup> When creating biographies, all healthcare providers should use inclusive language, and be cognizant that grouping oneself into a religious category could exclude future patients that fear judgment of their personal, differing beliefs.<sup>(40)</sup>

Questionnaires can provide insight into both mental health status and cultural, spiritual preferences.<sup>(19,41)</sup> There are several options for Spiritual Questionnaires; however, most use reference words which may favor specific religions, thus excluding spiritual minorities, and biasing towards specific religions.<sup>(41)</sup> For example, the Spiritual

Needs Questionnaire for Palliative Care which was created in a highly Catholic area has several Christian based reference words, while Holistic Health Status Questionnaire, created in Hong Kong, specifically mentions Karma. <sup>(41)</sup> A wide range of variability exists regarding the questions in these assessments. Some are ratings based, while others use open ended questions. <sup>(41)</sup> There are several questionnaires with neutral religious language, but this vagueness can muddle the patient's needs, making interpretation difficult for the provider. <sup>(41)</sup> Physical therapists should be cautious to integrate a Spiritual Needs Assessment if they are not able to delegate the time or resources to follow up with the needs found. <sup>(42)</sup> A spiritual needs assessment should always be “optional” for patients to provide, and only according to their comfort level.

There is a lack of research combining the physical, mental and spiritual aspects of healing in physical therapy. There has been some research addressing both mental health and physical needs, specifically for low back pain, but most of the research does not include spiritual or social aspects of care that may also affect outcomes. <sup>(2)</sup> It is our responsibility to address these disparities at all levels as they impact the mental, physical, and spiritual aspects of healing.

## **9) FACILITATORS TO INTEGRATION**

Physical therapy practice is an autonomous, direct access practice, which focuses on collaboration with, instead of delegation by, the patient’s primary care provider. In the context of musculoskeletal disorders, such as fractures or sprains, physical therapists are consistently capable of finding and diagnosing ailments the referring physician may have missed. <sup>(43)</sup> As physical therapists become first line

providers, it is necessary to implement practices on how to address these needs within our scope of practice and to refer out for anything beyond.<sup>(14)</sup>

Incorporation of spirituality and mental health screening into clinical practice may be easier than previously thought.<sup>(42)</sup> A physical therapist's greatest tool is asking open ended questions, and allowing the patient to tell their story. Successful incorporation of spiritual care consists of asking open ended questions, actively listening to the answers, and using the patient's goals for care to provide a creative, personalized plan of care.<sup>(42)</sup> Physical therapists often teach mindfulness, which can involve breathing, movement, awareness of body sensations and mantras, which can incorporate both mental and spiritual needs.<sup>(35)</sup>

The core values for physical therapy already provide a framework for incorporating both trauma-informed care and spiritual needs into clinical practice. When physical therapists ask open-ended questions and let the answers guide the treatment plan, they incorporate quality care as defined by our core values of altruism, collaboration, excellence, compassion and caring.<sup>(5)</sup> When physical therapists hold space for a person that has experienced trauma or has specific spiritual or cultural needs physical therapists practice the core value of inclusion.<sup>(5,26)</sup> Referring to other medical, spiritual or mental health providers demonstrates accountability, altruism, duty and collaboration.<sup>(5)</sup> It is our ethical duty to be political advocates of change for basic human rights in regards to access to healthcare and physical therapy services.

It takes a high level of autonomy, resilience and personal awareness to be effective in this model of care. Listening to a patient's history of trauma or oppression can be triggering to the provider, especially if the provider has a history of domestic

violence or shares a similar trauma.<sup>(15)</sup> Providers should seek out the above described services for their own well-being if they are having difficulty holding space for their patient.<sup>(22)</sup>

## **11) CLINICAL EXAMPLES**

The following scenarios are examples of clinical application of trauma-informed care and spiritual needs assessments into care. Please be advised that these examples contain descriptions of birth trauma, sexual abuse, and medical trauma that may be triggering to some readers.

1) A woman presented to an outpatient physical therapy clinic with lower back pain. Through the course of several sessions, she developed a rapport with her therapist, and disclosed a previous history of sexual assault and reports of current pelvic floor dysfunction symptoms. Her initial physical therapist did not have training to perform pelvic floor assessments and so she referred to the pelvic floor physical therapist (PFPT) working in the clinic. The initial therapist spoke with the patient regarding an assessment with the PFPT, and gave a brief handoff to the PFPT prior to the patient's next visit. The initial therapist assumed that the patient would disclose her previous trauma to the new therapist, but the patient did not. The PFPT chose to perform an external assessment with clothing in place as this patient was unfamiliar to the new therapist, and had initial complaints of an orthopedic nature. During the assessment, the patient was prone, and the therapist placed one hand on her ankle and the other on the patient's buttock to assess hip mobility. This hand placement was triggering to the patient's trauma, and resulted in the patient having a panic attack in the room. The new therapist was not aware that the patient was triggered until the patient

was observed to hold her breath several minutes into the assessment. Once the touch trigger was identified, the new therapist attempted to calm the patient, but to no avail. The patient did not return for follow up.

Multiple strategies could have prevented this retraumatization. The initial therapist could have disclosed the patient's previous trauma to the new therapist. Asking the patient for consent before touching or starting the assessment in a position where the therapist could see facial expressions could have limited the retraumatization. The new therapist did make a sound decision by not immediately initiating an internal examination, but could have taken more time to interview the patient and determine the patient's comfort level with having a new therapist.

2) A young woman presented to the clinic with an initial complaint of hypermobility, incoordination and weakness. At her eighth visit, during palpation of her hamstring region, she was noted to breath hold and tense her body. When asked if she was doing ok, she reported that she was, and requested to continue treatment; however, the patient's affect did not change. When the physical therapist removed their hands from her body, the patient exhaled. The physical therapist suggested changing the therapy treatment plan due to the patient's response, but the patient insisted that the treatment continue. The patient reported that she would be fine because she had received dry needling to that area, and had never had this reaction. The physical therapist ultimately stopped the session as the patient became more emotional, and appeared to have a PTSD event. After stopping, the patient was coached on touch boundaries and encouraged to tell providers "no" if she was not comfortable with any

treatment. The patient later disclosed that she had had medical trauma with touch in that area.

The patient had not yet processed her traumatic experience as trauma, thus could not verbalize what was happening to her. The therapist did a good job of recognizing the trauma, stopping the session and discussing touch boundaries with the patient. Even though the patient was well known to the physical therapist, the physical therapist should have asked for consent to touch.

3) A physical therapist had a male patient post prostatectomy experiencing erectile dysfunction. The physical therapist ordered the patient a penis pump, and over the next several months, he reported that he barely used it. It was not until the physical therapist asked him, "What are your barriers to using the pump?" that he openly shared his shame stemming from his spiritual upbringing. The physical therapist and patient collaborated using open communication to find the comfort level of the patient, which led to increased compliance and improved attendance to his therapy treatments. The physical therapist researched some local and online resources that discussed this barrier in the context of the patient's spiritual preferences.

The patient could have been labeled as non-compliant after just a few sessions, but by asking about his barriers, the therapist created rapport and trust instead of creating more shame. The patient was initially fearful of disclosing his spiritual beliefs for fear of rejection, but the physical therapist's use of open ended questions regarding his non-compliance gave the patient the opportunity to share his whole story. The physical therapist continued to provide quality care in the biopsychosocial framework by

researching the patient's stated belief system within the context of their treatment strategies.

4) My last example is my own birth story. My daughter is now an adult, and all parties involved have consented to me sharing this story publicly. I had just turned 20 years old, and had just delivered my daughter after 46 hours of hard labor and four hours of pushing. I requested they allow me to sleep for just a few hours as exhaustion set in. The nurse replied, "you should have thought about it before you got yourself pregnant." I, like so many other women who have undergone trauma during pregnancy, had not yet processed my trauma, so I did not have the words to tell the nurse that I had been date raped. I did not know how to tell her that my boyfriend was not the baby's father, and that he also abused me. The nurse had an influx of patients, and did not take the time to address my emotional needs, my trauma, nor the spiritual conflict that stemmed from having an unwanted pregnancy and having to keep the baby. She likely did not have any trauma training. She was understaffed with an influx of patients, and made a quick quip that would haunt me for years to come. I acted out in promiscuity, not realizing that this was driven by my trauma. It was years later when I was discussing my sins of promiscuity with a pastor that he stopped me. He told me that my sins were because of the trauma I had endured, and referred me to a free clinic that could address my mental health. My mental healthcare provider provided me with local resources to continue my healing journey. I would go on to become a physical therapist, and later a foster/adoptive mom to three more children. During that time, no one in the medical field addressed my poor attachment, difficult recovery postpartum, or signs of PTSD.

If I had been seen by a trauma-informed PFPT during my pregnancy, I would have had a resource to prepare my mind and my body for the delivery room, which may have decreased the levels of PTSD I experienced due to my poor interactions with the staff combined with my traumatic pregnancy. A PFPT may have also been able to recognize my mental health needs and refer me to a provider sooner. Throughout these experiences of trauma, I have hoped that someday these would be used to help other women and clinicians. They shape and inform my own clinical physical therapy practice.

## **(12) CONCLUSION**

These experiences have taught me about the human condition, and allowed me to create a practice with a biopsychosocial focus. Treating in the biomedical model is easy. X fixes Y, and everytime you see Y you do X. When we treat in the biomedical model, very little attention is given to the patient's needs as a whole person. We are only focused on the problem at hand. If the biopsychosocial model is used as a framework for practice, practitioners become collaborators with the patient, instead of an omnipotent director of the patient's care. This practice forces the physical therapist to be aware of their own implicit biases regarding culture and religion and the differences that might exist between their views and their patient's views, and be open to collaboration with the patient. It requires the physical therapist to have variability with examinations and creativity with treatments. It allows for the patient to be their own advocate as the practitioner respects personal, physical, spiritual, and trauma trigger boundaries. The biopsychosocial approach to medicine requires more from the practitioner, but with continued needs for trauma-informed care in a culturally and

language diverse society, now is the time to integrate this approach. Trauma-awareness as it relates to spiritual and mental health needs are integral to the health outcomes of all patients in physical therapy. It is imperative that health care providers, including physical therapists, recognize our own personal biases, naivety, and boundaries in order to help our patients. Research should focus on standardized ways to incorporate trauma-informed practices in a meaningful way that reduces retraumatization and improves the quality of care for all patients.. Let us work toward providing peace and compassion through a trauma-informed lens, knowing that when the mind and spirit are at ease, the work on the body can begin.

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