Trauma-informed Care: A Therapeutic Approach in Communication

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Abstract

As medical providers, it is crucial to use therapeutic communication when building relationships with patients. Bias, stigma, and judgment often manifest through a provider's body language and choice of words, exacerbating patient trauma and leading to health disparities. Trauma-informed care (TIC) addresses these issues by emphasizing respect, compassion, and empathy. TIC has been extensively studied in high-income regions such as Australia, Europe and the United States, but its application in low- and middle-income countries (LMIC) such as Kenya, is less understood. The aim of this study was to assess the knowledge, attitudes, and skills of nurses working in a rural community clinic in Chogoria, Kenya. Objectives were achieved through pre- and post-workshop surveys and exploratory qualitative interviews conducted after an in-service workshop on Trauma-Informed Care (TIC). Healthcare workers demonstrated a 3% increase in knowledge, attitudes, and skills in postsurvey results following an in-service workshop on TIC. Analysis of focus group narrative data revealed three themes: relevance, cultural stigma and bias, and additional needs in the community. TIC's therapeutic communication helps to mitigate biases and stigma, foster empathy, and address patient trauma, ultimately reducing health disparities. The findings of this study indicate further research regarding TIC should be conducted in LMIC to identify ways in which providers can enhance the quality of health care delivery and promote holistic healing.

Keywords: adult trauma, adverse childhood events, harm reduction, trauma-informed care

Introduction

Trauma-informed care (TIC) offers a framework and therapeutic approach to healthcare delivery that focuses on understanding and addressing trauma, along with proactively avoiding institutional practices that could retraumatize individuals seeking care (Harris & Fallot, 2001., U.S. Department of Health and Human Services, 2014). When healthcare providers care for victims of trauma, it is important to minimize the potential for retraumatization. Re-traumatization stems from a lack of awareness of how body language and communication can produce a systematic negative feedback cycle. Moreover, providers often fail to link a patient's past traumas and their current challenges under these circumstances (Stevens et al., 2019). Empathy and compassion are often misplaced by bias, stigma, and judgment, leaving the patient feeling distressed, more vulnerable to victimization, unsupported and misunderstood (Schimmels et al., 2021). To foster an environment conducive to healing, healthcare providers must integrate the use of a patient-centered approach to trauma using six key principles (a) safety; (b) trustworthiness and transparency; (c) peer support; (d) collaboration and mutuality; (e) empowerment; and (f) cultural, historical and gender issues (SAMHSA, 2014).

Trauma, as evidenced by its long-lasting effects, can occur at any age, and the significant impact of childhood trauma can follow well into adulthood and have detrimental effects on learning, behavior, emotions, and physical well-being. Extensive research in several articles has been conducted on these distressing occurrences, commonly referred to as adverse childhood events (ACEs) (Bellis et al., 2023; Giano et al., 2020; Madigan et al., 2023). ACEs occur before the age of 18 years old and are traumatic events that happen during early development; these events go on to have tremendous lifelong physical and psychological impacts. Examples of ACEs include physical abuse, emotional or verbal abuse, sexual abuse, substance use,

incarceration, divorce, death, mental illness, racism, natural disasters, war, terrorism, food insecurity, financial insecurity, and homelessness (Bellis et al., 2023). Continued exposure to trauma triggers toxic stress responses in the body, heightening the risk of developing comorbidities and mortality. These prolonged periods of physical and mental anguish can lead to impaired memory and learning loss, increased anxiety, depression, difficulty in interpersonal relationships, poor physical and mental health, substance use, and suicide (Zarnello, 2023).

The World Health Organization estimated 4 in 10 adults in Europe had experienced at least one ACE as of 2023 (Bellis et al., 2023). This number increased to 6 in 10 adults in North America (Madigan et al., 2023), and in Australia, 62% of the general population had experienced at least one ACE (Thapa et al., 2024). Trauma transcends borders; yet, although TIC has received significant attention in Australia, Europe and the United States, there is a notable lack of research emphasis in lower to middle income countries. Such oversight neglects the diverse cultural and experiential backgrounds of individuals, undermining the comprehensive understanding of trauma's impact on global populations. Prior research in industrialized countries has indicated educational training programs for providers on TIC show promising results in enhancing mental health and substance use disorder outcomes, along with reducing hospital stay durations through the promotion of improved patient–provider relationships and harm reduction strategies (Nimura et al., 2019). To our knowledge, no study has examined the role of TIC education among healthcare providers in Kenya. This study aimed to assess effectiveness of a TIC workshop and answer the following research question: Can a trauma-informed care workshop increase the knowledge, attitudes, and skills of registered nurses in rural Kenya?

Methodology

Study Design

This study used a mixed methods approach and was conducted by a research team comprising of a 3rd year Psychiatric Doctoral Nurse Practitioner (PMHDNP) student and a PhD professor from the University of San Francisco. Institutional Review Board approval was obtained to ensure the study is ethical and the rights and welfare of participants are protected. As the Psychiatric Nurse Practitioner student and lead researcher of this study, I created a flyer to recruit volunteers for the study, which was open to all healthcare professionals and administrative staff employed at Hopecore Clinic in Chogoria, Kenya. A presurvey, postsurvey and consent form was prepared in a packet for each participant. The consent form provided a brief overview of the project and emphasized the voluntary nature of participation, ensuring anonymity of submission by not collecting identifying information.

Sample and Setting

The sample for this study was selected from a rural clinic in Chogoria, Kenya, and included all healthcare providers aged 18 and older who were proficient in English. The clinic manager informed staff about the voluntary workshop, which took place in a private conference room. The second lead of our research team facilitated approval to conduct the workshop at the clinic and helped develop and implement the semi structured interview guide, drawing from previous TIC research among healthcare workers (Choi & Seng, 2015; Hall et al., 2016). As first lead, I led the workshop, including the delivery of material, PowerPoint presentation, and administration of pre- and post-surveys. Additionally, I assisted in asking questions during the focus group interviews.

Participants

Using a convenience sampling approach, 16 healthcare workers volunteered to participate in the study, comprising of seven registered nurses, six community health field officers, one nutritionist, and two administrative support officers. Eligible participants were 18 years old or older and spoke Swahili and English.

Instruments

Quantitative data were gathered using a survey instrument. The 10-item TIC pretest–posttest survey was adapted and used with permission from Choi and Seng's (2015) research. The survey assessed knowledge, attitudes, and skills using a 5-point Likert *agree* and *disagree* scale. Scores ranged from 10–50, with higher scores indicating achievement of TIC learning objectives.

Qualitative data were gathered using a semi-structured interview guide. All the healthcare workers who participated in the TIC workshop were also invited to take part in a focus group 7 days after the lecture. The focus group, which lasted for 60 minutes, took place in a private conference room. Verbal consent was obtained to audio record the session and no self-identifying information was collected from the participants.

Procedure

Each participant received informed consent along with the pretest–posttest survey in a packet. The consent form provided a brief overview of the project and emphasized the voluntary nature of participation, ensuring anonymity of submissions by not collecting identifying information. Participants were eligible to receive a certificate of completion upon finishing the workshop.

Data Analysis

All participants who completed the survey were incorporated into the analysis ($n = 16$). The analysis of pretest–posttest data was performed using a paired t test and basic descriptive statistic functions in SPSS Statistics software. Application of a significance level of $p < 0.001$ indicated any increase in knowledge, skills, and attitudes was not due to chance and is generalizable. The t test aided in assessing the average improvement estimate across all three learning objectives. Simultaneously, 95% confidence intervals indicated the probable range and true difference in improvement estimates. Using the software application Cockatoo ® and Dovetail ® qualitative data was transcribed by the lead researcher, and three themes were identified: (a) relevance in training, (b) cultural stigma and bias, and (c) additional needs in the community. During the qualitative interviews, participants had the opportunity to explain the concept of trauma in their own language and cultural context, with some terms requiring participant translation from Swahili to English.

Results

Quantitative Findings (TIC)

In this sample, a total of 16 participants (i.e., seven registered nurses, six community health field officers, one nutritionist, and two administrative support officers) attended the TIC workshop and completed the pre- and post-test surveys. The primary outcomes of the current study conducted in Chogoria, Kenya are displayed in Table 1. The pretest scores were high across all three variables: 11.53 for knowledge ($SD = 1.96$), 14.50 for skills ($SD = .63$), and 19.33 for attitude ($SD = .82$), $p < .001$. In the posttest, skills showed a modest increase (14.88; $SD = .34$), and attitudes remained unchanged with a mean score of 19.33 ($SD = 1.18$). The most

significant improvement was observed in knowledge, with scores rising from 11.53 ($SD = 1.96$)

in the pretest to 14.20 ($SD = 1.15$) in the posttest.

Using a two-tailed t test, we determined there was a significant difference between the

means of pretest versus the posttest scores. Tables 2 and 3 show the mean difference and

variance by an overall increase of 3% with ($p < .001$). The confidence intervals of 95% ranged

from CI (1.61) lower bound to CI (4.39) upper bound.

Qualitative Findings (Perspectives of TIC)

Of the 16 healthcare workers who completed the TIC workshop, five volunteered to

participate in an audio-recorded focus group. The session took place in a private conference

room and was conducted in English with no collection of self-identifying information. The

interview questions were collaboratively developed by both facilitators of the project and aligned

with the content of the TIC workshop. The questions were designed to evaluate the relevance of

TIC within the hospital setting and its potential to elucidate how trauma influences patient

outcomes, as well as the cultural stigma and biases within the community. Qualitative data were

gathered through thematic analysis to identify, analyze, and report patterns within the audio-

recorded content. Qualitative data was analyzed using two applications: Cockatoo®, which

transcribed the audio recordings into PDF format, and Dovetail®, which was used to identify

themes from the transcriptions. The focus group interviews revealed the following themes: (a)

relevance of the training, (b) cultural stigma and bias, and (c) additional needs within the

community. The themes were based on the effectiveness of TIC education in Kenya and how

trauma was perceived in the participants' communities.

Relevance in Training

Participants shared the training program on TIC provided helpful information regarding ACEs and the connection to mental health, physical health, and behavior. Additionally, participants expressed interest in the topic and recalled personal encounters with patients whom they had seen in the clinic. Many of the participant's stories described how TIC could be beneficial in their community for example, Participant B stated the following concerning the impact of TIC:

> Since COVD, there's so much that has happened, and people have become depressed and have not been able to address [trauma] in the way it's supposed to be. So, it's a good step maybe to start doing something better about trauma.

And Participant C responded, adding:

> It [TIC] helped me to understand that almost everybody is going through a lot and maybe we should take a little more time to get the history, information from them.

Cultural Stigma and Bias and challenges

During the informal qualitative interviews, the nurses discussed how cultural stigma and bias significantly influence decisions not to disclose personal trauma and life events. Many nurses noted there are often feelings of vulnerability when speaking about trauma, and men in particular, tend to suppress their emotions.

The 2nd lead in the study asked the group:

> How does the group feel about it [talking about personal stress or trauma]? Do you have somebody that you trust or can invite in? Like a friend or family member that helps support you with your thoughts or emotions?

Participant E stated:

I only share what's necessary. It depends on the thoughts and the emotions. Of course you

don't trust anyone. There are only certain situations [I can share]. Most men don't speak

out [about emotions], they are not like ladies. Men don't disclose their issues. If a man

does disclose, like myself, I have one person. I can share with him. I don't share

everything though.

Participant B chimed in and stated:

I feel comfortable sharing with you [Both leads of the current study], because I know you

are coming to Chogoria, and then going back to the [United States] so long as you are not

around every day. Otherwise, I won't feel comfortable. I don't want my problems going

around (the community) and people gossiping.

The second facilitator of the study then asked participants if there was a Swahili word used in the

community for trauma. Participant B responded, stating:

The word people usually think is "masuala ya afya ya akili" [mental health issues]. When

it's used in a local language, it's not a nice word. People think you are just mental, like

maybe you have psychosis [and they judge you].

Additional Needs in the Community

Regarding needs within the healthcare system and Kenyan community, the second lead facilitator

stated:

This was a small study on TIC in Kenya. Do you think a monthly informal debriefing and

educational session for providers, would be beneficial for educating and sharing your

thoughts and feelings on patient cases encountered within the community?

All 5 participants nodded in agreement and stated:

Yes

The second lead followed up by asking:

> Is there anything else you would like to share? Anything that comes to mind [that
>
> could help your practice within the community]?

Participant B responded, stating:

> Something I wish for is a children home, like a rescue center. We have so many children
>
> in primary school and [they tell you what they are going through]. We had a student in
>
> school. She had been sexually assaulted by her relatives. Three different men. She was in
>
> the fourth grade, and she kept changing schools because every time she sees a man she
>
> thinks that they are going to harm her. It's very traumatizing for her. She is ashamed. We
>
> referred her to a psychologist. It will take time. Healing is a process.

Participant A adds:

> I wish our leaders would not be so corrupt anymore. We go to the police, but the police
>
> are corrupt, then the case is closed, so there's no justice.

Participant D states:

> I wish people were more informed about these mental issues. If we got more [trauma-
>
> informed] information, more education, it would help us a lot so that we are better able to
>
> diagnose

Participant E concludes:

> We need a platform that these children can use, whenever these cases are brought up and
>
> end up being negated, so these children can have a place for them to talk about what's
>
> happening. Almost like a [TIC] support group.

Discussion

This study examined the effects of a 1-hour TIC workshop given to employees of a rural community clinic in Chogoria, Kenya. The workshop introduced the participants to the concept of TIC and how it can benefit their interactions with patients. The workshop was conducted via PowerPoint presentation and highlighted the following objectives: (a) trauma and ACEs, (b) TIC and harm reduction, (c) principles of therapeutic communication, and (d) therapeutic communication approaches during screening in the clinic. Participants learned how to use the six key principles taken from the SAMHSA's TIC framework (U.S. Department of Health and Human Services, 2014). Using these approaches, participants were able to discuss as a group how they would incorporate this framework into practice for their community.

The findings of this study align with previous research on Trauma-Informed Care (TIC) in developed countries, demonstrating a direct relationship and positive correlation with an increase in learning objectives. Given that scores were initially high on the pretest, the overall improvement in skills, knowledge, and attitudes was modest, at just 3%. This percentage was expected because the sample size consisted of medical professionals who were familiar with trauma and the effects it has in the community and among their peers. Still, many participants found the training to be useful and relevant. During the qualitative focus group interview, some participants voiced the need for additional resources such as more TIC training, along with establishing a trauma resource center to provide additional support services in the community. Participants also expressed a desire for more information on recognizing the signs and symptoms of depression, anxiety, and other mental illnesses, with the aim of providing appropriate care and referrals. Training approaches that highlight the importance of a common foundational

knowledge are justified and care should be taken to also consider the needs of different levels of knowledge and expertise.

This research, conducted in Kenya, complements previous studies on TIC from more developed countries. Specifically, Choi and Seng's (2015) study in the United States served as the prototype for the Kenyan study. Choi and Seng implemented a TIC in-service training program to 47 perinatal health care providers; their 1-hour, in-service TIC training program included information about trauma and its effects on health, specifically effects of trauma on childbearing women. Choi and Seng concluded most participants found the training useful and relevant to their practice, and their presurvey scores were high on all three variables. Presurvey scores showed the following knowledge ($SD = 12.8$), skills ($SD = 12.0$), and attitudes ($SD = 18.9$). Postsurvey scores showed an increase in knowledge ($SD = 13.5$), skills ($SD = 13.1$), and attitudes ($SD = 19.4$). Qualitative interviews produced three themes: relevance, additional learning needs, and depth of training. Relevance and usefulness were evident, and participants expressed interest in the topic and learning objectives. Additional learning needs were expressed by participants, suggesting healthcare workers with whom they work would greatly benefit from this information and that TIC should be a collaborative effort within the multidisciplinary team. Although participants found training useful, they commented on wanting more advance training.

Another study conducted in Australia by Hall et al. (2016) implemented a TIC training program with 34 ED nurses who participated in a TIC education workshop followed by a postworkshop focus group. First, Hall et al. found there was meaningful change in 9 of the 18 survey questions ($p < 0.01$, $r \geq 0.35$). Nurses in the study recognized TIC's potential to reduce re-traumatization and expressed a desire to implement it in practice; however, they faced significant challenges due to the time constraints inherent in the fast-paced, task-oriented

environment of the emergency department. Hall et al. (2016) identified two themes from the qualitative focus group interviews: (a) effectiveness of TIC education and (b) changes in nursing practice. The effectiveness of TIC education was linked to improved understanding and attitudinal changes among nurses. This understanding fostered a more holistic view of the patient experience. However, despite their intent to use TIC, participants cited significant challenges in promoting practical changes due to time constraints and rapid turnover, highlighting the need for further development in TIC's practical application. In contrast, the Kenyan nurses in this study did not experience the same time constraints when conducting onsite home, school, and community visits. Patients were afforded more time with clinicians, allowing for more extended interactions.

In our TIC Kenyan study, three themes emerged from qualitative interviews: (a) relevance in training, (b) cultural stigma and bias, and (c) additional needs in the community. Regarding training relevance, Kenyan healthcare workers expressed a strong desire to learn about TIC and better understand mental health to refer patients appropriately; however, specific challenges in this community included patient reluctance to share private information about mental illness due to stigma, shame, and fear of gossip. Healthcare workers also emphasized the need for more resources to address mental illness effectively.

According to World Health Organization (2022), Dr. Mwiti, a psychologist in Kenya, stated, "Mental Health is a neglected field, and Kenya currently has only 100 psychiatrists and 400 psychologists" (para. 3). This metric is in stark contrast to the country's estimated population of 55 million people. Understanding the severe shortage of mental health professionals in Kenya is vital for implementing TIC. With only 100 psychiatrists and 400 psychologists serving a population of 55 million, efficient resource allocation, and the training of healthcare workers and

community leaders become essential. This information highlights the need for increased

investment in mental health services, guiding policy advocacy and the development of

complementary care approaches such as peer support and telemedicine. Public awareness

campaigns and community-based initiatives can help mitigate the professional shortfall.

Additionally, this knowledge underscores the importance of further research, data collection, and

international partnerships to bolster mental health support in Kenya.

Limitations and Strengths

The survey utilized in this study was a self-reported appraisal tool developed by Choi and

Seng (2015). As their research pointed out, the lack of direct knowledge test questions prevented

a direct assessment of knowledge gains. In retrospect, the current study had several limitations

that should be acknowledged, beginning with the small and homogenous sample size, which

impacted the internal consistency when measuring test reliability using Cronbach's alpha. The

small sample size likely led to closely related participant scores, given all participants had

experience working with patients who have undergone trauma. Despite these limitations, the

findings were statistically significant. Additionally, because the workshop was voluntary, there

may have been a selection bias among participants who had a prior interest in the topic. The

effect size might be greater with a larger, more diverse group of participants, particularly if

attendance were mandatory rather than voluntary.

Despite these limitations, the study had notable strengths. First, it is the first known study

of its kind on TIC and healthcare in Kenya. The qualitative data enriched the survey findings by

identifying which learning objectives participants deemed important and how they intended to

apply them in practice. Together, the survey and qualitative data underscore the need for further

research in TIC and the development of culturally relevant in-service training to enhance the wellness and health of the populations being served.

Conclusions

This study centered on a training initiative regarding TIC among nurses in rural Kenya, offers valuable insights for the further development of continuing education programs globally, as trauma is a universal experience. Conducting a learning needs assessment at each training site is crucial to enhance the knowledge, skills, and attitudes of professionals. This approach aims to diminish stigma, bias, and judgment, fostering stronger therapeutic relationships between providers and patients, thus reducing harm and improving healthcare outcomes.

In this research, participants embraced the opportunity to learn and share insights on trauma in their community, along with the resources available to them. The results suggest the need for more advanced TIC training and regular staff debriefings to facilitate discussions on case studies and patient experiences. This approach would allow providers to evaluate evidence-based practice guidelines applicable to their work.

Further research is necessary to assess knowledge acquisition and retention, and the pre- and post-test surveys should be expanded to include questions that can measure participants' understanding of TIC. As therapeutic advancements continue, there should be a focus on global inclusivity, recognizing that trauma affects individuals worldwide, transcending cultural and linguistic boundaries. Ultimately, by fostering empathy and understanding of human suffering, TIC can be a unifying force that benefits all of humanity.

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Table 1

Descriptive Statistics for Study Outcome Variables

Variable	Pretest mean (*SD*)	Posttest mean (*SD*)	Mean change	95% CI for change	*t*	*df*	*p*
Knowledge	11.53 (1.96)	14.20 (1.15)	2.67	1.87, 3.47	7.14	14	< .001
Skills	14.50 (.63)	14.88 (.34)	.38	-.05, .80	1.86	15	.08
Attitude	19.33 (.82)	19.33 (1.18)	.00	-.51, .51	.00	14	1.0

Note. CI = confidence interval.

Table 2

t Test: Paired Two Sample for Means

Statistics	Pre	Post
Mean	45.4	48.4
Variance	5.4	3.68
Observations	15	15
Pearson correlation	0.31	
Hypothesized mean difference	0	
df	14	
t Stat	-4.63	
P(T< = *t*) one-tail*	0.00	
t Critical one-tail	1.76	
P(T<= *t*) two-tail**	0.00	
t Critical two-tail	2.14	

Note. * = one-tailed *p* value; ** = two-tailed *p* value.

Table 3

Mean Difference and Confidence Interval

Difference	
Measurables	Results
Mean	3
Standard error	0.64
Median	3
Mode	3
Standard deviation	2.50
Sample variance	6.28
Kurtosis	-0.32
Skewness	0.12
Range	9
Minimum	-1
Maximum	8
Sum	45
Count	15
Confidence level (95.0%)	1.38
lower bound	1.61
upper bound	4.38

Note. We are 95% confident that the true difference is in between 1.61 and 4.39.