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Trauma-Informed Care

Positive and Adverse Childhood Experiences and WOC Nursing: An Integrative Review

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INTRODUCTION

Healthcare providers are gaining awareness that exposure to adverse childhood experiences (ACEs), defined as negative life events occurring before age 18 years, causes biological changes that persist through adulthood, contributing to unhealthy risk behaviors and the leading causes of death in the United States.[1-3] Exposure to ACEs generates toxic stress, described as chronic and pervasive stress that overwhelms coping mechanisms and shifts the body's stress response from adaptive to maladaptive. These maladaptive mechanisms influence brain development and genetic expression, impacting immune and endocrine system function as well as attachment style, self-image, and the ability to self- and co-regulate.[4-6] Twenty-plus years of diverse population ACE studies internationally have demonstrated that ACEs are prevalent and highly interrelated, with ACE scores of 4 or more having a dose-response relationship with the leading causes of death; an ACE score of 6 or more puts a person at risk of dying 20 years younger when compared to a person with an ACE score of zero.[1-3] Globally, the association of childhood trauma with adverse health consequences has been recognized since the early 1900s, having been examined in both developed and undeveloped countries.[7] Ongoing research is recognizing expanded categories of ACEs to include community and climate as well as household aspects (see Figure 1).[8,9]

Recent data on positive childhood experiences (PCEs) indicate a higher ratio of PCEs to ACEs mitigates the impact of childhood adversity on health outcomes.[10-13] For example, study participants with an ACE score of 4 or less in the presence of a high PCEs score had no increased risk of developing leading causes of death, while those with high ACE scores had reduced risk compared to participants without PCEs.[10] Examples of PCEs include at least one caregiver with whom one felt safe; the ability to talk to family about feelings; having a sense of belonging in high school; feeling safe and supported by friends; beliefs that gave one comfort; good neighbors (at least 2 nonparent adults who care); and a predictable home routine.[10,13] Researchers postulate that the presence of PCEs increases the ability to manage stress, thereby decreasing allostatic load (cumulative burden of chronic stress).[14] Trauma-informed experts in the United States are increasingly referring to PCEs and ACEs as PACEs; this term is designed to acknowledge that lived experiences, both good and bad, influence health outcomes across the lifespan.[15]

As our understanding of PACEs has evolved, so has the quest to find evidence-based primary, secondary, and tertiary interventions to improve health indices. Trauma-informed care models have been applied across disciplines that have been shown to improve multiple patient outcomes.[16] This integrative review of literature seeks to answer the question: How can trauma-informed care (TIC) be applied to the discipline of WOC nursing? In addition to providing context for ACEs and PCEs, trauma-informed care as an appropriate intervention is explored and explained with implications for WOC nursing.

METHODS

A literature search was conducted by the authors in 3 databases for WOC-related foci: CINAHL (C), Medline (M), and PubMed (P). For the years 2009 to 2022 and in English language articles, the searches yielded the following number of articles for search term combinations, respectively: adverse childhood experiences or ACEs or child abuse or child neglect, and wounds or wound development or wounding and adults or adult or aged or elderly (C = 28; M = 97; P = 57); positive childhood experiences, wounds, and adults (C = 12; M = 12; P = 0). The same ACEs terms were applied to gastrointestinal (GI) system (C = 7; M = 49; P = 7) and genitourinary (GU) system (C = 0; M = 11; P = 4). Trauma-informed care models and WOC care were searched (C = 0; M = 0; P = 14). Abstracts were reviewed. Duplicates, articles not pertinent to the topics, or with wrong age ranges, were removed. Seminal articles outside of year delimitations were used selectively. A total of 35 articles were selected for use.

Adverse Childhood Experiences in Persons With Wounds, Gastrointestinal, and Genitourinary Disorders

Children exposed to violence and injury are at increased risk of experiencing similar experiences later in life.[17] An increased risk for injury and suicide attempts are 2 of the health outcomes strongly correlated with ACE exposure.[1,3] Bryan and Beitz[18] identified an overlap between risk factors generated by

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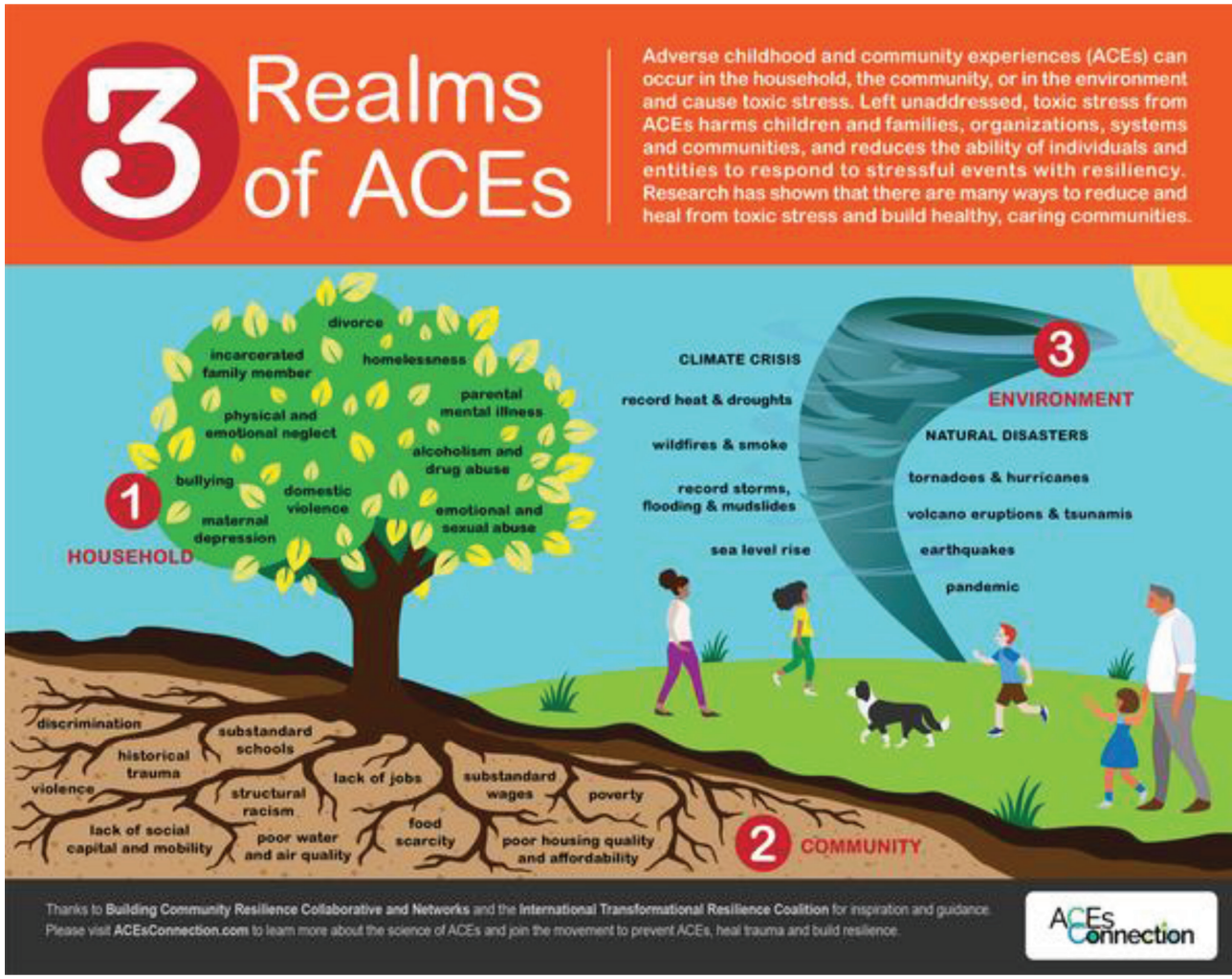

Figure 1. Three realms of adverse childhood experiences. Public domain from pacesconnection.com.

ACE exposure with risk factors for wounding and poor wound healing (Figure 2). ACEs also play a substantive role in the development of GI and GU disorders (Figure 3).[19]

Adverse childhood experiences also play a role in adult GI disorders such as irritable bowel syndromes, inflammatory bowel disease, and colorectal cancer. Clinicians are usually aware that genetics play a role in disease susceptibility, but ACE research supports that lived experiences can increase risk via *epigenetic* influences on the immune system and GI microbiome.[18,19] Epigenetic influences are defined as the effects of behaviors and environment on genetic expression.

For continence care, ACEs are also associated with multiple GU disorders in a dose-response manner, and selected factors such socioeconomic status, race, gender, identity, and physiologic state (eg, obesity) confer even higher risk. Associations are noted for such disorders as pelvic pain syndrome, perimenstrual pain, pregnancy pain, endometriosis, and severity of gynecological symptoms.[19] Based on this literature review,

Figure 2. Overlap between adverse childhood experience and wound healing risk factors.[18]

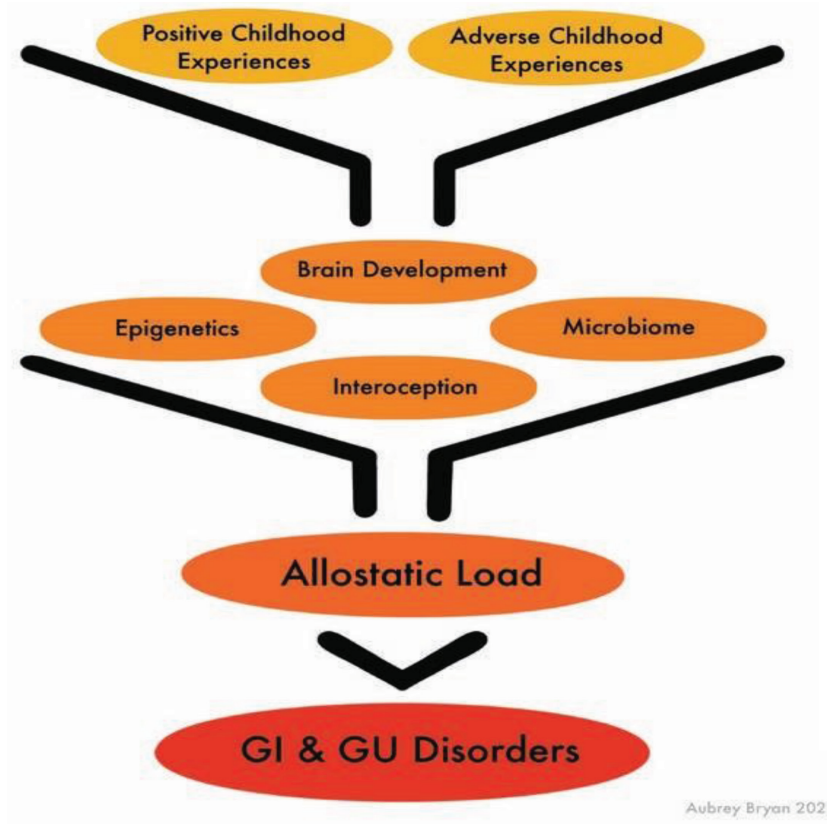

Figure 3. Contributors to allostatic load influence on gastrointestinal and genitourinary function.[19]

we believe this is the first article to consider PCEs in relation to WOC disorders.

Trauma-Informed Care

Trauma-informed care (TIC) is a patient-centered approach emphasizing screening for and recognition of trauma and realizing its effects on health outcomes.[20,21] It evolved organically, often at the grassroots level, in both private and public settings. Early published models include Bloom's Sanctuary Model[22] and the Missouri Model of Trauma-Informed Care.[23] At the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed its trauma-informed model in 2015, making many resources available.[24] Essential principles guiding the use of TIC include: (1) awareness that trauma effects are pervasive; (2) the effects are lifelong; (3) trauma affects both clinicians and patients; (4) healing or amelioration of these negative effects is possible; and (5) resilience can be nurtured. Some authors suggest that TIC should be universally practiced; this assertion is based on a presumption that all humans are affected in some way by childhood trauma.[15,25,26] The SAMHSA identified 4 main points defining TIC for clinicians (Table).[24,27]

The Centers for Disease Control and Prevention[28] and others[29] note SAMHSA's 6 core principles of care when informing TIC. They are safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. The challenge to clinicians underlying these characteristics and principles is how to interpret and implement TIC in the real world.

Leitch[25] notes the occurrence of unintended consequences of TIC when applying principles of ACEs to clinical care such as excessive attention to the ACEs as compared to PCEs. Focusing solely on ACEs, problems and risks and omitting resilience and protective factors, past and present, gives a lopsided view of patients. She notes the need to ask strength-based questions of patients to get a fuller picture. She also notes ethical issues related to possible retraumatizing persons when asked about trauma-specific data. Challenges in relationship and manageability will likely occur in vulnerable individuals. Many childhood trauma survivors have relationship difficulties including those formed with healthcare professionals. Trust and safety should be slowly built and maintained and not threaten either patients or providers. Finally, TIC must be enacted in understanding the mind-body system. When integrated with skill and knowledge, TIC moves ACE science from information

TABLE.
Substance Abuse and Mental Health Services Administration 4 Main Points Informing Trauma-Informed Care for Clinicians

Realizing	Trauma has a widespread impact on individuals, families, groups, organizations, and communities that requires an understanding of pathways to recovery
Recognizing	Signs and symptoms of trauma in clients (patients), staff, providers, and others in the system
Responding	Integrating of trauma knowledge into policies, practices, and programs
Resisting	Avoiding retraumatization

gathering to action through promoting patient self-regulation skills. Specifically, the clinician is challenged to move from questioning promoting dysregulation to queries promoting calm and resilience.

Trauma-informed care is not just information about the concept and processes. It also requires patients and providers to modulate their own reactivity. Specifically, providers have experienced ACEs and therefore must develop skills and knowledge to promote resilience in themselves and for their patients. A need exists to understand and use the autonomic nervous system (sympathetic vs parasympathetic) to get into the "resilient zone" where flexible, adaptable, prosocial behaviors are supported.[25,30] Strauch and colleagues[31] caution that an ACE focus cannot replace the need for critical communication in primary and other care settings. The lack of ACE information in the electronic medical record (EMR) may be hampering communication about childhood adversity because there is no reminder or alert to start the conversation.

Kameg and Fradkin[21] note that ACEs also affect inexperienced clinicians. They discuss ACEs in nursing students and the need for self-awareness and resilience training and development of competencies for self-care, managing stress, and examining one's attitudes, beliefs, values, and biases early in one's career. They emphasize the need for young clinicians to identify risks that nurses and other providers can experience while working with ACEs-affected individuals.

Oral and coworkers[32] stratify TIC based on stages of prevention. Programs that prevent childhood trauma promote family stability and teach positive and effective parenting are crucial in primary prevention of ACEs. Programs that intervene with families experiencing violence and abuse are foundational to secondary prevention of ACEs. Trauma-informed care can be used to identify and immediately intervene with ACEs. Finally, treating and reducing long-term consequence of ACEs is a cornerstone of tertiary prevention of ACEs such as integrating TIC-informed practices in management of chronic illnesses. Programs can also be developed to identify and reduce risky behaviors associated with ACEs.

Trauma-informed care is so crucial to quality patient care several authors have described it uniquely. Schimmels and Cunningham[33] call TIC a form of cardiopulmonary resuscitation based on its potential to promote purposeful wellness. Others[25,26] have called TIC part of universal precautions promoting optimal blending of mental health into medical/physical health.[27]

Shifting Organizations to Trauma-Informed Care

Machtinger and coworkers[34] report their experience of integrating trauma-informed primary care (TIPC) into practice. Aspirational in nature, they recommend beginning with incremental element implementation such as basic education for every member of the practice (from front desk through to the examination room). The TIPC model they developed addresses environment, screening, and response built on a foundation of trauma-informed values, robust partnerships, clinic champions, support for providers, and ongoing monitoring and evaluation. "At its core, TIPC is good patient-centered care."[34(p196)] We recommend applying their insights to other care settings.

Menschner and Maul[35] share key ingredients to successful TIC implementation. Critical to success is shifting organizational culture to trauma-informed thinking through clear communication about the transformation process, including the patient voice as trauma-impacted stakeholder, developing policies that address secondary traumatic stress in staff, creating a physically and emotionally safe environment, and hiring a trauma-informed workforce.

As TIC evolves, psychometrically sound measurement tools are increasingly needed to evaluate the extent of an organization's awareness of TIC and effectiveness in implementing TIC-related interventions. Champine and cowrokers,[36] conducted a systematic review of TIC articles and identified 49 systems-based measures. Nevertheless, they also identified disparities in definitions and measurements that require further study. Baker and colleagues[37] published the first psychometrically valid measure of TIC, the Attitudes Related to Trauma-Informed Care Scale; this instrument measures attitudes, not behaviors.

Trauma-informed care is based on the notion that trauma-impacted individuals can heal because they can change. Patients are not responsible for things that happened to them when they were children. Rather, affected persons cope as well as they are able; unfortunately, given the paucity of TIC-informed interventions promoting resilience, they often adapt less effective coping mechanisms. The positive message of possible healing at any time in the lifespan is powerful. For example, research supports that religiosity can help moderate ACEs in middle and older age.[38] However equally important is the fact the past trauma must be shared; trauma that is not named cannot be transformed.

Trauma-Informed Care in WOC Nursing

Paradigm Shifts

The first step every organization (administration, staff, and providers such as WOC nurses) must take is to screen themselves for both ACEs and PCEs. This task is fundamental because it disrupts concepts of "us versus them" philosophy based on misconceptions that patients but not clinicians are affected by ACEs.[39] A brief introduction to TIC is provided, followed by reporting of ACE and PCE scores through anonymous group screening (using anonymized polling technology). The outcome of this paradigm shift is to move TIC from an us versus them conceptual framework to a "we and us" framework that decreases the risk of TIC becoming a fad, along with inappropriate use of ACE scores.

The second step is to shift from "what's wrong with you," to "what happened to you," when considering health risk behaviors and outcomes.[22] This shift places the patient in the center of a supportive healthcare team and providing insights that often for interventions or next steps.[15] This concept is consistent with our traditional belief that the WOC nursing care focuses on the whole patient rather than the disease, disease or wound driving them to seek care.[18,19]

The third paradigm shift is to realize resilience overcomes ACEs, and that naming "what got you through it (PCEs)" allows patients to affirm their strengths. Resilience varies by genetic predisposition and life experience; nevertheless, it can be learned and strengthened across the lifespan and WOC nurses can work with nursing staff and other providers to elicit patient-perceived strengths.[40]

Screening

To screen or not to screen individuals for ACEs is hotly debated.[41-45] The ACE survey was developed for epidemiological research, not for individual risk assessment (Box 1). As seminal

BOX 1.

The Adverse Childhood Experiences Survey[a]

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___ If yes, enter 1 __
2. Did a parent or other adult in the household often or very often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___ If yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever … Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___ If yes, enter 1 __
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___ If yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___ If yes, enter 1 __
6. Were your parents ever separated or divorced?
   No___ If yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___ If yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___ If yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No___ If yes, enter 1 __
10. Did a household member go to prison?
    No___ If yes, enter 1 __

Now add up your "yes" answers: _ This is your ACE score

[a]From https://acestoohigh.com/got-your-ace-score/; public domain document.

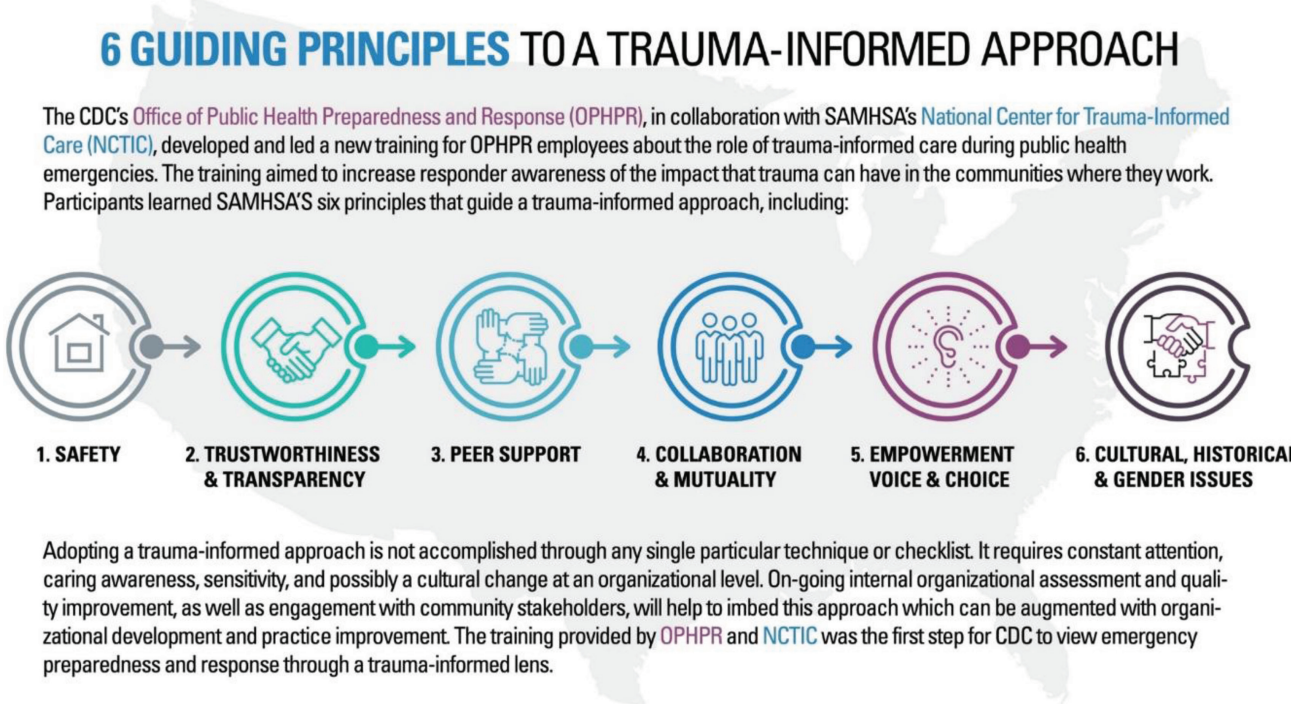

Figure 4. Guiding principles to a trauma-informed approach. Public domain (https://www.cdc.gov/cpr/infographics/00_docs/TRAINING_EMERGENCY_RESPONDERS_FINAL.pdf).

ACEs study coresearcher Robert Anda observes, "(the) ACEs score is a relatively crude measure of cumulative childhood stress exposure that can vary widely from person to person. Unlike recognized public health measures, such as blood pressure or lipid levels, that use measurement reference standards … the ACEs score is not a standardized measure of childhood exposure to the biology of stress."[45(p293)] Evidence does not yet exist to demonstrate improved health outcomes in response to ACEs screening, while researchers note the potential for harm exists, for example, trauma triggering (again, without evidence).[41,43]

Despite the potential for unintended consequences, Dube[42] and Harris[44] note the urgency of ACEs as a public health crisis, inviting clinicians to use ACEs screening to identify those at risk for toxic stress physiology. Harris[44] asserts that ACE scores are not the outcome of interest. Rather, a comprehensive ACE screening involves clinical assessment that incorporates assessment of protective factors and ACE-associated health conditions to assess the magnitude of toxic stress risk in an individual patient.[45] Dube[42] encourages clinicians to transition from a traditional allopathic approach where the clinician is the expert outside observer (etic approach), to an emic approach where the clinician seeks to understand health outcomes from the patient's perspective. Thus, conceptualizing an ACE score as diagnostic is not helpful. Instead, Dube[42] is encouraging clinicians to adopt an emic construct, where the ACE scores add insight into the complexity of a patient's presentation, with the potential to shift assessment and response. Dube[42] compares screening for ACEs to screening for tobacco use, which also lacks evidence for improving health outcomes. Bryan[15] notes that multiple studies of ACE screening in the primary care setting have demonstrated feasibility; patients are comfortable with answering ACE questions when providers are comfortable discussing them. WOC nurses can access ACE screening in the EMR and assess scores with care implications.

Screening for PCEs (Box 2) along with identification of ACEs is recommended as it is a strengths-based approach that provides hope as the individual confronts childhood trauma.[10] Stevens[16] describes that PCEs as "the other half of the equation" and asserts that integration of one's ACEs and PCEs is essential before healing can occur. Thus, a practice or facility must prepare as an organization prior to implementing patient screening by screening the staff of the practice or facility for PACEs, educating the entire organization about PACEs science, establishing supportive policies for self-care, and providing referral resources.[44]

Trauma-Informed Care Principles and WOC Practice

Knowledge of PACEs and TIC has substantial implications for WOC nursing across our caring community. Recognizing the role that ACEs play in adult pathology is crucial for WOC nurses. For example, risk factors generated by ACEs are the same as those generating wounds (Figure 2). For morbid (Class 3) obesity patients, ACEs, especially sexual abuse, may play a role in current health status. Asking questions like "What happened to you?" and "What got you through it?" may shed light on the genesis of the obesity issue and an opportunity for the patient to heal in a comprehensive manner. Facilitating healing, in turn, provides these patients a sense of control and empowerment, for example, when consulting them about usual approaches to activities of daily living.

SAMHSA 6 Guiding Principles to Trauma-Informed Care

This section focuses on application of SAMHSA 6 guiding principles to a trauma-informed approach (Figure 4).[24]

Safety

Patients and WOC staff must feel physically, emotionally, and morally safe when providing care. This multifaceted construct of safety has implications for every step of the patient-provider experience, from the tone of voice and body language used in the treatment setting (virtual and in-person), to asking permission before touching the patient, to minimizing any unpredictability or uncertainty such as calling patients immediately with diagnostic test results rather than waiting for the next visit. Decisions should feel morally "right" by all involved parties. Lighting, adequate space, and privacy contribute to a sense of physical safety.

Trauma-informed care alters physical examination processes. Gorfinkel and colleagues[46] describe genital/gynecological exam processes using a TIC perspective emphasizing avoidance of triggers, giving patients control of processes, and considering "self-testing" (having patients take samples). Staff need to feel safe processing emotional labor. The stress of unpredictability in healthcare is at times unavoidable but usually modifiable—from having routines for check-in and check-out, to announcing oneself before entering exam space, and reducing potential triggers to improve patient experiences.[15]

Continence care often involves inspection or manipulation of the perineal area. Trauma-informed care provides great insight into how to interact with patients in less stressful ways. If an ACEs-affected patient has been sexually abused, caregiving strives to be atraumatic, and TIC-informed approaches support communication and safety between patients and caregivers not triggering fear responses. Such approaches require screening for ACEs (including sexual abuse). Open communication between WOC nurses and patients can establish safety as a core component.

Trustworthiness and Transparency

Trust must be established through relationship building before any shift in health outcomes can be expected. This task is facilitated by transparency throughout the organization, including patients served by the organization, regarding operations and decisions. WOC nurses can be instrumental in generating resources to inform and empower patient choices. For example, both patients and staff with similar circumstances benefit from connecting with others for support and mutual self-help. Creating space for affirming such connections has the potential to be healing. WOC nurses could recognize trauma-impacted patients and offer connections to community support programs.

Collaboration and Mutuality

Flattening the traditional hierarchy within healthcare recognizes the value of every role on the healthcare team. Power differences are minimized while partnering is emphasized, focusing on including the patient as a part of the caring team. WOC nurses can be leaders in informing fellow providers (physicians, therapists, and administrators) about the science of PACEs and ensure integration of TIC and trauma knowledge into responsive policies, practices, and programs.

BOX 2.

CAHMI Overview of Positivethe Childhood Experiences (PCEs) Metric from Bethell et al, JAMA Pediatrics (9/09/19)

Reference link: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2749336

Citation: Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA Pediatr*. 2019;173(11):e193007. doi:10.1001/jamapediatrics.2019.3007

Positive Childhood Experiences (PCEs) Score: The PCEs score includes 7 items asking respondents to report how often or how much as a child they: (1) felt able to talk to their family about feelings; (2) felt their family stood by them during difficult times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled); (5) felt supported by friends; (6) had at least two non-parent adults who took genuine interest in them; and (7) felt safe and protected by an adult in their home. The PCEs score items were adapted from four subscales included in the Child and Youth Resilience Measure-28 (CYRM-28): (1) four items from the Psychological, Caregiving subscale (see PCEs items 1,2,7 and 6 listed above); (2) one from the Education subscale (PCEs item 4); (3) one from the Culture subscale (PCEs item 3) and (4) one from the Peer Support subscale (PCEs item 5). Items were designed in the CRYM for cultural sensitivity, and their validity was supported by associations with improved resilience. Psychometric analyses confirmed use of a PCEs cumulative score.

Scoring: The PCEs metric is a cumulative scored as a cumulative score using 0-2, 3-5 and 6-7 categories. Other scoring options were evaluated and the cumulative score (versus categorical or item by item scoring) demonstrated the strongest validity properties. In this scoring approach, combine "often/very often" and "most of the time/all of the time" response options for items to count as a PCE. Be sure to clean the data to remove "don't know" and "refused" responses, but note frequency. These "missing cases" are a concern if they exceed 3% of all responses. Cases that are missing because a person never had received the survey or was asked the questions do not count as missing. Rather they are non-response due to having dropped out of the survey before the items were administered or refused to answer the survey at all.

Questions: All questions refer to the time-period before you were 18 years of age.

Opening Statement: Now, looking back before you were 18 years of age …

1. For how much of your childhood was there an adult in your household who made you feel safe and protected?
Would you say never, a little of the time, some of the time, most of the time, or all of the time?
(NOTE: OK TO PROBE. THIS COULD BE ANY ADULT IN THE HOUSEHOLD, NOT JUST A PARENT.)
1 = NEVER
2 = A LITTLE OF THE TIME
3 = SOME OF THE TIME
4 = MOST OF THE TIME
5 = ALL OF THE TIME
7 = DON'T KNOW
9 = REFUSED

2. How often did you feel that you belonged at your high school?
Would you say never, rarely, sometimes, often, or very often?
(NOTE: IF R ATTENDED MULTIPLE HIGH SCHOOLS, ASK R TO RESPOND ABOUT THE HIGH SCHOOLS IN GENERAL.)
1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = VERY OFTEN
7 = DON'T KNOW
9 = REFUSED

3. How often did you feel supported by your friends?
Would you say never, rarely, sometimes, often, or very often?
(NOTE: IF R SAYS SOME FRIENDS DID/DIDN'T, ASK R TO ANSWER ABOUT FRIENDS IN GENERAL.)
1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = VERY OFTEN
7 = DON'T KNOW
9 = REFUSED

4. How often were there at least two adults, other than your parents, who took a genuine interest in you?
(Would you say never, rarely, sometimes, often, or very often?)
1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = VERY OFTEN
7 = DON'T KNOW
9 = REFUSED

5. How often did you feel that you were able to talk to your family about your feelings?
(Would you say never, rarely, sometimes, often, or very often?)
1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = VERY OFTEN
7 = DON'T KNOW
9 = REFUSED

6. How often did you enjoy participating in your community's traditions?
Would you say never, rarely, sometimes, often, or very often?
(NOTE: IF R ASKS WHAT WE MEAN BY "COMMUNITY" OR "TRADITIONS", SAY "whatever it means to you".)
1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = VERY OFTEN
7 = DON'T KNOW
9 = REFUSED

7. How often did you feel your family stood by you during difficult times?
(Would you say never, rarely, sometimes, often, or very often?)
(NOTE: IF R SAYS SOME FAMILY MEMBERS DID/DIDN'T, ASK R TO ANSWER ABOUT FAMILY IN GENERAL. IF R'S FAMILY SITUATION WAS COMPLICATED, SAY "whoever you considered your family when you were growing up".)
1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = VERY OFTEN
7 = DON'T KNOW
9 = REFUSED

Empowerment, Voice, and Choice

Recognizing the ubiquity of traumatic experience can be unifying across traditional power differentials. All organizations committed to adopting TIC must include community voice in decision-making. This may include a paid community member board member to provide feedback on practice. Leung and coworkers[30] conducted a systematic review about resilience after ACEs. They discuss emotional capital (the need for persons with ACEs to be counseled and supported, the need to reflect on ACEs and stop living in the past, the need to connect with significant others, to generate a "self-righting" capacity in self-reliance, and to develop financial capacity, financial independence). WOC nurses must realize that trauma is much more prevalent than commonly presumed, and that these experiences affect all races and socioeconomic strata, with increased risk in certain groups.[3] Adverse childhood experiences are intertwined with social determinants of health and a lack of access to these determinants can increase toxic stress.

Cultural, Historical, and Gender Issues

Finally, ACEs are inequitably distributed by race and ethnicity, demanding clinicians to embrace the practice of cultural humility.[47] Cultural humility turns the lenses of race, culture, and gender upon self rather than other, inviting a stance of curiosity and self-awareness, rather than judgment stemming from implicit bias.[48] Culture and gender also influence TIC needs; WOC nurses should ask patients about gender identification, cultural preferences, and practices. In addition, ACEs are prevalent in all genders but differences in impact based on identified gender have been demonstrated, including increased prevalence of sexual abuse in females.[19]

CONCLUSIONS

WOC nurses have a critical role to play in trauma-informed therapeutic interactions. They can help persons involved to realize that traumatic experiences are common and cumulative, to recognize the ways early life experiences (survival) have driven thought and behavior, to recognize how PCEs have contributed to their resilience, and to respond by integrating trauma knowledge into clinical practices and policies. These activities may involve direct care interactions, education of fellow caregivers, and shifting practice policies and procedures.

KEY POINTS

- Trauma-informed care is patient centered and has the potential to improve patient engagement and health outcomes.
- Clinicians, as well as patients, can benefit from adopting trauma-informed care principles.
- Learning the science stemming from positive and adverse childhood experiences studies is critical to effective adoption of trauma-informed care.
- Trauma-informed care is based on the premise that ACEs-affected adults can heal from past adversities.
- Trauma-informed care should be part of universal precautions presuming that all patients have some degree of past trauma.

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