Trauma-Informed Care Training in the Women's Healthcare Setting

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Abstract

Purpose: This project is designed to improve knowledge and use of trauma-informed care in the midwifery setting.

Background: Research has shown that medical procedures and treatments can be distressing and trigger post-traumatic stress disorder symptoms in those with trauma histories. Obstetric and gynecological evaluations and procedures are intimate and invasive, putting the patient in a vulnerable situation. Midwifery facilities are in a unique position to provide support through trauma-informed care. However, despite evidence showing the benefit of trauma-informed care provision, training and implementation in the women's healthcare setting are limited.

Design: A validated pre- and post-survey was utilized to assess changes in knowledge, attitude, and practice of trauma-informed care at a small, rural clinic in Montana following a trauma-informed care training.

Results: A statistically significant increase between the pre- and post-survey scores for the questions measuring attitude (MD = 0.167, $p < 0.05$) and the overall score (MD = 0.198, $p < 0.05$) was identified. A statistically significant difference in mean scores for questions measuring practice of trauma-informed care between job roles was identified, with those with an administrative support job role having a statistically lower mean scores for questions measuring practice of trauma-informed care, than participants with a healthcare support job role (MD=1.375, $p<0.05$).

Implications: The results suggest not all job roles practice trauma-informed care equally. Further investigation should focus on looking at the differences in knowledge, attitude, and practice between job roles and how those gaps can be closed to improve the overall provision of trauma-informed care and to focus training efforts.

*Keywords***:** trauma-informed care, midwifery, obstetrics, education, in-service training

Trauma-Informed Care Training in the Midwifery Setting

It is well documented that trauma can have long-lasting health effects physically and mentally (Carroll & Banks, 2020; Long et al., 2022; Owens et al., 2021). In addition to the sequelae of trauma, individuals may experience retraumatization in a setting or situation that activates their trauma response (Long et al., 2022). Research has shown that medical procedures and treatments can be distressing and trigger post-traumatic stress disorder (PTSD) symptoms in persons with trauma histories, particularly those with childhood abuse, intimate partner violence, and sexual assault (Carroll & Banks, 2020; Stevens et al., 2019). Women are disproportionately affected by trauma, with high rates of child sexual abuse and sexual violence (Smith et al., 2018). Additionally, women and pregnant persons are subject to obstetric and gynecologic evaluations and procedures, which are often intimate and invasive, putting the patient in a vulnerable position (Long et al., 2022). Midwives are in a unique position to provide support through trauma-informed care. However, despite evidence showing the benefit of trauma-informed care provision, training and implementation in the women's healthcare setting are limited (Long et al., 2022).

Background and Significance

Project Purpose

Given the need for trauma-informed care for those seeking reproductive health, the purpose of this project is to implement and evaluate trauma-informed care training for staff in a women's healthcare setting. The trauma-informed care is not targeted to specific individuals but provides universal trauma-informed care to all who access care in the midwifery setting. The specific goals of this project are: 1) to improve staff knowledge related to trauma-informed care, 2) to increase the confidence and ability to identify signs and symptoms of trauma, and 3) to increase the use of trauma-informed care.

Literature Review

In the writing of this section of the paper and the introduction, the terms used are mirrored in the literature which was reviewed, which included “woman,” “women,” and “maternity.” Unfortunately, there is a lack of data that encompasses the multitude of gender identities, often only disaggregating a person as woman/female or man/male (King et al., 2019). While these terms will be used throughout this section, it is understood that these labels are not comprehensive and are exclusionary. It is also recognized that not only cisgender patients utilize or have the need to access reproductive health care or the services of midwives. Sex-disaggregation is a binary representation of cisgender females and cisgender males, and it can only be assumed that the data used in the literature reviewed follow that interpretation. The continued use of binary interpretation further discriminates and perpetuates the marginalization of the non-cisgender population (Colaço & Watson-Grant, 2021). Further efforts need to be made to collect gender-disaggregated data so that the available data can be representative of all people and populations (Colaço & Watson-Grant, 2021).

For the purpose of this paper, *trauma* is defined as "an event or series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional or spiritual wellbeing" (SAMHSA, 2014a, pp. 7). *Collective trauma* is “cultural, historical, social, political, and structural traumas (i.e., racism, bias, stigma, oppression, genocide) that impacts individuals and communities across generations” (Grossman et al., 2021, pp. 2). *Psychological trauma* is the impact a traumatic experience has on an individual, rather than the event itself (Law et al., 2021). Individuals may also experience *polytraumatization*, which is the exposure to multiple traumatic events over a lifetime (Killian-Farrell et al., 2020). Studies have a positive correlation between the number of traumatic events

experienced by a person and the prevalence of health sequalae (Grossman et al., 2021; Killian-Farrell et al., 2020). *Retraumatization* occurs as a conscious or unconscious reminder of a past trauma, triggering the trauma response and causing the individual to feel as if they are re-experiencing the initial trauma (SAMHSA, 2017; Shelly et al., 2016).

Having a history of trauma is widespread throughout the United States, with over 60% of adults having experienced or been exposed to violence or trauma as a child (American College of Obstetricians and Gynecologists' [ACOG] Committee on Health Care for Underserved Women, 2021; Merrick et al., 2019). Trauma can occur to anyone, without regard to gender, race, ethnicity, or age. However, there are noted differences in trauma rates amongst groups. For example, women, LGBTQ+ people, American Indian/Alaska Native, Blacks, and other underrepresented groups are exposed to more traumatic events in their lifetime than white men (ACOG Committee on Health Care for Underserved Women, 2021; Merrick et al., 2019; Owens et al., 2021).

Women are disproportionately affected by trauma, experiencing more systemic trauma related to gender inequality, social disadvantage, and marginalization (Long et al., 2022). Women experience higher rates of childhood maltreatment and sexual abuse than men, and as adults, have higher rates of sexual abuse and gender-based violence (Epstein & Gonzalez, 2017; Long et al., 2022; Sperlich et al., 2017). According to the Centers for Disease Control and Prevention (CDC), 43.6% of women experience sexual violence in their lifetime (Smith et al., 2018). In addition to women having high rates of trauma prior to delivery, they are also prone to experience trauma during their delivery, with 45.5% of women describing "their birthing experiences as traumatic" at 4-6 weeks postpartum (Long et al., 2022, p. 2).

Years of research have shown that trauma leads to sequelae of adverse mental and physical health outcomes, including chronic disease and premature death (Center for Disease

Control and Prevention [CDC], 2021; Owens et al., 2021). This sequela also affects perinatal and reproductive health outcomes, leading to more complicated pregnancies, increased pain intensity during pregnancy and birth, poorer birth outcomes, decreased breastfeeding success, and impaired child health and development (Cook et al., 2018; Geller & Stasko, 2017; Long et al., 2022; Olson et al., 2018; Sperlich et al., 2017; Vogel & Coffin, 2021).

In addition to the sequelae of adverse health outcomes, a history of trauma can cause "profound effects on attitudes toward medical care" (ACOG Committee on Health Care for Underserved Women, 2021, pp. e95). Clinical encounters may be anxiety inducing or cause retraumatization. These effects can show up as acute effects on the body, including hypertension, tachycardia, perspiration, poor concentration, exaggerated startle response, agitation, dissociative, and appearing withdrawn, numb, or detached from the event (ACOG Committee on Health Care for Underserved Women, 2021; Vogel & Coffin, 2021). These effects can be triggered by hospital sounds, smells, procedures, certain providers, intrusive thoughts, or flashbacks (Vogel & Coffin, 2021).

Trauma-informed care provides a framework that acknowledges the "impact of trauma on health outcomes; recognizes the signs of trauma exposure, responds to patient and staff needs with a culture of physical, psychological, and emotional safety; and avoids retraumatizing survivors" (Owens, 2021, pp. 2). The framework has six fundamental principles, which can be used across different care settings (SAMHSA, 2014a; Sperlich et al., 2017). These principles are: "1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice, 6) cultural, historical, and gender issues" (SAMHSA, 2014a; Sperlich et al., 2017, p. 665). The trauma-informed care approach also acknowledges that healthcare procedures and processes may themselves be traumatic, trauma-invoking, or exacerbate previous trauma (Long et al., 2022). Emphasis is placed on providing a safe space and

empowering environment for all patients, especially those with trauma, from the moment they walk in the door (Fleishman et al., 2019; SAMHSA, 2014b).

Given the high prevalence of trauma exposure in the general population, it is recommended to assume all patients have potential underlying trauma, thus treating everyone with trauma-informed care (ACOG Committee on Health Care for Underserved Women, 2021; Long et al., 2022). Universal trauma-informed care is essential for healthcare providers working with patients in the midwifery setting, who are subject to intimate and invasive obstetric and gynecological procedures.

Although it is recommended to use universal trauma-informed care, studies have shown a lack of formal training and self-perceived competence among healthcare providers in providing trauma-informed care (Bruce et al., 2018; Stevens et al., 2019; Vogel & Coffin, 2021). Significant barriers to providing basic trauma-informed care have been identified as lack of training, time constraints, fear of retraumatizing patients, and conflicting information about trauma-informed care (Bruce et al., 2018; Long et al., 2022).

Given the widespread rates of trauma and prevalence of the burden of the sequelae, it is imperative to provide training on universal trauma-informed care to healthcare providers. As women are disproportionately affected by trauma, and research has shown the adverse effects trauma history can have on maternal and perinatal health and outcomes, this project is designed to implement trauma-informed care training in a women's healthcare setting (Long et al., 2022; Smith et al., 2018; Sperlich et al., 2017).

Conceptual Framework

The Donabedian model for quality of care was used as a framework for this project. The Donabedian model is designed to evaluate the improvement in quality of care by looking at structure, process, and outcomes (Agency for Healthcare Research and Quality [AHRQ], 2015;

Donabedian, 1966). Donabedian defines healthcare quality as comprised of seven pillars: efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy, and equality (Donabedian, 1990). Efficacy is healthcare's ability to improve health and well-being (Donabedian, 1990). Effectiveness is the improvement in health that can be achieved under ordinary circumstances (Donabedian, 1990). Efficiency is the ability for the most significant health improvements using the lowest cost method (Donabedian, 1990). Optimality is the ability to balance the costs and benefits (Donabedian, 1990). Acceptability is the patients' expectations, accessibility of care, a positive provider-patient relationship, and cost of care to the patient (Donabedian, 1990; Franklin, 2019). Legitimacy is the social acceptability and impact of care (Donabedian, 1990; Franklin, 2019). Lastly, equity is the fair distribution of care and its benefits across a population (Donabedian, 1990).

The Donabedian model measures the quality of care through structural, process, and outcome measures (AHRQ, 2015; Donabedian, 1966). Structural measures look at the physical and organizational setting in which healthcare is delivered (Donabedian, 1966; Franklin, 2019). Process measures evaluate the mechanism by which patient care is provided (Donabedian, 1966; Franklin, 2019). Lastly, outcome measures evaluate the healthcare effect on the patient and health status (Donabedian, 1966; Franklin, 2019).

For this project, structural measures will include the culture of the clinic and current education requirements on trauma-informed education. The process measures encompass the trauma-informed interactions between patients and providers/staff and the number of people receiving trauma-informed training through this project. Lastly, outcome measures will include the change in attitude and the use in the practice of trauma-informed care.

The use of this framework allows for flexibility in implementing and evaluating the project. This framework and Donabedian's definition of healthcare quality compliments the

overarching elements of trauma-informed care, particularly the six fundamental principles of trauma-informed care. Much like the quality of care, trauma-informed care adheres to key principles rather than a defined set of practices or procedures (Sperlich et al., 2017). Both place value on patient expectations, collaboration and mutuality between provider-patient, and the social impact of care (Donabedian, 1990; Sperlich et al., 2017).

Methods

Setting & Participants

An in-person training was provided at a midwifery and family health clinic in a small town in rural Montana. This clinic comprises a multi-disciplinary team of nurse practitioners, medical assistants, and administrative support staff, providing pre and postnatal care to approximately 400 persons annually. All clinical, non-clinical, and frontline staff were invited to participate voluntarily in the training.

One week prior to the training an informational e-mail and calendar invite was sent out to all clinic staff. A total of seven staff who were present at the office the day of the training attended. The training was held over the lunch hour and food was provided for those in attendance. All participants signed a consent form prior to taking the pre-survey (see Appendix A).

Intervention

This quality improvement project is designed to increase the knowledge, attitude, and skills of using trauma-informed care in the clinical setting. The project focuses on improving the current interactions and treatment of patients to include a trauma-informed approach by providing training and a toolkit. The training aims to guide staff to understand the impact of trauma in the healthcare setting and how the organization and themselves can provide care

sensitively and compassionately. Prior to implementing the training, the project underwent institutional review board (IRB) approval at Seattle University.

An assessment of the clinic's gaps and needs for trauma-informed care was completed with stakeholders at the clinic. This information guided the design of the training, with emphasis placed on using trauma-informed care principles to guide interactions with patients while taking health histories, dealing with challenging situations, and providing compassionate and professional care.

Resources from the Substance Abuse and Mental Health Administration Services (SAMHSA) National Center on Trauma Informed Care and the United Kingdom National Health Services was utilized as a contextual framework in developing the course content (Law et al., 2021; SAMHSA, 2014). The course content included: 1) an overview of traumas as defined by SAMHSA; 2) an overview of trauma and health sequelae; 3) trauma-informed care core assumptions and principles; 4) use of trauma-informed language; 5) strategies for implementation; and 6) case-study examples of trauma-informed care in practice.

The training was provided in person and facilitated by both investigators. The session was guided by a PowerPoint presentation (see Appendix B) and included time for group brainstorming and discussion. The training lasted approximately 45 minutes. A twenty-two-page toolkit (see Appendix C) on trauma-informed care was provided to the clinic and staff following the training. This toolkit was designed to address the specific needs identified for the clinic and includes 5 sections: 1) introduction to trauma, 2) trauma's impact on health, 3) how to become trauma-informed, 4) using trauma-informed care in specific situations (i.e., general clinic visits, trauma disclosure, difficult situations, pelvic exams, and pediatric patients), and 5) local and national resources. Two printed copies and a digital version of the toolkit were provided following the training.

Measures

Descriptive data was be collected on the pre- and post-survey, including age and participants job category (provider, care support staff, or non-care staff). This information will be used to assess differences in knowledge, attitude, and practice based on job category.

Qualitative data will be collected using a validated survey consisting of twenty-one questions that measure knowledge, attitude, and practice related to trauma-informed care (King et al., 2019). The questions consist of a 5-point Likert scale with responses from *strongly disagree* to *strongly agree.* The tool was found to be a good to adequate fit, with a root mean squared error of approximation of 0.077, a comparative fit analysis of 0.857, and a Tucker-Lewis index of 0.839 (King et al., 2019). The overall Cronbach's alpha for the tool was 0.86, with 0.84 for knowledge, 0.74 for attitude, and 0.78 for practice (King et al., 2019).

Authors of the validated survey define knowledge as "the degree to which staff members were aware of, informed about, or familiar with the applicability of trauma-informed care in the healthcare setting;" define attitude as "how staff felt or thought about trauma-informed care;" and define practice as "how staff applied their knowledge and attitudes about trauma-informed care into their practice" (King et al., 2019, pp. 2). Of the twenty-one questions, six questions measure knowledge, nine measure attitude, and six measure practice (King et al., 2019).

All participants were given a pre-survey prior to the start of the training and a post-survey at the conclusion of the training. Each participant created a five-digit identification code to match their surveys for data analysis.

Results

Analysis

The data from the pre- and post-surveys were coded, cleaned, and organized by the project's lead investigator. The responses were coded from one to five, with strongly disagree

coded as one and strongly agree coded as five. The data was cleaned, identifying duplicates, errors, missing data, and unanswered survey responses. The co-investigator reviewed the coding and cleaning for errors and to reduce bias.

Using Microsoft Excel, descriptive statistics, including mean, median, mode, and frequency, were computed for the job category and knowledge, attitudes, and practice measures (McKenzie et al., 2017). Bivariate data analysis was computed to test the null hypothesis that no differences exist between the pre- and post-survey scores (McKenzie et al., 2017). A dependent t-test, using a one-tailed p-value of $p < 0.05$, assessed the change in knowledge, attitudes, and practices between the pre- and post-survey scores. A two-way analysis of variance (ANOVA) without duplication was used to evaluate the correlation between job category (variable 1) and participation in the intervention (variable 2) with the mean pre- and post-survey scores. Further analysis, using two-way ANOVAs without duplication, was calculated to evaluate the effect of variable 1 and variable 2 on pre- and post-survey scores for each of the three topic areas: knowledge, attitude, and practice. See Appendix D for the list of questions per focus area. A p-value of $p < 0.05$ was used to determine the statistical significance of the ANOVA (McKenzie et al., 2017). For the ANOVA results found to be statistically significant a post-hoc Tukey honest significant difference (HSD) was completed.

Project Results

Although 7 participants completed the training and at least one survey, the analytic sample was reduced to 6 participants who completed both the pre- and post-surveys. Table 1 describes the characteristics of the study sample. All the participants were female (100%) with an average age of 41.67. Participants identified their job roles as provider (50%), administrative support staff (33.33%) or healthcare support staff (16.67%).

Table 1

Sample Characteristics

	% (n)
Age in years, mean (range)	41.67 (33-52)
Gender Identity	
Female	100% (6)
Male	0% (0)
Job Role	
Provider	50% (3)
Healthcare support staff	16.67% (1)
Administrative support staff	33.33% (2)

Note: N = 6

T-Test

Table 2 compares participants' total pre and post-survey scores as well as scores in the three topic areas of knowledge, attitudes and practice using paired samples t-tests. Both the total score (MD = 0.198, $p < 0.05$) and the questions measuring attitude (MD = 0.167, $p < 0.05$) showed a statistically significant increase in scores between the pre-survey and post-survey. The data showed no statistically significant difference between pre-survey and post-survey scores in the topic areas of knowledge (MD = 0.306, $p = 0.088$) and practice (MD = 0.133, $p = 0.127$).

Table 2

Comparison of Pre-Survey and Post Survey Scores Among Trauma-Informed Care Topic Areas.

Topic Area	Pre-Survey (N=6) mean (SD)[a]	Post-Survey (N=6) mean (SD)[a]	MD	t-stat	df	*p-v*alue
Knowledge (Q1-Q6)[b]	4.667 (0.459)	4.972 (0.068)	0.306	-1.571	5	0.088
Attitude (Q7-Q15)[b]	4.454 (0.323)	4.620 (0.223)	0.167	-2.236	5	0.038*
Practice (Q16-Q21)[b]	4.072 (0.323)	4.206 (0.377)	0.133	-1.287	5	0.127
Total (Q1-Q21)[b]	4.428 (0.279)	4.626 (0.152)	0.198	-2.111	5	0.044*

Note: [a] Five point Likert scale

[b] Survey questions that correspond to each topic area. See Appendix D.

* p-value < 0.05

Analysis of Variance

A two-way ANOVA without replication was performed to compare the effect of job role and participation in the intervention on the survey scores. This analysis did not find a statistically significant interaction between job role or participation in the intervention on the survey scores ($p = 0.167$ and $p = 0.200$). Table 3 describes the findings.

Table 3

ANOVA Comparison of Job Role or Participation on Pre- and Post-Intervention Survey Scores

Source of Variation	*SS*	*df*	*MS*	*F*	*p-value*	*F crit*
Job Role	0.331	2.000	0.166	4.981	0.167	19.000
Training Participation	0.118	1.000	0.118	3.550	0.200	18.513
Error	0.067	2.000	0.033			
Total	0.516	5.000				

Note: N = 6. ANOVA = analysis of variance

*p-value < 0.05

The results were further analyzed using two-way ANOVA without duplication to look at the mean survey scores for the grouping of questions measuring knowledge, attitude, and practice in relation to job role and participation in the intervention. Three two-way ANOVAs were computed, finding a statistically significance difference in mean scores for practice between job roles (F (2, 2) = 31.257, $p = 0.031$). Table 4 describe the results from the two-way ANOVAs for knowledge, attitude, and practice.

Table 4

ANOVA Comparison of Job Role or Participation on Pre- and Post-Intervention Survey Scores by Topic Area

Source of Variation	SS	df	MS	F	p-value	F crit
Knowledge						
Job Role	0.131	2	0.065	0.743	0.574	19.000
Training Participation	0.296	1	0.296	3.368	0.208	18.513
Error	0.176	2	0.088			
Practice						
Job Role	1.938	2	0.969	31.257	0.031*	19.000
Training Participation	0.068	1	0.068	2.195	0.277	18.513
Error	0.062	2	0.031			
Attitude						
Job Role	0.329	2	0.165	7.981	0.111	19.000
Training Participation	0.070	1	0.070	3.393	0.207	18.513
Error	0.041	2	0.021			

Note: N = 6. ANOVA = analysis of variance

*p-value < 0.05

Post-hoc Tukey

A post-hoc comparison using the Tukey HSD test indicated that the participants with an administrative support job role had statistically lower mean scores for questions measuring practice of trauma-informed care, than participants with a healthcare support job role (MD=1.375, $p<0.05$). There was no significant difference between provider and both the administrative support group and the healthcare support group. Table 5 describes the findings.

Table 5

Post-hoc Comparison of Pre- and Post-Survey Scores Between Job Roles

Job Role		MD	SE	95% CI		*p*-value
				Lower bound	Upper bound	
Provider	Healthcare Support	0.500	0.124	-0.537	1.537	0.184
Provider	Administrative Support	0.875	0.124	-0.162	1.912	0.069
Healthcare Support	Administrative Support	1.375	0.124	0.338	2.412	0.029*

Note: N = 6.

*p-value < 0.05

Discussion

Despite extensive evidence of the impact of trauma on health outcomes, the risk of retraumatization in the clinical setting, and the benefit of providing trauma-informed care, training and implementation are limited in the obstetric and gynecological setting (Long et al., 2022). This project addressed a small area of trauma-informed care, the lack of provision of training and implementation.

For a trauma-informed approach to be most effective it needs to be a multilevel, integrating trauma-informed care into policy, physical environment, training, leadership, and financing into an organization (SAMHSA, 2014a). This project touched a piece of the trauma-informed approach, providing training and workplace development for all job roles in the clinic. The toolkit provided includes information on further steps to take to become a trauma-informed clinic. However, there is much more that was not addressed in this project that would be beneficial to providing a full trauma-informed approach, including analysis of policy, engagement with clients to address their needs, evaluation of the physical environment, continue training and workforce development, and progress monitoring (SAMHSA, 2014a).

Like other studies, this project identified a statistically significant increase in pre- and post-survey scores and the scores measuring attitude towards trauma-informed care following training (Bruce et al., 2018; Cannon et al., 2020; Purtle, 2020). While increases in knowledge and attitude toward trauma-informed care have been found in other studies, that was not identified in this study, although the overall pre- and post-survey scores did increase significantly (Cannon et al., 2020; Purtle et al., 2020; Stevens et al., 2020;). However, while many studies have looked at trauma-informed care in the healthcare and obstetric and gynecologic setting, training is not standardized and various data collection tools are used, including many unvalidated surveys (Jackson & Jewel, 2021; Long et al., 2022; Purtle et al., 2020). This lack of consistency makes it difficult to compare various studies.

Most of the research has focused on the effectiveness of trauma-informed care training for providers or nurses and has not assessed the differing levels of knowledge, attitude, and practice for all clinical job roles (Cannon et al., 2020; Sperlich et al., 2017; Stevens et al., 2019). This project examined changes across three job roles (providers, healthcare support staff, and administrative support staff). Although this project consisted of a small number of participants (n=6), the results showed that not all job roles practice trauma-informed care equally. However, given the small sample size, the findings cannot be generalized to other populations. Further studies should focus on trauma-informed care across different job roles in the clinical setting.

Limitations

This study has several limitations. First, the data was derived from a sample of staff at a small, rural Montana clinic. Given this study's small sample size, we cannot generalize the findings to another group or have confidence that the results are not due to chance. To better assess the impact of this training in rural settings, the training could be provided at multiple rural healthcare clinics to generate a larger sample size, thus reducing the sample size bias. Due to

limitations with time and travel, this was not feasible but should be considered by future investigators.

Second, only pre-survey and post-survey data were collected for this project. This project was implemented later than initially planned due to unforeseen scheduling complications, limiting the time for follow-up and analysis. With only collecting immediate post-intervention results, we cannot assess if there were changes in knowledge, attitude, or practice of trauma-informed care longer-term. Future studies should examine the long-term impacts of trauma-informed care training on knowledge retention and implementation in practice.

Third, there was random missing data for several questions on the pre- and post-surveys. A total of five missing data points were identified during data cleaning. However, given the small number of participants, it was not feasible to completely exclude the surveys missing data. The missing data were removed from analysis along with the corresponding data response on the pre- or post-survey.

Lastly, those attending the training were aware that the training included a pre- and post-survey on trauma-informed care. Therefore, it is possible that social desirability influenced the survey answers, thus impacting the validity of the results. Having a larger sample size or comparing results to a group of people not receiving the training could address this area of bias.

Implications

This project's findings indicate that the training increased participants' attitudes and overall knowledge, attitude, and practice of trauma-informed care. This project's results suggest that further research should focus on the gaps in the practice of trauma-informed care between the different job roles in the healthcare setting. Trauma-informed care should be practiced by

everyone in a healthcare setting, from the person greeting the patient to the provider treating the patient. However, there is a lack of research examining the degrees of knowledge and practice between job roles, including if a gap exists. Most research has focused on providers or nurses being trained in trauma-informed care, despite emphasizing that the trauma-informed approach includes people at all levels of an organization (SAMHSA, 2014a). Future investigation should focus on looking at the differences in knowledge, attitude, and practice between job roles and how those gaps can be closed to improve the overall provision of trauma-informed care and to focus training efforts.

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Appendix A

Consent Form

CONSENT TO PARTICIPATE IN RESEARCH

TITLE: **Trauma-Informed Care Training in Women's Healthcare**

INVESTIGATOR: Molly Nicholson, Nurse Midwifery, Seattle University College of Nursing, 406-465-1201
Aimee D'Avignon, Nurse Midwifery, Seattle University College of Nursing, 435-830-3561

ADVISOR: (if applicable) Elizabeth Gabzdyl, Nurse Midwifery, Seattle University College of Nursing, 206-296-6951

PURPOSE: You are being asked to participate in a research project that seeks to investigate the effectiveness of trauma-informed training on the knowledge of, attitude towards, and use of trauma-informed care. You will be asked to complete a brief survey immediately before and after the trauma-informed training. This survey should take less than 10 minutes to complete.

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in nursing practice in nurse midwifery at Seattle University.

RISKS: There are no known risks associated with this study. However, information about trauma-informed care may elicit mild distress. This discomfort is not expected to be greater than those encountered in everyday life.

BENEFITS: Your participation in this study will contribute to the understanding of how trauma-informed care can be implemented in the healthcare setting and provide tools you can use in your everyday practice.

INCENTIVES: You will receive no gifts/incentives for this study. Participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Indirect identifiers will be collected, including participants job category (provider, care support staff, or non-care staff) and years of experience in similar position. No direct identifiers will be collected. Each participant will be instructed to create a unique code and list this same code on their pre- and post-intervention surveys. No information will be collected that links participants to their unique codes. All research materials and consent

forms will be stored online in a password protected electronically encrypted folder. Human subjects research regulations require that data be kept for a minimum of three (3) years. When the research study ends, any identifying information will be removed from the data, or it will be destroyed.

RIGHT TO WITHDRAW: Your participation in this study is *voluntary*. You may withdraw your consent to participate at any time without penalty. Your withdrawal will not influence any other services to which you may be otherwise entitled.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request. Requests can be made to Molly Nicholson at 406-465-1201 or mnicholson@seattleu.edu. The summary will be available in May 2023.

VOLUNTARY CONSENT: I have read the above statements and understand what is being asked of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason, without penalty. On these terms, I certify that I am willing to participate in this research project.

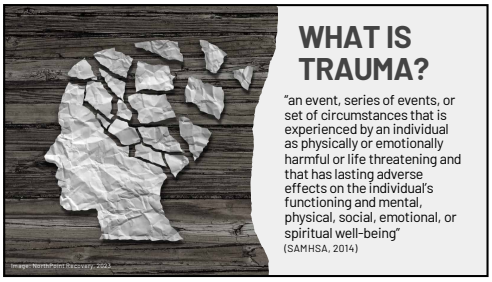
I understand that should I have any concerns about my participation in this study, I may call Molly Nicholson or Aimee D'Avignon who are asking me to participate, at 406-465-1201 or 435-830-3561 respectively. If I have any concerns that my rights are being violated, I may contact Dr. Michael Spinetta, Chair of the Seattle University Institutional Review Board at (206) 296-2585.

Participant's Signature	Date
Investigator's Signature	Date

Appendix B

PowerPoint

1



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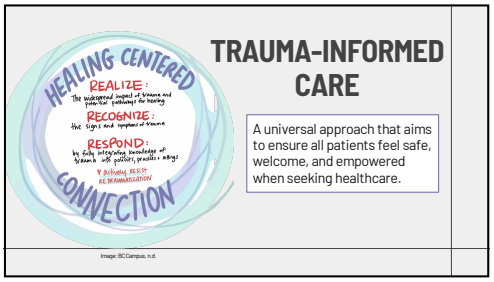

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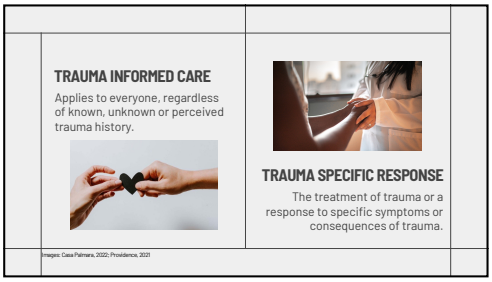

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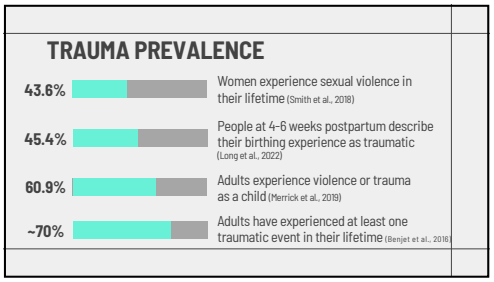

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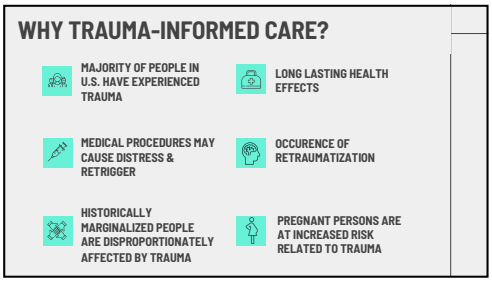

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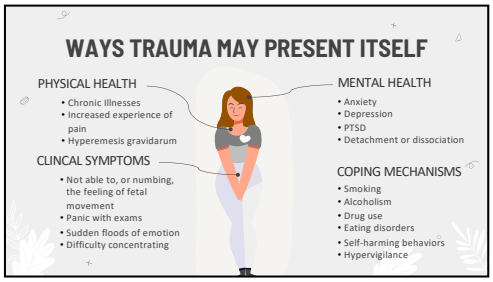
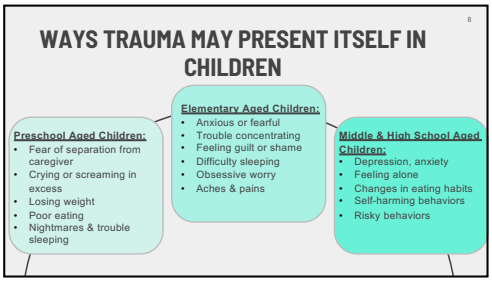

WAYS TRAUMA MAY PRESENT ITSELF
PHYSICAL HEALTH
• Chronic Illnesses
• Increased experience of pain
• Hyperemesis gravidarum
CLINCAL SYMPTOMS
• Not able to, or numbing, the feeling of fetal movement
• Panic with exams
• Sudden floods of emotion
• Difficulty concentrating
MENTAL HEALTH
• Anxiety
• Depression
• PTSD
• Detachment or dissociation
COPING MECHANISMS
• Smoking
• Alcoholism
• Drug use
• Eating disorders
• Self-harming behaviors
• Hypervigilance

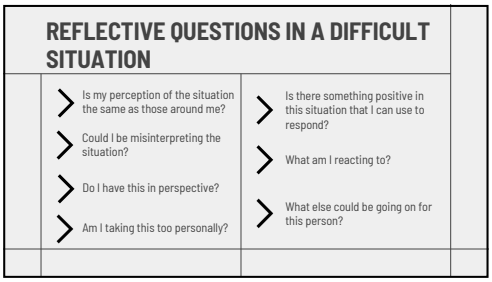
7


WAYS TRAUMA MAY PRESENT ITSELF IN CHILDREN
Preschool Aged Children:
• Fear of separation from caregiver
• Crying or screaming in excess
• Losing weight
• Poor eating
• Nightmares & trouble sleeping
Elementary Aged Children:
• Anxious or fearful
• Trouble concentrating
• Feeling guilt or shame
• Difficulty sleeping
• Obsessive worry
• Aches & pains
Middle & High School Aged Children:
• Depression, anxiety
• Feeling alone
• Changes in eating habits
• Self-harming behaviors
• Risky behaviors

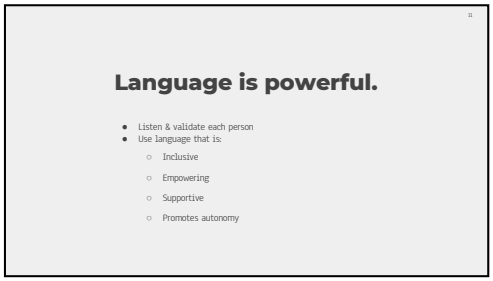
8


DIFFICULT PATIENTS OR SITUATIONS

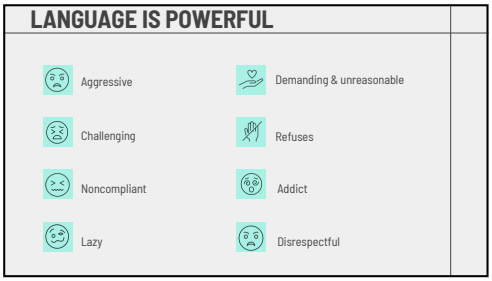
9


REFLECTIVE QUESTIONS IN A DIFFICULT SITUATION
Is my perception of the situation the same as those around me?
Could I be misinterpreting the situation?
Do I have this in perspective?
Am I taking this too personally?
Is there something positive in this situation that I can use to respond?
What am I reacting to?
What else could be going on for this person?

10


Language is powerful.
Listen & validate each person
Use language that is:
Inclusive
Empowering
Supportive
Promotes autonomy

11


LANGUAGE IS POWERFUL
Aggressive
Challenging
Noncompliant
Lazy
Demanding & unreasonable
Refuses
Addict
Disrespectful

12

RESPONDING TO DIFFICULT PATIENTS

- Remain calm
- Give your full attention
- Speak slowly and calmly
- Acknowledge their distress
- Listen to their concerns
- Don't interrupt too quickly
- Active listening
- Summarize back to them
- Avoid using jargon
- Ensure the person understands

13

APPROACHING PATIENTS WHO MISS APPOINTMENTS OR SHOW UP LATE

- Reinforce the positives
- Ask if something makes it difficult to come in or to come on time
- Ask how/when they would like an appointment reminder
- Ensure the patient knows the purpose of the appointment
- Give choices for timing, length, and number of appointments
- Give grace when possible
- Reframe your perception

14

USING TRAUMA-INFORMED CARE TO GET A GOOD MEDICAL HISTORY

- Set expectations for the visit
- Be clear and straightforward
- Start with a neutral statement when asking about sensitive topics
- Give choices whenever possible
- Don't ask personal or medical questions in the lobby or hallway
- Always ask permission before touching someone and allow them to adjust their own body and clothing

15

CASE STUDY

Jane is a 23-year-old G4P2 who arrives 20 minutes late to her 30-week appointment. She hasn't been seen since 24-weeks. She appears flustered as she approaches the front desk.

Image: Yuko, 2022

16

IF TRAUMA IS DISCLOSED

THE 4 "Cs":

- Be calm
- Contain the interaction
- Care for the patient and yourself
- Focus on coping

17

IF TRAUMA IS DISCLOSED

- Affirm they do not deserve to be treated that way
- Do not dismiss the disclosure
- Express concern for the patient's safety
- Provide available resources
- Give a warm handoff to a person or organization that provides trauma-specific treatment

18

Benjet, C., Bromet, E., Karam, E.G., Kessler, R.C., McLaughlin, K.A., Ruscio, A.M., Shahly, V., Stein, D.J., Petukhova, M., Hill, E., Alonso, J. Atwoll, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J.M., de Girolamo, G. Florescu, S., Gureje, O., Huang, Y., Lepine, J.P., ... & Koenen, K.C. (2016). The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. *Psychological Medicine*, 46(2), 1-17. https://doi.org/10.1017/S0033291715001981.

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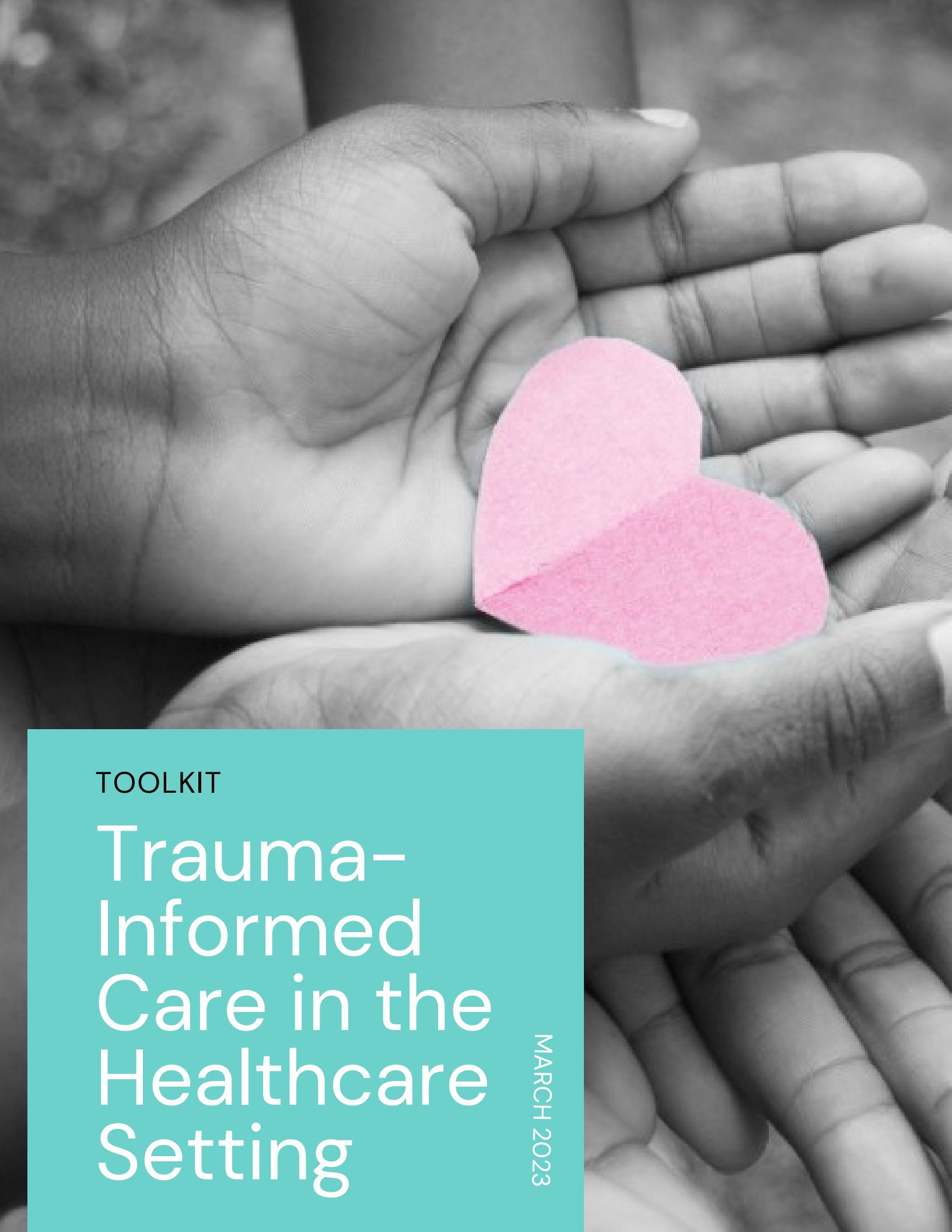
Appendix C

Trauma-Informed Care Toolkit

Page 32-56



TOOLKIT

Trauma-Informed Care in the Healthcare Setting

MARCH 2023

Table of Contents

The information contained in this document may be triggering for some people. Please read this in a space where you feel both physically and emotionally safe.

Introduction

Trauma can have long-lasting physical and mental health effects [1, 2, 3]. In addition to the health consequences of trauma, individuals may experience retraumatization in a setting or situation that activates their trauma response [2].

Research has shown that medical procedures and treatments can be distressing and trigger post-traumatic stress disorder (PTSD) symptoms in persons with trauma histories, particularly those with childhood abuse, intimate partner violence, and sexual assault [1, 4].

More than 2/3 of adults have experienced at least once traumatic event in their lifetime [5].

Given the high prevalence of trauma exposure in the general population, it is recommended to assume all patients have potential underlying trauma and thus treat everyone with trauma-informed care [2, 6].

There is no standardized trauma-informed care education for healthcare professionals. The absence of widespread practice implementation has led to deficits in provider knowledge, low levels of confidence in providing trauma-informed care, and a lack of support for patients at risk of experiencing trauma or re-traumatization in the healthcare setting [2, 7, 8].

Healthcare providers with good intentions, but without the proper training or knowledge of trauma-informed care (TIC), can unknowingly retraumatize or trigger patients with trauma histories.

Purpose

This guide is designed to help all healthcare staff (clnical and non-clinical) understand trauma's impact on health and respond in a compassionate, sensitive and trauma-informed way.

What is trauma?

Trauma is defined by Substance Abuse and Mental Health Services Administration (SAMHSA) as "an event or series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individuals functioning and mental, physical, social, emotional or spiritual wellbeing" [9, pp. 7].

Psychological trauma is the impact a traumatic experience has on an individual, rather than the event itself [10]. Psychological trauma overwhelms a person's ability to cope.

Trauma is very individualized. Each person experiences an event differently, and what one may find as traumatizing may be not traumatizing to another person. For example, parents divorcing may be traumatic for some children and for others it may not.

Examples of trauma include:

- Childhood neglect or abuse;
- Experiencing or witnessing physical, sexual, or emotional abuse;
- Family members with substance abuse or mental health disorders;
- Medical interventions;
- Community violence;
- Poverty;
- Homelessness;
- Dangerous environment;
- Systemic discrimination;
- Cultural, intergenerational, and historical trauma;
- Exposure to war or conflict;
- Natural disasters [11, 12].

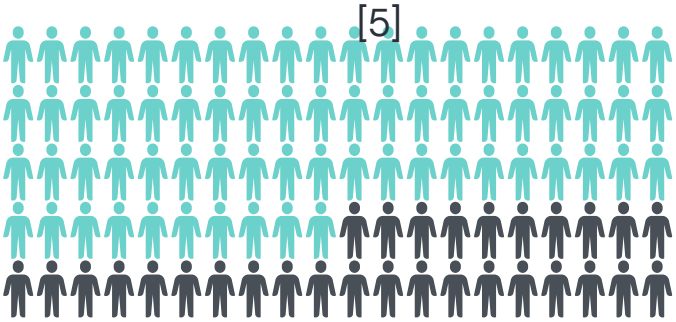
Key aspects of trauma:

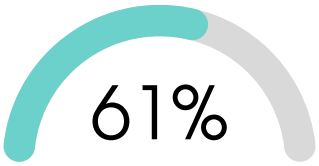
- Events
- Experience of events
- Effect of events

Trauma Prevalence

Having a history of trauma is widespread throughout the United States. Trauma can occur to anyone, without regard to gender, race, ethnicity, or age. However, there are noted differences in trauma rates among groups, including: LGTBQ+, women, American Indian/Alaska Native, Blacks, low socioeconomic status, & other underrepresented groups [6, 9, 13].

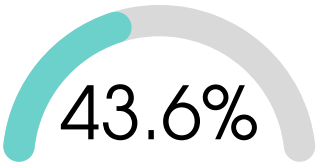
70.3% OF ADULTS HAVE EXPERIENCED AT LEAST ONE TRAUMATIC EVENT IN THEIR LIFETIME [5]





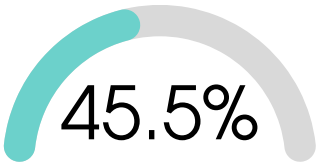
61%

of adults experience at least one traumatic event before age 18 [14]



43.6%

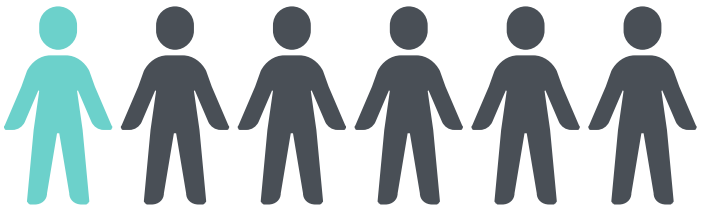
of women experience sexual violence in their lifetime [15]



45.5%

of birthing persons describe their birthing experience as traumatic at four to six weeks postpartum [2]

1 in 6 adults experienced four or more potentially traumatic events as a child [16].



Women experience higher rates of sexual abuse than men, and as adults, have higher rates of sexual abuse and gender-based violence [2, 17, 18]

How does trauma impact health?

Years of research have shown that trauma leads to sequelae of adverse mental and physical health outcomes, including chronic disease and premature death [3, 16]. When a person experiences a traumatic event, the body releases stress hormones that activate the fight, flight, or freeze response [18]. Repeated exposure to this response, especially during childhood, can change brain structure and contribute to chronic physical and mental health issues [16, 18]. Below are ways trauma can present [3, 9, 10, 16].

Physical Health

- Chronic illnesses
  - Diabetes
  - Heart Disease
  - Cancer
  - Kidney disease
- Increased experiences of pain
  - Vaginismus
  - Chronic pelvic pain
  - Persistent headaches or stomachaches

Mental Health

- Anxiety
- Depression
- PTSD
- Suicide
- Intrusive thoughts or flashbacks
- Dissociation or going into a trance
- Repressed memories

Clinical Symptoms

- Hypertension
- Tachycardia
- Perspiration
- Exaggerated startle response
- Agitation or anger
- Panic or extreme anxiety with exams or procedures
- Sudden floods of emotions (crying, irritability, anger)
- Difficulty concentrating & making decisions

Coping Mechanisms

- Substance use
  - Smoking
  - Alcohol
  - Drugs
- Eating disorders
- Self-harming behaviors
- Hypervigilance

[3, 9, 10, 16]

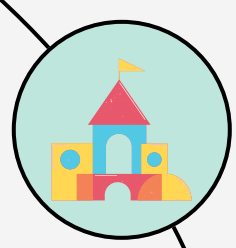
Trauma in Children

Trauma can have long-lasting effects on children, some lasting well into adulthood. Children who experienced trauma may experience:

- Trouble forming relationships [19, 20, 21]
- Difficulty learning & problems in school (e.g., lower grades, absences, suspensions, increased risk of dropping out) [19, 20]
- Executive function challenges limit their ability to plan, focus, and process information [19, 21]
- Chronic or recurrent physical symptoms (e.g., headaches, stomaches) [21]
- Body dysregulation, leading to over-responding or under-responding to sensory stimuli [20]
- Difficulty identifying, managing and expressing emotions [20]
- Dissociation and mentally separating themselves from overwhelming experiences [21]
- Long-term health consequences, including chronic illnesses & early death [3, 14, 16, 21]

Ways Trauma May Present in Children

The signs of trauma present differently in children than adults. In addition, based on a child's age, reactions may vary. Below are common signs of traumatic stress experienced by different age groups.



Preschool Aged Children

- Fear of separation from caregiver
- Crying or screaming in excess
- Losing weight
- Poor eating
- Nightmares and trouble sleeping [19, 20, 22]

Elementary School Aged Children

- Anxious or fearful
- Trouble concentrating
- Feeling guilt or shame
- Difficulty sleeping
- Obsessive worry
- Aches and pains [19, 20, 22]

Middle & High School Aged Children

- Depression, anxiety
- Feeling alone
- Eating disorders
- Self-harming behaviors
- Use of drugs or alcohol
- Risky sexual behavior [19, 20, 22]

What is trauma informed care?

Trauma-Informed Care is not targeted to specific individuals, rather it is a **universal approach applied to all who access care.** Given the high prevalence of trauma exposure in the general population, it is recommended to assume all patients have potential underlying trauma, thus treating everyone with trauma-informed care [2, 6].

Emphasis is placed on **providing a safe space and empowering environment for all patients**, especially those with trauma, from the moment they walk in the door [23, 24].

During a trauma response, the brain moves resources away from thinking and towards survival. Trauma-informed care's goal is to reduce the experience of threats and to help restore the ability of the part of the brain (prefrontal cortex) that allows thinking, problem solving, planning, and inhibition [25].

Trauma-informed care provides a framework that acknowledges the impact of trauma on health, **recognizes** the signs of trauma, avoids **retraumatization**, and **responds** with a culture of physical, psychological, and emotional safety [3, 9]. The framework has six fundamental principles, which can be used in any care setting.

Trauma-Informed Principles

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice, & Choice
- Cultural, Historical, & Gender Issues [9, 18]

Becoming Trauma-Informed

Creating a supportive environment is an essential part of trauma-informed healthcare. The physical environment as well as the content of policies and procedures have an impact on patients and staff.

Trauma-Informed Design

The Physical Environment

- Clear sightlines, few barriers
- Cool colors (blue, green, purple)
- Natural light
- Warm, adjustable artificial lighting
- Visually interesting but not cluttered
- Quiet, private exam rooms
- Plenty of seating
- Non-institutional flooring
- Easily accessible parking
- Clear signage [11, 26, 27]

Trauma-Informed Policies and Procedures

- Keep patients and staff safe
- Clear purpose and intent
- Easy to access
- Created in collaboration between staff and leadership
- Ongoing assessment, review, & openness to change [11, 26, 27]

Reviewing Existing Policies

Use these questions to help in the review and development of trauma-informed policies. Not all questions may be applicable to all settings or policies.

- Are policies flexible? Can they be altered when needed to fit a specific person or situation?
- Do staff have a clear understanding of what the policies are and why they were developed?
- Do staff know how to implement the policies? Is it clear who is responsible for implementation?
- Is there ongoing inclusion of people with lived experiences when developing new policies or updating old ones?
- Have staff been consulted about the policy?
- Are the policy documents easy to access?
- Does the policy result in confidences being broken?
- Does the policy put staff or patient safety at risk? if so, what precautions are in place?
- Are patients aware of the policies that impact them? [28]

Trauma-Informed Language

Language is powerful. It is important to be mindful of the words used when talking about and to people, particularly those who access services. The words we choose to use influence attitudes and can impact the way we interact with others [12]. We are not trying to be politically correct with the words we choose. Instead, we are trying to empower clients, make them feel safe and heard, and fight stigma [12].

Trauma-informed language involves changing our thoughts from "what is wrong with this person?" to **"what happened to this person?"** [29]. It is important to use person-centered language, where instead of focusing on the behavior, we focus on the individual [12]. By focusing on the person, you are showing that you respect the person's autonomy and worth. Choose words that are empowering and strength-based.

USE LANGUAGE THAT IS:

Empowering
The focus should be on the person's ability to thrive and not their experiences or trauma.

Inclusive
This allows the building of a comprehensive culture of care, where it is a safe space for everyone, regardless of their background or identity.

Supportive
Supportive language does not victim blame, but lifts people up. Victim blaming language can impact the way people are treated by providers and reinforce negative aspects of their trauma.

Promotes Autonomy
Language should be used to create a safe space that gives people a voice, choice, and power. Honor and support their choices [12, 30, 31].

Trauma Sensitive Terminology

INSTEAD OF SAYING:	TRY SAYING:
Aggressive	In a heightened emotional state, distressed
Attention-seeking	Trying to get needs met, seeking help regulating
I'm going to touch, you'll feel	Place my hand / speculum / tool
Manipulative, demanding, unreasonable	Trying to self advocate, resourceful, boundaries are unclear, trying to get their needs met
Suffering from	Is experiencing, living with, working towards recovery of
Non-compliant	Prefers alternative treatments or interventions, chooses not to
Refuses	Chooses not to
Dangerous, angry, agressive	Patient tends to (describe the action) when upset
Challenging patient	Is experiencing distress or a challenge
High- vs. low-functioning	Doing well vs. needs support
Denial, unable to accept illness	Has been given multiple diagnoses and none sit comfortably with their lived experience [30, 32]

For trauma sensitive language specific to working with children visit:
https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-arts-and-social-sciences/research/research-centres-institutes-groups/rccf-words-matter-trauma-sensitive-language.pdf

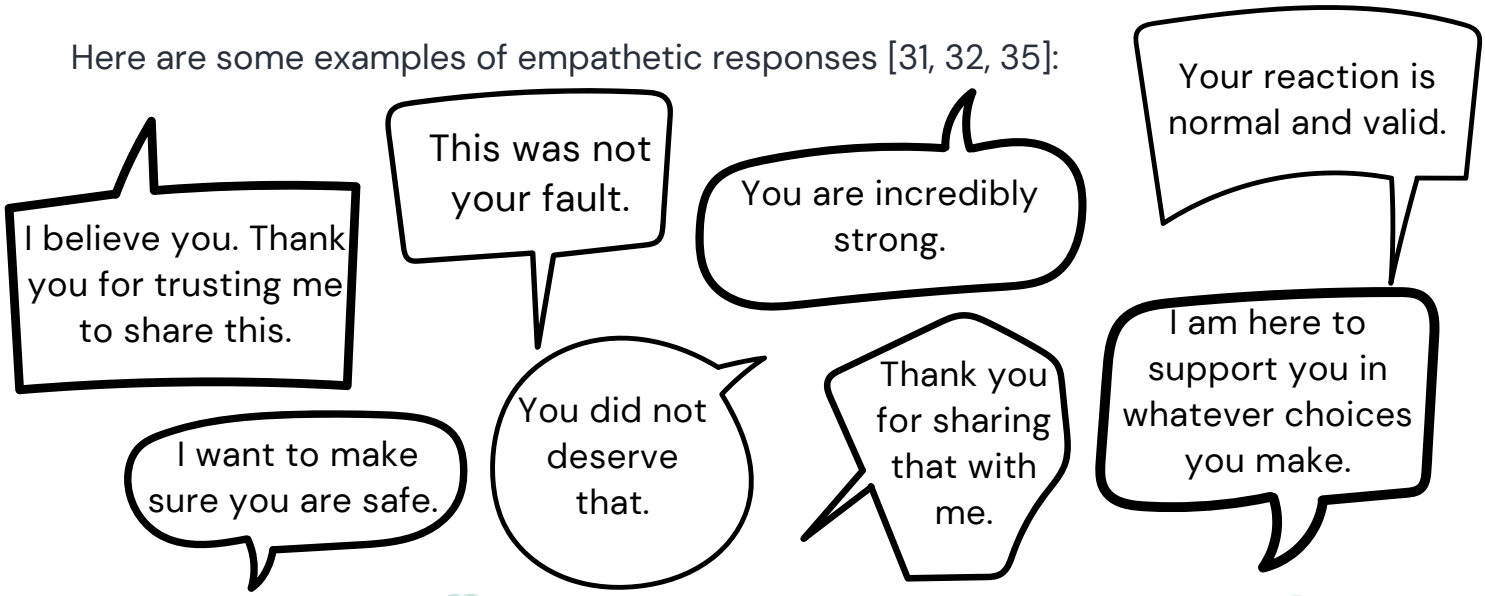
General Principles for Clinic Visits

- **Greet patients** but don't ask personal or medical questions in the lobby or hallway.
- **Set expectations for the visit**
  - Re-iterate the reason for their visit (e.g., "I see you are here for your first prenatal visit")
  - Briefly state what they can expect during the visit: timeline and expected procedures (e.g., "I'm going to ask you a few questions and take your blood pressure then I will let the midwife know you are ready. We will also ask you to leave a urine sample and get some blood drawn at the lab.")
- **Give choices whenever possible**
  - "Would you like to fill out this medical history form or talk through it with an MA?"
  - "Which arm would you prefer we use to take your blood pressure?"
- **Always ask permission** before touching someone and allow them to adjust their own body and clothing.
  - Instead of pushing up their sleeve for them, ask the patient to adjust clothing themselves.
  - Direct them to make movements and adjustments instead of moving their body/clothing with your hands.
  - Minimize the number of times and the amount of time you are touching someone.
- **Be clear and straightforward**
  - Don't use medical jargon or acronyms if possible. if it makes sense or is necessary to use them, explain what they mean.
- **Start with a neutral statement** when asking about sensitive topics
  - Example: "More than half of people experience trauma in their lifetime, which we know can have significant health effects. We ask all our patients to fill out this form which asks questions about trauma. Is that something you feel comfortable doing?" [9, 33, 34]

How to respond to a trauma disclosure

If a patient discloses trauma, responding with empathy and acknowledging their disclosure is essential. Listen to what they are saying, don't interrupt or offer advice. Don't dismiss or react in a way implying you do not believe or are judging them. Remember, this is about the person and their experience; keep your emotions in check and keep from sharing personal experiences.

Here are some examples of empathetic responses [31, 32, 35]:



Use the 4 C's to guide your response to trauma disclosure:

- **Be calm**
  - This is emotionally regulating for a patient who has experienced trauma.
- **Contain the interaction**
  - You do not need to have a detailed trauma history to be compassionate and offer help.
- **Care for the patient and yourself**
  - Provide information, resources, and referrals in a way that is emotionally manageable for both you and the patient.
  - It is common for patients to feel guilt and shame, respond to them in a nonjudgmental manner.
- **Focus on coping**
  - Emphasize the patient's strength and resilience.
  - What has worked for the patient in the past to overcome difficulties? [36]

Adapted from *From treatment to healing: Inquiry and response to recent and past trauma in adult healthcare*. Women's Health Issue. (2019) https://doi.org/10.1016/j.whi.2018.11.003

How to respond in difficult situations

'Difficult situations' may occur when a person displays challenging behaviors, such as presenting agitated, aggressive, or upset. While these behaviors can make a situation challenging, the person exhibiting these behaviors is often responding to feelings of frustration, anxiousness, confusion, and powerlessness or has had a trauma memory triggered [12].

Responding with a trauma-informed care approach can help de-escalate the situation and provide the person with a safe space. Respond with a person-centered approach, focusing on the person, not their behavior. Listen with empathy and provide them with your full attention [12]. Allow the person to speak without interrupting, allowing them to express their concerns [12]. Acknowledge their emotional state (e.g., 'I can see this is frustrating for you.'). Ask them what you can do to help or what they need (is it someone to listen, time alone, a resource?) [12].

REFLECTIVE QUESTIONS TO ASK YOURSELF

- **Is my perception of the situation the same as those around me?**
- **Am I misinterpreting the situation?**
- **Do I have this in perspective?**
- **Am I taking this too personally?**
- **Is there something positive in this situation that I can use to respond?**
- **What am I reacting to?**
- **What else could be going on for this person?**

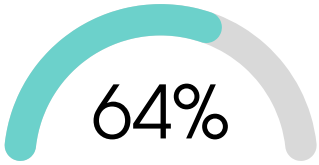
Adapted from *Trauma-informed practices for responding to difficult situations.* Network of Alcohol and Other Drug Agencies. (2022, November) https://nada.org.au/wp-content/uploads/2022/12/Trauma-informed-practices.pdf

Pelvic Exams

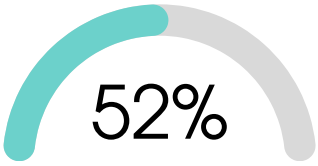
Persons accessing obstetric and gynecological (OB-GYN) care are often subject to evaluations and procedures that are intimate and invasive, putting the patient in a vulnerable position [2]. This type of care can be triggering for people with histories of physical, sexual, or emotional trauma. Care should be provided that considers the high levels of trauma experienced by those accessing OB-GYN care [37]. In 2021, the American College of Obstetrics and Gynecology recommended **universal trauma-informed care in all healthcare encounters** [3, 6].

Persons with a history of sexual abuse report more discomfort, pain, and stress during pelvic exams [2, 39]. Additionally, those with a history of childhood sexual abuse have increased anxiety about gynecologic exams, which can lead to delays in returning to care or avoidance of care [38]. However, research has found that only 7.6% of women share their history with their provider [39]

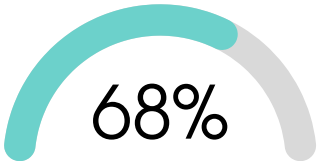
During and before a pelvic exam up to:



of women felt anxious or worried [38]



of women experienced embarrassment [38]



of women experienced pain [38]

Signs of high levels of anxiety or distress during a pelvic exam include:

- Closing or covering the eyes
- Hands on their legs, abdomen, shoulders
- Hands covering their breasts or pubic area
- Holding another person's hand
- Tightening muscles, especially pelvic and buttocks
- Exaggerated startle response when touched [38, 39]

Tips for Pelvic Exams

Before the exam

- Discuss the exam with the patient clothed
- Stay within eyesight and respect personal space
- Explain the exam and set an agenda for the visit
- Normalize or standardize the procedure ("this is something we do with all of our patients")
- Ask for questions or concerns
- Ask what can make the patient more comfortable
- Give specific directions on what clothes to remove and how to wear or position the gown and drape

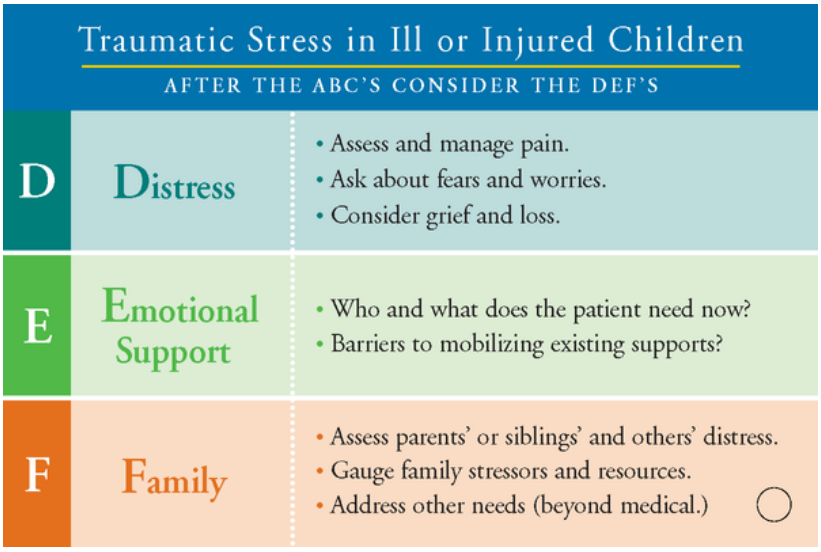
During the exam

- Explain the examination steps before beginning
- Explain the medical relevance
- Ask permission throughout the exam ("Is that alright?", "Is it ok to proceed?")
- Be open to patient assistance (e.g., self-insertion of speculum or swabs, patient's hand over the provider's)
- Check in throughout the exam
- Have patient get dressed before discussing findings or concerns
- Ask "What questions do you have?" - keep it open ended [39]

Think about the words you choose and how someone may have heard them in other traumatic situations [3]. Below are some examples of ways to be more trauma-informed during pelvic exams [3, 39]:

INSTEAD OF SAYING:	TRY SAYING:
Bed, lay down on the bed	Exam table, lay down on the exam table
Open your legs	Allow your knees to fall to the side, butterfly your legs, frog legs
Stirrups	Leg rests
Look at, feel, touch	Inspect, examine, check

Working with Pediatric Patients



D **DISTRESS** See pocket card for brief assessment and recommended interventions to address and treat pain, fears and worries, and grief and loss. **Recommendations include:**

- Actively assess and treat pain, using your hospital's protocol.
- Provide child with information about what is happening and choices regarding treatment decisions when possible.
- Listen carefully for child's understanding and clarify any misconceptions.
- Ask about fears and worries.
- Provide reassurance and realistic hope.

E **EMOTIONAL SUPPORT** See pocket card for brief assessment and recommended interventions to address child's emotional needs, and barriers to mobilizing existing supports. **Recommendations include:**

- Encourage parents to be with their child as much as possible and to talk with their child about worries and fears.
- Empower parents to comfort and help their child.
- Encourage child's involvement in age-appropriate activities when possible.

F **FAMILY** See pocket card for brief assessment and recommended interventions to address parents' and siblings' distress, family stressors and resources, and needs beyond medical care. **Recommendations include:**

- Gauge family distress and other life stressors; identify family strengths and coping resources.
- Encourage parents to use own coping resources or support available at the hospital or in the community.

Full Resource:

D-E-F pocket guide, toolkit and poster The National Child Traumatic Stress Network. https://www.nctsn.org/sites/default/files/resources/pediatric_toolkit_for_health_care_providers.pdf

NCTSN The National Child Traumatic Stress Network www.NCTSNet.org

From *Pediatric medical traumatic stress.* The National Child Traumatic Stress Network. (2014).https://www.nctsn.org/resources/pediatric-medical-traumatic-stress-toolkit-health-care-providers

Resources

Local

Abbie Shelter

- https://www.abbieshelter.org
- 24-hour Helpline: 406-752-7273
- Services:
  - Court advocacy
  - 24-hour helpline
  - Counseling
  - Shelter for people leaving dangerous relationships

Flathead County Victim Advocate – Help for victims of partner or family member assault. The County Attorney's Office may file criminal charges against the abuser.

- https://www.flatheadcountysheriff.com/crime-victim-advocate/
- Services:
  - Kalispell: 406-758-7780
  - Flathead County 406-758-2108
  - Victim Witness Advocate: 406-261-9084
  - Help Net: 406-752-8181
  - 24-hour Toll Free: 800-332-842
  - Stillwater Therapeutic Service (children only for outpatient therapy): 406-752-6100
  - Chemical Dependency: 406-756-6453
  - Adult Services: 406-257-1336

Safe Harbor

- 24-hour Hotline: 406-676-0800
- Services – all services free of charge for those seeking relief from domestic violence, dating violence, sexual assault or stalking in Lake County and on the Flathead Indian Reservation
  - Emergency shelter
  - Crisis intervention
  - Emergency Advocacy
  - Can help with transportation and provide emergency vouchers (for groceries and fuel)

Flathead Youth Home – Eight bed group home for short-term crisis intervention and longer-term group care for youth, ages 10-18

- http://www.flatheadyouthhome.org
- 406-721-8937, fax 406-721-0034
- Services:
  - Child & family counseling
  - Foster care & adoption
  - Family support services
  - Group home care

Western Montana Mental Health Center 24-hour mental health crisis intervention

- https://www.wmmhc.org/
- Crisis Hotline: 406-752-6262

Resources

National

Crisis Text Line:

- https://www.crisistextline.org/text-us/
- Text HOME to 741741 (in US & Canada)

National Sexual Assault Hotline:

- 1-800-656-4673
- https://www.rainn.org/get-help
- Online Hotline online.rainn.org
- More info: https://www.rainn.org/about-national-sexual-assault-online-hotline

Substance Abuse & Mental Health Helpline treatment, referral, and information service for individuals and families facing mental and/or substance use disorders

- 1-800-662-4357 (1-800-662-HELP)
- https://www.samhsa.gov/find-help/national-helpline

Suicide & Crisis Lifeline:

- 988
- https://988lifeline.org/

Substance Abuse & Mental Health Services Administration (SAMHSA)

- Provides information, training, & technical assistance
- Has an Interagency Task Force on Trauma-Informed Care
- https://www.samhsa.gov/programs

The National Child Traumatic Stress Network

- Resources related to child traumatic stress
- Information for families & caregivers, child welfare professionals, justic system professionals, school personnel, healthcare providers, youth, & policy makers
- https://www.nctsn.org

Trauma-Informed Care Implementation Resource Center

- Resources for implementing Trauma-Informed Care in healthcare
- https://www.traumainformedcare.chcs.org

US National Domestic Violence Hotline:

- 1-800-799-7233

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Appendix D

Pre- and Post-Survey Questions

21 Item- Knowledge, Attitude and Practice Related to Trauma Informed Care

Factor	Survey Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Knowledge	**1. Exposure to trauma is common.**					
	2. Trauma affects physical, emotional, and mental well-being.					
	3. Substance use issues can be indicative of past traumatic experiences or adverse childhood events (ACE).					
	4. There is a connection between mental health issues and past traumatic experiences or adverse childhood events (ACE).					
	5. Distrusting behavior can be indicative of past traumatic experiences or adverse childhood events (ACE).					
	6. Retraumatization can occur unintentionally.					
Attitude	**7. Recovery from trauma is possible.**					
	8. Paths to healing/recovery from trauma are different for everyone.					
	9. People are experts in their own healing/recovery from trauma.					
	10. Informed choice is essential in healing/recovery from trauma.					
	11. Trauma-informed practice (TIP) is essential for working effectively with our patients and their families.					
	12. I have a comprehensive understanding of trauma-informed practice (TIP).					
	13. I believe in and support the principles of trauma-informed practice (TIP).					
	14. I share my expertise and collaborate effectively with colleagues regarding the use of trauma-informed practice (TIP).					
	15. I would like to receive more training on trauma-informed practice (TIP).					
Practice	**16. I maintain transparency in all interactions with patients.**					
	17. I offer patients choices and respect their decisions.					
	18. I help patients and peers to recognize their own strengths.					
	19. I inform all patients of my actions before I perform them.					
	20. My interaction with each patient is unique and tailored to their specific needs.					
	21. I practice self-care (taking care of my own needs and well-being).					

S. King, K.D. Chen & B. Chokshi (2018)