

Primary care is where trauma shows up first. It arrives as abdominal pain that defies scans, a sleep problem that resists melatonin, a panic episode mistaken for asthma, or hypertension that spikes after a slamming door. In exam rooms and telehealth slots set at 15 to 20 minutes, clinicians meet trauma in fragments and symptoms, not as a labeled diagnosis. That is the challenge and opportunity of integrating trauma therapy into primary care: to recognize patterns early, to deliver something helpful now, and to build a reliable bridge to more intensive care when needed.

The quiet prevalence behind common complaints

Across studies, 10 to 20 percent of adults in primary care meet criteria for posttraumatic stress at some point. If you loosen the definition to people living with significant traumatic stress reactions, the numbers climb higher. Survivors do not present with tidy PTSD checklists. They come with migraines, pelvic pain, poor sleep, irritability, missed appointments, or glucose readings that swing wildly. Trauma distorts inflammation, sleep architecture, threat perception, and the ability to trust a healthcare system that may have harmed them before. This is not a niche issue. In a typical panel of 1,800 patients per full-time primary care physician, you will care for hundreds who carry trauma.



When primary care treats trauma as an organizing lens rather than a specialty silo, visits become easier to navigate. We avoid unnecessary tests, we reduce over-prescribing of benzodiazepines, and we help people make sense of their bodies again. That alone reduces suffering and waste.

What integration looks like when it works

There are several workable models. Clinics rarely adopt one in a pure form. They adapt to staffing, payer mixes, and community resources.

Collaborative Care integrates a behavioral care manager and consulting psychiatrist into the primary team. The care manager tracks a registry of patients with trauma, depression, and anxiety, reaches out between visits, delivers brief structured psychotherapy, and adjusts care based on symptom measures. The primary clinician remains the prescriber and point of continuity. A weekly caseload review with the psychiatrist supports decision making. This model has robust evidence and fits trauma because it treats comorbidity as the rule.

The Primary Care Behavioral Health, or PCBH, model embeds a behavioral health clinician for same day warm handoffs and brief visits focused on functional goals. Appointments last 20 to 30 minutes, often two to six sessions, using focused skills: grounding, sleep restructuring, exposure planning, and pain pacing. The PCBH clinician is a consultant to the team, not a separate clinic. For many patients with trauma, that immediacy makes the difference between no care and real progress.

Some systems build co-located therapy with a trauma track. Think of a licensed therapist trained in trauma focused cognitive behavioral therapy, prolonged exposure, or cognitive processing therapy who sees a subset of patients in longer visits. This suits complex trauma, dissociation, or when short primary care interventions prove insufficient. It requires intentional referral pathways so patients do not fall through cracks.

The best programs blend these. A clinic might run Collaborative Care for measurement and psychiatric support, use PCBH for rapid grounding skills, and refer a smaller group to a dedicated therapist for deeper work.

Trauma informed care as the clinic's baseline

Integrated trauma therapy starts long before a screening tool. It lives in the way staff greet a person, how gowns and doors work, and whether a patient can choose to sit near the exit. Small steps make visits safer: offering a chaperone without drama, telling a patient before you touch them, and scheduling procedures with time for questions. Trauma informed care trains the whole team to ask what happened to you and how has it shaped your health, not what is wrong with you. This shapes everything from phlebotomy scripts to pelvic exams.

I have watched a blood draw room transform after staff adopted grounding scripts and soft closure statements. Needle fainting dropped. Patients returned for follow up rather than delaying care. None of this required a new EHR module. It required training and practice.

From screening to action without losing momentum

Screening should be useful, not performative. Choose tools that trigger real workflows. A single question like Have you had any experiences that continue to bother you or affect your sleep, mood, or health can open a door. For measurement, the PC-PTSD-5 is quick and practical in primary care. The PCL-5 is more detailed when you want a baseline and to track change. For many patients, PHQ-9 and GAD-7 scores tell you just as much about trauma's daily footprint.

Here is a practical sequence that fits a 20 to 30 minute visit, particularly when paired with an on-site behavioral clinician.

- Normalize and name the pattern briefly: explain how bodies alarm after threat, validate symptoms without pathologizing the person.
- Offer one immediate skill: paced breathing, feet-on-floor grounding, or a simple sleep frame they can try tonight.
- Check safety and stability: current violence, coercion, firearms in the home, substance use that spikes risk, and a two-sentence crisis plan if needed.
- Arrange a warm handoff or follow up: a same day or next week behavioral health visit, or a phone check in with the care manager.
- Start measurement for stepped care: baseline PCL-5 or PC-PTSD-5, plus PHQ-9 and GAD-7, then plan to reassess in 2 to 4 weeks.

This is not about squeezing therapy into a visit. It is about setting an arc for care that continues between visits.

The clinical playbook for brief work in primary care

Brief trauma therapy in primary care differs from specialty psychotherapy. You cannot unpack a full trauma narrative in two visits, and often you should not. The aim is to increase safety, reduce physiologic arousal, re-establish sleep and daily routines, and build momentum toward longer work when needed.

Psychoeducation matters when it is specific. I keep a simple explanation: Your nervous system learned to protect you by staying on high alert. That helped you survive. Now it sets off alarms even when there is no fire. We can retrain that alarm.

Grounding and breathing skills can start in three minutes. Use concrete cues: name five blue objects, press your heels into the floor, breathe in through your nose for four counts and out for six. Avoid jargon. Ask patients what has helped them in the past, then amplify it.

Sleep work pays big dividends. Trauma disrupts sleep timing and depth. Anchor wake up time, reduce late caffeine and nicotine, add a wind down routine, and use stimulus control. If nightmares dominate, imagery rehearsal therapy techniques can be taught in primary care. Prazosin can be considered for distressing nightmares in many adults, with careful blood pressure monitoring.

Graded exposure can be started carefully. The primary care version is functional. If a patient avoids grocery stores, collaboratively design a tiny step: park in the lot and sit for two minutes, then leave. Celebrate tiny wins. When a PCBH clinician is available, hand off to expand this into a structured hierarchy.

Cognitive work in primary care is light but potent. Identify one stuck belief, like I should have prevented it, and test it with Socratic questioning that fits the person's values and history. You do not need to reconstruct the trauma to shift a global self-blame belief toward a more balanced view.

Substance use often rides alongside trauma. SBIRT workflows fit naturally. Ask neutrally about alcohol and drug use, offer nonjudgmental feedback, and link to medication options like naltrexone or buprenorphine if indicated. Emphasize that reducing substance use can lower anxiety and improve sleep within days.

Medications as part of integrated care

No pill cures trauma. Still, medications can reduce symptom load enough to let therapy work. The strongest evidence for PTSD symptoms lies with certain SSRIs and SNRIs. Sertraline and paroxetine have the most explicit approvals in some regions. Venlafaxine can be effective, especially when depression or neuropathic pain coexist. I tell patients we will watch for effect over 4 to 6 weeks and adjust based on function, not just checklists.

Benzodiazepines are tempting for acute relief, but they tend to worsen avoidance, disrupt consolidation of therapeutic learning, and bring dependence risk. In my practice, I reserve them for narrow, time limited uses after a clear discussion of trade offs. Hydroxyzine can help short term without the same risks. Propranolol can blunt performance anxiety in discrete triggers but is not a trauma medication per se.

Prazosin can reduce nightmares for many adults. Start low, like 1 mg at bedtime, and titrate while watching blood pressure and dizziness. For sleep initiation and maintenance, nonpharmacologic measures lead. If medication is needed, short courses of doxepin at very low doses or trazodone can be reasonable. Avoid multiple sedatives.

Where pain intersects trauma, duloxetine can serve two masters. It may reduce neuropathic pain while also addressing anxiety and mood. Avoid opioids where possible. Trauma increases the risk of problematic opioid use and does not make analgesic tolerance kinder.

Special populations and comorbidity: more than PTSD

Trauma rarely comes alone. Anxiety therapy tactics, especially interoceptive exposure and acceptance based skills, apply directly. Many patients with trauma present as generalized anxiety, panic, or health anxiety. When you frame therapy as learning to turn down a chronic alarm, buy in increases. Panic worksheets are welcome in primary care if they are brief and personalized.

For OCD therapy, trauma can muddy the water. Some compulsions try to neutralize danger after an assault or accident. Exposure and response prevention still works, but you pace it and monitor dissociation. When trauma and OCD mix, involve a behavioral health clinician early.

Autistic and ADHD patients experience and process trauma differently. Sensory overload, rejection experiences, and communication differences can compound risk. Autism testing and ADHD Testing within primary care is expanding through partnerships, screening tools, and tele-assessment, and it changes how we tailor trauma work. For autistic patients, give clear, concrete steps, visual supports, and predictability in visits. For ADHD, emphasize external structure: alarms for medication and sleep, written exposure plans, and more frequent shorter check ins. Stimulants can be appropriate even with trauma, especially when inattention predates the trauma. Monitor for worsened hyperarousal and adjust dose timing.

For immigrants, refugees, and people with limited English proficiency, trauma may include persecution or war. Use trained interpreters. Allow more time. Ask about family separation, asylum processes, and legal stressors, which can spike symptoms independently of past violence. Cultural idioms of distress matter. Instead of forcing Western trauma language, ask open questions about what the body feels and what helps in their community.

Children, adolescents, and families

Paediatrics introduces different levers. Much of the work is with caregivers. Parent led versions of trauma focused cognitive behavioral therapy can begin in primary care through coaching on routines, praise for brave behavior, and graded exposures tied to school or sleep. Screening can start with brief tools like the Child Trauma Screen, paired with depression and anxiety screens. Safety checks must include bullying, online harassment, and household violence. Developmental screens are relevant, and when concerns arise, routing families toward Autism testing or ADHD Testing pathways can clarify overlapping behaviors. Early clarity prevents years of mislabeling defiance or moodiness.

Schools are allies. A simple note that explains the child is working through trauma related symptoms, without disclosing details, can unlock accommodations: more predictable transitions, a calm space, and reduced punishment for behaviors rooted in hyperarousal.

Measuring progress without losing the person

Measurement based care, done well, keeps treatment honest. The registry view in Collaborative Care shows who is falling behind and who needs a medication tweak or a different therapy approach. Use PCL-5 scores as trend lines, not verdicts. A 10 to 20 point drop usually reflects real change. But always ask how life feels. I have seen PCL-5 scores plateau while a patient returns to church, reconnects with estranged siblings, <https://dantennis611.raidर्सfanteamshop.com/group-anxiety-therapy-is-it-right-for-you> and sleeps 6 hours again. Those wins matter.



Document functional goals in plain terms: can attend grandchild's game, drives across town without detouring, sleeps through the night three times per week. Celebrate those equally with scale scores.

Data, privacy, and documentation nuances

Trauma stories belong to patients. Document what you need for care and billing while protecting privacy. Use trauma informed language in notes. Write "patient reports history of sexual assault, avoids pelvic exams, requests chaperone and time to discuss procedures" rather than explicit details that can retraumatize when read in portals. If legal proceedings are active, coordinate carefully and consider the risks of detailed descriptions in records.

Electronic health record prompts help with consistency. Build a trauma care panel that auto-flags: last PCL-5 score, therapy status, sleep and nightmare status, current medications, and safety plan reviewed. Keep decision support short enough to use in real time.

Paying for the work so it endures

Integrated trauma care must be financially sustainable. Collaborative Care codes allow billing for the psychiatric consultative framework and care manager time. PCBH often bills brief psychotherapy codes, health behavior assessment and intervention codes, and problem focused E/M codes with behavioral modifiers. Develop a compact cheat sheet for clinicians and front desk staff. Track your denial rates and adjust documentation templates. Grant funding can kick start a program, but stable billing keeps it alive.

Partnerships with community therapists create a two way street. Offer curbside consults and training sessions for local clinicians in return for timely access for your patients who need deeper trauma work. Many community therapists appreciate a primary care partner who shares measurement data and medication plans.

Training the team and building culture

Skills beat slogans. Run brief drills: how to do a 3 minute grounding exercise, how to ask about firearms safely and respectfully, how to perform a warm handoff. Train medical assistants and nurses to recognize trauma signals and to page behavioral health for same day visits. Supervisors should model calm, nonjudgmental briefings after incidents in the clinic, such as a patient panic episode in the lobby. Debriefing protects staff from secondary trauma and improves care.

Language shifts help. Replace noncompliant with facing barriers. Replace drug seeker with person at high risk of substance use disorder. These words shape attitudes, which shape care.

Edge cases and judgment calls

Some people cannot engage in exposure based work immediately. Unstable housing, active legal danger, or ongoing domestic violence change the priorities. Safety planning, legal advocacy, housing support, and cash assistance may do more to quiet the nervous system than any worksheet. Collaborate with social workers and advocates. Document lethality assessments succinctly. When a patient is in ongoing danger, trauma therapy becomes harm reduction and stabilization.

Dissociation, especially in complex trauma, can complicate primary care interventions. Teach grounding before cognitive or exposure work. Encourage sensory anchors like holding an ice cube or textured object, and build a shared signal for when dissociation spikes in visits. Involve a specialty therapist sooner.

Somatic symptoms such as functional neurologic disorders require careful framing. Avoid the false binary of physical versus psychological. Explain brain body pathways and how retraining movements and attention can restore function. Gentle physiotherapy integrated with behavioral coaching fits well in primary care.

A brief story from clinic life

A middle aged patient, a bus driver, came in for uncontrolled hypertension. He missed follow ups and disliked waiting rooms. While we adjusted his lisinopril, I asked about sleep. He said he slept with the TV on because silence felt loud. He had been at the scene of a fatal crash 18 months earlier. The PC-PTSD-5 was positive. We named what his body was doing, tried a five minute breathing and grounding practice in the room, and set a goal to keep the TV off for the first 15 minutes of the night with a podcast instead.

Our PCBH clinician met him the same day. She built a hierarchy for driving routes he avoided and started brief exposure between visits. We added prazosin for nightmares and set a phone check in a week later. At 6 weeks, his PCL-5 dropped by 14 points, he resumed the shorter route that saved him 20 minutes per shift, and his blood pressure readings averaged 6 points lower. He later declined long form therapy. That was fine. He had enough to live better.

Getting started in a small clinic

If you run a two to four clinician practice without on site therapy, you can still build an integrated approach that fits your scale.

- Pick a simple screen and workflow: PC-PTSD-5 at annual visits and when PHQ-9 scores stay high.
- Train one medical assistant in grounding and warm handoff scripts, and give them permission to use them.
- Build a referral list with three therapists who accept your major payers and do trauma specific work, and meet them once to set expectations for communication.
- Use a shared spreadsheet registry to track patients with positive screens, scores, and current plans.
- Choose one medication protocol and one brief skill you will standardize across clinicians to keep care consistent.

Start small and make it dependable. Patients notice when a clinic follows through.

What a year of integrated work can look like

After a year, clinics that invest in trauma integration tend to see a cluster of changes. No show rates drop modestly when warm handoffs become normal and when staff call patients by name. The use of benzodiazepines often decreases by 20 to 40 percent as alternative skills and medications take root. Behavioral health no longer feels like a separate hallway but part of the plan for diabetes, pain, and blood pressure. Patients tell different stories about themselves. They arrive earlier for procedures because they trust that someone will explain each step and stop when asked.

When integrated trauma therapy sits inside primary care, we do not promise to solve everything. We promise to notice, to act, and to stay with people as they reclaim sleep, safety, and movement. The work is pragmatic, sometimes messy, and deeply human. That is why it belongs exactly where patients already are.

Dr. Erica Aten, Psychologist

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Wednesday: 9:00 AM – 5:00 PM

Thursday: 9:00 AM – 5:00 PM

Friday: 9:00 AM – 5:00 PM

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Dr. Erica Aten, Psychologist provides online therapy and evaluations for adults in Oregon and Washington.

The practice focuses on neurodivergent-affirming support for late-diagnosed and self-identified autistic adults, especially women, nonbinary, and femme-presenting clients.

Listed services include anxiety therapy, trauma therapy, OCD therapy, autism and ADHD support, autism testing, ADHD testing, LGBTQ+ affirming therapy, and therapy for neurodivergent women.

Listed modalities include Exposure and Response Prevention, Inference-Based Cognitive Behavioral Therapy, Cognitive Processing Therapy, and Prolonged Exposure Therapy.

Dr. Erica Aten also lists clinical supervision for mental health professionals and business development consultations as additional services.

The official site connects the practice with Portland, Oregon and Washington State, with online care designed for clients who prefer therapy or evaluation from their own space.

The practice may be relevant for high-achieving adults, perfectionists, burned-out people pleasers, late-diagnosed autistic adults, AuDHD clients, and people navigating anxiety, OCD, trauma, identity, or masking-related exhaustion.

Prospective clients can call (309) 230-7011, email draten@portlandcenterebt.com, or visit <https://www.drericaten.com/> to ask about consultation calls and availability.

The public map listing for Dr. Erica Aten, Psychologist appears to represent a broad online/service-area listing, so clients should use the official website for the most direct scheduling and service information.

Popular Questions About Dr. Erica Aten, Psychologist

What is Dr. Erica Aten, Psychologist?

Dr. Erica Aten, Psychologist is an online clinical psychology practice offering therapy and evaluations for adults in Oregon and Washington.

Does Dr. Erica Aten offer online therapy?

Yes. The official contact page states that Dr. Erica Aten offers online therapy and evaluations to Oregon and Washington residents.

Where is Dr. Erica Aten located?

The official site lists Portland, OR and Washington State. A public street address was not verified for this dataset, and the supplied map listing appears to represent a broad online/service-area listing rather than a walk-in office.

What services does Dr. Erica Aten list?

Listed services include anxiety therapy, trauma therapy, autism and ADHD support, OCD therapy, LGBTQ+ affirming therapy, therapy for neurodivergent women, autism testing, ADHD testing, clinical supervision, and business development consultations.

Does Dr. Erica Aten offer autism or ADHD testing?

Yes. Autism testing and ADHD testing are listed on the official website, with a focus on adults and neurodivergent-affirming evaluation.

What therapy approaches are listed?

The official site lists Exposure and Response Prevention, Inference-Based Cognitive Behavioral Therapy, Cognitive Processing Therapy, and Prolonged Exposure Therapy.

Who does Dr. Erica Aten work with?

The official site describes work with neurodivergent adults, especially late-diagnosed and self-diagnosed autistic women, nonbinary, and femme-presenting clients, as well as high-achieving, perfectionistic, or burned-out people seeking support with masking, boundaries, and self-trust.

What are Dr. Erica Aten's listed hours?

The matching public listing shows Monday through Friday from 9:00 AM to 5:00 PM, with Saturday and Sunday closed. Appointment availability should be confirmed directly.

Is Dr. Erica Aten, Psychologist an emergency mental health provider?

No crisis or emergency service was verified for this dataset. Anyone in immediate danger or experiencing a mental health crisis should call 911, contact 988, or go to the nearest emergency room.

How can I contact Dr. Erica Aten, Psychologist?

Call (309) 230-7011, email draten@portlandcenterebt.com, visit <https://www.drericaten.com/>, or use the listed official social profiles: <https://www.instagram.com/drericaten/> and <https://www.tiktok.com/@dr.ericaten>.

Landmarks Near the Oregon & Washington Online Service Area

Dr. Erica Aten, Psychologist provides online therapy and evaluations for Oregon and Washington residents, rather than a verified walk-in office. Clients near these regional landmarks can call (309) 230-7011 or visit <https://www.drericaten.com/> to ask about online therapy, evaluations, consultation calls, and availability.

- [Portland, OR](#) — The official site lists Portland, OR as a practice location reference for online services.
- [Downtown Portland](#) — A practical Oregon reference point for clients seeking online therapy connected with the Portland area.
- [Powell's City of Books](#) — A well-known Portland landmark useful for local orientation around the Oregon service area.
- [Washington Park](#) — A major Portland park and regional landmark for Oregon clients.
- [Oregon Health & Science University](#) — A major Portland healthcare and education landmark; clients should contact Dr. Erica Aten directly for outpatient online therapy or evaluation scheduling.
- [Seattle, WA](#) — A major Washington service-area city for online therapy and evaluations.
- [Pike Place Market](#) — A recognizable Seattle landmark for Washington clients orienting around the online service area.
- [University of Washington](#) — A major Seattle education landmark within the Washington online service area.
- [Bellevue, WA](#) — A major Eastside community where eligible Washington residents can ask about online care.
- [Vancouver, WA](#) — A Washington city near Portland and a practical regional reference for online therapy eligibility.
- [Olympia, WA](#) — Washington's capital and a statewide service-area reference point.
- [Spokane, WA](#) — A major eastern Washington city where clients can visit the website to ask about online therapy and evaluation options.