Season 4 Episode 2a
Trauma-Informed Care Part 1
Transcript

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Learning Objectives:

1. Define the terms trauma, trauma-informed care, and adverse childhood experiences.
2. Gain familiarity with SAMHSA's 3 E's of trauma and 4 R's of trauma-informed care.
3. List 2 ACE (adverse childhood experiences), and describe how ACE screening/intervention fit within the larger framework of trauma-informed care.

Co-hosts' Notice: Physician and provider are terms used interchangeably by many in the medical community, The DEI Shift podcast team endorses and supports the use of physician in place of provider where applicable as outlined in ACP policy.

[0:00] Intro

Maggie Kozman: Welcome to The DEI Shift, a podcast focusing on shifting the way that we think and talk about diversity, equity and inclusion in the medical field. I'm Dr. Maggie Kozman, a Med/Peds dual hospitalist, and one of the senior producers of The DEI Shift, and my co-host today is...

DJ Gaines: Dr. DJ Gaines, an Internal Medicine hospitalist and Senior Producer of The DEI Shift. Today, we're excited to bring you an episode on trauma-informed care, a topic that has gained significant traction over the last several years within the pediatric world, but less traction thus far in the adult healthcare world.

Maggie Kozman: One aspect of diversity we don't talk often about in our patients, but which frequently leads to subsequent health disparities, is their variable experiences of trauma. And similar to surveys asking patient's desire for providers to ask about their religious and spiritual diversity, many patients also endorse that those who've experienced trauma in their past have never been asked about their trauma experiences by a healthcare professional, but that they'd like to be asked about that history because they feel their physicians could help in some way, if they were aware of it. People who've experienced trauma, who we call trauma survivors as opposed to victims, tend to utilize healthcare at higher rates than the general population. And they use primary care services more than mental or behavioral health services. But these patients will interface with all levels of care within the healthcare system. So it's incredibly important that we as healthcare professionals learn to engage with our patients in trauma-informed ways to facilitate their recovery and healing.

Speaking with us about this crucial topic are two phenomenal guests, who've done groundbreaking work in trauma-informed care, Dr. Moira Szilagyi and Dr. Edward Machtinger. Dr. Szilagyi is a primary care pediatrician and a professor of Pediatrics in Los Angeles, California. She is the current president of the American Academy of Pediatrics, which granted her the 2021 Lifetime Achievement Award for Advocacy on Behalf of Vulnerable Children prior to the start of her term throughout her career, she's become one of the leading experts on the health of children in foster and kinship care, as well as an expert on childhood trauma and resilience. She pioneered the first healthcare standards for children in foster care. And she's continued to advocate for her patients in a number of ways, including policy statements, technical reports, and a book she co-authored, which we'll talk about today.

DJ Gaines: And Dr. Machtinger is an Internal Medicine physician and a professor of Medicine in San Francisco, California. He is the director of the women's HIV program and director of the Center to Advance Trauma-Informed Healthcare at the University of California, San Francisco. He's also a co-principal investigator of the UCLA/UCSF ACE Aware Family Resilience Network, a University of California multi-campus initiative housing the state of California's ACE Aware programs that address the health impacts of adverse childhood experiences (ACE) and toxic stress. He also works to expand access to mental health and substance use treatment by integrating them into primary medical care.

Maggie Kozman: Thank you both so much for being here with us and sharing your expertise and insights into trauma-informed care in both the pediatric and the adult worlds.

Moira Szilagyi: Thank you for inviting us to be here.

Maggie Kozman: We like to keep things casual here on our podcasts. So in addition to asking you both to call us by our first names, Maggie and DJ, we'd like to ask if it's okay for us to call you Moira and Edward?

Moira Szilagyi: Um, certainly fine to call me Moira.

Edward Machtinger: Of course. And you can call me Eddy.

Maggie Kozman: Okay, great. Thank you.

[3:40] “A Step in Your Shoes” Segment

DJ Gaines: Well, thank you so much. So before we get started, uh, talking about trauma-informed care, we like to ask each of our guests on the day shift to share something with our listeners about themselves. This can be something like a hobby, favorite food, a meaningful experience of yours. And this helps us get to know you and your background a little better and helps us flex our cultural humility muscles. We call this our Step in Your Shoes segment.

So Eddy, what would you like to share with the audience today?

Edward Machtinger: I love dogs and all animals and all nature. I find animals in nature kind of miraculous. And, I think my original intention to go to medical school was I just found all life kind of miraculous and the idea that I'd be able to go to medical school and learn about kind of the human body and human life and the human psyche and spend a number of years just trying to understand that and figure out ways to engage it and kind of help it be healthy and happy in its experience. Um, this was very exciting to me and I still, of all the different things in my career, really love being with patients more than really anything else, despite those other things becoming the dominant aspect of my career.

DJ Gaines: Well, thank you so much, Eddy. That's very interesting how that initial desire for life kind of transitioned to where you are now. So we really appreciate you sharing that with us.

Maggie Kozman: And Moira, what would you like to share?

Moira Szilagyi: Well, I think, like Eddy, I am always grounded in my patients and I think the population I chose to work with. I don't think I even put two and two together for a long time, but I'm an immigrant. I came here as a child with my Irish parents. I can actually do an Irish jig, but I don't. I felt like I was, um, just really fortunate in my life; even though I grew up in a low-income neighborhood where violence was not an uncommon thing, I grew up in a wonderful, wonderful family. And I think what I learned from that is just how important it is, that children have that safe harbor of family and other resources in their childhood. Um, because my brother and I were probably the only two kids in my entire neighborhood who went to college-- had the opportunity to pursue careers that we were both really interested in. And so I feel like my life has kind of come full circle in a way, but everything I've ever been or done has somehow ended up informing the professional I am, the pediatrician I try to be. And how I hope that this work in childhood trauma improves the lives of so many other children and their outcomes.

Maggie Kozman: That's really interesting to hear because it ties in really wonderfully with what we're going to talk about today, how our early life experiences impact us in ways that maybe we don't anticipate or don't fully realize until later. So it's great to hear how your background in many aspects has influenced the work that you've done for so many of your patients. Thank you so much for sharing that with us.

[7:50] Defining Trauma and Trauma-Informed Care

DJ Gaines: Let's get started. Perhaps we can start with some definitions first. So Moira, how would you define trauma and trauma-informed care?

Moira Szilagyi: Well, a lot of my work has been done with the American Academy of Pediatrics, a team at UCLA, and a team at the University of Massachusetts.

And we use SAMHSA's, the Substance Abuse and Mental Health Services Administration's definition of trauma. There are various definitions of trauma. So this is not the only one, and this is the one for individuals. And, what they say is that individual trauma results from an event or a series of events or a set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening, and that can have lasting adverse effects on how an individual functions and on their mental, physical, social, emotional, or spiritual well-being.

Trauma, you know, you can witness trauma, or feel threatened by something that you hear about. And this is particularly important for children because their parents really mediate the world for them. And if a parent is experiencing trauma, as it's now happening in Ukraine, for example, as a very cogent, current example that you can almost see watching those pictures, how parents are trying to protect the children, even though they themselves are very stressed, and kids are always reading their parents' cues and taking cues from them. And so, for a child, even hearing about trauma that affects somebody they love can be traumatizing for them without those buffering relationships. And we're probably going to talk about that in a bit.

Maggie Kozman: Absolutely. And thank you for bringing in current events to what we are discussing because it's extremely pertinent and things that will impact the families in Ukraine and in Russia and the surrounding areas for decades and even few future generations to come.

To your definition of trauma by SAMHSA, I really liked that definition as well. It comes from their 2014 concept paper on the topic of trauma-informed care. And just to highlight what might be known to different members of our community are the three E's of trauma from that definition. So you talked about Event or Events that can threaten the physical or psychological harm or even be severe or life-threatening child neglect, threatening their healthy development. So the first E is Event. The second is Experienced. So an event can be experienced as traumatic for one person, but not for another. And how a person subjectively labels or assigns meaning to a particular event determines if it is traumatic for them. And that's important for us to remember as providers when we are hearing the experiences relayed to us by our patients. And then the third E of the three E's of trauma is Effects. And you mentioned that this event experienced by a patient can have adverse outcomes on the person, whether they're immediate or delayed, whether it's short or long-term effects and whether or not the person recognizes those effects as being the result of a particular traumatic event in their life. How would you define trauma-informed care Moira?

Moira Szilagyi: Well, again, this is not my definition. We borrowed this one from the National Child Traumatic Stress Network, which is probably the organization in the country that has the most experience with training and education of mental health providers school officials, child welfare workers in providing trauma-informed care.

So they define it as care, depending on what type of care you provide, in which all those who are caring for children recognize, assess, and respond to the effects of traumatic experiences on children, their caregivers, and on ourselves as, as the healthcare providers. And anyone listening who is in a medical profession will appreciate that in medicine, we're a very problem-focused profession. You know, you come to us with your chest pain, we make a diagnosis based on the history. And then we treat according to that. So our question is often "What is wrong with you?" Trauma-informed care, changes that question and moves us into asking "What happened to you, and what is strong with you, so that I can understand you and to help you heal?"

And this is crucially important when we put our trauma-informed lens on because what the science has now taught us is that traumatic experiences in childhood don't just have an impact in childhood, but can physiologically affect us throughout our lives. It changes, um, if not buffered, if not helped in some way to heal, um, things just kind of get physiologically embedded. So it's really kind of a crucial shift in focus in care.

DJ Gaines: I really liked that comment that you made about how as physicians, we tend to think, try to be as objective as possible, but given the definition of trauma-informed care, this is very much a subjective experience. And as such, we have to change the line of questioning that we are typically used to. So I really liked this way of questioning, because it does allow the patient to share their experience in an open manner and also, um, doesn't necessarily pigeonhole them or box them into a particular response. Well with that in mind, Eddy, would you define or highlight any other aspects of trauma and trauma-informed care beyond those definitions?

[00:14:45] SAMHSA's 4 R's of Trauma-Informed Care

Edward Machtinger: Well, there's a great paper by SAMHSA, the Substance Abuse and Mental Health Services Administration, that describes the 4 R's of trauma-informed care and they're pretty meaty, so I'm gonna explain each one individually, so that they can really hopefully resonate. So the first is to Realize the impact of trauma on patients and the correlation between that trauma and health.

So trauma has a very, very strong correlation with later adult health outcomes. And it's actually the degree of the correlation is actually very startling. The best data and the most popularized data about this comes from the adverse childhood experiences study, which was a study of adults in an obesity clinic in Kaiser Permanente. And they asked them about traumatic experiences that they had as a child, and then correlated those answers to the various adult conditions they were facing at that time. And the correlation was just striking. So for example, people who reported four or more ACEs and ACEs are kind of one of 10 big ticket childhood types of trauma. People who reported four or more ACEs had twice the rate of lung and liver disease as an adult, three times the rate of depression, 11 times the relate, rate of injection drug use, and 14 times the rate of attempting suicide than people who didn't have any ACEs. And those are really incredible numbers in terms of correlations.

And just to give it a different way of looking at it. The CDC just came out with a paper and looking at the percentage of each disease that is attributed specifically to trauma. So we could say, okay, for one disease, what part of that disease is due to trauma? And so for heavy drinking as an adult, over 20% of that disease is caused just by the ACEs, adverse childhood experiences and childhood.

And so that doesn't even account for other traumas beyond the 10 ACEs in childhood or trauma as an adult. Over 30% of lung disease as an adult is caused by the 10 ACEs and 44% of depression. That's, that's just from the 10 ACE categories.

Maggie Kozman: Hmm.

Edward Machtinger: So that Realization is, um, very important to be able to understand why that patient in front of you is presenting with the illnesses they, they are. The second part of it is Recognizing, R, the second-- first one is Realizing the impact of trauma on health. The second is Recognizing the signs of trauma. And those signs of trauma are often

due to PTSD that result from trauma-- post-traumatic stress disorder. People who have had significant trauma, especially repeated trauma as adults or children can have either regular PTSD or complex PTSD as an adult. And the symptoms of that tend to be reactivity, you know, being very reactive to the people and maybe getting very easily annoyed or upset or angry, or being quite the opposite, dissociating and practically being invisible or being very, very anxious or having very disruptive relationships with others. Oftentimes as physicians or clinicians or staff, we respond to those, that reactivity and that anger or that kind of weirdness in how someone's engaging you, very defensively, very personally. We take it personally as if that's because of us, but if we can understand that that is actually a classic PTSD or trauma response, and knowing that the condition they're presenting with, whether it's alcoholism or obesity or lung disease or heart disease, is from trauma, we can then take those two things together and be far more compassionate and patient with them.

And to me, that understanding is so crucial. I don't know how I would survive and practice as a primary care clinician without really understanding the impacts and symptoms of trauma on the patients. Otherwise, patients would be a mystery and I would take things very personally, and frankly, patients are a mystery to most clinicians and they are very reactive to them and that'll get to the final R.

So the third R there, there's Realizes, there's Recognizes, and there's Responds. So it's very important that we as clinicians take that understanding and that recognition and translate that into a trauma-informed approach for our patients that really builds in an understanding of trauma into our clinics policies, into how we engage them from the moment they walk in and to the various services that we offer, some of which can be really improved by understanding and addressing trauma and PTSD while addressing that others, that disease. For instance, a substance use disorder that's been shown to be far more effectively treated if you treat PTSD that goes along with it.

And the last R is to Resist retraumatization. And this is I think probably the most important first step of any clinic or any clinician, any individual trying to be trauma-informed, do no harm. And so we want our patients to come in and feel safe and connected and loved, um, as the basis for them, for them to be able to reveal themselves to us and, um, have us, you know, know truly what's going on in their lives, whether they're taking their medicines or not, whether they're using substances, whether someone's hurting them and the goal of ours should first be to not traumatize them. So when people first come in to the office, if they're really keyed up, or if they're, they seem really agitated, or if they're late, an example would be to not have a policy that we, you know, say, "Hey, you know, you're late, you have to reschedule your appointment" or, you know, just responding in a compassionate and nonjudgmental way such that they feel accepted and loved by us is really the first step of trauma-informed care.

And so the journey of becoming, going from trauma, you know, of trauma-informed care goes from a clinic or a person that is really traumatized. So clinics and people, practitioners can exhibit the same signs of trauma that patients have. You know, they can be reactive and disorganized and fragmented and hierarchical. And individuals in clinics can actually, because they're that way, traumatize patients. And the journey is from being traumatized to being trauma-informed, and then ultimately to be a trauma responsive healing organization.

[22:00] Signs and Symptoms of Trauma in Children

Moira Szilagyi: I so agree with Eddy about what he just said. And I would just like to put a little bit of pediatric spin on recognizing the signs and symptoms of trauma because adults

are able to come in and tell us their own stories, whereas children are not. So that is always filtered through the eyes of a parent who may not even know some of the traumas their children are experiencing. And so as clinicians, when we see certain signs and symptoms in kids, whether those are signs of depression or acting out or trouble sleeping, some of the really common things that walk in our front door, we have to have our trauma-informed lenses on and ask, you have to ask families and we have to ask patients if they're old enough to tell us, and if they're too young, we still have to keep that lens on and make sure that we explore that issue and alert a caregiver that the stress may be an issue here.

[23:15] Dr. Szilagyi's Addition to SAMHSA's 4 R's

Moira Szilagyi: And I must say because I always like to change things a little bit, I've added another R to SAMHSA's R's. And I think my final, my other R is Relationship-based care that promotes Resilience. So I guess that's two R's.

Maggie Kozman: I love that. Can you tell us more about why you add those?

Moira Szilagyi: Just because I think it fits with what they were trying to get at herein recognizing signs and symptoms, understanding the impact and providing trauma-informed care, which is really this relationship-based care that identifies not just what's happened and the bad things going on in people's lives, but then also what their strengths are, because that's what we're going to build on to help them to recover and heal from what has happened in their lives. And so from our parking lots and front doors, all the way through our practices, what is it that makes a patient know that they are welcome here, that we care about them, that we're here to help them. These are important messages and they begin with how someone answers the phone. Right? How do you schedule an appointment? How do people talk to you when you arrive late for an appointment? Are they yelling at you and impatient with you? Or are they just grateful that you were able to get there today?

Maggie Kozman: Definitely. Yeah. Well, thank you both so much. I think you've brought up such important depth to the conversation and you've hit on a lot of concepts. So I just want to summarize, we talked about SAMHSA's three E's of trauma, and then Eddy, you mentioned the 4 R's and Moira added a couple extra R's that I love.

Can you, Moira, share with us what these, what the ACEs are that we're referring to for those who may not be familiar?

[25:15] The ACE Study and ACEs

Moira Szilagyi: Yeah. I think what I'd like to clarify about the ACE study and have everybody walk away understanding is that it was a seminal study, even though it was somewhat flawed in its conception, but it has been repeated over and over again in a whole variety of populations. The CDC has actually been doing national surveys on subsets of states every year, since about 2009. And it was found that the prevalence of ACEs across the general population is still about two thirds of the population having experienced at least one and 16% of the general population of the United States having experienced four or more. And that's an important kind of cutoff number because it is at that dose of ACE in childhood that we start really seeing very poor outcomes in adults. But the important thing about the ACE study is that it looked at things that happened in childhood and not just in childhood, but inside the family, which is supposed to be every child's safe harbor in life. And certainly in the first three to five years of life, it's often where children live and play and learn until they hit the school

system, or if they're fortunate, pre-K. And so the family context is crucial because it is truly where the child's brain develops and their immune system and everything else. And, and so if the family is not safe for the child, if there's abuse or neglect, if there is parental interpersonal conflict or violence, if there's parent's substance use that distracts them from their role as parents, if there is parent mental health problems that are to such a point that they make parenting very challenging, or the parents in and out, there's just a lot of chaos in the home, or a parent is absent from the home.

These things are really stressful for children, and those are the ACEs. There are other traumas that can impact families, but those occur outside the family, or they affect the family. So dire poverty, community violence, discrimination, and racism, but the parents are supposed to be the protectors of children in that case. And I think this is what I saw in my own neighborhood and growing up, and this is why I ended up doing the work I do. The kids in my neighborhood who grew up in safe, stable, and nurturing families did well. The kids in my neighborhood who grew up with parents with mental illness or where there was a lot of hostility toward the child or where there was a lot of substance use did not fare so well. Three of my friends died of suicide by the time I was 18 years old, and that was three of the 10 who had died by that time. And nobody died of a medical illness. And that's my way of saying that 80% of what happens in health, that affects our health, happens outside of what we're doing as a profession, it precedes us or happens around us.

So I think it's just really important that ACEs, like adverse doesn't sound as bad as the word trauma, but these are really traumatizing experiences for children and they affect their entire development, their emotional and mental health. And those are the things that we see earliest in children and ultimately, it leads to changes in their physical health, or can, if we don't intervene.

There's something we can do about it, and what we can do about it is rooted in resilience science, attachment science, evidence-based mental health treatment, brain development. I mean, there's a lot of science that backs up that there are things to do. They're things that we are often doing everyday in pediatric care without having a framework in which we provide that care.

[30:25] Closing Remarks

DJ Gaines: Moira, thanks so much for sharing. And I can say as someone who's trained in internal medicine that I feel like we often forget how much of an impact trauma can have when we are young and in childhood can really affect us as adults.

We have so much great discussion and content here, and we're intentionally dividing this into two episodes for our listeners.

Maggie Kozman: We genuinely appreciate all that you've both already shared about trauma, trauma-informed care, ACEs, resilience, and how we can make sense of all these terms and acronyms so we can build on this foundation with tangible changes we can each make to our practice, which we'll discuss in part two of this trauma-informed care discussion!

Edward Machtinger: Thank you.

Moira Szilagyi: Thank you.

[31:00] Outro

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