Podcast Transcript

Trauma Informed Care: Healing through Understanding

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Abbie Schmitt, RN, MSN, is an accomplished Nurse Educator and Author with a master's degree in nursing from Liberty University. She has a diverse background, including roles in CPR instruction, incident management, nursing education, and clinical practice, demonstrating her versatility in the healthcare field. Abbie holds multiple certifications and licenses, reflecting her commitment to professional growth. Her published CE courses and her dedication to improving healthcare practices underline her significant contributions to the nursing profession.

Host: Candace Pierce: DNP, MSN, RN, CNE

Dr. Candace Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. PIERCE: strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Episode 1: Trauma Informed Care: Healing through Understanding

Transcript

Candace Pierce: Hello, I'm Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. Our discussion for today for this series is trauma-informed care, and joining me for this discussion is Abbie Schmitt. Welcome back, Abbie.

Abbie Schmitt: Thank you so much for having me.

PIERCE: Absolutely. I'm really excited to learn more about trauma-informed care. And kind of what I know about it is that it's a framework that really recognizes the impact that trauma has on individuals and really just tries to emphasize safety, trust, and empowerment within healthcare settings. So what I'm hoping through this series is that we're able to just really break down the foundational principles of the trauma-informed care framework with a goal to equip our listeners with the knowledge to try to integrate these principles into their practice.

SCHMITT: Yes, absolutely. Yes, and moving forward, it's important to break down trauma itself. So what exactly does that look like? It looks like a variety of different things. But from a healthcare standpoint, sometimes we as providers hear trauma and think about bodily injury or traumatic injury, even a trauma unit. But that's under the broader view of trauma. So can you think, you know, just spitball ideas? Are you familiar with different types of trauma?

PIERCE: Well, yes, I know one of the traumas that we hear a lot about, and a lot of states have mandates on, is domestic violence. Also, being a mandated reporter for child abuse. So those are the two that really stand out to me, domestic violence, child abuse, betrayals from family, from friends, spouses also I think really bring about a big trauma response. And I know that trauma-informed care is really associated with fostering healing and recovery for patients. And so it really focuses on the interactions and the outcomes. But can you help us understand what is trauma-informed care? Why is it important?

SCHMITT: Yes, absolutely. The majority of people, evidence and studies have shown that most people will experience a traumatic event. So it's important because we will definitely come in contact with someone who has a history of traumatic events. Trauma-informed care is basically a shift in how we see people, from a body with symptoms to an actual whole person with lived experiences, both good and bad. I think about it like a suitcase. Everyone is just walking around with an invisible suitcase, and in it are their lived experiences, whether good or bad. The majority have a combination of both. But for some people, they have an abundant amount of trauma, which includes fear and a loss of the ability to cope.

So going back, I know we had spoken about trauma itself, but the DSM-5 terms define it as an emotionally overwhelming, highly upsetting event. Essentially, this is when individuals who have either gone through ongoing trauma or experienced it at an early age can't quite cope any longer. They can't function, and they can't process it because they can't move forward. The care that I'm hoping for, or that is the goal of the trauma-informed care model, is that we don't actually diagnose PTSD, but we look at how the trauma is impacting their relationship with care and their willingness to seek care. Like you said, safety is key, and we must make sure that we are providing safe care and looking at the whole individual.

PIERCE: I saw a statistic. You're talking about most people that we come in contact with have experienced or will experience a traumatic event. I saw a statistic that upwards of 70%

of adults in the US have experienced some type of traumatic event at least one time in their lives. So you're pretty much guaranteed as a provider that you're going to run into a patient, probably multiple patients in a day, that have had this traumatic event in their life. So how does that trauma, that traumatic effect, really impact the physical and mental health of someone?

SCHMITT: Right. There are a lot of times we'll hear, "It's just in your head," or, "Think positively," or, "Just calm down." Well, there is proven evidence that neurobiological processes are connected with psychological trauma. First and foremost, when someone has experienced trauma, their brain and nervous system can become wired for survival brain function to become a priority over logic. I'm sure you may be familiar with survival brain.

PIERCE: Mm-hmm. You just live in that fight-or-flight state, and you can't come out of it because your nervous system doesn't recognize what safety is anymore, even when you are in a safe place. So you just live in this state of "I have to survive."

SCHMITT: Exactly. The part of the brain that is specifically called the survival brain is the amygdala. It initiates the fight, flight, or freeze response and activates the body's stress response system. It's fast and automatic. It kind of takes control and minimizes the logical brain, which is the prefrontal cortex. That's the part that says, "This doesn't make sense, let's think about this, let's think this through." I don't want the amygdala and the survival brain to get a bad rap, because we need it. It's a good thing. Its main goal is to keep us alive, so it is very important.

But when it is repeatedly triggered in patients, it can have devastating physical, emotional, and psychological effects. Chronic stress correlates with cardiovascular disease, autoimmune diseases, gastrointestinal conditions like IBS, and also chronic fatigue. Essentially, those areas of the body are often neglected. When your body thinks you're about to die, your brain isn't going to say, "I need to digest what I just ate," or, "I need to protect myself from a microorganism." It dulls those functions. As far as mental health, you'll see depression, PTSD, anxiety, and often substance abuse disorders.

PIERCE: To try to numb the feeling, to try to get it to go away. Super high cortisol levels too. I mean, the super high cortisol levels really do a number on your body that we don't realize just how bad it is.

SCHMITT: Yes, absolutely. That whole, I think that the, it's called the hypothalamic-pituitary-adrenal axis or the HPA, and that initiates all sorts of metabolic and hormonal triggers. So it's not just psychological, it really is systemic here.

PIERCE: You can't control it. You can't come out of it. So that's why it's so hard when you hear people like, "Just calm down." But it's like, can't. I don't know why, but I can't. What are the key principles of trauma-informed care? And then how can we start to apply those in practice?

SCHMITT: There are a lot of models and different frameworks, but I like the Substance Abuse and Mental Health Services Administration. So in a nutshell, the SAMHSA. Yes, I don't know if I'm saying that right, but SAMHSA, they have six principles.

PIERCE: Yes, SAMHSA.

SCHMITT: So safety, trustworthiness and transparency, peer support, collaboration, empowerment, and cultural inclusion.

SCHMITT: So those are the basics, and I really like that because it hits all the important topics. So first and foremost, the safety that we had talked about and avoiding re-traumatization, because that is what we're trying to avoid is making them relive it again. One of the components in practice with safety is explaining safety and predictability. So explaining everything that we're doing. It may sound, you may feel odd or uncomfortable at first, but anything you do, even if you're going to, if you're going near, "Hey, I'm going to grab this pen near you," or especially when you're about to touch them, "Okay, I'm going to touch you, I need to get your blood pressure, it's just a normal process," things like that. Explain why you're doing it and what you're doing. And then also reducing loud noises, bright lights, as far as, as much as possible.

PIERCE: I want to go back to touching really quickly before you move on because I see this too for pediatric patients. Not even just traumatized patients who come in, but for example, I took one of my daughters to an ER a few years ago and the nurse comes in, she doesn't tell me what she's doing, she doesn't tell my daughter what she's doing. And my daughter was in middle school at the time, and she takes my daughter's arm, and she ends up either starting to IV or taking blood. I can't remember which one it was, but she doesn't tell her anything that's happening. And you know, you're watching this with my daughter, but you're, as a nurse, thinking you're watching this child, that you're basically, you are creating a traumatic event for this patient by not even telling them what you're doing. "Hey, I'm going to take your arm. I'm going to take some blood. This is what I'm going to use. This is my name." You didn't even introduce yourself and say who you are. And so in moments like that, I think we can cause a traumatic response to our patients. Then they come back to the hospital, and they are going to remember, and they are going to have that fear as well. So when you're describing some of these things, a lot of it to me just makes sense that this also prevents this from being a traumatizing event for somebody.

SCHMITT: Yes, yes, absolutely. That's a major point, because we can be so focused on our duties and the things we need to get done that we're not realizing that we're actually interacting with a human being that is not familiar with it. Maybe we've done it a hundred times, you know, but they have not.

PIERCE: Yes, but that pediatric patient is usually not, and a lot of adults have usually not. Like for me, I'm a nurse and I know what you're about to do when you walk in. I would still love for you to introduce yourself and tell me what you're going to do, but I see what you're carrying, so I know what's coming. But you have patients that don't know what's coming.

SCHMITT: Yes, exactly, the fear of the unknown. If you'll just explain that very quickly, you don't have to go in depth and say, well, this is the name of the device and I'll be collecting two mLs of blood. You just explain it on basic terms. Yes, it doesn't take very long. Yes, absolutely.

Another point is when you've realized that someone has had either a very recent or a far-in-the-post traumatic event, one thing that maybe is a misconception is retelling their story. And as nurses and as just human beings, we kind of think, well, they need to get it out. And you say, what happened? You know, our curiosity takes over and says, what happened? That is a major trigger for a lot of people. They have to repeat it over and over again. You can always say things like, I'm here if you decide, if you make the choice to share with me what's happened or share with me an experience, I'm here, I'll listen, you're safe with me, but don't feel pressured to talk about it unless it's absolutely necessary. If it's something that they have to for further care, if they have to go into detail about so we can evaluate, things like that.

But yes, and what you said, explaining or introducing yourself, that is the next point and principle, is the trustworthiness. So just being consistent, honest, and transparent about what you're doing and why you're doing it, even if it's uncomfortable, even if you don't want to, you know, do that. It's important, even with errors.

When I worked in the emergency room, I had made a mistake, and I didn't want to tell the patient. I had, so I had it, actually, I did, I had drawn their blood, and I'd sent it off and did the wrong thing and I needed to redraw it because of my own error. So I went in there and I wanted to, first of all, be dishonest and say, oh, the doctor ordered more blood, but I knew in my heart that's not who I am. So I did say, I made a mistake, I'm so sorry, I can't apologize enough. This is, and I remember the service member saying, oh, thanks for being honest, I'm surprised you told me, you didn't have to fess up to that, and things like that. And it wasn't a big deal to him. But yes, just being honest and explaining, you know, if you're using their information and why you're asking questions, things like that are really important.

Also, peer support. Evidence is continuously showing that these individuals with traumatic experiences are healing and showing better improvement and recovery when they have support groups and meaningful one-on-one contact.

PIERCE: Was that all? I'm trying to remember how many. Was there five?

SCHMITT: There's six. So the fifth, I apologize, is collaboration. So just making sure you're involving the patient in their own care. What do you think this is about? Things like that. And empowerment, giving them a choice at every aspect, because a lot of times trauma takes their power away. So this is the goal, is to give them back that power and choice. So yes.

PIERCE: Now, how can we recognize signs of trauma in patients? Can we recognize signs of trauma in patients? I really feel like, though, we should be taking all six of those principles anyway because it's good patient-centered care.

SCHMITT: Yes, that's what it's moving toward, is universal. It's that kind of like, you know how standard precautions, you put on your PPE, like every single patient has a contagious, communicable bloodborne pathogen. And it's the same thing, treat patients as every single one of them. Like you said, 70%. So seven out of ten of them, going to, you know, those three just got extra care. But treat everyone with those principles.

But as far as recognizing it, there are ways to, but everyone's unique. It's important to recognize when they are in crisis. So that's a term that is thrown around a lot. And what it basically means is they have reached that point where their survival brain is in charge, and their logical brain is in the backseat. Their survival brain is driving, and they are distraught, and they cannot cope any longer.

And often we try to prevent that in healthcare settings, but sometimes it's very common that they come in and they're already in that crisis. So signs of that are increased heart rate and blood pressure, rapid shallow breathing, often GI upset, so nausea, vomiting, diarrhea, things like that, stomach pain, chest discomfort. Sometimes they can just be in a state of shock or glossed over. Sometimes they will be disoriented in the hospital.

PIERCE: Boy, that differential, the diagnosis differential for these patients that you're describing is going to be very tough. I mean, because it's like every system is affected, but is it affected because of the sympathetic nervous system or is it affected because of the reason that they came to see you?

SCHMITT: Exactly. So yes, our hierarchy of priority. Yes, when they've got chest pain and, you know, tachycardia and breathing. Yes. Yes. And a lot of times the signs of crisis, it isn't known right off the bat. It's like days, weeks later they say this actually was, you know, after exhaustive studies and mental health involvement, things like that. But yes.

PIERCE: All right. Here comes that, yes.

SCHMITT: Before that happens is what is essential to look for to signs that they've experienced it, but they're coping somewhat. They're not completely out of control as far as their life and everything is.

Look for some signs, maybe avoidance, like avoiding eye contact, avoiding appointments altogether. Maybe it's missed appointments, multiple canceled appointments, their general state of anxiety, kind of hypervigilance, looking around, jumpy, a few sudden movements may trigger them to respond in that manner. You'll also see a long list of vague symptoms or consistent ER visits, things like that, as well as they have difficulty describing their symptoms.

Maybe it's a headache, but they're not concerned about the headache. They're like, well, that's not the biggest, it's because my stomach is hurting, or my muscles are hurting. It's kind of vague, everywhere.

PIERCE: It reminds me of when we look at things through a lens. So you have a patient that is probably looking at everybody and everything that comes in that room through this lens of trauma, whatever that might be, like through a lens of pain, maybe a lens of distrust because of whatever that traumatic event was. So everything that you come in and do, they're going to question. So I just see that these lenses that they are looking at the world and every situation through.

SCHMITT: Right, right, and you hit it right on the head, because when you say betrayal, they expect betrayal from everyone. It's not just that they're maybe, you know, wondering, it's like, okay, this person's probably going to somehow betray me and betray my trust. But yes, absolutely, that lens, that's a really good way to put it. I like that.

PIERCE: When it comes to our role and how we should be interacting with that patient, where do you see the role of empathy and the act of listening that you're taught in nursing school and probably med school, of how to listen to patients? What role do you see those playing in this framework of trauma-informed care?

SCHMITT: Yes, they play a huge role. And one aspect that I'm not sure if you kind of went over it in nursing school, but we didn't really talk about self-care. Because a lot of times, you know...

PIERCE: Yes, we didn’t either.

SCHMITT: A lot of times we have you heard of the airplane? Like you have to put your oxygen mask on before you help someone else?

PIERCE: Right. I wasn’t either. Yes.

SCHMITT: Yes, we can't if we don't show ourselves compassion, then we can't provide genuine compassion to others and empathy and just self-care. So it starts there, just giving yourself the time to heal from anything that we've experienced. And we don't have to reach far, because we've either seen it firsthand or experienced it in personal or professional life.

So a huge, huge portion of this goal is to show empathy and active listening. That is a biggie. That's hard because we have already a workload that seems overwhelming as it is, but it is important. So active listening is just fully engaged, fully committed to what this individual, at this moment kind of like mindfulness, let everything go except for that, unless it's something, you hear a code, things like that. And just focus in. That really has to do with eye contact, validating or reassuring them, either repeating what they say back or saying, go on, I understand. Things like that really build that bond of trust and show that I'm

investing in you. I'm not here just to take care of your body. I'm here to take care of your whole person.

PIERCE: I think that trustworthiness that you hit on as one of the key principles too, when I think about that, and I've shared this story before on a different podcast and it was in a not trauma-informed framework, but like in a different lens, I guess, would be you go into your patient's room. I got report about this patient, and they were telling me just how terrible they were and how needy they were. But all I did during that particular shift was tell the patient, I'll be back at two o'clock to check on you. And hey, I showed up at two o'clock or two, you know, it might be a few minutes late, but around two o'clock, I'm going to be back to check on you. And I went back and checked on them.

"Hey, I'll be back at four o'clock." You know, like I gave them a time, and not one time did they hit the call light because, you know, they saw that I was going to come back. So even if I was a few minutes late, they knew that I was going to come back, and they would save their requests, like, "Hey, can I have ice?" or "Can I have some energy?" They would save those requests for me rather than continuing to hit that call.

So I just think it's so important for our, well, first of all, we have to show that we are trustworthy to them. And that's a pattern. Trustworthiness is a pattern. And if we break that pattern, we have to be willing to be like, "I'm so sorry I was late. My other patient was coding," or "I think that that's so important for all patients." Because when we do not hit on those principles, then we do cause a traumatic event for our patients. "They never came back. They never came back to see me. I couldn't even get anything to drink. I don't even think anybody knows I'm here."

SCHMITT: Yes, and it could have brought back memories of something from the past where someone had said, you know, "I'll do this," and then they didn't follow up. They didn't keep that word. So then it's like a projection of that event on to this. It's the same exact event, even though your intentions weren't the same. But yes, I love that example.

PIERCE: And I think that really sets us up too for my next question about healthcare environments and how healthcare environments can be adapted to support trauma-informed care.

SCHMITT: Yes, so the whole goal is avoiding that being re-traumatized, right? And that happens long before you even see the patient. So it's a team effort. It can start, you know, with the lighting, the furniture, the parking lot. Is parking difficult? Are signs clear where you are, like if you're in radiology, is it difficult, are there maps, are there arrows, are they clearly labeled? Things like that. Before a patient can ever get to you or the waiting room, they may already be at a stress level that's above the roof. So things can only just get worse from there, and they're already aggravated or stressed and potentially ready to leave before they even reach you.

So the environment, and then once they get there decorations, lighting, smells too. Mildew, like urine, different smells really can have such a, you know, the smell is, I've heard this, but the smell is the closest link to memory. So there's horrible smells. The next time that you think about going back to the doctor's office or the hospital or wherever, it's going to say, my gosh, you're going to get a feeling of dread.

So I want you to just think about this. You don't have to close your eyes or anything but just imagine walking into this dark hallway and it's kind of dark. You don't see any signs of even where you're at, what unit you're at. There are wheelchairs everywhere. So it's cluttered. There might be a desk over here that's stacked full of papers, and some of them look like they're about to fall off. Then you come up to a receptionist that's barricaded in this like really thick glass, and she doesn't even look at you and acknowledge that you're there. How are you feeling right now? How would you say you're feeling?

PIERCE: I shouldn't be here. You don't want to take care of me. Scary place. No.

SCHMITT: Yes, yes. I'm not wanted here. Yes. And about the barricade, I know that for COVID, they integrated more safety for healthcare providers, our professionals, which is essential. But I remember hearing a patient say, "COVID is going to need a jackhammer to get through that thing." You know, so, you know, we need to minimize the PPE as much as necessary, so it doesn't look like we are terrified of getting some sort of disease from patients.

So now think about how would you feel if you walked in and it was very well lit, not cluttered, there was plenty of seating, lovely artwork on the wall, maybe a water fountain sound, and just a very welcoming, warm receptionist that's, "Welcome, we're glad you're here," things like that. Or even a station with snacks, just comfort. Comfort. It's little things that make a huge difference.

Yes, so that's a lot about the environment. And then exits. It's a really important thing to remember that these patients may be making sure that they know where all the exits are because at any moment, they want to be able to leave. And, or if they are not a flight and they're a fight, they may want to grab something like a lamp because their brain is telling them that they need to fight. So there doesn't need to be a ton of possible weapons around, things like that.

PIERCE: Totally, totally off topic, kind of, kind of off topic. So, you know, I'm not sure about the other states, but I know in the state of Florida, we have the Baker Act, where you can, you know, hold somebody basically in a mental state for up to 72 hours, I believe is what it is. But I was just thinking about this not that long ago. And we're talking about trauma-informed care. And you're talking about this warm environment and how this should be. And the very people who need this are those who have been traumatized, which goes back to mental health.

I can't think of anything that falls into trauma-informed care when I think of being held in a mental facility or being placed under a mental hold at a psych hospital or the department within a hospital. I can't think of anything that makes me see trauma-informed care. I see cold, dark, and scary. And I just find that interesting. You know, what you're describing, what we're talking about here, trauma-informed care and the framework of how to take care of people who have been traumatized. And a lot of these people have been traumatized.

SCHMITT: Right, yes. And they are in a constant state of fear and a loss of control. So then it's taking away additional control. Yes, absolutely.

PIERCE: Right, yes. Placed in a cold room with nothing, you can’t even have your own clothes. So I just, as we're talking about this and the importance of this, I'm just, I don't know, my mind just kind of went to that. Those people who really do need this mental health care aren't receiving trauma-informed care.

SCHMITT: There has to be a better way at this point. In research and just the initiatives of compassionate people, there have to be more ideas. We have to come together from all standpoints, from the mental health professionals to administration to nursing and to the medical providers. We have to come up with something. Because the physicians are thinking, well, physical harm, or the providers are thinking, okay, we have to, at all cost, we have to reduce the physical harm or self-harm or harm to others. But what you're doing is kind of kicking the ball down the road, because you're increasing the likelihood that later on, they are going to hurt themselves or someone else.

PIERCE: Right, yes. Well, we are at time for this first episode, Abbie. Thank you so much for being here for this discussion. Yes, and to our listeners, make sure that you tune into our next episode where we're going to continue this discussion and talk about strategies for implementing trauma-informed care in your clinical practice.

Episode 1: Trauma Informed Care: Healing through Understanding

Transcript

PIERCE: Welcome to episode two of the Trauma Informed Care Healing Through Understanding series. If you missed our first episode, Abby helped us really to understand the framework of trauma-informed care, and she is back, and she's going to be sharing how we can implement trauma-informed care into clinical practice. Thank you for coming back to join us, Abby.

SCHMITT: Yes, absolutely. So implementing trauma-informed care. Organizations are definitely jumping on this innovation. It's being seen in emergency rooms a lot. There's redesigns of the infrastructure and the layout, the seating, the decor, things like that. We also seeing a lot more education, so training for staff from not just clinical one-on-one patient employees, but also security, custodial, maintenance, administrative, things like

that. Everyone is receiving that ongoing training, not just the initial orientation when you begin employment.

PIERCE: Are you seeing, so I know we have like crisis management training per se and a lot of times you would see those with ER staff, you'd see them with OB and pediatric staff as well, but is that, is the trauma-informed care a piece of that crisis management or is this different?

SCHMITT: This is actually, it is a part of that. You'll see, so sometimes there's curriculum. So with de-escalation tactics, that is also in workplace violence. But there's such a, like a close relationship because they overlap with each other because workplace violence, a lot of times, it's lateral violence. So your coworker is experiencing a crisis themselves. So that kind of makes sure that we're looking at all four groups including our patients, our patients' caregivers, our coworkers, and ourselves. So yes, that de-escalation tactics of how to calm a situation and how to properly report suspicious activity, things like that, that is a part of trauma-informed care as well. And then it'll be reintegrated or like kind of spoken again in the workplace violence education.

PIERCE: Now, what can you share some successful, apparently the word successful is hard for me to say today, implementation of trauma-informed care in the healthcare settings?

SCHMITT: Yes, so we're seeing a lot of more integration of mental health professionals. So it's not just stay in your lane now. It's not like the emergency room is just for this or, you know, there's consistent integration of mental health and resources. And then a major one is the screening. So now I'm not sure if you've noticed there's a significant increase in screenings. So you'll see it for PTSD, you'll see it for socioeconomic stressors, you know, if someone is burdened over their capacity as far as living situations. And then you'll see it for adverse childhood events or ACEs, and then domestic violence and elder abuse. There's so many screening tools now. So that's a main one. I love that.

SCHMITT: In every pediatric visit that I take my sons to, I fill it out at home. So that's really good because you know you could feel rushed and uncomfortable in the doctor's office and you're like, no, no, no, no, no. But if you're in your own environment then you could take time to say, let me be truthful, let me be self-reflective, let me honestly answer these questions. So yes, I love the tools. And also outreach into the communities. You're seeing a lot more of that. Kind of reaching out to community leaders and organizations, homeless shelters, the local VA, things like that. Just a collaborative approach.

PIERCE: Now, what are you seeing as far as, I mean, I know that we have screenings, we have screenings for everything. There are so many screenings these days, but I don't necessarily see that as an advanced strategy per se. It's really just like, let me highlight this, let me see if this is something that could potentially come up with a patient. So what are more of those advanced strategies that help integrate this type of care into practice?

SCHMITT: Okay, so a lot of times we'll see that like we had said the training of staff and you can go deeper not just have staff watch a video you can do interactive role play situations with each other go to seminars go to support groups themselves have a lived experience of a patient or someone who's willing to come in and speak to staff. This is my experience and be very open to hearing their criticism. So a lot of times you'll see suggestion boxes or anonymous suggestions for patients to say, how was your experience today? And that's really good feedback because you see what is working, what is not. Maybe we triggered someone today unnecessarily. So yes, a lot of training. And then like we said, the changing up the setup of the healthcare environments and exam rooms, and then more training on just respect of the patient and not bringing them into another state of stress.

PIERCE: Right, and then you talked a little bit about collaboration, specifically with mental health professionals coming in and playing a role. So what does collaboration look like? Who all is playing a role in this type of care besides the nurse and the physician or healthcare provider?

SCHMITT: Yes, so it goes all the way from the administration. It needs to start at the top to get, you know, to set the tone of a culture of safety. It can't, it's not just one discipline. It has to be administrators. It has to be leaders. It has to be those in maintenance and custodial, you know, anyone that is interacting or even having an impact on the environment that the patients are coming in.

Definitely getting advice from the mental health side of things. Those people who consistently see these patients and see things that are triggers. And I was saying the informed consent or that when we are explaining things that come in to play also just at check-in as well, making sure whoever's checking these individuals in.

PIERCE: How does, go ahead. No, go ahead.

SCHMITT: Say, this is why we need your information, this is how it will be used, things like that. And it goes from all the way until after the visit, follow-up. Are there policies that are already in place to follow up to remind these patients of appointments?

PIERCE: Where do mental health providers come into the collaboration?

SCHMITT: I think on the policy development and procedures, that they are physically available for warm handoffs, that they are part of the training, a part of just ongoing strategies. And another major thing is just making sure that we're not keeping up with stigmas and taboos about health, mental health, normalizing it.

Saying, you know, a lot of people struggle with mental health. So this is, you know, very common, just normalize it, because a lot of times people hear mental health and they say, they think I'm crazy and then triggers go off. But just make it a normal thing in society. Everyone needs a check on their mental health.

PIERCE: Right, and we see that statistically 70% of Americans or of people in the US are going to have a traumatic event. And sometimes you need help. And I do see that stigma where even just asking for a medication, “Can I just have something to just help me get through this time in my life?” Just, you know, this is a really hard, scary time. “Can I just have something to help me with,” you know, “manage my emotions or manage what I'm going through?” And there shouldn't be a stigma about that. And I see a lot of times patients come in and they're very quiet about what they've gone through because they don't want that stigma around them.

SCHMITT: Yes, and even medications. I already remember asking patients about their medications and I had the list in front of me and was just going over line by line. And a lot of times they would either not say it at all or look down when they'd say, “I'm on citalopram,” or “I'm on Zoloft.” When they, you know, they're on a blood pressure medicine and they didn't, they're not ashamed of that. So why would they be ashamed of taking an antidepressant or something for anxiety? Yes, or even, you'll see schizophrenia, different conditions and they feel like they're going to be judged because of that. So we have to just be that normalizing figure. You have to consistently do it, not just at work, but at home, at the grocery store, at school, with friends. So we just have to continue this culture to make it a normal human process.

PIERCE: Yes, and by incorporating this framework for everybody, you really do make this easier for those who are struggling with mental health or with some type of traumatic event. And you know, a lot of times our traumatic events happen in the hospital or at the clinic. And it's not because of something a healthcare provider did per se, it's because it is a traumatizing event. If you are sick enough or something is wrong with you that you are in the hospital, that alone is traumatic and scary.

SCHMITT: Yes, yes, or loved ones as well. Yes, and since COVID, I think that this has dramatically increased because I think that the exposure was unavoidable at younger ages. I think we're seeing, you know, the results, the trickle effect of being under, you know, in early stages of development when COVID happened and just to see a society collapse and seeing loved ones and the constant fear of being diagnosed with that. So I think that's going to have a bigger effect than we realize.

PIERCE: Absolutely. And something else that has really gained attention is cultural competence as well within how we treat patients. So how do we see the role of cultural competence in trauma

informed care within that framework?

SCHMITT: So it's not, first, before we say what it is, let's talk about what it's not. Because there's a lot of miscommunication and misunderstanding. It's not knowing every single cultural practice and food and language and everything. It's not being an expert. It's curious

and open and warm about this. It's about being non-judgmental. So instead of knowing already or being expected to know, that's just going to lead to misunderstandings and putting your foot in your mouth because you've said the wrong thing. So it's going to look like saying, "Can you tell me more about any cultural practices or religious practices, especially those that affect your healthcare decisions?" Just ask, don't assume. The worst thing to do is assume something. But it will affect their care if there are miscommunications. And trauma is experienced very differently between cultures.

So, right, so in some cultures it's not acceptable to. It's a sign of weakness that you're asking for help. So it'll be more of a somatic disorder, like an objective symptom rather than a subjective. So they'll come in with an actual, "My chest hurts," but they're actually just emotionally and psychologically overwhelmed. And pain, you know, pain is a definite sign of weakness among some cultures. Just that cultural backgrounds, values, language, and lived experience, it just changes how the healing process and everyone's relationship with getting and accepting healthcare.

PIERCE: Absolutely. And I do think it's so important to be curious. I like how you use the word curious, being open to learn, but then also being open to follow through where you need to follow through. You know, if you have a patient who can't eat certain things and just making sure that that is known, making sure it didn't show up in their room, that's where our curiosity then takes action to make sure our patients are well cared for.

SCHMITT: Yes, absolutely. You can't just hold that information and say, okay, I know all about you. You have to continue to make sure that that's respected everywhere they go. Another cultural difference is, so with most patients, we want them to make their own decisions and practice autonomy and give them power. In some cultures, the decision-making is up to another family member. So instead of us being you know, judgmental or saying, "You need to make your own decisions," and "They're not allowed in this room," we need to accept that that is that's their practices. That's who they are.

PIERCE: But also when things like that happen, we ought to be, I have my pencil, being that we are so, I don't know, we have to go through domestic violence courses and all these things. And so when you see something like that, sometimes your head automatically goes to, "This must be an abusive situation." When really, no, that's their culture, that's their practice, that's how their culture makes decisions, and we should respect that. But we don't know unless we're curious about their culture. So when you say don't assume, you know, that's a point where sometimes assuming something could cause damage to that family.

SCHMITT: Yes, absolutely. Yes, and they're not going to, a lot of times people project like this experience will happen at every facility. So that's why we have to make sure that what we're saying and doing, that could have a long-term effect on their willingness to accept care.

PIERCE: Right and create a very traumatic event that might deter them from coming back for care when they need it or going for care anywhere when they need it.

SCHMITT: Yes, yes. And the limited availability of languages. Sometimes in hospitals, you only have a certain amount of languages. Just having a wide expanse of the capability to get an interpreter and not use family members. Even if it's a very uncommon language seen in the United States, it still needs to be available and accessible for those patients.

PIERCE: Absolutely. Now, what challenges do you see with implementing this framework for care?

SCHMITT: So, first of all, just the buy-in. You have to help people realize that this is important. This is going to impact an individual's long-term health outcomes. And this is valuable to us as professionals as well, our well-being, and our interaction within our fulfillment in our positions. But another challenge other than buy-in is awareness. A lot of people just aren't aware, especially those who haven't really been exposed to traumatic situations. They're just not aware of how common it is and the prevalence.

So, time and resource constraints, like we said earlier, nurses especially already have an overloaded workload, or your workload is at capacity, and it just feels like another thing. And also, secondary traumatic stress and compassion fatigue, burnout, things like that. You just don't have the capacity to take on anymore. Kind of like that suitcase, my suitcase is full. I can't cram anymore. And often when you hear traumatic experiences, you're kind of like, “Okay, this doesn't really pertain to me. I'm really nice to people, and that's all I need to do.” It needs to go beyond that. You need to understand the physiological effects. You have to understand how this impacts an individual's life. And so, yes.

PIERCE: Absolutely, and I was thinking about, I mentioned suitcase, but also kind of see the suitcase as like my emotions, like my emotional baggage. Like I can't fit anything else emotionally in this suitcase. But then I think about workload and my plate is so full, and now, and now maybe staffing is so short, but now you're telling me I have to go take a class.

I have to go sit through this long class, because I've seen classes for this up to eight hours. And I have to go sit, because it's usually with your crisis management training and your de-escalation and all that stuff mixed in with that, you have the trauma-informed care. And now I have to figure out how to fit this in. And do I even really care or am I just frustrated while I'm sitting through this class? I have to sit through this class, and I really don't care what you're teaching me because I don't want to be here because I'm tired.

PIERCE: There are some challenges too.

SCHMITT: Yes, and that's when creativity and innovation need to come in. It doesn't, I mean, logically you shouldn't sit there and listen, just auditory listen if you're not that type of learner. Like, it's hands-on. Most of us learn either by watching it or doing it ourselves or hearing it or different ways. So, it needs to be a creative integration. And that can look like, we said, role play, like five minutes of role play, debriefings, team huddles, and just making sure that staff are psychologically safe and then staff wellness. It’s kind of like a puzzle. So,

if we want this trauma-informed care to work out, we're going to have to fit all the puzzle pieces in. And that begins with the staff. Make sure that they're okay so they can help the patients.

PIERCE: Absolutely. So also, the mental health of our staff is just as important as the mental health of our patients. If, I don't know, maybe it's more important, because without taking care of the mental health of our staff, how are they going to take care of the mental health of the patient?

SCHMITT: Right. Yes. And they're going to feel it. You can't fake it. You can't fake patience. You can't fake compassion. You can't, you know, fake all of this. You can try to, but I mean, people are pretty smart, right? People are pretty in tune. I think I'm a pretty good reader of people's intentions. And I can always tell when somebody wants to end our conversation, you know, wants to get away, but they're saying, "Tell me more," things like that. But,

PIERCE: Yes, like really don't, but I'll say this because I'm supposed to. Yes.

SCHMITT: Yes. And I'm halfway out the door and I'm looking at my pager or, you know, right, right. Yes.

PIERCE: Phone or my watch. Yes. So those are definitely some things that we are going to have to overcome in order to implement trauma-informed care well. But what about technology and data? How can we use technology? What types of data can we use to help support bringing this framework into our practice?

SCHMITT: Well, telehealth and remote visits, virtual visits, I feel like that's become a game changer for individuals who are sometimes triggered or hesitant to go to a physical location. So, I think that's a huge advantage, especially for chronic conditions management, preventative care, or acute illnesses. That's really helpful, that technology. However, we have to take a step back and say, look at access. So not everyone has access to this technology. So, there are initiatives from a policy and governmental standpoint of making Wi-Fi more accessible and then satellite communication, things like that. But that's, I think that's a huge deal, patients being able to see a provider within the comfort of their home.

Also, apps. There are apps where you can speak via text message with a mental health provider. There are apps where you can practice self-regulation like breathing exercises and grounding techniques. Even therapies like cognitive behavioral therapy and EMDR, they can be practiced remotely. Well, not always. I take that back. Not always. In some certain situations, it's not appropriate to do that remotely, but...

And like we had said, we had mentioned before the screening tools and using large sets of data and kind of analyzing them for quality improvement. So, looking at statistics and looking at missed appointments and no-show rates and even questionnaires. That's a big deal, making sure that the questionnaires are set up in a way that patients can

anonymously give suggestions on their experience and truthfully give honest feedback. And also looking at staff burnout rates and turnover.

PIERCE: Right, because it's not just about the patients, it also is about our staff. Now, what resources and training opportunities are actually available for healthcare professionals to really deepen their understanding of trauma-informed care?

SCHMITT: Okay, so there's several resources. I personally, like I mentioned, use SAMHSA, Substance Abuse and Mental Health Services. They have a wide variety of tools and programs. Then there's the Administration of Veteran Affairs, which is the VA. They actually have a really good council, which is called the National Center for PTSD. So, they have screening tools as well and patient educational materials and provider resources. I think that's a really good one, and the most evidence-based, or like the most recent things that have proven as far as what strategies are more effective, what strategies are less effective, things like that.

But specifically talking to trauma-informed care, you can go to specific organizations. The CDC has a good database on trauma-informed care. Center for Child Counseling integrates that into their patient tools and worksheets, things like that. And then the American Nursing Association, different mental health organizations, and the American Hospital Association have their own. So, each one has a little bit of a different framework. I was going to say there's the International Institute of Trauma-Informed Care, which offers programs and courses to kind of dive deeper into what it looks like to implement this into practice.

PIERCE: So, there are quite a few resources that they can look at to help to bring this to their facility if they have not actually had it brought to their facility.

SCHMITT: Right and just grabbing a mental health professional. So, if you have a counselor or a psychologist, psychiatrist in your facility, social workers have a great amount of training in this as well. So, I'm always saying, pick the brains of human beings, because lived experiences are where you're going to gain wisdom. So, if you have a close, I mean, a friend or an acquaintance, or just get to know someone within your facility, reach out and say, "Hey, what do you think about the situation?" or "Do you have any suggestions?" Things like that.

PIERCE: Right and then finding somebody who can champion this type of care and bring this type of care to your facility I think is so important as well. But we are at the end of our time for this episode. So, before we close out, I just wanted to ask if there's anything that maybe I didn't touch on or that you just really want to make sure listeners walk away from this series knowing.

SCHMITT: I don't think so. I just want to kind of home in on the self-care aspect. Self-reflection, make sure that you're okay. Do, you know, mindfulness, yoga, healthy eating,

balanced diet, exercise, physical activity, meaningful connections with others. Make sure you're okay before you try to save your patients. Just make sure.

PIERCE: Absolutely, absolutely. I couldn't agree more. Yes, we've talked about the 70% statistic, or seven out of 10, however you want to really look at that, but that includes healthcare professionals. I mean, they're included in that statistic as well. So, they have also, we have also, experienced some type of traumatic event at least once in our life. You're going to have patients where it's going to be important to use these strategies. And I think that that just really highlights how important taking time to learn about trauma-informed care and being able to provide that type of care to all of your patients is so important. Your efforts in just trying to create this environment will just make a profound difference in the lives of your patients. Abbie, thank you for being here for this discussion. Thank you for sharing your insight on trauma-informed care and for your passion of not just taking care of patients but making sure that we as healthcare professionals take care of ourselves too.

SCHMITT: Absolutely, thank you.

PIERCE: Yes, to our listeners. Thank you for joining us. And I encourage you to explore many of the courses that we have available on elitelearning.com to help you continue to grow in your careers and earn CEs.