NCPD 2.5 HOURS
Nursing Continuing Professional Development

Trauma-Informed Care in Nursing Practice

How to achieve optimal health outcomes in trauma survivors through person-centered care.

ABSTRACT: Over the past 30 years, researchers have found that childhood trauma and its subsequent stress have a strong and cumulative effect on health in adulthood. Trauma in childhood often leads to mental health problems, skeletal fractures, and early death from conditions such as heart disease, cancer, lung disease, and liver disease. Compounding the effects of traumatic stress, health care systems often create a population of "never-served" persons who avoid health care settings because they've been subject to judgment and marginalization. Trauma-informed care (TIC) is a skill underutilized by health care providers and organizations, yet nurse ethics and respect for human rights require us to care for all patients equally without judgment, including those living with the stress of complex trauma. The TIC approach respects human rights and supports nursing ethics, promoting a welcoming, inclusive environment in health care systems and patient–provider relationships that eschews implicit and explicit bias toward patients, regardless of presentation or personal circumstances. TIC foundational principles guide the application of the nursing process using patient-centered care to create safety, the first principle in TIC. Here, the authors discuss the application of these core principles in nursing through a deidentified case study.

Keywords: nursing care, patient-centered care, trauma, trauma-informed care

Trauma is a pervasive human experience, yet trauma-informed care (TIC) is a skill that is underutilized in health care organizations. Traumatic events are those associated with actual or threatened risk of serious injury, death, or sexual violence that are experienced directly, indirectly (by witnessing them), or vicariously (through the experiences of a close friend or loved one).[1] Such events affect people of all ages, ethnicities, religions, vocations, socioeconomic backgrounds, sexual orientations, and gender identities throughout the world when there is war, disaster, social upheaval, family dysfunction, adverse childhood events, or chaos.[1,2]

Responses to traumatic events vary widely, as they are influenced by a person's sociocultural history, a person's interpretation of the events, the meaning a person ascribes to the events, and the associated physical and psychological effects of the events.[2,3] Although the stress that follows traumatic events affects each person differently, it often produces lasting emotional, mental, physical, social, or spiritual upheaval, altering the person's ability to function.[2]

THE ENDURING EFFECTS OF TRAUMATIC STRESS

Over the past 20 years, biomedical research has shown that a wide range of chronic diseases, poor mental health outcomes, early deaths, and trans-

Figure 1. The Six Principles of Trauma-Informed Care

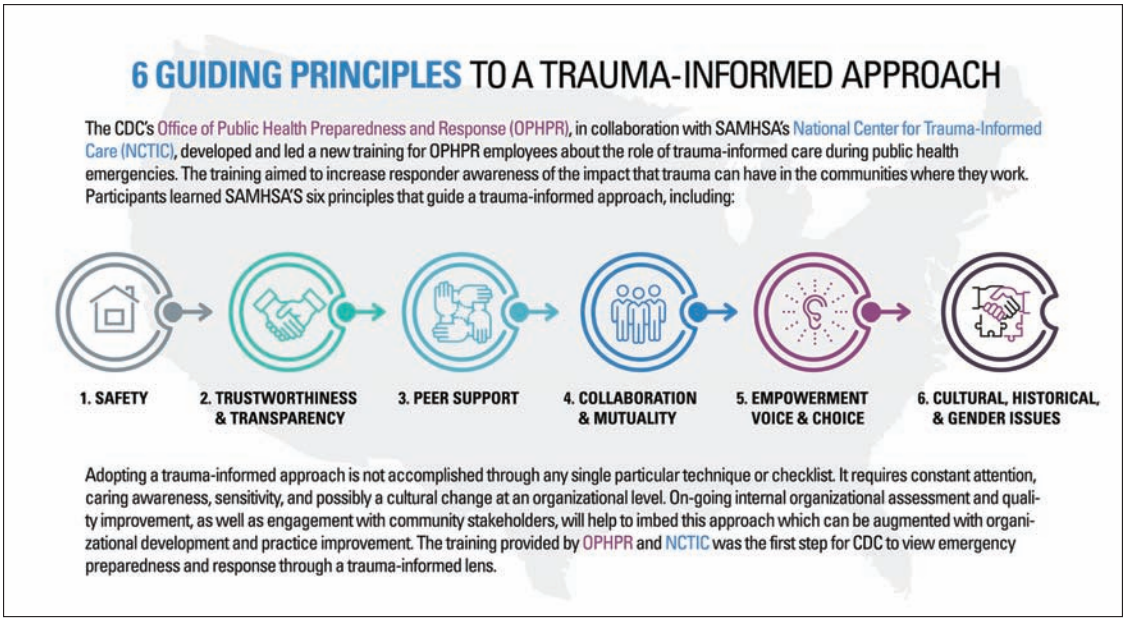

Image courtesy of the Centers for Disease Control and Prevention's Center for Preparedness and Response.

generational epigenetic changes have been associated with stress stemming from traumatic events that may have occurred years or even generations earlier.[4-9]

Potential forms of enduring traumatic stress include the following:

- *chronic stress*, which occurs when continuous trauma persists over an extended period[10]
- *toxic stress*, which Harvard University's Center on the Developing Child describes as potentially occurring in children who experience "strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support"[11]
- *stress associated with complex trauma*, which the National Child Traumatic Stress Network says occurs when a child is exposed to "multiple traumatic events—often of an invasive, interpersonal nature," such as sexual or physical abuse, domestic violence, or profound neglect, which often produce wide-ranging, long-term effects[12]
- *trauma coercive bonding*, which results when fear is overwhelming and there is no opportunity to escape, as occurs with domestic violence and human trafficking[13]

HOW TRAUMATIC STRESS AFFECTS THE BRAIN

Any form of traumatic stress can affect a person's neurologic, immunologic, endocrinologic, autonomic, inflammatory, and metabolic processes,[14] though the effects vary depending on the stage of brain development at which the trauma occurs.[15]

The neurochemical response to traumatic stress includes a rise in the levels of cortisol and norepinephrine, which in conjunction with neuroendocrine, autonomic, immune, and metabolic mediators can produce lasting changes in the amygdala, hippocampus, and prefrontal cortex, thereby affecting brain function, including neuropsychological aspects of memory.[15, 16]

The stress of repeated trauma creates a cascade of hormones that can result in a phenomenon known as *allostatic load*, in which normally adaptive processes for mediating stress are distorted such that they exacerbate pathophysiologic changes.[14, 16, 17] Risk factors for allostatic load include advanced age, low socioeconomic status, and being single.[17]

JUDGMENT AND BIAS EXACERBATE TRAUMATIC STRESS

Because trauma and violence are frequent precursors of chronic disease, addictions, and other risky behaviors, clinicians' judgments of trauma victims frequently dissuade those with traumatic stress from seeking necessary health care. When interact-

ing with health care providers, victims of trauma may perceive that they are being judged for their lifestyle, homelessness, addictions or other risky behaviors, or for their gender identity, age, race, ethnicity, sexual orientation, or other aspects of social identity.[18] Such patient perceptions can create a population of "never-served" persons who choose to avoid health care or to not disclose a history of drug or alcohol use to health care providers whom they perceive as judging them.[19]

Both explicit (conscious) and implicit (unconscious) racial and ethnic biases among health care providers are well documented,[20] as are the health care disparities experienced by patients based on race or ethnicity. The same disparities may result from provider judgments based on implicit or explicit biases related to gender identity, sexual orientation, and other aspects of social identity or lifestyle, or to homelessness, addictions, or other risky behaviors.[21]

Citing the Institute of Medicine's 1999 report *To Err is Human: Building a Safer Health System*, which indicated that nearly 100,000 U.S. patients die annually as a result of medical errors, Fargen and colleagues describe what they call "cognitive biases" that make clinicians prone to error.[22,23] Such biases include what they term "fundamental attribution error," which they define as a "tendency to blame patients for their situation" rather than examine the circumstances under which problems develop, and "ineffectual bias," which they define as a "tendency to underestimate the potential benefit of treatment." Either or both of these biases may be behind a decision to not perform mechanical thrombectomy on a patient with an emergent large vessel occlusion, for example, because the patient smokes and isn't taking prescribed medication.

To overcome beliefs in stereotypes that feed both explicit and implicit biases, health care providers must reflect on the circumstances that contribute to the social determinants of health and engage in experiential learning techniques, such as anti-bias training, intergroup contact, perspective taking, emotional expression, and counter-stereotypical exemplars.[24] Understanding comes from experiences with specific psychomotor skills in face-to-face classrooms, and in clinical and simulation labs using the "see-one, do-one, teach-one" method of acquiring skills. Such experiences reinforce that patients' personal circumstances, and the subsequent choices patients make to mitigate allostatic load, are often out of the patients' control and that health care provider judgment and bias can contribute to poor health care outcomes.

THE TRAUMA-INFORMED APPROACH

TIC recognizes that effective care requires an understanding of patients' lived experiences and may improve patient participation, treatment adherence, and health, as well as provider well-being, through the use of strategies that increase hope by pointing patients toward their goals.[25-27]

TIC guides health care providers and organizations in understanding the sequelae of trauma and in accepting and supporting victims of trauma through positive adaptation and healing.[28] It recognizes the signs and symptoms of traumatic stress and acknowledges the role trauma may play in a patient's life.[2]

Below we use a deidentified case study of a patient who has experienced complex trauma to explain the six principles of TIC (see Figure 1) and to demonstrate application of the real-world nursing interventions necessary to deliver person-centered care to patients who have experienced traumatic stress. Table 1 provides online links to resources that can help nurses recognize traumatic stress and respond appropriately to patients who have endured its effects so as to prevent retraumatization.

TIC is founded on the following core principles[2]:

- safety
- trustworthiness and transparency
- peer support
- collaboration and mutual support
- empowerment (voice and choice)
- cultural and historical sensitivity

CASE STUDY

DJ is a 34-year-old woman who arrived with police at the ED following an argument with her male partner. (This is a real case we and our colleague Annie Lewis-O'Connor encountered in clinical practice. Identifying details have been changed or omitted to protect the anonymity of the patient and her family.) She described her relationship with her partner as financially supportive, but with episodes of violence. She said he had choked and beaten her that day and on previous occasions, her children had witnessed the couple's fights, and police had previously been called to the scene of the brawls.

DJ told the ED nurse she didn't want her partner to know she was currently in the hospital. When asked about her medical history, she told the nurse she had been diagnosed at age 16 with type 1 diabetes mellitus with neuropathy and chronic pain and has a history of posttraumatic stress disorder.

DJ resides alone with her two children (ages 10 and two) and works part-time in computer science. She is 5 ft. 10 in. tall, weighs 142 lbs. and has an athletic build. Physical assessment revealed patterned injuries (specifically, bruise patterns in various stages of healing all over her body), and three (3 cm × 1 cm) linear abrasions over the trapezius muscle on the right side of her

Table 1. Trauma-Informed Care Resources

Resource	Link
ACEs Aware	www.acesaware.org/ace-fundamentals/principles-of-trauma-informed-care
Administration for Children and Families, Department of Health and Human Services	www.acf.hhs.gov/trauma-toolkit
Center for Preparedness and Response, Centers for Disease Control and Prevention	www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
Center on the Developing Child at Harvard University	https://developingchild.harvard.edu/science/key-concepts/toxic-stress
National Child Traumatic Stress Network	www.nctsn.org/trauma-informed-care
Substance Abuse and Mental Health Services Administration: *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*	https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884
SAMHSA: TIP 57: Trauma-Informed Care in Behavioral Health Services	https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
SAMHSA: Trauma and Violence	www.samhsa.gov/trauma-violence
SAMHSA: Resources for Child Trauma-Informed Care	www.samhsa.gov/childrens-awareness-day/past-events/2018/child-traumatic-stress-resources
Trauma-Informed Care Implementation Resource Center	www.traumainformedcare.chcs.org

neck. Given her admission history of nonfatal strangulation, the priority nursing action focused on monitoring her airway and her type 1 diabetes. (On admission, her glycated hemoglobin level was 13%.)

A contrast computed tomography scan revealed swelling of the right carotid artery and soft tissue in the neck. Laboratory tests indicated that she had diabetic ketoacidosis (DKA). The health care team initiated a medication regimen to safely control her DKA and to prevent stroke while she healed. When an ICU bed became available, she was transferred there for medical management.

SAFETY

Safety in TIC refers to the physical and psychological safety of patients and family members that is created by providers within the health care organization to prevent retraumatization, a universal goal of TIC.[2] Creating a safe space in the environment promotes access to services and fosters engagement between patients and nurses. In health care systems, safety planning for patients and their families is a nursing responsibility and often includes all staff (nurses, administrators, providers, security, and support staff). A major tenet of safety in TIC is environmental safety, which requires health care providers to ensure that accommodations are safe and welcoming for all patients without judgment regarding age, sex, sexual orientation, gender identity, race, socioeconomic status, or social determinants of health. Patients with trauma backgrounds are often hypervigilant to their environmental safety. Promotion of safety is patient centered and entails direct communication that encourages patients to self-identify with regard to how they wish to be addressed.

Case application. Physical and psychological safety for both patient and staff became a priority during DJ's time in the ED and after her admission to the ICU. The ED nurse noted that, over time, DJ had become increasingly agitated with repetitive staff and provider attention, physical assessments, fingersticks, and ED activity.

Applying the first principle of creating safety, the nurse asked her directly, "What do you need to feel safe here right now?" DJ immediately responded, "I can't have all these people coming at me. It's too much—too much touching, too much noise, just too much." The nurse moved DJ out of the trauma bay, which was near the ambulance entryway, and into a nonurgent room where the nurse was able to close the door.

The nurse posted signage on the door asking all staff and visitors to contact the assigned nurse before entering the room. DJ also told the nurse that she feared her partner, who was also her assailant, would find and kill her.

Following protocol, the nurse took swift action to gain DJ's permission for anonymity, which allows patient profiles (including room numbers, names, and hospital records) to be flagged for privacy. Using the nursing process of ADPIE (assess, diagnose, plan, intervene, and evaluate), the nurse assessed the situation, formulated a plan, and offered the intervention of anonymity to DJ, who accepted the nurse's suggestion that she be "blocked" in the health care system to outside inquiry. Following these nursing actions, DJ's anxiety and agitation levels dropped noticeably. The ED nurses received DJ's permission to share their assessment with other necessary team members and the ICU staff. DJ was present during report from the ED to the ICU so she could validate the message to the team. DJ's presence during report also reduced her anxiety about being judged for the circumstances that had led to her admission to the ICU and improved her sense of safety.

Following the TIC cue given by the ED nurse, the ICU nurse asked DJ what she needed to feel safe. DJ said she needed to rest in a private room, if available, so she could listen to her music, which helps her stay calm. During her nine-day stay, the nurses implemented a safety plan for DJ that included consistent, coordinated, and clustered care to minimize disturbances, thereby providing dedicated periods for her to rest between timed blood glucose monitoring and nursing evaluations of her neurologic state and neck swelling.

TRUSTWORTHINESS AND TRANSPARENCY

By following the American Association of Colleges of Nursing's *The Essentials: Core Competencies for Professional Nursing Education*[29] and the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements*,[30] nurses build trust among staff, patients, families, and community members. A central focus of *The Essentials* is person-centered care, which emphasizes diversity, equity, and inclusion, and incorporates a nursing care plan stated in plain, people-first language, using health literacy concepts to promote patient understanding.[29] For example, explaining what is meant by health confidentiality versus anonymity, what consent actually means, or how the Health Insurance Portability and Accountability Act (HIPAA) defines ownership of information, recognizing that the data belongs to the patient and the physical documents belong to the institutional practice,[31] promotes transparency and trustworthiness.

Transparency, which fosters trust, is founded on principles of anticipatory guidance and the use of educational pedagogy to determine understanding, as in the teach-back method. The minimal additional time required to develop transparency in the nurse–patient relationship builds trustworthiness by encouraging patients to participate in their care. Practiced responses may help nurses demonstrate patient-centered care when there are complex disclosures. For example, the nurse might say, "Do I have your permission to write about your experience?" or "Would you like me to document these details in your medical record for the next nurse?" Nurses who share their laptop screens with patients help their patients control information in their health record. Often, patients want some information removed, such as the disclosure of a past traumatic event that isn't associated with the current hospitalization and medical treatments.

Trauma-informed care recognizes that effective care requires an understanding of patients' lived experiences.

While in the ICU, nurses taught DJ evidence-based methods for reducing anxiety, including deep breathing, thought interruption, imaging, and moderating anxiety-provoking external stimuli such as media, electronics, and phones. In addition, the nurses noted the vocal and gesticular cues that indicated DJ was feeling anxious—a raised voice or flailing hands while speaking—which helped them intervene with questions such as "Do you feel safe?" and provided an opportunity to review anxiety-reducing techniques by asking, "Which technique would you like to use now?" By offering person-centered choices and creating predictable structure around clustered nursing actions, the nurses allowed DJ to feel safe and to self-regulate her anxiety.

Case application. On day 3 in the ICU, DJ felt safe enough to share information about a recent sexual assault by her partner. She had previously disclosed that her partner is the father of her youngest child and was arrested at the scene of her most recent assault. DJ confided that her partner made her "perform sex acts with other men for a pay-

check," which meets the definition of human sex trafficking.[32] She also disclosed that she often ignores her personal health as a strategy for attaining respite at a hospital, explaining that EDs help her get away from him, and adding that no one had asked about the challenges she faced to maintain her health. For a variety of reasons, many people use EDs for nonurgent care.[33] Understanding that DJ was in crisis, the nurse listened without judging DJ or opining on actions she "should have" taken.

Building trust requires health care providers to accept that patients are in the best position to know the options available to them at any given time. One way to look at DJ's ED visits and hospitalizations is that she made the right choices during the assaults because she is alive in the hospital and receiving treatment.

PEER SUPPORT

The peer role is deeply rooted in the idea of not trying to "fix" people but rather to help them find inner strength by connecting them to supportive peer services in communities that mirror their culture, religion, beliefs, practices, and experiences.

Peer support plays an important role in empowerment (discussed below), as it recognizes individual power (self-efficacy with voice and choice) and interrupts the retraumatization cycle for the person with traumatic stress.[2]

Peer support groups for trauma survivors typically include other trauma survivors.[2] Peer support groups have personalities allowing for voice and choice, though not all personalities work in all such groups (some voices may be rejected because of a person's culture, religion, beliefs, practices, or experiences, for example). Effective peer support for trauma survivors is rooted in TIC that builds on shared experiences and mutual exchange by fostering relationships that establish new ways of understanding experiences of or reactions to trauma. Anticipatory guidance that offers trauma survivors several choices from which to find a peer support group in their community (where options may be limited) that feels like the "right fit" for them is important in helping them build self-efficacy and become empowered to make decisions for themselves based on where they are in their recovery trajectory.

Environmental safety requires health care providers to ensure accommodations are safe and welcoming for all patients.

Trustworthiness and transparency require frank conversations about safety, organizational capacities, and choices available to the patient in the hospital and in the community. DJ's complex relationship with her partner has the appearance of intimate partner violence (IPV). Knowing the stages of IPV in which the abuser attempts to "make up," the nurse realized that DJ's partner would first call her cell phone from jail, which he did. He convinced DJ she was better off with him because he had an income, and he promised to never make her have sex with others again. While DJ wanted a "truce" in the safe confines of the hospital, for the sake of transparency the nurse explained that the risks of liability and danger were greater than the need for DJ to engage with her partner on the premises. The nurse explained that hospitals are not prepared for hostage negotiations should things go sour. DJ understood and explained to the nurse that without her partner, she had no job, income, car, or stable housing, and she would need temporary medical assistance. She also shared her growing concern for how her children were doing, particularly the child her partner had fathered, as she was in the hospital and her partner was in jail. The police, following policy, called child protective services, which opened a child welfare investigation case. The nurse listened, explaining to DJ that the stress she was experiencing had adversely affected the medical management of her diabetes and anxiety.

Often survivor choices in finding allies in support groups require leaving behind a life with former associates, family, and enablers, so the grief or sense of loss may be profound. Trauma patients frequently revisit old lifestyles outside of their new support group and community services, risking their health through recidivism (relapsing into previous addictions or other risky behaviors). Often trauma survivors can pinpoint an event that pivoted them toward a former unhealthy lifestyle. Health care providers need to remain nonjudgmental, optimistic, encouraging, and welcoming to such patients, recognizing that they are navigating a nonlinear maze of barriers from previous life experiences.

Case application. Given the complexity of DJ's case and incorporating the principle of empowering

voice and choice and a patient-centered approach, team meetings involving health care providers, community service providers, and DJ were scheduled for every other month and held either in person or by conference call. These meetings empowered DJ to create a comprehensive priority list that addressed her basic needs for housing and her children's welfare because her worries about these issues continued to keep her stress hormone and glucose levels elevated, increasing her risk of stroke.

After collaborating on the priority list, DJ shared that she felt her "voice was heard," making her feel "like a human being people cared about." DJ's continued sense of safety and trust from TIC enabled her to share information about her repeated victimization and feelings of shame with her peer support group, her health care team, and other service providers, saying, "I'm disgusted with myself. I wash myself 100 times a day. I have no self-esteem, and lots of anxiety." DJ's experience with rape during episodes of IPV and her need for trauma-focused cognitive behavioral therapy (TF-CBT) was then made a priority.

Advocacy was imperative in providing DJ an opportunity to discuss with attorneys her specific legal options concerning her former partner, including the child welfare investigation, which ultimately mandated that he could only have supervised visits with his biological child at a downtown office twice a month. In addition to legal advocacy, lay advocacy was provided to DJ initially by the hospital social worker and at discharge by a counselor at the local women's shelter and a community advocate, who offered DJ emotional support throughout the child welfare investigation.

Depending on the community, advocacy groups may offer more wraparound services. DJ enrolled in TF-CBT, and attended peer support meetings and church services, from which she said she got so much positive support.

COLLABORATION AND MUTUAL SUPPORT

Collaboration and mutual support in TIC require that all institutional staff and providers view patients as active partners in their care and as the expert on their lived experience. Nurses and other health care team members share and support the goals identified and prioritized by the patient, then together with the patient, they create a plan of care and discharge. After collaborating, the health care team makes recommendations, and the patient, understanding her limitations, makes the final decisions about health care avenues. Understanding patients' capacities in their lived environment (housing, childcare, employment, education, and other social determinants of health) helps health care teams avoid judgment and offer reasonable choices with the best opportunity for success.

Case application. In the case of DJ, disease management was the lifesaving goal, and not surprisingly, the health care team members had identified her type 1 diabetes as the health priority. The nursing team had identified the potential for stroke following the nonfatal carotid trauma from strangulation that had occurred in the latest assault, while noting the high lethality index of prior nonfatal strangulation (that is, it substantially raises the risk of subsequent fatal femicide by strangulation).[34] However, when asked by the team, "What is important to you as we think about your discharge plan?" DJ had identified as her health priorities physical safety (safe housing for her and her children) and finding employment. Therefore, the ICU team recommended that upon discharge DJ transfer directly to community wraparound services, which are available in most urban and some rural areas and could provide a variety of assistance including transitional housing, job training, day care, medical care, and TF-CBT.

Empowerment of patient voice and choice is the foundation of trauma-informed care.

Nurses are responsible for knowing about community services that address such health-related conditions as IPV and human trafficking and are encouraged to build bridges with coordinated community response teams addressing the needs of the vulnerable populations in their community.

Along with nursing and the inpatient team, the ICU clinical specialist collaborated with DJ to build the outpatient team. This health care team created a secure HIPAA-compliant group text to keep in touch about DJ's care and treatment. The team's primary outpatient nurse, acting as case manager, initiated group texts every other month. The system

of routine updates enabled members of the team to use their time more efficiently when meeting with DJ, who indicated that she felt relieved to no longer have the burden of keeping everyone up to date and taking the time to explain her circumstances repeatedly, saying, "I don't have to relive everything over and over."

CULTURAL AND HISTORICAL SENSITIVITY

Cultural and historical sensitivity encompasses all aspects of a person's identity, including race, ethnicity, sexual orientation, age, religion, gender identity, and geography, as well as all of their life experiences and interpersonal relationships beginning with the family of origin. It encompasses their beliefs and core values and extends into their experiences of public spaces, such as schools and workplaces. Those who seek health care bring their personal experiences, traumas, and historical narratives of trauma to the nurse–patient or provider–patient relationship. Historical trauma is defined as a traumatic event shared by a group of people that often adversely affects the parenting ability, physical health, and mental health of multiple generations.[35] This is because stress not only can cause loss of sleep; anxiety; depression; other psychiatric disorders; and such unhealthy behaviors as eating a poor diet, overeating, smoking cigarettes, excess use of alcohol, social avoidance, and lack of exercise, but it often produces epigenetic changes that alter gene expression both before conception and during gestation.[14]

Case application. DJ's situation reflects the cultural, historical, and gender issues experienced by many. When the community nurse case manager met with DJ and asked, "Is there anything else going on in your life you feel needs to be addressed today?" DJ responded that she'd "quit" her last job because the owner was her partner and she'd left him.

Understanding DJ's need for employment to facilitate leaving the abusive relationship, and recognizing the necessity of approaching the subject of employment in a culturally and historically sensitive manner, the case manager explained to DJ that she believed she could help her find employment through education and retraining, and asked, "Which of your skills do you see as transferable to other employment?" DJ responded that she worked from home in information technology, but that the work "was spotty and that's why I had to have sex to make the rent and why I'm leaving!"

Understanding the culture of trafficking, the case manager helped DJ enroll in a job training service for formerly trafficked persons. While this is one way to address DJ's challenges, the needs of patients like DJ vary. These patients require considerable nonjudgmental acceptance, which in DJ's case was communicated when the nurse acknowledged that DJ had made difficult decisions during her life in order to survive and preserve her family. She is now emerging empowered and ready to move on, because the nurses she encountered provided trauma-informed nursing interventions.

EMPOWERMENT OF VOICE AND CHOICE

Empowerment of patient voice and choice is the foundation of TIC and reflected in all its core principles. TIC empowers patients by offering them a voice, respecting their choices, and developing their health literacy by both building on their strengths and addressing their weaknesses.

Quality nursing care begins with valuing the person seeking care. By using nursing core competencies, ethics, and values, nurses have the potential to implement and deliver TIC in a holistic safe and supportive environment, where patients thrive and eventually flourish in their quest for a higher level of wellness. ▼

For seven additional nursing continuing professional development activities on the topic of trauma-informed care, go to www.nursingcenter.com.

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REFERENCES

1. Muldoon OT, et al. The social psychology of responses to trauma: social identity pathways associated with divergent traumatic responses. *Eur Rev Soc Psychol* 2019;30(1):311-48.
2. Substance Abuse and Mental Health Services Administration, SAMHSA's Trauma and Justice Strategic Initiative. *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. Rockville, MD; 2014 Jul. HHS Publication No. (SMA) 14-4884. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf.
3. Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. *Trauma-informed care in behavioral health service*. Rockville, MD; 2014. HHS Publication No. (SMA) 14-4816. Treatment Improvement Protocol (TIP) Series, No. 57.
4. Felitti VJ, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study. *Am J Prev Med* 1998;14(4):245-58.
5. Garfin DR, et al. Acute stress and subsequent health outcomes: a systematic review. *J Psychosom Res* 2018;112:107-13.
6. Gudsnuk K, Champagne FA. Epigenetic influence of stress and the social environment. *ILAR J* 2012;53(3-4):279-88.

7. Jones CW, et al. The transgenerational transmission of maternal adverse childhood experiences (ACEs): insights from placental aging and infant autonomic nervous system reactivity. *Psychoneuroendocrinology* 2019;106:20-7.
8. Palma-Gudiel H, et al. Psychosocial stress and epigenetic aging. *Int Rev Neurobiol* 2020;150:107-28.
9. Thayer Z, et al. Early life trauma, post-traumatic stress disorder, and allostatic load in a sample of American Indian adults. *Am J Hum Biol* 2017;29(3).
10. American Psychological Association. *Stress won't go away? Maybe you are suffering from chronic stress*. 2019. https://www.apa.org/topics/stress/chronic.
11. Center on the Developing Child, Harvard University. *Toxic stress*. n.d. https://developingchild.harvard.edu/science/key-concepts/toxic-stress.
12. National Child Traumatic Stress Network. *What is child trauma? Trauma types*. n.d. https://www.nctsn.org/what-is-child-trauma/trauma-types.
13. Sanchez RV, et al. A concept analysis of trauma coercive bonding in the commercial sexual exploitation of children. *J Pediatr Nurs* 2019;46:48-54.
14. McEwen BS. Allostasis and the epigenetics of brain and body health over the life course: the brain on stress. *JAMA Psychiatry* 2017;74(6):551-2.
15. Bremner JD. Traumatic stress: effects on the brain. *Dialogues Clin Neurosci* 2006;8(4):445-61.
16. McEwen BS, et al. 60 years of neuroendocrinology: redefining neuroendocrinology: stress, sex and cognitive and emotional regulation. *J Endocrinol* 2015;226(2):T67-T83.
17. Juster RP, et al. Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neurosci Biobehav Rev* 2010;35(1):2-16.
18. Weiss KG. Too ashamed to report: deconstructing the shame of sexual victimization. *Fem Criminol* 2010;5(3):286-310.
19. Speck PM, et al. Vulnerable populations: drug court program clients. *Nurs Clin North Am* 2008;43(3):477-89.
20. Maina IW, et al. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Soc Sci Med* 2018;199:219-29.
21. McPeters SL, et al. The quagmire of social determinants of health for the LNC: evaluting failure to thrive. *The Journal of Legal Nurse Consulting: a Publication of the American Association of Legal Nurse Consultants* 2021;32(3):15-25.
22. Kohn LT, et al. *To err is human: building a safer health system*. Washington, DC: National Academies Press; 2000. Consensus study report; https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system.
23. Fargen KM, et al. Physician, know thyself: implicit and explicit decision-making for mechanical thrombectomy in stroke. *J Neurointerv Surg* 2020;12(10):952-6.
24. Joint Commission. *Implicit bias in health care*. Oakbrook Terrace, IL; 2016 Apr. Issue 23. Quick safety; https://www.jointcommission.org/-/media/tjc/documents/newsletters/quick-safety-issue-23-apr-2016-final-rev.pdf.
25. Menschner C, Maul A. *Key ingredients for successful trauma-informed care implementation*. Hamilton, NJ: Center for Health Care Strategies; Robert Wood Johnson Foundation; 2016 Apr. Issue brief; https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-white-paper-040616.pdf.
26. Anderson CL, Feldman DB. Hope and physical exercise: the contributions of hope, self-efficacy, and optimism in accounting for variance in exercise frequency. *Psychol Rep* 2020;123(4):1145-59.
27. Duncan AR, et al. Positive psychology and hope as lifestyle medicine modalities in the therapeutic encounter: a narrative review. *Am J Lifestyle Med* 2021;15(1):6-13.
28. Cutuli JJ, et al. Introduction to the special issue: trauma-informed care for children and families. *Psychol Serv* 2019;16(1):1-6.
29. American Association of Colleges of Nursing. *The essentials: core competencies for professional nursing education*. Washington, DC; 2021 Apr 6. https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf.
30. American Nurses Association. *Code of ethics for nurses with interpretive statements*. 2nd ed. Silver Spring, MD; 2015.
31. Harman LB, et al. Electronic health records: privacy, confidentiality, and security. *Virtual Mentor* 2012;14(9):712-9.
32. U.S. Congress. Public Law 106-386—Oct 28, 2000. Victims of Trafficking and Violence Protection Act of 2000. Washington, DC 2000.
33. Sieck CJ. Why do they do that?: Looking beyond typical reasons for non-urgent ED use among Medicaid patients. *Patient Exp J* 2016;3(2).
34. Campbell JC, et al. Risk factors for femicide in abusive relationships: results from a multisite case control study. *Am J Public Health* 2003;93(7):1089-97.
35. Patel RA, Nagata DK. Historical trauma and descendants' well-being. *AMA J Ethics* 2021;23(6):E487-E493.