Providing HIV Primary Care in the Context of Trauma: Experiences of the Health Care Team

Abstract

Background: Trauma-informed health care for women living with human immunodeficiency virus (WLHIV) attends not only to HIV treatment but also to the many common physical and emotional health consequences of trauma. One principle of providing trauma-informed care is the acknowledgement that working with a population that has experienced extensive trauma affects the team members who care for them in the clinic, as well as the interactions between those team members.

Methods: To understand the needs of one primary healthcare team, we conducted in-depth interviews with 21 providers, staff, and collaborators who provide care to patients within the clinic. We use symbolic interaction and grounded theory methods to examine how interactions unfold within the clinic and how they are influenced by trauma.

Results: The clinic team serves a highly traumatized and vulnerable population. Within this context, interactions between clinic staff unfold and trauma surfaces, and power dynamics play out along the lines of professional hierarchy. While power differences cause tension within the clinic, professional hierarchy also serves as an important division of labor in times of medical crises.

Conclusions: Clinic power dynamics may be influenced to improve the care environment for patients, and to realize a more effective and satisfying trauma-informed health care clinic for both patients and staff.

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Responding to the health needs of women living with human immunodeficiency virus (WLHIV) requires attending not only to their physical health along the continuum of HIV care (Centers for Disease Control and Prevention, 2018), but also to their well-being, which is affected by their experiences of lifetime trauma (White House Interagency Federal Working Group, 2013). We consider trauma broadly, as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Substance Abuse and Mental Health Services Administration, 2014). Trauma can include childhood and adult physical and sexual abuse, neglect, intimate partner violence (IPV), community violence, and structural violence such as racism, sexism, transphobia, homophobia, xenophobia, and HIV-related stigma. Experiences of trauma can have long-term impacts on health including, but not limited to, complex post-traumatic stress disorder (CPTSD) (Karatzias et al., 2017), symptoms of which include re-experiencing trauma, avoiding reminders of trauma, hypervigilance and arousal, negative self-concept, and relationship disturbances. In addition, childhood trauma has been linked to substance use, depression, and other poor physical health outcomes such as obesity, diabetes, heart, lung, and

liver disease (ACE Study, 2014). Beyond affecting health, trauma may affect a patient's ability to communicate with and trust providers, and engage in care, which is especially important when treating HIV (Dawson-Rose, et. al., 2016).

Being attentive and responsive to patients' experiences of trauma and the ways that it affects their ability to engage in care – a trauma-informed approach – includes supporting the staff who care for them (Substance Abuse and Mental Health Services Administration, 2014). In particular, trauma-informed principles call for clinics to establish true interdisciplinary partnership among staff; acknowledge and minimize power differences among staff; and proactively address the needs of staff. Such support is considered crucial because health care providers and clinic staff who work with traumatized patients may experience compassion fatigue, vicarious trauma, and secondary traumatic stress (Nimmo & Huggard, 2013), which can reduce client satisfaction (Baird & Jenkins, 2003; Brookings, Bolton, Brown, & McEvoy, 1985; Collins & Long, 2003; Finklestein, Stein, Greene, Bronstein, & Solomon, 2015; Kosny & Eakin, 2008; Leiter, Harvie, & Frizzell, 1998; Maslach & Jackson, 1981; Perry, 2014; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Wies & Coy, 2013) as well as staff well-being. Clinic staff who have experienced trauma themselves may be at greater risk of being triggered about their own trauma, and thus experience distress when helping traumatized patients (Pearlman & Mac Ian, 1995). Further, a lack of

interdisciplinary partnership can lead to poor health outcomes for patients and high turnover among staff (Johnson, 2009; Sirota, 2008).

Many staff members may lack the knowledge, skills, and agency to respond most appropriately to patients' traumatic experiences. How the clinic staff perform their work, as well as the environmental and organizational space of an HIV clinic, has bearing on how HIV care for women is delivered. In addition, the clinic and its workers are affected by financial pressures to prioritize medical work over behavioral and social work, pressures that present across healthcare generally (Crampton & Elden, 2016). Structural issues, such as gender, also affect both the care that is provided to patients, as well as the relationships between staff members. Empirical findings demonstrate that implicit bias regarding gender results in disparities in symptom presentation, diagnosis, and treatment, and that female patients are perceived as having fewer symptoms and less morbidity across disease conditions (Blair, Steiner, & Havranek, 2011; FitzGerald & Hurst, 2017; Schafer, Prkachin, Kaseweter, & de C Williams, 2016). Gender differences between professions and roles also affect staff and staff relationships, with female employees experiencing more detrimental effects of stress than male employees (Kim, Murrmann, & Lee, 2009), and job satisfaction and commitment affected by the gender balance in the workplace (Olafsdottir & Einarsdottir, 2016). Professional role differences in clinic staff roles can also be gendered and impact power (e.g. physicians being male, and nurses and

social workers being predominantly female). In addition, multiple institutionalized forces can affect the care that is delivered, and can undermine collaboration and mutuality, ultimately contributing to the creation of power dynamics in which the experiences, expertise, and contributions of some members of the clinical team are devalued (Street, 2003). These dynamics and considerations are critical in a movement toward healthcare that is trauma-informed.

Our work takes a symbolic interactionist approach to power dynamics and their impact on the selves of workers in a HIV primary care clinic. For interactionists, the self is “fundamentally social”; it is created as individuals interact with one another, interpret the meanings of those interactions, and create new meanings, including ideas about who they themselves are (Blumer, 1969; Charmaz, 1983; Mead, 1934). This reflective process also considers the social situation in which individuals find themselves, including employment situations. For example, within a clinic, workers interpret the meaning of the social environment and their position within it in relation to other workers, patients, and visitors. As part of this process, workers imagine who they are and who they can be in relation to who they imagine others to be. Such an interpretation, or “definition of the situation,” is often established by the institutions and groups of which individuals are a part (Thomas, 1978). The process of defining the terms of a situation, then, is a process of enacting power, as some terms, and some individuals’ and

institutions' meanings, come to be those that are valued. Power dynamics include, therefore, the language and communication practices, or discourses, through which power is legitimized and reinforced (Clarke, 2005; Foucault, 1994). Further, power is not only a repressive force but may also be a productive one, which matters for what selves individuals can and do express within their social environment.

We also consider how broader social systems matter for what happens in the clinic. For example, we will discuss the presence of different professions on the care Team, and their varying amounts and content of education and training. Further, we address the role of the broader U.S. healthcare system, and the higher value that it generally places on medical work than other work. Finally, we examine the impact of this particular social environment – a clinic that serves a highly vulnerable and traumatized patient population – on the selves of those who work there.

The analysis in this paper is a crucial early step in a larger project of implementing a model of trauma-informed health care (TIHC) developed by a national working group led by our co-authors (Machtinger, Cuca, Khanna, Dawson-Rose, & Kimberg, 2015; Machtinger et al., 2019). As one part of effectively transitioning an HIV primary care clinic to a TIHC clinic, we focus on the organization and relationships of the clinic Team, i.e., all clinic employees as well as close collaborators. While some existing literature

demonstrates the effects of trauma on the health of people living with HIV (Brezing, Ferrara, & Freudenreich, 2015; Decker et al., 2016; French et al., 2009; LeGrand et al., 2015; Machtinger, Wilson, Haberer, & Weiss, 2012), the impact on providers and staff of caring for a highly traumatized population of people living with HIV has not been documented. Therefore, we explore the institutional and interpersonal contexts in which work in an HIV primary care clinic happens, and the experience of Team members working with patients who experience high rates of trauma. Using a symbolic interactionist frame (Clark, 2005; Goffman, 1961), we consider how the roles, responsibilities, and interactions of staff are structured, and the dynamics of individuals who are a part of the Team.

Methods

This study is part of a prospective, mixed methods study designed to evaluate the implementation and impact of a new model of trauma-informed health care on patients and staff of an HIV clinic (Cuca et al., 2019). Results reported here are from baseline qualitative data collection, which took place August to October 2015, before the implementation of any TIHC changes in the clinic.

Clinic Setting

The study site is an HIV primary care clinic for women living with HIV, situated within a larger academic medical center in the San Francisco Bay

Area. The clinic serves adult cisgender and transgender women of color who have experienced trauma in their lifetime (Cuca, Shumway, Machtinger, Khanna, & Dawson-Rose, 2016). Services in the clinic are partially supported through the Ryan White HIV/AIDS Program, which provides essential support services in addition to HIV primary care (Health Research and Services Administration, 2014). The clinic offers a breadth of services beyond medical care, including nursing, social work, case management, psychotherapy, and on-site medical specialty services. Clinic staff are primarily women (83%) and the majority are white (57%). Staff include six primary care providers; two administrative and program staff; five case managers from a collaborating agency; two other clinical staff members; four social work providers; and four medical assistants.

Data Collection

Investigators presented the study at a clinic case conference meeting that included the clinic staff as well as individuals from two other agencies that work very closely with the clinic, providing case management and therapy services. After providing informed consent, participants were contacted by email with a personalized link to an online quantitative survey. After completing the online survey, participants were contacted to schedule a one-on-one qualitative interview at a time and location of their choice. Interviews took between 45 and 60 minutes. Interview questions explored how participants understand the impact of trauma on the clinic's patients, and

participants were asked to describe their own experiences of working in the clinic with both patients and other team members. Participants received a $25 gift card. In total, 21 (17 women and 4 men) of the 25 clinic staff participated in individual interviews. The investigators also observed clinic staff and patients in the clinic waiting room, at case conferences, and at other clinic meetings. The study received ethical approval from the University of California, San Francisco's Human Research Protection Program.

Data Analysis

Following grounded theory methods, the investigators initially reviewed the transcripts to develop a codebook, and double-coded four of the transcripts (19%) to ensure an intercoder reliability of 90% (Charmaz, 2006). Data from field notes and clinic observations were incorporated into the codebook. Investigators met on a regular basis to review codes and memos and further interpret data, creating themes that were emerging from observational data and integrating these with themes emerging from interviews. The investigators used ATLAS.ti software to manage the data coding.

Initial summary results were presented in a clinic Team meeting. In addition to updating the Team on the study findings, investigators used this opportunity for respondent validation of our initial analysis. Results of this analysis are presented below.

Results

Power, Hierarchy and Autonomy

Power dynamics in the clinic are principally articulated through a hierarchy based on profession, rather than purely along administrative lines. This hierarchy exists along a continuum ranging from primary care “providers” (physicians, nurse practitioners); to “staff” with varied professional degrees (e.g., nurses, social work staff, pharmacists, therapists, case managers, and programmatic staff), to “frontline Staff” (medical assistants, pharmacy technician). “Clinical leadership” includes the Medical Director and Nurse Manager. We use the term “team” to refer to the entire group of individuals who work at or with the clinic. The hierarchy is complicated by the fact that some team members are shared between this clinic and another, creating some inconsistencies in how practices are managed and challenges for collaborative problem resolution.

As in most clinics, a feature of clinic hierarchy is the difference in team members’ autonomy, with providers having autonomy to provide care as they deem best. One provider acknowledges the autonomy that he has over his work and his schedule:

> I think when I notice that a patient really needs me, or that something special is happening…, I can clear my brain. And I can, I can let go of the fact that someone else is waiting for me and is gonna be mad at

> me because I'm late, who doesn't need me as much. And I can… and I do make those choices all the time, to be with somebody who's actually opening themselves up to being helped and revealing something that might be very special and important. (Male Provider)

The provider expresses caring through focused attention on a patient in need, while also exercising autonomy over his time and schedule. Some staff, particularly social work staff, are also afforded a degree of autonomy in their work as they assist patients. While this autonomy allows for provision of individualized and tailored care, it has a direct impact on others in the clinic. In this case, for example, other staff are left to respond to patients who are upset about having to wait when the provider chooses to spend more time with another patient.

In contrast, frontline staff have much less autonomy in their work. These team members are the patients' first point of contact, coordinating visit logistics, and working with patients who may be feeling and presenting stress as they enter the clinic. While providers move *through* the front office/ waiting area space, the front desk is an exposed space from which frontline staff members can rarely move if they are assigned to it that day.

Variation in team members' autonomy and power also happens through differences in how clinic policy is applied. For example, frontline staff can feel limited in what actions they can take to manage challenging patient actions

or behaviors. Team members have reported incidents such as patients bringing non-service animals to clinic, being called “faggot” in a telephone conversation, being yelled at by patients, patients having “outbursts” in the clinic waiting room, and “people coming in just totally high and totally tanked”. If any staff member feels that a patient has acted inappropriately, has been threatening, or has broken clinic rules, staff members may write and submit a formal complaint. In most cases, such patient behaviors occur toward frontline staff, and staff member explains:

> Each time something happened [with a patient], we … write [an] encounter and document what [happened], but sometimes I feel little bit disappointed because I wish, you know, there would be some kind of follow-up with the patient, but usually I feel [there’s] not. (Male frontline staff)

Although these staff do at times write and submit formal complaints, clinic leadership is not always responsive in a way that the frontline staff member believes is important. As a result, these staff members experience a sense of invalidation.

In addition, the hierarchy that is generally built into clinics mandates that those at the top make executive decisions that directly affect all who work there. This is not necessarily problematic, but its consequences can be negative depending on how authority is exercised. In this clinic, a few team

members had been laid off for various reasons in the 5 years prior to the study. One described the effect of a worker's departure:

> I think … that really undermined our sense of place, and our sense that we are respected as hard-working people. [The employee]… was a hard-working, well-intending, you know, was not always effective, but so can be said about a lot of people. …So I think the impact was one of, of just everybody feeling really unsettled and unsafe for a while. (Female provider)

Hierarchy, when it is enacted in ways that violate team members' sense of fair play, can affect staff members' selves as it makes them feel unsafe.

Not all experiences of hierarchy are invalidating, however. The varied professional disciplines present at the clinic can produce a sense of complementarity and commitment among Team members. One participant recalls a patient's seizure in clinic as one such galvanizing moment:

> I mean it was a scary moment and it was interesting to see everyone kind of come together and do what they were supposed to do and handle the situation, and afterwards the…[social work staff] did all the follow-up and, um, they all worked together and the MAs [medical assistants], you know, like everyone, they called to attention…, they did everything they needed to do and it worked, and they fell together like seamlessly. (Female staff)

Such coordination gives individuals a sense of the importance of their unique contributions to the team and, because of this, a feeling of being “invested in being involved,” as one team member put it. The effect of division of labor in such moments can be a sense that the clinic situation is “less chaotic” than it otherwise might be. Each person has an important defined role in the overall team.

Clear hierarchy can also mean that, for some team members, there is regular supervision that helps them feel valued and supported. In these cases, supervisors clarify roles for supervisees and can help supervisees address challenges that they are having. Supervisors can also offer a space to express and deal with day-to-day frustrations of work. One team member said their supervisor was “wonderful,” and others appreciated the space that their supervisor gave them for self-care, a process that enabled them to be more fully present in clinic.

Training and Multiple Kinds of Knowledge

The presence of different professions and degrees of power and authority in clinic also means that discourses about how to understand and work with patients, including those who have experience trauma, are distributed unevenly in clinic. The varied professions represented in the clinic receive substantially different training through the health professions education system in working with patients who have experienced trauma, and whose

behavior is sometimes labeled as “complex” or “challenging.” Prior to working independently, physicians, nurses, and mental health staff participate in residencies and direct patient care training that provide them with opportunities to interact with patients and to practice such interactions. Frontline staff, in contrast, generally do not receive training about therapeutic communication or the assessment skills that may be needed when interacting with individuals who have suffered trauma or who may have mental health issues. Less training may also mean less overall experience working with patients; in this clinic, Providers have worked with vulnerable populations for an average of 15 years, while frontline staff have only 7 years of experience on average.

This situation can mean that team members who lack such preparation or experience, particularly frontline staff, feel unprepared when interactions with patients do not go well. One frontline staff member describes the difficulty:

> I’ve kind of learned how to, um, not take … [interactions with patients] so personal. But it’s hard not to when, you know, … [patients are] … cursing at you and stuff like that. … I just wanna like understand that part of it, like why are they so angry, you know, kinda learn to deal with it, ‘cause I still take it pers-, that part personal. (Female frontline staff)

This difference in training and experience, combined with differences in team members' power and autonomy, can cause tension in clinic. One participant offers their interpretation of frontline staff members' experiences:

> [A patient] will come to the front desk, there'll be a negative interaction, … [then the staff member will] say to me, 'So-and-so said this to me,' and I'll say- … 'Lighten up,' kinda thing, you know what I mean? It's not that serious. But it's so offensive and it <u>is</u> serious. So maybe I look like I don't really care about their feelings and it's not that I don't, it's that I feel like, without me going into the whole, you know, 'This person has this mental health issue and this is the way that she operates,' and I'm not saying that it's right, but you have to kind of account, like a lot of our patients, this is what they do and this is not… personal. (Female staff)

Without certain types of training in communication, and with less experience with the purpose of a therapeutic environment and working with patients, frontline staff are less well versed in a style of speech and meaning-making central to clinic culture. Instead, these team members draw upon their own work and personal experiences, as well as behavior modeled by others in clinical interactions and clinic case conferences.

When frontline staff's lack of training in valued forms of communication intersects with their lack of authority, they are left with little recourse. As noted above, frontline staff members may go to clinic leaders for help but

not get the response they had wanted. Again, this lack of response may be due to the value placed on skills for managing complex patients, and the perception that their colleagues lack it. Given this, leadership may not always see frontline staff member complaints as meaningful, or they may prioritize the patient experience over that of the frontline staff. The process of adjudication can also mean that the narrative of an event coalesces into one that favors a provider or other team member who is higher in the hierarchy.

Valuing Medical Work, Devaluing Other Work

The clinic's placement within the broader health care system means that discourses that emphasize medical care can at times be valued over other forms of care. One individual notes:

> Here … [the work is] all medicalized. All of it. … [The social worker] will intervene and say, 'Well have you thought about this or that?' in the mental health piece and … [the providers] don't think like that, everything's like, 'Did you get on this medicine or that medicine or diagnosis?' … and it's all focused on that. (Female staff)

That the work is "medicalized" does not mean that physicians do not understand patients' experiences. Rather, Providers know well that patients' experiences are informed by trauma and that understanding patients' broader social experience is critical to their care; however, the social structuring of the clinic can mean that Providers' attention is at times more

narrowly centered on the medical, and that the psychosocial is less well-integrated. At times, team members desire this division of labor so that patients will not be triggered by having to discuss painful experiences repeatedly; at other times it can mean that medical language and work are valued over other language and work.

This factor is perhaps amplified by the clinic's setting in the larger system of health care, in which medical services are billable and others are not. This comes up as some team members at times are unable to attend to requests for which they are not paid, for example. One staff member explains, "The pushback that I get all the time, because I often do wanna meet with providers, it's like, 'Well I'm not there,' or 'I'm not paid'." Non-billable work does not always get done because providers are paid to work a 4-hour clinic, and administrative tasks such as meetings, charting, and follow-up with other team members are less well supported by the system.

The emphasis on the medical is also apparent in the dynamics of regular case conferences, in which all team members meet to discuss patients and their care. The meetings are generally organized around provider reports on their own work. Some team members characterize their own input as "minimal," saying that, because the work of social work staff, collaborators, and medical assistants is not discussed, the meetings are less helpful to

them. Some team members say they sense a hierarchical order in the meetings:

> I feel like there's such a strong trajectory of the arc of the conversation that sometimes when I intervene …it's not really, it doesn't really settle. Maybe it settles later, um, but …I feel like there's kind of, there is a hierarchy in those meetings. (Female staff)

We might say that hierarchy in the meeting's organization creates a legibility issue: providers direct the meeting, start the meeting, and more frequently speak in terms of medical needs and what the focus is for the primary care appointment. Therefore, it can be difficult for information about psychosocial and other relevant aspects of a patient's trauma experience to be raised and addressed.

Discussion

Implementing TIHC includes examining the experiences of clinic staff. These data highlight how broader social structures may influence the clinic staff, and how professions present within the clinic organize and compartmentalize health care. Given these structures, individuals are differentially accorded power to define their work and the boundaries of the organization. At the same time, the clinic's medical discourse prioritizes medical work over other work. These processes can make a difference in how team members' see their role in everyday interactions. That said, these same social structural issues mean that Providers can and do stretch boundaries to provide the

best care possible to WLHIV. The broad array of professions present in the clinic mean that it is well equipped to address multiple issues that WLHIV face beyond medical care, producing a sense of complementarity and solidarity among staff. Team members acknowledge the importance of psychosocial concerns, even if they are not always completely skilled in how to respond to them. Organizational hierarchy in the form of supervision can also produce opportunities for staff to feel supported and to grow.

Our TIHC model (Machtinger et al., 2015; Machtinger et al., 2019), while originally designed to improve patient care, also acknowledges the experience of staff working with WLHIV who have experienced trauma, and provides guidance for implementing changes that affect both staff and patients. The model conceptualizes a trauma-informed approach as having four main components: 1) an environment that ensures that Team training, clinic physical space, and Team relationships promote safety and healing; 2) education and inquiry that ensures that all patients are screened for recent trauma and the consequences of lifetime trauma, and are provided education and resources regardless of whether they screen positive; 3) a response to recent and past trauma that is supportive and includes trauma-specific therapies and interventions onsite or through partnerships; and 4) a strong clinic foundation, including realizing the values of trauma-informed care throughout the broader service environment in which the clinic

operates. The data reported here support the importance of each of these elements for improving patient care and for supporting staff.

First, to improve the environment of care, TIHC includes training all clinic staff about the impact of trauma on health and about how to respond to manifestations of trauma. This process involves creating a shared language of care to facilitate treatment and team relationships, as well as the acknowledgement that staff may also have experienced trauma. Trainings may include role plays to increase team members' preparation for working with patients who have experienced trauma or who behave in unexpected ways. Our findings affirm the model's attention to creating a clinic environment that reduces power differentials among staff, not just for the impact that it may have on patients but also for the well-being of staff. While a complete leveling of power differences may not be possible within current U.S. medical structures, TIHC is predicated upon partnership and a team approach to care among the varied medical professions, and upon policies and procedures to ensure that stakeholder voices are heard, providing an opportunity for staff to reconstruct their selves. Further, a trauma-informed environment and approach, including education for all members of the clinic staff about the link between trauma and health, can open the doors for staff to deal with their own trauma by raising awareness of the link between trauma and health, and serving as an impetus for them to seek care themselves.

Our findings also indicate a role for staff to be able to identify and respond to the consequences of trauma when providing care for WLHIV. This change could provide staff with the opportunity to engage patients in a process of healing from some of the manifestations of trauma, which may include hyperarousal or substance use during clinic visits. Because these manifestations may have a negative impact on staff – for example when a patient raises their voice in anger and a team member takes the behavior personally – responding to patients therapeutically can help not only patients but also staff. Finally, our findings support the model's focus on foundational trauma-informed values and relationships, especially collaboration and mutuality. To this end, efforts to increase participation and acknowledge the voices and opinions of all staff as a way to reduce hierarchy as much as possible are crucial. This can include attending to psychosocial issues in clinic; transparency in how decisions are made so that staff do not feel that their jobs are threatened; strengthening the clinic team such that all staff input and effort is valued; restructuring meetings and interactions so that all voices are heard equally; and allowing and supporting the positive synergies that can come from people's differences (e.g., different training and different life experiences). The findings also suggest that links to the wider healthcare system to which the clinic is connected may be important to what happens in clinic. Advocacy to relieve pressures within the clinic (e.g., improved reimbursement structures for nonmedical work) may improve relationships

between staff. We note that this is in line with existing work suggesting organizational interventions to care for clinical team members working with traumatized populations (Bell, Kulkarni, & Dalton, 2003; Morley, 2012).

Limitations

A potential limitation of this study is the small sample size, which may have caused some participants to be concerned that their comments would be identifiable to others on the team. The themes that emerged from the data, however, cut across most interviews and observational data, and therefore are not specific to one or two individuals. Another limitation is the study's setting in an HIV primary care clinic rather than general primary care, and the fact that women living with HIV have disproportionately high levels of trauma. Although this may make the data somewhat less generalizable, it brings to light more strongly the impact of patient trauma on the staff who care for them, and may be useful for other clinics caring for highly vulnerable individuals, such as safety net clinics.

This study does not address issues of institutions that perpetuate race, class and gender divides that are nevertheless relevant in the clinic. The social hierarchy in the clinic mirrors these hierarchies, which exist in healthcare more broadly. That is, predominantly women of color work in the lower level jobs, white women are in the middle of the hierarchy, and white men are at the top. These data are drawn from one clinic only and although gender

differences within the clinic hierarchies exist, gender was not a focus of this analysis and deserves further study. Future research could include critical race and gender perspectives on these processes, and how they may be manifested in clinic interactions and larger organizational processes.

Implications for Practice and/or Policy

Although TIHC is focused on the clinic and individuals within it, its implementation can be a catalyst for larger system change. It can model how health care systems and education systems can be more responsive to patients' and staff members' needs. Implementing TIHC can bring challenges to an environment that is derived on a care model that is ideologically different, such as the medical model (Anderson, 1995). Moreover, this approach allows us to consider the medical clinic not as a static environment where only pre-existing discourses exist, but rather as a site in which a trauma-informed approach could amplify competing discourses in such a way as to fundamentally change the constitution of a primary care clinic. For example, childhood trauma and structural violence are not typically considered to be in the domain of adult primary medical care. TIHC, in contrast, identifies both conditions as underlying and perpetuating many common health problems, and includes opportunities to heal from past trauma and cope more healthfully with persistent trauma. At a policy level, our findings suggest that people who work at all levels of health care need to be better trained and supported in TIHC, in the linkages between trauma and

health, in working with patients who are different from them and have had different experiences, and in effectively dealing with the vicarious trauma that may occur when working with highly traumatized populations. Further, health care that values interdisciplinary practice may be more amenable to becoming trauma-informed and may show value in addressing social determinants of health, of which trauma is among the most important, and to understanding organizational processes of healthcare, as both of these shape not only patients' experiences but also staff members'. TIHC offers a promising model to effect this change.

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