Integrating Trauma-Informed Practices into Reproductive Health Services
August 30, 2023

Nicole Nguyen:

Hi, everyone. Good afternoon and thank you for joining us today for our webinar, titled Integrating Trauma-Informed Practices into Reproductive Health Services. We hope you're all doing well and staying safe. My name is Nicole Nguyen. I'm the program manager of the Family Planning Access Care and Treatment Program, or also known as Family PACT, at the California Prevention Training Center. The CAPTC, under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event.

Nicole Nguyen:

So, before we get started with the webinar, let's go over some really quick housekeeping slides for those who are not familiar with the GoToWebinar platform. So first, please check your audio and select your desire setting to either join through your computer audio or to call in through your phone. And if your internet connection is a bit shaky, we highly recommend that you call in through your phone for the best possible sound.

Nicole Nguyen:

And then also, please check that you're able to see the viewer screen with the slides on the left, and the GoToWebinar control panel on the right. Then, there's this orange box with the white arrow, and this is how you can hide or show your control panel if you don't want to see it, or if you accidentally clicked it, this is how you can make it appear again. Right under that is also the audio tab where you can change your audio preference at any time. And then third, please submit all your comments and questions via the questions box. Today's webinar will take about 90 minutes and will include time at the end for the presenter to answer all your questions. So, please send them in throughout the whole webinar and our speaker will address as many of them as possible at the very end. The webinar will be recorded and any responses to questions not answered today will be sent out to the participants later, along with the recording and the slide deck.

Nicole Nguyen:

There is an evaluation at the end, so please fill that out because your feedback is extremely important to us and really helps guide us in developing our future content. And then also, this is how we can track your participation for CME purposes. Then speaking of CMEs, we want to acknowledge that we are working with the University of Nevada Reno School of Medicine to provide CMEs for this event. This webinar qualifies for 1.5 CME credits and is only available to those who watch the entire webinar live today. Those who watch the recording will not be eligible for the CME credits, and the link to access your certificate will be included with a follow-up email along with the recording, slides, and evaluation. And then of course, also for transparency's sake, we wanted to disclose that all presenters, planners, and anyone in a position to control the content of this continuing medical education activity have

indicated that they do not have any financial relationship with commercial entities related to the content of this activity.

Nicole Nguyen:

So now, I get to introduce our wonderful presenter. We are really excited to have Dominika, or Nika Seidman join us today. Nika is an OB/GYN and Associate Professor at San Francisco General Hospital. She co-founded Team Lily, a trauma-informed multidisciplinary care team providing wraparound services to pregnant people affected by homelessness, substance abuse, and significant mental illness in San Francisco. She also provides reproductive health services at the San Francisco County Jail, and her research and clinical care focus on developing and using trauma-informed practices to improve care experiences of individuals facing intersecting barriers to care. So welcome, Nika.

Nicole Nguyen:

Then lastly, before I hand off the mic, I just want to note that while this webinar is sponsored by the Office of Family Planning and the Family PACT Program, the information Nika will be discussing is more focused on integrating trauma-informed practices into reproductive health services for clients who have experienced trauma, and won't dive into specific Family PACT policies or any program benefits like billing or coding. If you have questions regarding those specific administrative things or if you're wondering if your client will qualify for Family PACT services, continue to send those questions in and we'll get them answered in the written Q&A that will be sent out after this webinar ends. So, while we won't be able to answer all those questions live today, we will collect them and get you the answer at a later time. And so, with that, thank you so much for joining us today and welcome, Nika. The mic is yours.

Nika Seidman:

Thank you so much, Nicole, and thank you especially to everyone for joining us today. At least in San Francisco, it's a hot day. I'm going to share my screen. Give me just one second while I do that. Okay. Are you able to see that?

Nicole Nguyen:

Yes, we can see your screen.

Nicole Nguyen:

Go for it.

Nika Seidman:

Okay, great. Hello again everyone and thank you so much to Family PACT and the California PTC for having me today. Thank you especially to Nicole for coordinating this event and working with me on all the technical challenges. I'm really glad to be with you here today to talk about integrating trauma-informed practices into reproductive health services... Give me just a moment as I adjust my screen.

Nika Seidman:

Okay, perfect. So, over the next hour or so we're going to talk about trauma-informed practices and the goal here is to really think through ways that we can implement these practices in our work. I really want to start with my one and only disclosure, which is while I do research, my work in this area is truly as a clinician, and I have learned everything that I know today from my patients and my collaborators who I'll mention in just a moment. And so with that in mind, I really hope to offer these ideas, and then I'm thrilled to think through other ideas that you have or questions or thoughts that you have in the conversation at the end and the discussion at the end because I think that we all really need to work together to think through how to support each other in terms of providing trauma-informed work in our clinics, and also really importantly, taking care of ourselves so that we can continue to sustain this work in the long-term.

Nika Seidman:

So big picture, we will briefly talk about definitions of trauma and triggers just so that we all have a shared understanding of what we are talking about. We'll then briefly go through big picture principles of trauma-informed care. There are many different frameworks to think about. I chose one that I find practical and easy to remember, but just to say there are definitely others that people can refer to. Very importantly, I'll mention that there are a lot of trainings and resources about how to screen for history of trauma. This webinar is not about that: this webinar is really more about once we know someone has a history of trauma, or really more importantly I would argue, using universal precautions in our work in the reproductive healthcare system and setting because we know that reproductive healthcare traumas are so common that when we use those universal precautions, AKA assuming that everyone has some form of experience that may or may have been traumatic to them in the past, we can use these principles universally. And so again, the goal is to really offer some concrete practices that we can use every day.

Nika Seidman:

One key part of that, as I mentioned, is taking care of ourselves and our teams as I mentioned. So, I'll talk about some ideas for that and then at the end I'll talk a little bit about where I hope we can go in the future. A full disclosure, again, I think we have so much work to do in this area, so these are really ideas, and I look forward to the conversations afterwards to think more about what you're thinking about as where we need to head.

Nika Seidman:

So, I inverted my slides a little bit to put my acknowledgements at the beginning because of just what I said. I really consider myself a learner still in this area. And with that, I really wanted to acknowledge my teachers. First and foremost, on the upper right-hand side of your screen is Dr. Rachel Logan. She is a qualitative researcher who I have developed with Ms. Leisha McKinley-Beach, who's right next to her on trauma-informed practices, some of which those concepts are integrated in our talk today. Rachel is an incredible qualitative researcher trying to understand how we can better provide reproductive health services to black women, and Leisha is an HIV activist who has been working in the field of HIV care and prevention for many decades, specifically with a trauma-informed lens thinking about how we can provide those services in public health departments.

Nika Seidman:

Over the rest of your screen, you'll see a variety of clinicians, community-based organizations, organizers, and most importantly, patients. I just wanted to highlight a couple of those groups: public health nurses in our community in San Francisco, specifically street-based public health nurses do tremendous trauma-informed work, and I've learned so much from their work. The midwives you'll see on the bottom right have been practicing trauma-informed care for decades and even centuries, and we have so much to learn from them. The Women's Option Center on the bottom left provides the most trauma-informed abortion services you'll ever see, including trauma-informed counseling, and I've learned so much from the counselors, nurses, and providers there. And then finally on the top left, you'll see some clinicians from the Jail Health Services who also provide incredibly trauma-informed care in a setting that is absolutely set up to be the opposite of trauma-informed. And so, their ability to transform the [inaudible 00:09:58] clinics truly is remarkable.

Nika Seidman:

Lastly, I wanted to appreciate the patients with whom I work. I'm really lucky to work with Team Lily, as Nicole mentioned. Team Lily is a multidisciplinary care team based in San Francisco. We work with social workers, navigators, mental health providers, OB providers, substance use providers to provide low-barrier reproductive health services to people experiencing homelessness, with substance use disorders, and significant mental illness. That's where I provide the majority of my clinical care. And our patients are so brave to come into our services. And at the end of working with our team, we do exit interviews with people, and they give us feedback, and so many of the strategies that I'm offering in this talk today come from patients who have told us how we can do a better job at welcoming them and supporting them in their care.

Nika Seidman:

So, with that, we'll move on to content. And first and foremost, we're going to start with definitions... Excuse me, as I take a sip of water as it's hot in San Francisco today. So, to make sure that we are all on the same page about definitions, what is trauma? I like this definition because I think it's quite clear: trauma results from an event or series of events or set of circumstances that is experienced by an individual as physical or emotionally harmful. It has lasting adverse effects on the individual's functioning, mental, physical, social, and emotional or spiritual wellbeing. The reason I like this definition is because it reminds us that two different people could experience the same event and one could experience it as trauma and somebody else. So, it's a really personal definition, which is really important to remember. So, it's not like somebody who witnessed one event necessarily has experienced a trauma. It's really if that event is experienced by them as traumatic and has lasting adverse effects.

Nika Seidman:

The other piece that I think is important about the definition of trauma is by definition, the trauma will overwhelm our coping capacities. And I really apologize if there's anybody who's studied neurobiology who is listening today, but I did want to just pause and say that there is a tremendous amount of incredibly important work demonstrating that there is biology to the response to trauma that we are trying to overcome. And I like this picture again because it's simple and reminds me of what is happening in people's brains when they are triggered remembering a past traumatic event. So looking at this slide, big picture: when we experience an event or when we experience something that reminds us

of an event, our brain can connect to our prefrontal cortex, which allows us to think and process and evaluate and plan and make a decision about how we are going to act or it can connect to the part of our brain that turns us into our fight or flight mode.

Nika Seidman:

That's the place where our memories are stored, and it controls our emotions. Big picture: in people who've experienced trauma, that relationship of our brain and our memory to the area of flight or flight, that overwhelming sense of both physical and emotional response is really strong, and the connection to our abilities to pause, to think, to logically consider what is happening and then decide how we're going to respond is significantly weakened. And so, what does that look like? In the clinical setting, we have all experienced this, a patient or even we have maybe experienced it ourselves, have experienced a trigger.

Nika Seidman:

I really love this image, which I borrowed from Dr. Lauren McAfee because I feel like it really speaks to me about what happens in a trigger. So this person said, "One tiny little stupid thing, a song, a smell, somebody tapping me on the shoulder, or even an unexpected hug, that's the trigger and I'm a disaster for the rest of the day," so what happens in triggers is that something sets off that connection to the fight or flight response that completely overwhelms our coping capacities and we become dysregulated. It triggers this stress response that has both emotional and physical changes, and for many people, that experience can affect the entire day, not just that one moment.

Nika Seidman:

Okay, so now that we've talked about big picture, what are definitions of trauma and what is a trigger, I wanted to remind us of all that I think we know that there are multiple different types of traumas. I was taught in medical school about trauma as really focusing on the individual level trauma. For example, intimate partner violence or adverse childhood experiences, for example, living in a home where a parent had mental illness or had substance use disorder. And I think our understandings of trauma have really grown over time to recognize that there are many other types of traumas that are equally, if not more important. On this slide, I wanted to highlight a couple: first and foremost, we know that there are experiences of interpersonal collective and structural traumas. Specifically, racism is a critical piece of a structural or collective trauma that people have experienced and bring into their healthcare visits every day. Very specifically in the healthcare system, people have experienced trauma at the hands of the healthcare system in the setting of discrimination. As an example, I take care of a lot of patients who have substance use disorders, who have been mistreated, coming into emergency rooms, having their concerns pushed aside, being told to wait a long time. Those types of experiences, either whether it's held by themself or their peers that they've heard about, they bring that into their future visits, and the healthcare setting becomes a trigger for them.

Nika Seidman:

I also wanted to highlight some common reproductive healthcare triggers or traumas that we know, and more and more data about these, particularly through qualitative research, have been coming out. So, for example, examples of birth trauma: not being listened to during people's labor and delivery experiences, having child protective services remove people's babies at birth, having people experience reproductive coercion, having contraceptive providers force a contraceptive on someone or declining

someone have their IUD or their implant, long-acting reversible contraceptive removed. All of those different types of experiences can also be experienced as a reproductive trauma, and certainly people bring those into their sexual and reproductive healthcare visits.

Nika Seidman:

I highlight those because I do think that while everyone in healthcare is working in an intersection or in a place where trauma is at play, I do think that we as providers in the reproductive healthcare setting in particular see a lot of these types of experiences of trauma and people are consequently triggered. And a lot of that is because of the history of the healthcare system that has so actively participated in discriminatory practices around who has the right to give birth, who do we think should not give birth, who do we think should not be a parent. All of those concepts of reproductive justice are very wrapped into people's experiences of trauma in the reproductive healthcare setting.

Nika Seidman:

Okay, so as we've talked about healthcare experiences in the past, either individual experiences that people have held or people's communities have experienced and people have heard about, people bring those into our healthcare clinics, and so because of that, medical settings can absolutely be a trigger. So, I wanted to give some examples of those. Physical triggers: touch, removal of clothing, invasive procedures or tests, vulnerable positions, putting people's feet in footrests, closed spaces, the definition of every clinical space. As well as and in addition to, we have lots of emotional triggers. For example, just personal and invasive questions. I've had patients say that even questions that seem as benign as about their housing can feel extremely emotionally triggering. People's power dynamics or loss of control is absolutely a trigger, loss of privacy, coercive or stigmatizing language or discriminatory language, and finally, lack of choice: all of these apply to every healthcare visit and particularly to reproductive and sexual healthcare visits and make these clinical environments ripe for triggering spaces.

Nika Seidman:

And so, how can we respond? The point of this is to not belabor what we already know and experience in clinics every day, but how we can try and change our spaces to help people feel safe and comfortable and create a trauma-informed environment. First and foremost, as I said for this talk, I'm really going to focus on the concept of using universal precautions. So, as we all remember from the world of HIV, we were taught about universal precautions: we always wear gloves for every patient when we're drawing blood, as an example. Similarly, we can use universal precautions in terms of trauma, and we can assume that every patient that we care for has had some possible history of trauma. And so, we want to use if trauma-informed practices with everybody, again, with that acknowledgement that reproductive healthcare settings might be particularly triggering.

Nika Seidman:

What does that look like? We're going to go into detail about the concepts of trauma-informed care, but big picture, I love the overarching reframing of whereas historically when someone comes into care, they've missed all their visits, they haven't been there for their follow-up care, we as a healthcare system say, "Where have you been?" The reframe in a trauma-informed practice is to say, "Welcome back. We are so glad that you made it here and we're ready and able to listen to you and care for you today." Again, we'll go into what those practices mean and look like specifically, but that's the overarching theme. And finally, our goal is to have a trauma-informed system. We recognize that so

many of the things that we might talk about today are confined to the clinical space in the clinical room, and yet people interpret and can be triggered at every single step in terms of their encounter with the healthcare system. And that starts with walking in the door.

Nika Seidman:

So, for example, when I walk into my clinical space, first you have to walk through someone who's going to hand you a mask. Then you'll check in at a counter. Someone's going to ask you about your insurance, your appointment time. Someone's going to direct you into the elevator, you're going to go up to your clinic floor, you're going to check in, you're going to be in a waiting area. There are people who will check your blood pressure, who will draw your blood, who will room you into a clinical room. There are opportunities for triggering events or trauma-informed practice at every single one of those. Just as an example, when someone is coming in and is 14 minutes late, instead of saying, "Where have you been?", we can say, "We're so glad you made it."

Nika Seidman:

When someone is getting their blood drawn for a phlebotomy and they have scars all over their arms, instead of saying, "Wow, it looks like you have a lot of track marks," you can say, "Oh, let me make sure that I do the best job possible. In terms of your drawing your blood, do you have any advice on where it's been the best to draw your blood in the past?" There are so many different reframes that we can do, and today we're going to focus on mostly frames and practices that can be practiced on behalf of the clinician or provider. And just to say, these practices need to be practiced from the very moment someone walks on campus to the moment that somebody leaves.

Nika Seidman:

If you don't believe that trauma-informed practice is the right thing to do just as a component of person-centered care, I can also offer that we know based on data that trauma-informed care can contribute to improving patient engagement and the likelihood that people will come back into your care. There's some data that suggests it's associated with treatment adherence and can overall improve health outcomes. Of course, these studies are hard to conduct, but big picture, there is research behind these practices that are related to concrete health outcomes.

Nika Seidman:

So, moving on to specifically what are the components of trauma-informed care? And just as a reminder as I said before, this is one framework, but there are other ones that are just as good. I just like this one because it's relatively simple and easy to go through. So first and foremost, in a trauma-informed care system or practice, some of the key principles include first and foremost, safety: making sure that people are safe in their physical and emotional environment. And just to say, we'll go through these in a moment in more detail about concrete steps of ways that we can make our clinical spaces safe. But these, again, are the main principles or tenets.

Nika Seidman:

Second of all, choice: making sure that individuals have choice and control at every single step in their healthcare experience. Collaboration: making sure that we and especially as providers, share power with our patients and recognize their expertise in their experience, their abilities, their values, and their

goals. This is important in every area of medicine and in particular in reproductive healthcare, and the place where I think you all have had a Family PACT webinar on shared decision-making. Shared decision-making is really the heart of that collaboration in many ways in the sexual and reproductive healthcare visit, and a beautiful way to uplift principles of trauma-informed care.

Nika Seidman:

Fourth, trustworthiness: making sure that we are clear, that we are consistent and that we have boundaries, and we'll go through what some of those practices can look like in a couple of minutes. And then finally, empowerment, which is a name I don't love: I think that this is much more about providing person-centered care, about listening to people, about respecting their expertise and making sure that they are making the final decision, based on information and expertise from the healthcare provider. But again, we'll talk about that more in depth in a moment.

Nika Seidman:

Okay, so again, we've gone from the theoretical. Now, we're going to home in on the practical and think through, what are ways to practice trauma-informed care in our clinical spaces? So first of all, we talked about safety. What might a trauma-informed encounter look like? Well, first of all, we want to think about our physical space and making sure that our space is safe and respectful. That could look like things like what is on the walls in our waiting room? Is there information or pictures that are stigmatizing or discriminatory? Also, making sure that the things on the walls are welcoming to everyone who might come into our clinic. For example, if someone is transgender or non-binary, making sure that the images reflect our patient population and make everyone feel welcome.

Nika Seidman:

In terms of that there are clinic rooms, really importantly and very concretely, we want to make sure that we give patients power and control whenever is possible. One simple way to do that is to not just knock on the door, but to knock on the door and then wait for a response. I know at least in our clinics, we've gotten very good at knocking, but we often just knock and barge right-

Nika Seidman:

Our clinics, we've gotten very good at knocking, but we often just knock and barge right in. So that pause and waiting is a sign of respect and giving the patient control and the ability to say, wait a second, or come on in.

Nika Seidman:

Recognizing that we want to start when she or the patient or they are ready and taking a break if needed. Again, asking permission whenever we can, and finally, meeting the patient with their clothes on. These are all principles that many of us learned in training, but again, we forget in our systems that are so focused on efficiency, and we lose sight of these, but we really importantly want to listen, not interrupt, and be fully present.

Nika Seidman:

In so many of our clinic rooms, for example, there's a computer screen that sits between us and the patient or we're asked to turn away and type over here while talking to our patient. As much as we can trying to be fully present during our clinical visit can signal to people that this is a safe environment where they are respected, and they have our full attention. Paying attention to nonverbal cues, especially if we think that that might be the start of a trigger, can be really helpful in terms of our recognizing it and apologizing it and apologizing about it and then trying to help people through that trigger early on can be incredibly important.

Nika Seidman:

Unlike what I'm doing right now, we should slow down our speech. As somebody from Boston, this is really hard for me, but I am working on it as I will continue to work on in this webinar. But slowing down our speech, making sure people know that we have time for them and their visit, and being patient to hear what they have to say again, is a way to build safety in our clinical settings.

Nika Seidman:

And then finally, this last one I think is incredibly hard in our systems where we are asked to complete so many check boxes. And I've heard in qualitative research and just in one-on-ones with my patients very frequently how important it is to avoid invasive questions, especially if they don't serve a purpose. As an example, if somebody is coming in and they are coming in about their implant removal, and that is the only reason they're there, they're very focused on that, you can screen for intimate partner violence at that time if you have a robust way to respond and offer resources. And what I've heard from my patients is that if you are going to just screen and not do anything with that information, that is harmful and that is triggering. So, consider trying to restructure your questioning to a way that only asks the questions that you are able to do something or act on the information as opposed to just clicking a box.

Nika Seidman:

Again, I recognize we all work in systems that require us to do certain things, but I think it's an incredibly useful practice to work through as our clinics and think through where are the places that we're asking these questions, is this the right place to do it, and cut out the places where it's not. One piece of creating a safe environment is thinking about the words that we use. Some of you may have seen this slide in the past. This is a slide that I developed with one of my colleagues. And there are so many additions we could add to it but recognizing that the language that we use reflects our respect for individuals and creating a safe clinical space.

Nika Seidman:

Some of the words ... and I really have worked on trying to mirror the language that my patients use and also ask people, how does this word sound to you? But some of the words that our patients have specifically said feel offensive are things like, for example, with substance use disorder, calling someone an addict, an abuser, a junkie, or a user. Trying to use person-first language recognizes that a person is first. So, they are a person first who may have a substance use disorder, who may have an addiction.

Nika Seidman:

Referring to somebody as clean or dirty in terms of their substance use. People are not clean or dirty. People either have a substance in their body or they're not. Similarly, when we talk about urine that has drugs in it, the urine is also not clean or dirty. The urine either has a substance in it or not. As I said, I work with a lot of people with substance use disorders and they're very clear that the drug that they are using is no longer a drug of choice. It is a drug that they are using, and many of them wish they were not using it. So, it is not a choice. That is part of the definition of a substance use disorder. It's a substance that they're using at that time.

Nika Seidman:

Similarly, again, when using person-centered language, we can start with saying the person who's experiencing homelessness as opposed to a homeless person. Some people prefer the term houselessness. Big picture. In all of our settings, we really want to think about our language, try to reflect the language that our patients use and really listen to our advocates who are amazing, I think interpreters between people with lived experiences and us as clinicians and use their guidance around what words are the most person-centered and supportive, and respectful.

Nika Seidman:

Okay, so that was a lot to talk about how to make our clinical environments feel safe. And the second principle is thinking about choice in trauma-informed encounters, we really want to make sure that individuals or patients or clients have choice or control in their decision-making. And what does that look like? The way that I think about that is that anytime in our clinical environment that I think we have only one option to offer the patient, I think to myself, and we think as a team, are we really thinking creatively enough in this moment to take care of this patient? Is there any other option that we can consider? And I'd say 99% of the time, we can always think of another option, giving the patient or the client the option to make a choice. That is critical to trauma-informed practice, providing options so that a user or a client can make a choice. And as we then help people in making that decision, sorry about that, we can use that practice of shared decision-making.

Nika Seidman:

I wanted to pause for a second and throughout the rest of this talk, I'm sprinkled in some work from a study I worked on with Dr. Christina Schmidt and Erin Wingo. This is a study that we worked on in San Francisco doing qualitative interviews and surveys and focus groups with people experiencing homelessness who had a history of being pregnant while homeless or with substance use disorders in the setting of experiencing homelessness in pregnancy.

Nika Seidman:

And we asked people, what messages would you like to pass on to healthcare providers about working with women experiencing homelessness? And I love this quote that somebody replied. She said, "Don't try and push anything. If someone doesn't agree (and you push it), they will completely shut down about anything you have to say afterwards." So first and foremost, why did I put that in the section on choice? If we are only offering someone one option that's pushing it and we are risking their shutting down. So first and foremost, we have to create choice so that someone can be able to make a decision about what's right for them.

Nika Seidman:

And then the second piece about this quote that I really love is it's just such a good example of in real life, what being triggered can look like, that shutting down, that disengaging from the clinical visit, that is a really good example of being triggered and increases the likelihood that someone's not going to come back to our care. So, I wanted to pause for a second because I think these concepts in theory sound amazing and in practice are really, really hard. So, I wanted to go through a couple of scenarios for us to just think to ourselves, what does it really mean to provide choice in these settings?

Nika Seidman:

So as, again, I work a lot with people experiencing homelessness and people with substance use disorders and with significant mental illness. So that's where these come from. But I think many of us on this webinar have been in many of these different scenarios. So first of all, I just wanted to think for yourself. Imagine you are in clinic and a woman who is unsheltered comes in, she has psychosis, she's sexually active, she states that she doesn't want to be pregnant and that no contraception works for her.

Nika Seidman:

Another scenario is that how do you feel if a woman comes in who's actively injecting fentanyl regularly in the community, she states she doesn't want to get pregnant and she also declines treatment for her opioid use disorder? And then finally, how do you feel about a woman who drops into your clinic, she has a positive pregnancy test. She also has a positive syphilis test and she declined syphilis treatment that day because she feels like her top priority is to go and find her partner?

Nika Seidman:

I have to be honest with you, I think in every single one of these scenarios, I have a strong emotional response and feeling about what is the right answer and the right decision for this patient. And I wouldn't be honest with you if I didn't admit that. And the reason I put this slide up is because I wanted to remind each of us that our patients feel our emotional responses. Our patients feel our wanting them to use contraception, our wanting them to use treatment for their opioid use disorder, our wanting them, and disappointment when our patients don't accept their syphilis treatment in pregnancy because we have been drilled into us that we need to prevent congenital syphilis.

Nika Seidman:

This work is incredibly hard and providing those choices in a way that is true choice that doesn't reflect our inner priorities and goals is incredibly hard and may even be impossible. And I want to acknowledge that and to say that we're not trying to be superhuman. What we're trying to do is to be our best and how can we do that, how can we provide trauma-informed care while also being true to ourselves about what our biases and goals are, I think is kind of the essence of trauma-informed practice.

Nika Seidman:

And so, what can we do in those settings when we have those emotions bubbling up inside us? First and foremost, there are a gazillion different things you can do, but first and foremost, you can pause, which is what I'm going to ask all of us to do right now as well. You can take a deep breath, you can get a glass

of water, you can step out of the room, you can go and talk to a colleague for a second about strategizing, about how to best care for this patient. And then you can go back into the room and be ready to listen to the patient uplift their goals and priorities, make sure you are sharing the clinical information that you have that may inform their choice, and then respect their decision.

Nika Seidman:

And again, when we share our clinical knowledge and expertise, we are going to be sharing what ... and oftentimes we're going to be making a recommendation when a recommendation is needed. And if our recommendation is founded in biases around who should have a baby or who shouldn't, who should use a certain type of contraception or who shouldn't, those are the places where that pause can really help us reflect, and we can make sure that the recommendation we are making is really about clinical outcomes and not based on, again, our biases around who should be controlling their reproduction and who shouldn't.

Nika Seidman:

So I'd be happy to talk more about that in the discussion section at the end, but I did want to kind of bring in that concept and recognize how hard this type of work is and recognize that we also may be triggered in these encounters, particularly if we've seen bad outcomes happen to people who made decisions that we didn't necessarily agree with, and we may be trying to prevent those in the future, but again, we need to kind of process these in our own and then come back to this space as calmly and as clearly as we can and try to listen to the patient and uplift their values and goals to come to the decision that's right for them.

Nika Seidman:

So, with that, I'm going to take a glass of water. And we'll move on to the next pillar of trauma-informed care, which includes collaboration. This one again is really uplifting the concept of shared decision in many scenarios, but more broadly, what we're trying to do using the concept of collaboration is acknowledging that the patient is the expert in their own body, their past experiences, their current situation, and one way to do that, it's not just about when people are making decisions, but about how to make this visit this clinical encounter together better for them.

Nika Seidman:

So just as an example, before doing a speculum exam or a bi-manual exam or even an implant removal, I'll ask patients or clients, what can I do to make this experience better for you? Sometimes people have ideas, sometimes they won't. Sometimes I'll also offer the alternative. I'll say, you've mentioned that you had a bad experience in the past. Can we try and think through what didn't go well for you so we can try and avoid that this time? If people don't have ideas or it's a first-time experience, I'll offer ideas that worked for other patients. For example, do you want to listen to music? Do you want to know each and everything that I'm doing, or is that too much information for you? Do you want someone in the room with you while we go through this exam? Trying again to provide options and collaborating with the patient to recognize they're the expertise in terms of making this experience work for them.

Nika Seidman:

Second is a very basic principle of making sure we're asking questions rather than making commands, asking people when you're ready, would you, may I please begin the exam rather than put your feet up we're starting now. Finally, it's really important with collaboration to acknowledge and validate people's priorities and concerns. Even if we think, for example, that the history that they're providing perhaps doesn't make as much clinical sense as we might think, we still want to validate that experience and say, thank you so much for sharing that with me. I understand and I hear how that could affect your decision-making today.

Nika Seidman:

Okay, I put up this image because again, in theory, the idea of collaboration is wonderful, and yet in practice, so much of what happens is this experience of the provider who has their agenda that might include labs or vaccines, how many other patients are waiting for you and the patient or the client who might have their priorities or concerns, which might include, where am I going to sleep tonight? I hope my stuff is still where I left it, I need to charge my phone and I have a court date. It's going to be horrible. How do we kind of bring these two spheres together in order to collaborate?

Nika Seidman:

It is incredibly challenging, and I think one of the ways to do that is quite simple. Again, uplifting one of the respondents to the study I mentioned earlier. We asked patients, or excuse me, we asked participants, what message would you like to pass on to healthcare providers about working with women experiencing homelessness? And the respondent responded, "Housing is real and it's hard. That is the biggest thing for everybody out here- to be homeless." Now, again, I'm not talking just about people experiencing homelessness, but the point here that this person is making is that if someone tells you that their main priority right now is housing, if someone tells you that housing is what is affecting their contraceptive decision-making, their decision around their substance use, their decision around their testing for STIs, we have to hear that, and our job is to listen to that and prioritize that and integrate that into our counseling.

Nika Seidman:

So, what might that look like? As an example, if someone is ... even if we're not a social worker and we're not able to connect someone to housing resources that day, we can think about how people's housing status or their access to a phone, for example, might affect their ability to receive their results. So first and foremost, we can be creative in the types of ways that we can offer a person ways to do outreach to them. Yes, we can get their cell phone. We can also ask for the number of their friends or family members. We can ask for their email. At least in San Francisco, so many people have email addresses that they use regularly, and they're very open to hearing about results via email. We can find out if there is a community organization where they go to frequently that we can call and reach them there.

Nika Seidman:

We can find out if there is an intersection where their tent is, where a street-based community organization might be willing to come and help us. Big picture, we can be creative and try to address how housing or whatever their main priority is addressing or is affecting their sexual and reproductive

health concerns that day. Second of all, as I said, it is so important for us to collaborate with community partners who are way farther ahead than we are in terms of providing trauma-informed services, asking people if they're already working with community-based organizations than contacting people at the organization and asking, Hey, would it be okay if I can't reach this person to reach out to you? Look, they've given me your permission. It takes extra work on our side, and it is one of the best ways to first of all, provide our patient with better care, but second of all, to build relationships with organizations who are doing tremendously important work that affects all of the sexual and reproductive health outcomes that we're working on in a very confined clinical space.

Nika Seidman:

These are some examples in San Francisco that I work with frequently, the Homeless Outreach Team, the Homeless Youth Alliance, Public Health Nursing. There are so many that are so localized to your setting and doing the work of finding out who those organizations are and finding a contact at them can be incredibly important in doing this work. One of the last tenets of trauma-informed practice is trustworthiness. This is rather self-explanatory and cannot be underemphasized how important it is. What does trustworthiness look like? First and foremost, I hear from patients all the time how important it is to be consistent. What does that mean? It means trying throughout our clinic to provide consistent messaging about what are options and what is kind of the counseling and messaging.

Nika Seidman:

Really importantly, I think a lot of us have a tendency to make a promise that we can't keep, and that breaks people's trust. So, for example, if you say that, oh, if you come in for your gonorrhea treatment today by five o'clock, and they come in at 4:59 and the front desk is closed, we've broken their trust. And so really trying to make sure that we uphold the promises that we keep.

Nika Seidman:

Finally, maintaining boundaries. I think this is more in the form of thinking about how we need to remain professional in our work, not working outside of our scope of work, telling people when we're available, when we're not available. I think that happens less in sexual and reproductive healthcare settings, but sometimes more in the pregnancy care setting, but making sure that we are ... again, part of consistency is being consistent across the system of maintaining professional boundaries, and so that people can have a clear expectation of the services they'll receive, whichever provider that they're working with.

Nika Seidman:

The last key concept is the concept that this framework uses for empowerment. Again, I don't love that word because I don't think we empower people. Really, what I think this is more about is providing person-centered care, making sure that we are uplifting and respecting the decisions that individuals make. Another way to put that is making sure that individuals feel validated and affirmed at each and every contact. So how can we do that in a practical way? First and foremost, we can use affirming language. If you can't think of anything positive to say, at the very least you can say, I'm so glad you're here. That is always true. For so many patients, making it in the door is a huge accomplishment, and being able to recognize that is incredibly affirming.

Nika Seidman:

In addition, we want to recognize people's strengths and resiliency. Recognizing if someone makes it through an exam that they were really worried about, that is a huge success. Finally, and I think this is the piece that I think we, again, it kind of intersects with some of those prior ideas we've talked about, but making sure that we continue to recognize and affirm the patient or the client as the expert in their experiences, their abilities and values. And if someone says, for example, I can't do this, respecting that they know they can't and that they won't, and so we need to come up with a different plan.

Nika Seidman:

Again, this is another pause moment. Mary Howe is the founder of the Homeless Youth Alliance, which is an incredible organization in San Francisco working with youth who are experiencing homelessness. And Mary has lived experience herself. She wrote this incredible manifesto to providers about how to work with youth experiencing homelessness. And I wanted to read this because I think this is really the essence of what this whole concept of "empowerment" is about. So, Mary wrote, "While we would all love to receive instant respect and gratitude, and by the we here are providers, we aren't going to get it. And the sooner we accept that, the easier and more fulfilling our work will be. The youth we encounter don't owe us anything for working with them. While they appreciate our presence and willingness, they are here because they need something. These youth are incredibly tough, resilient, and more often than not, resistant to traditional forms of care. They are seeing us as a last resort because they can't fix the problem themselves. You will need to be accepting, humble, consistent, and patient to earn their trust. Nobody saves anybody else. People save themselves. Dignity and self-worth are not things we are going to give them. Self-esteem is a result of their own skills and resilience. By treating them with respect and dignity, it helps create opportunities for those qualities to grow."

Nika Seidman:

So, I just add this quote here because first of all, Mary is writing this manifesto directly to us, to healthcare providers. And I just think there's so much wisdom packed in here. But first and foremost, it just shows that again, we are not empowering people. What we are doing is we are providing the dignity and respect that each individual deserves, and supporting people to fix the problems themselves because they are, at the end of the day, the people who will be doing the work of actually moving forward, of taking the medication, of accepting the intervention. And we need to respect and value that. And I think Mary says it better than anybody else.

Nika Seidman:

So I wanted to take a step back again, because again, in the reproductive healthcare setting and in the setting of contraceptive counseling, we talk about shared decision-making all the time, and I think shared decision-making is such a critical part of trauma-informed care that I wanted to pause for a second and talk a little bit about one way that I think about shared decision making and how that interacts with concepts of trauma-informed care.

Nika Seidman:

So, there are lots of different ways to think about shared decision-making, but the one way that I was taught and appreciate from my mentor, Dr. Christine [inaudible 00:53:23], was to first and foremost think about building rapport and trust in a clinical environment to then elicit someone's preferences. For

example, if you're using shared decision-making, usually, someone's making a decision about, for example, what contraceptive they're going to use that day. So, finding out about how do they feel about the bleeding profile, or how do they feel about the way of taking the method? Is it a patch? Is it a ring? Do they want to take a pill? Do they want an injection? We're then going to offer our medical expertise, offering detail to inform their decision-making. We're going to facilitate a method selection, and then we're going to make sure that people know that they can come back ...

Nika Seidman:

... and then we're going to make sure that people know that they can come back anytime to that decision. We can make a follow-up plan, and something isn't going as planned.

Nika Seidman:

So, what does that look like in the context of trauma-informed care? Well, really, these same principles map really beautifully onto shared decision-making. So, when we are building rapport and trust, what we are really doing is building that trustworthiness and making that safe clinical environment. When we elicit people's preferences, when we respect people as the experts in their own lived experiences, priorities, and goals, and then when we offer enough information to inform decision-making, we are collaborating. We are providing choices and we are then listening to and trusting someone to make the decision that is right for them or that empowerment piece.

Nika Seidman:

So big picture, shared decision-making is a key part of trauma-informed care. And I would say in the context of trauma-informed care, one of the most important parts of shared decision-making is that focus on building rapport and trust. If we don't have that, if we don't create a safe clinical environment, we really can't go through any of the other steps of shared decision-making. So, trauma-informed care really highlights the importance of creating that groundwork first and foremost.

Nika Seidman:

I think the other piece I would add is that so often shared decision-making is applied to making a decision about an intervention, but it can also be used around making a decision about an agenda for your clinical visit. Again, when we think back to that image of the provider who has one agenda and the patient or client who has another, we can use these same tools to think through a shared agenda to move forward in the clinical visit that day.

Nika Seidman:

So, the last part of this talk is I wanted to move on to even when we try our best, when we do our best trauma-informed work, triggers still happen. It happens to everybody, and we want to have tools to be able to respond to them.

Nika Seidman:

So, what can that look like? First and foremost, if someone is triggered, we want to reassure them and normalize that their response is a normal response. They are responding appropriately to an anxiety-producing event.

Nika Seidman:

We want to use a calm and matter-of-fact voice, again, speaking slowly, which I am really challenged by, but I'm working on. We want to avoid sudden movements. We want to explain what we're doing and pause, and explain if we need to do something else, to explain why first, and pausing and waiting if they ask us to wait. Or if we say we're going to wait... Again, this is part of our trustworthiness and accountability. If we say we'll wait for them to tell us when to go again or to start again, we will actually do that.

Nika Seidman:

And then lastly, one of the most useful strategies I've found is trying to use a strategy to bring someone back to the moment. So, offering people a glass of water, taking a breath together, asking someone if they want to walk out of the clinic room, go for a walk around the clinic or down the hall or even outside. All of these can help people come back to that moment.

Nika Seidman:

The flip side is that it is, again, quite hard to do that. And very frequently when we are at the end of our day, when we're thinking about our kids at home or our partner or our leaking roof or how our car didn't start this morning, it is very easy to respond to someone who's triggered by being triggered back and yelling back. So, in this next couple minutes, I wanted to talk a little bit more about how we can train ourselves and encourage ourselves to take a deep breath and respond to people who are triggered in a trauma-informed way.

Nika Seidman:

The key part of that, I think, is taking care of ourselves and taking care of our teams. There are so many different ways to think about this, and I did a training with Dr. Rachel Logan and Leisha McKinley-Beach in Florida, and these are some of the very practical, small, tangible ways that people talked about taking care of themselves and each other in a busy clinical environment.

Nika Seidman:

People talked about taking a walk, again a drink of water. We are very similar to our patients and clients and can respond to a trigger in the same way. We can breathe. The other piece a lot of people talked about was lotion. Having a smell that feels calming or different or bringing us back to the moment. Using stress balls, turning on some music, getting something to eat, checking in with a colleague. I'd love for you to think to yourselves kind of what other strategies you use that are very concrete ways that you can take care of yourself and your team at work, and maybe in the discussion, we can throw out other ideas.

Nika Seidman:

And again, those are really small actions in the setting of what we know is a much larger and more complicated problem. We know that trauma and triggers in the healthcare setting are certainly not limited to patients. In addition, we are in a moment in history where we all just lived through a pandemic. We are all burnt out and tired and juggling more things than we have in our entire lives. Each of us bring our own experiences, and those experiences shape the way that we encounter our work

every day and our interactions with patients. So, lotion or a walk or water is not going to fix any of those, and these concepts of self-care require short and long-term attention.

Nika Seidman:

The other piece is that this is not something that somebody can take on their own. If I, as an individual, Nika, an OBGYN in this massive San Francisco Department of Public Health in our public hospital, decide that, "I'm going to go on a mission to take care of myself," I'm fighting against all of these different bureaucracies that are saying, "Don't do that," based on my clinical schedule, based on my work responsibilities, based on all of the different pieces that make departments of public health, hospitals, clinical environments the busy places they are.

Nika Seidman:

So, I am not trying to say that any of us can transform our clinical environments on our own. What I wanted to really suggest is that we can take these short-term measures, and, over time, we really need to think and brainstorm together about how to transform our clinical environments and our structures of care to support each of us in new ways. I have to admit, I don't have the answers. It's not an admission. I don't have answers to those pieces, but I recognize that we need a structural solution to a structural problem. And many others have recognized that as well.

Nika Seidman:

I wanted to highlight the organization Trauma Transformed, which is a great community organization in the Bay Area that works on concepts and trainings related to trauma-informed care. They really focus on how to transform our organizations, recognizing again that these trauma-inducing workplaces require structural solutions. I love this slide because I think, again, it provides a critical visual to what many of us are experiencing.

Nika Seidman:

So many of us work in organizations that are trauma-organized. These organizations are reactive. These organizations involve a lot of reliving or retelling traumas that continue to kind of focus on traumas and triggers and triggering and trauma just keep happening. That results in people being avoidant and numb. It fragments us. It creates an environment of us versus them. It leads to inequities, and it leads to authoritarian leadership.

Nika Seidman:

The goal is to move more in the direction of a trauma-informed organization. What might that look like? It's a place where the understanding of the nature and the impact of trauma in recovery is shared. And doing a training like this is one of the first steps in terms of moving an organization towards a trauma-informed place. We develop a shared language so that we can talk to our colleagues about what is happening, what we're seeing and feeling and experiencing so that we can begin to be able to say something like, "Hey, I need a break right now. I need to go get a glass of water, because this environment, the way I'm going to respond is not okay."

Nika Seidman:

In addition, in those trauma-informed places, we can recognize the sociocultural trauma and structural oppressions that have existed. And I think one of the critical pieces for us as healthcare providers in healthcare systems to do is to recognize how much trauma we have inflicted on so many different types of patients. Very specifically, forms of medical racism, forms of discrimination against people with substance use disorders, with significant mental illness, with homelessness, how we've excluded those patients from our care, provided them with unequal or pressured care or coercive care. When we recognize those pieces, we can begin to think about how we can make amends and respond appropriately and recognize why our patients are coming into our care and are so triggered.

Nika Seidman:

The dream is to move towards this image on the far right, which is a healing organization. In that organization, its reflective, meaning is made out of the past, we kind of understand our roles and what has happened and kind of move towards a shared future. We're growth and prevention-oriented, we're collaborative, there is equity and accountability across our care, and leadership is relational. Full disclosure, I have never worked in an organization like that, and I would love to hear from anyone who feels like they do, but I appreciate how Trauma Transformed names what we're working towards and recognizing that so many of us are way far to the left of your screen. We're around trauma-organized and we're moving towards trauma-informed. And the goal long-term is to really get towards this healing-oriented organization.

Nika Seidman:

I wanted to highlight, in closing, Dr. Shawn Ginwright, who I think has really beautifully explained this idea of a healing-centered engagement or a healing-oriented environment more than that last picture. The article on the bottom is the essay that I'm referring to. But what he really highlights are some of the challenges with trauma-informed care, which focus so much on deficits. Put another way, he writes that people are more than the worst thing that happened to them. We can't just focus on this pile of mounting traumas. Individuals are much more than that. And instead, what we want to think about is building a healing-centered environment and using healing-centered engagement.

Nika Seidman:

What that looks like is recognizing that first and foremost, collective traumas have happened, and therefore, we need a collective response. When we only treat individuals, we miss opportunities for advocacy and structural change. And I feel like in some ways, I've fallen into that pit in this talk. But again, I say that because I think I've focused on the practical things that we can do today. That's not to suggest that we don't need to continue to advocate for structural change to make our structures more trauma-informed and healing-centered as a whole.

Nika Seidman:

And finally, he emphasizes how when we just focus on suppressing our symptoms of trauma, of just addressing triggers, we'll never be able to move beyond them. So, we really need to think more about how to create a healing strength-based and wellness-based clinical environment. And again, this is the dream. I think we have a long way to go to get there, but I think it's important for people like Dr. Ginwright to have laid it out as part of the long-term goal.

Nika Seidman:

So lastly, I'm going to leave you again with a quote from one of that same study that I worked on, because I think these respondents again framed it really beautifully what Dr. Ginwright was saying in a different way. So, in that same study that I talked about, where we asked people experiencing homelessness, "How can we improve care for people experiencing homelessness?" First of all, we asked a group of providers what we could do, and the providers said all kinds of creative things like we could provide drop-in services, we could provide mobile care, we could expand clinical hours, all of these concrete ways to build access, some of which were super creative and complicated.

Nika Seidman:

And the patients or the participants or people with lived experience responded with this, "Just treat us like people. Educate yourself." Do not go and build all these complex systems of care. You can do that, but what we really need you to do, and I'm paraphrasing kind of the rest of this quote, but what we really need you to do is to listen to us, to treat us with dignity and respect, to use those trauma-informed principles to build trust, to use the tools we have every day rather than spending a gazillion dollars on fancy services. We can have all of those fancy structures, but if we don't treat individuals like people, if we don't educate ourselves, consider and reflect on our biases, and provide trauma-informed services, we're really just kicking ourselves in the foot.

Nika Seidman:

So, our takeaways for today, I'm sorry I ran a couple minutes over, include first and foremost, just a recognition that the healthcare environment can be a traumatic or triggering environment. Big picture, a trauma-informed response is that we want to welcome people into care. We want to focus on trust-building, on collaboration, and respect. And in so doing, we have to take care of ourselves and our team in order to do this incredibly challenging work.

Nika Seidman:

So, thank you, everyone, so much, and I really look forward to your questions and comments. These are some resources as well. Thank you.

Nicole Nguyen:

Okay, wow, which was wonderful, Nika. Thank you so much. So yeah, so now we will start the Q&A portions. I think you have some questions. And for everyone in the audience, please send your questions in the questions box and Nika will start addressing them one by one.

Nika Seidman:

Great. The first question, sorry, it's just going to take me a second to read them. The first question is, "Are there tips for practicing all these trauma-informed care necessities in the reality of today's practices where visit times are limited, and people are needing to be seen more and more?"

Nika Seidman:

I really appreciate... I think Vanessa wrote in this question. That is so true, and this is an example of how our structures are not set up to provide trauma-informed practice and care. I think on an individual level, we can use some of those tips and tricks that we talked with at the beginning. So, for example, knocking on the door, waiting. Building trust does not need to be a 30-minute endeavor. Building trust can be as simple as greeting someone, saying hello, asking how you're doing.

Nika Seidman:

There was this great study that Dr. Christine Dehlendorf did about building trust in a family planning visit, and they found that just greeting someone and asking a question about how someone's doing that day increases people's trust in the provider. So, these don't have to be long, drawn-out interventions. And Vanessa, I totally agree, we're not going to be able to provide the types of kind of sitting down and really providing trauma-informed care until we change our structures that are including seeing 20 patients a day in 15-minute visits. But I think using those little pieces can help along the way.

Nika Seidman:

Okay. Great. The next question is from Stephanie. Such great questions. Stephanie asked, "I'm curious to hear your thoughts on navigating choice fatigue while of course still wanting to give choices to all patients." I love that question. So, Stephanie, I'm curious what other people think. I would approach that response by saying I agree, our patients do have choice fatigue. And one of the ways we can respond to that when we're thinking about our counseling and providing choices, recognizing that providing a huge, long menu is exhausting and annoying to people. People zone out and don't really listen. What we can do is by eliciting people's preferences first, we can narrow the choices that we discuss to the ones that people say are best for them. So, in the setting of contraception, for example, if someone says, "There is no chance that I'm going to put something into my uterus and there is no chance that I can take a pill every day," do not talk about those options when we are doing contraceptive counseling. So, I think, again, when we restructure and listen to the patient first, as opposed to what so many of us are used to doing, which is laying out a menu of contraceptives and going through all of them, I think that can both increase our efficiency. It can also be respectful because we're starting with eliciting preferences and priorities of the patient, and we can start to overcome some of that choice fatigue.

Nika Seidman:

Okay. Great. So, Nancy asks, "How do you explain to the patient or client why you're stepping out of the room? Could this be triggering too?" Totally. Nancy, I think that's such a great point. Sometimes you're going to do things that unintentionally can trigger people as well. I think it's always a balance. Sometimes I'll just say I have to step out for a moment. I don't make an excuse. Especially if the conversation is getting heated, I'll say something like, "It looks like you could use a break. I'm going to step out for a moment." Or if it's at a moment in the conversation where someone is trying to make a decision and it seems like they need more time, I'll say, "It looks like you are thinking about your options right now. Would it be okay if I step out for a moment?" Again, if the stepping out for a moment is for them, I'll ask permission. If the stepping out is for me, if I'm not able to provide good care in that moment, I will make it more assertive and say, "I'm so sorry, but I do need to step out for just a moment. I'll be right back. Can I get you some water while I'm out there? Can I get you a snack while I'm out there?" If we don't take care of ourselves, we won't provide the best care to our patients. So, I totally agree, there is always a risk in any action that we do, for example, by stepping out. And to me in

that scenario, when we are not able to provide the best care, the benefits outweigh the risks because we need to be fully present and able to take care of the patient in that moment. It's a great question. I really wish this platform had conversation, because I would love to hear other people's ideas about this.

Nika Seidman:

Okay, let's see. What would you do with a pregnant patient who is positive for syphilis? What would you do-

Nicole Nguyen:

Sorry. I just want to confirm, I know we're having a lot of questions coming in, and I know, Nika, you were so gracious enough to actually stay on an extra 10 minutes, if that's still okay.

Nika Seidman:

Yeah.

Nicole Nguyen:

So, if anyone who needs to leave straight at 1:30, please go ahead and do so, but Nika will stay for an extra 10 minutes to continue answering questions. And this is all recorded, so we'll send out the recording and the slides after in a few weeks. Thank you. Okay, go ahead.

Nika Seidman:

Let's see. What would you do with a pregnant patient who is positive for syphilis and wants to leave the clinic? Again, great question. I've been in that scenario so many times. What I have done in that scenario, which I don't know if it's right or wrong, and I would love to hear other people's thoughts, I explain to the patient why treatment of syphilis in pregnancy is so important. I talk about congenital syphilis, I talk about IUFD, and I explain how efficacious, if it's just one dose of penicillin or if it's three shots, the medicine is and how important it is to do early in pregnancy. I'll often do a teach-back, hopefully not in a too annoying way. But I'll ask... I just say, "I just want to make sure that I'm doing an okay job explaining. Can you help me make sure that you understand what the consequences of untreated syphilis in pregnancy are?" And then if they're like, "No, I've got to go, I've got to go," if they say something like, "No, I have to go pay my parking meter," or, "I have to go call my friend," I will try and troubleshoot with that. I'll say like, "Hey, would you like to use the phone right here? Tell me where your car is parked. I am happy to send someone out to go pay for it right then, out to put change in your meter." Again, not every clinic is able to do that, but trying to think creatively and work with the patient, I have found to be the most helpful way to respond to those situations. Sometimes by creatively thinking together, the patient agrees to their treatment. Sometimes they don't. If they don't, I say, "I totally hear you. I respect your decision, and I really want to make sure that you are able to get this treatment when you're ready. Can I do outreach?" I mean, again, depending on your resources, but again, I work with a lot of people experiencing homelessness, so I'll say, "Can I do outreach to the shelter nurse? Can I ask the homeless outreach team to bring a shot to your tent?" I mean, whatever it is that you're able to do, "Can we make an appointment for you to come back tomorrow? Can I call you tomorrow? Can I text you?" There are so many different ways, and again, this is where if our response is just, "She didn't get her syphilis treatment," that is we're not thinking creatively enough. And I think

even in the most limited settings, there are second and third and fourth plans that we can try to use to help that person get treated.

Nika Seidman:

Let's see. How do you work with the autonomy needed in trauma-informed care? So, this question is a really thoughtful question. "How do you work within the autonomy needed in trauma-informed care and patient responsibility for their health?" Margaret asked this question. Margaret, I really wish I could ask you more about kind of what you mean by that. But what I'm interpreting is that people are responsible for their health, and that we want to respect their responsibility and also hope that they will take responsibility. And I would say that I think my response is to that word, responsibility, which is that I think people's ability to take care of their health is so impacted by their environment and their experiences of healthcare in the past. So, when people are expressing autonomy about a decision, I try to probe a little bit, and it's, for example, a decision that to me seems counterintuitive to what would be best for their kind of just circumscribed health outcome. I try to explore with the person, are there barriers that I'm not understanding or structures that I'm not understanding that are affecting their decision-making. And if that's true, are there any ways that I can help think around those or help facilitate those to be different? I think these are some of the hardest questions, and it's very related to that patient who says, "I have to leave right now. I can't do syphilis treatment right now." "I have to leave right now. I can't do syphilis treatment right now." I think again, developing a trusting environment so that you can ask questions about what are affecting this and then creatively and collaboratively working with the patient to come up with an alternative route or understand what they're doing as making the right decision for them is the best that we can do. I feel like I muddled that question a little bit and I would love for a follow-up, Margaret, if you're able.

Nika Seidman:

Luisa asked how trauma-Informed care looks for work with youth. Luisa, I think that's great. I have to be honest, I work primarily with adults, and with some adolescents, but mostly with adults. If there are any providers who work with youth on the call, I would love to hear their perspectives. My colleagues who work primarily in pediatrics and adolescents say many of the principals are similar except that I think one of the things that is an added factor are, for example, when you're working with youth who are so in their phone, how to get their attention and respectfully say, "Hey, can we put that away for right now?" Or "Is there something going on right now? Do you want to have this visit at a different time?" I think there are so many different strategies about ways to connect with young people, and one of those pieces is through engaging around what are priorities to them. But again, I am not a primarily youth provider and I'd love to hear from any people who focus on youth in the audience.

Nika Seidman:

Oh, this is great. Okay, so Ying asked, "Can you comment on how to balance asking invasive questions like the number of partners, practices, et cetera, and having enough documentation to show why a particular test was ordered? I have a client who came in for STI testing and responded, 'it's none of your business' to some of the more personal questions." Oh, such a great question. So, I think that client is definitely channeling the same response that I hear from my clients all the time. And I think what I would respond is when we have, for example, a teenager who comes in who says, "I need Depo," and they're like, "I don't want to talk about if I'm sexually active or not. I don't want to talk about anything else. I just need Depo." We don't probe. We let it go and then we treat them.

I think we have to have the same philosophy of trusting people when they say that they need something, that we do it. Now, the documentation piece is another piece. If you really have to document something in order to get that request filled. I think the other piece that I've had a lot of success with is saying, "I fully understand that this information isn't going to affect whether we do the test or not, and we're going to do the test no matter what, but in order to order the test, I need to document when your last sexual exposure was or if you have discharge in order to be able to have the test paid for. I apologize for asking you that question, but if you give me the answer to that, then we can order the test." I found transparency on our part of explaining why we're asking the question, acknowledging that the answer to the question is not going to affect whether we do the test or not can be very useful. And I found that patients and clients understand that we're working in a bureaucracy, and we can sometimes even have a bonding experience about how annoying it is the bureaucracies we work in and the questions they ask. And then another thing I can respond and say is like, "Hey, I really appreciate you're giving me that feedback that that was an offensive question. I'm going to go back to my team and see if we can get rid of it." And I've done that before because getting that feedback I think is another opportunity to say, "Wow, thank you so much for providing that feedback that you feel like this question was offensive to you. We really need to look into this." And then I'll ask things like, "Were there other questions today that were offensive to you?" And you'll get all kinds of interesting feedback to help improve your care. So again, feedback like that I take as an opportunity to open up a conversation to build trust and to appreciate someone for sharing their opinion because so rarely do we get those opinions in healthcare.

Nika Seidman:

Okay. Okay. Lisa asks, "I teach native Alaskan lay people to provide medical care for their villages. Often these providers themselves have experienced multiple traumas. How can I help them help their patients that are also victims of trauma?" First of all, Lisa, thank you for doing this incredible, incredible work and that sounds incredibly challenging. I also work in teams with a lot of people who have lived experience and I think the two or three, I'm trying to, well, I'm not going to say a number, the things that have been most helpful in our practice have, number one, we set up regular opportunities for reflection and discussion of how cases or encounters with patients are affecting us and how our experiences affect our work. The goal of these sessions is not for people to have to disclose their prior trauma, which is never the goal, but to reflect on how all of our experiences affect how we do this work. Creating a safe space as a team for regular reflection we have found has been incredibly helpful to sustain all of us in our work and to... I think I personally have learned so much from individuals listening to them reflect, it's also helped me reflect and recognize how I'm responding in a certain way. So, I think if you have the space, building in regular time, ideally with a trained facilitator, if not just as a group. So that's one way. A second way is if you know that there was a specific experience that occurred that triggered a provider or a multitude of providers, making sure you schedule a debrief with everybody on the team who was involved in that event as a private debrief that's not like a clinical tearing apart of what happened, but more talking about how did I emotionally respond to this experience and why did that happen? And finding out sometimes how team members may have helped or didn't help. I think the third piece is kind of building into that work training and structures, and this is where you have a shared language for someone to be either able to say in their team, and again, I keep using the word team, I think one of the key pieces of trauma-informed care work is working in a team because we all need to tap out sometimes or we need someone to tap us and say, "Hey, you look like you're not having a good day. Maybe it's time to take a break." If we can develop shared trust and language within our teams so that number one, we feel comfortable asking for a break when we need it, or number two, we're not offended when someone comes up to us and says, "Hey, it looks like you need a break. Can I step in for you for a

second?" That I think has been also really helpful. Again, though, these are all structural solutions in a setting where that may or may not be supportive of those types of solutions, but wherever you can, I think creating spaces for reflection, doing training on trauma-informed care and recognizing together as a group how this work affects us and how we bring our past experiences to this work. I'm sure that the people who you're working with will have lots of examples of how they have been triggered in settings and how they respond to people who are triggered. And just even opening up a space for reflection I think can be incredibly powerful. I think the last thing is recognizing that those individuals are at the highest risk for burnout because, A, their risk of being triggered at work is really high. And when you are triggered at work, you become exhausted. Again, thinking about that domino effect, how it affects the rest of your day, it affects the rest of providers days too, and we need to create systems so that people can take a break when they need it, they're not seeing a gazillion patients in a day and recognizing that as a team, we might not be able to reach all 50 people in a community that was our goal. But if we reach 40 and we're able to take care of ourselves and sustain ourselves, we'll be able to continue this work for the long-term that is better than doing 50 and then being burnt out and all quitting and not having the work be done in the long-term. So I think again, it's that discussion of it as a team, having a shared language and developing a community-based, excuse me, a trauma-informed organization and an organization of self-care that is so important and that has to start at the leadership and I'm responding at this point to Lisa's organization, but all of our organizations. I am so, so grateful to my bosses when they show me how they are integrating trauma-informed practice into their work. They're turning off their email on vacation, not responding to texts and cell phones. That gives permission to the rest of us to take that space as well. And so again, I think for people on the call who are in leadership positions, even just saying out loud what you are doing to take care of yourself has impacts on the rest of your team. Okay.

Nika Seidman:

Okay, great. So RW Blue, I think again related to that, asked a great question about could you talk a little more about the influence that, sorry, let me go back a second to give context to the question. "Thank you for talking about trauma experiences as service providers may bring to work and to our encounters with clients and fellow staff. Could you talk a little bit more about the influence trauma has on how staff treat other staff?" Again, such a great question. I think this again relates to that concept and the importance of creating a shared language as a staff and recognizing that we may be triggered by other staff. I'm not sure if this participant was referring to being triggered by other staff, but what comes to mind to me is when one team member may do or say something inadvertently that triggers another team member or describes a client experience or has an interaction with a patient or client that triggers another team member. I think again, this is the space where it's so important to have that shared language as a team, to do trainings as a team and to do reflections as a team. What we have done in our organization, because this has come up not infrequently, is when someone is triggered by something that someone else on the team did or some interaction, we'll have a debrief just like we do if there is a patient outcome that is impactful to the team. In the debrief, we set a lot of ground rules around respect, I statement, not interrupting, making sure that all conversations stay in the room. And one of the things we'll do is we'll talk about what happened in chronological order and each person will just kind of tell their story of the experience of what happened to them in the sense of like, "I heard X, Y, and Z person say X, Y, and Z, and this made me feel X, Y, and Z way because of my experience of this." And then the person who was the person who said that will say, "Oh, I said X, Y and Z thing because it was in the context of this conversation and I moved on because I got six different calls from every other person and I didn't get to really respond in the way I wanted to," or blah, blah, blah. The point is that people give their perspectives of what happened in a safe and uninterrupted space without criticism. It's just

kind of putting your feelings out there of what happened. And in my experience in a team that's working well is that people are able to hear what made them act in that way and develop a lot of empathy. And people who may have triggered someone else have the opportunity if they feel it's right to apologize and say, "Hey, I have no idea I did that to you," or "Wow, that makes total sense. I'm so sorry that you experienced things this way or that I contributed to harm to you." Does it always work as magically as that? No. But I think first and foremost, setting aside time to recognize what happened, unpack it in a way that is in a safe and trusting space is really important because that stuff brews and it numbs people and it leads to that burnout that we know is so common, whether it's from being triggered by a client or being triggered by another staff person. But again, I think what's so hard is that all of those conversations can't happen without underlying levels of trust, and that starts with having conversations about how hard the work is, about what we bring to the work, et cetera.

Nika Seidman:

Okay. Okay. So, Keisha, great question. "How do we integrate, I think trauma-informed care when we don't have adequate staffing and we still have patients who have other needs as well?" So great question, and again, this is where I just have to be honest that I think all of the things that I'm saying are in the context of us needing structural change in terms of the way that we provide services of not having days that are with a gazillion patients and not even eating lunch and running patient to patient with increasing needs throughout the day. I think how do we integrate the concepts that I talked about? I think we try our best. We integrate the self-care pieces that I mentioned before as much as we can. It doesn't take long to go get a sip of water. It doesn't take long... Sometimes what I'll do is I'll often have a really busy day. Before going into the next room, I'll just pause for a second and take a deep breath. Just full disclosure, I'm not somebody who meditates, I'm not somebody who does yoga. I don't know. I think I'm a busy clinician. I'm sure many of you can identify. And I find it so helpful before just going into that door, even just reminding myself to pause. And what that deep breath allows me to do is to remember that, oh, I'm going to knock and pause. That's another time to take a deep breath, waiting for someone to respond. I know other people who wear coats, they'll keep something in their pocket that grounds them, they'll keep a rock in their pocket they'll hold or something that's fuzzy, something tangible that kind of grounds them between going room to room so you don't bring the experience of the last room into the next patient's room. And then the last thing is you keep arguing to your clinic director that this is too many patients, that we can't take care of this many patients and need to come up with creative solutions.

Nika Seidman:

I, oh, Signy, I have to say is also one of my teachers and mentors and Signy is a midwife who does incredible work in this area. So, Signy, thank you for your question. Signy asked, "How do you acknowledge the harms of trauma caused by the system while working in the system?" Such a great question. I would be very curious how other people would respond to this, but I think about that a lot in a lot of the different places I work, and especially in the jail because I have a lot of personal, moral, ethical conflict about providing services in the jail. And the reason I work in the jail is because I hear from patients how important it is to access healthcare services while they're in jail. And so, I feel a continuous tension in doing the work that I will frequently, hopefully not in distracting ways, but not infrequently I'll say to patients, so for example, actually, I'll say it differently. Some of the ways I respond are by ways that I say to patients, and some of the ways I respond are ways that I don't say to the patients, but I try to change my behaviors. So first of all, if I am working in a system that I know has been harmful or continues to be harmful to my patients, like the jail, I will try and I think about my care in

those settings as more equity-based care. And what I mean by that is as opposed to trying to provide everybody with the same amount of care, I feel like in the jail setting, which is an incredibly oppressive setting to work in, those patients deserve the most time. And I can kind of push or resist that system a little bit in the jail because unlike in clinic at the hospital where I have to kind of sometimes have these visits that are every 15 minutes, in jail, I can use as much time as I want. So, I can resist the system by trying to provide those patients as much time as they need. Sometimes that's an hour, sometimes that is just... And again, it comes at the detriment of kind of self-care, but for me it is really important to provide those patients with the best care possible. I'll also acknowledge that in jail to our patients, that there's been, for example, if people are alluding to a history of people being forced into decision-making that they didn't want, I'll make very clear that people don't need to make this decision now. That we can talk about it as many times as they want. That they can come back to it. I create, I think even more spaces or opportunities for autonomy than I do in a non-incarcerated setting to try and recognize the trauma of that place. So that was a long-winded response, but I think big picture, thinking about ways that you can either overtly or subtly try to resist the structure that you're working in can be really important, both for your ability to do the work and feel comfortable in doing it, and to be able to show to the patient that you recognize this history or this ongoing history and that you are actively working to try and at least acknowledge it, that it's kind of there and influencing the decision-making.

Nicole Nguyen:

Wow, that was amazing. Thank you so much, Nika. I know we went over a little bit tab, but I didn't want to interrupt such a wonderful response to a really important question. So that is it. So that concludes our webinar today. Thank you so much. There'll be a survey that pops up when you exit, and please fill that out for your CME credits and also to provide us feedback for our future content. And I want to say an amazing thank you so much to Nika. This was an incredible presentation. I will send you some of the comments that we're getting. People are really, really enjoying and this was such a needed topic and a very timely topic as well. So, thank you for delivering that. And I think that was it. We hope you all enjoyed the presentation, and we'll get you all the CMEs, the recording, the slides in a few weeks after. And we hope you all stay safe and have a great rest of your week. Thank you so much and thank you Nika. Really appreciate it.

Nika Seidman:

Thanks everybody. I really appreciate your questions and comments.

Nicole Nguyen:

And we'll collect all the questions and send it to Nika for any that she didn't get to answer live today. So, you will get your questions answered. Thank you so much.