UNDERGRADUATE NURSING STUDENTS' LEARNING NEEDS AND ATTITUDES ABOUT TRAUMA AND TRAUMA-INFORMED CARE

by

Katalyn Kelsey Mangus

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DEDICATION

I would like to dedicate this to my parents, John and Celia, for all their love and support over the past four years. I also dedicate this to Dr. Mallory Newman for always believing in me.

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ABSTRACT

Trauma is a very prominent and pervasive problem that causes numerous and harmful effects on the physical and mental health of those affected. Trauma-informed care (TIC) is a care framework that encourages healthcare workers to acknowledge trauma and care for patients in a way that takes past traumas into account. The practice of trauma-informed care leads to better healthcare experiences, better health outcomes, better trauma recovery, and more health compliance in trauma survivors. Unfortunately, many healthcare workers, including nurses, recognize the significance of trauma but feel unprepared to provide trauma-informed care to patients. The doctor of nursing practice project presented here sought to assess the current level of TIC education for undergraduate maternal-child nursing students at Montana State University College of Nursing. A secondary aim of this project was to provide guidance and recommendations to maternal-child nursing faculty for revisions to current curriculum. In order to achieve this aim, nursing students were recruited to participate in a survey that evaluated participants' attitudes about trauma, trauma-informed care, and which aspects of trauma-informed care they felt most strong and most weak in. The data were analyzed to evaluate undergraduate nursing students' current preparedness for providing trauma-informed care in their future nursing practice. The findings indicated that participants did feel somewhat confident in their understanding that trauma is impactful on women and that trauma-informed care can be beneficial. The participants also understood that working with trauma-affected patients can emotionally impact or re-traumatize a healthcare worker. Participants reported a lack of confidence in their ability to recognize trauma, recognize trauma-affected patients, and provide appropriate TIC to these patients. These data were used to guide the creation of a trauma-informed care education resource for nursing educators to utilize for teaching future nursing students about trauma-informed care. Ideally, this resource will encourage and facilitate the implementation of basic TIC education for nursing students, which will help future Montana State University nursing cohorts become more knowledgeable and confident in trauma-informed care as they prepare to join the nursing workforce.

CHAPTER ONE

INTRODUCTION

A significant number of people have been exposed to some form of trauma at some point in their lives (Gelaye et al., 2013; SAMHSA, 2014). The consequences of trauma are numerous and harmful (SAMHSA, 2014). Trauma often produces long-term effects on physical health as well as psychological health (Bruce et al., 2018; Gilliver, 2018; SAMHSA, 2014). The stress of healthcare encounters can induce symptoms of past traumas or even re-traumatize patients (Muzik et al., 2013; Sperlich, Seng, Li, Taylor, & Bradbury-Jones, 2017). For women, the perinatal period can be especially challenging; these patients are at high risk for stress and re-traumatization during their perinatal health encounters (Huth-Bocks, Krause, Ahlfs-Dunn, Gallagher, & Scott, 2013; Kim, Harrison, Godecker, & Muzyka, 2014). Patients exposed to trauma may even try to avoid healthcare encounters altogether in order to prevent triggering experiences (Kim et al., 2014).

Healthcare workers, including registered nurses (RNs), often do not fully understand the effect past trauma can have on a patient's present healthcare experience (Li et al., 2019; Stokes, Jacob, Gifford, Squires, & Vandyk, 2017). In many instances, RNs recognize the power of trauma but feel unknowledgeable and unprepared to improve the trauma-affected patient's experience (Bruce et al., 2018; Choi & Seng, 2015; Isobel & Delgado, 2017; Schiff, Zuckerman, Wachman, & Bair-Merritt, 2017; Stokes, Jacob, Gifford, Squires, & Vandyk, 2017; Weiss et al., 2017). Research on the effects of trauma began to gain traction in the 1970s as researchers were measuring trauma and linking it to physical and mental wellbeing (SAMHSA, 2014). Trauma research highlighted a need for healthcare that better acknowledged trauma, and the concept of

trauma-informed care began to take shape in the 1990s (SAMHSA, 2014). Trauma-informed care (TIC) is a conceptual framework based on a set of key assumptions and principles about trauma. TIC is designed to help healthcare workers understand how to acknowledge trauma and care for patients in a way that takes trauma into account (SAMHSA, 2014). Researchers suggest TIC is effective and patients who receive TIC have better healthcare experiences, better health outcomes, better trauma recovery, and are more compliant with healthcare recommendations and more willing to seek healthcare (Cannon et al., 2020; Gilliver, 2018, Muzik et al., 2013; Rouland Polmanteer, Keefe, & Brownstein-Evans, 2018; Sperlich et al., 2017). Preparing healthcare workers to learn and apply the principles of TIC is essential for promoting improved outcomes for trauma exposed patients. Healthcare providers trained in TIC have been shown to possess improved trauma awareness, development of their TIC skills, and increased confidence in their ability to provide care that accommodates for the effects of trauma (Broughton, 2017; Isobel & Delgado, 2017; Weiss et al., 2017). Some healthcare facilities are introducing continuing education training on TIC; unfortunately, most RNs have still had little to no specific training on TIC (Cannon et al., 2020; Choi & Seng, 2015; Li et al., 2019; Stokes et al., 2017). Many RNs report feeling confused and uncertain as to how to apply TIC to their own nursing practice (Bruce et al., 2018; Choi & Seng, 2015; Isobel & Delgado, 2017; Schiff et al., 2017; Stokes et al., 2017; Weiss et al., 2017). Registered nurses do not typically receive TIC training in nursing programs, though some researchers have shown that incorporating this training into the curriculum can significantly improve students' TIC knowledge and skills (Cannon et al., 2020, Li et al. 2019). Providing TIC training in nursing programs could increase the prevalence of TIC and help RNs become comfortable with providing consistent, high-quality TIC early on in their

careers (Wheeler, 2018). Currently, there is a limited amount of research focused on nursing students' TIC knowledge and skills. Additional insight could guide nursing programs as they seek to incorporate TIC into their curriculums. This project seeks to assess nursing students' knowledge of trauma and their confidence in their ability to provide TIC and identify perceived strengths and deficits. This information will be used to guide the creation of a curriculum resource for nursing faculty members.

Purpose

The vulnerable nature of perinatal healthcare encounters can deleteriously affect the symptoms of previously experienced trauma in patients, which can have short- and long-term impacts on the mental and physical health of both mother and child (Kim et al., 2014; Muzik et al., 2013; Sperlich et al., 2017). Trauma-informed care reduces the stress of perinatal healthcare encounters for women who have been previously exposed to trauma (Cannon et al., 2020; Gilliver, 2018; SAMHSA, 2014; White, Danis, & Gillece, 2016). Researchers have shown that, when healthcare providers are trauma-minded, trauma-exposed women feel safer and more trusting; thus, women report an overall improved healthcare experience (Muzik et al., 2013; White et al., 2016). Women exposed to trauma report feeling less embarrassed during their healthcare visits, more willing to communicate with their providers, and better prepared to be mothers (Muzik et al., 2013). Unfortunately, many RNs, including perinatal nurses, felt unprepared to provide TIC as they have never formally received TIC training (Cannon et al., 2020; Choi & Seng, 2015; Li et al., 2019; Stokes et al., 2017). The doctor of nursing practice (DNP) project presented here seeks to assess the current level of TIC education for

undergraduate maternal-child nursing students at Montana State University (MSU) College of Nursing. A secondary aim of this project is to provide guidance and recommendations to maternal-child nursing faculty for revisions to current curriculum.

Rationale

Educating RNs about trauma and TIC early—preferably while they are still in their nursing program—is a strategy that could help to reduce or even prevent discrepancies in TIC knowledge, confidence, and skills that is currently experienced by many RNs (Cannon et al., 2020). Many nursing programs do not yet include TIC training in their curriculums, or only discuss the relevance of trauma very briefly (Cannon et al., 2020). Obtaining definitive data on MSU nursing students' understanding of trauma and its effects on the healthcare experience of their patients, as well as the students' intentions to provide TIC in their future nursing practice, could offer useful insights into tailoring of nursing curriculums for these students. The data about the learning needs of these students will be used to create specific suggestions that MSU faculty can refer to for future curriculum implementation. Ideally, subsequent nursing students will receive more in-depth and customized education on trauma and TIC.

Definitions

The participants in this project were junior-level undergraduate nursing students from the MSU College of Nursing. The MSU College of Nursing is a multi-campus program with students in several major cities across Montana: Billings, Bozeman, Great Falls, Kalispell, and Missoula. The participants in this project were from the Billings campus. An assessment tool was

used to analyze maternal-child nursing students' current attitudes, self-efficacy, skills, and knowledge about trauma and TIC. The definitions of trauma and TIC during this DNP project came from literature from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA (2014) defines trauma as something which

> results from an event, 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 individual's functioning and mental, physical, social, emotional, or spiritual well-being (p. 7).

Trauma-informed care is grounded in four key assumptions and six key principles (SAMHSA, 2014). The four key assumptions of TIC are realization, recognition, response, and resisting re-traumatization (SAMHSA, 2014). SAMHSA (2014) expounded on these key assumptions with the following:

> A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (p. 9).

Limitations

A significant limitation of this project was that the sample size was small and comprised solely of undergraduate maternal-child nursing students. The subjects came from only one university, so applicability to other students and universities nationwide may be limited. Another limitation of this project was that it only measured students' current knowledge and attitudes; there was no evaluation of changes in the subjects' responses or measure of the success of any future curriculum changes or TIC trainings.

Theoretical Foundation

The theoretical foundation for this project is Ajzen's Theory of Planned Behavior (Cornally, 2014). This theory explores the links between four different constructs—attitudes about a behavior, the outside pressure to perform a behavior, the belief in one's ability to perform a behavior, and the intention to perform a behavior—and actually performing the behavior (Cornally, 2014). The four constructs are called "explanatory variables" that together influence and predict how likely it is that a behavior will be carried out (Cornally, 2014).

The DNP project assessed nursing students' relationships with these four constructs as they apply to trauma and TIC. The project explored students' attitudes about TIC, their belief in the need to use TIC, their self-efficacy in using TIC, and their intention to use TIC in their future nursing practice.

Understanding the degree to which each of these constructs are currently being fulfilled helped guide decisions about what explanatory variables nursing educators should focus on as they incorporate trauma education into their curriculum. Educators will be able to specifically increase the influence of each of these explanatory variables as needed; thus, hopefully, expanding the likelihood that the desired behavior—that of providing TIC—will be implemented in students' future practice.

CHAPTER TWO

REVIEW OF LITERATURE

Trauma is becoming an increasingly popular topic in healthcare, but TIC is still a relatively new practice modality. Thus, it was essential to conduct a thorough literature review of the research on trauma, perinatal trauma, TIC, and TIC education in order to recognize knowledge gaps that this project would be striving to bolster. The aim of the literature review was to evaluate (1) the effects of trauma on perinatal health, (2) the current usage of TIC in perinatal care, (3) nurses' self-efficacy in providing TIC, (4) the effectiveness of TIC training efforts, and (5) the current degree of TIC training for undergraduate nursing students. The sources for this literature review were obtained through an extensive search of the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, and PsycInfo. Key words in the search were combinations of trauma, adverse childhood experiences posttraumatic stress disorder, trauma-informed care, trauma-informed, perinatal, pregnancy, nursing, education, and students. The articles reviewed included publication years ranging from 2013 to 2020. The key themes identified in this review include the dramatic effects of trauma on perinatal health, the value of educating healthcare providers about trauma and TIC, and the limited amount of TIC education currently provided to nurses and nursing students.

Articles reviewed were chosen for their discussion of the effects of trauma in perinatal healthcare, for their discussion on the experience and effects of TIC training, or for their research into the currently typical degree of TIC training for nurses, nursing students, and other healthcare providers. Literature that focused on TIC training for nurses were preferred; however, the literature on TIC knowledge and training for nurses—especially perinatal nurses—is scant, so

many of the articles on TIC training were focused on the general population of healthcare professionals.

Trauma and Perinatal Health

Trauma is widely recognized as a harmful response to experience that affects the health of many people around the world (SAMHSA, 2014). Trauma occurs through a person's exposure to events or circumstances that cause the individual to experience physical harm, emotional harm, or risk of death (SAMHSA, 2014). Trauma can be caused by many different exposures, including war, physical violence, emotional abuse, sexual assault, neglect, etc. (SAMHSA, 2014). Researchers have shown that people who have experienced trauma are likely to have experienced more than one traumatic event, with one survey conducted in the United States finding that "the average number of lifetime traumatic events was 3.3" (Gelaye et al., 2017). Individuals experience trauma differently and in different degrees. The experience of trauma is often dependent on factors such as prior traumas, overall stress levels, poor coping abilities, and/or possessing a poor support network (Bruce et al., 2018). Regardless of the severity of the trauma or the individual response, it is well-understood that trauma regularly has long-term consequences for the emotional, mental, and physical wellbeing of the affected individual (Bruce et al., 2018; Gilliver, 2018; SAMHSA, 2014).

One of the primary concepts in trauma is adverse childhood experiences (ACEs) (Gilliver, 2018; Olsen, 2018; Sperlich et al., 2017). The most significant ACEs include sexual abuse, physical abuse, emotional abuse, emotional or physical neglect, exposure to domestic violence, substance abuse in the home, mental illness in the home, parental separation, or

imprisonment of a household member (Gilliver, 2018; Sperlich et al., 2017). In the 1990s, extensive research on ACEs found a significant relationship between having ACE exposures and experiencing health issues as an adult (Gilliver, 2018; Li et al., 2019; Muzik et al., 2013; Olsen, 2018). Individuals who experienced ACEs are far more likely to have chronic physical health conditions as adults, including cancer, heart disease, obesity, and emphysema (Gilliver, 2018; Muzik et al., 2013; Reeves, 2015; Sperlich et al., 2017). Individuals who experienced ACEs are also more likely to experience mental health issues such as depression, alcoholism, substance misuse, and uncontrolled anger. Additionally, these people are also more likely to commit violence, face prison sentences, experience teenage pregnancy, and contract sexually transmitted infections (Gilliver, 2018; Muzik et al., 2013; Reeves, 2015; Sperlich et al., 2017). Trauma is "an almost universal experience of people with mental and substance use disorders" (SAMHSA, 2014, p. 2).

Trauma in adulthood, not only that experienced in childhood, can also affect individuals negatively (Li et al., 2019). Many adults are subjected to ACE-like traumas, including violence, sexual assault, and physical, verbal, and emotional abuse (Linden, Torchalla, & Krausz, 2013). Adult females are particularly prone to intimate partner violence (IPV) (Huth-Bocks et al., 2013;Linden et al., 2013). Large-scale studies have led to estimates that 20–38% of women experience IPV at some point during their life (Huth-Bocks et al., 2013).

The perinatal period can be an especially difficult time of change and stress for women who, during pregnancy, often face issues such as financial concerns, feelings of inadequacy, relational changes, and a tendency for increased IPV (Huth-Bocks et al, 2013; Kim et al., 2014). The numerous potential stressors of pregnancy can provoke or trigger worsening symptoms of

posttraumatic stress disorder (PTSD) from adult traumas or ACEs (Huth-Bocks et al., 2013; Olsen, 2018).

Adult trauma, IPV, and ACEs have been found to play a significant role in the perinatal health of mothers and their newborns (Choi & Seng, 2015; Kim et al., 2014). A history of trauma is linked with increased antepartum and intrapartum risk factors and complications such as alcohol use and smoking during pregnancy, poor prenatal compliance, preterm delivery, and reduced coping/increased distress during labor and delivery (Kim et al., 2014). Post complications include postpartum depression, increased maternal stress infant emotion dysregulation, impaired bonding, and impaired maternal caregiving (Choi & Seng, 2015; Kim et al., 2014). Prenatal stress is also linked with the development of long-term physical and mental conditions in both the mother and child, including metabolic syndrome and psychiatric disorders (Kim et al., 2014).

Relevance to Nursing

As discussed above, trauma can have many negative consequences for women in the perinatal period. Unfortunately, even routine perinatal healthcare encounters can be vulnerable and stressful experiences for patients with a trauma history, and these encounters actually have the potential to trigger PTSD or worsen trauma (Muzik et al., 2013; Sperlich et al., 2017). Promoting a trauma-informed approach to the care of these patients can help heal trauma and reduce the risk of PTSD episodes or worsened trauma (Cannon et al., 2020; Gilliver, 2018; SAMHSA, 2014; Sperlich et al., 2017).

Due to their frequent interactions with patients, registered nurses are in a prime position to recognize and mitigate the effects of trauma in their patients by caring for them using TIC techniques (Li et al., 2019). The four core principles of TIC are to (1) realize the widespread effects of trauma, (2) recognize the signs of trauma, (3) respond appropriately to identified trauma, and (4) reduce re-traumatization during care of the patient (SAMHSA, 2014). Nurses trained in TIC understand trauma and the characteristics of trauma survivors; thus, they are better able to recognize behaviors that are symptoms of trauma and can recognize when patients are struggling to cope with trauma (Li et al., 2019). Nurses trained in TIC understand that patients experience and conceptualize trauma in unique ways. These nurses make a conscious and compassionate effort to reduce the potentially triggering nature of a health visit by being mindful of their patients' known and unknown past traumas and working with the patient to reduce stressors (Gilliver, 2018; SAMHSA, 2014; Sperlich et al., 2017).

Caring for patients with a trauma-informed approach helps patients feel safe and less threatened, increases patient compliance, reduces avoidance of healthcare, improves health outcomes, improves parenting ability, reduces the risk of re-traumatization, and can help with trauma recovery (Cannon et al., 2020; Gilliver, 2018; Muzik et al., 2013; Rouland Polmanteer et al., 2018; Sperlich et al., 2017). Actually discussing trauma with every patient is a useful, but not essential, component of TIC, although research has found that perinatal patients do appreciate when healthcare workers are willing to compassionately discuss trauma with them as needed (Muzik et al., 2013; White et al. 2016). The perinatal period can actually be an excellent time to identify and treat trauma because mothers often see this as a time to heal themselves for the sake of their new child (Muzik et al., 2013).

Using a trauma-informed approach benefits nurses as well. Nurses trained in TIC are shown to be more understanding, compassionate, and flexible, and experience less burnout (Gilliver, 2018). Another noteworthy benefit of TIC training is that it helps healthcare providers learn to better cope with their own personal traumas. Providers who have been traumatized are at risk of re-traumatization when they are exposed to the traumas of patients (Cannon et al., 2020, Li et al., 2019; Sperlich et al., 2017).

Educating Nurses in Trauma-Informed Care

Nurses are at the forefront of healthcare and have significant amounts of contact with trauma survivors. However, most nurses have received little to no formal training in the relatively new concept of TIC (Li et al., 2019; Stokes et al., 2017). Many healthcare professionals hold high opinions of TIC but feel they do not fully understand it, do not understand how to incorporate TIC into their day-to-day work, and lack confidence in their ability to provide TIC effectively (Bruce et al., 2018; Choi & Seng, 2015; Isobel & Delgado, 2017; Schiff et al., 2017; Stokes et al., 2017; Weiss et al., 2017). There is a clear need for greater amounts of consistent TIC training in all of healthcare (Choi & Seng, 2015). There is very little published research specifically regarding TIC training for perinatal nurses, with most research focused on other specialties and/or incorporating professions besides nursing into the evaluation.

Overall, TIC training is shown to improve healthcare workers' knowledge of trauma, favorable attitudes about TIC, and their confidence in their ability to provide effective TIC (Broughton, 2017; Isobel & Delgado, 2017; Weiss et al., 2017). Even small amounts of training can effectively increase TIC knowledge and promote TIC in practice (Broughton, 2017; Hall et

al., 2016; Weiss et al., 2017). Hall et al. (2016) conducted a pilot study which found that even a one-day TIC training for 34 emergency-department nurses produced significant improvement in confidence in several TIC skills. The participants reported more confidence in their ability to talk to patients about trauma ($p = .001$, r = 0.41), respond to disclosure of family violence ($p = .001$, r = 0.41), and understand how their practice is trauma-informed ($p = .001$, r = 0.53). Broughton (2017) provided TIC education to 90 pediatric nurses and found significant increases in participants' ability to recognize signs of trauma ($t(87) = -13.801$, $p < .0005$), their reported ability to respond to trauma-exposed children ($t(87) = -14.499$, $p < .0005$), and their understanding of the importance of applying TIC ($t(87) = -5.441$, $p < .0005$).

Those nurses who do receive trauma education often obtain it through continuing education courses or training from their employer (Cannon et al., 2020; Li et al., 2019). Despite its known value, education on trauma and TIC is not yet part of the standard curriculum for the majority of nursing programs (Cannon et al., 2020; Li et al. 2019). Wheeler (2018) reinforced the necessity of ensuring that nursing students are prepared to provide the most current, evidence-based care for trauma survivors, describing a "critical need to develop and disseminate core competencies in trauma for nursing education and practice" (p. 21).

Although the need has been established, there has been little research on efforts to implement TIC content into the curriculums studied by nursing students. In one recent study, Cannon et al. (2020) implemented TIC content into the curriculums of undergraduate and graduate nursing students at a large Midwestern university. The pre-intervention and post-intervention survey results found that the 128 participants' attitudes about TIC were already positive and did not change with the training, but the training did significantly improve their

knowledge and skills (Cannon et al., 2020). Specifically, there were knowledge increases with large effect sizes in "confidence in understanding TIC" ($t(127) = 15.20$, $p < .001$, 95% CI [1.087, 1.413], Cohen's $d = 1.343$), "the ability to define TIC" ($t(127) = 16.57$, $p < .001$, 95% CI [1.197, 1.522], Cohen's $d = 1.464$), "the ability to identify trauma triggers and symptoms" ($t(127) = 14.59$, $p < .001$, 95% CI [1.135, 1.490], Cohen's $d = 1.290$), and "understanding the neurobiology of trauma ($t(127) = 22.64$, $p < .001$, 95% CI [1.667, 1.986], Cohen's $d = 2.010$) (Cannon et al., 2020). In response to post-intervention open-ended questions, many participants discussed ways in which they intended to apply TIC to their future practice (Cannon et al., 2020). Overall, the students' reception to the training was positive, suggesting that nursing students are eager and receptive to learning about TIC if presented with the opportunity (Cannon et al., 2020).

Summary

Undergraduate nursing students are in a prime position for learning about trauma and developing TIC skills, which is knowledge they will likely use in the care of many of their patients. Since many nursing programs do not routinely teach TIC, despite research suggesting its utility, it may be valuable for researchers and educators to specifically evaluate nursing students' trauma-learning needs and consider implementation of TIC content in school curriculums in the future. To help attain this objective, this DNP project sought to assess the learning needs of maternal-child nursing students and facilitate any indicated need for improvements in nursing-school curriculums.

CHAPTER THREE

METHODS

Because TIC has been found to improve patient experience and patient outcomes, it is important for RNs to feel comfortable working with trauma-affected patients and providing TIC to these patients (Cannon et al., 2020; Gilliver, 2018; Muzik et al., 2013; Rouland Polmanteer et al., 2018; Sperlich et al., 2017). Although there are increasing opportunities for continuing education in TIC, many RNs have not had adequate training in trauma and TIC and lack confidence in their ability to provide appropriate TIC (Bruce et al., 2018; Cannon et al., 2020; Choi & Seng, 2015; Isobel & Delgado, 2017; Li et al., 2019; Schiff et al., 2017; Stokes et al., 2017; Weiss et al., 2017). Incorporating TIC training into nursing-school curriculums would ensure earlier and more widespread dissemination of TIC and more regular application of TIC into nursing practice (Cannon et al., 2020; Wheeler, 2018).

Project Description

The purpose of this DNP project was to identify MSU nursing students' knowledge and concerns about trauma and caring for trauma-affected patients. From these data, the project sought to derive a relevant TIC resource packet of curriculum suggestions for MSU nursing professors. To achieve this aim, the project explored the demographics of the participating nursing students and obtained quantitative and qualitative data about the students' understanding of trauma, their understanding of TIC techniques, and their confidence in their ability to provide TIC. The project identified the most substantial areas of deficiency, and a resource packet of

curriculum suggestions was created to address these areas of concern for future MSU nursing students.

Population of Interest

This DNP project specifically examined the perceptions and knowledge of trauma in junior-level undergraduate nursing students studying maternal-child nursing at MSU's College of Nursing. Montana State University's College of Nursing program serves students on campuses in five major Montana cities: Billings, Bozeman, Great Falls, Kalispell, and Missoula. There are approximately 40 maternal-child nursing students on the MSU-Billings campus each semester. The participants were recruited from this group of students. The perinatal period can be a highly stressful time for patients with a history of trauma, and past trauma is associated with increased risks for both mother and baby. Additionally, perinatal healthcare encounters often carry a high risk of re-traumatization (Huth-Bocks et al, 2013; Kim et al., 2014; Muzik et al., 2013; Sperlich et al. 2017). Therefore, maternal-child nursing students are excellent candidates for an assessment of current trauma knowledge and perceptions, and ideal recipients of future trauma education.

Procedure

Recruitment and selection for this DNP project occurred in January, 2021. Data collection occurred February, 2021. Data were then analyzed and utilized to aid in the creation of a curriculum resource kit that will be available to nursing educators by the summer of 2021.

Human Subjects

As this DNP project utilized human subjects for its data collection, approval from the Institutional Review Board (IRB) was necessary. This project was submitted to the IRB for approval before proceeding. Before any data collection began, participants received full disclosure about the project and were asked to provide appropriate consent.

Participant Selection

During MSU's spring 2021 semester, all students enrolled in a maternal-child nursing class at the MSU-Billings campus were informed of the project and recruited to voluntarily participate. To meet inclusion criteria, participants needed to be undergraduate students in good standing at MSU's College of Nursing and actively enrolled in a maternal-child nursing class. Participants needed to be 18 years of age or older.

Plan

After completing a consent form, all participants were asked to complete a demographics questionnaire (Appendix A). Following the demographics questionnaire, all participants were asked to complete an adaptation of the Trauma-Informed Medical Care Questionnaire (TIMCQ) (Appendix B) (Weiss et al., 2017). Data gathered from these questionnaires were analyzed to examine the demographic characteristics of the participants and examine participants' attitudes about TIC and which aspects of TIC they feel most strong and most weak in. The results of the data analysis were used to evaluate undergraduate nursing students' current preparedness for providing TIC in their future nursing practice. These results then guided the creation of a TIC education resource kit for nursing educators.

Measures

The measures used in this project were a demographic questionnaire and an adaptation of the TIMCQ developed by Weiss et al. (2017). The demographic questionnaire was created specifically for this project and consisted of four questions regarding age, gender, ethnicity, and any prior healthcare experience. The TIMCQ adaptation asked nine questions that evaluated participants' attitudes about trauma, TIC, the impact of trauma on medical care, and their confidence in their ability to care for those affected by trauma (Weiss et al., 2017). Eight of the questions were be rated on a 5-point Likert scale, while one open-ended question solicited qualitative responses about how TIC will impact participants' nursing practice.

Analysis

Analyses were conducted using SPSS statistics software. Demographic data and TIMCQ data were evaluated both independently and in conjunction with each other. Qualitative responses were assessed for key themes. The information gathered aided in the creation of a relevant educational resource guide to improve nursing student TIC training.

Demographic Data

Demographic data were analyzed to assess the number of participants that fell into different categories of age, gender, ethnicity, and healthcare work experience. These data were used to reveal any limitations of the project findings. Additionally, the demographic data were used alongside the TIMCQ data in order to identify any associations between trauma perceptions and various demographic factors.

Project Data

The results of the TIMCQ were analyzed to evaluate participants' perceptions of trauma and their self-identified strengths and weaknesses in providing TIC in their future nursing practice. The results for the eight Likert scale questions quantitatively indicated how much apprehension nursing students felt about caring for trauma-affected patients. This suggested how important TIC training in nursing programs is and how useful a TIC education resource kit would prove. Additionally, the results of the specific questions demonstrated what domains of TIC the participants felt most deficient in. This guided the creation of the project's TIC education resource kit. The topics of questions that averaged 3 points or fewer on the 5-point Likert scale were given priority attention during the creation of the resource kit. Topics that averaged above 4 points on the 5-point Likert scale were still addressed in the resource kit as needed, but were given less focus. The open-ended ninth question of the TIMCQ provided qualitative guidance for the resource kit.

Summary

Since TIC is not yet routinely taught in nursing programs, many RNs do not feel confident providing TIC to their trauma-affected patients (Bruce et al., 2018; Cannon et al., 2020; Choi & Seng, 2015; Isobel & Delgado, 2017; Li et al., 2019; Schiff et al., 2017; Stokes et al., 2017; Weiss et al., 2017). This project addressed this deficiency by administering questionnaires to undergraduate maternal-child nursing students at MSU that evaluated students' demographics, attitudes, confidence, and learning needs regarding TIC. The data collected from these questionnaires were used to determine how deficient these students felt in their trauma knowledge and TIC confidence, as well as in what domains of TIC they needed the most

training. This influenced the formation of, and enhanced the usefulness of, a TIC education resource kit for nursing educators. The availability of this resource kit will hopefully lead to the implementation of more TIC training in undergraduate nursing studies.

CHAPTER FOUR

RESULTS

The purpose of this DNP project was to assess the perceptions, knowledge, and training on trauma and TIC of undergraduate maternal-child nursing students at the MSU College of Nursing. Nursing students from MSU were recruited to voluntarily participate in a survey that included demographic data, quantitative and qualitative data about participants' understanding of trauma, TIC skills, and their confidence in their ability to provide TIC. The findings were analyzed to assess for areas of strength and areas of deficit in participants' knowledge and confidence about trauma and TIC. The data were used to guide the creation of a TIC training resource guide for nursing school faculty.

Characteristics of Participants

A total of 33 undergraduate nursing students in a baccalaureate nursing program in Montana agreed to participate in this project. Students currently enrolled in a maternal-child nursing course at the MSU-Billings campus were informed of the project while attending a class. The students were informed of the background and goals of the project and offered a paper copy of the survey to be self-administered during class time. Students were informed that participation was voluntary and would not affect their standing in any of their classes.

Demographic Data

Demographic data were obtained in order to assess the characteristics—including age, gender, ethnicity, and prior healthcare work experience—of the population being surveyed.

These data were desired in order to reveal limitations of the findings, to try to find significant associations between these and the TIMCQ data, and to ensure the TIC training resource kit was relevant for the population it was designed to help educate. Demographic data are presented below in Table 1.

Table 1. Participant Demographics

Table 1: Participant Demographics (*n* = 33)		
Characteristic	***n***	**%**
Age		
18-24	27	81.8
25-29	4	12.1
30-34	1	3
35+	1	3
Gender		
Female	29	87.9
Male	4	12.1
Transgender	0	0
Non-binary	0	0
Prefer not to say	0	0
Ethnicity		
American Indian	0	0
Asian	0	0
Black	0	0
Hispanic	0	0
Pacific Islander	0	0
White	32	97
Two or more races	1	3
Prefer not to say	0	0
Healthcare Experience		
None	7	21.2
<1 year	10	30.3
2-3 years	13	39.4
4+ years	3	9.1

The majority of participants were between the ages of 18 and 24 (*n*=27, 81.8%). The next most common age group was 25–29 (*n*=4, 12.1%), while only one participant was between the ages of 30 and 34 (3%), and only one participant was age 35+ (3%). Most of the participants identified as female (*n*=29, 87.9%) and white (*n*=32, 97%). While most participants reported some prior experience in healthcare (*n*=26, 78.8%), the number of years in healthcare varied, with 10 participants (30.3%) reporting less than a year of experience, 13 participants (39.4%) reporting two to three years of experience, and three participants (9.1%) reporting more than four years of experience.

Trauma-Informed-Care Knowledge Assessment

Participants' perceptions of trauma and their confidence in providing TIC were measured using an adaptation of the TIMCQ by Weiss et al. (2017). The questionnaire asked nine questions about participants' understanding of the impact of trauma on perinatal women and the staff who work with these patients, as well as participants' confidence in their ability to care for those affected by trauma. The data were collected via a self-administered paper form. The TIMCQ data are presented below in Table 2.

Table 2. Trauma-Informed Medical Care Questionnaire Scores

Table 2: Trauma-Informed Medical Care Questionnaire Scores

Question	***M***	***SD***
understanding TIC	2.21	0.91
identifying signs or symptoms of emotional trauma	2.79	1.07
responding to a woman who has been exposed to trauma	2.59	0.93
providing TIC to patients, incorporating TIC into work	2.24	1.05
understanding prevalence of trauma in pregnant and postpartum women	2.68	1.27
understanding the impact of trauma on women	3.15	1.23
recognizing staff can be affected by working with perinatal patients in emotional/ physical pain	3.97	0.92
understanding staff can be reminded of past trauma while working with perinatal patients in distress	4.21	0.99

The TIMCQ used a 5-point Likert scale. A score of 1 equated to “not confident at all,” and a 5 equated to “very confident.” Selecting 2 equated to “a little confident,” 3 equated to “somewhat confident,” and 4 equated to “confident.” Participants, on average, felt “a little confident” to “somewhat confident” in their responses to the first five survey questions, which were regarding understanding TIC, identifying trauma, recognizing the prevalence of trauma, responding to trauma, and providing TIC. Question #1, “I understand trauma-informed care,” had a mean score of 2.21 (*SD*=0.91), indicating participants felt “a little confident.” Question #2, “I can identify signs or symptoms of emotional trauma,” had a mean response of 2.79 (*SD*=1.07), indicating participants felt “somewhat confident.” Question #3, “I know how to best respond to a woman who has been exposed to trauma,” had a mean response of 2.59 (*SD*=0.93), indicating participants felt “somewhat confident.” Question #4, “I can provide trauma-informed care to patients or incorporate trauma-informed care into my work,” had a mean response of 2.24 (*SD*=1.05), indicating participants felt “a little confident.” Question #5, “I understand the prevalence of trauma in pregnant and postpartum women,” had a mean response of 2.68 (*SD*=1.27), indicating participants felt “somewhat confident.” Participants averaged higher levels of confidence on the last three quantitative questions, which discussed understanding the impact of trauma and recognizing that staff can be affected or re-traumatized by working with trauma-affected patients. Question #6, “I understand the impact of trauma on women,” had a mean response of 3.15 (*SD*=1.23), indicating participants felt “somewhat confident.” Question #7, “I recognize staff can be affected by experiences working with perinatal patients in emotional and/or physical pain,” had a mean response of 3.97 (*SD*=0.92), indicating participants felt “confident.” Question #8, “I understand staff can be reminded of past trauma while working with

perinatal patients in distress" had a mean response of 4.21 (*SD*=0.99), indicating participants felt "confident."

The last question of the TIMCQ was an open-ended question soliciting a qualitative response. The question asked participants how the practice of TIC changed their care of patients. Thirty of the 33 participants responded to this question. Two key themes arose from these responses: (1) participants had limited experience with trauma-affected patients and TIC training and did not feel well-versed in trauma or TIC and (2) participants had very positive feelings about TIC and were receptive to learning more, as they did believe it would benefit their nursing practice and their patients.

Summary of Findings

In summary, participants did feel somewhat confident in their understanding that trauma is impactful on women and that TIC can improve their care of these patients. They also understood that working with trauma-affected patients can emotionally impact or re-traumatize a healthcare worker. Participants reported a lack of confidence in their ability to recognize trauma, recognize trauma-affected patients, and provide appropriate TIC to these patients. The following chapter will discuss the implications of these findings for the future education of nursing students.

CHAPTER FIVE

DISCUSSION

The survey administered to maternal-child nursing students at MSU for this DNP project offered insight into nursing students' perceptions of trauma and their degree of confidence in providing TIC. The participants indicated that they felt confident about some aspects of trauma and TIC, such as the understanding that working with trauma-affected patients can negatively impact a healthcare worker. They also felt somewhat confident in their knowledge that a history of trauma can be extremely impactful on women. The participants expressed interest in learning more about TIC, as they did feel like it would improve the care and outcomes of their patients. The participants were less confident—reporting only "a little" to "some" confidence—in their ability to recognize those affected by trauma and respond with appropriate TIC. Overall, these results were unsurprising, as similar research on nursing students' trauma knowledge and attitudes has had comparable findings; namely that nursing students lacked TIC knowledge and skills but were eager and receptive to learning (Cannon et al., 2020).

Limitations

This project and the data collected had several limitations. One major limitation was the small sample size of 33. The sample was taken from one nursing cohort at one university, and the participants were predominantly young, white, and female. Applicability of these results to nursing students and universities on a national level or broader demographic scale may be limited. Another limitation of this project was that it only measured participants' trauma knowledge and attitudes at one point in time. There was no intervention performed and there was

no follow-up data collection, so there is no measure of how responses may have changed due to any TIC trainings, nursing curriculum changes, or naturally over the course of time. Finally, this project only measured nursing students' perceived trauma knowledge; there was no objective measurement of participants' actual trauma knowledge or skills. Despite these limitations, this project did provide useful information about MSU nursing students' deficits in trauma knowledge and TIC confidence.

Implications

The survey results highlighted a likely need for intervention and improvement in nursing student trauma education. Implementing more TIC training into nursing school curriculums could potentially increase nursing students' knowledge and confidence in trauma and TIC. Helping nurses feel confident in TIC before they even graduate could increase their ability and likelihood to apply TIC principles to their nursing practice immediately out of school. This would lead to many more opportunities for trauma-affected patients to receive high-quality, trauma-specific care from nurses who are familiar with and confident in TIC, bringing about better patient satisfaction and patient outcomes.

Curriculum Resource

One of the objectives of this DNP project was to create TIC curriculum suggestions for nursing educators. The data collected from this survey had immediate practical value, as they were used to steer the creation of a TIC training resource for MSU nursing school faculty to use in future curriculum development (see Appendix C). This resource is a 34-slide PowerPoint that can be utilized in lectures to teach nursing students some basic concepts of trauma and TIC. The

presentation discusses trauma definitions, adverse childhood events, consequences of trauma, the relationships between healthcare and trauma, the four key assumptions of TIC, and suggestions on how to apply TIC into one's own practice. An electronic copy of this resource will be delivered to the MSU College of Nursing and made available for distribution to MSU nursing faculty across the state of Montana. Faculty will be encouraged to adapt or modify the presentation in whatever ways may be necessary for it to have the best impact on faculty members' individual classrooms. Ideally, this resource guide will encourage and facilitate the implementation of basic TIC education that covers the four key assumptions of TIC. If this curriculum resource is utilized, it will help future MSU nursing cohorts receive more training in trauma and TIC so that they feel more confident as they prepare to join the nursing workforce.

Conclusion

Trauma is a highly prevalent condition that negatively impacts individuals in many ways (Gelaye et al., 2013; SAMHSA, 2014). Trauma can play a negative role on peoples' physical and mental health and social circumstances (Bruce et al., 2018; Gilliver, 2018; Muzik et al., 2013; Reeves, 2015; SAMHSA, 2014; Sperlich et al., 2017). Healthcare encounters, particularly perinatal encounters, are high-risk scenarios that can trigger or exacerbate trauma symptoms, but practicing under the framework of TIC has been shown to help prevent re-traumatization, improve patient satisfaction, and improve patient outcomes (Cannon et al., 2020; Gilliver, 2018; Huth-Bocks et al., 2013; Kim et al., 2014; Muzik et al., 2013; Rouland Polmanteer et al., 2018; Sperlich et al., 2017). As one of the main faces of healthcare, nurses have the potential to be a key provider of TIC (Li et al., 2019). Unfortunately, although nurses and nursing students typically acknowledge the impact of trauma and the importance of TIC, they often do not have

confidence in their ability to provide care that is trauma-informed, as supported by the data collected in this DNP project (Bruce et al., 2018; Choi & Seng, 2015; Isobel & Delgado, 2017; Schiff et al., 2017; Stokes et al., 2017; Weiss et al., 2017).

It would be ideal if nurses entered their careers already feeling prepared to provide TIC to their patients. If nurses must wait for or never receive adequate trauma and TIC education, that could amount to many missed opportunities for positive TIC interactions with patients. Nursing educators should help nursing students be prepared to provide quality TIC immediately upon entering the workforce, as they will certainly encounter trauma-affected patients almost immediately. Resources such as the TIC training resource guide developed as part of this project can assist educators with recognizing and meeting these learning needs. Hopefully, as the importance of TIC and the deficits in TIC education continue to become clear, there will be a national increase in TIC-education resources and TIC in nursing school curriculums. As nursing students become more knowledgeable in the care of trauma-affected patients, the nursing workforce will become increasingly confident in TIC, and this will lead to more ideal healthcare and health outcomes for trauma survivors.

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APPENDICES

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. What is your age?
    a. 18-24
    b. 25-29
    c. 30-34
    d. 35 or older

2. What is your gender?
    a. Female
    b. Male
    c. Transgender
    d. Non-binary
    e. Prefer not to say

3. What is your ethnicity?
    a. American Indian
    b. Asian
    c. Black or African-American
    d. Hispanic
    e. Pacific Islander
    f. White
    g. Two or more races
    h. Prefer not to say

4. Years worked in healthcare?
    a. None
    b. <1 year
    c. 2-3 years
    d. 4+ years

APPENDIX B

TRAUMA-INFORMED MEDICAL CARE QUESTIONNAIRE

Trauma-Informed Medical Care Questionnaire

Section 1: Please circle the number to indicate your level of confidence in the following statements:

1) I understand trauma-informed care.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

2) I can identify signs or symptoms of emotional trauma.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

3) I know how to best respond to a woman who has been exposed to trauma.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

4) I can provide trauma-informed care to patients and their parents or incorporate trauma-informed care into my work.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

5) I understand the prevalence of trauma in pregnant and postpartum women.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

6) I understand the impact of trauma on women.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

7) I recognize staff can be affected by experiences working with perinatal patients in emotional and/or physical pain.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

8) I understand staff can be reminded of past trauma while working with perinatal patients in distress.

1	2	3	4	5
Not confident at all	A little confident	Somewhat confident	Confident	Very confident

Section 2: Tell us about trauma-informed care and your work.

1) How does the practice of trauma-informed care change your care of patients?

APPENDIX C

TRAUMA-INFORMED CARE CURRICULUM RESOURCE

TRAUMA-INFORMED CARE TRAINING RESOURCE FOR NURSING EDUCATORS

Trauma is highly prevalent and has the potential to cause long-term negative consequences for the mental and physical well-being of the affected individual. A history of trauma also plays a serious impact on the quality of patients' experiences in the healthcare system. Being on the frontlines of healthcare, nurses can have a very influential role in determining if a healthcare encounter is a positive or a negative experience for a trauma-affected individual. Practicing under the framework of trauma-informed care helps healthcare workers understand how to recognize and acknowledge trauma, care for patients in a way that takes trauma into account, and minimize the triggering of trauma symptoms or re-traumatization.

Unfortunately, at this time, many nurses and many nursing students do not feel confident in their knowledge of trauma or prepared to provide trauma-informed care. Researchers have found that even small amounts of trauma-informed care training can be beneficial for healthcare workers. Incorporating brief education on trauma and trauma-informed care into nursing curriculums could greatly benefit students and provide them with the knowledge and confidence to begin providing effective trauma-informed care immediately out of school.

Trauma-informed care is generally not yet a standard part of nursing school curriculums nationally. A survey was conducted of undergraduate nursing students enrolled in a maternal-child nursing class at Montana State University (MSU) in February 2021. The results indicated that students understood that trauma can be extremely impactful on their patients, but the students lacked confidence in their knowledge of trauma and trauma-informed care and their ability to recognize those affected by trauma and respond with appropriate trauma-informed care.

The students did express interest in learning more about trauma-informed care, as they did feel like it would be beneficial for the care and outcomes of their patients.

This survey was conducted as part of a DNP project, for which the objective was to identify MSU nursing students' knowledge and concerns about trauma and caring for trauma-affected patients. One of the other objectives of this project was to create trauma-informed care curriculum suggestions for nursing educators. The data collected from this survey had immediate practical value, as it was used to steer the creation of a trauma-informed care training resource for MSU nursing school faculty to use in future curriculum development. This resource is a 34-slide PowerPoint that can be utilized in lectures to teach nursing students some basic concepts of trauma and trauma-informed care. The presentation discusses trauma definitions, adverse childhood events, consequences of trauma, the relationships between healthcare and trauma, the four key assumptions of trauma-informed care, and suggestions on how to apply trauma-informed care into one's own practice. This presentation may be adapted or modified in whatever ways may be necessary for it have the best impact on faculty members' individual classrooms.

Between the efforts of great nursing faculty and nursing students' eagerness to be prepared for the treatment of trauma-affected patients, it is reasonable to be optimistic that the nursing workforce will soon grow increasingly confident in trauma-informed care, and this will in turn lead to more ideal healthcare and health outcomes for trauma survivors.

Trauma and Trauma-Informed Care

KATEE MANGUS

1

This discussion examines trauma, traumatic events, and the long-term effects of trauma. This discussion may bring discomfort or trigger distress in some people. If at any point you need to take a break, meditate, or talk, please do so.

(The Philadelphia ACE Project, 2016)

2

What is trauma?

3

What is trauma?

Trauma is not an event

Trauma is a response to an event or events

Trauma responses are unique to the individual

Defined as the "3 Es of Trauma"

1. Event
2. Experience
3. Effects

(SAMHSA, 2014)

4

"Individual trauma results from an **event**, 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 individual's functioning and mental, physical, social, emotional, or spiritual well-being."

- Substance Abuse and Mental Health Services Administration

(SAMHSA, 2014, p. 7)

5

What causes trauma? How does trauma vary among individuals?

Event - can be caused by exposure to many different circumstances or events, including war, physical violence, emotional abuse, sexual assault, neglect, etc.

Experience - everyone experiences and responds to events differently; two people can experience the same event but not experience the same degree of trauma

Effects - the effects of a traumatic experience are often dependent on factors such as prior traumas, overall stress levels, poor coping abilities, and/or possessing a poor support network

(Bruce et al., 2018; SAMHSA, 2014)

6

Types of Trauma

Acute trauma – single incident of experienced or witnessed injury or potential injury, or a violation of bodily integrity

Chronic trauma – repeated exposure to traumatic events, accumulative sense of fear, loss of trust, decreased sense of safety

Complex trauma – exposure to many severe and pervasive traumatic circumstances, common in children, broad impact on development and relationships

(Philadelphia ACE Project, 2016)

7

Adverse Childhood Events

Childhood trauma is often a chronic or complex toxic stress with long-lasting effects on development, interpersonal relationships, and health

The Adverse Childhood Events (ACEs) study in the 1990s with 17,000+ participants found major link between ACEs and reduced physical and mental health and life expectancy

ACEs are common; 2/3 of study participants had at least one ACE, more than 20% had 3+ ACEs

(CDC, 2020; Gilliver, 2018; Muzik et al., 2013)

8

Adverse Childhood Events

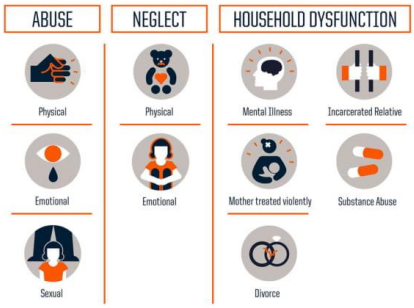
Ten ACE categories; not comprehensive, simply the ten most common forms of childhood trauma

ACE Score – receive one point for every category experienced before 18th birthday

Higher score indicates higher risk

ACEs do not guarantee or directly predict poor outcomes; remember trauma is based on the experience of the individual

ACEs do not consider individual resiliency, coping skills, good support systems, positive childhood influences, etc.



(CDC, 2020; NPR, 2015; Philadelphia ACE Project, 2016)

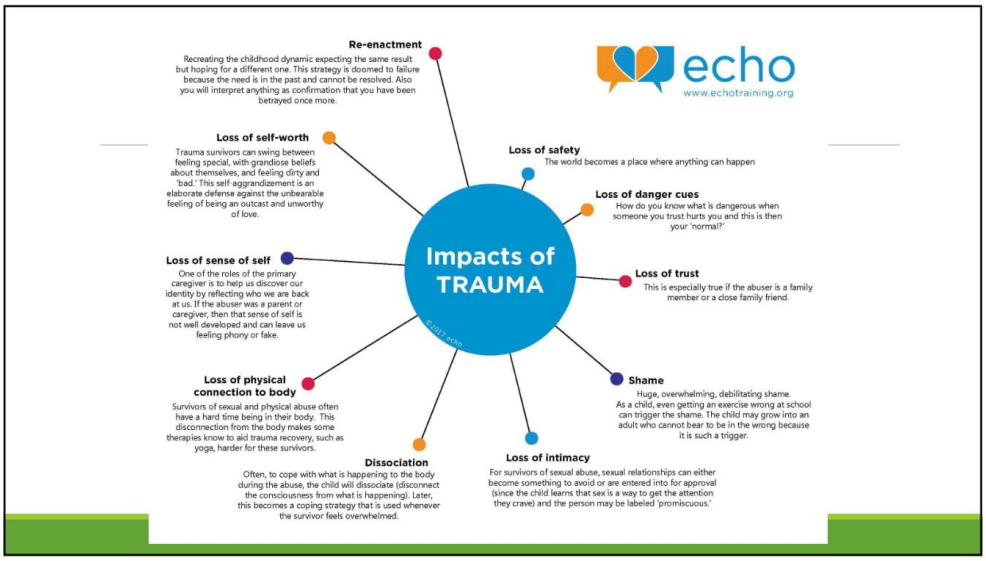
9

ACEs are associated with

Cancer	PTSD
Heart disease	Uncontrolled anger
Obesity	Smoking
Diabetes	Alcohol use disorder
Stroke	Substance misuse
COPD	Committing violence
Decreased activity	Missed work
Suicide attempts	Prison sentence
Depression	Teen pregnancy
Anxiety	Sexually transmitted infections

(CDC, 2020; Gilliver, 2018; Muzik et al., 2013; Reeves, 2015; Sperlich et al., 2017)

10



11

Trauma in Adulthood

Childhood trauma impacts risk for encountering trauma as an adult

Trauma in adulthood, whether acute or new-onset chronic, can still affect individuals in negative and pervasive ways

Many adults are subjected to acute and chronic traumas, including violence, sexual assault, household dysfunction, and physical, verbal, and emotional abuse

Adult females are particularly prone to intimate partner violence; large-scale studies have led to estimates that 20-38% of women experience intimate partner violence at some point during their life

(CDC, 2020; Huth-Bocks et al., 2013; Linden et al., 2013)

12

Pregnancy and Trauma

Perinatal period can be time of increased change and stress for women; often face financial concerns, feelings of inadequacy, relationship changes, and a tendency for increased interpersonal violence

These stressors can provoke or trigger worsening symptoms of adult traumas or ACEs

A history of trauma is linked with increased pregnancy risk factors and complications such as alcohol use and smoking during pregnancy, poor prenatal compliance, preterm delivery, reduced coping during labor and delivery, postpartum depression, infant emotion dysregulation, impaired bonding, and impaired maternal caregiving

Prenatal stress is also linked with development of long-term physical and mental conditions in both the mother and child, including metabolic syndrome and psychiatric disorders

(Choi & Seng, 2015; Huth-Bocks et al, 2013; Kim et al., 2014; Olsen, 2018)

13

Posttraumatic Stress Disorder

Posttraumatic stress disorder is an intense emotional and possibly physical response to thoughts of or reminders of a traumatic event

Not all ACES or other trauma become PTSD

An acute trauma response should resolve within three months of the event that precipitated it

If the trauma response worsens or lasts longer than three months, it is considered PTSD

PTSD is a manifestation of difficulty processing/resolving a trauma

Sometimes PTSD does not emerge immediately (delayed-onset PTSD)

(CDC, n. d.)

14

PTSD Symptoms

Three categories of PTSD symptoms:

- "Re-living;" reminders of the trauma trigger flashbacks, nightmares, guilt, extreme fear of harm, shaking, chills, heart palpitations, and headaches
- "Avoidance;" staying away from activities, places, or thoughts related to the trauma, feeling detached from others, numbness
- "Increased arousal;" hyperacute sensitivity, being overly alert or easily startled, poor sleep, irritability, anger outbursts, poor concentration

(CDC, n. d.)

15

Healthcare and Trauma

Healthcare encounters have the potential to symbolically or literally resemble past trauma and exacerbate symptoms or trigger PTSD

Even routine encounters can be vulnerable and stressful experiences for patients with a trauma history—unfamiliar location, strange people, invasive procedures, triggering touches, triggering words, sense of powerlessness, etc.

Patients lose sense of control the situation, much like they had no control over their traumatic experience(s)

Trauma survivors will often try to avoid healthcare encounters to avoid triggers, especially if they have already had a negative healthcare experience

May also have low compliance; using avoidant behavior and shutting down during their visits, agreeing to treatments they have no interest in doing

(Kim et al., 2014; Muzik et al., 2013; Sperlich et al. 2017)

16

Caring for Trauma Survivors

Nurses are at the frontlines, in a position to make a huge positive impact on trauma survivors

Trauma and ACEs are concepts still relatively new in healthcare

Nurses recognize that trauma matters but are concerned that they may not know how to recognize trauma or provide the best support

(Bruce et al., 2018; Choi & Seng, 2015; Weiss et al., 2017)

17

How do you care for a trauma survivor?

18

Trauma-Informed Care

Trauma-informed care is a conceptual framework based on a set of key assumptions and principles about trauma

Trauma-informed care is designed to help healthcare workers understand how to recognize and acknowledge trauma, care for patients in a way that takes trauma into account, and minimize the triggering of trauma symptoms or re-traumatization

(Gilliver, 2018; SAMHSA, 2014; Sperlich et al., 2017)

19

The Four Key Assumptions of Trauma-Informed Care

1. Realize trauma's impact
2. Recognize trauma
3. Respond with trauma-informed practices
4. Resist re-traumatization

(SAMHSA, 2014)

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1. Realize Trauma's Impact

Trauma survivors often have a low stress tolerance and are easily triggered into defensive or PTSD responses such as explosive anger, aloofness, low amiability, apathy, and overcompliance

These patients also utilize coping mechanisms such as substance misuse, self-injury, low compliance, and avoiding healthcare altogether

These behaviors and attitudes can be very frustrating to nurses who do not realize the prevalence and drastic impact of trauma

(Sweeney et al., 2018)

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1. Realize Trauma's Impact

Trauma-informed care begins with a change in perspective

"The fundamental shift in providing support using a trauma-informed approach is to move from thinking 'What is wrong with you?' to considering 'What happened to you?'" (Sweeney et al., 2018, p. 319).

This shift in word choice and perception is subtle, but it is the difference between frustration and compassion; when nurses better understand and appreciate post-trauma behaviors, they can respond more appropriately

(Sweeney et al., 2018)

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2. Recognize Trauma

Trauma can be challenging to recognize, often indiscernible

- PTSD symptoms: symptoms of "re-living," avoidant behaviors, increased arousal
- ACE outcomes: suicide attempts, depression, anxiety, anger outbursts, smoking, alcohol use disorder, substance misuse, violence, incarceration, teen pregnancy, sedentary lifestyle, obesity chronic health conditions
- Not everyone with these mental and physical disorders has a trauma; you probably can't really know for sure unless you know the patient's history, or they tell you

Some organizations are recommending "universal precautions," much like is done with gloving; every patient should be treated as if they may have some unknown past trauma

(Sweeney et al., 2018)

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2. Recognize Trauma

Although some organizations recommend formal trauma screening, this should be done judiciously; such questions can be triggering to the patient, especially if they are repeated at every encounter and never lead to any kind of solution

You do not have to confirm trauma or elicit details about it if the patient does not wish to share (unless you are concerned about safety); when in doubt, apply universal precautions

(Muzik et al., 2013; Sweeney et al., 2018)

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3. Respond with Trauma-Informed Practices

Trauma-informed care is not intended to treat or cure trauma; it is intended to help mitigate the risk of healthcare exacerbating or triggering the effects of trauma, make healthcare a more positive experience for trauma survivors, and facilitate trauma recovery

Trauma-informed care is about how you treat the patient throughout their entire healthcare encounter, it does not necessarily involve a conversation about trauma unless the patients wants to talk about it; nurses must gauge each situation individually

If trauma survivors share their burden with a healthcare provider but feel like they were unheard, this can lead to unresolved trauma complications, reduced trust, and reduced desire to seek help in the future

(ITTIC, n. d.; SAMHSA, 2014)

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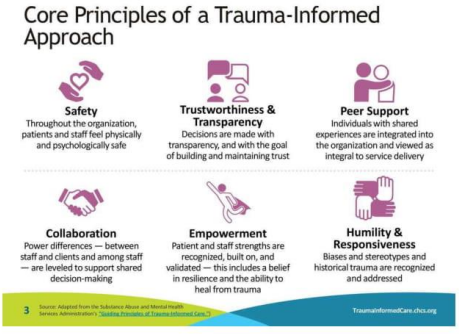
3. Respond with Trauma-Informed Practices



- Patients must feel safe
- Transparency is key, no sense of secrecy
- Patients must feel valuable and supported
- Patients should be involved in decision-making
- Patient should feel empowered, respected, and believed in
- Biases and stereotypes should be recognized

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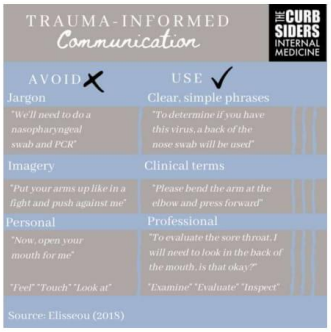
3. Respond with Trauma-Informed Practices

There are specific trauma-informed phrases and actions that nurses can learn to use that will reduce likelihood of a trigger and reduce the stress of the encounter



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3. Respond with Trauma-Informed Practices

Other helpful behaviors

- Emphasize your commitment to confidentiality
- Sitting down during interactions to decrease the power differential
- Asking for permission prior to an exam or intervention; talk the patient through the process beforehand and as you go
- Give the patient choices, i.e., "shall we do this first or this first?"
- Let them know you can stop or slow down a procedure or exam at any time if they need
- Using suggestive instead of instructive language, i.e., "now take a deep breath," vs. "you may find it helpful to take a deep breath"
- Having the patient move their own clothes out of the way during an exam or intervention
- Describing the sensations a patient may hear/feel during an exam or procedure
- Promote a warm, welcoming, quiet environment with options for privacy

(Ravi & Little, 2017)

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4. Resist Re-traumatization

When healthcare encounters mimic or trigger past traumas, they have the potential to cause re-traumatization and worsened outcomes for the patient; obviously not a good outcome and what we are most striving to avoid with trauma-informed care

When working with trauma survivors, nurses run a risk of being triggered by the recollection of their own traumas, or they may even experience vicarious trauma through learning of their patients' traumas; being trauma-informed actually reduces this risk

(ITTIC, n. d.; Sperlich et al., 2017)

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Learning Activity

Divide into pairs and take turns being nurse/patient A or patient B (patient scenarios on next slide)

Choose a scenario such as a head-to-toe exam, foley insertion, IV insertion etc.

Go through how you would prepare the patient for the exam/procedure and talk to them as you go through it as well

Remember to avoid jargon, avoid stressing imagery, use professional terms, avoid too personal of language, ask permission, give the patient choices, use suggestive instead of instructive language, avoid a power differential

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Learning Activity

Patient A

Personal hx: obesity, alcohol use disorder, depression, hx of suicidal ideation

Physically, emotionally, and sexually abused by father as a child

Emotionally neglected by parents

Mother was abused

Patient B

Personal hx: substance misuse, smoker, recently incarcerated

Physically abused by parents as a child

Physically and emotionally neglected as a child

Parents were substance users

Parents incarcerated several times

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Learning Activity

How did it go? Thoughts?

What was the most challenging part?

Easiest part?

How did you feel as the patient?

How did you feel as the nurse?

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Benefits of Trauma-Informed Care

There are proven benefits to trauma-informed care

Patients who receive trauma-informed care

- report better healthcare experiences
- Have better health outcomes
- better recovery from their trauma
- are more compliant with healthcare recommendations
- are more willing to seek healthcare

(Gilliver, 2018, Muzik et al., 2013; Sperlich et al., 2017)

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"How trauma-informed care saved my life."

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