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Exploring Nurses' Knowledge and Experiences Related to Trauma-Informed Care

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Abstract

Trauma-informed care is an emerging concept that acknowledges the lasting effects of trauma. Nurses are uniquely positioned to play an integral role in the advancement of trauma-informed care. However, knowledge related to trauma-informed care in nursing practice remains limited. The purpose of this article is to present the results of a qualitative study which explored nurses' understandings and experiences related to trauma-informed care. Seven semistructured interviews were conducted with nurses and four categories emerged from the analysis: (a) Conceptualizing Trauma and Trauma-Informed Care, (b) Nursing Care and Trauma, (c) Context of Trauma-Informed Care, and (d) Dynamics of the Nurse–Patient Relationship in the Face of Trauma. These findings highlight important considerations for trauma-informed care including the complex dynamics of trauma that affect care, the need to push knowledge about trauma beyond mental health care, and noteworthy parallels between nursing care and trauma-informed care.

Keywords

nursing, qualitative analysis, qualitative descriptive design, relationships, trauma, trauma-informed care

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Background

Recognition of the significance of psychological trauma and its impact on individuals, families, communities, and society at large has greatly expanded over the past 20 years (e.g., Brown, Baker, & Wilcox, 2012; Fallot & Harris, 2009; Muskett, 2014). Current research continues to further our knowledge of trauma and its biological, psychological, and often self-perpetuating social consequences (Brown et al., 2012; Fallot & Harris, 2009; LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015). To date, research has linked exposure to trauma with significantly higher rates of health care usage and physical and mental disorders (e.g., Cohen, Scheid, & Gerson, 2014; Felitti et al., 1998; Herman, 1997; Jennings, 2008). Trauma may be experienced at any point in a person's life. Early traumatic life experiences can alter an individual's psychological and physiological development, contributing to increased risk behaviors, as well as a collection of unfavorable emotional, social, economic, and health consequences (Jetmalani, 2015; Miller, 2013). Later life traumas may also occur. These traumas are acute or prolonged in nature, and may destabilize or damage one's sense of safety, self, and self-efficacy, as well as one's ability to moderate emotions and navigate interpersonal relationships (Poole & Greaves, 2012).

In the current context, specialized services, known as trauma-specific services, exist to care for persons affected by trauma. Yet, individuals who have experienced trauma most commonly receive care through general health care systems. Without specialized knowledge of trauma and its relation to the presenting concern (Harris & Fallot, 2001), trauma is rarely adequately assessed or addressed (Madhusoodanan, 2016). Researchers suggest a shift toward viewing every patient as though they may have a trauma history, and expanding capacity to care for the effects of trauma into all health services (Elliott, Bjelajac, Fallot, Markoff, & Glover Reed, 2005; Muskett, 2014). This lens of "universal trauma-precautions" is

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at the core of trauma-informed care (TIC). TIC is built on an appreciation of, and responsiveness to, the consequences of trauma, and it requires individuals and organizations to provide services and care that offer a sense of safety for both patients and providers (Hopper, Bassuk, & Olivet, 2010; Jetmalani, 2015; McCann & Pearlman, 1990). TIC philosophy is founded on the premise that every person is doing their best to cope within the context of their experiences and development (Chandler, 2008). TIC is designed to recognize and support the special needs of persons who have experienced trauma (Elliott et al., 2005; Harris & Fallot, 2001; Hodas, 2006) and is delivered in a manner that is sensitive to the effects of trauma on an individual's life and development, while reducing the risk of re-traumatization (Elliott et al., 2005).

Nurses, as direct care providers who work within a holistic perspective, are positioned to play an integral role in the advancement of TIC within health care services. Unfortunately, some literature suggests that nurses are often left confused by vague definitions and struggling to know how to translate TIC ideas into day-to-day practice (Hall et al., 2016; Muskett, 2014). Though there has been an emergence of implementation efforts of TIC within various nursing specialties, including mental health (Muskett, 2014), emergency (Hall et al., 2016), perinatal care (Choi & Seng, 2015), neonatal and pediatric acute care (Kassam-Adams et al., 2015; Marcellus, 2014), and correctional settings (Harner & Burgess, 2011), the views and knowledge of TIC among nurses in general remains largely understudied. The purpose of this study, therefore, was to explore the understandings and experiences related to TIC among nurses.

Method

Design

This was a qualitative descriptive study (Sandelowski, 2000) exploring nurses' understandings and experiences related to TIC, which was part of a multiphase research project on TIC. Qualitative descriptions strive to present a comprehensive and sound testimony of the meanings that participants ascribe to phenomena (Sandelowski, 2000). This method draws from the principles of naturalistic inquiry, and aims to study individuals and phenomena in their natural state (Lincoln & Guba, 1985; Sandelowski, 2000).

Participants and Recruitment

Recruitment of participants was done in two distinct phases. In Phase 1, individuals completed an online survey related to their knowledge and attitudes toward TIC (Stokes, Vandyk, Squires, Jacob, & Gifford, 2017), which included the Attitudes Related to Trauma-Informed Care Scale (the ARTIC; Baker, Brown, Wilcox, Overstreet, & Arora, 2016). The participants were asked to include their email addresses if they consented to be contacted for a related qualitative study. Of the 248 individuals providing their email addresses, 18 met our inclusion criteria, which consisted of (a) being a registered nurse, (b) a general level of English proficiency, (c) scoring in the top 20th percentile on the ARTIC survey, and (d) current nursing employment in the province of Ontario, Canada. The decision to target individuals with higher scores on the ARTIC scale was based on our presumption that these individuals would have a greater awareness of and interest in TIC and, therefore, provide a richer perspective to explore. Interview participants were limited to Ontario to provide a degree of homogeneity within the sample, as all participants practiced in the same provincial context and were licensed according to the same professional standards and competencies. In Phase 2, all 18 potential participants were invited to participate in the qualitative interviews, with seven participants consenting and included into the study.

Ethical Considerations

Potential participants were contacted through email with an invitation to participate, along with the study information sheet and consent form. Informed consent was obtained prior to each interview. The complete project, including this study, received ethical approval from the Research Ethics Board at the University of Ottawa (File: H10-15-04).

Participant Characteristics

Of the seven participants included in this study, six identified as women and one identified as a man. Their ages ranged from 32 years to 55 years. All participants reported working in a psychiatric or mental health setting. Their total years nursing ranged from 7 years to 34 years, with a mean of 18 years. Participants were educated at varying levels; one was diploma prepared, two had an undergraduate university degree, and four reported having completed graduate level degrees (Table 1).

Data Collection

Data were collected through semistructured, face-to-face, and telephone interviews designed to guide discussion around the participants' understandings of and experiences with TIC. We piloted the interview with a nonparticipant nurse to assess coherence and relevance of the interview guide. Example interview questions were as follows: (a) "What is your understanding of TIC?" and (b) "Could you tell me about your experience(s) in using TIC in your practice?" Interviews were approximately 60 minutes in length and were audio-recorded and transcribed verbatim. All identifying information was removed from the transcripts. We kept memos after each interview to record personal impressions related to the interview and to capture contextual information, which were considered during the analysis.

Table 1. Participant Demographics.

Study ID	Sex	Age	Years of Experience	Education	Work Setting
Participant 1	F	41–60	11–20	Diploma	Mental health
Participant 2	F	41–60	21–30	Master's	Mental health
Participant 3	F	41–60	>30	Bachelor's	Mental health
Participant 4	F	41–60	21–30	Master's	Education/mental health
Participant 5	M	41–60	<11	Master's	Mental health
Participant 6	F	21–40	<11	PhD	Mental health
Participant 7	F	21–40	<11	Bachelor's	Mental health

Data Analysis

We analyzed data using constant comparison (Glaser & Strauss, 1967), as organized and presented by Paillé (1994). Although Paillé's approach is based on the principles of grounded theory (Strauss & Corbin, 1998), this approach to analysis is commonly used in qualitative descriptive work (e.g., Paillé & Mucchielli, 2003). Data analysis occurred iteratively with data collection (Lincoln & Guba, 1985). Specifically, coding of transcripts commenced and continued after the first interview, and preliminary findings were considered in the conduct of subsequent interviews. The principal investigator was primarily responsible for data analysis and respected the following procedure: (a) immersion in the data by reviewing and rereading all the interview transcripts, listening to the audio-recordings, and exploring the content and possible meanings of the data; (b) breaking down and refining interview data into discrete codes, or units of meaning; and (c) systematically comparing each coded element with all previously coded elements for similarities and differences (Sandelowski, 2000). During analysis, we guided our thinking by asking questions such as "What is happening here?" and "What does this indicate?" (Paillé, 1994).

A second investigator independently coded three transcripts, which were compared with the principal investigator's coding to identify disparities in the interpretations of the data. Once these three transcripts were coded and agreed upon, the two researchers began to aggregate codes into categories and a third team member was consulted to discuss the construction of the emerging categories. Categories were continuously reevaluated as the analyses continued to ensure that they remained internally homogeneous (grouped codes were aggregated appropriately, creating a coherent categories) and externally heterogeneous (categories were mutually exclusive). Throughout the analysis process, the researchers regularly returned to the initial transcripts and recordings, helping to ensure that the findings were grounded in the data.

Trustworthiness

We followed Guba and Lincoln's (1994) five criteria of trustworthiness: (a) credibility, (b) dependability, (c) confirmability, (d) transferability, and (e) authenticity, to support rigor of this study. Credibility, or confidence in the truth of the findings, was enhanced through investigator triangulation by including all research team members in the data analysis process. This challenged assumptions of individual researchers and ensured that the findings remained grounded in the participants' experiences. Dependability and confirmability were promoted through the construction of an audit trail, including raw data and memos from data collection and analysis that logged observations, impressions, reflections, process notes, and the basis of analytic decisions. Transferability was enhanced through thick description of the demographic profiles, context, and experiences of the participants. These rich depictions, and the inclusion of participant quotes in the findings, support a fair and faithful presentation of the range of participant realities. Authenticity refers to multiple dimensions of fairness, awareness, and action; that is, the authenticity criteria reinforces the need to give a voice to the stakeholders, to educate and improve understandings of personal constructions, and to stimulate and empower action (through dissemination of findings). This study raised awareness of the importance to TIC among participants and, hopefully, the results from this research will stimulate discussions and actions both at the micro (unit and hospital) and macro levels of nursing care (education, conceptions of care).

Findings

In keeping with Paillé's (1994) analytic scheme, participants' experiences in relation to how they conceptualized trauma and its effects on practice were grouped in four main categories: (1) Conceptualizing Trauma and TIC, (2) Nursing Care and Trauma, (3) Context of TIC, and (4) Dynamics of the Nurse–Patient Relationship in the Face of Trauma. A general overview of the main categories, as well supporting quotes, is presented below. Given the importance that participants put on (2) Nursing Care and Trauma, this category is further divided into three subcategories: (2.1) basic nursing practice, (2.2) labels and preconceptions, and (2.3) safety and control.

Conceptualizing Trauma and TIC

This category captured the participants' understandings of trauma and its effects on their practice. Most participants reported not receiving formal trauma-informed education as part of their schooling and, as a result, very few stated that

they were familiar with the actual concept of TIC. Instead, participants described what trauma and trauma-sensitive care meant to them. Furthermore, participants described how their motivation to learn about trauma stemmed from their own experiences, from their patients' experiences, or from family and friends who experienced trauma. Learning about trauma and its effects on patients was more of an inductive process where they saw a need to better understand trauma in practice, thus prompting them to explore it in more detail.

> Well, it was encounters with patients, with clients, that had told me about trauma, and then it was my desire to learn more, in particular about what the trauma was, and as an example I can remember . . . I remember there was one young man who was in, charged with assault, and he revealed to me that he had been sexually abused by a teacher at school, and over the course of the two years that I knew him, he began to talk to me more and more about it, and because I thought, you know I don't understand this issue, I don't know how to support him, I don't know what to say to him, I began seeking out resources and ways to learn about what his experience was, and how to help him. (P3)

When describing their understandings of trauma, the participants spoke of an inherent individuality in how trauma is experienced, and that this subjectivity might include variations in time, place, and meaning:

> . . . and trauma's defined by the person not by me, like I can't say well, that's a real trauma, and that's just, like that's just life, you know what I mean? (P4)

As these participants explained, care informed by trauma is care that meets the patient where he or she is at. Such care requires acknowledging the individual experience of trauma and its effects on one's life story. In addition, participants described the variability of the effects of trauma and articulated the potential physical and psychological manifestations, including anxiety, (emotional) dysregulation, disassociation, addictions, personality disorders, and psychosis. Common to all participants was the notion that trauma can change a person; create or alter the very core of the individual—their identity: "It [trauma] creates the person, who the person is that day . . . it [trauma] affects the entire . . . identity of the person, and how they express who they are, and cope with things" (P1). Finally, all participants highlighted how trauma stories might not always be known to either the patient or the health care provider. Using the example of trauma that is experienced in childhood, this participant explained the notion of silenced trauma and how it might lead to manifestations of symptoms, even without direct access to the story:

> Because his trauma occurred so young, you can't actually have a conversation about the trauma because they may not even realize it exists in there, you know, like if you've witnessed domestic violence . . . (P7)

Nursing Care and Trauma

In this category, the participants' views of providing nursing care in the context of trauma are described. Participants emphasized that TIC is pertinent to all patients regardless of setting, not just in psychiatric/mental health care, where trauma care is traditionally considered relevant. According to participants, nursing care from a trauma-informed perspective was related to (2.1) basic nursing practice, (2.2) labels and preconceptions, and (2.3) safety and control.

Basic nursing practice. Participants noted that, while current scientific knowledge of trauma is key in the provision of trauma-informed nursing care, for them, some of the principles of TIC also relate back to the fundamentals of nursing—the importance of patient-centered approaches and the centrality of the therapeutic relationship. As this participant explained, TIC related to a fundamental nursing goal of providing holistic care:

> Yeah, and that's [TIC] related of course to patient-centered care, which I think nurses practice everywhere. It's treating people as people and it's just part of our values . . . Treating other people the way you'd want to be treated yourself . . . It's about understanding experiences that people may have had, and understanding what they need in terms of [their] trauma. (P5)

However, participants equally highlighted that without the acknowledgment of trauma in practice, there was a possibility of superficial or even harmful care, where individual needs are not addressed.

> I find it's a very superficial level that we deal with a lot of traumas, that's all, I guess. Which then I think recreates trauma, it actually, like, makes it worse. (P1)

As such, participants explained the importance of approaching every patient as if they might have experienced trauma. Some participants equated this principle to the idea of "universal precautions", commonly used in nursing for infection control:

> I usually say, just as it's a very big deal with certain body secretions, we just consider that maybe this is a communicable disease, and when we are handling body secretions with universal precautions, we use all those barrier precautions. It's the same when we are dealing with mental health clients. I just consider [there] could be history of trauma, but I might not be aware of that trauma. (P6)

Labels and preconceptions. Participants spoke of acknowledging their patients as people and being aware of labels and preconceptions in practice (e.g., reducing patients to a diagnosis). A particular emphasis was placed on the need to focus on patient strengths (rather than their weaknesses) in the provision of care. For example, one participant spoke of disliking the term *victim* and preferred to use the term *survivor*:

> I don't particularly like the term victim, because anybody who has gotten through a trauma, I think they've survived, no matter what level they're at of getting through a trauma. So then it's hoping that the person can be helped to recognize that they've, well survived something, which is a . . . strength as opposed to a weakness. (P1)

Labels extended to TIC as well, with one participant concerned that the novelty of TIC could ultimately reproduce further patient "labeling" and a deficiency-based perspective of care:

> I'm worried that the term [TIC], might be seen, unless it's carefully done, . . . sort of negative, and people are wounded, battered, armed, kind that label stuff again, going back to that label thing. (P4)

Rather than focusing on labels, participants spoke on the importance of "walking alongside" the person receiving care. This idea denoted the role and responsibility of the nurse to move beyond preconceptions and to be compassionately present when supporting their patients:

> I absolutely care for a person no matter what they say or wish to share with me, because that's part of empathy and . . . the healing process; me walking alongside that person and staying alongside of that person . . . continuing to open the doors for talk and communication to work it through. (P4)

Safety and control. Inherent to nursing care in the context of trauma were references to notions of safety and control. On one hand, participants spoke of safety in relational terms, emphasizing its role in the establishment of trust; elements that were seen as foundational to the development of a therapeutic rapport. In their roles as nurses, the participants identified how they can model for the patient interpersonal relationships that are trustworthy and dependable:

> Because they have had a hard time trusting people, and you have developed that trust with them, it's important to maintain it because it's not really about me, a one-time nurse they will meet in one unit. It's basically about knowing that there are people in this world who can be trusted, so I'm just giving them that knowledge or that information that there are people in this world who can be trusted and you can develop relationship, a good relationship with certain people in the world . . . I don't want to be categorized in that category of others who they cannot trust, or you know, who are fake or manipulative. (P6)

Conversely, the nursing responsibility to ensure safety (of self and patient) led participants to also speak of a tension that exists in the provision of care in the context of trauma. A few participants explained how, at times, the staff's needs for personal safety could result in controlling practices, which might threaten their patients' perceptions of safety:

> Because it's easy just to control the situation, as opposed to actually, allowing the person to express the feeling and feel safe, to find a safe way. I think the importance of feeling safe is really really important and that's one of the things . . . the staff feeling safe is more important than the patient feeling safe. And that's concerning to me, because, it's easy to make the staff feel safe by medicating and restraining, where it's actually, if we can make the patient feel safe then indirectly we would have that same effect, which is to decrease trauma for everybody. (P1)

As such, some participants described a "conflictual relationship," where there was a conscious realization that certain nursing acts designed to maintain safety might actually cause further trauma:

> Nurses are one of the caregivers, and they kind of have a conflictual relationship, because sometimes what nurses need to do, or are required to do, are sometimes not therapeutic, or . . . can be quite traumatizing, or in conflict with where the person is at, maybe psychologically or emotionally, but physically they may need [the intervention]. So it's a difficult spot to be in, when you're a nurse. . . (P1)

Context of TIC

Further to discussing the role of trauma in nursing care, participants suggested specific contextual factors that influence the application of TIC in practice. Participants commented on the nursing profession as becoming more methodological and quantified, particularly with advances in technology. Participants questioned the effects of quantification on nursing care and fostering approaches that support TIC:

> I just think of an emergency room nurse and a triage nurse, and I can see, if you pull out another questionnaire and ask them, "ok ask them if there's some trauma," right? Which sounds really, very nice, let's get this done. We're going to be really practical when bringing trauma-informed care into practice, it's really important. Ok, so we're going to have a best practice guideline for it, we're going to sit it in there, and then the person says, "yeah, well, actually I do have a trauma." And then you go, "thank you, check," and then you move on. Woah, you just made it worse, because you haven't really been therapeutic in nature, you know what I mean? (P4)

Furthermore, participants shared a sense of some staff losing interest in the essence of their role, becoming set in their ways, and performing their functions by rote: ". . . because you're trying to just, come in, get your job done, and leave, is kind of the attitude . . . and I don't think nursing is just that" (P1). Participants explained that when staff become set in their ways, it is difficult for them to be open to different or new approaches to practice.

The element of time was highlighted by participants as particularly important in providing care in the context of trauma. Time was described as both a lack of time to spend with the patient and an organizational timeline of

expectations of the patient toward recovery and discharge. As the following participant remarked,

> Time, time. Time would be a big one that we jump out . . . on a busy unit . . . a person gets to a place where they maybe have a moment . . . their [the patient's] behaviour is such that makes you question, there must be something more to this, then you want to seize the moment and sort of say, hey I'm here do you want to talk? But I've got three minutes, you know. We have a busy unit, I have ten people . . . (P4)

Finally, the participants discussed solutions to their perceived barriers. They suggested integrating knowledge of trauma and TIC into existing nursing curricula, on both theoretical and practical levels (i.e., both "knowing" about trauma and TIC and "knowing-how" to act in practice), and spoke about the need for leadership to support and advocate for TIC initiatives.

Dynamics of the Nurse–Patient Relationship in the Face of Trauma

In this category, the participants' recounts of how trauma can complicate the nurse–patient relationship along several dimensions are explained. These included the aspects of how care can traumatize (or re-traumatize) patients, how nurses might vicariously and/or directly be traumatized by their patients, and how trauma is a dynamic process that affects nurses beyond the individual nurse–patient relationship.

All participants spoke about the importance of being aware of the risk of re-traumatization and being cautious of triggering a patient's traumatic experiences through care. Some participants described this principle of avoiding re-traumatization as a major pillar of nursing from a trauma-informed perspective:

> I mean of course when it comes to trauma-informed care our main concern is not to re-traumatize people, but overall it's just easier for everyone if people have a good experience or have as close as possible to resembling a good experience, so I think it's just kind of critical . . . if we can do our best to not do things that might trigger people in a traumatic way . . . (P5)

Participants explained how all aspects of care could be potentially (re)traumatizing:

> There's a case where it was a little boy . . . I guess, I looked like his mother, so . . . I couldn't actually care for him because I was re-traumatizing him, because I looked so much like her that it was actually bothering him. It was fine when I was on the unit, but then when I left, it was like, his mother leaving again, so it was actually re-traumatizing. (P1)

Participants also reflected on how trauma can affect them as nurses and described two distinct forms of trauma experienced by the nurse: (a) vicarious traumatization (when the nurse is traumatized by the patient's story) and (b) direct traumatization (where the patient can traumatize the nurse through his or her actions). The following participant described how nurses can be affected over a relatively long period of time by the acts or behaviors of their patients:

> And the other fellow that I told you about that I first started seeking help [to learn about trauma], he ended up hanging himself in correction . . . I suppose in a small sense that's a trauma—hung with me for my whole life. You know, as we talk about it . . . I feel how terrible it was for me and people around us at the time when he died. (P3)

Beyond the individual traumas experienced by patients and nurses, participants spoke of how trauma can spread through nurse–patient interactions (i.e., trauma may perpetuate more trauma). A nurse might (re)traumatize their patient through the care they are delivering and this same patient might traumatize their nurse through their reactions to this care. The nurse can then carry that trauma burden to other patients and perpetuate a continued trauma cycle:

> And, also for themselves [the nurses], there can end up being . . . a back and forth relationship . . . any trauma that can happen towards the patient can also be happening towards the nurse at the same time. And that later then can lead to the nurse also placing that [trauma] on another patient or family. It can keep growing . . . one person to the next person, and the nurse can be the middle person. If they don't deal with how that trauma affects their patient . . . then can possibly affect themselves [the nurses]. It can have a bigger effect than is realized. (P1)

Finally, participants explained how trauma, and working with patients who have experienced trauma, can take its toll and affect them as nurses. They spoke of a cumulative burden that can shape and influence their interactions with patients and families:

> Some of our more experienced staff have done so many years of caring for these super unwell and kind of demanding kids, they get to a point that they almost don't want to make themselves feel vulnerable to feel, and engage the patient . . . It's almost like they are used up, they may a refuel . . . If you're not getting that sort of reprieve and refill then they start to almost put up like their own little wall, to not feel as connected. (P7)

To safeguard themselves from the negative effects of trauma, participants described protective strategies that they use in their practice. In general, protective strategies revolved around self-reflection at individual and team levels and the importance of knowing yourself—your history, your strengths, and weaknesses. The participants explained how the self-reflective process is a way to continuously improve the self as a therapeutic agent:

> From the premises of the instruments or the tools we use, [they] are really just ourselves, and we have to be really aware of our

> own strengths, of our own weaknesses, our own vulnerabilities, our own traumas, our own things, and we have to find a way to process them in a way that keeps us healthy and well. (P4)

Discussion

In this study, we explored the understandings and experiences of nurses related to TIC. Although most participants were not familiar with the concept of TIC as it is currently defined in the literature (e.g., Fallot & Harris, 2009; Substance and Abuse Mental Health Service [SAMHSA], 2014), they nonetheless described some of the essential components when asked to explain their understanding. These components included the importance of knowledge of trauma in practice and recognizing manifestations of trauma, developing rapport and adapting care, and avoiding re-traumatization. These components mirror the SAMHSA (2014) principles of TIC, which are realizing, recognizing, responding, and avoiding re-traumatizing. Most participants also echoed the definition of Fallot and Harris (2009) when they spoke of the principles of safety, trust, collaboration, choice, and empowerment when working with people who have experienced trauma.

The findings of this study also highlight several important considerations for the advancement of knowledge in the area of TIC. These considerations include the complex dynamics of trauma that affect nursing care, the need to push TIC boundaries beyond mental health care, and the parallels between nursing and TIC.

The Dynamics of TIC

Most literature on TIC emphasizes the importance of recognizing the effects of re-traumatization of patients through care (e.g., Hall et al., 2016; Harner & Burgess, 2011; SAMHSA, 2014). Our participants not only described this facet of the dynamics but also further elaborated on the effect that trauma can have on nurses and the care they deliver, as well as how trauma can perpetuate more trauma. They spoke of how caring for patients with histories of trauma is draining for nurses and also highlighted the contextual elements that come to affect and shape their capacity to support and respond to patients' needs. Similar to the work of McElvaney and Tatlow-Golden (2016), the results of our study suggest that combined effects of working with complex patients along with competing demands of the health care system affecting resources and responses may result in what these authors termed a "traumatised and traumatizing system" (p. 66). McElvaney and Tatlow-Golden (2016) noted how professionals' responses to the complex needs of patients in their care often included helplessness, frustration, and feelings of incompetence, resulting in a traumatic response that paralleled that of their patients. For example, the authors explained how working with helpless patients under current system conditions over time eventually triggered a similar helplessness in the health care professionals caring for these patients, which was then conveyed back to the patient. They concluded that both an inadequate system response and vicarious traumatization on the part of the professionals contribute to this dynamic process (McElvaney & Tatlow-Golden, 2016). This phenomenon closely mirrors our participants' depictions of how trauma perpetuates trauma. Moving forward, it will be important to acknowledge how trauma affects not only the patient but also health care providers and the health system as a whole. More work is needed to fully understand the effectiveness of strategies designed to safeguard nurses against emotional distress caused by caring for persons with a history of trauma. We suggest that research expand upon current practices of debriefing to establish ongoing opportunities for self-reflection.

Wolf, Green, Nochajski, Mendel, and Kusmaul (2014) reported that although administrators of social service agencies are working toward implementing the principles of TIC for their clients, they might also be neglecting the same principles as they pertain to staff within the organization. Their findings suggest that leaders of these agencies are not aware of the relevance of these principles for their own employees (Wolf et al., 2014). As the participants of our study suggested, there is a need to pay attention to contextual conditions that promote an organizational culture of trauma-informed values. As with other authors (e.g., Bloom, 2010; Marcellus, 2014), we suggest that effective TIC is not simply brought about through a frontline intervention, but rather through whole organizational shift in paradigms.

TIC: Beyond Mental Health Care

Given that TIC is an emerging concept within nursing, we recruited nurses from diverse practice areas and purposefully did not specify nursing specialty. Interestingly, through this strategy, our sample consisted entirely of participants who identified primarily as mental health nurses, suggesting that mental health nurses overall are more attuned to and familiar with TIC. Yet, most participants in this study acknowledged a need for TIC within all areas of nursing. This need to push the boundaries of TIC beyond mental health is also reflected in the literature (e.g., Kassam-Adams et al., 2015; Ko et al., 2008; Reeves, 2015). Based on some of our recent work as clinicians, educators, and researchers, we know that the principles of TIC are beginning to emerge in entry-to-practice competencies for generalist nurses. Efforts should be directed at increasing TIC capacity in undergraduate nursing programs (Strand, Popescu, Abramovitz, & Richards, 2016), so that all nurses entering the profession are at least familiar with trauma theory and the application of TIC in practice. The integration of TIC into curricula must reflect the importance of this philosophy of care for all persons entering the health care system, not only those accessing mental health services.

TIC Has a Home in Nursing Care

Two prominent nursing theorists, Peplau and Neuman, help situate our findings within central aspects of nursing care, specifically within the therapeutic relationship. Peplau (1991) positioned the therapeutic relationship as a dominant concept within nursing care; one that gives prominence to the patient's individual story as a foundation to nurse–patient interactions. In her writings, Peplau reinforced that the common goal of nursing is establishing safety and security for the patient through the therapeutic relationship by attending to the patient's needs, and not simply to their actions and behaviors (see also D'Antonio, Beeber, Sills, & Naegle, 2014). Furthermore, in Neuman and Young's (1972) systems model, they return to the nurse–patient dyad to inform how one's experiences, strengths, and skills come to influence how one copes with and reacts to stressors, and guides both one's journey and interactions within care (Neuman & Young, 1972). Participants in this study also stressed the centrality of the therapeutic relationship to both basic nursing care and to TIC; this emphasis was described as knowledge that demands an individualized (holistic) approach to care.

In this discussion, we take the stance that TIC is in fact part of basic nursing care, albeit informed by the ongoing development of knowledge related to trauma. This process is no different than any other aspect of nursing care that is continually instructed by emerging knowledge. In describing the environmental context of providing trauma-informed nursing care, our participants highlighted current health care realities that standardize approaches to care. These pressures tend to encroach on nurses' abilities to engage in the therapeutic relationship and all that is considered the art of nursing. TIC, thus, seems to be a novel approach that embraces flexibility instead of standardization, individuality instead of mass treatment plans, and subjectivity over objectivity. However, based on the experiences conveyed by our participants, TIC intersects with the essence of true nursing care and the TIC movement might simply be a symptom of a system that is perpetuating a shift away from the ideals of care espoused by the nursing profession.

Participants described an ongoing transition in nursing toward a practice that is task-oriented, quantifiable, and efficient. When nursing is practiced in this way, the subtleties of the art of nursing are at risk of being lost (Mays, 2012). For example, we note that the concept of compassion is one that was frequently mentioned by our participants as being important in the delivery of TIC. As noted by Mays (2012), we can understand how it is difficult to quantify compassion, challenging to capture it in electronic medical records and, as a result, equally challenging to formally integrate this concept in practice. The current health care context is one that stresses legal accountability and standardization. In a perhaps misguided attempt to legitimatize nursing in this context, it appears as though nurses are spending more and more time on tasks that increase efficiency and less time being with their patients (Simpson, 2011). As knowledge translation activities emerge in the area of TIC, it is important to ensure that the art of nursing and of person-centered care is incorporated into efforts to standardize and evaluate the effectiveness of trauma-informed nursing tasks.

Study Limitations

There are three limitations to note when considering the findings of this study. First, as with all qualitative interview studies, the findings are limited to the participants' extent of disclosure and accuracy concerning the topic of interest. Second, because TIC is a sensitive topic, participants may have censored their thoughts and professional experiences to avoid feeling uncomfortable or judged. To minimize this potential limitation, the interviewer (who has extensive experience working with trauma) reminded participants that all data would be de-identified and maintained a nonjudgmental demeanor throughout the interviews. Third, our selective recruitment strategy resulted in a study sample composed entirely of psychiatric/mental health nurses. Therefore, caution should be applied when evaluating the transferability of these findings to all nurses.

Conclusion

In this study, we explored nurses' understandings and experiences with TIC. While the participants were not familiar with the term *TIC*, their understandings of trauma and what it means to care from a trauma-sensitive perspective closely resembled existing definitions of the concept. Interestingly, the participants did not describe TIC as a unique philosophy of care but instead emphasized how TIC is fundamentally part of nursing care, with an emphasis on holism and the therapeutic relationship. An important finding of this study, which is not yet described in existing literature, is the complex dynamics of the nurse–patient interaction in the context of trauma. (Re)traumatization is possible for both the patient and the nurse and trauma may perpetuate more trauma through these interactions. More work is needed in this area to fully understand this complex interplay. Finally, several contextual elements complicating the implementation of TIC in practice are explored. These elements need to be addressed if efforts aimed at improving TIC are to be successful.

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