


Trauma in Collaborative Care Management

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Trauma

- Adverse childhood experiences
- Verbal abuse
- Physical and sexual abuse/assault
- Natural disasters
- Bullying
- Race-based trauma
- Life-threatening events
- Medical trauma
- Intimate partner violence
- Forced separation/displacement

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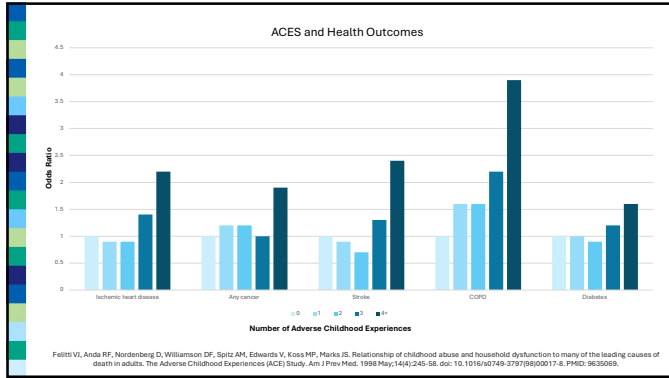
Trauma

“Any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of functioning.

Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual’s view of the world as a just, safe, and predictable place.”

Trauma. American Psychological Association. Accessed April 21st, 2026. <https://www.apa.org/topics/trauma>

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ACEs in North Carolina

Among North Carolina adults, 58% reported at least one ACE and 22% reported 3 or more ACEs. Among NC Medicaid respondents, 41% reported experiencing 3 or more ACEs. Additionally, among those that reported 3 or more ACEs were 32% of uninsured, 25% with military insurance, 19% covered by private insurance, and 15% by Medicare.

Tilson EC. Adverse Childhood Experiences (ACEs): An Important Element of a Comprehensive Approach to the Opioid Crisis. *N C Med J.* 2019 May;79(3):168-169. doi: 10.18043/ncm.79.3.166. PMID: 29735620.

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Post Traumatic Stress Disorder

- A. Exposure to actual or threatened death, serious injury, or sexual violence
- B. Intrusive symptoms associated with the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma
- D. Negative alterations in cognition and mood
- E. Marked alterations in arousal and reactivity

1. Duration of disturbance is more than 1 month
2. Causes clinically significant distress or impairment
3. Disturbance is not due to effects of a substance or medication

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. <https://doi.org/10.1176/appi.books.9780890425596>

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A Trauma Informed Approach

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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Trauma in CoCM

The BHCM Perspective

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Trauma in Primary Care

Patients rarely say "I have trauma"

<ul style="list-style-type: none"> • Functional Impairment <ul style="list-style-type: none"> • Sleep and concentration challenges • Somatic Symptoms <ul style="list-style-type: none"> • Chronic pain, headaches 	<ul style="list-style-type: none"> • Avoidance <ul style="list-style-type: none"> • appointments • Emotional Dysregulation <ul style="list-style-type: none"> • Irritability, shutting down • Maladaptive Coping <ul style="list-style-type: none"> • substances
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What a BHCM does with Trauma

- Provide trauma-informed engagement
- Screen and track symptoms
- Brief, evidence-based interventions
- Normalize trauma responses without exploring narratives
- Coordinate care
- Support PCPS
- Monitor of symptoms beyond treatment in CoCM

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What a BHCM **does not** do with trauma

- Trauma-processing or trauma-exposure therapy
- Narrative work
- Exploring detailed memories
- Complex parts work
- Anything requiring > 30-45 minute sessions
- Long-term therapy models

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Evidence Based Interventions

These fit 15-30 minute BHCM encounters

<ul style="list-style-type: none"> Behavioral Activation <ul style="list-style-type: none"> Rebuilds routines Perfect for patients who feel stuck Problem-Solving Therapy <ul style="list-style-type: none"> Supports health behavior adherence CBT for anxiety/trauma symptoms <ul style="list-style-type: none"> Trigger management Cognitive Coping Skills 	<ul style="list-style-type: none"> Distress Tolerance and Grounding <ul style="list-style-type: none"> 5-4-3-2-1 Box Breathing Self-soothing through senses TIPP Sleep Interventions <ul style="list-style-type: none"> Routines Stimulus control
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Manualized Trauma Treatment Options in CoCM

Written Exposure Therapy (WET)
&
Cognitive Processing Therapy (CPT)

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Written Exposure Therapy

- 5 session, highly structured writing protocol
- Predictable, manualized, time-limited
- Requires BHCM training + protected 45-60 min appointments
- [PESI WET Training](#)
- [WET Manual](#)



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Cognitive Processing Therapy

-  12 Session structured protocol targeting "stuck points"
-  Uses worksheets + cognitive exercises
-  Formal training + longer sessions
-  [Medical University of SC CPT Training](#)
-  [PESI CPT Training](#)

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Guardrails for using WET or CPT in CoCM

<p>Appropriate when</p> <ul style="list-style-type: none"> • BHCM is trained • Able to offer time protected sessions • Patient is stable, motivated and prefers PC-based care 	<p>Not Appropriate</p> <ul style="list-style-type: none"> • Patient needs open-ended processing • Caseload is too large to allow fidelity • Trauma complexity exceeds primary care • Patient destabilizes during structured work
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Trauma Screening and Symptom Tracking

- PCL-5
- Administer every session
- Reliable change = decrease of 5-10 points
 - Responding to treatment
- Clinically significant change = decrease of 10-20 points
 - Meaningful improvement
- Track score in registry
- PHQ-9 for comorbid depression
- GAD-7 for comorbid anxiety

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Knowing when this is more than CoCM can handle

- Active Dissociation
- Flashbacks disrupting functioning
- Severe emotional dysregulation
- Poor response to brief BHCM Interventions
- Recurrent destabilization
- Patient wants deep trauma processing

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Helpful Phrases

If a patient starts trauma narrative:

- "Thank you for trusting me. Here in CoCM we focus on helping you feel safe and more in control of your symptoms. When you're ready, I can help you connect with someone who does deeper trauma work."

If a patient wants trauma therapy from you:

- "My role here is to help you stabilize and build tools so you're prepared for trauma therapy. Think of this as step one."

To Pivot Back to Skills (Groundedness)

- "I want to make sure we honor your story, but I also want to make sure you leave today feeling steady. Let's pause the narrative for a moment and focus on a grounding tool you can use if these memories show up later today."

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Helpful Phrases Continued

When a Patient Gets Overwhelmed (Self-Regulation)

- "I can see how much this still affects you. My priority is making sure you don't feel 're-traumatized' during our brief time together. Let's work on a way to 'dial down' that intensity right now."

Explaining the "Step-Care" Model (Transparency)

- "Think of me like a physical therapist for your recovery. We are building the strength and coping muscles you'll need so that when you *do* go into deep trauma processing later, you have the tools to handle it safely."

To Gently Redirect a "Deep Diver"

- "You have so much to share, and I want to be respectful of that. Because our sessions are short, I want to make sure we spend our time on the strategies that will help you sleep better and feel more focused this week. Does that sound okay?"

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CoCM = Trauma Informed,

Not Trauma Processing

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