Using Trauma-Informed Care in Practice: Evaluation of Internal Medicine Resident Training and Factors Affecting Clinical Use

Binny Chokshi, MD, MEd1; Ellen Goldman, EdD2

ABSTRACT

Introduction: Trauma-informed care (TIC) acknowledges that childhood traumas can profoundly affect health outcomes and aims to create a safe, nurturing medical environment. TIC curricula in graduate medical education are limited and lacking in assessment of the application of TIC in practice.

Methods: This mixed-methods study followed implementation of a 4-hour required training session for 91 internal medicine residents at George Washington University Hospital. Pre- and posttests were administered to determine change in knowledge, attitude, and confidence. Six weeks after the training, individual participant interviews were conducted to ascertain how TIC is practiced in the clinical setting.

Results: For the 47 participants with matched pre- and post-test data available, there was a statistically significant score improvement after the session on 13 of 16 items (excluding only 3 attitude items). Six themes emerged: 1) patient characteristics trigger recognition to utilize TIC; 2) time plays a critical role; 3) the acute medical setting is a barrier; 4) the patient-doctor relationship impacts TIC application; 5) concern about next steps influences TIC use; and 6) incorporating TIC requires repetition, practice, and supervisor support.

Conclusion: This study demonstrated that a 4-hour TIC session can promote growth in resident knowledge and confidence related to TIC. The findings highlight that TIC education needs to account for contextual factors that can impact its clinical application. A focus on work environment factors such as time, resources, and supervisory support can help to maximize TIC learning, retention, and application in practice.

INTRODUCTION

Individuals and communities often face disadvantages in achieving health equity because of their exposure to detrimental social determinants of health. One of the most destructive and heartbreaking negative social determinants is childhood trauma. In the United States, two-thirds of individuals have been exposed to at least one childhood traumatic event. The Adverse Childhood Experiences Study conducted by the Centers for Disease Control and Prevention demonstrated how exposure to 10 specific childhood traumas can profoundly affect health outcomes across the lifespan in a dose-dependent manner. Exposure to trauma has been shown to impact the likelihood of medical illness, ranging from substance use to asthma, obesity, and heart disease. Most strikingly, individuals exposed to 6 or more childhood traumas have a decreased life expectancy by 20 years. These study findings, together with overwhelming data showing a higher incidence of traumatic exposures in marginalized communities, highlight the importance of physician training on strategies to contextualize the effects of trauma and maximize patient health. Despite this, healthcare practitioners report discomfort in addressing a history of trauma with their patients, and the impact of traumatic exposures is not routinely included in health professions education.

Trauma-informed care (TIC) is an approach to healthcare that acknowledges the events, experiences, and effects of trauma on an individual. It focuses on converting the medical environment into a safe, nurturing space where children and families can receive interprofessional help to diminish trauma’s effects on body and mind as well as participate in a collaborative and holistic approach to their health and wellbeing.

To create a TIC environment requires healthcare professionals to appreciate the science of adversity and the neurobiology of trauma and to gain proficiency in specialized interviewing and physical examination. It also requires leadership skills to bring the entire medical staff on board and create a warm atmosphere that promotes patient engagement and collaboration. With increasing evidence that TIC can lead to improved patient care outcomes, healthcare institutions are recognizing the importance of clinician competency in TIC.

There is a global need for TIC curricula for health professionals, but the need is particularly evident for graduate medical education. A recent review identified 22 articles that described trauma-informed educational curricula, and only 2 were in nonpsychiatric medicine. Beyond this scoping review, there are additional models for adversity and TIC

Author Affiliations
1Department of Pediatrics, George Washington University School of Medicine and Health Sciences and Children’s National Hospital, Washington, DC
2Department of Human and Organizational Learning, George Washington University Graduate School of Education and Human Development, Washington, DC

Corresponding Author
Binny Chokshi, MD, MEd (bchokshi@cmmc.org)

Keywords: adverse childhood experiences; mixed methods; transfer of training; trauma-informed care; virtual education

Abbreviations: IM = internal medicine; TIC = trauma-informed care
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ORIGINAL RESEARCH ARTICLE

George Washington University institutional review board. The study was approved by the Washington University Hospital. The session was repeated 5 times to allow for maximal participation; each session had approximately 18 IM resident participants. The session occurred during regularly scheduled mandatory teaching time for IM residents at George Washington University Hospital. The study was guided by one central question: How do internal medicine (IM) residents at George Washington University Hospital incorporate TIC into their clinical practices? There were two subquestions: 1) How does a TIC educational session affect gains in knowledge, attitude, and confidence? 2) What contextual factors influence the transfer of TIC training to a clinical setting?

METHODS

This study utilized mixed methods. Pre- and posttests were administered to determine change in knowledge, attitudes, and confidence following a TIC educational session. This was followed by individual interviews to ascertain how TIC was being practiced in the clinical setting. Participants included first-, second-, and third-year IM residents at George Washington University Hospital. The study was approved by the George Washington University institutional review board.

Educational Session

A 4-hour virtual education session about TIC, utilizing the principles of adult learning theory to create a high-engagement and interactive learning environment, was facilitated for IM residents at George Washington University Hospital. The session was repeated 5 times to allow for maximal participation; each session had approximately 18 IM resident participants. The session occurred during regularly scheduled mandatory teaching time for IM residents at George Washington University Hospital. Although planned as an in-person session, it was modified to a virtual platform to accommodate COVID-19 safety measures.

The session began with an overview of the science of adversity and the neurobiology of trauma. The principles of a trauma-informed approach to care were described utilizing the acronym CARES: C, central tenet of TIC; A, ask about stressors; R, do not retraumatize; E, empower and educate; S, self-care. The content included a review of a trauma-informed physical examination. It ended with a review of universal trauma precautions and the pros and cons of screening for trauma and adversity. The didactic component included audience response multiple-choice questions and breakout rooms to foster engagement. Breakout topics included why COVID-19 should be considered a community trauma and also the merits and potential pitfalls of screening for adversity. A 10-minute simulated video was shown of an IM resident utilizing TIC with a standardized patient, who presented with concern for systemic lupus erythematosus and ultimately was diagnosed with chronic pain.

Following group viewing of the video, participants again went into breakout rooms to focus on what the resident did well and could have improved upon. The session ended with an interactive discussion of any points from the educational session requiring further clarification and how residents intended to utilize what they learned in their practice.

Quantitative Data Collection

Before the educational session, participants were invited to participate in the research study and received an information sheet to review. They were then directed to a 16-question, Likert-scaled pretest (Appendix A) on Qualtrics, with 5 questions on knowledge, 5 on attitudes, and 6 on confidence. Following the educational session, participants were asked to complete a posttest, which included the 16 pretest questions and questions about overall course satisfaction and suggestions for improvement (Appendix A). Participants were asked to create a unique identifier for both questionnaires to protect their anonymity while allowing for matching of pre- and posttest responses.

Qualitative Data Collection

Six weeks after attending their TIC virtual education session, each resident received an emailed invitation to participate in a virtual, semi-structured interview with the TIC course facilitator. The interview protocol included 9 questions focusing on the application of TIC in the clinical setting (Appendix B). Each interview was recorded with Zoom technology and then transcribed verbatim, using the Zoom transcription feature. A colleague supervising the study reviewed the first 2 interview transcripts to ensure effective interview technique, such as the use of probing and appropriate, non-leading questions. Interviews were conducted until saturation was achieved. Participants were compensated with a $25 Amazon gift card.

Data Analysis

Quantitative data were analyzed by comparing pre- and posttest scores on the 16 Likert-scaled items using the
Wilcoxon signed rank test. Each item was compared individually and with aggregate calculations by category: knowledge, attitude, and confidence.

Qualitative data were analyzed by applying standard methods for a basic interview study. The principal investigator reviewed and coded the first 3 transcripts and then the study supervisor provided peer review; areas of difference were discussed to reach a consensus and establish the codebook. The principal investigator subsequently coded the remaining transcripts, grouped the codes into clusters, and identified themes for each cluster. Themes were reviewed with the study supervisor and discussed until consensus was reached. Trustworthiness was ensured through the use of epoche, peer review of the first 2 transcripts for effective technique, peer review of coding and themes for 3 transcripts, member checks, and thick rich description.

RESULTS

Quantitative

A total of 91 IM residents participated in the TIC educational session; 77 completed the pretest and 63 completed the posttest. On a scale of 0 to 5, the overall rating for the educational session was 4.3. Participants rated the effectiveness of the presenter in meeting learning objectives as 4.62 and satisfaction with teaching method and tools as 4.53. Their likelihood to incorporate TIC into clinical practice was rated 3.91.

Forty-seven participants completed both the pre- and posttest with unique identifiers that matched, allowing for paired analysis. There was a statistically significant score improvement after the session on 13 of 16 items. The 3 items that were not statistically significant were in the attitudes category (Table 1). The greatest magnitude of change was seen in the knowledge category.

Qualitative

Thirteen residents were interviewed; saturation was achieved at 12 interviews. Six themes emerged from the data: 1) patient characteristics trigger recognition to utilize TIC; 2) time plays a critical role in TIC delivery; 3) the acute medical setting is a barrier to TIC; 4) the patient–doctor relationship impacts the application of TIC; 5) concern about the next step influences use of TIC; and 6)

Table 1. Trauma-informed care training evaluation results

<table>
<thead>
<tr>
<th>Item</th>
<th>Question</th>
<th>Pretest mean</th>
<th>Posttest mean</th>
<th>Mean pre-post difference</th>
<th>p value</th>
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</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Adverse childhood experiences</td>
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<td>3.79</td>
<td>1.66</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>2</td>
<td>Link between traumatic exposures and health outcomes</td>
<td>2.64</td>
<td>3.91</td>
<td>1.27</td>
<td>&lt; 0.001</td>
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<td>3</td>
<td>Central tenet of trauma-informed care</td>
<td>1.72</td>
<td>3.87</td>
<td>2.15</td>
<td>&lt; 0.001</td>
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<td>4</td>
<td>Trauma-informed physical examination</td>
<td>1.66</td>
<td>3.53</td>
<td>1.87</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>5</td>
<td>Resources to support patients with history of trauma</td>
<td>1.60</td>
<td>3.09</td>
<td>1.49</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>Average</td>
<td>1.95</td>
<td>3.64</td>
<td>1.69</td>
<td>&lt; 0.001</td>
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<tr>
<td>Attitudes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Inquiring about trauma during patient visits</td>
<td>3.36</td>
<td>3.74</td>
<td>0.38</td>
<td>0.005</td>
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<td>7</td>
<td>Discussing trauma and health relationship with patients</td>
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<td>3.87</td>
<td>0.32</td>
<td>0.006</td>
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<td>8</td>
<td>Training clinic staff on link between trauma and health</td>
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<td>3.94</td>
<td>0.19</td>
<td>0.141</td>
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<td>9</td>
<td>Training for clinic staff on trauma-informed care principles</td>
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<td>4.02</td>
<td>0.19</td>
<td>0.078</td>
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<tr>
<td>10</td>
<td>Discussion of resiliency during patient visits</td>
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<td>0.30</td>
<td>0.018</td>
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<tr>
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<td>0.066</td>
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<td>Confidence</td>
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<td></td>
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<td></td>
<td></td>
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<td>11</td>
<td>Incorporating central tenet of trauma-informed care into patient visits</td>
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<td>3.2</td>
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<td>12</td>
<td>Inquiring about past trauma during patient visits</td>
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<td>3.09</td>
<td>1.3</td>
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<td>13</td>
<td>Incorporating a discussion regarding the link between trauma and health during patient visits</td>
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<td>3.22</td>
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<td>3.22</td>
<td>1.13</td>
<td>&lt; 0.001</td>
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<tr>
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<td>Offering resources of support to a patient with past trauma history</td>
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<td>3.02</td>
<td>1.26</td>
<td>&lt; 0.001</td>
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<tr>
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<td>Average</td>
<td>1.83</td>
<td>3.13</td>
<td>1.31</td>
<td>&lt; 0.001</td>
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*Values are from a Likert scale ranging from 0 to 5.
incorporating TIC into care delivery requires repetition, practice, and supervisor support. Table 2 presents illustrative quotations for each theme.

Residents noted that often the characteristics of a patient prompt recognition to utilize TIC. For example, a patient who is noncompliant with appointments or treatments may raise a red flag for stressors that could be impacting care. A patient who is combative with medical staff or difficult in demeanor similarly may prompt recognition. Residents commented that they tend to favor using TIC in vulnerable patients with a known unequal distribution of social determinants. Lastly, patient characteristics listed in the electronic medical record, such as patient demographics or problem list, could also prompt use of TIC.

Residents sensed that TIC takes time and cited time as a frequent barrier to TIC inclusion. They noted the multitude of visit components, such as obtaining the history of the present illness and reconciling medications, that make it difficult to find time for TIC. Accordingly, residents viewed the acute medical setting, such as the emergency room or the inpatient wards, as unsuitable for TIC delivery. In these settings, residents felt that active medical complaints and emergent

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplary quotes</th>
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| 1. Patient characteristics - trigger recognition to utilize TIC      | • If I’m in a youth clinic for runaway children, I know that they come from unstable homes most of the time; I know that a lot of adverse childhood events are at play; and, in that group, I use it. And then in general medicine, I don’t think to use it because it’s not a super high-risk setting. But that means that I am missing people that might benefit from it. (Participant 6)  
• It doesn’t quite make sense to me, just from a 30,000-foot view, that somebody would go looking for help and then as soon as you find a resource shut down and not want anything to engage and get helped because he took that first step. And I think just deep down, if they’re coming to you, they do want help. You just kind of have to work with them to figure out what's really the underlying issue. I think a lot of the times it’s that you have to build that trust and make sure that you have a good approach with the patient. (Participant 7) |
| 2. Time plays a critical role in TIC delivery                        | • I can’t imagine having a trauma-informed discussion with the patient in 15 minutes and then also having to go through like all of the other chronic medical problems. (Participant 13)  
• Just having clinic is so overwhelming and they only give us three patients so far per morning and I’m still so overwhelmed .... At this point in my training, I can’t even address the traumas that you’ve previously faced. I’m just trying to get through your med list and address whatever it is that brought you in today. (Participant 4) |
| 3. The acute medical setting is a barrier to TIC                     | • The hospital setting itself often doesn’t lend to you to have the most personalized encounter .... You’re often with another patient; you’re in a room; the patient is with another patient in the other room .... It can be a privacy thing .... Just sort of the business of the hospital setting and the demands of what goes on within the hospital kind of get in the way of creating a space for a TIC. (Participant 8)  
• It’s very disorienting for the patient just to be in the hospital .... You’re just laying in bed and someone will come talk to you for maybe 5 minutes during the day and then you may not see them for the day .... If somebody asked you    "tell me about your childhood," essentially, it’s (a) like, who are you? (b) where’s this coming from? and (c) how is this going to address why I’m in the hospital? ... It’s hard to make that connection with them during the inpatient setting. (Participant 9) |
| 4. The patient-doctor relationship affects the application of TIC     | • Time constraints are a huge thing when I’m trying to do all the things that we do in primary care—their screenings, and then also, since my panel of patients is still brand new, it’s usually the first meeting, then sometimes I don’t feel completely comfortable going deep into certain things when it’s my, it’s just my first visit. (Participant 3)  
• Maybe is it more appropriate to do in a visit after you’ve established some sort of relationship with the patient and established trust with them? Would it be more appropriate then? When we watched that video of the encounter, one of the things was building trust and building rapport, which can be hard to do when you’re meeting them for the first time and you’re trying to figure out everything that’s going on with them medically. (Participant 6) |
| 5. Concern about next step the influences use of TIC                  | • Maybe if there’s an administrative person we could go to right away, and say, “Hey, we have this patient who needs a little bit more, … needs a therapist because their trauma’s affecting their overall medical care.” Then maybe you can provide them with some resources. Maybe somebody we could go to, that would be really nice. A therapist on hand, mental health worker, … somebody that we could go to and they would help set all this up for patients would be really great. (Participant 5)  
• Without having that access [to mental health providers], it creates a hesitancy to even begin to take that approach if you don’t feel you can then make the next step to getting them the right mental health services .... That’s been the biggest challenge for a lot of the clinic. (Participant 2) |
| 6. Incorporating TIC into care delivery requires repetition, practice, and supervisory support | • Consistent reminders and didactics about it, I think, would help .... A lot of people have had training before or have perspective or are already practicing a lot of these things without realizing .... Just by putting a name to it and having reinforcement on a regular basis .... helps bring a different perspective. Every time you're in clinic or every time you're seeing patients, the more you’re thinking about it, the more you’re actually acting on it. (Participant 2)  
• I’ve never seen it practiced in the clinic or in the hospital (a) because we have so little time and (b) you have to have a good mentor .... So much of medicine is an apprentice-based model: If you don’t see it, you can learn about the concepts, but the onus is on you to actually take it into practice yourself .... I’ve never seen like a good model of TIC. (Participant 4) |

TIC = trauma-informed care.
medical issues took precedence over TIC. In addition, residents commented that patients can be vulnerable in these settings, interacting with multiple healthcare professionals, which could make the intimate inquiries that often accompany TIC appear intrusive. Residents also emphasized that TIC benefits from a longitudinal, respectful, and trusted doctor-patient relationship, which is often lacking in the acute setting.

Residents noted that concern about the lack of follow-up resources and treatment influenced their use of TIC. They recognized that TIC often necessitates the involvement of social work or mental health professionals; if they lacked access to these supports, they felt it would be unfair to engage in TIC with patients.

Residents commented on the role of supervisors in modeling and reinforcing TIC. They mentioned that supervisor support can help structure their own TIC approach, particularly with respect to a treatment plan, and seeing a supervising attending modeling a TIC approach would serve as a reminder and reinforcement to use TIC in clinical practice.

Lastly, residents recognized that incorporating TIC requires repetition and practice. They recommended offering an introduction to TIC earlier in training, with the opportunity to practice in the clinical environment. They remarked that standardized patient practice and role play would help build their confidence employing a TIC approach in the clinical setting.

Figure 1 illustrates a model connecting the qualitative findings listed above, highlighting the contextual clinical factors that prompt, promote, and reinforce resident incorporation of TIC into their clinical practice.

DISCUSSION

This study demonstrated that a 4-hour virtual TIC educational session can be effective in promoting growth in resident knowledge and confidence related to TIC. The session differed from existing TIC curricula in that it utilized active learning techniques, such as discussing a standardized patient encounter and providing an easy-to-use mnemonic to enhance retention, to maximize learner engagement. Although this session was delivered virtually due to COVID-19, it still received a high satisfaction rating from participants.

The TIC educational session did not lead to statistically significant changes in the attitudes category of the pre-posttest. This may be explained by the fact that the session focused on knowledge and active skills. As a result, attitudes related to TIC were not as affected as knowledge and confidence.

A central question of this study was to examine the factors that influence the transfer of TIC training to a clinical setting. Figure 1 depicts a model connecting the elements that prompt, promote, and reinforce TIC. Detailed examination of this model reveals that those elements that prompt and reinforce the use of TIC map to the work environment transfer of training factor, specifically the sub-categories within this factor: 1) opportunity to perform, 2) climate, and 3) support. Sufficient time and an established patient-doctor relationship promote TIC by affording residents the opportunity to perform or utilize TIC in clinical practice. The nonacute setting, such as primary care, is perceived to be a suitable climate for encouraging TIC application. Support for TIC can include resources to support and address a diversity of patient needs in a work environment. Support from a supervisor, ie, an attending, can reinforce TIC, as can repetition and practice in the clinical setting.

Apart from the clinical setting, study findings also map to the training design factor. Specifically, findings emphasized the importance of repetition and timing of learning sessions (ie, earlier in training). Findings also underscored the importance of incorporating active learning techniques such as standardized patients and role play to allow trainees to develop confidence by practicing their TIC skills.

Implications for Practice

Consideration of the transfer of training factors is linked with enhanced learning and retention, and the study
findings highlight that a consideration of work environment and training design factors can maximize the success of TIC curricula.21

We suggest that TIC curricula focus on a universal trauma approach. Curricula need to acknowledge and discuss individual trainees’ biases that may lead them to preferentially apply a TIC approach with a particular subset of patients or in a particular setting, ie, nonacute. When a TIC approach is done appropriately and respectfully, patients can be receptive to it at any time during the medical encounter.25 Instead of being prompted to use TIC when confronted with specific patient characteristics, trainees can recognize that a TIC approach is applicable to all patients in any setting and could lead to beneficial outcomes for patients and providers alike. Education should focus on learners being able to plan and practice applying TIC universally, through the use of active learning opportunities including role-play and case-based exercises pertaining to a variety of clinical settings and with standardized patients representing a diversity of patient demographics and characteristics.

In light of the study findings regarding time and need for resources to support TIC use, residency programs should consider how they are structuring their trainees’ clinical time for routine patient visits in longitudinal clinics and incentivizing use of TIC. In addition, programs should prioritize providing residents with consolidated information on community resources of support or assisting them in working interprofessionally with social workers and mental health professionals. The impact of the patient-doctor relationship highlights that there may be a role to juxtapose teaching in TIC alongside education in patient-centeredness and communication skills. Educators should consider the timing of TIC education, as exposure early in training can offer opportunities to utilize skills through the years of residency. Solidifying TIC skills through practice may also help trainees recognize that TIC can infuse any medical visit and does not necessarily have to be considered a separate entity requiring additional time.

As the supervisors’ role in modeling TIC is critical to the learners’ experience with and understanding of TIC, institutions should also prioritize training all medical providers, including teaching faculty, to recognize the benefits of and utilize TIC.26 Residency programs should offer faculty development for attending physicians in TIC, so they can reinforce the knowledge and skills gained by their trainees. Given study findings demonstrating that trainees preferentially are cognizant of TIC use in specific settings, universal faculty development, beyond targeted training for primary care attendings, could be useful. Lastly, given the emphasis placed on multidisciplinary collaborations facilitating TIC, interprofessional curricula could be helpful in advancing TIC application.

Study Limitations
This study considered knowledge, attitudes, and confidence before and immediately after the educational session and practice application after 6 weeks. Long-term participant follow-up is needed to determine the effect of the educational session on participant behavior in the clinical setting. Going further, it would be beneficial to evaluate the effect of TIC use on patients and families, which could range from measurement of patient-level health outcomes to exploring patient clinical experiences and feedback on the healthcare encounter. Also important is that the study took place in an urban, academic institution within an IM residency program. Further study can elucidate training impact and TIC perspective beyond this setting. Lastly, as the research question focused on contextual factors that influence the use of a TIC approach in clinical settings, the findings did not explain any trainee characteristics that may impact the use of TIC. Further study can explore this transfer determinant, such as by studying how a personal history of adversity, personal experience in a helping profession beyond medicine, or exposure to TIC in practice may impact physician motivation and use of TIC in clinical practice.

CONCLUSION
Training physicians in a trauma-informed approach to care is a critical tool in advancing health equity. Graduate medical education curricula focused on TIC should account for the factors that can influence the application of a TIC approach in the clinical setting. We hope that the study findings and model (Figure 1) depicting the factors that prompt, promote, and reinforce the application of TIC in clinical practice serve as a guide. We also encourage educators to examine and reflect on their unique clinical and learning environments to tailor their educational TIC endeavors to meet their individual needs. This consideration can assist with thoughtful and sustained incorporation of TIC into clinical practice.

Supplemental Material

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The authors have no conflicts of interest to disclose.

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Author Contributions
Binny Chokshi, MD, MEd served as the principal investigator on this study, participating in all aspects of study design, data acquisition, and
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