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About Time: Making Space in the Classroom for Students' Experiences of Trauma

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Abstract

Many medical students have experienced trauma and conditions affecting their mental health. Throughout medical school, especially during psychiatry portions of the curriculum, students and educators may face challenges navigating course material. Adverse classroom and patient interactions can lead to further traumatization, isolation from course content, and lapses in professionalism. Contemporary educational environments have become increasingly sensitive to the prevalence of trauma among students, but debate remains over how to simultaneously respect student needs and ensure engagement with important course

content. In medical education, a major challenge is to create learning environments that are attentive to students' well-being, while preparing students to encounter clinical scenarios they may find distressing. Principles of trauma-informed medical education (TIME) support medical educators and medical students to work together to create curricula and learning environments that are psychologically safe and appropriately challenging. As students engage with difficult course content at a suitable pace with support, they build resilience, embrace growth and learning, and become better able to manage challenging clinical scenarios as future physicians.

It was the end of our first year at medical school. We had dedicated ourselves to mastering nearly every organ system, with a final hurdle remaining: the mind. As we delved into the psychiatry curriculum, it became clear that the mind involved dilemmas that had not been as relevant to our consideration of the lungs and kidneys.

The patient being presented was a graduate student in his 20's with symptoms of anxiety and depression. As details of the case unfolded, students shifted uncomfortably in their seats. I wondered, how many of our classmates had experienced this same situation? Sensing the uneasy atmosphere of the room, I looked down at my desk; others around me seemed similarly discomfited.

As the weeks progressed, our class continued to struggle with the content of the course. Several times, students packed up and left in the middle of class, heads down, appearing on the verge of tears. Could the discussions of mental illness, self-harm, and emotional distress have brought forth experiences they had lived through themselves or experienced through close friends and family? In one session in a large, dimly lit auditorium, as a survivor of childhood trauma described a violent assault, students in the front row walked out. Later, we engaged in tense dialogue about the students who had left and about others whose heads were immersed in phones and laptops during the session. Under pressure, one student reluctantly disclosed that looking at his phone quelled his sadness and fear, at least enough to allow him to remain in his seat.

Medical professionals have increasingly incorporated into their practice the principles of trauma-informed care.¹ A major societal theme of

our medical school curriculum, trauma-informed care acknowledges that the majority of patients have experienced trauma, defined as physically or emotionally distressing events leading to long-term adverse effects.² Students learn to assess patients for trauma, and to adjust medical history-taking, exams, and procedures to facilitate patients' comfort and trust when trauma affects their experience of care. Medical providers, whether physicians or medical students, have also experienced trauma.³ Trauma related to mental illness is prevalent among medical students; almost one third of medical students experience depressive symptoms and 11% have had suicidal ideation.⁴ How do we educate future physicians to be empathetic providers while acknowledging their own experiences of trauma—in other words, provide not just trauma-informed care but also effective trauma-informed medical education (TIME)?⁵

Students and faculty at our medical school have discussed whether and how the learning environment and curriculum should be modified when the course content is potentially distressing. Nationwide, media and cultural commentators have brought attention to university policies allowing students to isolate themselves and choose not to participate when confronted with difficult subjects in the classroom.⁶ From trigger and content warnings to subjects being dropped from the curriculum altogether to avoid controversy or distress, contemporary educational environments are increasingly attentive to the history of trauma within the student body, leading to new questions both for students and educators.

Students are entitled to protect themselves from feeling overwhelmed by painful recollections during learning sessions. At the same time, in

clinical settings, medical students will inevitably encounter situations reminiscent of their struggles. Clinicians arguably must assume the responsibility of tackling difficult topics with their patients. If we cannot, then who will?

Educators must strike a balance between these seemingly disparate concerns. While respecting the safety and well-being of students, educators must still prepare students to encounter and competently manage clinical scenarios they find personally distressing. A learning environment best equipped to do so fosters psychological safety, an atmosphere where beliefs and thoughts can be shared without fear of social or academic repercussions.⁷ Educators can achieve psychological safety in the classroom by clearly setting goals and expectations, and facilitating open, nonjudgmental communication.

Faculty play a critical role in determining whether the atmosphere of the classroom feels uncomfortable and closed to conversation versus safe for communication and learning. When teaching about mental illness, faculty should open with an acknowledgment of the prevalence of these experiences in medical students and a reminder to show consideration for fellow classmates who may have experienced trauma.⁵ These portions of the curriculum should be the subject of frequent student feedback, ideally in advance through volunteer student representatives, with the option to express any concerns about the learning environment.

Opportunities for open and nonjudgmental conversations must be available for students. Unlike the discourse that occurred among our classmates, students should never feel directly or indirectly pressured to disclose their traumas, even in charged conversations. Instead, students and educators should create spaces founded on empathy and begin with the assumption that all are putting forth their best efforts. Together, educators and students can facilitate compassionate communication by offering students more opportunities for reflection. Faculty may offer students opportunities to discuss or write about the links between what they are learning and their

own experiences or reflect together through optional and confidential discussion groups.

A compassionate approach using TIME does not necessarily mean giving students complete discretion to avoid all uncomfortable topics. As part of their careers, physicians will encounter traumatic and painful emotional experiences, as inevitably as seeing blood in a surgery. While students who feel unable to learn in the moment may step aside to engage in self-care, they should also try to re-engage with the topic at an appropriate time, seeking the support of trusted advisors or others in the community.⁵ Gradual, informed, and self-compassionate engagement with difficult topics builds emotional strength and resilience.⁸

The ability to practice self-care is an important skill for learners throughout the course of their education. Students can build self-care habits by learning new techniques, reflecting on processes of healing, learning, and growing, and discussing experiences with peers and mentors. Self-care includes exercise, creative expression, reflection and meditation, social connection, and more. However, while these practices offer many benefits, self-care alone is not sufficient. Medical schools must strive continually to examine their systems and promote supportive and psychologically safe learning environments, to prevent student re-traumatization and disengagement⁵ and professionalism issues in the future.³

The impacts of trauma are widespread in patients, providers, and students. Teachers and students can leverage principles of TIME for training future physicians to prevent and address alienation, isolation, and re-traumatization from course content.⁵ Medical schools should implement policies that recognize the prevalence of trauma in medical students and promote learning environments that are both psychologically safe and effectively challenging. The purpose of an education, after all, is growth. These principles encourage medical students to build resilience through self-compassion and a growth mindset.^{9,10} With time, they can become able to engage with their future work safely and wholly.

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REFERENCES

1. Raja S, Hasnain M, Hoersch M, Gove-Yin S, Rajagopalan C. Trauma informed care in medicine: Current knowledge and future research directions. *Fam Community Health*. 2015;38(3):216-26.
2. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA)14-4884. 2014:1-27.
3. Williams BW et al. Adverse Childhood Experiences in Trainees and Physicians with Professional Lapses. *Acad Med*. 2020.
4. Rotenstein LS et al. Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis. *JAMA*. 2016;316(21):2214-2236.
5. Brown T, Berman S, McDaniel K, Radford C, Mehta P, Potter J, Hirsh DA. Trauma-Informed Medical Education (TIME): Advancing Curricular Content and Educational Context. *Acad Med*. 2020.
6. Lukianoff G, Haidt J. The coddling of the American mind. *The Atlantic*. 2015 Sep 30;316(2):42-52.
7. Edmonson A. Psychological Safety and Learning Behavior in Work Teams. *Adm Sci Q*. 1999;44(2):350-383.
8. Cusack K et al. Psychological Treatments for Adults with Post-traumatic Stress Disorder: A Systematic Review and Meta-Analysis. *Clin Psychol Rev*. 2016;43:128-141.
9. Clark A and Sousa B. Definitely Unfinished: Why the Growth Mindset is Vital for Educators and Academic Workplaces. *Nurse Educ Today*. 2018;69: 26-29.
10. Osman NY, Sloane DE, Hirsh DA. When I say...growth mindset. *Med Educ*. 2020 Apr 3.