Title
Trauma Informed Care Training for Women's Health MSN Students

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Trauma Informed Care Training for Women's Health MSN Students

A dissertation submitted in partial satisfaction of the

requirements for the degree

Doctor of Nursing Practice

by

Laila Alexandra Shad

2022

ABSTRACT OF THE DISSERTATION

Trauma Informed Care Training for Women's Health MSN Students

by

Laila Alexandra Shad

Doctor of Nursing Practice

University of California, Los Angeles, 2022

Professor Wei-Ti Chen, Chair

Background: Intimate partner violence and sexual violence are a serious public health concern. Survivors of trauma admit unpleasant experiences with their gynecologic exams including triggering of traumatic memories. **Objectives**: The aim of this project is to demonstrate the effectiveness of a curriculum that may be widely utilized across healthcare facilities to create a more trauma-informed workforce. This innovative curriculum including didactic and discussion was developed to educate women's health MSN students on a trauma-informed approach to obstetric and gynecologic care. **Methods:** The one-hour course was evaluated using a pre and post-test for providers to assess gained knowledge and whether or not training was perceived as effective and valuable to curriculum, and if training increased knowledge of trauma-informed skills in clinical practice. **Results:** The course demonstrated improved confidence in the use of trauma-informed terminology and increased confidence in utilizing examination techniques for a more trauma-sensitive approach to care. Students agreed that the training was valuable to their

clinical practice **Conclusion:** This quality improvement educational intervention can be used as the foundation of future studies on trauma-informed care in an effort to continue to build a more sensitive and comfortable experience for patients.

The dissertation of Laila Alexandra Shad is approved.

Anita Bralock

Lauren Clark

Colleen Keenan

Wei-Ti Chen, Committee Chair

University of California, Los Angeles

2022

This dissertation is dedicated to my patients who have experienced trauma in their lifetime. It is my sincerest hope that this training can continue to provide a more informed and sensitive workforce in which all patients can feel safe receiving the care they need. I would also like to dedicate this to my family who have provided unconditional love and support in this journey, my parents for their continued support in all of my hopes and aspirations, and my little ones, may you always pursue your dreams and know that you are loved and supported. Of all the things I have done in my life, I am most proud of you both. I am so thankful to love you and know you.

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It is also important to acknowledge Dr. Sojobi of California State University, Fullerton for her time and dedication to the implementation of this project and for allowing for implementation of this quality improvement project at the university. Her dedication to this project made it a reality and allowed for the training implementation for students within her program.

I would like to additionally acknowledge Dr. Nancy Jo Bush and Soo Kwon for their tremendous dedication to the DNP program and its students. Their support has made many DNP projects a reality and will continue to do so for years to come. Thank you for changing the world of nursing through educating and developing more DNP prepared nurses!

Lastly I would like to acknowledge the University of Iowa Hospitals and Clinics for granting permission to share the Iowa Model Revised framework as well as MedEdPortal and Eliseo et al. (2019) for the publication and open-access to the trauma-informed physical exam research that guided the development of this project.

CURRICULUM VITAE
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EDUCATION

BS (Health Science)	Chapman University, Orange, CA	2011
BSN	Concordia University, Irvine, CA	2012
MS (Midwifery)	Frontier University, Versailles, KY	2016
DNP (In progress)	University of California, Los Angeles	Anticipate 2022

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Neonatal Resuscitation Program	American Academy of Pediatrics	Exp: 2023
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PROFESSIONAL EXPERIENCE

April 2013 - May 2015	St. Joseph Hospital, Orange, CA	Perinatal Educator
July 2013 - Oct 2017	Cedars-Sinai Medical Center, Los Angeles Charge RN (2014-2017)	Registered Nurse (Mother-Baby and Newborn Nursery)
2017	Natural Birth Center & Women's Wellness, Los Angeles	Certified Nurse Midwife
Nov 2017 - present	Kaiser Permanente, San Bernardino County, Fontana Medical Center	Certified Nurse Midwife
June 2021 - present	California State University, Fullerton School of Nursing	Part Time Faculty

PROFESSIONAL ACTIVITIES

2013-2015 St Joseph Hospital, Orange - Classes for pregnant and parenting families:

- Childbirth Education/Preparation (24 times per year)
- New Parents Class (16 times per year)
- Newborn Care (20 times per year)
- Lactation (6 times per year)

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- EMR Trainer
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2015 – present	American College of Nurse Midwifery	Member
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January 2021 *Trauma-Informed Care for obstetrics and gynecology.* invited by Dr. Mitchell, Course Instructor

Kaiser Permanente – Department of Obstetrics and Gynecology

March 2021 *Labor in Motion: Movement in Labor* invited by OB/Gyn Department

California State University, Fullerton – MSN Women's Health Concentration

April 2021 *Trauma-Informed Care for obstetrics and gynecology.* Junior Class, invited by Dr. Sojobi, Program Director

May 2021 *Trauma-Informed Care for obstetrics and gynecology.* Senior Class, invited by Dr. Sojobi, Program Director

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In progress *Trauma Informed Care Training for Women's Health MSN Students.* [DNP Scholarly Project, UCLA School of Nursing]

CHAPTER ONE: INTRODUCTION

Sexual assault occurs every 73 seconds in the United States (Rape Abuse and Incest National Network [RAINN], 2020). Survivors of trauma admit unpleasant experiences during gynecologic exams, including overwhelming emotions, triggering of traumatic memories, and unwanted thoughts (Robohm & Buttenheim, 1996 as cited in Reeves, 2015). Prior to 2013, The U.S. Preventive Services Task Force did not have a recommendation for screening patients for intimate partner violence (IPV) or sexual violence (SV) due to a lack of data supporting benefits of routine screening as well as lacking effective screening instruments (U.S. Preventive Services Task Force et al., 2018). Lack of screening recommendations has led to detection of patients with trauma history to be as low as 22% (Stevens et al., 2017).

In the United States one in three women have experienced sexual violence involving physical contact in their lifetime, and nearly one in five have been the victim of attempted or completed rape (Centers for Disease Control and Prevention [CDC], 2020). Many patients do not report a history of IPV/SV due to feelings of shame, embarrassment and fear (CDC, 2020). Additionally, IPV and SV are associated with poor compliance with routine clinical care such as Papanicolaou (Pap) screening (Leite et al., 2018). Training providers in trauma-informed care (TIC) has been shown to increase knowledge, improve provider confidence and increase the frequency of practicing TIC (Elisseou et al., 2019). Providers of obstetrics and gynecology (OB/Gyn), who routinely perform pelvic and breast examinations, must be equipped with examination tools to establish a safe space for sensitive care of all patients, regardless of the patient's comfortability with disclosure of their trauma history.

Providers agree that training in improving sensitive care is helpful, and that poor screening rates and lack of TIC practices may be secondary to a lack of confidence and competence in providing care (Walker & Allen, 2014). Providing TIC training to Women's

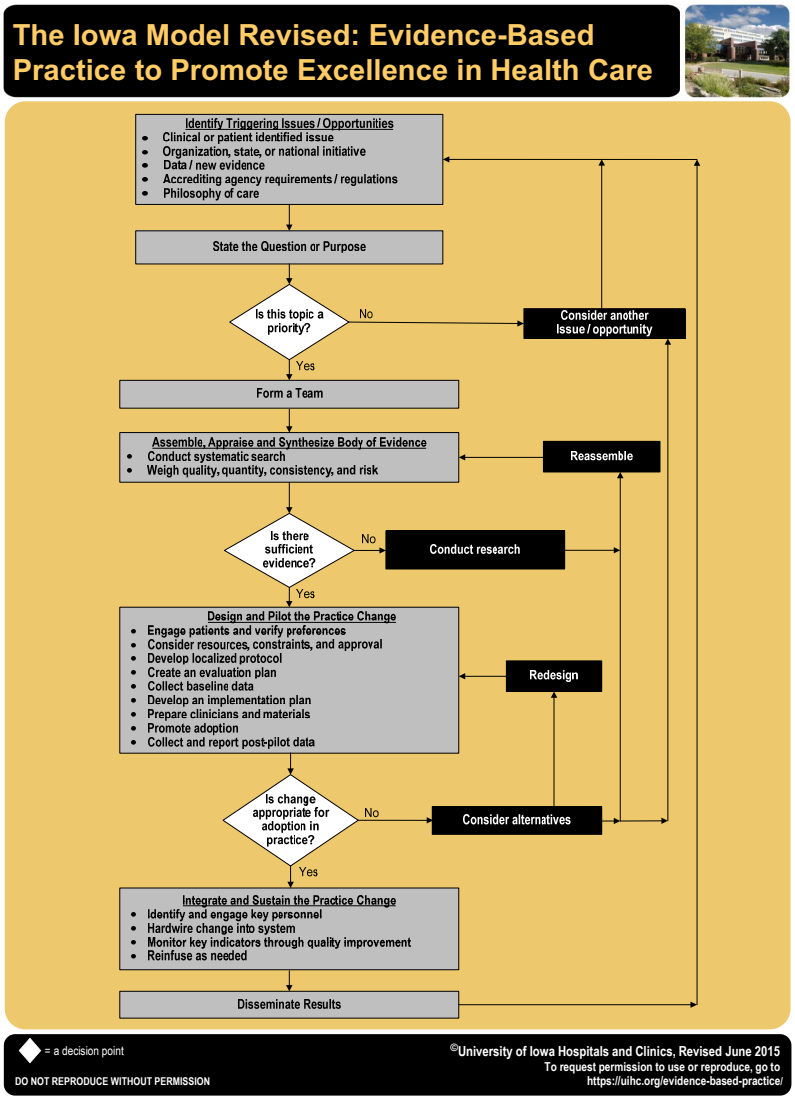
Health Master of Science (MSN) will offer skills for providing trauma-informed examinations as well as review ways to approach the topic of IPV and SV and improve students' confidence. Additionally, the American College of Obstetrics and Gynecology (ACOG) recently released a committee opinion recommending that obstetrician-gynecologists and other healthcare practitioners build a trauma-informed workforce by training clinicians to be trauma informed (ACOG, 2021). This DNP Scholarly Project is designed to be a quality improvement undertaking to improve student knowledge and confidence in TIC. Students will be assessed for their baseline confidence and then reassessed following training to evaluate the benefit of TIC training sessions. The aim of this evidence-based project is to improve provider confidence in providing care to patients, especially those who have experienced trauma in their lifetime, and to add value to their clinical practice.

CHAPTER TWO: THEORETICAL FRAMEWORK

The Iowa Model Revised (IM-R) is the framework that was chosen in the designing of this quality improvement project. The framework is comprised of 10 key elements, (1) identification of a clinical opportunity, (2) stating the purpose or question, (3) determination if the topic is a priority, (4) assembling a team, (5) gathering supporting evidence, (6) evaluating evidence sufficiency, (7) designing a practice change, (8) determining if change is appropriate for practice, (9) integrating practice change into practice, and (10) dissemination of results (Melnyk & Fineout-Overholt, 2019). This model allows for the development of a clinical practice change, in addition to reassessment throughout the implementation process to evaluate effectiveness and ensure the best outcomes. The steps of the IM-R served as roadmap to the development of this QI project. The ACOG committee opinion (2021) recommending that OB/Gyn providers be trained in TIC identified the clinical opportunity for this project. The IM-R

was applied to the development and implementation of the TIC training through assembling a team of stakeholders, reviewing the available data and designing the training for staff. With the help of the stakeholders, the training was then be integrated into the students' coursework and data collected. The IM-R guided the project implementation forward with best steps to integration, providing a process for implementing and evaluating a QI project.

Figure 1: *The Iowa Model Revised*



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CHAPTER THREE: REVIEW OF LITERATURE

Search Strategy

The primary focus of this literature search was trauma informed care, and sexual violence and pelvic examination. This review included PubMed, CINAHL Complete, and APA PsychInfo as electronic databases. search terms utilized included *sexual violence, sexual assault, rape, sexual abus*e or *sexual harassment, pap smear screening* or *cervical cancer screening, pelvic exams, training, education, faculty development,* and *trauma sensitive or trauma informed*. The initial data search yielded 242 articles that were then reviewed, and abstracts appraised for relevance to the research question. All duplicate studies from the databases were removed. All articles that did not meet the inclusion criteria for the database search, and those that were found to be irrelevant to the research question were eliminated from the review. In addition to databases, specific websites were reviewed for reports regarding IPV/SV and guidelines, recommendations and protocols for IPV/SV screening and trauma sensitive care including the Center for Disease Control and Prevention (www.cdc.gov), The World Health Organization (www.who.int), and The American College of Obstetricians and Gynecologists (www.acog.org). Inclusion criteria for all research reviewed was that the article be written in English, for research articles were peer reviewed, and had clear descriptive research applicable to the above PICOT question.

Literature Review

The initial step to providing trauma informed care to patients is to routinely screen patients for a history of IPV or SV. Sutherland et al. (2016) completed a cross-sectional online based survey for women of two different northeastern United States (US) universities. A sample of 615 women noted 36% of participants had experiences with IPV/SV in their lifetime (Sutherland et al., 2016). Of the 615 participants, nearly 63% (69.8% n = 178 at university 1, and

64% n=80 at university 2) of women who had health care visits off campus, and nearly 90% (92% n =214 at university 1, and 76.6% n=23 at university 2) of participants who had visits on campus reported that they were not being asked about IPV/SV. Despite ACOG's current recommendation that all patients be screened for IPV/SV, there continues to be low rates of screening resulting in many "missed opportunities." This research demonstrated the importance of creating a streamlined procedure to ensure screening is completed. The study had a large sample population which improves generalizability. A limitation to this study is generalizability as the sample population is limited to college students, in addition to recall bias as participants may over or under recall information pertaining to trauma questions during their visits (Sutherland et al, 2016).

In addition to research supporting screening for IPV/SV and potential barriers, another area of research important to this project is the impact IPV/SV can have on compliance with routine health screening. One particular study assessed association of IPV/SV with compliance in Pap screening. The study utilized the World Health Organization recommended tool for identifying violence and assessed 706 participants. Results noted that women who had suffered IPV and SV were, respectively, 1.64 and 1.94 ($p < 0.05$) times more delayed in their Pap screening than those who had never experienced IPV or SV (Leite et al., 2018). This study demonstrates the significant impact IPV/SV can have on care, but also demonstrates the importance of providing a safe space for patients to feel comfortable to encourage return for routine screening. Additionally, it supports the recommendation that all patients be screened for IPV/SV as it may be a clue to providers that a patient who screens positive may decline their routine Pap screening, encouraging the provider to offer alternative options to support the patient's comfort level. The major limitation of this study is that it takes place in a single

Brazilian health network (Leite et al., 2018). Recall bias must also be considered as a limitation as patients can underestimate the time passed since last performing Pap screening.

After appropriately screening patients for IPV/SV providers must create a safe environment for patients that is sensitive to any potential trauma they may have experienced. One study evaluated surveys completed by 41 pregnant abuse survivors (Stevens et al., 2017). The study utilized the childhood trauma questionnaire (CTQ) which assesses sexual, physical and emotional abuse, the Trauma History Questionnaire (THQ), a 24-item measure used to expose types of trauma including physical and sexual, the post-traumatic stress disorder (PTSD) symptom checklist for civilians (PCL-C), and lastly a modified version of Bandura's self-efficacy scale guidelines. This research noted that history of abuse was detected by patients' obstetricians in only 22% of cases on electronic medical record review. Additionally, the study found that both PTSD and depression were associated with lower sense of self-efficacy in the obstetric setting, supporting the hypothesis that trauma-related distress is associated with a lower capacity to communicate one's needs in the OB setting (Stevens et al., 2017). This research makes several recommendations regarding providing trauma informed care including; slowing or stopping an exam entirely if a patient becomes uncomfortable, communicating clearly while conducting exams, and directing patients in coping strategies effective for reducing anxiety with exams. This study is limited by its sample population, mostly (93%) insured by Medicaid or public assistance, compared with the planned study institution which is largely privately insured. Additionally, the study site was selected because more than half of participants reported incomes below the federal poverty line, and had known high rates of exposure to abuse, trauma and IPV (Stevens et al, 2017).

A mixed method study completed by Walker and Allan (2014) consisting of literature review, provider questionnaire, and focus group, intended to evaluate themes from the questionnaire in addition to investigating providers' feelings regarding care of these patients. The literature review demonstrated the long-term adverse effects of childhood sexual abuse. The questionnaire completed by 62 respondents (27% response rate) revealed staff anxiety regarding appropriate sensitive care and noted providers' acknowledgement of the importance of being able to respond supportively and appropriately to patients who have experienced trauma (Walker & Allan, 2014). Ninety-four percent of participants (n=51) reported that training in improving sensitive care when performing Pap screening for abuse survivors would be helpful. When performing self-assessments on provider confidence and competence, only 11.5% strongly agreed that they felt confident or competent in undertaking Pap screening with patients with history of childhood sexual abuse. Only 50% of respondents reported discussion regarding history of abuse during training on completing Pap screening. This study proves valuable to the research question as it demonstrates the importance of developing skills and knowledge regarding care of patients who have experienced trauma as it affects both patient and provider. Additionally, it demonstrates the need amongst providers to be more adequately trained and the desire to experience training. A limitation to the study is that it applies specifically to patients with a history of childhood trauma and excluded those who experienced trauma as adults. Another limitation to the study is that it was completed within a health network in London where training may prove to be different than US providers.

One key study supporting this research was completed by Elisseou et al. (2019). The study, completed at Brown University Medical School, included 148 first year medical students and was designed to address the knowledge gap regarding TIC by implementing a TIC

curriculum for physical examination skills. The curriculum included an hour-long lecture component and two hours of small group sessions including interviewing skills and physical examination skills. This convenience sample of participants were asked to complete a 7-minute survey that evaluated baseline knowledge and comfort with TIC on a 5-point Likert scale. Three months following the workshop students' familiarity with TIC concepts rose by 85% and confidence rose by 62%, frequency of practicing TIC skills rose by 61%, all demonstrating a significant change from baseline ($p<0.001$). Students admitted the use of a TIC approach to care was important ($M = 4.3$, $SD = 0.7$), and reported high levels of satisfaction with the curriculum ($M=4.1$, $SD = 0.8$). Limitations of the study include being a single university study, only applied to medical students, and not generalizable to other subspecialties, including nurse midwifery and nurse practitioners. Another limitation that must be considered is the duration of educational programs in different settings and whether participants would gain more or less depending on length of training. Lastly the population of learners were students, who have yet to establish a clinical routine which makes it challenging to generalize findings to well established providers.

A longitudinal study exploring the development of as well as assessing the impact of an integrated hospital based IPV program was completed at Virginia Commonwealth University (VCU) hospital (Aboutanos et al., 2019). The study involved a total of 737 trained providers, nurses (73%), social workers (13%), and the remaining sample including physicians, students, advanced practice providers and administrators. The study assessed the development over a ten year period and incorporated outcome based modifications throughout the implementation. Initial surveys noted that greater than 80% of employees did not screen patients for IPV, and 76% had no training regarding IPV or TIC and patient management. In the initial implementation, positive screening triggered a referral to Project Empower which incorporated

services in safety planning, crisis intervention, case management, counseling, education, legal services and more. In the first five years after implementation there were less than forty referrals to Project Empower encounters per year for services based upon history of IPV. Due to this finding, the researchers increased staff training and expanded to hospital wide awareness as well as the incorporation of a more specific screening tool, the Hurt, Insult, Threaten and Scream (HITS) screening tool. In doing so, referral rate went from forty per year with 575% increase to 450 referrals per year. The study noted IPV victims are often not captured, providers lack training and skills and workflow to implement integrated interventions. The study noted that only 4% of Project Empower patients were retreated at VCU for IPV related injuries compared to the average of 15-40%. Utilizing a system of integrated care that offers a multidisciplinary approach to the patient care may result in lower reinjury rate and IPV related homicide. This study is limited due to not accounting for patients who may have been treated for subsequent injuries at a different institution or may not have disclosed cause of injury. These findings demonstrate a need for providers across institutions to receive training to better serve patients.

Young-Wolff et al. (2018) performed a longitudinal retrospective cohort design study to examine whether sexual abuse (SA) is associated with changes in overall health and healthcare utilization. The study included 1350 participants with a SA diagnosis who were then each matched with 3 participants without a SA diagnosis who were similar in age and medical facilities. The study was performed through Kaiser Permanente in the Northern California region and spanned fifty three medical facilities. Participants with a diagnosis of SA had significantly higher prevalence of nearly all comorbidities and had a nearly 4-fold rate of psychiatric disorders (53.7% compared to 14.5%, $p< 0.001$). Rates of substance abuse were significantly higher in participants with SA diagnosis (11.7% compared to 1.5%, $p< 0.001$). Additionally, these

participants were significantly more likely to have gastrointestinal conditions, chronic pain, obesity and to be smokers. The study demonstrated that individuals with history of SA have higher healthcare utilization across a multitude of specialties. The study limitations include only involving participants who disclosed in a visit a history of SA, they may be higher risk individuals than those who elect not to disclose their history. Additionally, the specifics of their SA experience were not explored which could impact overall outcomes. This research noted a significant need for a team approach to care, and to ensure a workflow for referrals to appropriate resources given increased utilization. This research demonstrated increased health care utilization for conditions such as chronic pain, including pelvic pain, impacting providers of OB/Gyn.

Understanding how the patient perceives care is an important aspect in the design and approach to care. One study explored survivors' perspectives on care when inquiring about sexual trauma during prenatal care (White et al., 2016). The study involved a focus group of 6 adult females with a history of trauma and at least one live birth. Study participants were selected based upon a willingness to participate and ease in discussing trauma-related issues without causing distress. This is a limitation to the study as these participants have strong coping techniques and therefore may have different perspectives to care and are further along in their recovery and therefore may have differing needs from their providers as well. Another significant limitation to this study is the small sample size, thus lacking generalizability. The participants were asked to respond to questions both as a group and individually. Results demonstrated that patients feared admitting to trauma if screening was not framed as routine due to concerns for ulterior motives such as believing they would be unfit to care for their child. The study also noted that participants preferred resources were offered such as peer support and

counseling options. Participants agreed that knowing about useful resources made them more inclined to disclose a history of trauma. This study demonstrates a need for improved screening practices and a clear clinical practice guideline for those who disclose a history.

Synthesis of Literature Review

The literature findings denote several themes used to guide this research including the long-lasting impact of IPV/SV in many aspects of an individual's life, including adherence to care, comfort in the care setting, associations to substance abuse, depression and anxiety and much more (Aboutanos et al., 2019; Young-Wolff et al., 2018). Another notable theme is that providers believe in the importance of screening patients and providing competent care yet feel they lack the skills and knowledge to do so (Elisseou et al., 2019; Walker & Allen, 2014). Research findings demonstrated the importance of implementing training and the potential benefits it will have for both students and their patients.

There is a significant lack of data surrounding implementation of trauma informed training as the implementation is still considered novel. The existing data demonstrates a need for training, however minimal data exists on curriculum development and implementation of training. The current evidence-based practice proposal serves to bridge this knowledge gap and serve as a foundation for further studies including larger samples as well as across other disciplines.

Demonstrating impact on student competence and confidence within a single university can serve as foundation to further assess impact of trauma informed care in education and to current providers of obstetrics and gynecology as well as extend into other specialties such as primary care and emergency medicine. Additionally, this project lays the foundation to assess the impact on patient satisfaction scoring, and adherence to screening recommendations such as pap

screening and mammograms when providers are trained in TIC. Existing literature demonstrates a significant gap in clinical practice and clinical knowledge that this study aims to begin to investigate.

CHAPTER FOUR: METHODS

Design

The quality improvement (QI) project was a single group, quasi-experimental convenience sample utilizing a pre and posttest survey. Inclusion criteria for this project included being a student in a Women's Health focused advanced practice nursing program at a single campus within California State University, and an ability to complete required surveys (see Appendix A & B) as well as the training (see Appendix C). Additional inclusion criteria include the ability to use online survey formats via Google Forms and access to the TIC training held via Zoom sessions. This QI educational project was designed to evaluate the training for effectiveness, and benefit to clinical practice. Participants were advised that completing the post-intervention survey was consenting to participate in this project and participants were asked to create their own alphanumeric code as a unique identifier to compare pre and post data while maintaining each participant's anonymity.

Sample Population and Setting

The convenience sample included nineteen participants, all Women's Health specialty advanced practice students from a single California State University. The sample included thirteen dual Women's Health Nurse Practitioner (WHNP)/Certified Nurse Midwife (CNM) students, five WHNP-only students, and one CNM student. Participants were in their first or second year of the two year program and have not yet received any TIC specific training within the program.

Intervention Development

Following the publication of the newest ACOG recommendation that providers be trained in TIC practices, there is a need for streamlined training (ACOG, 2021). The TIC training intervention for this QI project was developed by adapting the training described in the Elisseou et al. study (2019). The basic principles of TIC were maintained in the training tool while adapting for more specific OB/Gyn procedures and care. Generalizable teaching points such as setting for physical examinations, and draping techniques were adapted from the Elisseou et al. (2019) curriculum. The original study design is generalized to TIC practices for primary care and was therefore adapted to include specifics pertaining to pelvic examination. In addition to adapting the curriculum from the Elisseou et al. (2019) study, the pre and post survey questions for this QI intervention were adapted from those utilized in the original study.

The one-hour training included didactic and discussion. The design intended to additionally offer a simulation session however given the constraints of the COVID-19 pandemic the training sessions were held via Zoom which limited ability to have effective simulation. The didactic component included a presentation to review basic principles of TIC. The open discussion was an opportunity to discuss potential barriers to implementation of skills, concerns, and any questions as well as discuss trauma-sensitive language and allow for students to share examples of less sensitive language they have heard or utilized and ways to re-word in a more sensitive way.

Table 1: *TIC Training Session Breakdown*

Topic	Time Spent (Minutes)
Introductions/Disclosures	2
Problem Why offer training?	3
Definition What is TIC?	2
Background	5
Steps to take BEFORE initiating physical exam	13
Steps to take DURING physical exam	13
TIC Language	10
the use of Foot rests	5
Self-insertion of vaginal probes/speculums	5
Recap	2
Total Time	**60**

Data Collection, Evaluation and Analysis

The primary research question that was analyzed through this project was whether or not a TIC training intervention increased student confidence of TIC skill utilization. For this analysis, a Paired Samples T-Test was used. In addition to the primary question other variables that were assessed included whether or not the training was perceived by participants as valuable to clinical practice and effectiveness of training. Because the study design is a pilot implementation additional information was gained in the post-test survey regarding strengths and areas for improvement in the training as well as what else students felt would be valuable to TIC training. Value of training was scored on the post-intervention survey using a Likert scale from strongly disagree to strongly agree. All questions on the pre and post surveys were either Likert scale based questions or free response. Effectiveness was evaluated on the post-intervention survey of effectiveness of each component of the lecture including helping to learn trauma-informed language and defining a trauma-informed approach to a physical examination. Surveys were designed to be completed in 10 minutes or less.

CHAPTER FIVE: RESULTS

This TIC curriculum was piloted in two courses for 19 Women's Health MSN students. Results demonstrated that following training, participants' confidence in draping techniques, TIC language, and ability to create a safe environment during a pelvic examination rose by 20%, 57%, and 21% respectively ($p < .001$). Familiarity with components of a TIC pelvic exam improved by 60% ($p < .001$). Sixteen of the 19 participants strongly agreed that this training was valuable to their clinical practice (84%) and the remaining 3 agreed (16%) on a Likert-scale from strongly disagree to strongly agree.

Figure 2: *Confidence in Draping Techniques*

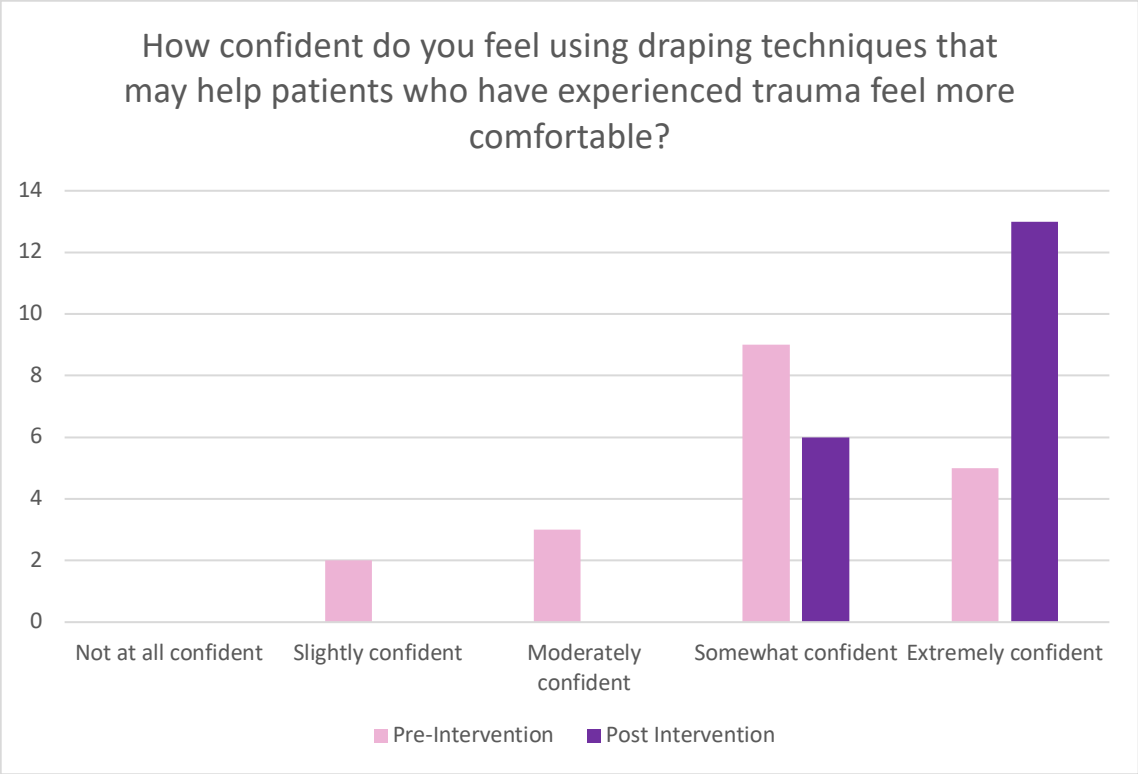


Figure 3: *Confidence in TIC Language*

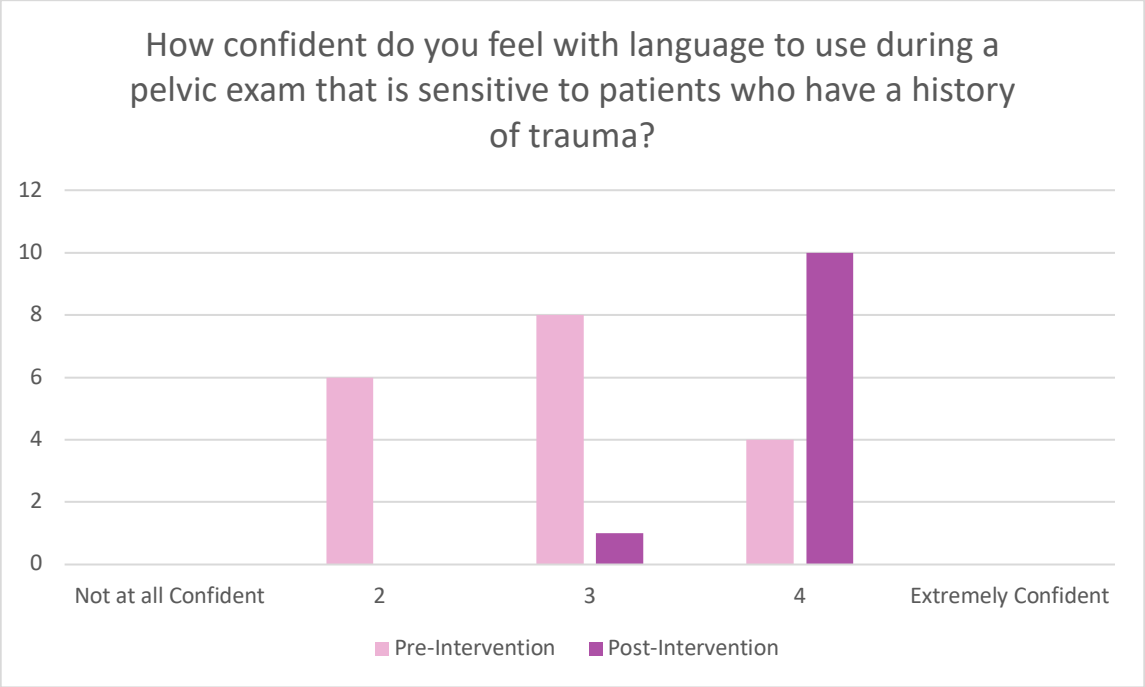


Figure 4: *Confidence in Creating a Safe Space*

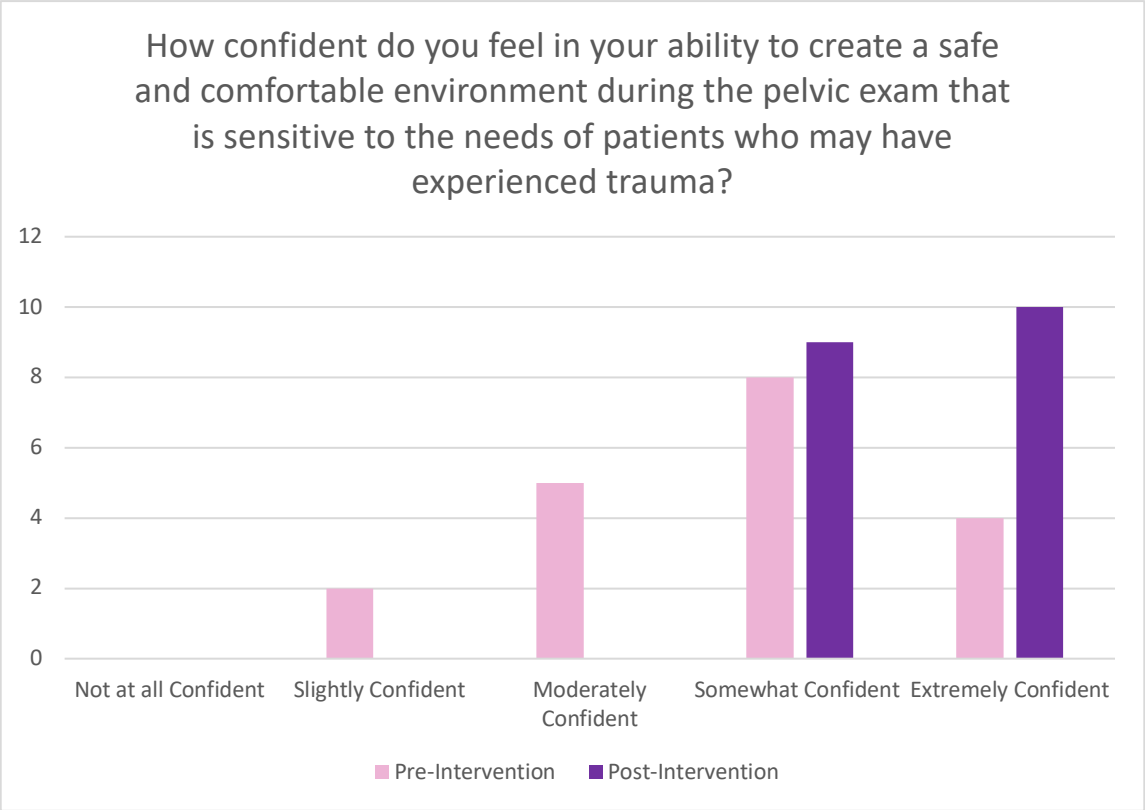


Figure 5: *Familiarity with Components of a TIC Exam*

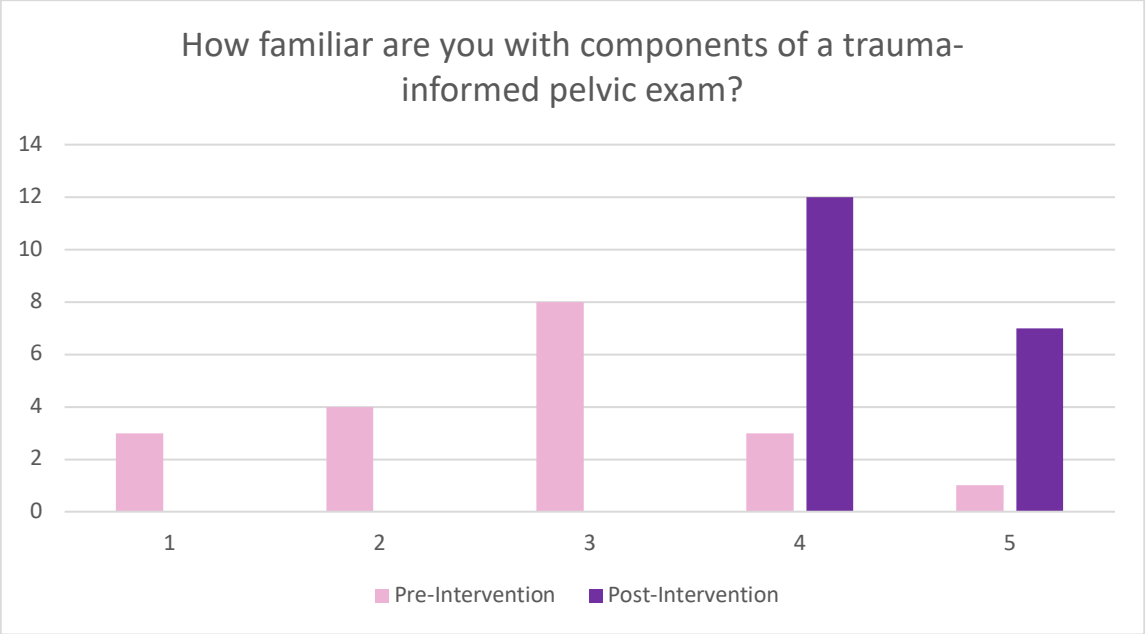


Figure 6: *Training Value to Clinical Practice*

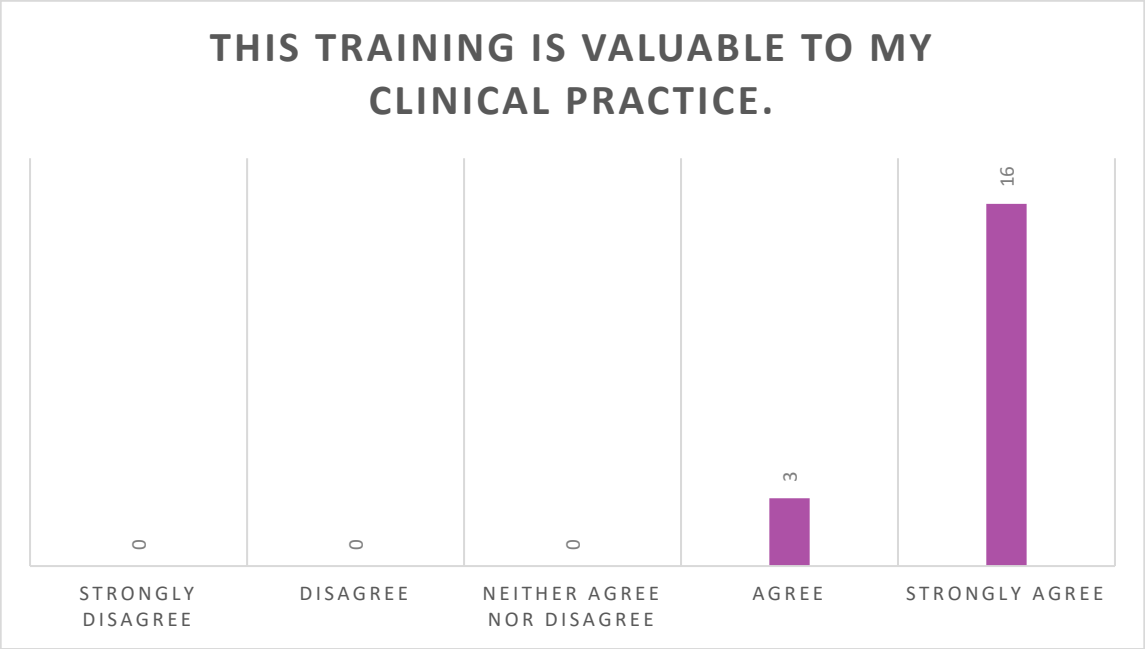


Table 2: *Demographics*

Specialty	*Total sample,* (n=19)	**% (n)**
Dual WHNP/CNM	13	69%
Nurse Practitioner	5	26%
Certified Nurse Midwife	1	5%

Table 3: *Major Themes for Strengths of TIC Training*

Major themes for strengths of training	
Ease of application	Great easy, interventions to implement into practice
	Presenter's knowledge and direction on specifics
	Being aware of ways we can alter our practice to help patients feel more comfortable and at ease when providing care that can be intimate and uncomfortable. I like the practicality and direct recommendations of techniques and verbiage to use to help provide trauma-informed care
	Tangible examples on how to improve language and exam performance
	A thorough explanation of the topic in a concise manner. Very informative.
Discussion with colleagues	Providing experiences and incorporating the student's personal experiences during their clinical setting
	Ability to discuss amongst peers' techniques used for TIC

In the post-intervention survey participants felt the strengths of this training included easy examples of interventions to implement into clinical practice, the ability to discuss examples and

techniques of trauma sensitive care, and examples of ways to keep the patient at the center of control during a physical examination. In a free response post-survey question, participants overwhelmingly agreed (53%) that areas for improvement in the training included a hands-on, face-to-face demonstration and that practice with scripts would be beneficial to their learning. Some participants felt that training in how to approach colleagues who are not using trauma sensitive techniques as well as additional information on next steps for patients who disclose IPV/SV to them would be beneficial to this training or subsequent trainings.

In summary, the results of this quality improvement intervention demonstrated that this TIC training added value to clinical practice and improved confidence in TIC skills of pelvic examination including draping techniques and language. Additionally, data supported that training improved participants confidence in creating a safe space for patients with a history of trauma. The data demonstrated a need for further development of the training to include a simulation portion as well as potential add on components such as interacting with colleagues and encouraging a trauma-informed workplace.

CHAPTER SIX: DISCUSSION

This QI intervention successfully offered participants training to perform a trauma-informed OB/Gyn physical examination, reviewing appropriate language, draping techniques and pelvic examination without the use of footrests and the offering of self-insertion of speculums and vaginal probes. Strengths of this intervention include ease of implementation, can be readily adapted and included into university programs as well as quickly disseminated in hospital institutions for practicing OB/Gyn providers as well as nurses alike. This pilot project lays the groundwork for future studies including the evaluation of clinical practice after training to assess for behavior changes in examination techniques. Most important will be future investigation into patient outcomes following trauma-informed OB/Gyn physical examination,

investigating whether or not trauma-sensitive pelvic examinations increase long term adherence to routine screenings such as mammograms and pelvic examinations.

A clear importance of TIC skills for OB/Gyn providers has been demonstrated, as well as the impact that trauma can have on patients. Because patients may avoid disclosing their history (CDC, 2020), and may not communicate their needs to their provider, (Stevens et al., 2017) it is important that providers approach all patients in a trauma sensitive manner to avoid potential triggers or re-traumatization. Training in TIC is well received by healthcare providers and students alike (Eliseou et al., 2019; Walker & Allen, 2014). The project implementation is in alignment with the newly released ACOG committee opinion recommending that OB/Gyn providers build a trauma-informed workforce by training clinicians to be trauma informed (ACOG, 2021).

Limitations

This QI project is to serve as a foundation for future studies on incorporating trauma informed training, however, does have limitations as an initial study. One limitation to this study is the sample. The sample size is small and limited to one university site where training may differ quite significantly from other universities. Another limitation to this project is the lack of long term follow up. As students begin to implement skills gained from the training further questions or issues may arise and therefore an additional follow up after several months may be beneficial to truly evaluate efficacy of training long term. An additional limitation to this project is the newly developed teaching tool. This tool, while utilizing principles from the Eliseou et al. (2019) study is a newly designed intervention and therefore lacks longstanding validity which may impact outcomes. The goal of this project is to evaluate the intervention for value and improve internal validity of the course materials and demonstrate the link between the QI

intervention and students' knowledge, confidence and perceived value of intervention. Utilizing some of the intervention principles and survey formatting from the Eliseou et al. (2019) study increased internal validity.

CONCLUSION

Survivors of trauma admit unpleasant experiences during their gynecologic examinations while providers report lack of confidence in providing care to these patient (Robohm & Buttenheim, 1996 as cited in Reeves, 2015; Walker & Allan, 2014). With a prevalence as high as one in three women experiencing sexual violence in their lifetime it is critical that providers be confident in their ability to care for these patients, most specifically, providers of OB/Gyn care (CDC, 2020). This project aims to assess the impact of implementation of TIC training on student confidence in care using a single group, quasi-experimental convenience sample of providers from one university. Implementation was completed over two one-hour Zoom sessions for women's health focused MSN students. Data collected as a pre and post-intervention survey was evaluated to assess impact on confidence as well as perceived value of training to clinical practice. A recent ACOG committee opinion has called for OB/gyn providers to build a trauma-informed workforce by training clinicians to be trauma informed (ACOG, 2021). This project is limited by its short time frame for evaluation and small sample size; however, it serves as foundation for increased TIC trainings within institutions and adherence to ACOG recommendations. Improving confidence in care through training can lead to further QI projects and research on improving patient care and experience as well as the impact of TIC on adherence to recommended care.

APPENDICES

Appendix A

TIC Pre-Intervention Survey

* Required

1. Please enter a 6 digit/letter unique identifier

_____

2. Which of the following describes your concentration? *

Mark only one oval.

- ◯ Nurse Practioner
- ◯ Certified Nurse Midwife
- ◯ Dual WHNP/CNM
- ◯ Other

3. Which describes your years in clinical practice as a registered nurse? *

Mark only one oval.

- ◯ New Practitioner less than 5 years
- ◯ 5-10 years in practice
- ◯ 11-20 years in practice
- ◯ Greater than 20 years in practice
- ◯ Student

4. How familiar are you with trauma-informed care? *

Mark only one oval.

	1	2	3	4	5	
Not at all familiar	◯	◯	◯	◯	◯	Extremely familiar

5. How confident are you with trauma-informed care? *

Mark only one oval.

	1	2	3	4	5	
Not at all confident	◯	◯	◯	◯	◯	Extremely confident

6. How do you define trauma-informed care? *

7. How familiar are you with components of a trauma-informed pelvic exam? *

Mark only one oval.

	1	2	3	4	5	
Not at all familiar	◯	◯	◯	◯	◯	Extremely familiar

8. How confident do you feel with language to use during a pelvic exam that is sensitive to patients who have a history of trauma? *

Mark only one oval.

	1	2	3	4	5	
Not at all confident	◯	◯	◯	◯	◯	Extremely confident

9. Please rate how much you agree or disagree with the following statement: A trauma-informed approach to the physical exam improves care for all patients. *

Mark only one oval.

- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Neither agree nor disagree
- ◯ Somewhat agree
- ◯ Strongly agree

10. How important do you think a trauma-informed approach to the physical exam is to patient care? *

Mark only one oval.

- ◯ Not at all important
- ◯ Slightly important
- ◯ Moderately important
- ◯ Important
- ◯ Extremely important

11. How confident do you feel using draping techniques that may help patients who have experienced trauma feel more comfortable? *

Mark only one oval.

- ◯ Not at all confident
- ◯ Slightly confident
- ◯ Moderately confident
- ◯ Somewhat confident
- ◯ Extremely confident

12. How confident do you feel in your ability to create a safe and comfortable environment during the pelvic exam that is sensitive to the needs of patients who may have experienced trauma? *

Mark only one oval.

- ◯ Not at all confident
- ◯ Slightly confident
- ◯ Moderately confident
- ◯ Somewhat confident
- ◯ Extremely confident

13. How regularly do you use trauma-informed language with patients? *

Mark only one oval.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

14. How regularly do you offer self-insertion of speculum or vaginal probe when performing a pelvic exam? *

Mark only one oval.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

15. How regularly do you perform a pelvic exam without the use of footrests? *

Mark only one oval.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

16. How often do you think about a trauma-informed approach when meeting with patients? *

Mark only one oval.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

Appendix B

TIC Post-Intervention Survey

* Required

1. Please enter your 6 digit/letter unique identifier

_____

2. Which of the following describes your concentration? *

Mark only one oval.

- ◯ Nurse Practioner
- ◯ Certified Nurse Midwife
- ◯ Dual WHNP/CNM
- ◯ Other

3. How familiar are you with trauma-informed care? *

Mark only one oval.

	1	2	3	4	5	
Not at all familiar	◯	◯	◯	◯	◯	Extremely familiar

4. How confident are you with trauma-informed care? *

Mark only one oval.

	1	2	3	4	5	
Not at all confident	◯	◯	◯	◯	◯	Extremely confident

5. How do you define trauma-informed care? *

6. How familiar are you with components of a trauma-informed pelvic exam? *

Mark only one oval.

	1	2	3	4	5	
Not at all familiar	◯	◯	◯	◯	◯	Extremely familiar

7. How confident do you feel with language to use during a pelvic exam that is sensitive to patients who have a history of trauma? *

Mark only one oval.

	1	2	3	4	5	
Not at all confident	◯	◯	◯	◯	◯	Extremely confident

8. Please rate how much you agree or disagree with the following statement: A trauma-informed approach to the physical exam improves care for all patients. *

Mark only one oval.

- ◯ Strongly disagree
- ◯ Somewhat disagree
- ◯ Neither agree nor disagree
- ◯ Somewhat agree
- ◯ Strongly agree

9. How important do you think a trauma-informed approach to the physical exam is to patient care? *

Mark only one oval.

- ◯ Not at all important
- ◯ Slightly important
- ◯ Moderately important
- ◯ Important
- ◯ Extremely important

10. How confident do you feel using draping techniques that may help patients who have experienced trauma feel more comfortable? *

Mark only one oval.

- ◯ Not at all confident
- ◯ Slightly confident
- ◯ Moderately confident
- ◯ Somewhat confident
- ◯ Extremely confident

11. How confident do you feel in your ability to create a safe and comfortable environment during the pelvic exam that is sensitive to the needs of patients who may have experienced trauma? *

Mark only one oval.

- ◯ Not at all confident
- ◯ Slightly confident
- ◯ Moderately confident
- ◯ Somewhat confident
- ◯ Extremely confident

12. What are the strengths of this training? *

13. What are improvements to be made for this training? *

14. What more would you like to learn about trauma-informed care in a subsequent session? *

15. Please rate the following training components: Effectiveness of the presentation content in defining a “trauma-informed approach to a physical exam”. *

Mark only one oval.

- Poor
- Fair
- Good
- Very good
- Excellent

16. Please rate the following training components: Effectiveness of the presentation content in helping you learn trauma-informed language. *

Mark only one oval.

- Poor
- Fair
- Good
- Very good
- Excellent

17. Please rate the following training components: In your opinion, how accurately did style and content of the presentation meet the criteria of trauma-informed care? *

Mark only one oval.

- ◯ Poor
- ◯ Fair
- ◯ Good
- ◯ Very Good
- ◯ Excellent

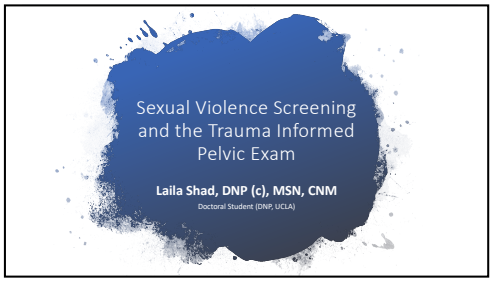
18. Please rate how much you agree or disagree with the following statement: This training is valuable to my clinical practice. *

Mark only one oval.

- ◯ Strongly disagree
- ◯ Disagree
- ◯ Neither agree nor disagree
- ◯ Agree
- ◯ Strongly agree

Appendix C

5/16/22



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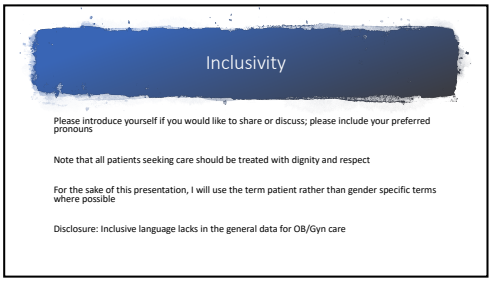

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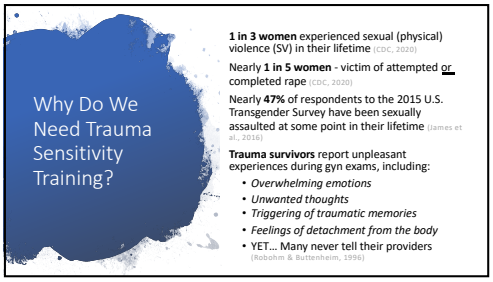

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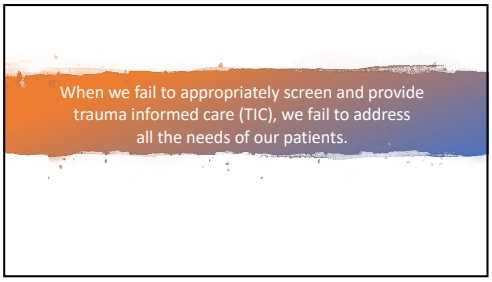


6

What is Trauma-Informed Care?

"Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment."

(The Trauma-Informed Care Project, 2022)

7

Background

ACOG recommends routine screening of all patients for history of SV

(ACOG Committee Opinion No. 777, 2019)

While most providers agree screening for SV is important:

only **15%** report they screen patients (Sutherland & Hutchinson, 2018)

Training providers in trauma informed care leads to:

- increased confidence
- increased frequency in utilization of trauma informed practice skills

(Elisseou et al., 2019)

8

Why incorporate SV Screening & TIC into practice?

- **First - do no harm**
- **Is the patient difficult, or has the patient faced difficulties in their lifetime?**
- Patients prefer **universal routine screening** - but reluctant to start the conversation (Freidman et al., 1992)

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 498 • August 2011
(Reaffirmed 2017)

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Adult Manifestations of Childhood Sexual Abuse

"Not asking about sexual abuse may give tacit support to the survivor's belief that abuse does not matter or does not have medical relevance and the opportunity for intervention is lost"

(ACOG Committee Opinion No. 498, 2011)

9

Before You Initiate Physical Exam

Establish your plan	*"I would like to do a physical exam that includes a chest or breast exam and a pelvic exam - if you are comfortable with that"*
Clarify standard practice	*"These are routine exams done with all patients at the start of pregnancy"*
Ensure comfortability	Privacy for undressing; provide drapes
Offer a chaperone	*"You have a right to a chaperone to be here with you. Would you like one?"*

(Elisseou et al., 2019)

10

During Exam

Ensure draping is appropriate and modest	Ex: A complete breast exam only requires one breast exposed at a time; allow patient to shift drape, or initiate by saying, *"Would it be ok with you if I lift the drape?"*
Stay within eyesight	Remember to lift the head of table so patient can maintain visualization of what is happening
Check in with patient regularly during exam	*"Are you doing ok?"* *"Do you need me to pause?"*
STOP if patient asks	If she communicates pain or asks that you stop, ask *"Do you want me to remove the speculum?"*

(Elisseou et al., 2019)

11

What You Say Matters
Trauma Sensitive Language

- ⊘ **Bed – Sheet – Stirrups**
- ⊘ *"Just relax"* or *"Relax"*
- ⊘ *"Open your legs"*
- ⊘ *"Relax your bottom"*
- ⊘ *"Relax and it won't be as uncomfortable"* or *"Relax and it won't hurt as much"*
- ⊘ *"Hold still: it will be over faster"*

- ✓ **Table – Drape – Foot rest**
- ✓ *"Try to take slow breaths and feel your muscles go heavy"*
- ✓ *"Allow your knees to fall to the sides"*

12

Language you use in your practice that demonstrates sensitivity

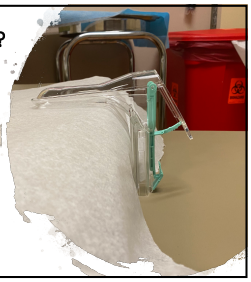
13

Foot rest v. No Foot rest?

Consider using the term **foot rest** rather than stirrups

Speculum exams without footrests are routine in the UK, Australia and New Zealand - no significant difference in quality of sample collected (Barr, 2006)

Women report:
- ✓less discomfort
- ✓decreased feelings of vulnerability



14

Self-Insertion of Speculum?

Consider offering **self insertion of speculum**

A study of 130 women who self-inserted found
- ✓ **91%** agreed or strongly agreed they were satisfied with the experience - **and**
- ✓ **would choose self insertion again** if given the option (Wright et al., 2005)

15

Recap

- ✓ **Screen every patient for history of sexual violence**
- ✓ **When performing exams,**
  - ❑ Ensure modest draping
  - ❑ Use clear concise language
  - ❑ Clearly review your plan prior to proceeding
- ✓ **Consider:**
  - ❑ Forego use of footrests
  - ❑ Allow patient to self insert speculum or vaginal ultrasound probe
- ✓ **Use trauma sensitive language when performing exams**

16

Remember: *What you say & do matters!*

17

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18

TABLE OF EVIDENCE

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Aboutanos, M. B., Altonen, M., Vincent, A., Broering, B., Maher, K., & Thomson, N. D. (2019). Critical call for hospital-based domestic violence intervention: The Davis challenge. *Journal of Trauma & Acute Care surgery, 87*(5), 1197-1204. https://doi.org/10.1097/TA.0000000000002450	Explore development and evaluate impact of an integrated hospital based IPV program	-Virginia Commonwealth University (VCU) level I trauma center -737 providers trained: nurses (73%), social workers (13%), others including physicians, students, advanced providers and administrators	- 10 yr initial development and growth of hospital based IPV/DV intervention program - 2010 hospital wide IPV screening training - 2013 noted limited resources, developed IPV crisis fund with resources for patients -2015 over 1,130 providers trained, expended to include OB/Gyn -2015-2016 workshops advocated for use of HITS DV screening tool - Services provided by PE: safety planning, crisis intervention, case management, counseling, Edu, legal services, etc.	- Initial survey of employees noted a knowledge deficit and that >80% didn't screen for IPV - 76% had no training - From 2014-2018 962 pts referred to PE. 799 (86%) were seen by the IPV intervention team - 127 referrals missed (14%) - <40 referral encounters in first 5 years, after increasing staffing and hospital wide awareness as well as use of the HITS screening tool 575% increase from 40/year to 450/year	- almost half of women killed by partners were seen at least once within the year of their death - IPV victims are often not dx - two goals – provide services to pts and train providers - Sustainability by reworking existing frameworks, e.g., adoption of HITS screening tool for routine screening - 4% of PE pts were retreated for IPV injuries, compared to research of 15-40% of IPV homicide cases. - may result in lower reinjury rate and IPV-related homicide - does not account for pt seen in different institution

NOTE: DiD = difference-in-difference; DV = Domestic Violence; Dx = Diagnosis; ED = Emergency Department; EDU = Education; HC = Healthcare; HITS = Hurt, Insult, Threaten and Scream; IPV = Intimate partner violence; pt = Patient; PTSD = Post-traumatic Stress Disorder; PE = Project Empower; SA = Sexual Assault; SV = Sexual violence; TIC = Trauma informed care; THQ = Trauma history Questionnaire

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Elisseou, S., Puranam, S., & Nandi, M. (2019). A novel, trauma-informed physical examination curriculum for first-year medical students. *MedEdPORTAL: The Journal of Teaching and Learning Resources*, *15*(1), 10799. https://doi.org/10.15766/mep_2374-8265.10799	To address the knowledge gap regarding TIC by implementing a TIC curriculum for physical exam skills for medical students	148 first-year medical students at Brown University medical school	- Convenience sample of 1st year medical students - TIC presentation delivered as a lecture then small groups to practice hands-on skills - Students were asked to complete a 7-minute survey that assessed baseline knowledge/comfort on a 5-point Likert scale - Students were assessed in their hands on skills by faculty with a suggested grading rubric	- 3 months after the workshop students' familiarity rose by 85%, confidence rose by 62% and frequency practicing TIC rose by 61% - all p<.001 - Students felt using TIC approach was important (M=4.3, SD = 0.7) - high levels of satisfaction with the survey (M=4.1, SD = .8)	- Training medical students in TIC increased their confidence and improved frequency in using TIC skills. Additionally, students had high satisfaction ratings with training programs -Limitations include one school program, not applied to other institutions, or other specialties (ie midwifery) - duration of educational sessions, may benefit from a more at length training. - Provides insight for training design as well as pre and post-intervention surveys

NOTE: DiD = difference-in-difference; DV = Domestic Violence; Dx = Diagnosis; ED = Emergency Department; EDU = Education; HC = Healthcare; HITS = Hurt, Insult, Threaten and Scream; IPV = Intimate partner violence; pt = Patient; PTSD = Post-traumatic Stress Disorder; PE = Project Empower; SA = Sexual Assault; SV = Sexual violence; TIC = Trauma informed care; THQ = Trauma history Questionnaire

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Leite, F., Amorim, M., & Gigante, D. P. (2018). Implication of violence against women on not performing the cytopathologic test. *Revista de Saude Publica, 52*(1). https://doi.org/ 10.11606/ S1518-8787. 2018052000496	To assess association between IPV/SV and adherence to Pap screening	Sample: - the study was performed across 26 health units - 706 women 30 years or older Setting: - Municipality's Health Units in Brazil	-The WHO violence against women tool was used, a 13 - question survey related to violence - The tools goal is to discern type of violence in psychological, physical, and sexual domains	- Higher prevalence of overdue Pap in women w/ hx of IPV/SV - women who had experienced SV had 64% higher prevalence of not performing their Pap on time - IPV had a 95% higher prevalence of overdue Pap	- Patients with hx of IPV/SV are more likely to delay routine screenings such as Pap - limited to women of one Brazilian institution - Concern with recall bias as participants tend to underestimate time since last screening -Patients avoid invasive examination due to triggering of thoughts, providing TIC may improve patient adherence to recommendations

NOTE: DiD = difference-in-difference; DV = Domestic Violence; Dx = Diagnosis; ED = Emergency Department; EDU = Education; HC = Healthcare; HITS = Hurt, Insult, Threaten and Scream; IPV = Intimate partner violence; pt = Patient; PTSD = Post-traumatic Stress Disorder; PE = Project Empower; SA = Sexual Assault; SV = Sexual violence; TIC = Trauma informed care; THQ = Trauma history Questionnaire

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Stevens, N. R., Tirone, V., Lillis, T.A., Holmgreen, L., Chen-McCracken, A., & Hobfoll, S. E. (2017). Posttraumatic stress and depression may undermine abuse survivors' self-efficacy in the obstetric care setting. *Journal of Psychosomatic Obstetrics & Gynecology, 38*(2), 103-110. Https://doi.org/ 10.1080/0167482x. 2016.1266480	To assess the rate that hx of SV was detected by obstetricians, assess if abuse survivors experienced more invasive exams than routine OB care and if it impacted self-efficacy as it pertains to articulating OB needs.	Sample: - 41 pregnant patients in OB care - low income, >50% living below poverty line - Eligibility criteria: English speaking; experienced at least one lifetime incident of physical, sexual or emotional abuse, sexual assault and had no other major comorbidities Setting: Large urban teaching hospital in Chicago. The site was selected as it serves primarily low-income, racially diverse population with high rates of exposure to abuse	Data collected from patients using the childhood trauma questionnaire (TQC), the THQ, the PTSD symptom checklist for civilians (PCL-C), the Patient Health Questionnaire (PHQ-9) Self-efficacy using Bandura's self-efficacy scale guidelines.	80.5% of the patients had been diagnosed with a pregnancy complication (ie HTN, anemia, STI, etc) - Nearly 54% reported significant symptoms of PTSD and 39% symptoms of depression - History of trauma was detected in only 22% of EMR reviews	Limitations - focus on low income population -lacked control group -demonstrated significant need for improved screening -demonstrated need for materials and programs that teach providers how to implement skills of TIC -PTSD and depression associated with lower sense of self-efficacy – diminishing patients' ability to communicate one's needs in OB setting - Supports approaching all patients from a TIC standpoint - women who are high risk for experiencing distress due to history and may be more likely to undergo distressing procedures

NOTE: DiD = difference-in-difference; DV = Domestic Violence; Dx = Diagnosis; ED = Emergency Department; EDU = Education; HC = Healthcare; HITS = Hurt, Insult, Threaten and Scream; IPV = Intimate partner violence; pt = Patient; PTSD = Post-traumatic Stress Disorder; PE = Project Empower; SA = Sexual Assault; SV = Sexual violence; TIC = Trauma informed care; THQ = Trauma history Questionnaire

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Sutherland, M. A., Fantasia, H. C., & Hutchinson, M. K. (2016). Screening for intimate partner and sexual violence in college women: Missed opportunities. *Women's Health Issues, 26*(2), 217-224. https://doi.org/10.1016/j.whi.2015.07.008	To examine screening for IPV/SV rates among the college population	Sample: -615 senior college females -441 respondents from university 1 and 187 from University 2 Setting: - 2 large universities, one private and one public, both in the northeastern US	Design: - cross-sectional study, data collected via web based survey - limited to senior students to avoid parental consent - survey included 2 inclusion criteria "senior-level female student" and "18 yrs or older"	- Mean age of Participants: 21.57 - 36% reported experiences of IPV/SV -more likely to report forced or unwanted sexual encounters compared to other experiences of violence -62.6% reported not being asked about IPV/SV at off campus visits and nearly 90% were not asked about IPV/SV at their on campus visit	- Demonstrated high number of "missed opportunities" for screening - need for workflow to incorporate IPV/SV screening to ensure patients are screened limitations: - sample from one geographic region and 2 universities - recall bias from participants

NOTE: DiD = difference-in-difference; DV = Domestic Violence; Dx = Diagnosis; ED = Emergency Department; EDU = Education; HC = Healthcare; HITS = Hurt, Insult, Threaten and Scream; IPV = Intimate partner violence; pt = Patient; PTSD = Post-traumatic Stress Disorder; PE = Project Empower; SA = Sexual Assault; SV = Sexual violence; TIC = Trauma informed care; THQ = Trauma history Questionnaire

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Walker, J., & Allan, H.T. (2014). Cervical screening and the aftermath of childhood sexual abuse: Are clinical staff trained to recognise and manage the effect this has on their patients?. *Journal of Clinical Nursing, 23*(1), 1857-1865. doi:10.1111/jocn.12390	To assess training needs & awareness of childhood abuse survivors in collecting cervical screening samples	Sample: - 226 providers who collect Paps - 62 were returned - lit review utilized the following search terms: cervical boundaries; they feel they share control; they can consent fully to medical interventions/care; they are aware that the professional understands the issue of childhood sexual abuse (CSA) Setting: Inner London primary care trust	Mixed method study including 3 phases: lit review, questionnaire, and focus group to further explore themes from questionnaire -questionnaire used a likert scale and open-ended questions - focus groups were 2 hrs in length and audio-recorded then analyzed	- surveys were returned (27% response rate) - only 50% of respondents felt confident and 66% competent in undertaking cervical screening in abuse survivors - 94% said that training in improving sensitive care would be helpful	- demonstrates need for sensitivity training due to high number of providers lacking confidence and competence - Providers believed training would be helpful, aiding in increased participation Limitations: - small sample size - 62 participants - specific to childhood abuse instead of any abuse in their lifetime - limited to one clinical practice site in London

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White, A., Danis, M., & Gillece, J. (2016). Abuse survivor perspectives on trauma inquiry in obstetrical practice. *Archives of Women's Mental Health*, *19*(2), 423–427. https://doi.org/10.1007/s00737-015-0547-7	Explore survivor perspectives about helpful approaches to inquiring about sexual trauma during prenatal care	-Focus group of 6 adult female volunteers -Selected based on hx of at least one live birth, hx of distant past trauma and a willingness and ease of discussing trauma and trauma-related issues without causing emotional distress evaluated through interviews -Ethnically diverse, ages 18->45 years	-Scripted focus group run by two female physicians. -3 female observers with SAMHSA present but did not contribute in any way to discussion - Participants were asked to respond as a group and privately to different scenarios - Transcripts then reviewed to identify major themes and sub-themes	-Participants reported fear of ulterior motives for screening: "afraid providers may believe I am unfit to care for my child" -Preferred that resources were offered including peer support and counseling options -Emphasized routine screening upfront -Participants agreed, not knowing about the prospect of useful interventions up front such as counseling options made disclosure of hx seem fruitless -Peer support was a common request	- reassurance that screening is routine, confidentiality is kept and an emphasis on offering trauma-informed resources was important - participants urged against over-emphasis on mental health referral (despite ACOG recommended primary intervention) - Limitations: small sample size, selected for better coping, may have a differing opinion of necessary resources. Participants further along in recovery from trauma.

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Young-Wolff, K. C., Sarovar, V., Klebaner, D., Chi, F., & McCaw, B. (2018). Changes in psychiatric and medical conditions and health care utilization following a diagnosis of sexual assault: A retrospective cohort study. *Medical Care, 56(*8), 749-657. https://doi.org/10.1097/MLR.0000000000000930	Longitudinal study to examine whether SA is associated with changes in health and healthcare utilization	-1350 KP pts from KP Nor Cal with SA dx and 4050 with no dx - Participants randomly matched to 3 women based on age, medical facility and continuous insurance throughout study -Sample across 53 medical facilities	-Retrospective cohort design Inclusion included only patients with SA, other types of abuse were not included -Health care utilization was extracted from EMR then characterized into psych, chem. dependency, primary care, OB/gyn, and ED visits - a DiD framework used to assess whether SA was associated with changes in the prevalence of comorbidities and health care utilization	-SA pts had higher prev. of nearly all comorbidities -Baseline SA patients' prevalence of psych disorders was nearly 4-fold matched (53.7% vs 14.5%, P <0.001) -Substance abuse 11.7% vs. 1.5%, P<0.001 -SA also sig. more likely to have GI conditions, pain diagnoses, obesity, and smoking Prevalence of PTSD from 11% to 24% in the first year following SA dx while non-SA had no significant rise in comorbidities -Mean # of healthcare visits was higher for SA	-Women with SA had sig. higher prevalence of medical and psych conditions and greater utilization in the year following dx - Prevalence of psychiatric disorders and stress-related somatic conditions and utilization of psychiatry and OB/Gyn increased significantly more among women in the year following the SA dx compared with women without a SA diagnosis, after adjusting for income and race/ethnicity - dramatic increase in PTSD - Limitations: only pts who disclosed SA, may be higher risk pts. Pts are insured - SA specifics not assessed, may impact outcomes -Providers, particularly OB/Gyn need training in referring to specialties such as psych

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