Walden University
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2023

Nurses’ Experiences With Trauma-Informed Care in Patients With Psychological Trauma

Ade J. Vinton
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Nursing Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Nursing

This is to certify that the doctoral dissertation by

Ade J. Vinton

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mary Martin, Committee Chairperson, Nursing Faculty
Dr. Janice Long, Committee Member, Nursing Faculty
Dr. Maria Ojeda, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

Nurses' Experiences With Trauma-Informed Care in Patients With Psychological Trauma

by

Ade J. Vinton

MSN, MBA, University of Phoenix, 2017

BSN, University of Phoenix, 2014

ADN, Wake Technical Community College, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing: Population Health

Walden University

May 2023

Abstract

The COVID-19 pandemic increased the need for research and discussions about trauma, trauma-informed care (TIC), and care delivery processes. Little is known about how nurses recognize, assess, treat, and support patients who experience trauma although knowledge of TIC is important for delivering care to trauma survivors. The purpose of this qualitative descriptive study was to explore nurses' perceptions of TIC principles and their experiences delivering care to patients with psychological trauma. Harris and Fallot's TIC theory was used to guide the study. Purposeful sampling was used to recruit ten nurses for individual semi structured interviews using open-ended questions conducted via Zoom. Interviews continued until saturation was reached. Thematic analysis included identifying codes and categories after which four themes emerged to answer the research questions. The four resulting themes were: (a) helpful tool, (b) education and collaboration, (c) avoiding retraumatization, and (d) increased care quality. Results showed that regardless of workplace challenges including TIC implementation, follow-up, and clinicians' background, TIC enables clinicians to provide appropriate trauma care and ensures the patient is an equal participant in the care process. Results also showed that nurses were concerned about preventing retraumatization even when they were at risk of experiencing trauma or reliving traumatic experiences themselves. Social change may be promoted by implementing policies that include TIC training for all nurses and providers. Future studies are needed to implement TIC in nursing curriculums and evaluate the effect on nursing outcomes.

Nurses' Experiences With Trauma-Informed Care in Patients With Psychological Trauma

by

Ade J. Vinton

MSN, MBA, University of Phoenix, 2017

BSN, University of Phoenix, 2014

ADN, Wake Technical Community College, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing: Population Health

Walden University

May 2023

Dedication

I dedicate this dissertation to my beloved parents, Julia W. Vinton (living) and Michael G. Vinton (deceased). Where do I begin? It seems there are insufficient words to express my gratitude. You have both been influential in my life and have made me who I am. Mama, from single-handedly carrying this family through the difficult times particularly when Papa passed until now, you are the absolute best mother in this world. God could not have chosen a better mother than you. Papa, although you are not physically present to see the fruits of your labor and this dream come to fruition, you instilled the importance of education in us and were always there to assist with homework and teach life lessons at any given time, whether we liked it or not. I have called on you many times and have asked you to pray for me and have asked God to help me get to the finish line. I was sure that you were listening. Now that I have reached the end of this educational journey, I know that you heard me, no doubt! Thanks be to God and you both for a job well done. I love you both, and to God be the glory!

Acknowledgments

First, all praise and thanks be to God because I definitely would not have made it this far without his constant help and direction. Secondly, I would like to thank my parents for their love, prayers, and hard work; my siblings; and my entire family and friends for their support and prayers. Aunty Annette thanks for your support, including the pursuit of my doctoral degree. When I said that I was pursuing this degree, you encouraged me to do so, and I thank God for you.

To Dr. Mary Martin, Dr. Janice Long, and Dr. Maria Ojeda, I am extremely appreciative of you and all of the support and assistance you gave me along the way. You were always available, provided much needed feedback, and encouraged deep thoughts about my work. Thank you for your knowledge and guidance along the way. Thanks to the library staff, who were willing to help with searching and finding more research and articles concerning my dissertation topic.

Sheree and Pam, we have been together since our time in the bachelor's program; how time flies! This time was different, however, because we have reached the pinnacle of our educational journey! All those nights we spent on the phone years ago into the early morning hours writing papers and sharing ideas. We experienced some challenging times but also some great times full of laughter, but we always knew when it was time to get serious and get back to work. Thank you and thank God for you both; I cannot say that enough. We have completed this doctoral journey! Finally, thanks to all of the nurses who voluntarily participated in the research process; I am sincerely grateful to you and nurses everywhere.

Table of Contents

List of Figures v

Chapter 1: Introduction to the Study 1

Background 3

Problem Statement 4

Purpose of the Study 6

Research Questions 7

Theoretical Framework 7

Nature of the Study 8

Definitions 8

Assumptions 9

Scope and Delimitations 9

Limitations 11

Significance 12

Summary 14

Chapter 2: Literature Review 16

Literature Search Strategy 18

Theoretical Foundation 19

Guiding Principles of the TIC Framework 20

Literature Review Related to Key Concepts 22

TIC Efficacy 22

Organizational Support 25

TIC for Patients With Mental Illness 27
Summary 32
Chapter 3: Research Method 34
Research Design and Rationale 34
Role of the Researcher 35
Methodology 36
Participant Selection 36
Instrumentation 39
Procedures for Recruitment, Participation, and Data Collection 40
Data Analysis Plan 41
Issues of Trustworthiness 42
Credibility 42
Transferability 43
Dependability 44
Confirmability 44
Ethical Procedures 45
Summary 47
Chapter 4: Results 48
Setting 49
Demographics 49
Data Collection 50
Data Recording 51

Data Variations 52

Unusual Circumstances.. 52

Data Analysis 53

Codes to Themes 53

Discrepant Cases 57

Evidence of Trustworthiness...57

Credibility 57

Transferability.. 58

Dependability 58

Confirmability.. 59

Results 59

Theme 1: Helpful Tool... 60

Theme 2: Education and Collaboration 61

Theme 3: Avoiding Retraumatization.. 63

Theme 4: Increased Care Quality 65

Discrepant Case 66

Summary 67

Chapter 5: Discussion, Conclusions, and Recommendations 69

Interpretation of the Findings..69

Theme 1: Helpful Tool... 70

Theme 2: Education and Collaboration 72

Theme 3: Avoiding Retraumatization.. 74

Theme 4: Increased Care Quality 76
Limitations of the Study 78
Recommendations 79
Implications 79
Conclusion 81
References 83
Appendix A: Recruitment Flyer for Nurse Participants 92
Appendix B: Participant Screening Guide 93
Appendix C: Interview Questions 94
Appendix D: Examples of Themes and Corresponding Quotes 95

List of Figures

Figure 1. Four Emerging Themes 67

Chapter 1: Introduction to the Study

Trauma can be experienced at any age regardless of an individual’s ethnicity, socioeconomic status, gender, or race (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). Trauma can affect an individual’s growth, decision-making capabilities, and daily function. People who experience trauma react and cope differently (National Child Traumatic Stress Network [NCTSN], n.d.). Not understanding how to navigate personal trauma or failure to deal with traumatic experiences early can cause an individual to relive the experience or cause the trauma to be manifested in other ways (SAMHSA, 2022). In the United States, trauma frequently occurs in individuals with mental and substance use disorders (SAMHSA, 2022).

According to the NCTSN (n.d.), not every individual who experiences a traumatic event will be affected by the trauma experienced or develop post-traumatic stress. However, it is important that trauma-informed screening, mental health assessments, and treatments be available to individuals who may be impacted by trauma. Some factors that may contribute to symptom development include a history of trauma, proximity, extant of the event, and family and community factors such as race, culture, ethnicity, and caregivers’ reactions (NCTSN, n.d.). SAMHSA (2022) posited that the result of a traumatic experience can be burdensome not only for the individual who experiences the traumatic event but also for the community and families. Therefore, the impact of trauma and the type of trauma must be understood so that options and strategies for healing can be explored (SAMHSA, 2022).

Psychological trauma is the occurrence of a bad or negative experience or several negative experiences causing an injury to the brain and altering its functionality neurophysiologically, psychologically, and cognitively (University of Pennsylvania, n.d.). According to the American Psychological Association (2020), greater than half of the United States population has experienced a traumatic event. It is important to understand and know how to appropriately react to a trauma survivor to avoid retraumatization (American Psychological Association, 2020). The Centers for Disease Control and Prevention (CDC, 2020) posited that trauma-informed care (TIC) approaches must be consistently carried out; an organization's culture must be changed and reflect its awareness and sensitivity. The organization must also conduct internal quality improvement assessments while also including or partnering with community members to assist with TIC approaches (CDC, 2020). Menschner and Maul (2016) posited that health care providers are crucial to providing TIC approaches because it includes understanding a patient's experience to provide effective and appropriate care, which may improve patient participation, care outcomes, treatment compliance, and staff wellness. Nurses' perceptions of TIC practices and their experiences with delivering care to survivors of psychological trauma should be explored to further understand whether TIC strategies are helpful and positively impact nursing care. Nurses should be given tools such as TIC training and education to provide safe, effective, and efficient care to patients or survivors of trauma, particularly psychological trauma, and avoid retraumatization. According to SAMHSA (2014), an important principle concerning TIC is the provision of a physically and emotionally safe environment. TIC practices should be a standard and

consistent practice in care facilities to assist with improving nursing care for trauma survivors. If nurses understand TIC and its guiding principles, they might be better equipped to recognize high-risk patients and might include increased support and sensitivity to the victim or survivor to avoid retraumatization (Stokes et al., 2017).

Background

There is an increased need for mental health help or support in the United States. According to the Agency for Healthcare Research and Quality (2016), trauma is a detrimental and public health concern that has no boundaries. Wheeler (2018) posited that mental health issues including diagnosed mental health or psychiatric disorders associated with trauma are concerning. Nurses must understand and recognize early signs and symptoms of trauma and be able to assess and provide appropriate, competent, and sensitive care and resources to patients at risk (Wheeler, 2018).

TIC training must be consistent in nursing care. According to Maguire and Taylor (2019), nurses who are trained in TIC must continue to implement associated strategies and keep up with ongoing TIC training and updates because health care practices are constantly changing, and new policies and treatments are being implemented. Nurses are often at the bedside administering care to patients and are trusted members of the health care team; however, their perceptions and experiences with patients who have experienced traumatic events are not widely documented (Stokes et al., 2017). The purpose of the current study was to explore nurses' perceptions of TIC, their experiences with care delivery, and their use of TIC approaches in terms of early intervention strategies, support, and treatment for patients with psychological trauma. These factors

are important in TIC practices, and exploring nurses' perceptions of TIC and experiences with delivering care might help to increase awareness for nurses and other health care professionals who may be unaware of TIC or have not been trained to use TIC strategies in the workplace or with patients or survivors of trauma, especially psychological trauma.

Problem Statement

According to SAMHSA (2014), trauma can cause negative reactions or consequences that may be risky and affect an individual or patient's health. Individuals who are at risk of experiencing a mental health crisis such as a traumatic event can be psychologically impacted. TIC principles might be the approach needed for health care workers in all health settings to recognize and provide TIC to individuals who have experienced traumatic events and improve mental health histories, treatments, and recovery.

TIC is a strength-based, holistic, and respectful approach that clinicians use to care for individuals experiencing or surviving trauma (Wilson et al., 2021). SAMHSA (2014) referred to TIC as the means through which treatments used and trauma addressed are attributed to outcomes from trauma survivors, individual services received, and individuals who work to staff the system. Therefore, it is important to explore nurses' experiences with TIC and care delivery in patients who have experienced psychological trauma to adequately recognize, treat, and prevent patients from reliving traumatic experiences and also ensure staff well-being. There is a gap in the literature about how nurses perceive TIC strategies and TIC impact, and their experiences with delivering care to patients who have experienced traumatic events or psychological trauma. Additionally, there was limited knowledge and education about TIC in nursing curriculums and some

work settings, and there was a need for nurses to recognize patients exhibiting signs and symptoms of trauma (Cannon et al., 2020). According to Stevens et al. (2019), empirical support for TIC is not widely known, and TIC has not been widely adopted by health care professionals.

Nurses may be able to identify patients who are at risk or are experiencing psychological trauma and assist them through caring and empathy, providing hope and motivation, and providing other resources to assist with psychological wellness (Stokes et al., 2017). Psychological trauma can cause economic, social, emotional, and physical problems such as increased heart rate, abdominal problems, sleep deprivation, anxiety, withdrawal, indulgence in risky behaviors, depression, and even death (Stokes et al., 2017). It is important that nurses' perceptions of TIC treatment strategies, impact, and efficacy, and their experiences with care delivery be explored to understand the impact of the approach and how it might benefit other nurses, nursing curriculums, and the nursing profession. Findings may also provide information that may inspire future studies in the area.

Psychological trauma not only has an impact on patients and patient care but it can also impact the nurse-patient relationship, family dynamics, communities, and society as a whole (Stokes et al., 2017). According to SAMHSA (2022), trauma can manifest early or later in an individual's life. It is important that nurses are able to recognize, assess, treat, and provide support using TIC practices and strategies for patients who are affected by and experiencing trauma. It is critically important to understand nurses' experiences because nurses play an integral role in patient care,

including building a trusting relationship with the patient or trauma survivor and caring for the patient's physical, emotional, and psychological health. Healthy People (2020) posited that 18.7% of all individuals lose their lives prematurely to disability from neuropsychiatric disorders that are accountable for the most disabilities in the United States.

Therefore, nurses' perceptions of TIC efficacy and their experiences with care delivery must be explored. Nurses may not adequately care for patients who have experienced traumatic events or psychological trauma without the knowledge, skills, and understanding of TIC practices. Because nurses are on the front lines of patient care, they need to be more active in helping to reduce traumatic effects on patients, especially when the individual is a child, and further decrease the consequences of mental illness after the occurrence of trauma (Lantz, 2020). The current study was conducted to fill a gap in the literature by exploring nurses' perceptions of TIC practices and efficacy and their experiences with care delivery in patients with psychological trauma. Findings may provide information about quality of care, support, resources, treatment, and avoiding retraumatization not only in patients or survivors of psychological trauma but also in nurses and other health care providers.

Purpose of the Study

The purpose of this qualitative study was to explore nurses' perceptions of TIC principles and their experiences with delivering care to patients with psychological trauma. It was imperative to explore nurses' experiences because nurses need to be able to consistently recognize high-risk patients and provide early interventions, support, and

treatments (Cannon et al., 2020). Additionally, Kassam-Adams et al. (2015) stated that nursing education concerning trauma is lacking, and nurses are exclusively placed to administer care that is appropriate and trauma informed. According to Yang et al. (2019), nurses need to be able to include TIC methods when working with patients in a joint effort to mitigate trauma, which is a public health concern. There was limited research that described how to educate and support nurses in a manner that will enable them to provide TIC, which delays appropriate assessments and treatments for individuals who have survived traumatic events (Yang et al., 2019). Exploring and understanding nurses' perceptions and experiences may also provide insight into how nurses build and maintain trusting nurse-patient relationships and provide supportive nursing care and resources specific to maintaining psychological health.

Research Questions

RQ1: What is the nurse's perception of trauma-informed care principles?

RQ2: What is the nurse's experience with care delivery using trauma-informed care principles in patients with psychological trauma?

Theoretical Framework

TIC theory was created by Harris and Fallot (2001). The TIC model is based on five principles: safety, choice, collaboration, trustworthiness, and empowerment (Harris & Fallot, 2001). TIC was developed as a means of assisting health care providers to respond appropriately to individuals who have experienced trauma and to help them toward recovery (Harris & Fallot, 2001). According to Harris and Fallot, TIC approaches or strategies ensure that organizations and clinicians appropriately assess the workplace

and culture and that patients or trauma survivors feel safe and are supported in a manner that promotes healing and recovery.

Nature of the Study

The study was qualitative with a thematic analysis approach. This approach was suitable for the study because it allowed me to use the data to recognize and discover patterns and themes that were meaningful in answering the research questions. According to Neuendorf (2019), the outcome of thematic analysis is its production of a deeper or richer understanding of the collected data. In the current study, the important aspects of the interview data and observations were reviewed and evaluated to determine their importance.

This approach allowed me to evaluate the data and provide significant information about nurses' perceptions of TIC strategies and their experiences with care delivery to patients with psychological trauma. According to Creswell and Creswell (2020), researchers conducting qualitative studies tend to gather their data in places where the research participants experience the phenomenon being studied. Researchers use the participants' settings to see how participants behave and speak with them because it is an important part of qualitative research (Creswell & Creswell, 2020).

Definitions

Mental health: An individual's psychological, social, and emotional health (CDC, 2018). An individual's mental health also impacts their thoughts, feelings, and behaviors, how they deal with stressful situations and relationships, and how they make good decisions (CDC, 2018).

Mental illness: Health issues that include alterations in emotional status, actions, thoughts, or all three factors combined (American Psychiatric Association, 2021).

Quality of care: The means through which services concerning an individual or population's health increase the possibility of positive health outcomes (World Health Organization, 2022).

Trauma-informed care: An approach adopted by an organization to be used by clinicians and other staff for providing sensitive and adequate care to patients or trauma survivors to ensure they feel safe and are supported in a manner that promotes healing and recovery (Harris & Fallot, 2001).

Assumptions

My first assumption was that the participants would be open and honest about the answers that they would provide during the interview process. I also assumed that the participants would be fully vested in the research process because they would be interested in the study and what it might yield. Third, I assumed that the participants would be truthful about their credentials and positions because the information they provided would be necessary in exploring their perceptions and experiences and gaining more insight into the use of TIC principles in patients with psychological trauma. Each participant was given an e-gift card after the data collection process or after the completion of each interview session.

Scope and Delimitations

The scope of this qualitative descriptive study consisted of nurse participants from diverse nursing backgrounds and specialties (RNs; advanced practice registered nurses

[APRNs] such as nurse practitioners, nurse educators, clinical nurse specialists, and nurse case managers; licensed vocational nurses; and licensed practical nurses) were also eligible to participate. I included nurses from varying backgrounds and specialties in the inclusion criteria because I thought that I might not be able to recruit a sufficient sample size if I chose to only include a specific type of nurse. Furthermore, because TIC is not widely known or taught, I may have found it difficult to recruit nurse participants if I had limited my participant pool to a specific type of nurse.

The recruitment criteria also included nurses who were trained to use TIC principles, including nurses who did not currently use TIC in the workplace but had previously used TIC and were trauma informed. It was important to include a variety of nurse participants because they would provide rich data that I needed to explore nurses' experiences with TIC and their care delivery to patients who had experienced trauma, particularly psychological trauma. I used purposive sampling to recruit the participants for this study. According to Braun and Clarke (2013), it is common in qualitative research to use purposive sampling because it consists of choosing participants who have experienced or have the characteristics specific to the topic of study. Purposive sampling was the best choice because I intended to generate a deeper and better understanding of the phenomenon.

A quantitative study on this topic would have been appropriate. By using a quantitative approach, I would have had to measure TIC efficacy including the nurses' experiences and views using numerical and other quantifiable data to explain TIC practices. According to Patton (2015), quantitative research is commonly based on

scientific reasoning using numbers and measurements as standard operating processes. The current study's purpose was not to collect numerical data or determine cause and effect. Rather, it was to provide a deeper understanding of nurses' perceptions of TIC and their experiences with care delivery in patients with psychological trauma. I focused on nurses' experiences with delivering care in terms of ensuring safety, building trust, providing support, treating patients with psychological trauma, helping them toward recovery, and maintaining and improving their psychological health. Understanding nurses' perspectives may provide crucial information on whether TIC and its associated principles can help to improve the quality of care. Understanding nurses' perspectives may also emphasize the need for TIC training and education, TIC's guiding principles to be standard in nursing curriculums, and TIC to be widely used in health care settings to assist healthcare workers and clinicians to recognize and treat patients with psychological trauma. Also, by including nurse participants from diverse backgrounds and specialties, I increased the probability of transferring the study findings to other settings is.

Limitations

The study included participants only from nursing backgrounds. Second, there were no licensed practical nurses, licensed vocational nurses or advanced practice registered nurses in the study. These types of nurses were eligible for participation, but none signed up to participate. The interviews were conducted using Zoom meetings, a virtual platform. Although Zoom was a safer alternative to collecting data with COVID-19 restrictions in place, I would have preferred in-person interviews. However, the participants seemed more comfortable and able to speak freely and honestly about their

experiences without the added pressure of an in-person interview. Moreover, participants had the option of selecting audio only if they were uncomfortable with being on camera. However, selecting audio only limited my ability to see and collect data about the participants' facial expressions, body language, and face-to-face interactions.

Another limitation of the study was that only trauma-informed nurses participated, and I could not collect field notes because of the virtual interview setting. Any member of the health care team can be trained in TIC, including physicians, occupational and physical therapists, social workers, and certified nurses' assistants. This means that the study's transferability may be increased because it could be repeated in other settings and with individuals from multiple professions/backgrounds. I ensured that as the instrument of data collection and analysis, I refrained from personal biases that would have affected the study in any way and alter the results. I had no prior TIC training, so I did not apply or project any personal biases during the study. This qualitative descriptive study was conducted in a manner that ensured its dependability and trustworthiness.

Significance

This study was significant because it revealed nurses' perceptions of using TIC principles and nurses' experiences with delivering care to patients with psychological trauma. Exploring and understanding nurses' perceptions and experiences with TIC in patients who experienced trauma, particularly psychological trauma, may provide an in-depth view into areas that could impact the quality of care, such as safety, support, treatment, and recovery; these factors are important for nurses administering care to

patients and survivors of psychological trauma. Nadeem et al. (2021) posited that TIC is imperative for supporting and communicating positively with patients who experienced traumatic events by providing patient-centered care and effective interventions. Stokes et al. (2017) stated that nurses' perceptions and knowledge about TIC are not widely explored.

Multiple researchers have explored TIC training and its effectiveness in health care (Broughton, 2017; Cannon et al., 2020; Stevens et al., 2019; Weiss et al., 2017). I, however, did not find any studies that addressed nurses' perceptions of TIC principles and their experiences with care delivery in patients who experienced psychological trauma. Therefore, my study may contribute new knowledge in an attempt to fill a gap in the literature while also increasing the need for future studies in this area.

The interview questions were created to gather more detail regarding nurses' perceptions of TIC principles and their experiences with delivering care concerning the quality of care, safety, support, and recovery in patients or survivors of psychological trauma. Potential implications for positive social change include using the findings from the study as a basis for further research and developing, promoting, and improving TIC training and education in health care settings. Potential positive social change implications further include promoting and improving TIC in nursing practice, policies, and curriculums. This may not only increase patient and staff satisfaction and knowledge but also increase safety, quality of care, support, treatment, and resources, and may prevent retraumatization of staff and patients or survivors of psychological trauma and consequently improve patient outcomes.

Summary

TIC and its guiding principles are important for health care and staff who interact with patients daily. TIC is a set of principles that should be used to improve workplace cultures, destigmatize, and avoid biases that may surround trauma and the individuals who survive traumatic events. TIC and its principles help to guide health care workers including nurses to recognize and care for patients experiencing traumatic events or survivors of psychological trauma. TIC principles can be used to guide patient care in terms of psychological trauma and assist clinicians with avoiding the retraumatization of patients. Therefore, clinicians must work to ensure that the quality of care and safety of these individuals are increased and consistent.

Nurses who are trauma informed must recognize, use, and rely on these principles to care for and build trusting relationships with individuals impacted by psychological trauma. With an increase in trauma-causing events and an increase in the number of individuals experiencing or having experienced trauma, TIC and its principles could not be more essential. Exploring and understanding nurses' perspectives with TIC and experiences with care delivery might reveal necessary factors and interventions that can aid in the safety, support, treatment, healing, and recovery processes for patients with psychological trauma while preventing patients from reliving the traumatic experience or retraumatizing patients. Without exploring and understanding nurses' perspectives and experiences with TIC, it might be challenging and perhaps impossible to make recommendations on how to best care for patients with psychological trauma, especially in health care settings where the staff may be untrained in TIC practices, the

organizational culture surrounding TIC may be uninformed, or the staff may be inconsistent with the model's guiding principles. Chapter 2 provides a description of the theoretical foundation and an in-depth review of the relevant literature.

Chapter 2: Literature Review

According to SAMHSA (2014), trauma can cause negative reactions or consequences that may be risky and affect a patient's health. Individuals who are at risk of experiencing a mental health crisis such as a traumatic event can be psychologically impacted. According to SAMHSA (2014), trauma can cause negative reactions or consequences that may be risky and affect a patient's health. TIC principles might be the approach needed for health care workers in all health settings to recognize and be able to provide TIC to individuals who have experienced traumatic events and improve mental health outcomes, treatments, and recovery.

TIC is a strength-based, holistic, and respectful approach that clinicians use to care for individuals experiencing or surviving trauma (Wilson et al., 2015). SAMHSA (2014) refers to TIC as the means through which treatments used and trauma addressed are attributed to outcomes from trauma survivors, individual services received, and individuals who work to staff the system. Therefore, it is important to explore nurses' experiences with TIC and care delivery in patients who have experienced psychological trauma to recognize, treat, and prevent patients from reliving traumatic experiences, and also to ensure staff well-being.

There was a gap in the literature about how nurses perceive TIC principles and efficacy, and their experiences with delivering care to patients who have experienced traumatic events, especially psychological trauma. The purpose of this qualitative study was to explore nurses' perceptions of TIC principles or strategies and efficacy, and their experiences with delivering care to patients with psychological trauma. I conducted one-

on-one interviews and asked open-ended questions to gain insight and understanding from nurses' perspectives.

There were some studies addressing TIC that combined clinicians from nursing and other disciplines and their perspectives on TIC and TIC efficacy, but limited research existed on nurses' experiences and perspectives on TIC efficacy and delivery of care in patients with psychological trauma. According to Palfrey et al. (2019), future studies should focus on TIC efficacy, trauma-focused cognitive behavioral therapy, and cost-effective measures of delivering care. For organizations that use TIC strategies, staff's (particularly nurses') views, thoughts, and experiences must be examined to determine whether their TIC practices are effective, especially during care delivery where the risk of retraumatizing a patient may be increased.

According to Bailey et al. (2019), it is difficult to evaluate the effectiveness of TIC principles/strategies within an organization, requiring creative measures. Understanding TIC efficacy or impact and its use in care delivery processes from nurses' perspectives might enable organizational changes that will improve TIC practices among all staff and also help to improve methods of evaluating TIC efficacy. Jankowski et al. (2019) stated that future research should focus on understanding which TIC principles or strategies and activities work best.

While performing research on the topic, I did not find any articles that addressed nurses' experiences with TIC, TIC efficacy or impact, or care delivery in patients with psychological trauma. However, I was able to find some articles (Bailey et al., 2019; Gigliotti et al., 2019; Jankowski et al., 2019; Walsh & Benjamin, 2020) that discussed

TIC implementation in the workplace, nurses' and other clinicians' perceptions of TIC and organizational support, and efficacy; these studies closely aligned with my study. chapter 2 consists of a synopsis of the literature that supports the need for the current study. The chapter also provides strategies and terms used to search the literature and the theoretical framework that I used to guide my research.

Literature Search Strategy

I used the following search engines and databases: EBSCOhost, CINAHL, Sage Journals, and ScienceDirect. I also used Google Scholar to search for relevant articles that aligned with my topic, but I did not find articles that I could include in the literature review. CINAHL and EBSCOhost produced similar articles, so I continued with EBSCOhost because it contained more articles based on my topic or articles that closely aligned with the topic.

Initial search terms used for EBSCOhost were *trauma-informed care* + *outcomes* or *benefits* or *effects* or *impact* + *effectiveness* or *efficacy* + *communication*. The search yielded 11 articles. I performed the search again, removing *communication*, and 319 articles were found. I also used *trauma-informed care* + *nursing* + *impact* or *effect* or *influence*, and 305 articles were found. Using the same database, I applied the terms *trauma-informed care* + *nursing* + *significance* or *importance*, and 54 articles were found. I used *trauma-informed care* + *nurses experiences*, *perceptions*, or *attitudes* as search terms for Sage Journals, and 2,036 articles were found. Lastly, I used *trauma informed care* + nurses delivering care to search ScienceDirect, and 1,999 articles were

found. For all databases, I searched for articles from 2016 to 2022 so that I would have articles written within the last 5 to 6 years.

I searched for only peer-reviewed articles. However, I expanded my search to include 2001 to search and find works by Fallot and Harris, who according to Wilson et al. (2021) were the first individuals to discuss the TIC model and its guiding principles. In cases where there was little current research about my topic, I used articles that closely aligned with the topic (Bruce et al., 2018; Dilks, 2020; Jankowski et al., 2019; Nadeem et al., 2021; O'Dwyer et al., 2019) that discussed trauma, TIC education, implementation, barriers, efficacy, and care delivery in health settings including mental health units, schools, and among refugees.

Theoretical Foundation

According to Wilson et al. (2021), the origin of TIC and its guiding principles is unclear. However, TIC theory and principles were first discussed by Harris and Fallot in 2001 (as cited in Wilson et al., 2021). TIC consists of five principles: safety, trustworthiness, choice, collaboration, and empowerment. Some organizations such as SAMHSA and the NCTSN have their version of TIC principles with six areas of focus (safety; trustworthiness and transparency; peer support, collaboration and mutuality; empowerment and choice; and cultural, historical, and gender issues) (SAMHSA, 2015), but their principles are based on the original five principles (safety, choice, collaboration, trustworthiness, and empowerment) discussed by Harris and Fallot (2001). SAMHSA and NCTSN have a modified version of the original TIC principles. The central tenets, however, remain the same; each organization understands the impact of trauma on

individuals and families; recognizes the signs and symptoms of traumatic stress in individuals, families, and staff; and increases safety both psychologically and physically by preventing retraumatization (Elliott et al., 2005; SAMHSA, 2014). Additionally, each organization understands the importance of incorporating TIC strategies into its policies and care practices (Elliott et al., 2005; SAMHSA, 2014). For the current study, I used Harris and Fallot's (2001) TIC model as the framework upon which my study was conducted.

Guiding Principles of the TIC Framework

- Safety: According to Harris and Fallot (2001), the organization must provide a setting that is physically and emotionally safe for staff and patients who have experienced or are at high risk of experiencing trauma.
- Trustworthiness: Information should be clear, concise, and consistent, and decisions and policies should be transparent with boundaries established and maintained so that trust between the organization, staff, and patients can remain stabilized (Harris & Fallot, 2001).
- Choice: Staff supports patients through shared decision-making processes, including patients in treatment and goal-setting activities, and assist in preparing patients for recovery rather than dictating or coercing the treatment plan (Harris & Fallot, 2001).
- Collaboration: Staff work with patients rather than create a power struggle. The environment should be one of collaboration and partnership, and every individual plays their role (Harris & Fallot, 2001).

- Empowerment: It is important that patients' strengths be recognized and skills developed so they feel empowered and resilient, and the staff and community assist with promoting healing and recovery from trauma (Harris & Fallot, 2001).

TIC strategies are simple and should become more widespread in health care settings. The implementation of TIC in clinical care settings must address its theoretical contexts that include the five main principles that are crucial for promoting health care quality, support, and trauma recovery (Harris & Fallot, 2001). Since the inception of TIC, several organizations have developed their versions of guiding principles and have used them to change workplace cultures and policies and assist clinicians and other staff in caring for patients who are at risk or have experienced psychological trauma.

TIC principles are the foundation for providing care in a setting that promotes a team-based approach in which clinicians recognize and provide support, experience, and resources to patients who have experienced psychological trauma. Nursing is also guided by similar principles because nurses are taught to build trusting relationships with their patients and empower patients by allowing patients to partake in their care, including making decisions regarding their care, creating a plan of care, and setting goals to assist with the patient's healing and recovery processes. Stokes et al. (2017) conducted a qualitative study in which nurses stated that trauma in the context of scientific knowledge is crucial. Nurses also stated that TIC principles are crucial to nursing fundamentals, including the focus on a therapeutic nurse–patient relationship. Nurses advocate for patients and ensure patient safety by avoiding harmful practices. TIC strategies helped to

guide the current study in which I explored nurses' perceptions of TIC practices and nurses' experiences with TIC concerning care delivery, including the quality of care, safety, resources, and intervention recommendations to improve TIC practices in patients with psychological trauma.

Literature Review Related to Key Concepts

The literature review addressed four important concepts: efficacy, organizational support, TIC for patients with mental illness, and therapeutic communication. Research describing nurses' experiences concerning TIC and TIC knowledge and training was limited. While searching the literature, I did not find any studies that addressed nurses' experiences with TIC and care delivery in patients with psychological trauma.

TIC Efficacy

There was limited research on TIC efficacy and care delivery practices when TIC and its guiding principles are used. Clinicians' and staff perspectives, particularly nurses', were also limited in this area. Although a few studies (McEvedy et al., 2017; Stevens et al., 2019; Sundborg, 2019) had been conducted on TIC efficacy, most focused on implementation processes or how TIC might be implemented in a work setting, trials, and education, and limited research focused on nurses as participants or included actual patients. Furthermore, participants consisted of a combination of nurses, social workers, medical students, physicians, and individuals who had experienced trauma or were trauma survivors. A variety of settings including private practices, larger health care settings, and organizations including mental health units had been used to conduct TIC research but with limited nurse participants. Nurses' and other clinicians' lack of

knowledge, training, and skills in TIC, as discussed in Hall et al. (2016) and Cannon et al. (2019) and as evidenced by the research discussed in this literature review, may be attributed to the deficit in research on TIC and TIC efficacy.

Hall et al. (2016) conducted a mixed-method study to assess the impact or effectiveness of TIC education involving emergency department nurses and to assess whether there would be any changes in clinical practice. The study found that emergency department nurses became more trauma-informed concerning the role that trauma plays in an individual's mental health. In a similar study, Lotzin et al. (2018) used a quantitative approach to determine whether "learning how to ask" training for inquiring and responding to trauma increases health providers' trauma inquiry behaviors. The study revealed that health care providers, if given short training, can develop trauma-informed skills, which may help to increase inquiry into traumatic events in a systematic manner.

McEvedy et al. (2017) used qualitative methods to report on the effectiveness of implementing train-the-trainer on sensory modulation and TIC in knowledge transfer of sensory modulation and TIC to staff (mental health nurses and allied health providers) and knowledge translation into the clinical practice setting. The findings showed that the transfer and translation of TIC and sensory modulation knowledge were effective across mental health service areas throughout the region of Victoria, Australia. In addition, Cannon et al. (2019) used a mixed-method approach to develop, implement, and evaluate TIC teachings in nursing students at both undergraduate and graduate levels. The study found that knowledge and skills in both graduate and undergraduate nursing students were increased from the provision of TIC content. Also, TIC content was transferrable to

students from non-nursing programs. The study was meaningful because it showed that TIC strategies can be used in settings that may not be specific to health care.

According to Sundborg (2019), theoretical or empirical studies that examine TIC commitment are insufficient, and among individuals involved or working in human services, psychological trauma is a common finding. Though organizations are beginning to prioritize TIC practices, their implementation processes are not moving quickly or falling short (Sundborg, 2019). Stevens et al. (2019) conducted a quantitative study to examine the personality traits of health care professionals relating to the efficacy of TIC, including their perceptions of TIC barriers and professional quality of life. The findings revealed that when health professionals perceived a lack of training in TIC as a barrier, decreased openness or open-mindedness correlated with decreased TIC efficacy. Additionally, Stokes et al. (2017) used a qualitative descriptive approach to explore the experiences and understandings of nurses concerning TIC. The study found that nurses were concerned and stressed the importance of TIC in every health care setting and for every patient rather than only in mental health or psychiatric institutions. Also, nurses were unfamiliar with TIC and its guiding principles but were driven to learn more about the model as a result of personal traumatic experiences, patient experiences, and friend and family experiences.

Bruce et al. (2018) conducted a mixed-method cross-sectional study to assess the knowledge, attitudes, capabilities or competence, and perceptions of the barriers of healthcare providers to TIC implementation. The findings showed that there was an increased need for training providers in patient support during medical procedures that

may be traumatic and also revealed providers' openness to providing TIC. Similarly, Shamaskin-Garroway et al. (2016) used a mixed-methods study to create and implement a curriculum of education, educate nursing and medical residents/trainees about medical care that is trauma-informed, and assess the curriculum's effectiveness. The findings showed improved care practices, attitudes, skills, and knowledge after training residents and nursing staff in TIC in patients with psychological trauma.

Organizational Support

An organization is only as good as its team. Its success may mostly depend on the individuals tasked with fulfilling the organization's mission, vision, goals, daily activities, and policies. Culture also plays a significant role within the organization and how employees interact with one another. According to Dilks (2020), a significant part of managing culture in the workplace is to ensure that the workplace is safe and secure and that positivity among staff is present, to administer and focus on increasing the quality of care.

Organizational support is important for the continued growth and success of an organization. Without adequate support from organizational leaders, it might be difficult to create or introduce change, and it might also be challenging for the staff to be open to accepting change. To establish trauma-informed care practices within an organization and ensure its principles are effective, the organization and its culture must be inclusive of leaders and staff. Gigliotti et al. (2019) posited that a significant part of organizational change success is its staff or stakeholder buy-in.

Walsh and Benjamin (2020) conducted a study in Tasmania Australia using a practice development methodology to institute TIC and its practices in a sub-acute mental health unit. The findings showed that organizational support is significant to TIC practices and staff involvement. It also includes keeping staff engaged, providing resources, and training, and identifying problems and solutions pertinent to trauma-informed care principles. TIC and its associated principles are crucial in in-patient mental health settings, especially in areas where the risk of re-traumatization is increased (Walsh & Benjamin, 2020).

On the other hand, Gigliotti et al. (2019) used a quantitative approach to assess the role of perceived organizational support in individual readiness to change. The results from the study revealed a direct impact of perceived organizational support on change readiness and an indirect impact on the emergence of trust. The study also showed that organizational change can be increased or improved if organizational support for employees is set in place before recommended changes are put in place.

Additionally, Marvin and Robinson (2018) conducted a quantitative study to assess the significance of staff attitudes and readiness to change within a non-profit human services organization. The study found that the research data supported the hypothesis that positive attitudes toward TIC correlated with individual readiness for change. Lotzin et al. (2018) used quantitative methods with a cluster-randomized trial and a control and intervention group to determine if “Learning how to ask” training for inquiring and responding to trauma increases health providers’ trauma inquiry behaviors

effectively. The findings revealed a significant increase in positive attitude, confidence, and knowledge of trauma inquiry in the intervention group to the control group.

Vincenti et al. (2021) conducted a mixed-methods study with 136 participants (mental health nurses), to assess nurses' attitudes toward TIC at a psychiatric hospital. The study found that it is important that nurses display positive attitudes and are aware of their behaviors within the organization to adequately care for and support their patients who have experienced trauma through treatment and recovery. Furthermore, Muslieu et al. (2019) conducted a qualitative study to describe what school nurses experience when caring for unaccompanied adolescents and refugee children. They found that nurses discussed, and understood the importance of self-awareness and having a positive attitude, as these factors can impact patient care. One strength of the studies was participants were of diverse backgrounds and included nurses, psychiatrists, and allied health staff. However, the studies were weakened because only single settings were used; therefore, the findings may not be generalized to all healthcare settings.

TIC for Patients With Mental Illness

Truesdale et al. (2019) used a qualitative approach to explore the perception of clinicians or healthcare providers concerning care delivery including mental disability and traumatic events or stress. The study found that evidence-based effectiveness of psychological interventions in terms of PTSD, training, and education of healthcare clinicians and staff, are warranted for service improvement in the mentally disabled population. The study also found that the need for international psychological therapies needs to be addressed to increase access and responsiveness to adults with mental

disabilities and PTSD. Additionally, child abuse is a well-known underlying factor that can be directly linked to trauma (Norton et al., 2019).

Clinicians must recognize signs and symptoms of stress, particularly traumatic stress (Inscoe et al.2021). Traumatic stress and suicide risk combined with a limited number of clinicians, particularly mental health providers, who are trained in TIC and can effectively meet the needs of individuals at risk of suicide, highlights the importance of being trauma-informed in the clinical setting (Inscoe et al., 2021). Trauma-informed systems incorporate TIC strategies into their policies, procedures, and clinical practices to prevent re-traumatizing trauma survivors who seek mental health assistance (Robey et al., 2021). Similarly, TIC tends to shift the narrative from asking a patient or trauma survivor “what is wrong with you?” to instead asking “what happened to you?” (Menschner & Maul, 2016, P. 2) which is how a trauma-informed clinician or practitioner should ask so that a trauma survivor does not feel blamed, or be triggered or re-traumatized. Rather, the individual might feel more empowered in seeking treatment (Norton et al., 2019); thus, further highlighting the importance of the five principles of TIC (safety, trustworthiness, support, collaboration, & empowerment). Therefore, increasing awareness through TIC implementation in health systems is the best method for creating trauma services (Truesdale et al., 2019).

Therapeutic Communication

A nurse’s relationship with his or her patient is extremely important. Trust is a crucial aspect of the nurse-patient relationship. It is the foundation of a positive care delivery process. A patient has to feel comfortable with and trust the nurse and nursing

staff to build a positive relationship. It is also important for individuals to reveal and discuss their medical history and current medical issues, and be willing to participate in the care, treatment, and recovery processes. When there is a lack of trust in the nurse-patient relationship, treatment barriers such as therapeutic communication issues, lack of patient-focused care, and most importantly, patient safety might be compromised. According to Nadeem (2021), presently, a curriculum in trauma, particularly psychological trauma, has not been adopted in all healthcare education; however, multidisciplinary health professionals play a significant role in administering trauma-based care to individuals who have experienced trauma.

Therefore, it is imperative that care delivery, especially where psychological trauma has occurred, is performed with the utmost compassion, respect, empathy, and trust. By using trauma-informed care (TIC) principles or strategies, nurses and other clinicians, and staff may be more equipped to deliver quality care efficiently and cohesively. This can be done by building trust, improving therapeutic communication and nurse-patient relationships, and ensuring patient safety; especially for individuals who have experienced or are survivors of trauma, particularly psychological trauma.

Stokes et al. (2017) used a qualitative method to explore the experiences and understandings of nurses concerning TIC principles. The study found that trauma-informed care principles are related to nursing fundamentals, including the focus on a therapeutic nurse-patient relationship. Similarly, Isobel and Delgado (2018) conducted a mixed-methods study in Sydney Australia, using peer role-play to increase knowledge of possible trauma impact on patients, and use its strategies to communicate therapeutically

with patients. The findings revealed nurses believed that reflecting on therapeutic communication and interactions after peer role-play was beneficial. Also, nurses admitted that they felt more capable and knowledgeable when they understood TIC and its principles and applicability in the workplace.

Muslieu et al. (2019) on the other hand, conducted an empirical qualitative study with nurses working with unaccompanied refugee children and adolescents, to describe nurses' experiences when delivering care to this vulnerable group. The findings revealed that some nurses did not have the knowledge and skills, or resources in the workplace, needed to adequately support and respond to the children. The nurses' expressed the importance of having basic training in PTSD and increasing learning opportunities in transcultural nursing. They also expressed the significance of TIC training for all nurses, collaboration with other organizations, clinicians of diverse backgrounds, stakeholders, and the community Muslieu et al. (2019). Likewise, Tiwari et al. (2021) also used qualitative methods to explore TIC implementations of care delivery within some communities in Ontario Canada. The study found that clinicians' main goal during care delivery was to use a patient-focused approach in terms of trauma treatments in youth with mental health issues, stemming from a history of child sexual abuse. Each individual's experience of trauma differs. Therefore, to ensure patients' stability and safety as a top priority, clinicians had to alter treatments for each patient who had experienced a traumatic event.

Kessler, (2016) conducted a qualitative study to explore the understanding, experiences, and perceptions of staff concerning TIC within a day program using trauma-

informed strategies for individuals with developmental or intellectual disabilities. The study revealed that understanding trauma is imperative, as it is a significant aspect of trauma-informed care. Also, Staff discussed the importance of eliminating trauma triggers, being cognizant of their responses and reactions when administering care, and ensuring the provision of a safe place or space to limit negative patient behaviors. Additionally, Reeves and Humphreys (2018) study used a qualitative approach to explore the experiences of female trauma survivors in terms of health care and TIC strategies. The study found that participants had survived multiple traumatic events, including child sexual abuse, severe auto accidents, and intimate partner violence. Furthermore, the findings also revealed the importance of thorough clinician assessments and screening processes, trauma histories, and developing a trusting and respectful provider-patient relationship. Building trusting relationships with patients is a crucial aspect of delivering care. Communicating therapeutically is one of many ways in which clinicians can begin the process of building a trusting and positive provider-patient relationship, particularly with patients who have experienced trauma.

Green et al. (2016) conducted a mixed-methods study to assess the possibility and acceptability of trauma-informed medical care (TI-med), and evaluate the effectiveness of TI-med with provider-patient relationships/interactions. The findings were that patients experiencing trauma and post-traumatic stress symptoms give low ratings to their providers on the patient-provider interaction scale. After provider training that included provider-patient interactions, provider ratings increased, but not significantly.

Summary

The literature review discussed several components of TIC that are imperative in caring for patients, especially patients who have experienced trauma. Researching the literature provided an in-depth look at the effectiveness of TIC, organizational support, and the nurse-patient relationship. It also shed light on the importance of patient safety, trust, and a therapeutic environment. While the studies provided information about TIC from multiple disciplines, clinicians, and viewpoints, they also provided suggestions for future research. From the existing research and the literature review, it is easy to see that more studies must be conducted with nurses, specifically to gather more data and adequately describe nurses' experiences with TIC, and delivery of care, using TIC strategies or principles to care for every trauma survivor or patient who has experienced psychological trauma.

More research with nurses, in particular, is also needed because it might help to increase awareness and implementation of TIC in health facilities and staff and help to improve patient and staff safety, quality of care, and trust, including provider-patient relationships. More research with nurse participants specifically might also help to improve organizational culture, support, and education, in terms of TIC and its guiding principles. It is important that future research involve nurses in particular, as nurses are usually the ones gathering patients' information, including trauma histories, and they may be more trusted compared to other clinicians. Nurses are also capable of providing non-judgmental, safe, and empathetic care. Furthermore, they spend the majority of their time delivering care and educating patients, a needed and large aspect of patient treatment and

recovery processes. Therefore, nurses must ensure that they build trusting relationships with patients. Nurses’ role in research is also crucial, both as researchers and participants. This will help to ensure more nurse-specific research that may improve knowledge in areas that have not been researched or have very little research. Chapter three will discuss the trustworthiness of the study, the research design and rationale, methodology, participants, and my role as the researcher.

Chapter 3: Research Method

The purpose of this qualitative study was to explore nurses' perceptions of TIC principles and efficacy, and their experiences with delivering care to patients with psychological trauma. Exploring nurses' experiences assisted me in understanding how nurses perceive TIC principles and develop trusting relationships with traumatized patients or trauma survivors, and provided insight into support, resources, and care practices for psychological health maintenance. In this chapter, I discuss the study's design and rationale, methodology, researcher's role, instrumentation, trustworthiness, and ethical practices in terms of the research process.

Research Design and Rationale

According to Creswell and Creswell (2020), a research design is a group of steps used to gather, examine, and explain the data. I used a qualitative descriptive design with a thematic analysis approach because this allowed me to capture and document in-depth and unexpected differences unique to the study (see Creswell & Creswell, 2020). I intended to collect rich and thick data from nurse participants who were TIC trained or used its strategies to care for patients who experienced traumatic events. The research questions were the following:

RQ1: What is the nurse's perception of trauma-informed care principles?

RQ2: What is the nurse's experience with care delivery using trauma-informed care strategies in patients with psychological trauma?

I used open-ended interview questions to elicit in-depth information with probing or follow-up questions for clarification.

Role of the Researcher

My role in the study was that of the recruiter and the interviewer. I collected, coded, and analyzed data for the study. As the researcher, I became embedded in the process as an instrument but did not impose my personal views, beliefs, values, and feelings into the study. I did not have any personal relationships with any of the participants. I was not an employee or in a supervisory role at the sites where the participants work, and I did not know anyone working at the sites where the participants were employed at the time of the study. All of the participants were unknown to me personally.

As the researcher, I avoided situations that would have caused problems with conflicts of interest. The participants volunteered their time and information about their experiences. Participants were given a $20.00 e-gift card as appreciation for participating after the interview processes were complete. The participants voluntarily participated in the study without solicitation or forceful participation for fear of retaliation from an employer. Creswell and Creswell (2020) posited that the researcher's time spent with participants is prolonged; therefore, the researcher must reflect on their feelings and thoughts about culture, history, values, and background that might influence the study and the researcher's explanation of the study. My researcher biases or power relationships were managed by focusing on the tasks at hand, particularly actively listening to the participants' descriptions and explanations of their experiences, asking appropriate follow-up questions for clarification, and ensuring that I understood participants' responses without the imposition of my thoughts judgments, or values.

Patton (2015) discussed the significance of collecting quality data by focusing on the interview's purpose.

As the researcher, I also remained mindful of ethical issues that could have emerged during the study because these issues could have interfered with the validity of the study. I had no personal experience with TIC practices and had not been trained in using TIC strategies in the workplace or otherwise. Therefore, the study was not tainted or influenced by my beliefs, thoughts, or feelings concerning TIC. Other ethical problems were avoided by ensuring that consent forms were signed and approved. I emailed a consent form to each potential participant. The participants reviewed the consent form, typed "I consent" to indicate that they wished to participate in the research process, and emailed the completed forms back to me. A full explanation of the research process was given, including maintaining confidentiality and protecting personal identifying information. I stored my data safely on a password-protected device to which only I knew the password and had access. I also did not use any of the participants' names or other identifying information in the study. Instead, I assigned a pseudonym (e.g., Participant A, Participant B) to each participant. The participants were also given time to ask questions and were told that they could withdraw from the study at any time.

Methodology

Participant Selection

The study's participants consisted of nurses with multiple levels of experience and from various nursing backgrounds including pediatrics, emergency room, case management, and orthopedics. Licensed practical nurses, licensed vocational nurses, and

APRNs including nurse practitioners and clinical nurse specialists were also included in the recruitment process and criteria, but no APRNs, LPNs, or LVNs signed up or participated. Nurses who were TIC trained and were currently using or had used TIC in the workplace were eligible to participate in the study. Trauma-informed nurse participants provided in-depth information that was essential to understanding their experiences and perceptions of TIC and their care delivery processes using TIC principles with individuals who experienced traumatic events.

Purposeful sampling was the sampling strategy for recruitment in the study. According to Creswell and Creswell (2020), purposeful sampling is the process by which the researcher provides rich data that reveals the phenomenon being explored. Exclusion criteria consisted of nurses who were not TIC trained and not knowledgeable about TIC principles or practices. To respectfully exclude a participant from the study, I engaged in active listening and communicated respectfully with the participant. I also provided a phone number for the participants to call for assistance or as a resource if needed or in case a participant became triggered (e.g., the 24-hour hotline to SAMHSA 1-800-662-HELP). If an individual met the inclusion criteria but chose not to participate, the individual was respectfully excluded.

Nurses were the purposefully selected participants. They were able to provide firsthand accounts of their experiences and provide substantial information that contributed significantly to the study. Research regarding nurses' experiences with TIC principles, efficacy, and delivery of care in patients with psychological trauma was limited. The inclusion criteria (i.e., nurses who were trained to use TIC including nurses

who were currently using TIC or those who had previously used TIC and were trauma-informed) were clear and concise so only participants who fit the criteria could respond and participate in this qualitative study.

According to Creswell and Creswell (2020), the main goal of gathering qualitative data is to acquire in-depth and rich data from a small group of individuals or participants. I planned to use eight to 10 participants for my research. I also understood that the necessary number of participants when conducting qualitative research is determined by saturation being attained. According to Braun and Clarke (2013), saturation represents a specific aspect of qualitative research in which the data provide a thorough and accurate story of the phenomenon.

Participants in the current study were given unique identifiers to ensure confidentiality and were contacted privately by email. The participants were recruited by posting my flyer on member sites such as Sigma Theta Tau and social media sites such as LinkedIn after permission was granted by Walden University's Institutional Review Board (IRB number 05-13-22-0870731). To provide a rich, data-filled study that was meaningful, reliable, and trustworthy, I applied the steps of ensuring trustworthiness (credibility, dependability, transferability, and confirmability) to my research. I followed ethical procedures and continued the interviewing and coding processes until no new information was obtained, at which point I reached data saturation (see Creswell & Creswell, 2020). According to Creswell and Creswell (2020), the qualitative researcher acquires a sufficient sample when they cannot obtain new ideas from newly collected data.

Instrumentation

As the researcher, I was the research instrument. The researcher's background, skills, and experiences are important in qualitative studies because the researcher is the instrument of the study and the individual tasked with participating in fieldwork and interview processes (Patton, 2015). I conducted Zoom meetings and audio recordings with a voice recorder as a backup. I also used a screening guide (see Appendix B) to ensure participant eligibility and used an interview protocol (see Appendix C) for consistency. The interview questions were open-ended and derived from the overarching research questions:

RQ1: What is the nurse's perception of trauma-informed care principles?

RQ2: What is the nurse's experience with care delivery using trauma-informed care strategies in patients with psychological trauma?

The interviews were private one-on-one Zoom meeting sessions between each participant and me so that confidentiality and privacy could be maintained. It was important to speak one-on-one with each participant so that I could better understand each nurse's perception and experiences with TIC. Originally, I planned to use field notes as a data collection instrument but did not because the interviews were conducted using a virtual platform. I ensured that my participants were comfortable, and I conducted the interviews in a respectful, nonjudgmental, and nonconfrontational manner. Historical or legal documents were not used as sources for data collection. The instruments were sufficient for collecting the data because they provided a means of gathering in-depth information with approved interview questions and adequate follow-up questions. The

recorded information was transcribed, verified with the participants for accuracy, and coded for emerging themes.

Procedures for Recruitment, Participation, and Data Collection

I created a flyer that was used to recruit the participants (see Appendix A). The flyer described the study, clarified participation requirements, and included my email and phone number so that potential participants could contact me if they were interested in being in the study. Once an individual agreed to participate in the study, I provided them with the informed consent document, and I used the opportunity to remind the participant that the Zoom interview would be audio recorded and that a copy of the transcribed document would be given to them for review. I also used the opportunity to inform the participant that they could withdraw from the research process at any time.

Using phone calls, Zoom, and audio recordings as data collection tools provided a convenient way of reaching participants who resided in other parts of the United States. Data collection occurred in a room in my home where only I was present. I collected, coded, and analyzed the data. The data collection process occurred only once with each participant. I did not have any questions or a need to contact the participants after the interviews were completed except for transcript verification purposes.

Interviews were 15 to 35 minutes long with an average of 25 minutes, and the interviews were recorded via Zoom with an audio recorder as a backup. My original recruitment plan resulted in a sufficient number of participants, so I did not use snowball sampling to recruit more participants. Patton (2015) described snowball sampling as a means by which a researcher uses a referral process in which study participants refer

others who may be able to participate in the study, and the referred participants also refer other individuals, thereby enabling the researcher to multiply or widen the sample pool. A researcher might use this method if other means of acquiring participants have failed, and the researcher should be careful in selecting participants and refrain from personal biases (Patton, 2015). According to Patton (2015), it can be helpful for a researcher to use social media platforms and the internet as methods for recruiting a sample for the study.

In the current study, every participant was debriefed after their interview. I asked if there was anything else that the participant wanted to add before we ended the session. Also, I reminded each participant that everything discussed would be kept confidential, including the participant's identity. I also reminded the participant that they could withdraw from the study at any time and that they would be given a copy of the transcribed interview to review for accuracy. I then informed the participant of the possibility of follow-up interviews, if needed, and I stated that they would be contacted in advance so that a time frame could be discussed for their convenience.

Data Analysis Plan

I conducted this qualitative descriptive study to explore and understand nurses' perspectives on TIC principles and care delivery in patients with psychological trauma. I used open coding to code the transcribed interviews so that I could be "open to the data" (Patton, 2015, p. 542). I reviewed the data for accuracy to ensure the research process and purposes were congruent. The process entailed multiple readings and coding of the data. According to Patton (2015), data analysis is dependent on the research purpose.

I used Otter.ai (a transcription software tool) to assist with transcribing my data before I edited and reviewed the document for accuracy. I used Braun and Clarke's (2013) approach to thematic analysis by applying their six-step process to analyze my data. Thematic analysis was best suited for this study. According to Braun and Clarke (2013), thematic analysis is a type of examination in which a theme is a mode of analyzing and viewing the data as a whole but from multiple sources to recognize themes. I used Microsoft Word to create a document that enabled me to organize the codes to reveal emerging patterns and themes. I mitigated discrepancies by reporting all findings regardless of what they revealed or represented, and I used diagrams and tables to reveal commonalities among the data so that I could be as transparent as possible, thereby increasing the validity of the study.

Issues of Trustworthiness

According to Patton (2015), every research must be valuable to be credible. In other words, it is essential that a researcher reports their findings rather than influencing the data to show the researcher's preconceived ideas (Patton, 2015). I collected and coded my interview data until no new patterns or themes emerged. I used the data to inform me whether data saturation had been reached.

Credibility

The credibility of my research was achieved by asking adequate and appropriate probing and or follow-up questions when conducting the interviews. It was essential to seek clarification during the interviews to allow participants to express and describe their viewpoints freely without interruptions and or judgment. I established triangulation by

recruiting sufficient and a variety of participants and continuing the interviewing process until I reached saturation. I also built trust with the participants and I was open and honest by sharing necessary information and allowing participants to feel comfortable throughout the process by actively listening and asking appropriate and adequate questions. Furthermore, I ensured that the participants' descriptions of their experiences were fully captured and that my explanations of their experiences were accurate and congruent. According to Creswell and Creswell (2020), this process is important for capturing in-depth and rich data which adds to the study's credibility.

Transferability

Transferability is the process by which the research findings can be applied to another area or situation and individuals (Creswell & Creswell, 2020). Data collected during the research were in congruence with the research questions by using established audio and video interviewing sessions. The transferability of the study is increased by providing in-depth and thick descriptions of the research methods, setting, and varying experiences and backgrounds of participants, as well as my comfort level during the interview sessions including body language, nonverbal communication, behavior, and attitudes. By providing such detailed information, the audience will be able to better understand the connection and relatability of the participants, researcher, and research environment, and understand the possibility of transferring parts of the study to another. According to Creswell and Creswell (2020), transferability is the process by which adequate information on the completed study is provided to the audience, in a manner

that enables the audience/reader to develop similarities between another study and the researcher's study and transfer its findings.

Dependability

According to Amin et al. (2020), the research is considered dependable when an independent auditor can evaluate the authenticity of the research process. I used data triangulation to show the credibility of the results, and reflected on the entire process by delving deeper into the research experience. Braun and Clarke (2013) posited that data triangulation can be achieved when two or multiple data sources are used to assess the same event, with a focus on acquiring the facts or veracity of the research. My journal entries, and reflection notes, enabled me to remain grounded and reflect on the interviews and assist with attaining triangulation. Similar studies on the topic were compared to the results of my research to show the study's transferability including participant selection. The study in its entirety was audited for its veracity; therefore, every aspect of the study is accurate, free of personal biases and influences, credible, and dependable. The research process was verified by my dissertation chair and second committee member to ensure the veracity of the research findings. I reflected on the study including the participants and give deeper thought to whether I ensured cultural competence, respect for the participants, and the research process.

Confirmability

According to Patton (2015), confirmability is the means through which biases are decreased, the research or study is as accurate as possible, and the researcher reports the good as well as the bad of the study, and remains impartial to his or her work. In this last

part of ensuring the trustworthiness of my qualitative research, all themes that emerged from the coded material were confirmed to ensure the right information had been analyzed and the results accurate. In other words, to show research rigor, my work was verified or audited by faculty (chair, and committee member) to ensure that my work portrayed actual findings and not what I perceived to be accurate. I also showed confirmability by using my notes, reflecting on my interview sessions and data, and noting whether I included any subjective or personal judgments/observations throughout the research process (Patton, 2015).

Ethical Procedures

Before I began recruiting participants and collecting research data, the university's IRB reviewed my research application for approval and also discussed possible restrictions for my study and study participants. I did not have any ethical concerns or other significant issues related to the research. Though my study did not include a vulnerable population, I was respectful of the participants and the time and effort they invested in the research process. The participants' data were de-identified by removing names and or any other identifiable information from the study. Pseudonyms were assigned to the participants to protect the participant and data.

Only I (the researcher) was present in the room when the interviews and data collection processes commenced; no one else was present. Also, information regarding the research was explained thoroughly, and extra time was allotted for questions to clarify information and miscommunication. Each participant was given a $20 electronic gift card as appreciation for volunteering only (not as payment for participation in the study).

Participants were told that they could withdraw at any time without consequences and that their information would be kept confidential. Walden-approved documents such as the consent form and recruitment flyer were used and are included as appendices. I provided a phone number on the consent form for participants to call if they became emotionally triggered or distressed during the research process, or if they wanted to reach out for further assistance. The Substance Abuse and Mental Health Services Administration (SAMHSA) can provide help; participants can call the helpline at 1-800-662-4357.

Informed consent was given to all participants to sign and submit. All other documents were filled out appropriately and submitted for review by the IRB to obtain research approval. Ethical violations were avoided by asking my committee for advice and clarification if and when needed. Participants were given full briefings about the study for transparency and to comply with ethical recommendations. The participants' information was stored on password-protected or encrypted devices to which only I have access. The data is and will be stored for the duration of the time (five years) required by Walden University. Participants were informed that they could refuse to participate or withdraw from the study at any time. All personal information was kept confidential whether or not a participant withdrew from the study. Each participant's personal information and data were de-identified by removing names and any other identifiable information. A pseudonym was created to replace the participant's name for protection. No one else other than the participant and I were present during data collection and interview sessions. No one withdrew while participating in the study but confidentiality

and privacy were maintained at all times. After the recommended time is passed, the data will be destroyed. The study was not conducted at my workplace or included participants that I knew or supervised to avoid conflicts of interest.

Summary

Chapter three discussed and described how the study was conducted in more detail, including participants, inclusion and exclusion criteria, the chosen methodology, and the analytical approach or plan. I also discussed potential ethical issues, how they would be mitigated, and confidentiality, privacy, and protection of participants and their information. The chapter provided the required documents for IRB approval such as the consent form, and recruitment flyer, and also provided the opportunity to explain how research veracity was acquired. It was necessary to discuss the trustworthiness (credibility, dependability, transferability, and confirmability) of the study because all aspects will allow the reader to understand that the information can be trusted and that the information has been verified and audited for accuracy. Chapter four will discuss in-depth recruitment information, and study results.

Chapter 4: Results

The purpose of this qualitative study was to explore nurses' perceptions of TIC principles and their experiences with care delivery in patients with psychological trauma. The research questions were the following:

RQ1: What is the nurse's perception of trauma-informed care principles?

RQ2: What is the nurse's experience with care delivery using trauma-informed care strategies in patients with psychological trauma?

To answer the research questions, I explored nurses' perceptions, feelings, and experiences because TIC nurses use TIC principles to care for individuals who have experienced traumatic events. This study was needed because TIC nurses' perceptions and experiences concerning survivors of psychological trauma were not widely known, and these nurses help to provide the best possible care to at-risk individuals and trauma survivors.

I conducted a qualitative descriptive study with a thematic analytic approach using Braun and Clarke's (2013) six steps to code and analyze each participant's interview, including journal notes and general observations. I used open-ended questions to allow each participant to describe their experience, and used follow-up questions as needed to allow the participant to elaborate on responses that required further clarification. Commonalities among the participants' information allowed me to code and group the data into categories and themes, which enabled me to explain the findings. In Chapter 4, I describe the setting, participant demographics, and data collection processes. Additionally, I discuss evidence of trustworthiness and present the results of the study.

Setting

Ten participants met eligibility requirements to participate in the study. If a candidate met the criteria for participation, they were scheduled to sit for the interview based on their availability, and I sent a Zoom invitation with the date and time. Seven potential participants did not meet eligibility. Three did not want to be on audio or Zoom video. One individual logged in but immediately left the meeting room and did not return; another individual rescheduled but did not show up for the interview. Two potential candidates were ineligible because they were not TIC trained. Otter.ai was used to transcribe each interview, and I manually reviewed each document for accuracy and made corrections where needed. All eligible participants were interviewed using Zoom meetings, and interviews were also audio recorded as a backup in case I encountered problems with the meeting platform.

Demographics

A total of 17 nurse participants consented to be interviewed, but only 10 were eligible. I conducted one-on-one interviews with each participant. The participants varied in terms of their nursing backgrounds and where they worked at the time of the study. However, each participant interviewed was a registered nurse with several years of nursing experience, and each was TIC trained. Four female and six male nurses were interviewed for the study.

Two participants were nurse case managers while another worked as a nurse midwife supervisor. One participant transitioned to pediatric nursing but had previously worked with adults where she was TIC trained and used it in her nursing role. Another

participant began her nursing career as an oncology nurse but transitioned to the emergency department; she received her TIC training before transitioning to the emergency department. Another participant worked as a surgical nurse in a hospital setting. The remaining participants were registered nurses who were working with adult populations in a variety of hospital settings throughout the United States.

Data Collection

Before I began data collection, I made sure that all willing participants were eligible. I sent each potential nurse participant the consent form via email. When I received a response with the potential participant's consent, I followed up with the screening guide to determine whether each volunteer met the inclusion criteria. If a potential participant met the criteria, then a date and time were mutually agreed upon, and a Zoom meeting invitation was sent to the volunteer. In total, 17 participants agreed to participate in the study, but only 10 were interviewed. Three participants chose audio only as their interview method, and other participants agreed to be on Zoom audio and video during the interview. I also used a voice recorder as a backup device in case there were technical problems that might have interfered with data collection.

When I received approval from Walden's IRB, I posted my flyer (see Appendix A) on the social media site LinkedIn and the nursing membership platform Sigma Theta Tau. I used the same flyer that I used for the IRB application to avoid any variations in the recruitment process. My flyer indicated my desire to recruit a variety of nurses and nursing backgrounds, an estimated time frame for the interviews, and my contact information by phone and email.

I specified in the flyer that the interview process would be between 15 and 60 minutes. Interview times ranged from 15 to 35 minutes with an average time of 25 minutes. One important aspect of the recruitment process was to ensure that I only included nurse participants who were TIC trained. This was important because the research questions could only be answered by interviewing nurses who were TIC trained and understood TIC concepts. I recruited nurse participants who were currently using or had previously used TIC in the workplace to deliver care to patients who had experienced trauma, especially psychological trauma.

Data Recording

Each interview was conducted one-on-one using open-ended questions to allow the participants to express themselves freely regarding their perceptions and experiences. I also probed where there was limited understanding or insufficient data. During probing, I was sure to not impose my personal views or ask leading questions that might sway a participant one way or another. I was not TIC trained, and this helped to ensure that the data were free of my influence, with honest responses and descriptions of the participants' experiences. Probing was different for each participant because it was based on the participant's response to a question that needed clarification. I conducted interviews between May 19, 2022, and July 23, 2022.

I used Zoom audio/visual recorder and a voice recorder as a backup. I also used my journal notes as an instrument for documenting my thoughts and noted the body language and facial expressions of the participants. This enabled me to associate each participant's nonverbal cues with what they described as their personal experiences

during questioning. After each interview via Zoom, the recording was uploaded to Otter.ai where it was transcribed verbatim. I then reviewed each transcription by listening multiple times (with earplugs for confidentiality purposes) to the audio-recorded version for accuracy, and I made corrections as needed. Once the document was corrected, I reviewed it again. After rereading the transcription, I sent the document to its respective participant to review. I stated in the consent form that I would send the document to the participant to review for accuracy. Only two of the 10 participants responded to inform me that the transcription was accurate. The other eight participants did not respond.

Data Variations

In Chapter 3, I stated that I would use field notes as an instrument for data collection. I collected my thoughts and feelings in my journal and relied on it as a reflection instrument because I conducted all of the interviews via the Zoom platform. None of the interviews were conducted in person, so I could not take field notes or include environmental conditions and attributes.

Unusual Circumstances

I encountered several unusual circumstances during my data collection process. On three separate occasions, there were some connectivity and technical difficulties with the participants' audio and video. I asked that the participants check their audio and video to ensure that they were unmuted and that the video option was available. As a last resort to resolve the issues, I asked the participants to exit and reenter the meeting room before proceeding with the interview. This approach usually worked.

One participant logged into the meeting room and experienced audio problems, so she logged out, waited a few minutes, and tried a second time. The audio worked on the second try, and I was able to proceed with the interview. Another participant entered the Zoom meeting room but both audio and video were not working, so I could not see or hear her. She used the chat box to ask if she could receive the gift card if she did not participate. I explained that the gift cards were given to participants as appreciation for participating in the study. The participant rescheduled her interview but did not show up. During the interview with another participant, the participant lost connection for a few minutes while answering a question, which delayed the interview, but she was able to rejoin the meeting. I repeated the question, and we were able to continue and complete the interview.

Data Analysis

Analyzing the data was a crucial step that followed data collection. To describe the research findings, I had to analyze each participant's transcript by coding the document and categorizing the coded data. I then recoded the coded data, placed them into categories, and developed themes based on similarities to ensure the research questions were answered.

Codes to Themes

I used Braun and Clarke's (2013) thematic analysis (a six-step process) to analyze the data. After ensuring the accuracy of each transcript, I created a table with columns and rows in a Microsoft Word document. I created a list and used a wider space to the far left of the table to store the raw data, and I used the middle and right sides for categories

and theme development. According to Saldana (2016), creating a list of the data allows the researcher to evaluate and organize the coded material. I also created another Microsoft Word document in which I stored excerpts or extracts of each participant's response so that I would be able to cross-reference the quotes when I began working on presenting results and interpreting the findings of my study. Braun and Clarke posited that the researcher must use the method that works best for them, but the coding process must be systematic, in-depth, and inclusive while moving through each aspect of the data analysis.

The first step when incorporating Braun and Clarke's (2013) thematic analysis was to ensure familiarity with the data. To accomplish this, I read each transcript in its entirety at least three times, or more if needed. The second step of the process was to create codes throughout the data (see Braun & Clarke, 2013). I accomplished this by extracting small chunks of the data and attaching code words and phrases specific to the data. According to Braun and Clarke, the third step in the thematic analysis process is to establish themes. I accomplished this task by using the coded material to look for similarities or emerging patterns or themes, which I placed in a separate column on the right side of the table. The fourth step of thematic analysis was reviewing the themes. To accomplish this, I reviewed the newly created themes and slowly read through the transcripts, categories, and themes to verify whether the themes made sense and related to the original data and codes and to verify that all relevant data were included. This step enabled me to connect the participants' perceptions and experiences with TIC and care delivery in patients who experienced psychological trauma.

According to Braun and Clarke (2013), a theme refers to similarities within the data that consist of crucial information that connects to the research question. I placed chunks of the raw data, highlighting recurring words and phrases that surfaced, in the wider left column during the initial coding process. Secondly, I used the highlighted data from the first column and created a list in the second column by grouping similar but significant individual words and short phrases to form categories. I then used the third and smaller column to identify the newly created themes. The themes were established by combining words from the listed categories and creating short phrases that described an overarching idea.

The phrase or term described the categorized list and provided a general idea of participants' perceptions and experiences. Next, I assigned names to each theme, which is the fifth step in the thematic analysis process. After naming the themes, I reviewed my research questions and themes to ensure connectivity and congruence and began to see the complete picture emerge in terms of nurses' perceptions and experiences with TIC. I then began to explain what the nurses described in their interviews; however, this time the information was combined rather than individualized but to form a complete narrative. There were four main themes: helpful tool, education and collaboration, avoiding retraumatization, and increased care quality. Themes and corresponding quotes from transcripts are located in Appendix D.

Theme 1, helpful tool, referred to the effectiveness of TIC as a trauma resource and guide when its principles are used to care for at-risk individuals who have experienced trauma and to avoid retraumatization. Theme 2, education and collaboration,

referred to increasing educational opportunities for all clinicians on the health care team to provide seamless care and improve teamwork and care practices for health providers, trauma survivors, and individuals at risk of experiencing trauma, particularly psychological trauma.

Theme 3, avoiding retraumatization, referred to the nurses' descriptions of showing empathy and compassion to their patients or trauma survivors. Avoiding retraumatization also referred to being aware of their thoughts and feelings toward patients to avoid retraumatizing the patient and themselves. In addition, avoiding retraumatization referred to the nurses' descriptions of incorporating TIC principles to decrease patient and caregiver stress and increase patient satisfaction, which can lead to an improved relationship between the clinician and the patient. Theme 4, increased care quality, referred to the participants' description of using their TIC training to provide patient-centered or individualized care and expand TIC education and knowledge. This would include all health settings, nursing curriculums, and students, and would provide refresher classes to all health providers to consistently provide TIC and improve the quality of care to trauma survivors and individuals at risk of experiencing traumatic events.

According to Braun and Clarke (2006), the sixth and final step in the thematic analysis process is to create a report of the data analysis. I accomplished this task by creating an in-depth description of the results. I also accomplished this by incorporating direct quotes and statements made by the participants into the final report.

Discrepant Cases

A participant whose perception and experience with TIC varied from the other participants revealed that although TIC as a whole was helpful for clinicians, she found TIC difficult to use in her work setting because clinicians simply did not have sufficient time to fully implement TIC practices into the patient's care. Many patients only stay for a limited time making it somewhat challenging to apply all five TIC principles. The emergency department may provide several opportunities for TIC implementation since it might be the first point of care for individuals who recently experienced trauma. However, the ED is a fast-paced environment that might also present challenges for trauma-informed nurses because they may not be able to use all five steps or follow through with trauma survivors or individuals at risk of experiencing trauma. I provided more information about the discrepant case in the results portion of the report.

Evidence of Trustworthiness

Credibility

When I thought I had reached saturation, I was a bit doubtful so I conducted a few more interviews to make sure I did not overlook anything. When the last few participants' data yielded nothing new, I realized that I had truly reached saturation. I interviewed 10 participants in total. I used my journal to reflect on my thoughts and feelings during each interview. I did this to avoid projecting my thoughts and feelings onto the participants and the interview and capture the richness of the raw data. Because I was also an instrument in the research, I had to ensure that I was self-aware of my thoughts and actions to prevent influencing participants or their responses.

According to Creswell and Creswell (2020), reflexivity refers to the researcher's biases concerning value systems, gender, background, culture, and more, and how they affect the researcher's analysis during the research process. As I conducted each interview, I tried not to impose any thoughts or feelings. Instead, I encouraged each participant to share their experiences freely. I also showed credibility by member checking as I stated I would in chapter three. I sent each participant a copy of the transcript to review for accuracy. Two participants responded and approved the data. The other eight participants did not respond to the request. Member checking was used to inquire whether or not the participants agreed with the final report and whether or not the participants deemed the report accurate (Creswell & Creswell, 2020).

Transferability

I provided a clear and in-depth explanation of the interview setting, provided information about the sample size, and provided a detailed explanation of the findings. I did this so that readers can use this research as a reference or backdrop and find similarities between my research and another study. According to (Patton, 2015) transferability refers to the researcher's provision of abundant information to readers so that similarities from the research can be made and applied to another study.

Dependability

All of the data collected for this study were collected from one-on-one zoom meeting interviews with TIC nurse participants who volunteered to participate in the research process. I transcribed the data using Otter.ai, then reviewed and manually corrected each document and read through each one multiple times to ensure accuracy

before sending a copy of the document to the participant. I coded the data using small chunks of the raw data, formed categories, and themes and followed Braun and Clarke's (2006) six-step thematic analysis process to describe the information that emerged from the data and capture the essence of what the participants had discussed as a whole. I also created traceable evidence in terms of data collection instruments (journal notes, voice recordings, and transcriptions), coded materials, and excerpts. To assess the rigor of the researcher's work and ensure authenticity, the researcher must establish an audit trail to provide a fair analysis, decrease bias, and increase accuracy (Patton, 2015).

Confirmability

According to Amin et al. (2020) confirmability refers to the evaluation of the research, analysis, data, and explanation. My journaled notes were helpful during data collection and throughout the analysis and writing processes because they kept me grounded. I described how I progressed from coding the raw data to theme development and the overall explanation of the research findings. I reflected on my thoughts and constantly reminded myself to be cautious and conscientious of my tasks and responsibilities during the interviews and the study in its entirety. I also avoided influential behaviors and questions that might sway or lead the participants to answer the questions in a particular way.

Results

RQ1: What is the nurse's perception of trauma-informed care principles?

RQ2: What is the nurse's experience with care delivery using trauma-informed care strategies in patients with psychological trauma?

Manual coding of each participant's interview transcript allowed four associated themes (Helpful Tool, Education and Collaboration, Avoiding Re-traumatization, and Increased care quality) to emerge from the data. From the emergence of the themes, the research question was answered using the participants' own words to emphasize their perceptions and experiences.

Theme 1: Helpful Tool

Most of the participants stated that through the education of TIC and collaboration between the care team, some individuals who experienced trauma also experienced good treatment outcomes. To provide some context regarding the theme "Helpful Tool", Participant A stated: "I also perceive it to be effective in the management of patients. TIC is the most appropriate approach. The strategies are actually the best approaches designed in the effective care of traumatic patients." He also stated, "It has handsomely improved patient experiences and outcomes, which is the ultimate goal of any nurse." Additionally, participant B stated "It is the best tool in providing care to traumatic patients. So it really guides us as nurses to actually make sure that we meet the expectations of the clients when taking care of or while they are receiving our care." Similarly, participant C stated, "It's a good approach in management of patients with trauma."

Participant D described his perception of the TIC principles as "The best nursing management tool towards management of people with conditions." Participant E also shared a similar sentiment and said "Based on the principle of let's say safety and collaboration, basically I have a positive perception towards the principles because they ensure like the clients with trauma, that is they are taken care of well." Participant I

declared “It’s been quite assistive, getting to talk to people or getting into analyze people based in trauma-informed care. And over the years, I’ve been able to relate more people. And this has been helpful for me.”

Meanwhile, participant J described her perception and experience with TIC as “I think it’s really helpful; especially to the healthcare professional.” All of the participants described their perceptions of the TIC principles as a resourceful tool that enables them to better care for individuals at risk of experiencing trauma and trauma survivors because it guides their care delivery processes from the time of admission to discharge. Several participants stated that overall, they had experienced better patient outcomes when they followed the five principles associated with TIC and incorporated the principles in the plan of care from the start, and remained consistent.

Theme 2: Education and Collaboration

Each nurse participant described their perception of TIC principles and their experiences with care delivery using TIC principles in psychological trauma survivors. However, during each interview, the participants also shared that although TIC was helpful in the workplace for clinicians who were TIC trained; it was not the same for everyone on the care team or all clinicians because TIC training was not widespread in the workplace. It is important to note that while all the participants were TIC trained, some received TIC training in previous work settings other than their workplaces at the time of the interview, and used their knowledge to provide TIC to individuals at risk and individuals who had experienced psychological trauma.

The participants discussed the importance of TIC education and collaboration among the clinical staff and patients. Some participants stated that not all clinicians in their work settings were TIC trained and that it was important for all clinicians to be TIC trained to ensure consistency and efficiency in care practices. For example, participant C stated, “It really needs much awareness, care providers actually really need to be trained about the same because they are not yet.” “The implementation part of it is what actually most of the care providers have yet to actually implement.” “I don’t know if it’s because maybe they are not yet educated more about it.” He also stated “In care, we usually collaborate; not only nurses that are attached in the caring of the patients, so this skill really needs to be all around the healthcare providers, regardless of opinion; be it a clinician, be it anyone else”.

Additionally, participant B stated “It’s maybe how we can be able to train more nurses, providers, on this informed care action through maybe workshops so that now they can be able to help clients.” Participant D shared “The care’s most satisfying to patients than the other care that my colleagues provide, and that’s why we can always try to actually make sure that almost all health care providers emulate this trauma-informed care.” Similarly, participant I declared “And for me, it’s a good move to educate other healthcare professionals on the TIC”. It was interesting to listen to each participant describe their perceptions and experiences concerning TIC. Each participant overwhelmingly shared similar thoughts and experiences about TIC, its use in the workplace, and collaboration among all members of the care team to efficiently and effectively administer care and avoid re-traumatizing trauma survivors.

Theme 3: Avoiding Retraumatization

One crucial aspect of TIC is to ensure that trauma survivors are not re-traumatized and also protect caregivers/clinicians from experiencing trauma and or re-living traumatic experiences. Two recurring words that emerged as a theme during data analysis processes were "avoiding re-traumatization". The participants described their feelings and personal experiences that emerged from caring for individuals who had experienced psychological trauma.

They described how they try to protect patients and themselves from reliving the traumatic event during care delivery. Some described protecting the patients while in the work setting but leaving the shift and experiencing re-traumatization themselves. They described replaying scenarios from the shift concerning trauma survivors and said it also affected them psychologically.

Participant A declared "Sometimes their experiences can really move you and feel down but I try to be empathetic rather than sympathetic." Participant B added "This actually sometimes loses the objective now of the therapy itself, because now you stop caring for the patient and you start crying. But most of the time we actually try to control ourselves; now, specifically me, in this case, to breathe and then continue emphasis on actually helping this client out rather than sympathizing." Similarly, participant C stated "Sometimes the patient's needs actually surpasses your expertise". "And you really feel like this patient really needs a lot than you can really provide." He also stated "Sometimes you can really feel like you've not provided enough because sometimes the

client tells you, you've not really really helped me the way I actually expected. So that's the other challenge."

All of the participants shared that they had in one way or another been traumatized while caring for patients or survivors of psychological trauma. However, some stated that they had not been affected significantly by the patient's trauma or they were able to cope in other ways. For example, participant D described his experience as such "Sometimes some experiences can be really scary and touching that you really feel it's not easy for the clients that you've taken care of." He also added, "The more I really experience, the more experience I have in handling such issues." However, participant E shared a different view and stated "It doesn't affect me that much. I may be emotional or calm. I may have empathy to the client. So it may affect my delivery of care." He elaborated "It may be easy for you to like respond to the trauma the client is going through. And it may be for you also to like put measures to prevent, that is reoccurrence of the trauma events." Participant F, on the other hand, was steadfast about her experiences and said "You know, after you leave the shift you think about a little bit, but you find you kind of get used to it and stop trying to, like, separate everything."

Meanwhile, participant G described her care delivery experience and said "It does affect me sometimes. You know, different people have different traumas that they have gone through so when they tell their story, you can really see the emotional part of you, so you feel connected to this patient." She added "And if something happens, it hurts you, too. So what I do is, I feel, I make the patient feel comfortable first you know, if I react, and she or he sees how I'm reacting, it might affect him or her. So, I keep the reactions to

myself and feel make the patient comfortable. And afterward, I may now start thinking about everything”. Participant H bluntly exclaimed, “The stress affects me”. She explained that as a nurse, caring for patients who had experienced traumatic events affected her because it created a stressful work environment.

Theme 4: Increased Care Quality

The third theme that surfaced after the first and second cycle coding processes was “Increased care quality”. Although many of the participants discussed feeling compassion and empathy for their patients who had experienced psychological trauma, some participants also experienced trauma while caring for trauma survivors. Nevertheless, the participants said that they strive to prevent their patients from re-traumatization, even when they (nurses) are at risk of being traumatized or re-traumatized. The participants expressed that being trauma-informed has helped them in different ways to administer care adequately. They also said that they had seen improvements in the quality of care of the patients.

The participants’ described witnessing improvements in patients who had experienced psychological trauma by discharge compared to the start of treatment or admission. When TIC principles were used during care delivery by clinicians who were trauma-informed compared to un-trained providers, the outcome, including the patient’s satisfaction and quality of care differed. For example, participant A stated, “The care I provide is unique and the client satisfaction is higher than the non-informed.” “I actually empathized with them and the turnout actually is very impressive, because those patients actually end up recovering better and coping up with life as they used to before.” He also

said, “It’s maybe how we can be able to train more nurses, providers, on this informed care action through maybe workshops, so that now they can be able to now help clients.” Participant C added, “It’s unique and more satisfying; it’s a good technique or tool that we should really implement that will really transition this kind of care, that is kind of good.”

The participants reported that TIC-trained nurses’ approach and administer care differently to trauma survivors and at-risk individuals than their colleagues who are not trauma-informed which can affect the patient’s satisfaction and overall quality of care. Participant H said, “With the care you are able to give them, to your patient, the patient will see the care you are giving and begin to earn your trust.” Participant I shared “It is really good to, to understand the concept of TIC. And for those who have been privileged to get proper training on how to handle situations like this, it has been a wonderful turn of events.” “And for me, it’s it’s a good move to educate other healthcare professionals on the TIC.”

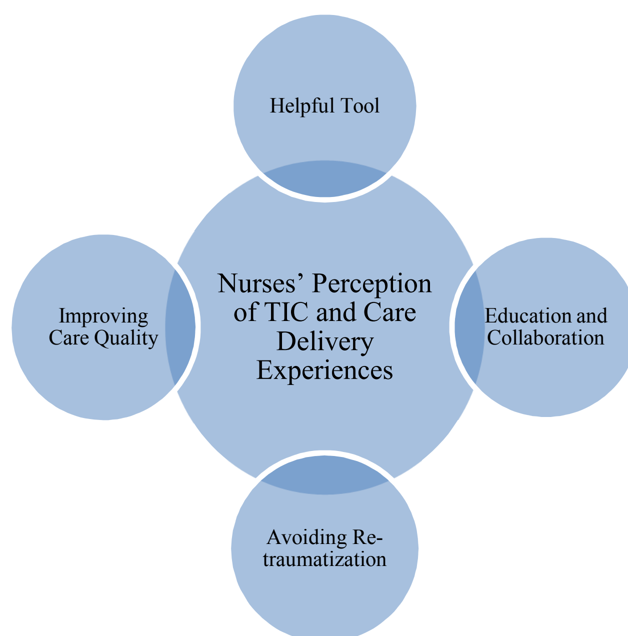
Discrepant Case

During the interview, one participant expressed that TIC principles work in theory but because of high patient turnovers and the fast-paced nature of the job, she found that incorporating TIC principles while delivering patient care in the ED was challenging. She said, “On a day-to-day basis, I, at least on my opinion, I find it a bit hard to use it sometimes. I, I feel like if I had like an extra training, it will help me.” Although the participant perceived that generally, TIC is beneficial, she also expressed that clinicians would benefit from extra training in TIC, citing “I think some extra training would be

good." "Even if it's like, I don't know, workshops and things you know, but I think it would help." She also stated, "I think that maybe a nurse that's not trained in it, she would be able to provide like similar care, like the similar quality that I do."

Figure 1

Four Emerging Themes



Summary

In chapter four, I discussed data collection processes including the setting, participant demographics, data analysis, trustworthiness, and the results. Four themes (Helpful tool, Education and collaboration, Avoiding re-traumatization, and Increased care quality) emerged from the data that were instrumental in answering the research questions:

RQ1: What is the nurses' perception of TIC principles?

RQ2: What is the nurse's experience with care delivery using TIC strategies in patients with psychological trauma?

The participants' descriptions of their experiences using their own words were used to underpin theme development. As previously stated, the interviews were semi-structured with open-ended questions. Each participant was asked the same questions but probing questions were individualized. Conducting one-on-one interviews allowed me to be fully engaged with the participants but also allowed them to be comfortable, open, and honest about their experiences without added pressures or influences from me or other participants.

Although there were commonalities among the participants' responses, there were also discrepancies which I discussed and gave an example. However, all the participants overwhelmingly expressed the importance of clinicians being equipped with the knowledge and understanding of TIC and being TIC-trained so that care practices can be cohesive across the healthcare continuum. They also discussed the possibility of including TIC education and training in nursing and other healthcare curriculums to better prepare clinical providers to deliver TIC to high-risk individuals and trauma survivors. Chapter five will consist of my interpretation of the findings, research limitations, and recommendations. Chapter five will also include possible implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to explore nurses' perceptions of TIC principles and their experiences with care delivery in patients with psychological trauma. I conducted a qualitative descriptive study and followed Braun and Clarke's (2013) thematic analysis approach to analyze my data. I conducted the study because little was known about nurses' perceptions of TIC or how to effectively care for trauma survivors. My study may help nurses and providers understand nurses' experiences with TIC practices. TIC nurses administer specialized care to trauma survivors and high-risk individuals using a five-step process (safety, choice, collaboration, trustworthiness, and empowerment) to care for patients and avoid retraumatization. There has been an increasing public health problem concerning trauma, and there was limited research that addressed nurses' perceptions and experiences with TIC and care delivery in trauma survivors, particularly survivors of psychological trauma. I interviewed participants from various nursing backgrounds with multiple years of experience. Each participant was trained and knowledgeable about TIC and its principles. The study findings were four main themes: helpful tool, avoiding retraumatization, increased care quality, and education and collaboration.

Interpretation of the Findings

This study confirmed findings from the peer-reviewed literature. I used the TIC theory by Harris and Fallot (2001) as the framework for my research. The theory is based on five principles that help to guide health organizations and providers to administer appropriate, consistent, and adequate TIC: safety, choice, collaboration, trustworthiness,

and empowerment. My study revealed that nurses who are trauma informed or have received TIC training and incorporated its principles in the workplace found it was a helpful and effective tool. The study also showed that TIC-trained nurses do their best to keep trauma survivors and high-risk patients safe and prevent them from experiencing or reliving their trauma despite the risks of trauma exposure to nurses.

TIC-trained nurses included in the study built trusting relationships with their patients and included them in the care delivery process by collaborating with and empowering them. By incorporating TIC principles in care delivery processes, trauma-informed nurses reported increased patient satisfaction between admission and discharge and also witnessed the increased quality of care among trauma survivors. Additionally, the findings showed that more education and training are needed so that all health providers can administer care cohesively, and that TIC education and training should be extended to nursing programs and curriculums backed by research discussed in the literature review.

Theme 1: Helpful Tool

When I began coding the data, words such as “effective,” “helpful,” and “tool” were common among the participants. All of the nurses expressed that they perceived TIC to be very helpful in the health setting, and they found the principles beneficial when they cared for trauma survivors and individuals at risk of experiencing traumatic events. Walsh and Benjamin (2020) used a multidisciplinary team of participants in a subacute mental health unit and found TIC practice helpful and effective among the staff and in care delivery, especially when used daily and consistently. Another study by Palfrey et al.

(2019) showed that nurses, allied health, and other medical personnel found TIC important and helpful. Participants' knowledge, behavior, and confidence improved significantly, while perceived barriers decreased.

Additionally, Hall et al. (2016) found that nurses in the emergency department found TIC helpful and expressed a need for its use in practice. However, the study also showed that the implementation of TIC in an environment such as the emergency department was difficult due to patient turnover, time, and complexity of patient issues. This sentiment was also shared by a participant in the current study who described TIC as helpful but not fully implemented in the emergency department. My study and previous research revealed that TIC principles can be helpful when implemented. However, providers must also have the ability and time to follow through and evaluate patients' and or trauma survivors' responses to treatment, especially in fast-paced and busy health settings such as the emergency department and other heavily trafficked areas.

Isobel and Delgado (2018) found that mental health nurses became more knowledgeable about TIC including implementing its principles in everyday practice after attending a TIC training workshop. The nurses found TIC helpful, and it made them think about practicing differently in terms of incorporating TIC into care delivery practices. Similarly, Bruce et al. (2018) examined the perspectives of a multidisciplinary team that included nurses, physicians, and therapists and found that the participants' views of TIC and TIC implementation in practice were positive and impactful.

Additionally, Truesdale et al. (2019) included participants from several different disciplines including nurses, psychotherapists, and social workers. The study showed that

TIC was effective among trauma survivors of Post Traumatic Stress Disorder and that health providers need TIC training to provide better care services to individuals who have experienced trauma, especially individuals who have experienced PTSD. No matter the professional background of the participants or the research focus in these studies, a general finding was that TIC is helpful in the recognition and treatment of trauma survivors and individuals who are at risk of experiencing trauma. These studies and my study showed that there is an increased need for health providers to be trained in TIC and its guiding principles.

Theme 2: Education and Collaboration

Education and collaboration was the second theme that emerged from the data analysis. The participants discussed the pivotal role TIC education plays in treating individuals who have experienced traumatic events. The nurses explained that TIC education is not only important for the providers but also for the patients because it encourages patients to participate in their care. TIC is not a tool that providers use to tell patients or trauma survivors how to deal with trauma; rather, it is a tool that providers and survivors use simultaneously to recognize and treat trauma. The patient must be a willing participant in the TIC process.

TIC ensures that participants are given choices and are empowered to be responsible parties in their treatment. TIC does not declare that the provider is the sole bearer of its principles. The nurses in my study reported that although it is important to educate patients, it is also important to educate providers so that care processes can be streamlined, collaborative, and focused. The nurses discussed frustration at times because

some but not all providers in the care setting were TIC trained. The participants explained that working with multiple disciplines required the right training, communication, and collaboration. However, because TIC education and training were not widespread, there were gaps in care delivery processes among providers.

Some participants received their TIC training in previous work settings or as interns and used their knowledge and understanding of TIC principles to deliver care. Others received their training at the workplace, but not all providers received TIC training. The participants in my study talked about TIC knowledge and training in the workplace, but they also discussed adding TIC to nursing and other curriculums and training so that every health provider can be prepared to administer TIC to every patient and or trauma survivor in need.

Nadeem et al. (2021) used a pre- and posttest after a TIC workshop and found a significant number of participants improved in knowledge concerning topics such as PTSD and acute stress disorder. In the qualitative portion, however, Nadeem et al. found that participants who conducted assessments among survivors of sexual violence were uncomfortable with the process because they did not feel knowledgeable. The participants discussed an increased need for incorporating trauma training for health care professionals of all backgrounds including medical and postgraduate students.

Similarly, Yang et al. (2019) declared that trauma instruction in nursing education and curriculums is lacking. Trauma programs offered by disciplines other than nursing can provide a foundation upon which nursing education concerning trauma care can be built (Yang et al., 2019). Reeves and Humphreys (2018) found that trauma survivors

valued a trusting and respectful provider–patient relationship and also found that TIC educational programs and training for providers were important to survivors because providers who are TIC trained can collect in-depth and comprehensive trauma histories and perform focused assessments that are conducive to the patient or survivor's trauma and care.

Additionally, Hall et al. (2016) found that after TIC education of the staff from multiple emergency departments, the emergency department nurses became more trauma informed and desired TIC's use in the department. Stokes et al. (2017) also found that most of the nurse participants were not trauma informed and had not received any TIC education or training. Participants viewed TIC as crucial in all care practices and not specific to mental health. The study also revealed that health care leaders should advocate and support more TIC education including nursing curriculums consisting of both theory and practice. The results from these studies support my study's findings that all clinicians should be TIC trained because it may be beneficial for providing quality, collaborative, and cohesive care.

Theme 3: Avoiding Retraumatization

The third theme that emerged was avoiding retraumatization. The participants discussed how they cared for trauma survivors by ensuring the patients did not relive their traumatic experiences during care delivery. Many participants described that they were affected by their patients' traumatic experiences. Some participants experienced trauma while caring for trauma survivors but chose to privately deal with the trauma at work, or they relived the experience at home rather than expose the patient to further

trauma or knowingly retraumatize the patient. The participants understood the implications of retraumatizing survivors and at-risk individuals.

One of the reasons that TIC is important is because it guides caregivers and promotes a responsive and collaborative partnership with the patient while preventing the recurrence of the trauma. My research is supported by previous studies. Walsh and Benjamin (2020) conducted a study with a multidisciplinary staff to incorporate TIC in the practice setting, an in-patient subacute mental health unit. The findings showed that staff working in all health settings and units must understand how trauma affects individuals who have experienced mental health issues.

At its core, TIC practice focuses on the idea that every patient must be approached and treated as if they have experienced a traumatic event because when care providers fail to recognize patients' trauma histories, the trauma survivors may be retraumatized by regular practices on the unit (Walsh & Benjamin, 2020). Stokes et al. (2017) also found that when nurses discussed traumatic experiences with trauma survivors in a mental health inpatient unit, the environment triggered the nursing staff in experiencing retraumatization. Moreover, Hall et al. (2016) found that nurses in the emergency department understood the impact of TIC practice and its role in decreasing retraumatization. The nurses described the implementation of TIC in the emergency department as challenging, but despite the challenges nurses also witnessed the effectiveness of TIC in patient care.

Additionally, O'Dwyer et al. (2019) conducted a study to understand the perceptions and experiences of health providers caring for female survivors of sexual

violence in a mental health inpatient unit. The findings revealed that some providers tried to avoid retraumatizing survivors but that negative attitudes, dismissals, victim blaming, and ignoring reports of sexual violence were some factors that revictimized and further retraumatized trauma survivors. Previous studies support the current study's findings that health care providers try to prevent retraumatizing patients who have experienced traumatic events. Previous research also indicated that although implementation and follow-up of TIC in a fast-paced environment such as the emergency department is challenging, TIC is helpful for delivering trauma-sensitive care to every patient in need.

Theme 4: Increased Care Quality

Increased care quality was the fourth theme to emerge from the data analysis. Many of the participants discussed using TIC and collaborating with other providers to provide adequate care. Participants expressed witnessing increased patient satisfaction during and after care delivery with the use of TIC and discussed how embedding TIC in the plan of care helped to improve their relationships with patients and increased the quality of care. Participants talked about experiencing positive changes in their patients, practices, and behaviors and noticed a difference in the quality of care, especially when TIC practices were administered consistently.

Previous research supports my participants' observations in terms of increased quality of care with the implementation of TIC. Wathen et al. (2021) conducted a study with participants from health and leadership backgrounds after 1 year to 2 years to assess the effectiveness of trauma and violence-informed care education. The findings showed that factors such as active listening, decreased judgment, empathy, and decreased use of

medical jargon correlated with improved care practices, open and trusting relationships, and patient/survivor satisfaction. The study also revealed that educating providers and other staff about trauma care practices can help pivot and de-stigmatize negative mindsets, attitudes, and behaviors.

Similarly, Purkey et al. (2020) found that trauma survivors experienced negativity in the emergency department when they felt stigmatized and/or labeled by clinicians. Patients seeking mental health help felt dismissed by clinicians and felt clinicians were ill-equipped to administer care appropriately. However, survivors felt less anxious and more satisfied with the quality of care, communication, and follow-up concerning medical-related issues by nurses, physicians, and medical residents when they felt heard, understood, and valued.

Additionally, Oral et al. (2020) declared that trauma-informed organizations that incorporate trauma-informed practices in the workplace can increase the quality of care for patients and their loved ones and also improve staff efficiency and health and decrease trauma provocations. Equally important, Ossowski et al. (2015) stated that regardless of whether policy changes concerning TIC occur at the state, federal, or agency level, the quality of care will improve as long as it reveals trauma effects on survivors and supportive networks. These findings support what the participants in my study discussed. TIC practices not only help clinicians to provide trauma-sensitive care, but they also help to increase patient satisfaction and improve the quality of care for patients who have experienced traumatic events.

Limitations of the Study

There were several limitations to the study. First of all, I was limited to a virtual platform (Zoom) for interviews and data collection processes; therefore, I could not gather field notes as I thought and mentioned in chapter one. Furthermore, three nurses chose to participate using the audio option so only seven participants used both audio and video. Secondly, the study was limited to nurses exclusively, and nurses who were trauma-informed and had received the education and training that encompasses TIC (safety, choice, trustworthiness, collaboration, and empowerment). Another limitation of the study was that no licensed practice nurses or advanced-practice nurses such as nurse practitioners or certified nurse anesthetists participated in the process.

Although the study was open to these nursing groups, they did not sign up to be considered or screened before or during recruitment or by the time I reached saturation. Advanced practice nurses may have differences in opinion about TIC and care delivery in patients who have experienced psychological traumatic events. Ensuring trustworthiness was important throughout the research. I focused on the participants' discussions, perceptions, and experiences and used the data to provide meaningful answers to the research questions. I also used the participants' own words to interpret the findings and a journal to reflect on my thoughts and feelings. I avoided personal judgment and prevented implicit and explicit biases from influencing the participants' responses or the study.

Recommendations

It is my recommendation that future research consists of advanced care practitioners from multiple nursing specialties because their perceptions and experiences concerning TIC might differ from the current research findings. Depending on the specialty, organizational, and workplace culture, advanced practitioners might or might not be TIC-trained. Their perceptions and experiences might benefit the organization, staff, and patients; especially where the quality of care, collaboration, recognition, and treatment of trauma survivors are concerned. Furthermore, education, collaboration, TIC impact and usefulness, and preventing re-traumatization were discussed by many of the participants and the findings were supported by previous research as was discussed in chapters two, four, and five of the current study.

I would recommend that future studies include TIC's impact on education and training in nursing and other healthcare and non-medical curriculums. It might better equip the individuals as future health and non-health providers with the right tools and resources to recognize and assist others in need; particularly trauma survivors and individuals at risk of experiencing traumatic events. Lastly, I would recommend that organizations and organizational cultures be more open and supportive of TIC, and consistently implement and evaluate policies and practices in the work setting to improve and increase the quality of care.

Implications

The current study can potentially impact positive social change by health organizational leaders using its findings as a foundational tool, upon which workplace

policies and procedures can be altered to incorporate TIC training and education for all members of the care team. This includes physicians, nurses, nursing assistants, and students. TIC training and education must also include case managers, social workers, and physical and occupational therapists because they also provide care and interact with patients and their families.

The participants expressed how impactful TIC is in the care delivery process of trauma survivors, but more importantly, the need for more training and education that is all-encompassing in adequately providing patient-focused and sensitive care, increasing patient satisfaction, and preventing re-traumatization. I used Harris and Fallot's (2001) TIC theoretical framework to guide my research. I am not a TIC-trained nurse and therefore could not use any personal TIC experiences to influence the participants' responses or research process. However, I was able to recruit several TIC-trained registered nurses with multiple nursing backgrounds and experiences.

The participants provided insight into an area of concern which includes mental health but specifically psychological trauma. Discussions about their perceptions and experiences concerning TIC in patients with psychological trauma can potentially impact positive social change by helping to decrease and or de-stigmatize perceptions about trauma and its effects on survivors and individuals at risk of experiencing traumatic events. My recommendation for practice is that multidisciplinary clinical teams recognize, assess, and collaborate to treat and provide respectful and consistent quality care to patients and or trauma survivors and prevent re-traumatization. These actions might also enable trauma survivors to build more trusting relationships with caregivers

and clinicians, expand communication, and provide more comprehensive trauma histories.

Conclusion

Mental health needs are increasing and becoming a serious and focused area of concern. As this happens, so is the need for more trained mental health personnel including physicians, nurses, case managers, social workers, and more. Correspondingly, Trauma, also a form of mental health, can be devastating and may affect an individual, an entire family, and even a population. Some individuals may not know how to deal with the challenges associated with trauma. TIC offers a means through which providers, survivors, and patients can work together for treatment purposes and help to restore mental health and balance.

Clinical providers, especially nurses, have a larger platform where they can assist individuals in need of mental health help. Nurses are equipped with several tools (empathy, patience, compassion, advocacy, and caring) that they can use to establish trusting relationships with their patients and families. They (nurses) frequently use these tools to provide patient-centered, respectful, and dignified care holistically. However, not all clinicians are knowledgeable about or are trauma-informed. Therefore, there may be many missed or neglected opportunities to recognize patients at risk or trauma survivors and collect pertinent information and medical histories to provide the appropriate help that they might be lacking.

I interviewed ten TIC nurse participants from various nursing backgrounds and with multiple years of nursing experience for this study. I conducted one-on-one

interviews with each participant, coded, and analyzed the data using Braun and Clarke's (2006) thematic analysis process. Four themes emerged from the findings that were significant in answering the research questions: Helpful tool, education and collaboration, avoiding re-traumatization, and increased care quality. The themes and findings from the study were supported by previous research discussed throughout the literature review, chapters four, and five. A major finding from the study, also supported by previous research, revealed that it is crucial for healthcare settings to implement TIC principles, develop policies, and ensure that all clinicians, regardless of background and experience, be TIC-educated and trained to deliver care appropriately and adequately.

Another finding of the current study supported strongly by previous research consists of incorporating TIC education in nursing and other curriculums so that students will have foundational knowledge and be able to recognize and provide necessary and collaborative trauma care. Moreover, by incorporating TIC teaching and training into educational curriculums, providers will be well-equipped with the tools that will enable them to provide exceptional quality care. Additionally, TIC education might help to increase patient safety, support, and satisfaction, and improve provider-patient relationships. It might also encourage newer TIC policies, and most importantly, enable providers to consistently deliver effective and efficient care to patients and trauma survivors; particularly survivors of psychological trauma, and ultimately improve patient care outcomes.

References

Agency for Healthcare Research and Quality. (2016). *Trauma-informed care*. https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/trauma.html

American Psychiatric Association. (2021). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness

American Psychological Association. (2020). *Helping people through trauma-informed care*. https://www.apa.org/members/content/trauma-informed-series

Amin, M., Norgaard, L., Cavaco, A., Witry, M., Hillman, L., Cernasev, A., & Desselle, S. (2020). Establishing trustworthiness and authenticity in qualitative pharmacy research. *Research in Social and Administrative Pharmacy*, *16*(10), 1472-1482. https://doi.org/10.1016j.sapharm.2020.02.005

Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). A systematic review of organization-wide, trauma□informed care models in out□of□home care (OoHC) settings. *Health & Social Care in the Community*, *27*(3), 1-14. https://doi.org/10.1111/hsc.12621

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. SAGE.

Bruce, M., Kassam-Adams, N., Rogers, M., Anderson, K., Sluys, K., & Richmond, T. (2018). Trauma providers' knowledge, views, and practice of trauma-informed care. *Journal of Trauma Nursing*, *2*(2), 131-138.https://doi.org/10.1097/JTN.0000000000000356

Cannon, L. M., Coolidge, E. M., LeGierse, J., Moskowitz, Y., Buckley, C., Chapin, E., Warren, M., & Kuzma, E. K. (2020, February). Trauma-informed education: Creating and pilot testing a nursing curriculum on trauma-informed care. *Nurse Education Today*, *84*(1), 1-8. https://doi.org/10.1016/j.nedt.2019.104256

Centers for Disease Control and Prevention. (2018, January). *Learn about mental health*. https://www.cdc.gov/mentalhealth/learn/index.htm

Centers for Disease Control and Prevention. (2020, September). *Infographic: 6 guiding principles to a trauma-informed approach*. https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

Creswell, J. W., & Creswell, J. D. (2020). *Research design: Qualitative, quantitative, and mixed method approaches* (5th ed.). SAGE.

Dilks, S. (2020). Psychiatric-mental health nurses leading a culture of safety. *Journal of the American Psychiatric Nurses Association*, *26*(2), 216–218. https://doi.org/10.1177/1078390320907094

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477. https://doi.org/10.1002/jcop.20063

Gigliotti, R., Vardaman, J., Marshall, D., & Gonzalez, K. (2019). The role of perceived organizational support in individual change readiness. *Journal of Change Management*, *19*(2), 86-100.

Green, B., Saunders, P., Power, E., Dass-Brailsford, P., & Schelbert, K. (2016). Trauma-informed medical care: Patient response to a primary care provider communication training. *Journal of Loss & Trauma*, *21*(2), 147–159. https://doi.org/10.1111/phn.12883

Hall, A., McKenna, B., Dearie, V., Maguire, T., Charleston, R., & Furness, T. (2016). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: A pilot study. *BMC Nursing*, *15*(21), 1–8. https://doi.org/10.1186/s12912-016-0141-y

Harris, M., & Fallot, R. D. (2001). *Using trauma theory to design service systems: New directions for mental health services*. Jossey-Bass.

Healthy People 2020. (2020, July). *Mental health and mental disorders*. https://wayback.archive-it.org/5774/20220413203325/https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

Inscoe, A. B., Donisch, A., Cheek, S., Goldston, D. B., & Asarnow, J. R. (2021). Trauma-informed care for youth suicide prevention: A qualitative analysis of caregivers' perspectives. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1-9. https://doi.org/10.1037/tra0001054

Isobel, S., & Delgado, C. (2018). Safe and collaborative communication skills: A step towards mental health nurses implementing trauma informed care. *Archives of Psychiatric Nursing*, *32*(2), 291-329. https://doi.org/10.1016/j.apnu.2017.11.017

Jankowski, K., Schifferdecker, K., Butcher, R., Foster-Johnson, L., & Barnett, E. (2019). Effectiveness of a trauma-informed care initiative in a state child welfare system: A randomized study. *Child Maltreatment*, *24*(1), 86–97. https://doi.org/10.1177/1077559518796336

Kassam-Adams, N., Rzucidlo, S., Campbell, M., Bonifacio, E., Slouf, K., Schneider, S., McKenna, C., Hanson, C., & Grather, D. (2015). Nurses' views and current practice of Trauma-Informed Pediatric Nursing Care. *Journal of Pediatric Nursing, 30*(3), 478-484. https://doi:10.1016/j.pedn.2014.11.008

Kessler, J. M. (2016). Trauma-informed day services for individuals with intellectual/developmental disabilities: exploring staff understanding and perception within an innovative programme. Journal of Applied Research in Intellectual Disabilities, 29(5), 481-492. https://doi:10.1111/jar.12197

Lantz, A. J. (2020). Pediatric Accidental Trauma: Screening and reducing psychological impact. *Pediatric Nursing, 46*(3), 111-114.

Lotzin, A., Buth, S., Sehner, S., Hiller, P., Martens, M., Read, J., Schafer, I., Pawils, S., Metzner, F., & Harter, M. (2018). 'Learning how to ask': Effectiveness of a training for trauma inquiry and response in substance use disorder healthcare professionals. Psychological Trauma: Theory, Research, Practice, and Policy, 10(2), 229-238. https://doi:10.1037/tra0000269

Maguire, D., & Taylor, J. (2019). A systematic review on implementing education and training on Trauma-Informed Care to nurses in Forensic Mental Health Settings. Journal of Forensic Nursing, 15(4), 242-249. https://doi:10.1097/JFN.0000000000000262

Marvin, A., & Volino Robinson, R. (2018). Implementing trauma-informed care at a non-profit human service agency in Alaska: Assessing knowledge, attitudes, and readiness for change. Journal of Evidence-Informed Social Work, 15(5), 550-563. https://doi:10.1080/23761407.2018.1489324

McEvedy, S., Maguire, T., Furness, T., & McKenna, B. (2017). Sensory modulation and trauma-informed-care knowledge transfer and translation in mental health services in Victoria: Evaluation of a statewide train-the-trainer intervention. Nurse Education in Practice, 25, 36-42. https://doi:10.1016/j.nepr.2017.04.012

Menschner, C., & Maul, A. (2016, April). Key ingredients for successful trauma informed care implementation. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Muslieu, E., Vasic, S., Clausson, E., & Garmy, P. (2019). School nurses' experiences working with unaccompanied refugee children and adolescents: A Qualitative Study. SAGE Open Nursing, 5, 1-8. https://doi:10.1177/2377960819843713

Nadeem, T., Asad, N., Hamid, S., Mahr, F., Baig, K., & Pirani, S. (2021). A need for trauma informed care curriculum: Experiences from Pakistan. *Asian Journal of Psychiatry*, 63. https://doi:10.1016/j.ajp.2021.102791

Neuendorf, K. (2019). *Applied research methods for applied psychology*. Routledge.

O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2019). Health professionals' experiences of providing care for women survivors of sexual violence inpsychiatric inpatient units. *BMC Health Services Research, 19*(1), 1-9.

Oral, R., Coohey, C., Zarei, K., Conrad, A., Nielsen, A., Wibbenmeyer, L., Segal, R., Wojciak, A. S., Jennissen, C., & Peek-Asa, C. (2020). Nationwide efforts for trauma-informed care implementation and workforce development in healthcare and related fields: a systematic review. *The Turkish journal of pediatrics, 62*(6), 906-920. https://doi:10.24953/turkjped.2020.06.002

Ossowski, J. D., Rosenzweig, J. M., Chudyk, S., Homan, J., Jetmalani, A. N., E, M., Kinniburgh, K. M., Funchess, M., Cady, D., Lulow, E. C., Flatow, R. B., Blake, M., Huang, L. N., & Goldman, J. H. (2015). Trauma-informed Care. *Focal Point, 29*, 1-40. https://www.pathwaysrtc.pdx.edu

Palfrey, N., Reay, R., Aplin, V., Cubis, J., McAndrew, V., Riordan, D., & Raphael, B. (2019). Achieving service change through the implementation of a Trauma-Informed Care Training Program within a mental health service. *Community Mental Health Journal, 55*(3), 467-475. https://doi:10.1007/s10597-018-0272-6

Patton, M. Q. (2015). Qualitative Research & Evaluation Methods. Thousand Oaks, CA: SAGE.   Purkey, E., Davison, C., MacKenzie, M., Beckett, T., Korpal, D., Soucie, K., & Bartels, S. (2020). Experience of emergency department use among persons with a history of adverse childhood experiences. *BMC Health Services Research, 20*(1), 1-10. https://doi:10.1186/s12913-020-05291-6

Reeves, E. A., & Humphreys, J. C. (2018). Describing the healthcare experiences and strategies of women survivors of violence. *Journal of Clinical Nursing*, 27, 1170-1182. https://doi:10.1111/jocn.14152

Robey, N., Margolies, S., Sutherland, L., Rupp, C., Black, C., Hill, T., & Baker, C. N. (2021). Understanding staff- and system-level contextual factors relevant to trauma-informed care implementation. *Psychological Trauma: Theory, Research, Practice & Policy, 13*(2), 249-257. https://doi:10.1037/tra0000948

Shamaskin-Garroway, A., McLaughlin, E., Quinn, N., & Buono, F. (2020). Trauma-informed primary care for medical residents. *Clinical Teacher, 17*(2), 200-205. https://doi:10.1111/tct.13082

Stevens, N., Ziadni, M., Lillis, T., Gerhart, J., Baker, C., & Hobfoll, S. (2019). Perceived lack of training moderates relationship between healthcare providers' personality and sense of efficacy in trauma-informed care. Anxiety, Stress, & Coping, 32(6), 679-693. https://doi:10.1080/10615806.2019.1645835

Stokes, Y., Jacob, J., Gifford, W., Squires, J., & Vandyk, A. (2017). Exploring nurses' knowledge and experiences related to trauma-informed care. *Global Qualitative Nursing Research*, 4(1), 1-10. https://doi:10.1177/2333393617734510

Substance Abuse and Mental Health Services Administration. (2014, July). SAMHSA's concept of trauma and guidance for a trauma-informed approach. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Substance Abuse and Mental Health Services Administration. (2022). Trauma and violence. https://www.samhsa.gov/trauma-violence

Sundborg, S. (2019). Knowledge, principal support, self-efficacy, and beliefs predict commitment to trauma-informed care. Psychological Trauma: Theory, Research, Practice & Policy, 11(2), 224-231. https://doi:10.1037/tra0000411

The National Child Traumatic Stress Network. (n.d.). *About child trauma*. https://www.nctsn.org/what-is-child-trauma/about-child-trauma

Tiwari, A., Smith, S., Wekerle, C., Kimber, M., Jack, S., MacMillan, H., & Gonzalez, A. (2021). Trauma services for youth victims of sexual abuse- does one size fit all? A qualitative study among service providers in Ontario, Canada. *Child Abuse & Neglect, 112*, 1-12. https://doi:10.1016/j.chiabu.2020.104903

Truesdale, M., Brown, M., Taggart, L., Bradley, A., Paterson, D., Sirisena, C., Walley, R., & Karatzias, T. (2019). Trauma□informed care: A qualitative study exploring the views and experiences of professionals in specialist health services for adults with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 32*(6), 1437-1445. https://doi:10.1111/jar.12634

University of Pennsylvania. (n.d.). *About Psychological Trauma*. https://www.med.upenn.edu/traumaresponse/trauma.html

Vincenti, S., Grech, P., & Scerri, J. (2021). Psychiatric hospital nurses' attitudes towards trauma-informed care. Journal of Psychiatric and Mental Health Nursing, 1-11. https://doi:10.1111/jpm.12747

Walsh, K., & Benjamin, R. (2020). Using participatory methods to engage multidisciplinary clinical staff in the embedding of trauma-informed care and practice principles in a Sub-Acute Mental Health Inpatient Unit. *Journal of Multidisciplinary Healthcare*, 13, 485-494. https://doi:10.2147/JMDH.S240240

Wathen, N. C., MacGregor, J. C., & Beyrem, S. (2021). Impacts of trauma- and violence-informed care education: A mixed method follow-up evaluation with health & social service professionals. *Public Health Nursing, 38*(4), 645-654. https://doi:10.1111/phn.12883

Wheeler, K. (2018, January). A call for trauma competencies in nursing education. Journal of the American Psychiatric Nurses Association, 24(1), 20-22. https://doi:10.1177/1078390317745080

Wilson, A., Hurley, J., Hutchinson, M., & Lakeman, R. (2021). "Can mental health nurses working in acute mental health units really be trauma-informed? An integrative review of the literature. Journal of Psychiatric and Mental Health Nursing, 1-25. https://doi:10.1111/jpm.12717

Yang, L., Cannon, L. M., Coolidge, E. M., Darling-Fisher, C. S., Pardee, M., & Kuzma, E. K. (2019). Current state of trauma-informed education in the health sciences: Lessons for Nursing. *Journal of Nursing Education, 58*(2), 93-101

Appendix A: Recruitment Flyer for Nurse Participants

EXTRA!!! EXTRA!!! PLEASE READBELOW!!
Nurse Volunteers

Wanted: Nurse Volunteers for a Research Study Exploring Nurses' Experiences with Trauma-Informed Care (TIC) and Delivery of Care in Patients with Psychological Trauma.If you are a nurse (LPN, LVN, RN, Nurse Case Manager, Nurse Educator, or Advanced Practice Nurse such as NP or Clinical Nurse Specialist) and are trained in Trauma-Informed Care (TIC), currently use TIC in your workplace, or have previously used TIC working with patients who have experienced traumatic events, or trauma survivors, you are needed and invited to participate in this study!!!

Your experiences with TIC practices and experiences with care delivery will provide significant insight into the effectiveness of TIC principles and practices in the workplace from a nurse's perspective because little is known about nurses' experiences in particular with TIC in patients with psychological trauma.

The interview session will be held via Zoom and will last between 15 and 60 minutes, and you will be allowed to read the transcribed document for accuracy. This study is needed for academic purposes only and is not associated with any organization's policies, programs, or goals. **This study is completely confidential! Your name or identity will not be revealed!** As a research participant, you will receive a $20.00 electronic gift card after the voluntary completion of your interview session!

If you are interested and would like more information about the study, please call and or email: Ade Vinton MBA, MSN, RN (Doctoral Student at Walden University) (919) 247-9911, ade.vinton@waldenu.edu

Appendix B: Participant Screening Guide

RN Participant #Date: Hello and thank you for your interest and possible participation in my research. My name is Ade Vinton. I am a Walden University doctoral student. My purpose for conducting this study is to explore nurses' experiences specifically, with trauma-informed care, and delivery of care in patients with psychological trauma.

a.) Are you a nurse? **Yes/No**

b.) Are you trained in trauma-informed care practices? **Yes/No**

c.) Do you currently use TIC principles in the workplace? **Yes/No**

d.) If you do not currently use TIC principles in your workplace, have you previously used TIC principles? **Yes/No**

e.) Do you object to being video/audio recorded during the interview? **Yes/No**

You will not be identified, and no information that can identify you will be used in the study. Furthermore, any information identifying you will be destroyed to avoid any unethical practices.

f.) Do you speak and read English? **Yes/No**

Appendix C: Interview Questions

1.) What is your nursing title?

2.) How long have you been a nurse?

3.) How long have you been in your current role?

4.) Do you currently use TIC strategies in the workplace?

5.) What is your perception of trauma-informed care (TIC) principles?

6.) What is your experience with care delivery using TIC strategies in patients with psychological trauma?

7.) What effect does TIC have on your care practices?

8.) Does caring for individuals who have experienced traumatic events affect you?

9.) Because you are trauma-informed, how is the care you provide different from nurses who are not trauma-informed?

Appendix D: Examples of Themes and Corresponding Quotes

Theme 1: Helpful Tool "I also perceive it to be effective in the management of patients. TIC is the most appropriate approach. The strategies are actually the best approaches designed in the effective care of traumatic patients." "It has handsomely improved patient experiences and outcomes, which is the ultimate goal of any nurse." "It is the best tool in providing care to traumatic patients. So it really guides us as nurses to actually make sure that we meet the expectations of the clients when taking care of or while they are receiving our care." "It's a good approach in management of patients with trauma." "The best nursing management tool towards management of people with conditions." "Based on the principle of let's say safety and collaboration, basically I have a positive perception towards the principles because they ensure like the clients with trauma, that is they are taken care of well." "It's been quite assistive, getting to talk to people or getting into analyze people based in trauma-informed care. And over the years, I've been able to relate more people. And this has been helpful for me."

Theme 2: Education and Collaboration

"It really needs much awareness, care providers actually really need to be trained about the same because they are not yet." "The implementation part of it is what actually most of the care providers have yet to actually implement." "I don't know if it's because maybe they are not yet educated more about it" "In care, we usually collaborate; not only nurses that are attached in the caring of the patients, so this skill really needs to be all around the healthcare providers, regardless of opinion; be it a clinician, be it anyone

else". "It's maybe how we can be able to train more nurses, providers, on this informed care action through maybe workshops so that now they can be able to help clients." "The care's most satisfying to patients than the other care that my colleagues provide, and that's why we can always try to actually make sure that almost all health care providers emulate this trauma-informed care."

Theme 3: Avoiding Re-traumatization

"Sometimes their experiences can really move you and feel down but I try to be empathetic rather than sympathetic." "This actually sometimes loses the objective now of the therapy itself, because now you stop caring for the patient and you start crying. But most of the time we actually try to control ourselves; now, specifically me, in this case, to breathe and then continue emphasis on actually helping this client out rather than sympathizing." "And you really feel like this patient really needs a lot than you can really provide." "Sometimes you can really feel like you've not provided enough because sometimes the client tells you, you've not really helped me the way I actually expected. So that's the other challenge." "Sometimes some experiences can be really scary and touching that you really feel it's not easy for the clients that you've taken care of." The more I really experience, the more experience I have in handling such issues." "It doesn't affect me that much. I may be emotional or calm. I may have empathy to the client. So it may affect my delivery of care." "It may be easy for you to like respond to the trauma the client is going through. And it may be for you also to like put measures to prevent, that is reoccurrence of the trauma events." "You know, after you leave the shift you think about a little bit, but you find you kind of get used to it and stop trying to, like, separate

everything.” “It does affect me sometimes. You know, different people have different traumas that they have gone through so when they tell their story, you can really see the emotional part of you, so you feel connected to this patient.” “And if something happens, it hurts you, too. So what I do is, I feel, I make the patient feel comfortable first you know, if I react, and she or he sees how I’m reacting, it might affect him or her. So, I keep the reactions to myself and feel make the patient comfortable. And afterward, I may now start thinking about everything”. “The stress affects me”.

Theme 4: Increased Care Quality

“The care I provide is unique and the client satisfaction is higher than the non-informed.” “I actually empathized with them and the turnout actually is very impressive, because those patients actually end up recovering better and coping up with life as they used to before.” “It’s maybe how we can be able to train more nurses, providers, on this informed care action through maybe workshops, so that now they can be able to now help clients.” “It’s unique and more satisfying; it’s a good technique or tool that we should really implement that will really transition this kind of care, that is kind of good.” “With the care you are able to give them, to your patient, the patient will see the care you are giving and begin to earn your trust.” “It is really good to, to understand the concept of TIC. And for those who have been privileged to get proper training on how to handle situations like this, it has been a wonderful turn of events.” “And for me, it’s it’s a good move to educate other healthcare professionals on the TIC.”