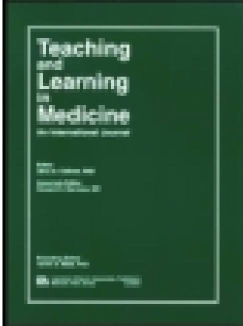

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OBSERVATIONS

On Triggering and Being Triggered: Civil Society and Building Brave Spaces in Medical Education

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ABSTRACT

Issue: How educators should respond to student reports of intense emotional reactions to curricular content—i.e., being triggered—invites intense debate. There are claims of insensitivity on one side and calls to "toughen up" on the other. These polemics aside, such instances sometimes represent a true dilemma, particularly within medical education where engaging highly sensitive content is essential to future patient care and where managing one's own emotions is a core competency. Parsing this convoluted and emotional debate into these domains illustrates how medical educators can simultaneously legitimize the lived experiences of students, engage in honest dialogue, and maintain a shared commitment to education. *Evidence:* While substantial energy has been spent debating the legitimacy of students' emotional reactions, the discourse lacks a clear conceptual framework and we often end up talking past each other. The concept of brave spaces offers an important alternative where sensitive subject matter can be engaged with civility. *Implications:* This paper offers a model for building brave spaces within medical education by clarifying the rights and responsibilities of both teachers and learners in each of three intersecting domains: intrapersonal, interpersonal, and civic. This model is exemplified in a case where students reported being triggered by course content. By parsing this case across the three domains, we can clarify how responses are multifaceted and we can simultaneously avoid indictment of another's lived experiences while preserving the pedagogical integrity of the curriculum.

KEYWORDS
Trigger warnings; learning environment; civil society; racism

Introduction

The conversation about students' sometimes intense emotional reactions to curricular content—i.e., "being triggered"—frequently devolves into an intergenerational shouting match. Students claim that medical educators' blind spots and their resulting offenses demand change. Educators retort that there are no "safe spaces" in medicine. Both perspectives represent valid concerns. It is important to foster equitable and inclusive learning environments and also to engage in discourse on sensitive subjects.

Previous work has largely centered on analyzing the legitimacy of these complaints or on mitigating them through curriculum management, such as the use of content warnings or trigger warnings.[1,2] These are important considerations, but how educators respond to students' emotional reactions first must be informed by a clearer framing of the rights and responsibilities of the different stakeholders involved. Doing so has become particularly important amidst recent social movements in protest of police brutality and systemic racism. Conversations on these topics had already come to medical education,[3] but their amplification by the recent social movements portend an increasing need to be especially deliberate in how we navigate the student experience within our curricula. In this article, we suggest a three-part civic framework to support efforts to build "brave spaces" by fostering a better understanding of how to navigate potentially upsetting content that nonetheless serves a legitimate and necessary educational purpose. In this article we will describe the brave spaces framework and then describe how paying attention to the intrapersonal, interpersonal, and civic domains of the learning environment can help us construct just such spaces for discourse.

We will begin with a disclaimer: The word "triggering" itself has been so widely parodied that it inherently may reek of dismissal or disdain.[4] We use

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it purposefully as a way to describe the real experience of some learners within medical education and write in good faith that we can simultaneously validate concerns about the emotional health of students and the educational demands of medicine.

Parsing a convoluted discourse

A triggering event can evoke a deeply emotional response and sometimes even be re-traumatizing. Slanted accounts of students taking great offense at seemingly ordinary events seem to get disproportionate attention.[5] Alternatively, however, consider a student who was recently sexually assaulted and is now trying to learn to conduct a sexual assault exam. It is not hard to imagine how this student's emotional reaction will disrupt their ability to learn. Because the term "triggered" can refer to such an expansive set of situations, the discourse on triggering has been dominated by discussion about which types of inciting events are legitimate.[6] Some suggest that triggering refers only to that which evokes past trauma. But stipulating the legitimacy of another person's lived emotional experience is an impossible and often offensive task. Trauma is a subjective experience rooted in individual biography.

Beyond the work of validating or invalidating claims of triggering, there has been lively discussion at the intersection of triggering and learning, particularly around content warnings or trigger warnings in syllabi and lecture slides. These terms are sometimes used interchangeably, but the former denotes a warning about content that may evoke any kind of negative reaction with varying degrees of intensity, while the latter is often reserved for content that has the potential to be re-traumatizing to a person in light of specific events in their past (e.g., having been sexually assaulted). Some suggest that these types of warnings promote emotional safety for students and therefore mitigate disruptions to their learning.[5] Others suggest that learning to deal with discomfort constitutes an important kind of learning itself.[7] A heated debate has erupted with accusations of insensitivity or even outright emotional neglect on one side and, on the other, claims that "trigger warnings" represent a "gun to the head of academia."[8] Polemics aside, whatever value trigger warnings might have for creating greater emotional safety, they are at least epistemically insufficient because they require predicting emotional reactions in advance.[9] We can often spot potential offenses, but learners bring a range of experiences to the classroom, which makes their emotional reactions impossible to predict reliably. Whatever efforts we make to prevent triggering, we ultimately still need a thoughtful way to respond when it inevitably happens.

Discussions about triggering have found their way into medical education specifically. Learning medicine inherently involves sensitive subject matter with the potential for "educational iatrogenesis," but students' abilities to engage that material with composure also is a core competency.[1,10] Despite common assumptions of a generational divide, surveyed medical students were evenly split in their support versus opposition to trigger warnings.[10] Mirroring the broader national debate, support for trigger warnings involved concerns about re-traumatization, while those opposed worried about developing resilience. Creating safe spaces for student reflection about challenging professional experiences is important for fostering professional identity formation and medical humanism amidst a historically dehumanizing hierarchical educational system.[11] However, safe spaces are not necessarily free of discomfort, which is indeed essential to medical education, particularly if we want physicians capable of helping patients who have suffered traumatic experiences.[1]

This has led to a shift toward "brave spaces" that sensitively facilitate engagement with provocative material rather than attempting to offer safety from this material altogether.[12] Drawing on Robert Boostrom's work reflecting on the functions and drawbacks of "safe spaces," Brian Arao and Kristi Clemens developed and popularized the brave space framework with the aim of preparing students to navigate more effectively the challenges of difficult conversations, particularly in the context of the learning environment.[12,13] They posited that classrooms functioning as brave spaces reflect five main elements:

1. Controversy with civility: Varying opinions are accepted as valid for discussion.
2. Owning intentions and impacts: Acknowledging and discussing where a discussion has affected the well-being of another person.
3. Challenge by choice: Having the option to step in and out of challenging conversations.
4. Respect: Demonstrating respect for others' basic personhood.
5. No attacks: Agreement not to intentionally inflict harm on one another.

By acknowledging that discussing provocative topics, particularly those having to do with human dignity, justice, and equity, carries inherent risk, the brave space movement, at its core, attempts to address students' tendency to conflate safety with comfort.[14]

Proponents argue that authentic learning about such issues inherently requires risk, difficulty, and controversy, all of which defy expectations of safety.[15]

At the same time, brave spaces are not complete departures from "safe space" models. After all, safety is a core value of community, even if we sometimes must balance it against other values like learning. Instead, the brave space framework treats the process of creating the ground rules for these discourses as part of the learning itself, rather than a prelude to learning. This is an important departure from traditional learning environments where the rules of engagement are handed down from faculty. Moreover, such a move toward democratizing the classroom complements broader efforts within medical education to foster genuine student engagement and even student ownership of the learning process. Indeed, the idea that part of discussing important and sensitive topics in a learning environment begins with involving teachers and learners in a meta-discussion about the structure of that discourse, underscores the nature of learning environments as full-fledged communities and the importance of the three-part framework we offer in the next section.

The brave space model also engages other important meta-discourses. For example, students are asked to remain attentive to ways in which patriarchal societies socialize people to view aggression and dominance as standard modes of engaging conflict. While the brave space framework calls on learners from targeted groups to recognize the inherent risk of controversial conversations, it also calls on learners from dominant groups to avoid replicating oppressive behaviors during those conversations.[12] While the brave space framework may, according to its critics, fail to sufficiently acknowledge the role that historical inequities and current power dynamics play in justice and equity conversations,[16–18] it clearly suggests a way out of the supposed dilemma where we must either choose safety over learning or academic freedom over civility. Indeed, it hints at a way to purposely employ a "pedagogy of discomfort"[19] by reimagining the learning environment as its own democratic society in which the rights and responsibilities of the both individuals and the collective must be continually negotiated.

To amplify the capacity of medical educators to reimagine their classrooms as brave spaces, if not altogether as civil-societies-in-miniature, we need a clear sense of how the rights and responsibilities of students and faculty are bounded by multiple intersecting social domains. We should start by recognizing that it is a shared commitment to education that brings into conflict two true conditions of triggering: 1) We must educate the student (e.g., about clinical exams for sexual assault) and 2) the content of that education may inherently trigger some students in a way that is disruptive to their education (e.g., sexual assault survivors). These seemingly conflicting premises can be navigated by considering how our responses should vary across the *intrapersonal*, *interpersonal*, and *civic* domains.

A case of triggering

The case below represents the kind of dilemma discussed above; an important lesson on bias in the diagnostic process was an important educational goal, but the content involved was inherently distressing to some students. We chose this example precisely because it represents a liminal case, where some would suggest that student complaints involve legitimate emotional trauma, while others would suggest they reflect emotional fragility (indeed, we have heard both responses from colleagues). The framework described in the next section illustrates how we can avoid compulsion toward that kind of judgment as we look toward creating brave spaces. Consider the following:

> A case-based learning activity on sickle cell disease was designed both to elucidate the role of stigma in pain management and highlight the insidious nature of bias in clinical judgment. To accomplish this, the discussion of one case intentionally underscored best practices for pain management of an acute vaso-occlusive pain crisis, including IV opioid therapy. In the very next case, a patient presented in exactly the same type of crisis, but the narrative was populated with numerous instances of biasing information, including noting that patient appeared to have "gang tattoos," and that the friend accompanying the patient appeared "to be high on something." The majority of the students failed to choose IV opioid therapy as the correct answer, frequently citing concerns about drug seeking, for which there was no evidence in the vignette. This motivated our discussion of how racism can corrupt clinical judgment. After all, the students were straightforwardly told the right answer in the preceding case, but still allowed irrelevant facts and stereotypes to affect their judgment. Following the session, two students reported being deeply offended by the case. One reported being so emotionally disturbed that he left the room after reading the case (prior to the discussion).

This case naturally evokes a range of opinions. Some see outright racial insensitivity or, at best, the kinds of blind spots often held by non-minority faculty. Others see an important educational moment. Still others fixate on the idea that the students were overreacting and need to "toughen up" to make it in medicine. But rushing to any of these judgments obviates important

features of our shared educational space. Instead, to create healthy spaces for important discourse, we need to think through at least three intersecting domains where each event must be considered.

Three domains of the educational space

The intrapersonal domain: A right to experiences and feelings

When a student says they have been triggered, there is a natural inclination toward defensiveness. After all, no one wants to make another feel badly, especially a student toward whom educators feel a level of responsibility. Such a report also can come as a surprise to a faculty member who may not have envisioned the potential for such feelings as they created the content. Finally, when a student perceives material as offensive, the faculty member unavoidably feels judged. As a result, our responses can easily devolve into some variant of "they should not feel that way." But this is the result of inappropriately mingling one's own concerns into the intrapersonal domain. Taking, for the moment, only the question of the student's feelings (temporarily leaving aside questions of what the teacher did and why), we can elaborate the rights and responsibilities of educators with respect to the *intrapersonal* experiences of the student more clearly.

Human experience is an emotional one. It is uncontroversial to say that our feelings often are motivated by our biographies in ways that are difficult for others who have not shared those experiences to fully grasp. When it comes to the intrapersonal dimensions of being triggered, then, we can stipulate that a student, like everyone else, has a right to their feelings, whatever they may be. Faculty, in turn, have a corresponding responsibility to not to disturb, diminish, or denigrate those feelings. This is implicit across several domains of the five characteristics of brave spaces defined above, most notably in the acknowledgment of the effects of discourses on the well-being of others, as well as more broadly within the basic tenet of respect. Bear in mind that this says nothing about the appropriateness of the material that triggered the students, or what should happen in response. The intrapersonal domain focuses only on the student's right to the terrain of their own emotions. In turn, *part* of the response in the case above should be to honor the intrapersonal dimension of the experience by acknowledging and legitimating it.

Just as importantly, the faculty member has a right to their own feelings (and this too says nothing evaluative about the event or material). A faculty member acknowledging and legitimizing their own feelings also is important in at least two ways. First, rights of faculty to their emotions and experiences can sometimes be lost in service to educating and supporting students. Second, a clear sense of one's own reactions to these student concerns is critical for the honest analysis required within the civic domain (discussed below) to avoid engaging in self-justifying rationalizations (e.g., where personal offense surreptitiously motivates claims about the educational value of the content).

Outside of considerations about the intrinsic legitimacy of each person's feelings, however, the expression of these feelings also involves relationship. While we should avoid allowing the interpersonal component of a triggering event to engender an attack on the intrapersonal experiences of the student and faculty, we certainly must address difficult questions about how to navigate the student-teacher dyad, where each has rights and responsibilities that must intersect.

The interpersonal domain: Responding to triggering in a relationship

While the intrapersonal domain invokes responsibilities of noninterference, expression of these feelings naturally compels reciprocal engagement. The first way to engage is to listen earnestly and actively. This goes beyond the responsibility of noninterference articulated above to involve acknowledging and legitimizing the student's emotional experiences. Feeling heard is sometimes even the primary goal of expressing one's emotions. Moreover, another's experiences are not always obvious to us, so we often must work thoughtfully and empathically to understand them. Not coincidentally, this is similar to clinical communication best practices we often teach student-physicians: asking open-ended questions, legitimating patient experiences, etc.[20] These strategies are particularly important in light of unequal power dynamics between faculty and students that may require us to put effort into eliciting honest dialogue (e.g., by ensuring an open, non-retributive space for that dialogue).

The interpersonal domain, however, involves not just faculty responsibilities. Students also have the responsibility to listen earnestly and actively. In the case above, as much as the students had emotional reactions that needed to be heard and validated, so did the faculty. The activity itself emerged on the basis of a rejection of racism and the sociological conviction that race-based biases in medicine must be appreciated for their insidious subtlety. Showing students—who often do not believe that they themselves hold prejudices—just how insidious unconscious bias can be, especially

in the diagnostic process, is a good educational goal. Recall that one of the students who felt triggered by this activity left the room before those messages could be delivered. Had he engaged the activity he may have been able to come to an appreciation of this perspective. While this does not invalidate the feelings he experienced, it does underscore the experiences and intentions of the faculty. The end goal here is not agreement about the meaning or validity of the activity per se, but rather a deeper understanding of each other.

Attention to the interpersonal domain of the learning environment also is essential to developing brave spaces. In particular, the five characteristics described above relay the core ethics of relationships, including respect, not just broadly but in the presuppositions about civil interactions (e.g., no attacks). Importantly, however, building these environments requires managing the distinct requirements of each of the three domains we articulate without allowing the concerns of one to bleed into the other. In exercising the rights and responsibilities of interpersonal communication between teachers and learners, neither perspective need be assigned priority or correctness. Instead, the rights and responsibilities of the interpersonal sphere are to genuinely hear and be heard.

The civic domain: Responding in the learning environment

Civil society is defined as "an arena of uncoerced collective action around shared interests, purposes, and values. In theory, its institutional forms are distinct from those of the state, family and market, though in practice, [those] boundaries are often complex, blurred, and negotiated."[21] The learning environment within academic medicine certainly engages with economic transactions (e.g., tuition and faculty remuneration) and political regulation (e.g., accreditation and licensure). But at its core it reflects aspects of civil society particularly where its citizens share underlying value commitments (e.g., education, health, patient care) and they undertake collective social projects in pursuing those values. Institutionally, it is important to create inclusive environments that promote these shared commitments, but also to recognize and address the ways in which some students can be excluded, not only by virtue of overt forms of discrimination, but also by gendered or racialized norms and expectations.[22] Shortcomings within the larger institutional setting likely contributed to the student's reaction in the case above, where, as observed by Browne, "Rather than risk being traumatized by yet another oppressive interaction, [black women medical students] chose to protect themselves by avoiding their institutions' facilities, classmates, and employees."[23(p76)]

Faculty should engage in sensitive topics in ways that are conscientious of broader institutional challenges with diversity, equity, and inclusion. But they also must balance respect for the emotional experiences of students with the need of all students to engage important curricular material.[1] The resulting dilemmas inherently raise underlying questions about balancing the rights of individuals against those of the community. All societies struggle to balance these, but civil society movements have attempted to do so without deferring to political or economic coercion. Similarly, navigating the rights and responsibilities of teachers and learners following a triggering event requires a nuanced approach that defies prefabricated rules and procedures of institutional oversight. Here again, the considerations of the civic sphere highlight and amplify core values of braves spaces, particularly in the acknowledgement of the value of varying opinions and in constructing free associations around these discourses where students may step out of and into different conversations.

In the civic sphere, faculty and students navigate rights and responsibilities within the larger social order of the learning environment. The civic domain first invites us to examine what it means to be a member of the community, and, relatedly, whether we are failing to meet the civic requirements of inclusion and equity for all community members (something that mirrors the meta-discursive processes of brave spaces). In this case, it is particularly important to consider whether the activity asked minoritized students to suffer indignities for the sake of the educational experience of non-marginalized students.[24] This is often the case when students who have historically experienced discrimination are asked to display those experiences, painful as they may have been, to aid classmates' learning. In this case, however, the session centered on the practical management of acute sickle cell pain crisis, something which can be negatively impacted by race bias. The lesson was not a gratuitous exploration of painful imagery, but an exploration of an important patient care issue. No student was asked to share personally their own experiences, but rather to analyze the cases as presented, though certainly we can recognize that everyone does this through the lenses of their own biographies.

Bearing witness to the stereotypes was difficult for some students in ways that it was not for others. This, however, was not a case of exploiting the biography of those students for the sake of others, but of portraying stereotypes that impact patient care and showing that

even those who ideologically reject overt racism may be susceptible to more subtle biases. Putting those various stereotypes on display, therefore, was integral to generating a critical conversation about how they subtly infiltrate clinical judgment. To discuss those in the abstract, or to remove them altogether, would have not offered a similar, or equally effective, learning experience.

Balancing the need to respond to student concerns with maintaining the educational value of the exercise, while being conscientious of the larger institutional context, was challenging. In the end, some modest revisions were made to the case presentation, but the core stereotypes that were the interrogative subject of the activity remained and without any sort of pretext (trigger warnings) that would have given away the intentions of the activity. Perhaps others would have reasoned their way to a different response, but we offer this as simply an example of thinking through the considerations of the civic domain. Importantly, while the faculty member felt an overwhelming sense of civic duty to preserve the learning experience, this changes nothing about the legitimacy of the students' emotional responses (intrapersonal) or the obligations of our relationships (interpersonal), nor does it change the commitments we all share in shaping the institutional climate so as not to require "opting out" to be a part of any students self-care portfolio (see Renn, Nicolazzo, and Quayefor a discussion of leaving "as a strategy of resilience").[25(p95)] That is, their experiences and feelings were no less valid even in the face of overriding civic concerns. Subsequent iterations of the activity have received no similar concerns from students; in fact the following year, the instructor received two emails from minority students who expressed gratitude for the activity and the way it directly highlighted the corruptive nature of racism in medicine.

Conclusion: Civil society and brave spaces

A great deal of energy has been put into deciding whether students have a right to feel triggered in this or that event and whether faculty have a responsibility to accommodate these reactions or whether, under the pretense of academic freedom, they have the right to ignore them. But these often-polemical arguments have skipped the important step of conceptually clarifying the terrain. Brave spaces represent a critical alternative, particularly where the content standards of medical education inherently require navigation of sensitive subjects. Building brave spaces, however, requires a conscious approach to the learning environment as its own small society. To foster this, we have highlighted how separately considering the intrapersonal, interpersonal, and civic domains in which a triggering event simultaneously occurs, offers novel insights into the multiple appropriate ways to respond. The intrapersonal domain highlights that we have a responsibility to honor the student's feelings over which they alone are sovereign. The interpersonal domain highlights that we have relational rights and responsibilities to listen and to be heard. The civic domain underscores our shared goals as an educational community as a way to evaluate whether or not an emotional reaction ought to motivate curricular revision. Considering each of these together, we can build brave spaces that take seriously the student's emotions, engage in genuine dialogue, and maintain educational standards all at the same time. Importantly, future research in medical education should explore the challenges of implementation of brave spaces and the utility of the three-part model proposed here for fostering the kind of discourse between students and educators that make brave spaces possible.

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No potential conflict of interest was reported by the authors.

Ethical approval

Not applicable.

Disclaimers

Cases described above have been blinded and extraneous facts removed to add an additional level of anonymity.

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