TRANSCRIPT OF EPISODE 7 OF BREAKING DOWN MENTAL HEALTH
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Dr. Christina Cwynar:

Hello and welcome to our podcast, Breaking Down Mental Health, with myself, nurse Practitioner, Dr. Christina Cwynar, Child and adolescent psychiatrist, Dr. Heidi Burns and social worker Syma Kahn. Unfortunately, Dr. Burns was unable to join us today.

We are very excited to be joined today by Dr. Kris Kullgren, to discuss trauma informed care.

Syma Khan:

Dr. Kris Kullgren is a pediatric psychologist and clinical associate professor of pediatrics at Michigan Medicine. She received her bachelor's in psychology from the University of Michigan and both her masters in PhD in clinical psychology from Georgia State University. She practices at CS Matt Children's Hospital where she directs a psychology inpatient consultation liaison service. In her work at Matt, she co-leads the hospital's Trauma Informed Care Committee and is co-investigator on the Rabbits Foundation grant aimed at improving trauma informed care in the hospital setting. She's additionally participated in various research studies published in various peer review journals, written book chapters, and has a very active teaching at the undergraduate and graduate levels. None of the speakers here today have any conflicts of interest or financial disclosures. Thank you for joining us today.

Dr. Kris Kullgren:

It's a pleasure to be here today. Thanks for having me.

Dr. Christina Cwynar:

Dr. Kullgren, if we may start with some definitions. What is trauma and how do we classify it?

Dr. Kris Kullgren:

So a traumatic event can be really any experience that's perceived to be scary, violent, and threatens life or personal safety. And this can be something that is a direct lived experience, something that you yourself experience versus something that is a witnessed or indirect experience. So something that you might see happen or know happens to another person. The kind of things that we commonly consider to be traumatic include physical, sexual or emotional abuse and neglect, natural disasters, violence in the community or family, refugee, terrorism and war experiences and serious accidents, life threatening illness and scary medical procedures. These traumatic experiences can lead to strong emotions and physical reactions that often last long after the event.

Dr. Christina Cwynar:

Thank you for sharing kind of those definitions. It sets us up for a good conversation today. Can you talk a little bit about what trauma informed care is?

Dr. Kris Kullgren:

So trauma informed care is an approach to the care of patients that acknowledges that trauma, first of all is very common and has a broad impact on health outcomes. Second, that we recognize signs of trauma in patients, family and staff, and that we integrate knowledge about trauma into our policies, procedures, and clinical practices. And finally that we work to actively avoid re traumatization. So really I think about it as a cultural shift from looking at patient or a person's behavior and kind of that knee-jerk

response where we think what's wrong with you for acting this way, to shifting our perspective to being more curious and trying to seek understanding in terms of what happened to the person, which has led to the behavior and trying to better acknowledge the patient's lived experience in their interaction with the healthcare system. For this to be effective though, it really has to be implemented from the bedside to the boardroom. Trauma-informed care works best when implemented at all levels of the healthcare system and with every person involved in a patient's care.

Syma Khan:

Thanks so much for explaining what is trauma informed care and providing those definitions. I think it's important to recognize that we have to be aware of trauma kind of when we're conceptualizing our cases and recognizing that we're going to treat like the medical concerns, the psychological concerns, and trauma is a piece of that that impacts both of those things.

Dr. Christina Cwynar:

I do appreciate that you pointed out that it not only needs to be addressed at the bedside, but all the way up to the boardroom and really integrated into our hospital policies and into our community and all settings which patient care is touched.

Syma Khan:

Yeah, thinking about trauma informed care within a medical setting, hoping that you could speak a little bit about what is medical trauma and how it manifests in the medical setting.

Dr. Kris Kullgren:

So the National Child Traumatic Stress Network, which is by the way a great resource for anyone who's interested in more information about traumatic stress in children, they define pediatric medical traumatic stress as a set of psychological and physiological responses of children and their families to pain, injury, medical procedures and invasive or frightening traumatic experiences. And so this can occur in many different ways. So first of all, for those of us who work in a medical setting, we have a really great understanding often that the care we provide, the things that we do to help children and their families, the experience of hospitalization can be very scary to kids and their families. This is especially true for kids who might be naive to medical care and haven't had a chronic experience with the medical setting or for kids who have had previous lived experiences that are traumatic or even some of our kids who have had a long history of illness and relationship with the medical system can have repeated or painful and scary procedures that then in the future when they have similar experiences, triggers those previous traumatic memories or events.

And then we have some kids who have previous traumatic experiences in their lives who come into our medical settings who then are much more vulnerable to experiencing our medical settings as traumatic. And we also, I think, have to remember that it's not just about the kids who are coming into our medical settings with previous trauma experiences. It's also important to remember that parents and other caregivers are coming into their child's care with their own trauma histories or experience with their child's illness that could affect how they perceive their child's illness and care and whether or not that's a traumatic experience for them. We often hear about families being perceived as difficult or obstructing care or directing care or being really nervous or anxious, not caring for themselves or being withdrawn

or disengaged. And I think it's really important that when we see these kind of behaviors in families, that we become curious about what role trauma may be playing in their interaction with the medical setting.

Dr. Christina Cwynar:

I appreciate you pointing out the parental experience being brought to the care of pediatric patients because that does play a huge factor in things. And as you said, just being curious and often just asking that question, what's going on? How can I support you? How are you holding up, can be really helpful for us understanding that parental experience. Now, speaking a little bit about trauma informed care. How do we apply some of those principles in an emergency room setting or the medical setting to help support these patients and families?

Dr. Kris Kullgren:

I think that's a really great question and it really highlights some of the challenges of providing trauma informed care in the medical setting. Ideally, it would be great if we knew ahead of time which patients were more vulnerable, who had previous trauma experiences, and then we could provide what's called targeted trauma informed care interventions. But those of us who work in the medical setting know that we don't have that kind of time or resources. And when we are really focused on life saving interventions, we either don't have the ability to ask those questions or the child or family member or not in a position to be answering questions about their life experience beyond what's going on with the current medical situation. And so what we end up really needing to focus on and the shift that we need to make in medical settings is providing universal trauma informed care to patients and their families.

And that's basically what I talked about earlier is about having that understanding that people are coming in with potential traumas that the care we provide is potentially traumatic, and that we shift our care so that we lead with the assumption that all families are vulnerable and at risk and any of the care we provide can be perceived as traumatic and working really hard to address worries and fears that patients, children and their families come in with that we're optimizing their pain management because pain is often can exacerbate and be perceived and felt as traumatic in their care. And that we provide support to parents so that they can be the supportive person at the bedside that their kids need and that we engage kids in their care that offering opportunities for kids to have choice and control in how their care is provided can help bolster their coping skills and control over the situation.

And in the hospital, especially at Mott, we're really lucky to have access to a lot of psychosocial supports within the setting from psychologists to social workers, child life psychiatrists and other providers who can help build coping strategies and help support families through this difficult time.

Syma Khan:

Thanks so much, Dr. Kullgren. I think it's important for us to also recognize that trauma is so prevalent that unfortunately the majority of patients and families that we see have likely experienced some kind of traumatic event in their lifetime. So using a universal approach likely causes much more benefit to the patients and families that we engage with and maybe adds a little bit of work in the interim or immediately, but the outcome is much better. And we do see better outcomes. We see discharges that are smoother, patients families don't have to come back as often, just overall they report better healing overall. And so I think those are the things that we need to walk away from that it's an active approach. We have to integrate these principles into our daily thinking. Every time we conceptualize a patient, we

see them, we have to be aware of that potential trauma and using that trauma informed lens to then help support them in the long term.

Dr. Kris Kullgren:

And I think that's such an important point that the front end work that we do throughout the care of any child who comes into our hospital or our clinics really help with longer term outcomes. We know that kids who have adverse childhood experiences and multiple medical traumas are at greater risk for poor and mental health outcomes. And so the work that we do from a prevention standpoint can do a lot to improve outcomes down the road for these kids and their families.

Syma Khan:

As mental health providers, we all meet individuals with various traumatic experiences on a regular basis. How the display this trauma can vary significantly. The manifestations of trauma can also be very based on age. How do you see trauma present different for different developmental ages and how can we support these children?

Dr. Kris Kullgren:

That's such an important thing to think about. And I think those of us who are in pediatrics are well-suited to understand how different issues can present differently at different ages and developmental stages. And trauma is no different. A young child, an infant or a toddler is going to look very different in terms of their trauma response than a teenager or young adult. So when we think about young children, and I also want to remind people that infants, very young children can experience events in their life is traumatic. And so this is really from birth until death. This is something that can affect people in their lived experience. So when we think about young children particularly, and also kids who present with developmental delays who might have cognitive or communication deficits, they may not be able to verbalize their experience or what their concerns are, what their fears are.

And so with younger folks, we really rely on behavioral observations. So how they're acting, we rely a lot on parents' description of their premorbid functioning. So what did they look like before they came into the hospital? How did they respond to strangers? How did they cope with stress or adversity or pain before to help us really know what's a change from baseline? We may see in younger kids a lot of developmental regressions, so we might see that somebody who was previously potty trained maybe wetting the bed, we might see new development of nightmares or fears. And commonly in very young children, the nightmares in fears won't necessarily align with what the trauma is, so they may just have more nightmares or more fears whereas in older kids, if we are seeing those sorts of things, they're more closely aligned with what the stress or trigger is.

Our school age kids, very often they have a good imagination and that tends to be their greatest weakness when it comes to trauma because they're at the age to develop a lot of hypothetical worries. And when parents or care providers aren't filling in the gaps in terms of what's going on or what's going to happen or what has happened, they tend to imagine very often the worst case scenario. For example, I've had school-aged kids who have been in motor vehicle accidents and a family member is not at bedside who was in the car. And they may assume that that person perished in the accident, but perhaps they're home caring for another relative or in another hospital. And if people are not giving them information, they're going to go to the worst case scenario. And so they really need information, they need to participate in their care.

They need parents and other care providers to model calm coping so that they know how to respond in a situation and to fill in the gaps in any of their misunderstandings. An adolescent is going to cope much more similarly to a trauma as an adult would where we would see a lot of struggling with focusing on getting through the present and the day to day impact of the trauma. They may be very sensitive to anything that has caused changes in their appearance related to the trauma. They may be impacted by having to be more dependent on other caregivers because they've been working on their independence and now whatever is happening in terms of their illness or injury might be shifting that. And then they may often try to cover up or protect others from their worries or fears. So they may hold their feelings in.

In teens, we often see traumatic stress reactions that look very similar to what we see in adults in terms of nightmares and flashbacks, avoidance of things that remind them of the trauma startling easily and those sorts of things. So it is really important and I think it's such a great point that we have to be aware of the child's developmental stage and includes age, but also cognitive and communication abilities to best understand what they understand about the trauma, but also to provide them the age or developmentally appropriate support to help them cope through the situation.

Dr. Christina Cwynar:

Now thinking about this and kind of a developmental lens, maybe we could walk through a little bit of a case and how we could support a kid. So let's say for an example, we have a six year old who has some chronic disease, it doesn't really matter what, who has a needle phobia. And every time a nurse walks in the room for their care, they're freaking out. How do we support that patient with simple things or seemingly simple things like vitals or the bigger question, how do we support that patient with a poke, a needle stick that they need?

Dr. Kris Kullgren:

That's such a great question and really a common example of what we see in the hospital setting. And so that sort of trauma often develops from pairing something that is not traumatic, like a nurse like yourself with something that is really scary and feels very threatening like a needle. And so helping a six year old, for example, get through something like a fear of needles and fear of nursing come in the room. And very often it ends up with many kids, it ends up generalizing. First it's the nurse and then it's all nurses, and then it's the doctors, and then it's anyone who comes in the room because they develop this fear that anything bad could happen at any moment by the hands of anyone. So on a very basic level, we work to make sure that the child understands who's coming in the room, why they're there, what they're going to do, so there's no surprises.

So keeping the child very involved in their own care. So I'm not going to come in and poke you, the person who's coming to get your blood pressure, no pokes. I'm coming to clean the room or change out the trash or bring your tray or whatever. So the child never has any reason other than their fear to expect anything other than what's going to happen. And so we don't lie, we don't negotiate. We are very honest with kids and a lot of adults have a hard time being honest with kids. But I think we've learned throughout the course of caring for many, many kids who experience medical trauma is that honesty, typically, is the best option. We would very often involve child life to come to the bedside to provide in the moment, or even preparatory coping strategies. So teaching the child ways that they can calm their body down or distract their brain.

When it is time to get pokes, we would help the child potentially even develop a step by step plan. At our hospital, we're really lucky to have what are called poke plans where the child and the family work

together with phlebotomy or child life or nursing to develop their own strategies and their own plan, which gives choice and control. And they have more agency over how things are done instead of feeling like terrible things are happening to them. Some kids benefit from having education, understanding what is a blood draw, what is the equipment, why do we do this, how is it helpful?

And for other kids who are really fearful and where we are needing higher levels of intervention, very often we'll have psychology involved and do what we call exposure treatment where they work on being comfortable at less stressful ways of being with the needle or the blood draw, just working on being in the room with the needle, working on having it closer to them, working on being calm when it touches your skin and working through those progressions where they can escape. They can't avoid it, it's going to happen. They learn that they're still safe and they learn they can cope with it. And then we're able to work up to progressing with the actual blood draw. And then for some kids, we need to support them with medication to help manage their anxiety. We have a great psychiatry team at the hospital who helps with that, and that's sort of a last resort. But we really want to work with helping the child develop a new narrative and a new experience was something that was previously very traumatic.

Syma Khan:

Thank you. So we know that trauma impacts the brain. It impacts development. There's a neuro biological component that actually changes physiological processes within the body. And so oftentimes we see trauma manifest in different ways. And what are the ways that we sometimes see it in the hospital that are unexpected?

Dr. Kris Kullgren:

That's a great question, and I think it's such an important question around the physiological response and also how bodies are programmed to protect us when it comes to threat or trauma. And when you think about what our bodies have to do to protect us from any threat or trauma, pretty much our bodies and our behaviors will do whatever it takes to keep us safe. And so in small children and older children, we can see just distress. So emotional distress, crying, screaming, pulling away from something when you think about whatever you would have to do to avoid something, aggression and agitation can often be a sign of trauma. So we often misinterpret that as a behavior problem. But very often that behavior is rooted in that escape and avoidance response. Again, it's very protective. So I think anytime we see those behaviors, it's important.

Again, back to what we talked about earlier, to be really curious about where that's coming from. We also see folks who kind of do the opposite, which is totally shut down. So we talk about in terms of our autonomic nervous system response, fight or flight or freeze. Some people can't participate in things or shut down or don't engage. We have kids who run, we have kids who fight, we have kids who fight verbally, we have kids who appear very anxious that exaggerated physiological response where we have a lot of kids who are hooked up to monitors in the hospital and you see their heart rate go up, you see their breathing rate go up, you see their blood pressure go up. And in the absence of a sort known physiological trigger, I think it's always good to be curious about what is happening physiologically. Is this a sign of trauma and a physical reaction to that.

Syma Khan:

Before we wrap up today, Dr. Kullgren, is there anything else that you would like to share with our audience?

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Dr. Kris Kullgren:

I think the most important take home is that when in doubt, we should always provide universal trauma informed care and to assume a curious mindset of understanding when children and families are showing emotional and behavioral signs of trauma. It's really important that pediatric providers educate themselves about what these signs are, what to look for, and then how to respond to them. The National Child Traumatic Stress Network is a great one stop shopping resource for providers who are more curious about getting more education and skills in providing trauma informed care to children. So it's a great repository of handouts for families, handouts for providers, educational resources, some really nice mnemonics for how to remember ways to provide trauma informed care that can really help to improve your practice as you're thinking about universally addressing trauma in the kids you care for.

Syma Khan:

The National Traumatic Stress Network is a great resource. I'm really glad that you've mentioned it. I think it's really helpful for providers. It's easy to access and the resources are free. They have podcasts and things like that, there are webinars. So I think it really helps as we're trying to use this universal approach. Also, recognizing that Free University of Michigan Health Trauma informed care is a priority. And so we are really working actively, both in pediatrics and in the adult world to integrate this into our practice, into our medical training for nurses, social workers, psychologists, physicians, nurse practitioners, APPs across the board. So I think this conversation is very timely for that and will hopefully help us deliver the best care we can to the patients and families we serve.

Dr. Christina Cwynar:

Dr. Kullgren, we truly appreciate your time and your expertise. Thank you to everybody who tuned in this week. Nurses, social workers and physicians can claim CMEs and CEs at U of M health.org/breaking down Mental health. You're able to do this at any time within the next three years of the initial air date. We hope that you will join us next time.