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Trauma-informed language as a tool for health equity

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INTRODUCTION

Trauma-informed care (TIC) is an organizational care delivery model designed to mitigate an individual's psychological trauma and prevent re-traumatization when receiving medical care. Many victims of violence have a history of prior traumatic experiences and TIC helps prevent continued traumatization. Prioritizing TIC leads to institutional change that utilizes compassionate, empathetic, and trustworthy care. Standard TIC education underemphasizes the importance of thoughtful verbal and written language. Problematic language is frequently used in patient care, and can lead to re-traumatization. Alternatively, trauma-informed language equips clinicians with skills needed to end cycles of re-traumatization, which benefits patients, clinicians, and the whole healthcare system.

TENETS OF TRAUMA-INFORMED CARE

The principles of TIC consist of four core tenets: (1) Realize the far-reaching impact of trauma, (2) Recognize the signs of trauma in patients, families, and those involved in patient care, (3) Respond by applying policies that ensure understanding, compassion, and ethical principles, and (4) Resist re-traumatization of patients and staff. These tenets offer a framework to mitigate difficult experiences and avoid re-traumatizing injured patients.[1] Also noted in the literature are the six principles of TIC (figure 1), which guide institutions on implementation of a trauma-informed approach.[2]

Although TIC curricula are often comprehensive, there is limited instruction on patient-centered language. It is unfortunately common in trauma centers to hear sarcastic, stigmatizing language used, perhaps as a negative coping mechanism. For example: labeling a patient as a 'frequent flyer',[3] or assuming a patient is inexplicably 'agitated' rather than afraid is dehumanizing and demoralizing at best, and at worst, harmful to patient care. This type of language leads to negative physician-patient interactions, patient distrust of the healthcare system, and the re-traumatization of both patients and clinicians.[4 5] Trauma-informed language combats this stigmatizing language; it fosters the ethical care of traumatized patients and promotes health equity and holistic healing.

CONSEQUENCES OF IMPROPER LANGUAGE

Words do matter. Physician communication to and about patients can have significant consequences for patients, clinicians, and the entire healthcare system.

Patients: Stigmatizing language increases the allostatic burden associated with a traumatic event. A person's allostatic load refers to the cumulative burden of stressful life events, including injuries. As the stress and trauma of an injury increases, so does the allostatic burden. Over time, patients' cumulative allostatic burden confers poor mental and physical health,[6] and even leads to higher mortality.[7]

Patients often internalize the language used in their care and may exhibit negative, self-deprecating speech patterns as a response.[8] One specific example is the use of the term 'recidivism'.[9] The Latin root '*recidivus*' literally means 'to fall back', and the term has historically been used within the criminal justice and psychiatric systems to refer to a relapse in negative behavior. In clinical research, the word 'recidivism' is used to describe re-injury, typically by similar mechanisms. Use of this word has been increasingly called into question because it implies criminality and culpability in an already vulnerable patient population.[10] Describing a patient as a 'recidivist' assumes that a *victim* of violence is a criminal. We owe it to patients to eliminate the word 'recidivism' from our clinical vocabulary so that we can shift away from negative language patterns and instead convey messages of positive self-worth.

Medical education: In medical education, communication is a learned skill. Students learn the true meaning of language through the subtle lessons of the 'hidden curriculum', where soft skills are learned by observing experienced clinicians. This hidden curriculum has the capacity to imprint an expectation of empathy, cultural competency, and professionalism. Unfortunately, it frequently manifests as attitudes, bias, and discrimination passed down from educators to trainees.[11] When educators use sarcasm, criminalizing language, and stigma in their everyday practice, learners internalize and perpetuate these habits. Addressing these biases

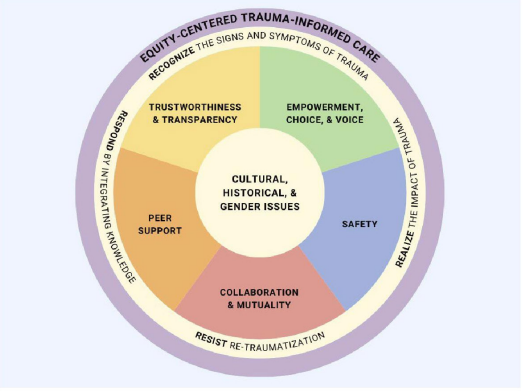

Figure 1 Core principles of equity-centered trauma-informed care. (Original artwork adapted from Thompson and Marsh [20]).

Box 1 How trauma-informed language improves health equity:

The use of trauma-informed language can improve health equity. Patient-centered language breaks the cycle of re-injury by decriminalizing patients and reframing violent injury. Rather than discussing a patient's re-injury as an inevitable result of bad character, it can be viewed as the unfortunate consequence of systemic racism, financial insecurity, or housing instability. This shifts the conversation away from blame and stigma, and towards a tangible solution where social needs are addressed. In this way, trauma-informed language reframes violent injury into a consequence of inequity, rather than a consequence of individual behavior.

and behaviors requires formal education on TIC and trauma-informed language at *all* levels of training.

Medical systems: Marginalized communities carry an understandable mistrust of the medical system. Although historical examples of racism in medicine, such as the Tuskegee Study, are frequently cited as a source of distrust, ongoing experiences of medical racism and biased language continue to contribute.[12 13] These violations of trust understandably cause patients to avoid care, underutilize preventative services,[14] have lower satisfaction with providers,[15] and have worse outcomes across all areas of care.[16] Repairing ongoing medical mistrust is the responsibility of hospital systems and physicians, not our patients.

In the trauma bay, mistrust may manifest as refusal of care, anxiety, and apprehension, which is often misinterpreted as 'agitation' or 'resistance'. In caring for traumatized patients, it is important to remember that patients are often afraid of the medical system.[17] We can have a positive or negative effect on their fear by the care we provide. When we stigmatize patients, their fear is confirmed and exacerbated. Conversely, when we use trauma-informed language, we treat patients with empathy, which can break down their mistrust. Trauma-informed language shows that physicians truly care about their patients and the communities they serve.

PROMOTING HEALTH EQUITY

Violent traumatic injuries disproportionately affect certain groups based on race, ethnicity, and socioeconomic status. Rates of firearm injury have a consistently disparate impact on men, young adults, and non-Hispanic black individuals. Communities with higher rates of financial insecurity have significantly higher rates of gun violence.[18] Victims of violent injury are a vulnerable population whose health equity can be improved through the use of TIC and trauma-informed language.

The social determinants of health that place disadvantaged populations at risk of injury also contribute to their risk of re-injury. TIC can help interrupt this cycle of re-injury by addressing inequity and mending core disparities. A trauma-informed framework is multidisciplinary and incorporates social workers,

Table 1 Patient-centered language solutions

Commonly used language	Potential provider error	Relevant trauma-informed care concept	Alternative language and solutions
'What's wrong with you?'	Implies patient is flawed rather than understanding that they have a medical condition for which they are seeking treatment	Safety, trustworthiness, collaboration and mutuality, empowerment, cultural and historical issues	What happened to you? How can I assist you? May I provide support?
'Man up', 'She's being a baby'	Underestimates physiologic/psychologic magnitude of pain, assumes weak character	Cultural and historical issues, demasculinization	Avoid unjustified assumptions about pain severity; standard-of-care pain management including emphasis of multimodal therapy, autonomy, and emotional needs
'You're lucky to be alive', 'He's lucky it wasn't worse'	Implicitly blames patient for injury, adds hyperbole to severity of injury	Safety, trustworthiness	Avoid and debunk statements that injured patients are lucky; there is nothing lucky about being injured or harmed by firearms
'Let's see if we can get away with….'	Gives impression of bending rules for convenience	Safety	Clearly and honestly discuss risks and potential pitfalls of the current treatment plan
'Repeat offender', 'recidivism'	Treats patients as criminals, explicitly blames patient for injury	Criminalization, cultural and historical issues, safety	Use alternative medical language such as 'recurrence' or 'reinjury'
'This isn't their first rodeo', 'frequent flyer'	Implicitly blames patient for risk of injury	Stigmatization, cultural and historical issues, safety	Use typical medical language such as 'recurrence' or 'reinjury'
'They're so crazy', 'He was agitated'	Essentializes mental health diagnoses, fails to recognize re-traumatization responses	Stigmatization of mental health	Discuss and treat actual psychiatric diagnoses; recognize that behaviors that seem maladaptive are often defensive responses to re-traumatization; minimize re-traumatization
'Stop resisting', 'They're refusing care', browbeating language	Underemphasizes autonomy, fails to recognize re-traumatization	Culture and historical issues	Emphasize autonomy and shared decision-making; selective use of anxiolytics as per patient wishes or patient safety
'I understand why they got shot'	Makes undue assumptions about pre-injury circumstances, propagates disrespect or hatred of patient	Criminalization, cultural and historic issues, safety	Reflect on negative assumptions and feelings towards patient; providers who think their patients deserve their injury may need to be reassigned
'Apparently they were just minding their own business'	Makes undue assumptions about pre-injury circumstances, assumes patient is lying	Criminalization, cultural and historic issues, safety	Leave investigation of the patient's culpability to professionals

Language is learned, and adopting trauma-informed language is an intentional process. Approach this process with open-mindedness and grace; there will be mistakes along the way. Above is a table containing examples of health-harming language, an explanation of how this threatens trauma-informed care, and alternative language solutions.

case workers, and mental health workers to improve both social drivers and health equity.[19]

Similarly, patient-centered language breaks the cycle of re-injury by reframing violent injury and re-injury as the consequence of systemic racism, financial insecurity, and housing instability rather than an inevitable result of bad character (box 1). Rather than focusing on blame, the focus shifts towards tangible solutions to address social needs. In this way, we address the inequities that are the root cause of injury and re-injury.

CONCLUSION

Adopting trauma-informed language is an intentional process that requires open-mindedness and grace. It is important to realize that there are many examples of health-harming language that threaten TIC (table 1). To combat this language, we must promote a culture of humanity, TIC, and receptive learning that allows providers to safely make mistakes along the way to self-improvement. We must look inward to analyze and change our own dialogue, and also have the courage to look outward to address cultural and structural barriers that perpetuate harmful language. As we expand our understanding of how to care for traumatized patients, we must approach TIC with empathy and compassion. Apathy and sarcasm undermine our ability to humanize and to provide excellent care. Everyone benefits from responsible language; we owe trauma-informed language to our patients, our co-workers, and ourselves.

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