President's Message

Francisco Maia, PT, DPT, CCRT

Even though you are all reading this letter in January 2021, I had to turn this in during the first week of November for publication. Needless to say that one way or the other a lot has changed in our country since then; however, there have been 2 things that have been consistent with the Animal PT SIG since I took over the role of President: first, we have been working hard behind the scenes to get things going with our 4 committees, and second, we are gearing up for Virtual CSM 2021.

In the October edition of the publication, I introduced myself and went over our plan to establish 4 different committees: legislation, research, membership, and communications. I am excited to say that we got 8 Rockstar individuals who have stepped up to the plate and we have been able to get the ball rolling on several initiatives. But before we continue, let me introduce them to you:

Legislation: Karen Atlas and Mary Beth Nunes
Research: Linda Marie Denney and Farley Schweighart
Membership: Jennifer Lyons and Katie Murphy
Communications: AJ Salch and Natalie Ullrich

By now you have already seen some of the work they have done, such as the more consistent posts in the AOPT social media pages about animal rehabilitation. We have also started to use the #PT4Animals to promote our field and we ask for you all to use that hashtag with your social media posts about animal rehabilitation as well. We have also added another resource to our website, a list of links to the physical therapy and veterinary practice acts for all 50 states, and we have been working on other resources that will soon be added to the website as well including an ongoing database of research articles in our field for you all to have access to the most recent research. These are just some of the projects that we have started and I wanted to invite you all to attend Virtual CSM 2021 to learn more about what we have accomplished and what we have planned for this year!

I have been attending CSM every year since 2017 and have seen consistent growth in physical therapists and students interested in making a career in this field. I find it fascinating that I have met a lot of students who have told me that their ultimate goal is to work with animals, and my goal has been to continue laying down the groundwork that was initiated by others in this field so we can continue to expand the ability for physical therapists to work with animals in all 50 states. The field of animal rehabilitation continues to grow exponentially, and I know we will need more and more physical therapists trained and certified in animal rehabilitation. I will certainly miss the personal connections that we can make during an event such as CSM and the ability to have an excuse to escape Chicago's winter for a few days; however, I am excited for the opportunities that arise from hosting a virtual event.

One of the biggest complaints I have heard in the past from our members was the fact that they were unable to attend CSM, and therefore would feel left out on what had been going on in our field and with the SIG. Well, this year you can all attend CSM from the comfort of your home! As I write this, we are still learning how CSM 2021 will work. Therefore, I don't have any details on how each section or academy will host their meetings and lectures; however, I highly encourage all of you to go online as soon as you are done reading this publication to look up when the Animal PT SIG will meet and mark that on your calendar! As I mentioned before, we will be able to fill you in on what we have accomplished in 2020 and go through our plan and vision for 2021. I want every single member to understand what we have been doing for them and see the value that our SIG brings to the field of animal rehabilitation. We are the only national organization in the United States led by physical therapists working in animal rehabilitation, and the future of our profession relies on what we do and your support.

Thank you,
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Application of Trauma Informed Care in Animal Rehabilitation: A Case Report

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TRAUMA INFORMED CARE IN HUMAN HEALTH CARE

Trauma informed care (TIC) refers to care that recognizes the effect of trauma on patients' health and implements patient-centered strategies that are sensitive to patients' trauma experiences. Originally used in mental health care, TIC is now recognized as an important component of all aspects of health care. Survivors of trauma will often use maladaptive coping behaviors that can lead to poorer physical health outcomes. Furthermore, trauma survivors may be high users of sick visits and the emergency room but be less likely to seek preventative care.[1]

Constant exposure to stress in children results in changes in behavior, including hyperarousal, over-reaction to non-threatening triggers, and disruptions in emotional attachment.[2] These behavioral changes can then lead to future challenges at home, at school, and eventually in the community as adults. Campbell et al[2] found an association between the number of adverse childhood experiences (ACE) and at-risk behaviors and morbidity. Children with ACE scores ≥ 4 (13.7% of the respondents in their study) had

increased odds of binge or heavy drinking, smoking, risky HIV behavior, DM, MI, CAD, CVA, and depression.[2]

Patients as well as coworkers in a physical therapy clinic may have trauma histories and thus warrant clinical policies and practices that are trauma-informed. In addition, trauma survivors may seek physical therapy services specifically for injuries sustained from abuse or torture. Common areas of orthopedic injury from abuse and torture include the spine, shoulder girdle, and feet.[3] Manual therapy can decrease distress and disability in survivors of torture even though the survivors report no changes in their pain perception.[4]

While there are many ways in which providers can implement TIC in their respective fields, the basic principles of TIC include:

1) _Trauma Awareness_ – understanding the prevalence and impact trauma can have on their patient population and within their workforce and adopting policies and practices that reflect this understanding.
2) _Safety_ – adopting policies and practices that are committed to maintaining emotional and physical safety for the patients and employees.
3) _Choice and Empowerment_ – avoiding re-traumatization by allowing patients and employees to feel empowered to make decisions about the services they receive or provide, respectively.
4) _Strengths Based Interventions_ – focusing on building strength and resilience during interventions to help patients move in a positive direction.

(Adapted from Hopper et al, 2010[5])

In a medical or physical therapy setting, these principles can be adopted by first creating an environment that is as comfortable and non-threatening as possible, which may include allowing for longer sessions or plans of care with visits spaced further apart so that the therapeutic relationship can develop more slowly over time.[3,6] Use of sensitive language can play a large role in building trust. Examples of trauma-informed communication outlined by Ravi and Little[6] include:

1) Explicitly explaining why and how a procedure will be done,
2) Allowing opportunities for the patient to have a choice and be involved in the procedure (example – try to perform procedures in their position of comfort; have the patient move clothing out of the way instead of the clinician), and
3) Using suggestive instead of instructive language (example – instead of saying “take a deep breath and relax”, say “some people find deep breathing to help them relax during this procedure”).

Trauma in Animals

Animal abuse and neglect often precedes or accompanies human abuse. Seksel[7] reported that in the United Kingdom, 88% of animals living in households with domestic (human) abuse are either abused or killed, suggesting that human domestic violence problems directly affect animal welfare. Data on animal cruelty in the United States has been collected by the National Incident-Based Reporting System (NIBRS) since 2016. A total of 3200 cases of animal cruelty were reported to the NIBRS in 2017, but only one-third of the US population participated in reporting that year, suggesting that the number of reported cases is likely much higher.[8]

Similar to humans, abuse and neglect in dogs can lead to pain and functional impairments, and physical rehabilitation may help to improve the quality of life of canine survivors of trauma. However, manual therapy, exercise instruction, and application of modalities by an animal rehabilitation practitioner will often be a new experience for our canine patients and therefore be perceived as threatening. Hyperexcitability, anxiety, and displays of aggression or fear, whether as a direct result of trauma or due to other genetic, medical, or experiential causes, may also present barriers to participation in therapy activities. By implementing trauma-informed care strategies, animal rehabilitation practitioners will likely be able to create more positive experiences for the canine patient and therefore improved physical and functional outcomes.

This case report summarizes a case of a 15-year-old Maltese mix with a trauma history and how TIC was integrated into the canine patient’s plan of care. The goal of this case is to exemplify how TIC in humans can be translated into a canine patient with a trauma history.

Olive, 15-year-old Maltese Mix, Spayed Female

The patient, Olive was referred to physical therapy upon the request of the client (Olive’s guardian) due to hindlimb ataxia and weakness after an adverse reaction to Gabapentin. Although “80% better” at the time of physical therapy consultation, Olive continued to demonstrate decreased gait endurance, intermittent buckling of the front limbs during gait, and residual hindlimb ataxia. The client also endorsed that Olive had been more hesitant to sit over the past year. The client’s goal for physical therapy was to increase Olive’s comfort and safety in her later years.

Olive’s past medical history was unknown when she was adopted at 5 years old. Before her adoption, she sustained a 5-year history of trauma as a breeder dog in a puppy mill. She lived with multiple dogs in 38"x38" stacked cages and only taken out of her cage twice a year for breeding. She was so severely emaciated that she could not walk more than 20 feet and could not ascend or descend stairs. After being rescued, she exhibited learned helplessness[9] during grooming and veterinary visits, as shown through severe trembling followed by shut down acquiescence to procedures.

By using innovations related to consent and cooperative care training,[10] Low Stress Handling®,[11] and Fear Free®[12] veterinary handling, Olive has been able thrive in her safe, nurturing, and enriching environment since adoption. These veterinary training strategies align with the principles of TIC:

1) _Trauma Awareness_ – Communicating the patient’s trauma history to her health care providers and enlisting their partnership in policies and practices that make treatment procedures predictable and low stress.
2) _Safety_ – Using an antecedent arrangement of the treatment setting, predictor cues (verbal and gesture cues to inform the patient of the type of handling to be expected), and the 3 seconds/3 times rule to maintain emotional and physical safety of the patient and care providers. The 3 seconds/3 times rule states that if a canine patient struggles for longer than 3 seconds and/or each of 3 times when a procedure is attempted, this indicates a need to stop and reassess if the procedure is necessary or can be attempted using a different method or at a future time.
3) _Choice and Empowerment Training_ – Using trained behaviors as “Start” and “Stop” buttons to enable communication of choice and consent.

These strategies were applied during her physical therapy consultation under the guidance of the client. For example, Olive was seen at her home to eliminate the stress of being in a new clinic environment. The physical therapy evaluation focused on posture analysis, movement observation, and active range of motion screening with the client providing verbal encouragement and treats to decrease the need for handling by the physical therapist. Handling was eventually performed later in the appointment time and was initially performed by the client, allowing the physical therapist to observe Olive's behavior and reaction to touch by a loved one. Before touch was initiated, the physical therapist gave a verbal cue "Touching" and a clear presentation of hand to lend predictability to the interaction. The client also provided insight into Olive's triggers, including being touched from above and having her front paws handled. These actions were avoided, and palpation and manual assessment were not performed by the physical therapist until Olive communicated adequate comfort. Olive's carrier was accessible at all times as her "safe space" and her retreat towards her carrier was her "Stop" button to indicate when she was uncomfortable with a procedure. She was allowed to go back to her carrier at any time, and periodically encouraged to retreat away from the treatment area to give her a break and relieve some of the social pressure that could result from continuous treatment.

By incorporating TIC strategies and collaborating with Olive and her guardian, we were able to develop a gentle therapeutic exercise program to improve Olive's hindlimb functional strength and gait endurance. Her plan of care focused on a home program that the client could perform in a stress-free environment, using training and communication principles already in practice by the client. This case highlights how physical therapists can apply principles of TIC to our canine patients to maximize participation and promote their physical and emotional well-being. Initiating Olive's physical therapy with these principles at the forefront of her care may increase the likelihood of the client seeking rehabilitative services at an earlier stage and may allow us to consider a wider range of treatment modalities in the future.

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