Physiotherapy in Primary Care

Module 3

Creating Safer and Braver Spaces for Clients, Support Networks, and Team Members

Please note: This course was designed to be interacted and engaged with using the online modules. This **Module Companion Guide** is a resource created to complement the online slides. If there is a discrepancy between this guide and the online module, please refer to the module.

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MODULE INTRODUCTION

Please see the online learning module for the full experience of interactions within this document.

Creating safer and braver spaces for clients, support networks, and team members is critical to being able to provide safe, accessible, equitable, and effective team-based primary care. By safer spaces, we refer to trauma-informed and culturally safe care that makes primary care more accessible and equitable. By braver spaces, we mean creating spaces in primary care for productive engagement in often uncomfortable, challenging dialogue around issues of privilege, oppression, and systems of inequality as they manifest in the clinical settings.[1]

This module aims to share foundational knowledge related to systems of inequality that contribute to privilege and oppression, trauma-informed care principles, and strategies for initiating action when a microaggression occurs. The module will help you identify personal learning needs related to equity, diversity, inclusion, and accessibility (EDIA) and plans to address the learning needs identified. EDIIA is a broader term, with the additional "I" recognizing Indigeneity. Please note Indigeneity is important in relation to this topic, and is covered in the interprofessional team resources corresponding with **Module 02: Foundations of Team-Based Primary Care**, which is why we have chosen the EDIA acronym to guide this module.

Module Learning Outcomes

By the end of this module, learners will be able to:

1. Recognize common "isms" that may need to be addressed and/or navigated in primary care spaces.
2. Summarize what "trauma-informed care" means and reflect on how the physiotherapist can apply trauma-informed care principles in all interactions.
3. Develop at least two strategies for initiating action when a microaggression occurs.
4. Identify personal learning needs/goals in the context of equity, diversity, inclusion, and accessibility (EDIA).

Note: A full reference list for topics discussed in this module can be found in the Conclusion section.

EDIA principles are cross-cutting and foundational to all domains of the **Competencies for Physiotherapists in Team-Based Primary Care**. Some of these are considered entry-to-practice competencies, while some will be developed in practice, with additional training and support. This module will most directly support you in identifying learning needs and plans to address those learning needs to enhance competencies 1.1, 1.2, 1.3, 1.14, 1.15, 1.16, 2.1, 2.2, and 4.3.

Continue to access the competencies that are relevant to this module.

Module Competencies

1.1 Provide person-centered care that considers the complex personal, social, cultural, and environmental factors contributing to a person's functioning and health.

1.2 Establish trusting, collaborative and often longitudinal therapeutic relationships with persons seeking care, along with their families and support networks.

1.3 Create and maintain spaces for physically, emotionally, and culturally safe interactions with communities and persons seeking care, along with their families and support networks.

1.14 Apply trauma-informed care principles when supporting persons seeking care, along with their families or support networks when appropriate.

1.15 Practice with cultural humility and provide culturally safe care.

1.16 Apply anti-oppressive practice approaches (anti-racism, anti-sizeism, anti-ableism, anti-settler colonialism, anti-heterosexism, anti-cisgenderism, anti-classism, anti-sexism).

2.1 Communicate clearly, openly, respectfully, empathetically, in a culturally safe and person-centered way to encourage participation of persons seeking care, their families and support networks.

2.2 Communicate clearly, openly, respectfully, empathetically, and in a culturally safe and person-centered way to encourage the participation and collaboration of all members of the interprofessional primary care team.

4.3 Contribute to the development, implementation, and evaluation of organizational policies that promote the safety of persons seeking care and interprofessional team members.

Continue to Section 01

SECTION 01: INTRODUCING SYSTEMS OF INEQUALITY AND "ISMS"

In this section, you will learn about systems of inequality. The coin model will be presented as a means of identifying common "isms," or systems of inequality. The coin model, adapted from Stephanie Nixon, will be presented as a tool to help you reflect on strategies to break down these systems in primary care.

Systems of Inequality

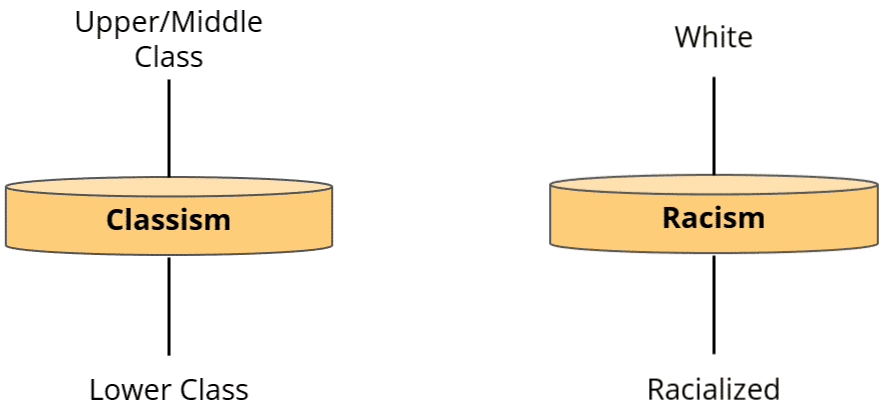
There are many systemic forces, often taken for granted, that privilege some social groups and oppress others. These are rooted in long histories and cultural worldviews, created and maintained by people. To change the systems that create and perpetuate inequities in healthcare, it is essential to first recognize our own role in such systems.

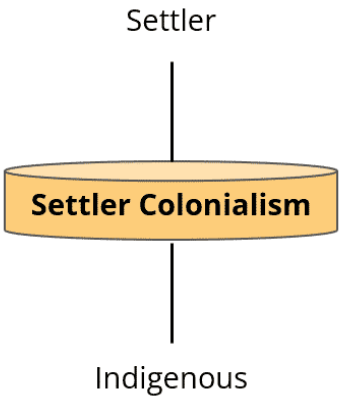
Stephanie Nixon proposes **the coin model** to help describe systems of privilege and oppression in Western societies and how they relate to health outcomes.[2] Systems of inequality are often identified as “isms” - and there are a number of them.

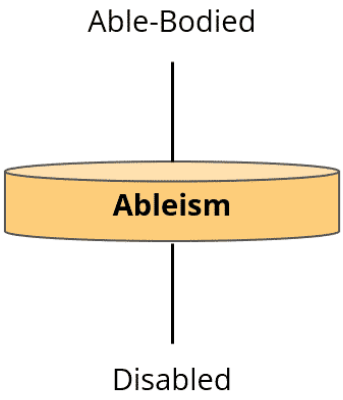
Recognizing Common “isms”: The Coin Model

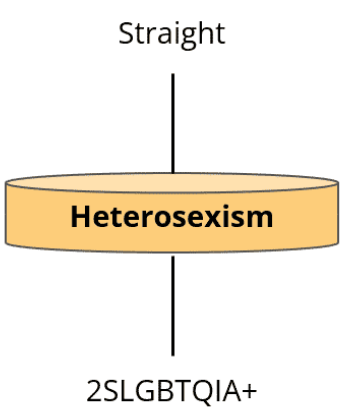
In a system of inequality, there are some people who are disadvantaged and experience oppression, and some people who are privileged or have an unearned advantage. No one exists outside of these two; all people exist within the same systems in a given time and place. Picture each system of inequality as a coin, with people who experience oppression on the bottom of the coin, and people with privilege on the top.[2] Often health care focuses on the problems that disadvantaged groups experience, while the relative advantages or privileges of other groups are often invisible. One consequence of focusing on the challenges faced by the disadvantaged group is that it makes it harder to perceive the system of inequality, as the privileged groups' experiences are treated as neutral and normalized.[2]

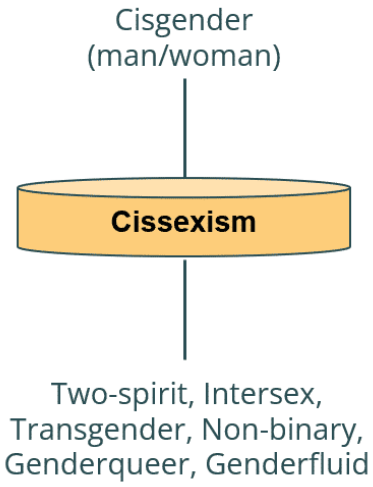
There are many ‘coins’ in society and they can intersect with each other to co-constitute inequalities.[2] Here are some of the systems of inequalities, or coins, you often encounter in dominant Western cultures.

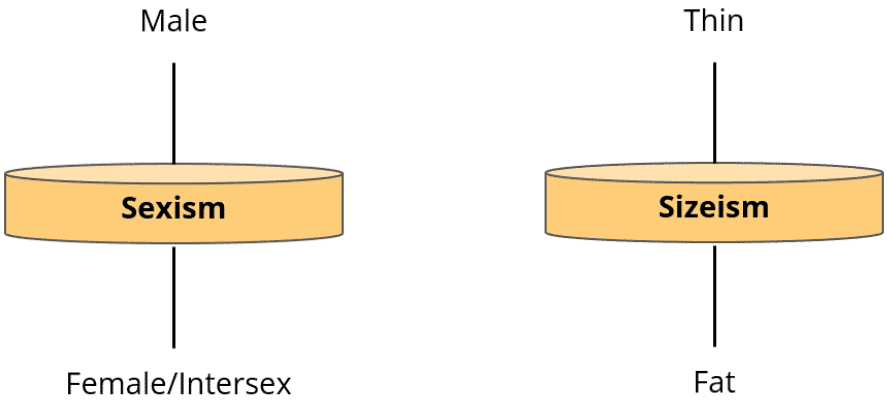



Settler
Settler Colonialism
Indigenous


Able-Bodied
Ableism
Disabled


Straight
Heterosexism
2SLGBTQIA+


Cisgender
(man/woman)
Cissexism
Two-spirit, Intersex,
Transgender, Non-binary,
Genderqueer, Genderfluid



Note: There are many other coins - systems of inequality - not presented in this module (e.g., age, religion, and skin tone).

Strategies to Address Systems of Inequality

Everyone has a position on each coin. Your position on a coin is not related to personal merit or behaviour. If we, as a society, ignore or make invisible the privilege side of the coin, then we are not able to address the social structures that cause the unjust and preventable health inequities.[2]

If we frame problems in terms of only the difficulties faced by a disadvantaged group, then our strategies will not address the whole systems of oppression, of unearned privilege, and of inequality. To avoid reproducing the systems again and again, we need to direct our focus to the social structures that create oppression and privilege, rather than only the group on the bottom of the coin.[2]

The challenge and responsibility for health care workers is to provide care that does not reproduce and strengthen inequalities.

One action you can take is to identify and articulate your position on each coin. This work can make the systems of inequality more visible. When you are in the position on the top of the coin, recognizing and reflecting on the ways you benefit from the system of inequality also makes it harder to justify the privileged position as normal and neutral. It is also important to recognize that people on the bottom of the coin - which can include yourself - are the experts on the systems of inequality.

People on the top of a coin can engage in **critical allyship** to work in solidarity with people on the bottom of that coin to create systemic change.[2]

Key steps to critical allyship are to:

- Understand one's own position.
- Learn from the expertise of those who are oppressed about how systems of inequality are reproduced.
- Increase knowledge of systems of inequality among privileged group members.

- Work in solidarity with and under the leadership of historically marginalized groups to take action on systems of inequality.

Let's start the work of reflecting on assumptions and identities in relation to these systems of inequality using a case study.

Case 1: Bias in Practice

Consider the case of Isabelle and Franc.

- **Isabelle and Franc**

Isabelle and Franc Hamilton are 18-year-old twins. They both attend university outside of their home communities using provincial financial support. Isabelle plays intramural soccer twice a week and goes to the campus gym regularly. Franc is interested in computer programming and is a member of a coding club. They both enjoy playing tennis with their family in the summer. Both Isabelle and Franc consider themselves to be in good health. Before starting this term at school, they scheduled appointments at their local family health team/primary care network with members of the team.

After reading this information, consider how you imagine Isabelle and Franc.

Note: The next series of activities is only to prompt a personal reflection; there are no correct or incorrect choices.

Activity: Reflecting on Isabelle

Each flashcard represents the two sides of the different "isms."Continue and decide which side of the "ism" you think applies to Isabelle.

Upper/Middle Class or Lower Class

Racialized or White

Indigenous or Settler

Able-bodied or Disabled

Straight or 2SLGBTQIA+

Two-spirit, Intersex, Transgender, Non-binary, Genderqueer, Genderfluid or Cisgender (man/woman)

Female/Intersex or Male

Thin or Fat

Now that you have identified what side of each coin you believe Isabelle falls on, take a few moments to reflect on why you made these decisions (judgments) and if you noticed anything about your own assumptions.

Answer the question based on your reflections about Isabelle's case.

Question: What elements of Isabelle's story and history did you make assumptions about, and

why did you make these assumptions?

Activity: Reflecting on Franc

Each flashcard represents the two sides of the different "isms." Continue and decide which side of the "ism" you think applies to Franc.

Lower Class or Upper/Middle Class

White or Racialized

Settler or Indigenous

Disabled or Able-bodied

2SLGBTQIA+ or Straight

Cisgender (man/woman) or Two-spirit, Intersex, Transgender, Non-binary, Genderqueer, Genderfluid

Male or Female/Intersex

Fat or Thin

Now that you have identified what side of each coin you believe Franc falls on, take a few moments to reflect on why you made these decisions (judgments) and if you noticed anything about your own assumptions.

Answer the question based on your reflections about Franc's case.

Question: What elements of Franc's story and history did you make assumptions about, and why did you make these assumptions?

Activity: Which Side(s) of the Coin are You on?

Now that you have reflected on your assumptions about Isabelle and Franc, reflect on your personal position within systems of inequality.

Note: This activity is only to prompt a personal reflection; there are no correct or incorrect choices. For the purpose of this activity, there are only two options for each "ism" based on the systems of inequality mentioned in **the coin model**.

Select which position of the coin model you identify with the most for each of the different "ims." Your information is not being saved.

Classism

a) Upper/middle class
b) Lower class

Racism

a) White

b) Racialized

Settler Colonialism

a) Settler
b) Indigenous

Ableism

a) Able-bodied
b) Disabled

Heterosexism

a) Straight
b) 2SLGBTQIA+

Cisgenderism

a) Cisgender (man/woman)
b) Two-spirit, Intersex, Transgender, Non-binary, Genderqueer, Genderfluid

Sexism

a) Male
b) Female/Intersex

Sizeism

a) Thin
b) Fat

Thank you for engaging in this activity. We appreciate it may be more challenging to select a 'side' for some coins versus others, and the goal of this was to help you reflect on your own positionality in preparation for the remainder of the module.

In this section you learned how the systems of inequality can be understood through the coin model, where common “isms” can be separated by the top (privileged side) and the bottom (oppressed side) of the coin. You then learned strategies for practicing critical allyship, which include understanding your own position and learning from those who are oppressed while increasing knowledge among those who are privileged. Finally, you reflected on your own assumptions around identity through a case study.

The content in this section helped increase your awareness of systems of inequality and your assumptions about people’s position within them. In the next section, you will learn how these systems manifest.

Continue to Section 02

SECTION 02: HOW SYSTEMS OF INEQUALITY MANIFEST

In this section, you will examine a scenario to frame how systems of inequality are created. You will learn about three levels at which these systems are created and perpetuated: population, institution, and interpersonal. You will then reflect on how you would address these systems and apply your knowledge. Finally, you will learn about three types of microaggressions and how to recognize them in a real-life scenario.

To become skilled at interrupting systems of inequality, you have to learn to perceive how these cultural systems of privilege/oppression manifest. They do so in a variety of ways, beyond individual thoughts and opinions. To illustrate these different manifestations, consider a second case study.

Case 2: Manifestation of Systems of Privilege/Oppressions

- **Brenda**

You receive a referral from a team member to help Brenda lose weight. You review her chart, noting she is 50 years old with a body mass index (BMI) of 32. You enter the appointment focused on determining how you can help Brenda establish a physical activity routine.

When Brenda arrives, you take a history. You learn that Brenda has played hockey for the last twenty years, practicing and playing weekly, and cycles in the summer to keep up her fitness. She has had occasional hockey injuries over the years, but recently her knee has been bothering her more consistently. When you mention the reason for referral - weight loss - she asks if you will help her with her knee pain. She adds that she is tired of people telling her to lose weight, including her doctor. She says that weight loss has been impossible to sustain, and that other health care providers have been talking to her about this for years. She previously saw a dietitian, who after reviewing her eating routines had little to offer, affirming Brenda's habits as good ones. Brenda then says that she is not interested in working with you if you won't help her with her knee pain and getting her back to playing hockey.

You will use Brenda's case to learn how systems of inequality manifest in healthcare at three levels: population, institution, and interpersonal.

Population Level

At the population level, systems of inequality can be reproduced through government policies, media representations, and public health campaigns.3 For example, human rights codes in Canada do not consider body size a "protected category." This means that people can fire or refuse service to a bigger bodied person because there is no legal framework in Canada that recognizes this as discrimination. In addition, media portrayals and public health campaigns sometimes recirculate the stereotypes that underpin systems of inequality.3

To unpack an example of population-level reproduction of inequality, visit this resource(opens in a new tab).

Reflection

Now that you have reviewed how systems of inequality manifest at the population level, pause and reflect on two questions.

Reflection Question 1

Can you name or identify any population-level examples that reproduce assumptions that an individual's body composition (thinness or fatness) is under individual control, a matter of discipline, or depends on the individual adopting the "right" eating or exercise habits? If so, what comes to mind?

Reflection Question 2

How have you noticed population-level influences talk about genetics, stress, or income as major determinants of body size and composition?

Institution Level

Within an **institution**, such as a health or community service organization, systems of inequality can be entrenched in discriminatory policies, exclusionary physical environments, and a lack of service provision to oppressed groups.3 Continuing with the weight-related example, discriminatory policies could include different care pathways on the basis of BMI. Exclusionary physical environments include not having chairs or clinic room beds that are the appropriate width for people with heavier, larger bodies. Posters on the walls or clinical handouts can also reproduce negative stereotypes, such as only picturing happy people in thin bodies.

Reflection

Now that you have reviewed how systems of inequality manifest at the institution level, pause and reflect on three questions.

Reflection Question 1

In Brenda's case, what might the referring clinician have missed by focusing on weight, instead of addressing the knee pain? What aspects of the clinician's knee assessment might have looked different Brenda were a a smaller-bodied person with the same knee pain?

Reflection Question 2

How well is your clinic designed to welcome people with heavier, bigger bodies?

For example:

- Do you have seating options that fit their bodies?
- Do your clinics' beds comfortably support people with bigger bodies?
- Do the images on the wall reflect a range of bodies in a positive way?

Reflection Question 3

What could you do today within your current practice setting to be more welcoming to persons with heavier, bigger bodies?

Interpersonal Level

When two or more people interact, systems of inequality and privilege can be reproduced at the **interpersonal level**. A common way this happens is through microaggressions.[3] As defined by Torino et al., (2018), "[m]icroaggressions are derogatory slights or insults directed at a target person or persons who are members of an oppressed group."[4] These types of comments or actions may be explicit actions or unintentional missteps. Either way, they reproduce cultural beliefs about group superiority/inferiority. In this way, microaggressions are incivilities that are not random.

Microaggressions take three forms, which are microassaults, microinsults, and microinvalidation. The use of the prefix micro- does not lessen the impact, but refers to the level where the aggression is taking place, the level of the individual, rather than a whole group or population.

Continue to contrast the three forms of microaggressions.

Microassaults

Microassaults are "a blatant verbal, nonverbal, or environmental attack intended to convey discriminatory and biased sentiment…related to overt racism, sexism, heterosexism, ableism, and religious [etc.] discrimination in which individuals deliberately convey derogatory messages to target groups." [4] Examples include using slurs or displaying racist symbols.

Microinsults

Microinsults are "behaviors or verbal comments that convey rudeness or insensitivity or demean a person" on the basis of some group identity they share with others.[4] These can be little snubs that share a hidden insulting message.

Microinvalidation

Microinvalidation are "verbal comments or behaviors that exclude, negate, or dismiss the psychological thoughts, feelings, or experiential reality of the target group." [4] Examples include statements like "I don't see colour, I only see the human being" or dismissing someone's report of unfair treatment or exclusion as whining. These run the range from intentional harm to unintentional.

Regardless of intent, microaggressions reflect a worldview that treats groups as normal or abnormal, superior or inferior.

Examples of health care microaggressions against people with larger bodies with visible body fat include assuming that bodily fatness signals that a person is not physically active, not invested in their wellbeing, or lazy. This manifests in biased clinical reasoning, and contributes to actions like failure to assess, doubting the patient's subjective history, and giving poorer quality exercise prescription or poor treatment advice.

Reflection

Now that you have reviewed how systems of inequality manifest at the interpersonal level, pause and reflect on two questions.

Reflection Question 1

When is recommending weight loss a microaggression?

Reflection Question 2

What other actions might Brenda's clinicians take that would be microagressions?

Continue to the audio transcript of Patricia Thille, PT, PhD, reflecting on microaggressions in the context of weight loss.

Start of the audio transcript:

In the experience of people who are disadvantaged by the system of inequality called sizeism, they are regularly told they need to "lose weight" or receive "eat less/exercise more" messages, both within and outside of healthcare. Such messages are examples of microaggressions. Here's why. Telling people to lose weight is like telling people to "lose cholesterol" or "lose blood pressure" or to "stop being anxious." Weight is an outcome with many influences, but it is often treated like it is under individual control and easily changed in safe and sustainable ways through changes to eating and physical activity. In contrast, determinants of weight, like with other bodily characteristics, are many and most are not under individual control.[5] Finally, lifestyle changes create only minimal reductions of weight, which is 3-5% from maximum weight, on average.[5]

End of the audio transcript

Microaggressions take a heavy psychological and physical toll on those targeted. Because of their frequency, microaggressions spur vigilance and stress responses. People who are routinely subject to microaggressions may be defensive in appointments with health care providers, including physiotherapists.

Reflection

Now that you have reviewed examples of microaggressions and their impact on patients, pause and reflect on two questions relating to Brenda's case.

Reflection Question 1

When you first reviewed the case, how did you respond to hearing Brenda's insistence that you help her with her knee pain rather than focus on weight loss?

Reflection Question 2

If you interpret Brenda's responses as being proactive in the face of potential microaggressions, how might you respond differently?

Case 2: Revisiting Brenda

Continue to learn how Brenda's appointment progressed.

- **Brenda**

You decide to focus on Brenda's primary concern - knee pain - and tell her so. Your assessment shows medial collateral ligament (MCL) laxity and pain associated with stress tests on the medial aspect of the knee. Together, the tests indicate bracing could help, and you initiate this conversation with Brenda.

After the appointment, you realize that without Brenda's insistence on focusing on her knee pain, these clinical findings and course of treatment may not have been identified given you had assumed she was inactive. You begin to think about how you will respond to future referrals for "weight loss."

In this section, you considered a second case study in which systems of privilege and oppression had manifested, and learned about impacts of these systems at a population, institution, and interpersonal level. You also reviewed three types of microaggressions: microassaults, microinsults, and microinvalidations. Through Brenda's case, you have learned to perceive how cultural systems of privilege/oppression manifest, and were invited to reflect on how you may respond to them in practice.

Continue to Section 03

Page link:

https://www.ajc.com/news/opinion/fight-obesity-not-the-people/2J8JayrYJCJSUox0RLDBzN/

SECTION 03: CULTURAL SAFETY AND TRAUMA-INFORMED CARE

In this section, you will learn how cultural safety and trauma-informed care are integrated into team-based primary care. You will explore the cultural safety model and learn about the factors that contribute to the model. You will learn about the four types of trauma: individual, interpersonal, collective, and structural. You will also be introduced to the three "E's" of trauma and learn about a trauma-informed approach to health care.

Cultural humility and safety are important to anti-oppressive practices. These are reviewed in **Module 02: Foundations of Team-Based Primary Care**.

The systems of inequality you learned about in the previous sections can create trauma; this makes trauma-informed care an important way forward. Dr. Krystyna Holland, DPT, describes trauma-informed care as:

"The continuous process of minimizing your own potential for perpetuating harm against others. It requires acknowledging you can perpetuate harm, and the ways in which harm can happen - regardless of not if this aligns with one's own experiences; and then minimizing opportunities for this harm to happen."

(Holland, 2022)[6]

Trauma-informed care and cultural safety are interrelated, as indicated by the Public Health Agency of Canada (2019).[3]

Continue to learn about trauma-informed care, anti-racism, and cultural humility as contributors to cultural safety.

Trauma-informed Care

Trauma-informed care is an approach to providing services and support that recognizes the impacts and root causes of trauma.

Anti-Racism

Anti-racism involves reducing power differences between groups.

Cultural Humility

Cultural humility is the process of self-reflection to understand personal and systemic biases and privilege.

Cultural Safety

Cultural safety is determined from the patient/community's perspective. It considers the social, political, and historical contexts, and requires practitioners to be self-reflective.

Given that systems of inequality create trauma, physiotherapists can deliberately provide trauma-informed care to create safer environments for all people accessing services. As you will learn later in

this section, a trauma-informed approach can also reduce the potential for re-traumatization and further harm.

Trauma-Informed Care

What is Trauma?

Trauma is a broad, multi-layered concept which includes individual, interpersonal, collective, and structural levels which do not necessarily occur in isolation.[7]

Continue for definitions of individual, interpersonal, and collective trauma.

Individual Trauma

Individual trauma is an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individuals' functioning and mental, physical, social, emotional, and/or spiritual well-being.[8]

Interpersonal Trauma

Interpersonal trauma can include "adverse childhood events, child maltreatment, domestic and sexual violence, human trafficking, elder abuse, etc." [7]

Collective Trauma

Collective trauma is understood as "cultural, historical, social, political, and structural traumas (i.e., racism, bias, stigma, oppression, genocide) that impact individuals and communities across generations." [7]

Three "E's" of Trauma: Events, Experience, and Effects

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014), when an individual is exposed to a traumatic or stressful **event**, how they **experience** it significantly influences the long-lasting adverse **effects** of carrying the weight of trauma.[8] This concept is summarized by the three "E's" of trauma.

Continue to learn more about events, experience, and effects as important considerations for understanding trauma.

Events

Events are the actual or extreme threat(s) of physical or psychological harm or severe life-threatening neglect that imperils healthy development.

Experience

Experience refers to how individuals label, assign meaning to, and are disrupted physically/psychologically by an event, which will contribute to whether or not an individual experienced an event as traumatic.

Effects

Effects may occur immediately or be delayed, and can be short to long-term.

Note: Remember that an event may be traumatic for one individual and not for another!

What is a Trauma-Informed Approach?

A trauma-informed approach is inclusive of trauma-specific interventions, and incorporates key trauma principles into the organizational culture.[8] A program, organization, or system that is trauma-informed realizes how common and widespread trauma is. It also realizes the close connection between trauma and systems of inequality, and how actions taken to address these systems may directly impact the prevalence and experience of trauma.

To be trauma-informed means:[8]

- Understanding potential paths for recovery.
- Recognizing signs and symptoms of trauma in clients, families, staff, and others involved with the system.

A trauma-informed approach is also important because you never know who is managing trauma. You will now learn more about the assumptions of a trauma-informed approach.

Key Assumptions in a Trauma-Informed Approach

A trauma-informed approach involves four key assumptions: realize, recognize, respond, and resist re-traumatization.[8]

Before learning about each assumption, continue to familiarize yourself with the definition of re-traumatization.

Re-traumatization

Re-traumatization means "exposure to one or more potentially traumatic events subsequent to an initial exposure to psychological trauma, with the subsequent trauma exposure serving as a reminder of a past psychological trauma and exacerbating the distress that is related to the prior traumatic experiences [...] traumatization should be distinguished from other constructs such as traumatic stress reactivation (short-term increase in distress results from reminders of past traumas) and revictimization (exposure to multiple traumas that have been perpetrated by another person.)" [9]

Continue to learn more about the four assumptions in a trauma-informed approach.

Realize

It is important for clinicians to **realize** that:

- People's experiences and behaviour are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances (past or present), or emotional distress that results in hearing about others' firsthand experiences.[8]
- Trauma is not confined to the health service sector, but is integral to other systems (e.g., child welfare, criminal justice, and peer–run and community organizations).[8]

Recognize

Trauma screening and assessment can assist in the recognition of trauma.[8] The signs of trauma can include: [10]

- Too much or too little emotion
- Depression
- Shame
- Fear, including fear of others
- Panic attacks
- Grief and/or sadness
- Physical complaints (e.g., headaches and stomach aches)
- Difficulty being too close to others
- Problems with concentration
- Infliction of self-harm

Respond

Clinicians can **respond** to trauma by applying a lens of trauma-informed care to all areas of the organization's activities.[8] Examples include:

- Modification of language, behaviours, and policy to consider trauma experiences by staff in every role.
- Staff training, mission statements, and manuals that promote a culture of resilience, recovery, and healing from trauma.
- Establishing client advisory boards.
- Creating physically and psychologically safe environments.

Resist Re-Traumatization

Staff should be aware of how to:

- Recognize organizational practices that may trigger painful memories and re-traumatize clients, and
- Work to reduce the risk of retraumatizing individuals (i.e., by applying what has been learned in this module).[8]

Practical Considerations

Using trauma-informed approaches as a universal precaution may address some experiences clients could find difficult due to a history of trauma during primary care appointments.7

Broad questions can be used to initiate conversations that may provide important considerations for how to structure care interactions and environments. Remember that as a clinician, you will need to tailor your question(s), and how and when they are asked, as you interact with your client(s).

Clinicians may want to consider when - and if - a broad/general question such as **"What life experiences do you feel have impacted your health and well-being?"** could be included as part of subjective histories.

Recall that a key step of a trauma-informed approach is to recognize trauma. Trauma responses may present in many forms, including anxiety, lack of eye contact, hesitancy to participate in the encounter, poor compliance, or pain out of proportion to injury or examination. It is important to understand that these can be reactions to previous trauma and to respond to all patients in a trauma-informed way includes:

- Protecting privacy in physical examinations and charting by ensuring consent is obtained throughout the process.
- Asking a patient when you need to physically touch them and explaining or describing why before doing so.
- Remaining at eye level with the patient.
- Explaining and asking for input on plans of care.

Guiding Principles to a Trauma-Informed Approach

he Centers for Disease Control and Prevention (CDC) highlight six guiding principles to a trauma-informed approach: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.12

Continue for examples of guiding guiding questions that might help you consider ways in which you and/or your organization can implement a universal approach to trauma.

Safety

Psychological safety is "a shared belief amongst individuals as to whether it is safe to engage in interpersonal risk-taking in the workplace." [13]

Ask yourself, is the physical setting physically and psychologically safe, and do interpersonal interactions promote a sense of safety? How do you know this?[12]

Peer Support

Peer support and mutual self-help are key for establishing safety and hope, building trust, enhancing collaboration, and using lived experience to promote healing.

Do you have peer support and/or mutual self-help resources available in your clinical environment? Why or why not?[12]

Empowerment, Voice, and Choice

Are clients supported in shared decision making, choice, goal setting, self-advocacy skills? How do you know this? Think of three examples to support your answer.[12]

Are staff strengths and experiences recognized and built on? Is the workplace organized to foster empowerment of staff and clients? Do all staff feel safe at work? How do you know this? How might you learn this if you are unsure?[12]

Trustworthiness and Transparency

Are organizational operations and decisions conducted with transparency with the goal of building and maintaining trust (i.e., with clients, families, and staff)? How do you know this? How might you learn this if you are unsure?[12]

Collaboration and Mutuality

Does the organization recognize everyone has a role to play in trauma-informed approaches? Is importance placed on partnering for shared decision making? How do you know this? How might you learn this if you are unsure?[12]

Cultural, Historical, and Gender Issues

Does your organization actively move away from cultural stereotypes or biases (i.e., based on religion, gender identity, etc.) and/or offer gender responsive services? Are there policies, procedures, protocols, and/or processes that are responsive to racial, ethnic, and cultural needs of individuals being served?

Revisiting Case 1: Bias in Practice

Now let's revisit Franc and Isabelle to apply the concepts of trauma-informed practice and how to respond to microaggressions you may notice in practice.

- **Isabelle and Franc**

You are the physiotherapist in the team room and you are aware that both Franc and Isabelle have signed in with reception. As you come out to the waiting room to greet them, you observe another member approaching Franc, addressing them as Isabelle, and Franc becoming quite flustered. As you start your initial assessment with Franc, you notice that they are quite quiet and not as forthcoming as you recalled them to be at previous appointments.

You decide that you want to address this situation with both Franc and the team member.

Before determining your next steps to address the situation, answer the questions to consolidate your understanding of microaggressions from Section 02.

Question: What type of microaggression occurred in this case?

a) Microassault

b) Microinsult

c) Microinvalidation

Feedback:

Correct response: b

We consider this to be a microinsult, which are rude or insensitive comments or actions which demean a person on the basis of an identity. In this case, the insensitive comment misgenders Franc.

Question: Do you think the microaggression was intentional?

a) Yes

b) No

c) Unknown from the information presented

Feedback:

Correct Response: c

Based on the information presented, it is unknown if the microaggression was intentional. It might depend on the information that the team member had (e.g., Was the chart incorrectly labeled? Does the chart have a section for pronouns?).

Reflection

Reflect on three questions related to Franc and Isabelle's case to help you decide how to address the situation.

Reflection Question 1

How would you initiate the conversation with Franc and/or the team member?

Reflection Question 2

What actions could be implemented throughout the clinic to reduce the risk of similar situations in the future?

Reflection Question 3

Take a moment to think through how you will respond the next time you are the person doing the microaggression. Note at least two ways to respond that will help repair the relationship with the person on the receiving end.

Thank you for taking the time to reflect on these interactions, and considering how interactions could be improved in future appointments. We encourage you to use these questions as a starting point for identifying any additional learning needs you may have.

In this section, you learned how cultural safety and trauma-informed care are interrelated. You learned about three types of trauma (individual, interpersonal, and collective), considered the three "E's" of trauma, and worked through the key assumptions of a trauma-informed approach (realize, recognize, respond, and resist re-retraumatization). You reflected on guiding questions for adopting a trauma-informed approach in patient care and workplace environments as described by the CDC's model of six guiding principles to a trauma-informed approach. Finally, you applied your new knowledge of trauma-informed practice to the case of Isabelle and Franc.

Continue to Section 04

SECTION 04: INDIVIDUALIZED LEARNING PLAN

This module, **Creating Safer and Braver Spaces for Clients, Support Networks, and Team Members,** was designed to help you develop new foundational knowledge, identify potential learning needs, and identify opportunities to address your learning needs related to equity, diversity, inclusion, and accessibility (EDIA).

Continue to review the new foundational knowledge presented in this module, as well as the potential learning needs and opportunities you may have identified.

New Foundational Knowledge from Module 03

- Systems of inequality contributing to "isms."
- Trauma-informed care principles.
- Strategies for initiating action when a microaggression occurs.

Potential Learning Needs and Opportunities

- Identifying and addressing common systems of inequality, or "isms."
- Applying trauma-informed care principles.
- Addressing microaggressions.

Revising your Individualized Learning Plan (ILP)

Now that you have completed this module, you will revise each activity within your ILP.

First, revisit Activity 1: Competency Self-Assessment.

- Review the self-assessment ratings, learning needs, and priority levels you identified for the Module 03 competencies when you first completed Activity 1.
- Modify your self-assessment ratings, add any new learning needs that you've identified, and adjust your priority ratings, if needed.

Continue to reveal the competencies relevant to this module.

Module Competencies

1.1 Provide person-centered care that considers the complex personal, social, cultural, and environmental factors contributing to a person's functioning and health.

1.2 Establish trusting, collaborative and often longitudinal therapeutic relationships with persons seeking care, along with their families and support networks.

1.3 Create and maintain spaces for physically, emotionally, and culturally safe interactions with communities and persons seeking care, along with their families and support networks.

1.14 Apply trauma-informed care principles when supporting persons seeking care, along with their families or support networks when appropriate.

1.15 Practice with cultural humility and provide culturally safe care.

1.16 Apply anti-oppressive practice approaches (anti-racism, anti-sizeism, anti-ableism, anti-settler colonialism, anti-heterosexism, anti-cisgenderism, anti-classism, anti-sexism).

2.1 Communicate clearly, openly, respectfully, empathetically, in a culturally safe and person-centered way to encourage participation of persons seeking care, their families and support networks.

2.2 Communicate clearly, openly, respectfully, empathetically, and in a culturally safe and person-centered way to encourage the participation and collaboration of all members of the interprofessional primary care team.

4.3 Contribute to the development, implementation, and evaluation of organizational policies that promote the safety of persons seeking care and interprofessional team members.

Next, revisit **Activity 2: Values Self-Assessment.**

- Refine your list of values if the module inspired you to consider any personal values that you did not initially identify.

Then, revisit **Activity 3: Professional Developing and Networking Self-Assessment.**

- Record any professional development or networking goals or opportunities you may have identified by completing this module.

Finally, revisit **Activity 4: Creating your Individualized Learning Plan.**

- Examine the competencies, learning goals, and professional development and networking opportunities you identified for the short-, intermediate-, and long-term. Update your ILP based on the refinements you made to your learning needs and priority ratings (**Activity 1**), values (**Activity 2**), and professional development and networking opportunities (**Activity 3**).

Continue to Conclusion

CONCLUSION

This module provided an introduction to systems of inequality that contribute to privilege and oppression. It provided foundational knowledge related to identifying and addressing common "isms" in primary care, trauma-informed care principles, and acting when a microaggression occurs. We hope that this module provides some valuable foundations for providing safe, accessible, equitable, and effective team-based primary care and help you identify opportunities to continue to learn and grow in these areas.

Additional Resources for Consideration

Continue to access additional resources relating to Module 03 content.

Seven-Step Framework for Critical Analysis and its Application in the Field of Physical Therapy

Coin Model Video

Krystyna Holland (DPT) Interview: What Do We Mean by "Trauma-Informed Care?"

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Page links:

https://doi.org/10.2522/ptj.20160149

https://ccnpps-ncchpp.ca/video-understanding-the-role-of-privilege-in-relation-to-public-health-ethics-and-practice/

https://open.spotify.com/episode/1dgOKKQ4aV3G2EsvbBvbKX?nd=1&si=cce30f038dfe42ec

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