***Unrestrained* Episode 20 - Transcription**

Guest: Laurie Barkin

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Terry: Hello and welcome to *Unrestrained*, the CPI podcast series. This is our 20th episode and I want to give a very heartfelt thank you to all who listen in. Today my guest is psychiatric nurse and author of *The Comfort Garden: Tales from the Trauma Unit*, Laurie Barkin. Hello and welcome, Laurie.

Laurie: Hi, thank you!

Terry: You're welcome.

Before publishing *The Comfort Garden: Tales from the Trauma Unit*, Laurie Barkin worked in psychiatry for 22 years as a staff nurse, head nurse, educator, and psych liaison nurse. Since leaving her position as a psych liaison nurse at San Francisco General Hospital, Laurie has worked as a consultant to the University of California San Francisco, providing emotional and psychological support for psychiatric staff. She is an active member of the Bay Area Red Cross Disaster Mental Health group and volunteers at a nursing home giving end-of-life care. Laurie began her career on a surgical ICU before transferring to psychiatric nursing. After five years working on in-patient units in and around Boston, she returned to Boston University School of Nursing and earned a master's degree in adult psychiatric nursing with a focus on psychiatric consultation and liaison nursing. Laurie and her husband have raised three children who are now all in their 20s. She is an avid walker, singer, and gardener.

The Comfort Garden is Laurie Barkin's account of the five years she worked as a psychiatric nurse on the surgical trauma unit at San Francisco General Hospital. Told against the backdrop of patients who survived motor vehicle accidents, falls, fires, fists, bullets, and knives, *The Comfort Garden* is a metaphor for the emotional support caregivers need. The story illuminates the issues of compassion fatigue and vicarious trauma that may develop in caregivers when exposure to tragedy becomes routine. *The Comfort Garden* won the 2011 Book of the Year from the *American Journal of Nursing* and the Nautilus Award in 2012.

So Laurie, then, let's begin. In the book's introduction, a professor of nursing at the University of Massachusetts Lowell describes the context for the experiences you write about as "a high-powered urban trauma unit that serves the breadth of humanity. The stories are exemplars of compassion in dealing with misery and courage in the face of grief." Could you tell our readers about 4D, the specific setting in San Francisco General Hospital where the stories in *The Comfort Garden* occur?

Laurie: Sure. 4D is called the trauma unit and it's the surgical unit that specializes in treating victims of trauma, so that's people with gunshot wounds, stab wounds, broken bones, and blunt trauma as opposed to people who are ill. Everyone who's in San Francisco who experiences major trauma, even if you're Mark Zuckerberg, a new resident to our city, is whisked to San

Francisco General Hospital, which is an inner city public hospital, because it's the county's Level I Trauma Center, which means that it's fully staffed 24/7 to accept trauma patients.

Terry: I see. And what was your initial motivation to begin writing *The Comfort Garden*?

Laurie: Well, to answer that, I need to tell you a little bit about my job. In my work as a psych liaison nurse at the General [the nickname staff gave San Francisco General Hospital], I consulted primarily to the trauma unit and to the AIDS unit. I conducted psych evaluations of patients and helped them cope with the emotional aspects of recovery. In the course of these interviews, not only did I hear the details of the current trauma that brought the patient to the hospital, but I also heard stories of early childhood trauma because I would ask the question, "Have you had other trauma in your life?" Then I would hear these stories and I would ask that to see how people coped with previous traumas, which was really important to know because that would predict how they were going to cope with this trauma. For example, if they coped with using alcohol and drugs then I would have something to work with there.

So anyway, I was an experienced psych nurse before I worked at the General; I'd been working for 16 years. So I'd heard and I'd seen a lot but nothing like what I heard and saw there. But stories that I heard there just haunted me and they made me angry. There was so much sexual abuse, physical abuse, emotional abuse, and neglect in their histories. So because I'm an empathic person and because each day at work I was receiving a high dose of other people's trauma, I developed the same symptoms as my trauma patients did after a few years. I had nightmares, intrusive images during the day, palpitations, shortness of breath, I feared for my safety and for my children's safety, and I just had this general sense of doom. I would wake up in the morning and feel like there was this elephant on my chest. I had never had any of those kinds of symptoms before, never had problems with anxiety—none of that. I was a pretty healthy person.

Terry: I see.

Laurie: So at a psychological trauma conference, I heard this phrase "vicarious trauma" and also "secondary traumatic stress," which are synonyms, and that was the first time I had heard that, and that was four years into my job and I realized that I had all the symptoms that they described.

Terry: Is this fairly prevalent in psych nurses that you're finding?

Laurie: Well, that's really hard to answer. Let's just say it is not uncommon.

Terry: Okay.

Laurie: Not uncommon in that now there's so much written about it. If you Google it, there's a lot written about it. I think that people didn't want to talk about it; there's something shameful about admitting that you were having a very human response to other people's stress.

Terry: And that was maybe key in your initial motivation to think, "I've got to get this story out there, because people are so reluctant to address it."

Laurie: Well, that was it, to break through that denial, absolutely, and give a name to it. I think it was just really important to give a name to—because that was so useful to me to hear, "Oh my God, all of those symptoms have a name," so I wanted that to be out there and I also wanted to show how it develops.

Terry: Oh, wow.

Laurie: That's why I wanted to tell the story of it and also, as I said, I was a healthy person. It's not like I had had substance abuse issues or serious mental health issues or anything like that. I wasn't impaired in any way.

Terry: I will have to say, the episodic structure of the book really brings home that repetitive trauma that you experienced. The structure of the book to the reader really brings home that secondary traumatic stress, because one after the other in these vignettes that you write about these patients, we learn another extreme situation of trauma.

Laurie: Right, and that's the point; it's an accumulation of these experiences that really live in your body. They say, researchers say, that trauma lives in your body. It gets stuck there.

Well, if you've ever had an experience, I was just thinking about an experience I had many years ago on an in-patient psych unit. We had a patient who set herself on fire. I was the charge nurse at the time and she'd gotten hold of some matches, and she had long hair and a polyester shirt on, and she went up; she was a human torch. People finally got blankets and smothered her, smothered the fire out. I had to send her and three mental health workers to the hospital.

But afterwards for years, even until now, I'm just hypersensitive to smoke if I smell smoke. My husband and I years ago, probably about five years after that, went to a concert in Paris to hear the U2, U-Deux, and it was in a tent way out in the far reaches of the outskirts of Paris and it was raining and everybody at that time was lighting their Bics. There were all these flames. I freaked out; I just had to go; I had to leave. He stayed. I stayed right near the door and watched the concert from the door. I could not stand being around all that potential—

Terry: How resonant that memory is.

Laurie: Yeah. That trauma lives in your body. Think about it; you probably have the same experience.

Terry: I have something similar—I do. To bring the listeners into what a day might be like, your book opens with this indelible scene, because it occurs in the hallway of this general hospital. Could you describe that for our listeners?

Laurie: I had come, my first day at San Francisco General; this was the scene. I had come from working as a psych liaison at a private hospital, so totally different. At 4D as soon as I got there, I heard this male voice screaming and cursing loudly, dropping the F-bomb, as my kids would say, and telling a surgical resident where he could go, so to speak. The head nurse went down there and she spoke to the patient, who was an IV drug abuser, and she found out that when the surgical resident was removing the packing from the wound, that he had just ripped it out and ripped out healthy tissue with it at the same time, which had caused the pain. What should've

happened is that the patient first should've been medicated for pain, and this is what the nurses did when they removed the packing, would've medicated him for pain first. Then they would have saturated the dressing with normal saline just to loosen it. So she confronted the resident about this and all but accused him of mistreating the patient, and he just fumed and said he was going to report her to the Chief of Surgery, which was just silly because she and the Chief of Surgery were friends and they worked together collaboratively for many years.

Terry: So there's a political angle.

Laurie: Yeah. But then when they looked at the note that the resident had written in the patient's chart, it said, "Patient uncooperative with care." Of course, who writes history here, right? That's what it is; he's writing the history. The victor writes the history and that says nothing about the fact that the resident was the one who had caused the harm to the patient, unconsciously or consciously, and that it was preventable.

So was he burned out? Was he angry? Was he numb? Had he spent most of the previous night on call in the ER dealing with IV drug abusers? I don't know. But after working five years with trauma patients in that kind of situation, I understood him a little bit more and I was worried I was going to become like him.

Terry: I see. One of the things I believe will be most resonant with our listeners is the very present reality of nurse burnout. In the preface, you begin with a warning: "The stories in *The Comfort Garden* recreate the fast-paced work and transient relationships with patients at San Francisco General. Due to the push to discharge patients sooner rather than later, our work together often ended abruptly. The overarching story in *The Comfort Garden* is my own, how vicarious trauma developed in an experienced psychiatric nurse, forcing her to confront personal issues of identity, dependency and survivor guilt." How would you say that those ideas relate to the theme of the book?

Laurie: Well, the themes from my book are vicarious trauma or secondary traumatic stress and compassion fatigue. I wanted to make the point that first responders and hospital staff or anybody else who bears witness to the pain and suffering of others—and that includes judges, public defenders, teachers, social workers, counselors, anyone—can be permanently affected by that kind of witnessing. So it affects your beliefs about the world, your sense of safety in the world, your sense of security, your belief in human decency, your beliefs about love and family, and it also affects your physiological, psychological, and emotional foundation. That's all shaken up or can be shaken up when you engage empathically with traumatized people. That is called vicarious trauma.

Terry: All right.

Laurie: But compassion fatigue is what you feel when your internal resources have basically hit a wall, when you can't recharge or renew yourself and you're just drained out. They're very related and interrelated. Burnout is related but a slightly different term, and it refers more to the stresses in the workplace that can happen in any occupation. So a heavy workload, chronic staffing shortages, poor management, too many hours spent at work. But most people refer to all of this as burnout. I highly recommend a book called *The Compassion Fatigue Workbook* by Françoise Mathieu, M-A-T-H-I-E-U. She talks a lot about compassion fatigue and she defines, she

does a nice job of differentiating all those concepts and addressing coping strategies, and she also has a great website.

Terry: Excellent. To give an idea of what that can be like, I know Chapter Two of *The Comfort Garden* is called "As Real As It Gets," and I think you say that that's the motto for San Francisco General Hospital. Is that true?

Laurie: It is!

Terry: All right. "As real as it gets," that's quite a slogan for a health care facility. But it also tells you you're at ground zero, doesn't it? That's what the implication is.

Laurie: Yes, and we were, especially in the AIDS crisis. We absolutely were.

Terry: Yeah. This chapter's really good; you describe what I assume is rather an ordinary morning. You're given a list of three patients. Could you talk about that so our readers get a sense of what a random morning might look like and bring these ideas of compassion fatigue and burnout a little more up close?

Laurie: Sure, sure. I'm just going to read from the book. "This was my list on a random morning. I was asked to see Reginald Carter, who was a 31-year-old single black male, a graduate student beaten by four young men with baseball bats. His status: post right scapula fracture, left clavicular fracture and ORIF, which is Open Reduction in Internal Fixation of left tibia-fibula fracture. He did not have a loss of consciousness and I was asked to evaluate his stress and coping.

The second new patient was Melinda Grayson, a 26-year-old single white female, truck versus motorcycle, open book pelvic fracture, four little fractures, cheek fracture, skull fracture with positive loss of consciousness and again, I was to evaluate stress and coping.

And the third new consult was Rose Menaro, a 41-year-old white divorced female, status post-MVA, which is Motor Vehicle Accident versus pedestrian, with Open Reduction in Internal Fixation of right tibia-fibula fracture, no loss of consciousness but she was in behavioral management for the staff and they wanted me to fix her, do something with her, she was driving them crazy." So that's a typical morning with three new consults.

Terry: So good morning! Wow.

Laurie: Yes. Doesn't your morning start off that way?

Terry: Not exactly. Well, that certainly puts a perspective on what you're facing through the day. In Chapter Four of *The Comfort Garden*, the charge nurse on your floor, a woman named Trudy, asks you if you have time for a little crisis intervention. You would tend to a young woman named Hope, who fell two stories at a rave party and suffered some pretty serious injuries. Can you describe that intervention?

Laurie: Yes, yes. Hope was 23 years old and she had fractured her arm and leg. Trudy, the charge nurse, asked me to see her because she was sobbing uncontrollably since the physicians had

seen her that morning during their rounds. When I walked in, she was hyperventilating and literally clawing her face. I noticed right away that she had cigarette burns and scars all up and down her arms. When I talked to her, I learned that she had freaked out because the trauma resident, the same one that I had described earlier, had marched into her room with a bunch of students and had just been incredibly insensitive. He didn't address her, he did not ask permission to lift up her johnny and show people her injuries, and she got rigid, and I determined later—she didn't tell me outright, but I talked to her therapist and—she definitely had a history of childhood sexual abuse that got triggered.

So I taught her some relaxation techniques and wrote out a treatment plan that only two people could come in a room at once and that permission must be granted before anyone touched her. The point is that we don't know the trauma histories of the people that we're dealing with, and the incidence of, for example, childhood sexual trauma is unbelievable, one in three to four women in the country according to the ACE study, Adverse Childhood Experiences study they did at Kaiser. One in three to four women in this country have experienced sexual abuse during childhood, and boys also, although they're much more reluctant to admit it, but I've seen estimates that are as high as one in six.

In the 1980s, we finally figured out that the great majority of so-called borderline patients had histories of sexual abuse and it's just really important to be sensitive to this fact. When you restrain someone, just restraining a person can trigger these memories. One more point about that is that a restraining situation like that can also trigger our own memories of abuse, our own memories with out-of-control people in our lives, so that all comes into the situation and we have to deal with it.

Terry: So your intervention for Hope, then, was essentially intervening for other staff members who were doing inappropriate or traumatic things in their normal duties.

Laurie: Yeah.

Terry: Wow, that's amazing. One thing I'd like to get to now if I can before we go too much further is the title of this book, *The Comfort Garden*. Could you describe that in real and symbolic terms to give us a frame of reference for the title of the book?

Laurie: Yeah, the Comfort Garden is a garden on the San Francisco General campus. It's about 20 feet wide by about 120 feet long, and it was established in 1992 to commemorate staff members who had died, mostly of AIDS. There are several benches where you can sit and really tall trees and shrubs, flowers, roses, camellias, dahlias, just beautiful, beautiful flowers and no patterns or anything, everything just shoved in there, but it just works and it's gorgeous. And there's a psychedelic orange Thunbergia vine that goes the entire length of the garden, which is kind of fitting for San Francisco.

Terry: Striking.

Laurie: Yeah, and it's lovingly cared for by the gardeners and constantly changing, and for me, it was a refuge.

Terry: Is Antoine still there?

Laurie: I'm sorry?

Terry: I think his name was Antoine, wasn't it, who runs the garden?

Laurie: Oh, that is not his real name, of course.

Terry: Right.

Laurie: He might have retired by now because I walk at Ocean Beach all the time and he lives nearby and I've run into him and I think he retired. But he was there for a really, really long time.

Terry: I thought the way you described him was very charming in the book as someone that really cared for a place that had become a place of solace, I imagine, for yourself and a lot of people in the hospital.

Laurie: Yeah, patients as well, patients and staff would just hang out there, even if you just had 10 minutes. It was very renewing.

Terry: Sounds like a world apart indeed. Now you once worked in a unit where there was a sign that read: "The struggle is the treatment."

Laurie: Right.

Terry: That's a really provocative statement. I'm wondering how that relates to process, and you refer to yourself in the book several times as "the process queen." Can you tell us about those two things, the struggle is the treatment and how it relates to this idea of process?

Laurie: Right, okay. Well, first I have to tell you a little about psychiatry.

Terry: Okay.

Laurie: I went to Boston University for my undergraduate and graduate degrees in nursing way back in the 70s and 80s. Psychoanalytic theory was the dominant theory in Boston and in the Northeast in general at that time, so that's what we focused on in school.

Terry: That approach is Freudian, then?

Laurie: Yeah. So attention was paid to feelings, unconscious and conscious, what provoked them, what memories they in turn evoked, so the idea was to help patients put their thoughts and feelings into words instead of acting them out. So the goal being self-knowledge, self-understanding, and importantly, self-compassion. Yeah, okay, you might have done this thing that you're really beating yourself up about but let's look and see why you did it, what motivated you to do that, what's going on, and then of course, now you can understand why you do that and then now what can we do to change that.

Terry: That self-discovery is the struggle then.

Laurie: Yes, yes. It's slow, it's methodical, and it's very painful to get to those places. So yes, that's the struggle. The process part is—I was working at McLean Hospital, very well-known psych hospital. James Taylor and all his siblings were there; he's very out with that so that's why I can say that.

Terry: Okay.

Laurie: Jonathan Winters, a lot of celebrities used to go there, before my time. But anyway, people would come. I worked on the admissions unit and people were there in the middle of a manic episode or they were floridly psychotic or they were absolutely bent on killing themselves and it was very acute. So all of us, doctors, nurses, social workers, mental health workers were required to attend a weekly process meeting. Required, this was mandatory, that we had to attend to talk about what was going on with us. How were we affected by our work? Once we had a young man who had murdered an elderly neighbor. We had lots of people who self-mutilated sometimes on the unit, and I told you about the woman who had set herself on fire and all kinds of other experiences.

It helped to have a place to talk about these things, and in those process meetings, it bordered therapy but it wasn't psychotherapy. It was to go through what had happened, how we felt about it, how we were going to cope with it, and how we were going to do it with the next patient, how we were going to improve.

So those are really, really important kinds of meetings to have, and when I moved to San Francisco in 1983 I was shocked by how psychiatry was practiced here, I have to say. It's not just my experience; most people I've talked to from the East Coast and Chicago, Michigan, those places, same thing. When I came, things had changed drastically. Hospitalizations were very short, less than a week, and the goal was rapid re-stabilization using medications. No one talked about feelings; they didn't help patients understand and cope with them; there wasn't time to do that. There just wasn't a culture of staff meetings, except in maybe one place, which is no longer, Mount Zion Hospital, which was very psychoanalytic but no longer exists.

I always joke that in Boston, the word "process" is a noun and a verb but in San Francisco, it's only a noun and a really boring one.

Terry: Right, I understand. That's quite a paradigm shift from the support structure that you had as a psych nurse, a very dramatic one.

Laurie: Right, from the East Coast. Now some trauma—I have since found out that some trauma programs do have a weekly debriefing session for staff. It really is a mandatory thing if you're going to be dealing with trauma. It's just that for whatever reason, as I say, the culture in San Francisco is not about that and it doesn't happen here. Except maybe, I've heard, in a rape crisis center it did.

Terry: You've got a—I want to get to this guy; you've got a chapter in your book about a patient named Pee Wee, who was in the unit for a collapsed lung; I think he sustained it while smoking crack, and he's walking around with a Pleur-Evac and a long pole. The chapter is called, "A Walking Time Bomb." Could you describe for our listeners Pee Wee and how you could see his

behavior escalating as his stay progressed? And I believe you even wrote up a nursing care plan for Pee Wee describing how and when to set limits on his behavior.

Laurie: Right, right. Oh, Pee Wee.

Terry: So many years ago, it seems.

Laurie: So many years, I can still see him very clearly. Pee Wee was really scary, he was 22, he was six-foot-five, he was all arms and legs, he was an alcoholic, he was HIV-positive, he was bipolar, and he used crack, which is what caused his collapsed lung, which is why he got admitted to 4D. While he was there, he was on God knows what kind of drugs, right, so you get the picture. He had tubes in his chest wall because of his collapsed lung and that was attached to a Pleur-Evac, which is a briefcase-sized hard plastic container that collects drainage from the chest wall. So that was on wheels or something. And he also had an IV so that was on a long IV pole and then he was toting both of them, pushing both of them around the unit. When I first saw him, he was pacing around the unit, sometimes going in other patients' rooms, but if you told him, "Hey Pee Wee, that's not your room; get out of there," he would get out of there. He was on pain medications, anti-anxiety medications, anti-nausea medications that didn't seem to touch him at all. All those things, especially in combination, would just snow the normal person but not him.

Terry: Because of his size and his tolerance to these things, perhaps?

Laurie: And his mania and crack, who knows how everything was interacting. I knew from his history in his chart that he was persona non grata at another hospital because he had ripped a room to shreds. I could see he was in tenuous control and I had worked with plenty of manic patients before in in-patient psych units. Two times I was almost very badly injured; both times involved manic patients. And I was also seven months pregnant at the time.

Terry: Oh!

Laurie: Anyway, on a surgical unit there are crutches, IV poles, wheelchairs, traction lying around, other equipment lying around in the unit, whereas there wouldn't be on a psych unit. But he couldn't be on a psych unit, which is where he belonged, because of his chest tubes and stuff. In a couple days it got to the point where Pee Wee was undirectable, so he would go in other people's rooms and then would not listen to you when you told him to get out, and he started to get very brittle and verbally explosive when you did set verbal limits on him. "You can't tell me what to do," that kind of thing. He got very gamy about taking him out for cigarettes, and I would do that. I was really babysitting him because people didn't know how to handle him. It's not a psych unit; there weren't any other psych nurses around.

Eventually, we got psych medication at least available in case we had to use it but—

Terry: Do you know if the other nurses in that unit had had some crisis intervention training to maybe get a little more familiar with how to handle a patient like Pee Wee?

Laurie: They might have but it was a surgical unit, and that was low on their list so probably not, probably not. I'm sure people in the emergency department did, and I know that staff on the in-patient psych unit did. I know that they did. But probably not in the med/surgical units.

Terry: No?

Laurie: Yeah, he was just—we don't have too many people like him on the in-patient med/surgical units, but when we do it's a huge problem. Eventually, we had to call the institutional police and they got all full of testosterone and went in there, ready to take control, and I was trying to talk with them, come up with a plan—

Terry: So this was a morning that this guy is ready to explode, finally. He's had it, right?

Laurie: Oh, yeah, yeah, he's clearly ready. We determined that we had to send him down to what's called the medical psych unit, which is mostly people who had overdosed or injured, self-injured. There were four beds in one room with one person watching those beds at all times. But these were orthopedic nurses who the hospital changes as they need to, and they were suddenly considered to be proficient in psychiatry, which of course they weren't.

When the institutional police came, Pee Wee calmed down with that show of force and he walked down there. But as his nurse was taking his vital signs (and she had to check the signs—it's just part of the normal transfer routine when you accept a new patient), first of all, she had positioned herself in between two beds and away from the door and he was between the door and her, which you never do when you're dealing with a psych patient. She was taking his blood pressure and he just exploded. He threw his Pleur-Evac, lifted it up and threw it through the windows, which were supposed to be non-breakable and broke, and then came back into the room, just missed her, and shattered the window—glass everywhere. At this point the IPs had left, the institutional police, and so I went, called them back, and they came, rushed in with the mattress, and put him into four-point restraints. Eventually, the mood stabilizers that he was given worked and I think he was transferred to psychiatry, but it was nasty; it was awful.

Terry: Expensive, dangerous.

Laurie: Expensive, dangerous, people could have been hurt, and really, it was sad. It was just so sad because when somebody's out of control, no one likes to be out of control. I've worked with psychotic patients. I remember one woman, Betsy, I worked with a long time ago would walk around when she was gearing up. She'd walk around the room with her fists clenched and her jaw clenched and she was hallucinating, and we would do a takedown with her, and I have to say we did it well. It was very respectful and coordinated because it was the staff who worked together and learned to do this well together. Afterwards, she was just so apologetic. She lashed out at me once and it was like, "Laurie, I'm sorry. Did I hurt you? Did I hurt you?" and this total—it affects their self-esteem because you learn from the time you're a little kid that being in control of yourself is important.

Terry: Right.

Laurie: So anyway, it's very painful, and as I said, again, many of these people have sexual abuse histories so then that gets reenacted and re-triggered.

Terry: I see. This idea of setting limits, one of the chapters in the book is titled, “Limit-Setting Will Not Be Tolerated in San Francisco;” that’s pretty provocative. Can you talk about what that meant in practical terms in the trauma unit?

Laurie: Yeah. You know San Francisco prides itself on being a very tolerant city that embraces diversity, right?

Terry: Right.

Laurie: Which is a very good thing; that’s why a lot of us live here and we love that. But San Francisco also tolerates behaviors in the street that other cities would not tolerate. I’m sure Milwaukee would not tolerate using sidewalks as a toilet, right?

Terry: No.

Laurie: Psychosis on the street, drug use on the street, homelessness of course is a huge problem for us, or people begging to the point of harassment.

Terry: Yes.

Laurie: We don’t seem as a city to be able to address this compassionately but with limits. It stymies us here. Sometimes that attitude extends to the hospital environment as well. We once had a patient on 4D who was an IV drug abuser who had necrotizing fasciitis, which people might remember is called the flesh-eating bacteria, literally eats muscles.

Terry: Hard to forget once you’re aware of it.

Laurie: And it eats literally in a matter of minutes; I mean, this is really fast. We had a rash of these cases that we traced back to dirty heroine from Mexico. We had a patient who had—her thigh was gone and she had to have—oh, sorry, I think it wasn’t her thigh, I think hers was the arm or something—anyway, she had to have a series of skin grafts where the disease had taken the muscle away. But see, when you get grafted, you have to stay on bed rest for 10 days.

Terry: For how long?

Laurie: Ten days.

Terry: Ten days.

Laurie: Ten days, you have to stay on bed rest, pretty strict bed rest for the graft to take. It grows; you’re putting, transplanting healthy skin onto this open wound.

Terry: But for an addict, 10 days could be an eternity.

Laurie: Yes, exactly and especially if you withhold pain medication, which happened all the time. Residents and physicians have a hard time giving people, especially drug addicts, the level of drugs that they need because they’ve developed a tolerance for these drugs. It was almost

never enough, right, and she would get up and go use drugs, and every time the graft then would fail, and then you go back to she has to be readmitted again through the emergency room, transferred up to the unit, back to the OR, back to recovery, back to 4D, and this happened four or five times. Nobody would read her the riot act; nobody would set a limit and say okay, this is the last time we're going to do this. It wasn't handled well and I think it should have been discussed by the ethics committee. I don't think it was. She probably, I don't know what happened to her but probably she didn't survive. Drug abuse is suicidal over the long-term.

Terry: Right, right.

Laurie: So it's either going to happen sooner or later. Probably it did.

Terry: Speaking to another aspect of culture that you bring up in the book, you write about a Dr. Gluznick who has sex with a patient, is it Gluznick?

Laurie: Yeah. Well, I made up these—that's not his real name, however you want to pronounce it.

Terry: I'm sorry, of course. Dr. Gluznick who has sex with a patient and then later, under the influence of methamphetamine, tries to kill him with an axe. You go on to say that physicians are reluctant to implicate their own as the repercussions played out for Dr. Gluznick. Then you go on to write this: "Nurses, in contrast, respond to each other's errors in the opposite way. In a flash, one nurse will write up her colleague for giving a patient an extra dose of Tylenol or missing a dressing change. Nurses judge each other to the point where some say we eat our young. Our problem is excessive criticism, not denial, not collusion." What about nursing culture creates this excessively severe and immediate judgment, do you feel?

Laurie: This is such a good question and if you Google "nurse-to-nurse bullying" or "nurse-to-nurse incivility" now, you will see how big a problem it is. I recently gave a talk about nurse-to-nurse bullying, and it's a lot of nurses trying to tease it out. I did research this; some people speculate that it has to do with "mean girl" behavior in the workplace. Literally, mean girls from junior high still using the same kinds of behaviors.

Terry: Tactics.

Laurie: And communication patterns, sorry?

Terry: Tactics.

Laurie: Yes, tactics and a culture that tolerates it, that doesn't set limits on it. From the top, you have to set limits on that, say what's acceptable, what isn't, and if it doesn't happen, it can run rampant. That's part of it. I speculate it has to do with a passive-aggressive way of handling anger in conflict that is more typical for many women, especially a lot of nurses. There's a long history of that in nursing, I think. Part of it stems from a general lack of resources. So it really gets down to the fact if you don't have enough staff to deal with a really acute unit, it's frightening. It's anxiety-provoking because you are dealing with life and death and everything in between, so it's really easy to attack each other.

Terry: I would also have to say that part of this has got to be a gender issue to where nurses are taught that they're second class to physicians who have primarily in this culture of late been male, and in that secondary status you have license to attack each other, perhaps.

Laurie: Well, yeah, I think it's changing.

Terry: That's good.

Laurie: What's happening, it's gradually happening, is that nurses in many states (I think it's close to 40 states now) have prescriptive privileges. This is shocking; it's true! Nurse practitioners, so they are becoming the primary prescribers in a lot of places, especially in more rural places where physicians don't want to work. In psychiatry, it's especially true because fewer residents, trainees, interns want to go into psychiatry because these days, it's all about medications.

Terry: Right. That leads into a question I have here. One of the main themes in *The Comfort Garden* is institutional denial—the administration in San Francisco General and, by extension, a lot of other hospital cultures in major US cities, maybe have become insensitive to the real need for trauma support for their staff. You've said to me in an earlier conversation, self-care is not enough. What do you think are the driving forces, the causes behind the critical shortfall in vision for administration at hospitals?

Laurie: It really is a shortfall in vision; that's a good way to put it. I think just as there are dysfunctional families that we're all familiar with, there are dysfunctional institutions because those people from those dysfunctional families are now heading, are in charge of, those dysfunctional institutions. Yeah.

Terry: It'd be hard to not see where that chain of events would be logical.

Laurie: Right, and think about it; a hospital recreates the same chaos that you might have experienced in your family, and in fact, in *The Comfort Garden*, I compare San Francisco General Hospital to a huge chaotic family where the parents are totally overwhelmed, unable to care for the kids or to keep the environment safe. If you recognize that as a problem, it's incumbent upon you to do something about it, right? And that always takes time and money.

Terry: And guts.

Laurie: And guts. You're incentivized then, especially when your resources are limited, just to deny that it's a problem. What problem? I don't have to fix anything. There's no problem. We live here in San Francisco; sometimes denial is useful, like here, because we live above a major geological fault that could shift as I'm speaking to you right now. In fact, we had a 4.0 last week.

Terry: Right.

Laurie: If I thought about that every minute, that my house could be devastated and everything could go up in flames . . . you'd go crazy, right? So denial is sometimes very useful. But on the other hand, as a country, we deny the scourge of childhood sexual abuse, which I keep talking about because we are in denial about it. When was the last time you heard a public official, like

maybe a Surgeon General, acknowledge the fact of childhood sexual abuse, even though it affects so many people and it costs us so much in the long run, right?

Terry: Right.

Laurie: Politicians won't talk about it. No one will talk about it. There's just so much denial about it.

Terry: I think it's a public relations gamble of a huge order for anyone in the public eye, and that's part of what really holds them back. What kind of scrutiny is this going to invite? It's unfortunate. It's a look that needs to be taken, but you could see political actors can sometimes be timid around controversial subjects. This might be one that's prime to step back from.

Laurie: I don't expect politicians to talk about it, but maybe a Surgeon General has to be political. But we've had some great Surgeon Generals in the past who stood up. Everett Koop stood up against cigarette smoking. Right?

Terry: Yeah, sure. Yes, he did. He got challenged by the tobacco lobby as if he was some sort of frivolous character, which was surreal.

Laurie: Yeah. But we've made huge changes in cigarette smoking as a result. So I think a Surgeon General could do this.

Terry: Excellent. You were the driving force behind trauma support groups at San Francisco General. I'm going to change gears a little bit here to something that you brought in because I know support is part of process. Talk about the group you started at San Francisco—I like that—the General, and why you believe so strongly in support groups and why the managed care business model doesn't favor such a thing.

Laurie: Support groups are valuable to people who are in them because it's an incredible relief to realize that you're not alone with your symptoms, with your disease, with your situation, having been raped or whatever the situation is. People feel very alone and isolated in those situations. You have the feeling no one's going to understand. It's very hard to talk to people who haven't experienced the trauma that you have, just like we've all heard about veterans returning from war zones and feeling utterly alienated from their friends and family members such that they want to go back for another tour, because they're around people who understand them. Right?

Terry: Right.

Laurie: Oftentimes, victims of trauma are met with what's called a silencing response from people who can't tolerate the discomfort from their experience. So in groups, trauma groups in particular, people can talk about scars and disfigurement; they can talk about pain; they can talk about discomfort, about their body image and sexuality; they can talk about their PTSD symptoms like flashbacks, nightmares, paranoia, hyper-vigilance, anxiety reactions, fear—stuff like that. They know that in a group of other trauma survivors, they're going to be listened to and understood, not blamed and not judged. That's the value of trauma support groups.

Under managed care, anything that had to be paid for was not going to be supported.

Terry: How did that culture change? You were there, in the book I read, for the very significant culture change. Can you just give us a little overview of how that came in and the shivery feeling that things were changing and not for the better?

Laurie: Well, we're a teaching hospital, so we taught the medical residents from UCSF. In a teaching hospital, you take time. Patients get very big workups because, not just for them, they should get them but they're extremely thorough because it is a teaching hospital. On the other hand, for the patient, you're interviewed by many, many, many, many people, again, because it's a teaching hospital.

But suddenly, the most dramatic thing is that we had to bill for our time. There wasn't any way for the nurses to bill; we actually come with the room rates. But we had to fill out all this paperwork, tons of paperwork. We had to give diagnoses for every patient; we had to give a synopsis of exactly what we did with the patients; we were told to do as many initial evaluations as possible as opposed to follow-ups, because initial evaluations get more money for the hospital. So everything became about money. Everything.

So the quality of care that we had talked about, that we had valued and cherished as a group, because, especially the physicians—the nurses there are paid well—the physicians probably could have made a lot more money in the private sector, so they're a pretty special group of people and they really valued quality of care. Suddenly, that is not on the table anymore. It's all about money. It was a huge value shift and it was depressing, because I felt like we were in a horse race to see how many hours you could bill for and that's what you got rewarded for. Health care is way over the top in terms of expenses. But one of the things that can drive those expenses, of course, areis unnecessary procedures and tons and tons of paperwork, right?

Terry: Right.

Laurie: So I think it could have been handled a lot differently than it was and certainly there was a lot of other waste, other than what we were doing.

Terry: If not driven by a profit motive at the General, then what would be the rationale for embracing a business model like that?

Laurie: Well, it was still costing the city tons of money pumped out of the general fund.

Terry: Oh, I see.

Laurie: It was still costing a lot. Part of that is training. I don't know how it works between UCSF, the money between UCSF and the city, but in any case—

Terry: It's nice to have extra money, but where would it be more effectively spent? I guess that's a question not for me to ask, but you wonder.

Laurie: One thing, I think it's not all bad; managed care was not all bad.

Terry: Okay.

Laurie: It really did get people thinking about real aspects about money and finances and how we're going to pay for all this. So for example, after I left, I heard that they started a room-care clinic, so instead of having to see patients in the emergency room, let's say people who were skin-popping, this is IV drug users with skin pops so they would shoot bacteria, dirt into their bodies basically to have an infection, just to get off the street for a while.

Terry: Oh my God.

Laurie: To be hospitalized, yeah. So that usually meant six weeks of IV antibiotics. So they did that. That cost the city unbelievable amounts of money. So finally what they did is they instituted an outpatient wound care clinic where people could come in for the day and get their antibiotics. It was much cheaper.

Terry: I see.

Laurie: So things like that that came out of it—that was really important. You do have to think about money. That makes hard choices like what to do with this other woman who refused to be compliant with care, with her skin graft.

Terry: Right.

Laurie: It makes for a lot of ethical issues.

Terry: Near the conclusion of the book, you quote your friend Jeanie who was a geriatric nurse in Connecticut, I believe, and she said to you, "No one's doing the deep work of therapy anymore. When you want to talk about how hard it is to listen to trauma, you're shot down because it's too uncomfortable to hear and because it's not a cost-effective use of time. That's the trend, sugar. It's over for people like us; you and I are relics." She has since left the profession, correct?

Laurie: No, she's back.

Terry: She's back, okay, all right. At the end of *The Comfort Garden*, she is actually—

Laurie: She left. She left for a while, but she's back.

Terry: How do you feel about that quote that I just read? Is there a lot of truth in that sentiment still?

Laurie: There is a lot of truth and I tell you, she's back but the two of us talk about it regularly and we're both in mourning about what was, but it's over with. Times have changed. But what can I say? For me, I was in therapy for five years during my 20s. There were two major breaks from my patients for my therapist pregnancies but it was really the best investment I ever made. Without having that time to untangle the knots in my makeup, my parents were in a very unhappy marriage and it affected us, I would have married the wrong person; I would have had kids; I probably would have screwed them up; they would have had kids that they would've

screwed up. That would be a legacy and I feel like those five years that I invested have ended that legacy, I hope, and that remains to be seen but I've been very happily married to my husband for 31 years and my kids are doing just fine right now.

Terry: You credit the "deep work of therapy" too as part of and instrumental in that success?

Laurie: Absolutely.

Terry: Wow.

Laurie: Now, in the latest, when you go to neuro-psych trauma conferences, the neuropsychologists are able to show that talk therapy can make positive structural changes in the brain.

Terry: I see.

Laurie: Talk therapy over time. The problem is the insurance companies won't pay for it. They want to just pay for the quick fix; they want to pay for the medications. But medications don't teach you how to cope and they don't give you self-knowledge.

Terry: In terms of long-term public health, they're taking the narrow view.

Laurie: Very narrow view, right. Talk therapy helps you make positive, lasting changes in your life, especially in your relationships and to think about that over time. That's worth so much.

Terry: Yes. Now Laurie, when you think back on your youth and deciding your own identity and what you're going to become as a professional out in the world, I'm sure you aimed at that, who was your inspiration? What were some of your inspirations or a moment of, uh huh, this is who I am?

Laurie: Well, I'll tell you, I was not one of those people who went into nursing because I always wanted to be a nurse.

Terry: Okay.

Laurie: I liked biological sciences but I was very artsy. I was a very artsy person. I did visual arts but I also played cello; I played piano; I sang; I composed.

Terry: Maybe that's why the garden is so resonant for you.

Laurie: I guess. I guess I just wanted something so I could support myself while pursuing something in the arts.

Terry: I see.

Laurie: But then I found psych nursing, and for me, it was very creative with feelings and I resonated with that and I loved it, so it was a big surprise to me. I had all these credits in—

because I liked biological sciences—and I just applied it to nursing. That seemed to be the fastest, quickest way to be able to support myself, and I really did fall in love with psych nursing.

Terry: Excellent. So Laurie, first of all, you have a website, lauriebarkin.com. That's L-A-U-R-I-E-B-A-R-K-I-N dot com, and people can get your book there and read about you. They can also get it through Amazon, correct?

Laurie: They can only get it through Amazon or Barnes & Noble, not off my website, unfortunately. I am not the most savvy person that way. No, not yet on my website but please go to Amazon or Barnes & Noble and you can go right to it; you can at least read about it there and read the reviews, et cetera.

Terry: All right, Laurie. Is there a last takeaway you might want to leave with our listeners?

Laurie: Oh, let's see, didn't think about that. I would say, feelings count.

Terry: Feelings count.

Laurie: Feelings count. Pay attention to them and value them and treasure them.

Terry: I like that, very nicely done. Well, my guest today on *Unrestrained* has been Laurie Barkin, psychiatric nurse and author of *The Comfort Garden: Tales from the Trauma Unit*. You can find it on Amazon.com. I want to thank you very much, Laurie, for joining us today.

Laurie: You're very welcome. Thank you so much for the opportunity.

Terry: You're welcome, Laurie.