LIBERTY UNIVERSITY

Wisdom & Compassion: The LUSON Journal

Volume 2
Issue 1 *Fall 2024*

Article 8

2024

Trauma-informed Care and Support for DEI: Exemplars in Diabetes and Self-Reflection

Karla Giese
Liberty University

Trauma-informed Care and Support for DEI: Exemplars in Diabetes and Self-Reflection

Cover Page Footnote

Dr. Karla Giese- School of Nursing, Liberty University

Abstract

Traumatic life experiences may disproportionately affect individuals with social disparities, marginalization, or injustices. Nursing advocates for diversity, equity and inclusion (DEI) to recognize and affirm all patient voices. Nurses can address DEI by developing competence in the evidence-based skills of trauma-informed care (TIC) and self-reflection.

Highlights

1. Traumatic life experiences disproportionally affect individuals with social disparities or injustices.
2. The Substance Abuse and Mental Health Services Administration offers an evidence-based approach to trauma-informed care.
3. The practice of self-reflection after difficult clinical encounters is a method of achieving the ethical duty to care for oneself and foster personal growth in the realm of diversity, equity, and inclusion.

Keywords: trauma-informed care, diversity, equity and inclusion, ethical duty to care, self-reflection, Johns Model for Structured Reflection

Trauma-informed Care and Support for DEI:
Exemplars in Diabetes and Self-Reflection

Nurses often unknowingly encounter individuals who have lived through traumatic life experiences. Adverse childhood experiences (ACE), include a number of traumatic experiences during childhood that have been heavily researched and found to be associated with negative health outcomes, including increased physical and emotional morbidity and mortality. (Felitti, et al., 1998; Kendall-Tackett, 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), n.d.). There are also traumatic experiences beyond ACEs that occur throughout the lifespan. These traumatic life experiences often disproportionately affect individuals with social disparities or injustices (Comas-Diaz et al., 2019).

Understanding trauma-informed care (TIC) is a basis for establishing a trusting therapeutic clinical relationship (SAMHSA, n.d.). The cumulative effects of trauma can result in an individual developing behavioral adaptations, which may manifest as a challenging clinical encounter. Working with survivors of trauma can bring out strong emotional responses in the nurse providing care (Grossman, et al., 2021). The ethical duty to patient care, however, is unwavering (American Nurses Association (ANA), 2015).

This article aims to explore the concepts of TIC, concepts of diversity, equity, and inclusion (DEI), and the ethical duty to TIC. Two case exemplars will illustrate these concepts. The article will conclude with a strategy for self-reflection when difficult clinical encounters occur.

Background: Nursing and Diversity, Equity and Inclusion (DEI)

Nursing, as a profession, is a longtime advocate for equality in health (ANA Enterprise 2023-2025 Strategic Plan; American Academy of Nursing; National League for Nursing, 2024). Promoting social justice and reducing health disparities by diversity, equity, and inclusion (DEI)

is at the forefront of nursing's mission, values, and strategic plans (ANA Enterprise 2023-2025 Strategic Plan; American Academy of Nursing (AAN, n.d.; National League for Nursing, 2024). Understanding the foundational definitions of DEI is important for nurses working to improve health disparities. The AAN defines diversity as affirming how people differ (AAN, n.d.). Equity, according to the AAN, assures the right conditions for all people to thrive and reach full potential. Inclusion, according to the AAN, welcomes all voices with a special emphasis to include historically marginalized populations. Advocating for "all" voices promotes social justice.

Historically, individuals who have experienced social disparities, and racial or historical injustices are at higher risk of traumatic life experiences (Comas-Diaz, et al., 2019). The coronavirus pandemic of 2020 brought increased recognition of trauma, and social and health disparities throughout the world. These factors contribute to the current urgency in understanding and addressing trauma and TIC (Comas-Diaz, et al., 2019). Given the universality of traumatic life experiences—transcending socioeconomic status, gender, age, culture, and clinical specialties—nurses in all specialties will encounter individuals needing TIC. Two strategies by which nurses can address DEI include developing competence in the evidence-based skills of TIC (Brown, et al., 2016; Goldstein, et al., 2024; Lewis, et al., 2021; SAMHSA, n.d.) and self-reflection (Berger & Erzikova, 2022; Burks, 2023).

Trauma and Trauma-informed Care

Trauma can be defined as "an event or series of events that overwhelms an individual's capacity to psychologically self-regulate" (Bargeman et al., p. 793). In addition to ACE, trauma can also be associated with acute and/or chronic illness, negative healthcare experiences, war, devastating natural disasters (hurricanes, tornados, earthquakes), loss of a loved one (death, or

significant loss of function), divorce, gender diversity, racism, and others (Bargeman, et al, 2022; Lewis et al., 2021, SAMHSA, n.d.). Trauma, in this sense, can negatively affect an individual's internal well-being, interpersonal relationships, and functioning in society.

Trauma-informed care acknowledges trauma's effects on an individual. A framework to help nurses recognize individuals presenting with trauma was developed by The Substance Abuse and Mental Health Services Administration (SAMHSA), a recognized authority in TIC (SAMHSA, n.d.). The framework has two parts: three "E's" for concepts of trauma, and four "R's" as key assumptions for a TIC approach to care (SAMHSA, n.d., p 8-10).

SAMHSA's Three "E's"

The concept of three "E's" for trauma includes the Event(s), the Experience(s), and the Effect(s) (SAMHSA, n.d.). The effect, for some individuals, will be an intense trauma response. A trauma response is an emotional response to reliving the traumatic experience. Emotional manifestations might include withdrawal, mistrust, missed appointments, anger, crying, or other intense emotional reactions (Lewis et al., 2021; SAMHSA, n.d.). These are often triggered by environmental sensory factors such as sights, smells, and sounds (SAMHSA, n.d.). A clinical encounter with a healthcare provider is one potential environment for re-triggering or re-traumatization (Grossman, et al., 2021, Lewis, et al., 2021).

Complex variables contribute to an individual's response to trauma (Ashworth et al., 2023; Bargeman et al., 2022; SAMHSA, n.d.). Repeatedly reliving trauma affects healing, and adversely affects physical and emotional health (Lewis et al., 2021; SAMHSA, n.d.). A dose-response to repeated trauma is well-established (Boyce et al., 2021). The degree and frequency of physical and psychological life disruption is a factor in developing long-standing trauma (Boyce, et al., 2021) When cumulative trauma is experienced during critical periods of early

development, long-term disruptions in brain development can occur, leading to prolonged activation of the stress response (Boyce et al., 2021) Ultimately this results in long-term changes in the neurocognitive, neuroendocrine, immune, metabolic, and genetic regulatory systems (Boyce, et al., 2021) Responses to these changes can include dysfunctional interpersonal functioning, mood changes, and risky or self-destructive behavior (Ashworth et al., 2023; Bargeman et al., 2022; Boyce, et al., 2021).

SAMHSA's Four "R's"

Expanding on the three "E's", SAMHSA developed four "R's" as assumptions, or principles, to guide TIC: Realization, Recognize, Respond, and Resist Re-traumatization (SAMHSA, n.d.).

Realization

Realize traumatic life experiences occur with surprising frequency. Affected individuals can develop coping strategies to survive overwhelming circumstances.

Recognize

Recognize, notice, or "see" signs of trauma, including physical or emotional/trauma responses. Recognizing indicators goes beyond outward signs. "Seeing" an individual includes "recognizing the human experience, informed by aesthetic ways of knowing: grasping, interpreting, and envisaging what is unfolding" (Johns, 2022, p 54).

Respond

Trauma-informed care focuses on the patient-centered process of acknowledging and understanding what might have happened in the past, rather than focusing on what is wrong (Trauma-Informed Care Implementation Resource Center, n.d.) The clinician works to "see" the

patient, understand the impact trauma may have had, and ensure psychological safety. The clinician is both sensitive and responsive to the traumatic experience(s).

Resist Re-traumatization

A TIC approach understands the pervasiveness of trauma and that any clinical encounter could be traumatizing (Bargeman, 2022; Levy-Carrick et al., 2019). Creating clinical environments for individuals to feel safe in physical, social, and emotional realms can potentially reduce the risk of re-traumatization (SAMHSA, n.d.). Welcoming individuals, ensuring support and respect supports person-centered care, shared decision-making, trust, and TIC.

The three "E's," four "R's," and the potential for re-triggering or re-traumatization can be illustrated with chronic diseases, such as type 1 diabetes. Type 1 diabetes is an auto-immune disease process that destroys the insulin-producing beta cells in the pancreas, resulting in a lifelong need for exogenous insulin administration (American Diabetes Association Professional Practice Committee, 2024). Type 1 diabetes has significant psychosocial impacts related to lifestyle modifications, intense daily management, fear of hypoglycemia, fear of complications, fears related to losing access to care, and frequent office follow-up care (Giese, 2018; Roth & Chard, 2021). Individuals living with type 1 diabetes will provide exemplars of trauma-related concepts. Exemplar one illustrates trauma concepts and SAMHSA's three "E's" and four "R's," while later, exemplar two illustrates trauma concepts and self-reflection.

Exemplar One

A 33-year-old new patient living with type 1 diabetes resides four hours away from specialty-level diabetes care. The patient has experienced significant gaps in insurance, medication, and healthcare access. Telehealth now provides improved access to diabetes specialists. The nurse warmly greets the patient by video and begins by collecting pertinent

medical history. The nurse notes a change in demeanor with stiffened body language, tears, and downcast eyes. The seemingly routine medical history questions related to type 1 diabetes-related duration, insulin use, glucose monitoring, diabetes-related complications, lifestyle management, and coping trigger a trauma response for the young woman. The nurse recognizes and quickly interprets the impact the intense lived experiences have had. Collecting past medical history triggers the patient to re-live her experience with gaps in medical care, insulin rationing, shaming from friends, family, and the health care team around "poor" self-care, as well as perceived abandonment by the nation's health system. The nurse creates a safe space for the patient to share their experiences and reassures the patient she will be treated with compassion and respect. As the visit concludes, the patient says, "Thank you for listening and understanding." In this case, the patient is not re-traumatized. Improved access to care provides hope and healing can begin.

American Nurses Association (ANA) Code of Ethics

The ANA Code of Ethics for Nurses is a foundational document outlining the core values and ideals of the nursing profession (ANA, 2015). It includes 9 provisions with interpretive statements for all nurses, in all settings. A main tenet is "to provide normative, applied moral guidance for nurses in terms of what they ought to do, be and seek" (p. xii). The ANA revises this document every ten years, with the next revision set for release in 2025 (ANA 2025 Code of Ethics for Nurses Revision Panel, n.d.). Awareness of the human impact of trauma has expanded since the 2015 revision. This author expects TIC and DEI to be explicitly represented in the 2025 revision.

Duty to Care: Patient

While TIC is not overtly mentioned in the 2015 ANA Code of Ethics, the principles are. Specifically, provisions 1-2 outline the nurse's primary commitment as the patient, conducting nursing practice with compassion, and respecting the inherent dignity and worth of all. Similarly, provision 8 discusses the nurse's obligation to reduce disparities and stresses the protection of vulnerable and socially stigmatized groups. Nursing has a long history of advocating for vulnerable, marginalized populations. Many patients with traumatic life experiences will fall into these categories. Therefore, trauma-informed patient care is ethical, socially just, and not optional for nurses.

Duty to Care: Self

The ANA code (2015) also directs the nurse's responsibility to care for self. Provision 5 discusses personal well-being, along with personal and professional identities. The code explicitly states, "when nurses care for those whose…attributes, lifestyle, or situations…conflict with…personal beliefs, nurses must render compassionate, respectful and competent care" (p. 20). Provision 5 goes on to advocate self-reflection and personal performance evaluation.

Self-Reflection

Self-reflection is a process of listening to, and continually self-assessing one's thoughts, values, assumptions, beliefs, expectations, experiences, and actions (Johns, 2022; Clawson, 2012). In clinical and professional practice, incongruities can occur between one's vision for performance and what transpires. Self-reflection is useful for understanding those incongruities in desired vs actual performance, and developing sensitivity to wider contexts when providing TIC (ANA, 2015; Berger & Erzikova, 2022; Burks, 2023).

Human inclination is to avoid high-stakes or emotionally charged issues (Berger & Erzikova, 2022; Burks, 2023; Camilleri et al., 2023; Johns, 2022). Avoidance inhibits problem-

solving or growth. Introspection that comes with self-reflection allows for transformative learning and self-improvement. Sharing personal or professional growth gleaned through self-reflection is a brave and vulnerable act, making psychological safety in the work or learning environment critical (Camilleri et al., 2023). While there are several published works to guide self-reflection, the Model for Self-Reflection provides clear phases to guide the process (Johns, 2022)

Model for Self-Reflection (MSR)

The Model for Self-Reflection (MSR) was developed and published by British nurse scholar, Dr. Christopher Johns in *Becoming a Reflective Practitioner*, now in its 6th edition. Dr. Johns (2022) suggests that the main goal of self-reflection is gaining insights into new possibilities for understanding oneself or a situation. These insights occur by "asking difficult, often self-exposing questions, and then facing the difficult answers to such questions" (p. 61). As with any personal reflective exercise, finding a quiet place—away from distractions, a block of time, having an open heart, an open mind, and a willingness to grow will yield the best results. The MSR is structured in six sequential phases as depicted in Table 1.

As previously discussed, clinical encounters can be traumatizing, and not every clinical encounter will go as planned. Case exemplar two illustrates TIC and a nurse utilizing the Johns MSR for personal growth and ultimately improved patient care.

TABLE 1 Model for Structured Reflection (MSR)

Phase	Focus / Questions
Phase 1: Preparatory	• Center the mind • Clear away distractions

Phase 2: Descriptive	• Describe an experience or issue, outlining brief salient points
Phase 3: Reflective	• What is significant to reflect on? • Why did I respond as I did? • Did I respond in tune with my vision? • Did my feelings and attitudes influence me? • Did past experiences influence me? • Did I respond ethically for the best?
Phase 4: Anticipatory	• Given a similar situation, how could I respond more effectively, for the best and in tune with my vision? • Am I skillful and knowledgeable enough to respond differently? • Am I powerful and poised enough to respond differently? • Do I have the right attitude?
Phase 5: Insight	• What tentative insights do I draw from this experience? • How do I now feel about the experience?
Phase 6: Representation	• How can I communicate my insights most effectively in written/performance format?

Johns, (2022).

Exemplar Two

A 24-year-old male, new patient, living with type 1 diabetes presents with severe hyperglycemia. He presents with a similarly aged female and a 5-year-old child. The nurse reviews past medical history and history of present illness (HPI). The nurse notes testosterone on the medication list and asks for confirmation and associated background. The patient becomes angry, stating he is not in the office to discuss other medications, only diabetes. The accompanying female abruptly stands up, whispers to the nurse "he's transgender," and leaves the room with the child. The patient elects to terminate the visit and requests reassignment to another care provider. The patient registers a formal complaint against the nurse, accusing the

nurse of being biased and insensitive. The complaint describes experiences with discrimination in multiple other offices due to gender identity and desire for gender-affirming hormone therapy. This case illustrates patient, clinician, and health system-related factors for trauma-informed care. A patient's trauma can be re-triggered with the collection of past medical history and medication reconciliation tasks. For the nurse, the suggestion of bias, insensitivity, and implied lack of compassion provides a necessary pause for self-care via self-reflection. For health systems, this case illustrates the importance of noting gender identity in electronic medical records.

Applying the Model for Structured Reflection in Gender Diversity

Individuals with gender-diverse experiences are a population at risk for trauma. Evidence from the 2022 US Transgender survey reported that of transgender respondents aged 18 and up who had seen a healthcare provider in the previous 12 months, 48% reported at least one negative experience (James, et al., 2024). These experiences included refusal of care, being misgendered, harsh language from the provider, or having a provider be physically rough or abusive during the encounter (James, et al., 2024). The slightest inflections in voice or mannerisms, even if unintentional, can re-trigger trauma or re-traumatize.

Nurses may feel unprepared to provide TIC for a transgender patient as in case exemplar two. The process of self-reflection improves the understanding of factors contributing to re-traumatization in the encounter. In this case, the nurse gained insight into divergent personal and patient values concerning gender-affirming hormone therapy. Presenting voice and body language were not neutral, suggesting the presence of an unconscious bias. Given past experiences, and lack of therapeutic communication, the patient quickly sensed this.

Affirmation is demonstrated through language, non-verbal communication, and listening. Johns (2022) defines affirming, person-centered care as "focusing on the needs of the individual receiving care, ensuring that their preferences, needs, and values guide clinical decisions and provide care that is respectful of and responsive to them." (Johns, 2022, p. 56). While a nurse may have a different value set, person-affirming care focuses on the needs of the individual receiving care (Johns, 2022). Asking "What would you like to focus on today?" and "How can I help?" are person-centered, sensitive, and welcoming initial questions as the nurse works to establish a trusting relationship. The clinical encounter in exemplar two did not go as planned. However, through intentional self-reflection, the nurse gained important personal insights to improve future care. In fulfilling Johns' MSR's last phase of representation, nurses should consider sharing stories and communicating insights with colleagues.

Conclusion

Clinical encounters are vulnerable times for individuals with a history of trauma. This work has uniquely connected the concepts of TIC with nursing's ethical duty to provide care to both the individuals and self. This work also serves as a clear call to action: nurses must actively incorporate TIC and DEI principles into clinical practice. Recognizing populations at risk, and accurately interpreting an individual's unfolding trauma story allows a nurse to "see" the person and respond with sensitivity and compassion. This approach promotes psychological safety, ethical DEI care, and helps reduce re-traumatization. Utilizing a self-reflection model promotes personal insight—"seeing" self, thereby promoting personal and professional growth. Sharing insights with colleagues will model transparency, open dialogue, and foster healing.

References

American Academy of Nursing (2023). *2023-2024 policy priorities to achieve health equity*. https://www.aannet.org/policy-advocacy/policy-priorities

American Diabetes Association Professional Practice Committee (2024). Diagnosis and classification of diabetes: Standards of care in diabetes. *Diabetes Care*, *47*, S20-S42. https://doi.org/10.2337/dc24-S002

American Nurses Association, (n.d.). 2025 Code of ethics for nurses revision panel. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/revision-panel/

American Nurses Association, (n.d.). *ANA Enterprise 2023-2025 strategic plan*. https://www.nursingworld.org/ana-enterprise/about-us/anae-strategic-plan-2023-2025/

American Nurses Association (2015). *Code of ethics for nurses with interpretive statements.* Silver Springs, MD: Author.

Ashworth, H., Lewis-O'Conner, A., Grossman, S., Brown, T., Elisseou, S., & Stoklosa, H. (2023). Trauma-informed care (TIC) best practices for improving patient care in the emergency department. *International Journal of Emergency Medicine*, *16*(38), 1-9. https://doi.org/10.1186/s12245-023-00509-w

Bargeman, M., Abelson, J., Mulvale, G., Niec, A., Theuer, A., & Moll S. (2022). Understanding the conceptualization and operationalization of trauma-informed care within and across systems: A critical interpretive synthesis. *Milbank Quarterly*, *100*(3), 785-853. https://doi.org/10.1111/1468-0009.12579

Berger, B. K.,& Erzikova, E. (2022). Self-reflection is the engine that drives, grows, and sustains DE&I among leaders, mentors, and public relations educators and professionals. *Journal of Public Relations Education, 8*(4), 59-90. (no DOI)

Boyce, W. T., Levitt, P., Martinez, F. D., McEwen, B. S., & Shonkoff, J. P. (2021). Genes, environments, and time: The biology of adversity and resilience. *Pediatrics, 147*(2), e20201651. https://doi.org/10.1542/peds.2020-1651

Brown, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., Tu, D., Godwin, O., Khan, K. & Fridkin, A. (2016). Enhancing health care equity with indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research, 16*. https://doi.org/10.1186/s12913-016-1707-9

Burks, D. (2023). *Tips for centering equity in improvement*. Institute for Healthcare Improvement.. https://www.ihi.org/insights/tips-centering-equity-improvement

Camilleri, M. A., Allegra, M., & Kearney, J. (2023). Answering the wake-up call to nurse leaders: Five practices to restore psychological safety after the Vaught case. *Nurse Leader, 21*(2), 213-217. https://doi.org/10.1016/j.mnl.2022.12.020

Clawson, J.G. (2012). *Level three leadership: Getting below the surface*. (5th ed.) Prentice-Hall

Comas-Díaz, L., Hall, G.N., & Neville, H.A. (2019). Racial trauma: Theory, research, and healing. *American Psychologist, 74*(1), 1–5. https://doi.org/10.1037/amp0000442

Felitti, V. J., Anda, R. F., Nordenberg, D., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Giese, K. K. (2018). The emotional burden of diabetes: A look at diabetes distress. *Nurse Practitioner, 43*(8), 23-27. https://doi.org/10.1097/01.NPR.0000541470.61913.1c

Goldstein, E., Chokshi, B., Melendez-Torres, G. J., Rios, A., Jelley, M., & Lewis-O'Connor, A. L. (2024). Effectiveness of trauma-informed care implementation in health care settings:

Systematic review of reviews and realist synthesis. *Permanente Journal*, *23*, 135-150. https://doi.org/10.7812/TPP/23.127

Grossman S., Cooper Z., Buxton H., Hendrickson S., Lewis-O'Conner, A., Stevens, J., Wong L. & Bonne, S. *Trauma Surgery and Acute Care Open, 6*(1), 1-5. https://doi.org/10.1136/tsaco-2021-000815

James, S. E., Herman, J. L., Durso, L. E., & Heng-Lehtinen, R. (2024). *Early insights: A report of the 2022 U.S. Transgender Survey*. National Center for Transgender Equality. https://transequality.org/sites/default/files/202402/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf

Johns C. (2022). *Becoming a reflective practitioner*. (6th ed.) Wiley-Blackwell.

Kendall-Tackett, K. (2020). The health effects of childhood abuse and adversity: Mechanisms, consequences, and trauma-informed care. In: Geffner, R., White, J.W., Hamberger, L. K., Rosenbaum, A., Vaughan-Eden, V., & Vieth, V.I., (Eds.), *Handbook of interpersonal violence and abuse across the lifespan*, pp. 4409-4424. Springer Nature Switzerland. https://doi.org/10.1007/978-3-319-62122-7_179-1

Levy-Carrick, N. C., Lewis-O'Connor, A., Rittenberg, E., Manosalvas, K., Stoklosa, H. M. & Silbersweig, D. A. (2019). Promoting health equity through trauma-informed care. *Family and Community Health, 42*(2), 104-108. https://doi.org/10.1097/FCH.0000000000000214

Lewis, C. L., Lathan, E. C., Selwyn, C. N., Agnew, G. A., McCabe, S. D., Gigler, M. E., & Langhinrichsen-Rohling, J. (2021). BITTEN at the bedside: An application guide for nurse practitioners. *Journal for Nurse Practitioners*, *17*(6), 691-696. https://doi.org/10.1016/j.nurpra.2020.12.006

National League for Nursing (2024). *Diversity & inclusion*. https://www.nln.org/public-policy/nursing-education-issues/diversity

Roth, E. G., & Chard, S. (2021). Affective practices of diabetes self-management among older adults: Cumulative effects of childhood adversity. *Gerontologist*, *62*(4):568-576. https://doi.org/10.1093/geront/gnab124

Substance Abuse and Mental Health Services Administration (SAMHSA). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* HHS Publication No. 14-4884.

Trauma-Informed Care Implementation Resource Center. https://www.traumainformedcare.chcs.org