Building a Resilient Healthcare Workforce through Trauma-Informed Care: An Exploratory Case Study to Understand Workplace Needs

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Report Prepared by: Research Team- Dr. Andrea Hetling, Dr. Rupa Khetarpal, Gabrielle Gault, MSW, E.J. Knopf, MSW/MPH Candidate, and Lillian McFarland, MPP

Project Summary

Our project, "Building a Resilient Healthcare Workforce through Trauma-Informed Care: An Exploratory Case Study to Understand Workplace Needs," aimed to understand the extent to which trauma-informed care (TIC) is understood and implemented in healthcare workplaces and where gaps may exist. Specifically, the project had two related research goals: 1) assess current trauma-related knowledge, perceptions regarding TIC, and use of trauma-informed practices in the workplace; and 2) document levels of burnout, experience of secondary traumatic stress and vicarious stress, and overall job satisfaction. The Rutgers Robert Wood Johnson Medical School Department of Medicine served as our case study.

To achieve these two goals, the project consisted of two phases:

- Phase I was designed to obtain grounded insights to inform the development of our Phase II survey. Phase I consisted of both individual and group interviews with student interns, hospital staff, and physician experts employed in hospital settings in New Jersey. The interviews focused on how TIC is understood and implemented by healthcare workers and were coded using thematic analysis.
- In Phase II, we developed our survey based on Phase I findings and existing validated tools. We piloted the survey with a diverse group of residents, faculty and staff at the Department of Medicine and conducted follow-up interviews to examine perceptions and experiences with the survey. Because we were not able to fully launch the survey, results are not generalizable and thus our second research goal was modified to be exploratory.

In sum, our results indicate that there are gaps in knowledge, confidence, and practice regarding TIC principles at the hospital. At the same time, study participants indicated both an understanding of why TIC is important and a willingness and interest in trainings and policies aligned with TIC principles. Informed by these findings, we are currently exploring additional funding to design a TIC training program for hospital staff and simultaneously launch a revised version of the survey to evaluate the impact of training.

Background

Nearly 70% of the U.S. population will experience exposure to one or more psychologically traumatic events in their lifetime (SAMHSA, 2014), with a mean lifetime exposure of 3.2 events (Kessler et al., 2017). Traumatic experiences are those that overwhelm an individual's ability to

manage the experience and result in symptomatology that adversely impacts their health and overall well-being (SAMHSA, 2014). The Centers for Disease Control and Prevention report that one in three women and one in four men have experienced severe physical violence from an intimate partner in their lifetime (CDC, 2022). For those with a trauma history, poorly designed healthcare services can be re-traumatizing and frequently lead to a lack of healthcare utilization (Cadman et al., 2012). Healthcare workers are also negatively impacted by exposure to their patients' trauma, experiencing secondary traumatic stress and burnout (Bride, 2007).

Trauma-informed care (TIC) refers to systems of care that establish the importance of understanding and recognizing trauma as both interpersonal and sociopolitical, emphasize the impact on human functioning, and develop effective service delivery models (Quiros & Berger, 2016). TIC is an organizational framework that builds on the existent knowledge on trauma and the impact on health, urging all helping professionals to: 1) realize the widespread impact of trauma, 2) recognize its signs and symptoms, 3) respond by integrating trauma related knowledge into policies and procedures, and 4) resist retraumatizing the beneficiaries (SAHMSA, 2014). The framework is operationalized by ensuring an environment that maintains physical and emotional safety, providing care that establishes trustworthiness and transparency in care, sharing decision making and obtaining client feedback to inform services, and practicing sensitivity to the cultural, historical, and gender differences (SAMHSA, 2014).

Current research on TIC in healthcare settings provides a thorough understanding of discipline-specific experiences. The literature suggests that TIC training can improve providers' well-being and reduce burnout and secondary traumatic stress (Fink-Samnick, 2022). A gap in knowledge exists, however, regarding how TIC is understood and applied in interprofessional health care settings and what the specific training needs are, particularly in large hospital networks.

Methodology

To answer our research questions, we employed a primarily qualitative research design, using the Rutgers Robert Wood Johnson Medical School Department of Medicine as our case study. The project was organized in two phases. Phase I consisted of in-depth individual and group interviews designed to explore hospital intern and staff members' experiences, perspectives, and confidence in implementing TIC and to inform the development of Phase II's pilot survey. Phase II consisted of creating and piloting a new survey and conducting follow-up interviews with survey participants. Before beginning these tasks, we conducted a thorough literature review of existing and validated TIC surveys and best practices. The information derived from this review informed elements of both phases of the research. Ethical approval for both phases of the study was obtained from the Rutgers Institutional Review Board.

Phase I – Pre-survey individual and group interviews

Recruitment and Sample

A total of ten participants were recruited to participate in Phase I interviews through purposive sampling using targeted email outreach. Graduate student interns working in healthcare settings were recruited through emails sent out by student services staff at the Rutgers School of Social Work and the Health Administration Program at the Rutgers Bloustein School of Planning and

Public Policy. Three Masters of Social Work (MSW) and four Masters of Health Administration (MHA) students volunteered to participate. To complement the student intern perspectives, two hospital staff members and one physician were invited via personal emails. All participants were selected based on their employment or internship affiliation with a healthcare setting.

Study Procedures and Analyses
A semi-structured interview guide was developed to explore key aspects of TIC knowledge and practice while allowing flexibility for participants to elaborate on their experiences. Individual and group interviews were conducted from October to December 2024. Group interviews were completed with 2-3 student interns at each session and lasted approximately 60 minutes. Individual expert interviews lasted between 25 and 50 minutes each. Participants received a $30 Amazon e-gift card as an incentive. All interviews were conducted via Zoom. Interviews were audio-recorded with participants' consent and transcribed verbatim for analysis.

Thematic analysis was employed to identify key patterns and variations in responses. Two research team members took the lead on coding the data. NVivo was used to facilitate coding and theme identification. This methodological approach ensured a systematic and rigorous exploration of the research topic, providing a rich understanding of participants' perspectives and insights on designing a survey for healthcare workers employed in a hospital setting.

Phase II – Pilot survey and follow-up interviews

Survey Development
Using the findings from Phase I, coupled with our initial literature review, we designed a brief survey for healthcare workers focused on their understanding and use of TIC as it relates to their work. In addition to demographic and professional background questions, the survey contained closed-ended questions related to four substantive topic areas: TIC knowledge and perceptions; TIC practices including screening and collaboration; workplace supports including training and how they gained their knowledge; and burnout and barriers to practicing TIC. When appropriate, we used validated scales from the field. For example, we used a validated four-question scale to measure burnout. The survey also asked two open-ended questions about the ways the hospital could support, firstly, TIC practices and, secondly, employee emotional health and well-being.

Recruitment and Sample
Recruitment of individuals to pilot the Phase II survey was completed with cooperation from partners at the Rutgers Robert Wood Johnson Medical School Department of Medicine. Emails were sent in April 2025 to residents, staff, and faculty with a link to the survey in Qualtrics. Twelve individuals completed the entire survey within one week of receiving the email. Survey respondents were mostly physicians with only one administrative staff member in the group. Eight of the twelve survey respondents volunteered and completed a follow-up interview. All of the interviewees were physicians, including two residents.

Study Procedures and Analyses
The survey was programmed in Qualtrics and took approximately 20 minutes to complete. Individuals who completed the interview and expressed interest were contacted to participate in a brief phone or Zoom interview to gather their impressions of the survey. These interviews lasted

between 15 and 30 minutes. Interviews conducted via Zoom were recorded and interviewers took detailed notes for phone conversations. Individuals received a $60 Amazon gift card for completing the online survey and an additional $30 gift card for the individual interview.

Survey responses were summarized using descriptive statistics, and interviews were summarized and organized around two sets of insights. First, we coded the interviews for insights related to the implementation of TIC at the Department. Second, we noted all suggestions on how to improve the survey.

Results

Phase I Interview Findings

Thematic analyses of the pre-survey interview transcripts revealed three themes: variability in knowledge of trauma-informed care, inconsistency in implementing TIC practices, and importance of supportive structures.

Variability in Knowledge of Trauma-Informed Care

The first theme that emerged from coding the interviews was the large variation in knowledge regarding TIC. Many participants articulated a general understanding of TIC, or some key facet of the broader definition, but more in-depth and conceptually accurate definitions and language was not uniform. Similarly, some participants had extensive training and demonstrated a strong understanding of TIC principles, while others had limited exposure. In discussing what TIC meant to them, participant responses reflected this diversity:

> *"Trauma-informed care pretty much is the type of care that assumes that the patient has experienced some type of trauma, whatever that will be where there's acute or not. And so you have to come with the lens of meeting them where they're at, and making sure that you be mindful of whatever intersectionality factors that may contribute to you know, either height, heighten it or reducing it. So just being careful and culturally sound"-MSW Student*

> *"So, my understanding of trauma-informed care is... approaching whoever it is, it doesn't necessarily have to be a patient, but. In a patient-centered way. In a caring and concerning way and creating a safe space for that person. Making sure you're meeting their immediate needs. Talking with them in a compassionate and empathetic way. And showing them that you care."-Administrative Staff*

Inconsistency in Implementing TIC Practices

The second theme that emerged from our analysis related to inconsistent or dispersed implementation of TIC approaches in healthcare delivery and participants' general lack of confidence in doing so regardless of their knowledge level. Even participants, who offered deep and accurate definitions of TIC, ended their statements with weariness about their confidence in implementing the concept into their practice. Interview questions probed about the ways participants felt able to help trauma survivors, and the hospital resources available. One of the most discussed examples of TIC practice implementation was patient screening, with many

participants discussing the screening process in great detail. Participants described the existence of targeted screening tools that are used in specific instances, but did not share examples of universal trauma screenings. For example:

> *"If they come in as a trauma patient, they are sure to get screened. I'm not exactly sure what happens if they just come in for a treat and release kind of thing in the ED."- Administrative staff*

> *"There's domestic violence. I don't know that it's really great screening. It's just a couple of questions that's asked" -Administrative staff*

Importance of Supportive Structures

The final theme that emerged from the interviews was the importance of supportive structures in facilitating TIC practices. Participants discussed three workplace practices that they felt helped them in applying TIC principles in their work: training, supervision, and a team-based working environment. At the same time, they described how these aspects are often absent at the hospital. One MSW student shared her perspective regarding training in this way:

> *"Yeah I mean, the information is there, it's available if you need it. There are online trainings that the hospital did for different topics. But I would say that my professional experience is where I got the real hands-on training that I needed for dealing with individual trauma work." -MSW student.*

Participants also spoke about the importance of strong supervision. Those who felt supported by their supervisors in implementing TIC reported greater confidence in using TIC principles and a better overall sense of well-being. An MHA student explained:

> *"I feel I have such an incredible support network. And I don't just have the one supervisor, you know. It's just part of my personality. I've asked for other support. I feel okay,"-MHA Student*

Lastly, informal knowledge-sharing among colleagues, particularly those working in teams, helped bridge gaps in TIC understanding. One administrator whose work related to staff professional development stated:

> *"It's helping teams develop a common sense of shared expectations for one another… In some ways, people might think of it as like a soft skills piece, but we think of it as the non-clinical element. How can we help you do the non-clinical stuff better, cleaner, easier? You know, more enhanced, so that your clinical skills can really shift"-Administrator*

Overall, however, interviewees felt these supports were lacking. One provider expressed frustration with the general culture and inability of leadership to bring a TIC lens to the workplace.

> *"Right like, How you do it? Don't tell us. We're not giving you any support. We're not giving you any training. You don't know how to do. You don't know how to ask these*

[screening questions]. No one's gonna show you how you do it, right? So the culture, how do you sustain that culture? Culture has to start from the teachers, from the administrators. And people have tried this and failed a lot. They I mean. Great administrators who have tried to teach this or bring this culture in aren't always successful."-Provider

Phase II Survey Findings

Survey results echoed many of the themes of our Phase I interviews. Results indicated that healthcare workers have a varied range of limited understanding related to traumatic stress and trauma-informed care, and that TIC practices were also lacking, particularly as related to trauma-related screenings. The lack of access to trauma-informed care training and organizational support for TIC underscored the need for trauma-informed care knowledge and practice skills, especially as participants recognized the adverse impacts on their emotional health while interacting with patients with trauma. The survey revealed that the major barriers to creating a trauma-informed workplace were primarily a lack of training and time constraints. These results, however, are not generalizable. As a pilot survey, our findings reveal themes for future exploration. These themes are highlighted in the table below.

Themes	Findings
Familiarity with definitions of concepts	➢ Over 50 % were very familiar with the definitions of trauma and traumatic stress ➢ Over 60 % were familiar with the definition of secondary trauma
Absence of screening	➢ 82% reported the absence of a universal trauma screening protocol for patients ➢ 55% screened for trauma sometimes, and 36% never screened for trauma
Referrals and resources	➢ 82% did not maintain a list of referrals for patients who disclose a trauma history ➢ 64% reported feeling confident in referring a patient with trauma
Agency support for TIC	➢ 42 % of participants reported they didn't know if the hospital provided regular supervision ➢ 67% didn't know if the hospital provided continuing education on the effects of trauma on helping professionals
TIC Training	➢ All the participants reported that they had not received any formal training in providing TIC
Personal impacts and responses	➢ 75 % of the participants recognize that interacting with patients with trauma impacts their own emotional health

Phase II Interview Findings

To gain more insight into survey respondents' experience with the survey as well as insights into TIC practices at the hospital, we conducted follow-up interviews. Overall, interviewees found the survey questions to be clear and reported being "interested," "curious," and "intrigued" about the content. Three of the eight interviewees shared that they initially assumed that the focus of the survey would be on physical, not emotional, trauma, though this confusion quickly resolved. Interviewees said that they were confident in their responses to the questions with the exception of training-related questions. Some shared that they weren't certain whether or not they had received trainings; others reported uncertainty on whether population-specific trainings could be counted as TIC. One interviewee explained that their "natural inclination" was that they should "say they had training because it sounds bad if you don't." This concern with social desirability bias, however, did not appear in the survey results as no one reported training. Interviewees also suggested a filter question before the supervision questions so that the questions could be better targeted to supervisors.

In addition to these survey development implications, the interviews yielded insights into the reasons behind our results. Regarding the lack of TIC screening practices, interviewees explained that screenings may sometimes be avoided by providers because it was pointless to ask "questions that we don't have answers to." Others shared that they felt they did not have time or needed to prioritize physical health. In the words of one interviewee, "If a patient has experienced trauma, sometimes physicians don't want to deal with it and want to focus on medical stuff." At the same time, most participants believed that not addressing the trauma had adverse impacts on patients. One interviewee shared, "[Sometimes] the patient cannot adhere to the medical treatment you want them to do because the trauma has not been addressed." Finally, interviewees expressed interest in trainings and a recognition of their importance. As one physician explained, "even if you don't want to deal with trauma, it will still impact everything else." As the same time, interviewees cautioned that trainings should be designed to provide balance and offer resources without being an added burden for workers.

Key Findings and Next Steps

The study findings indicate a wide range of knowledge and confidence levels in TIC practices in our case study of a health care setting in New Jersey. Some of the barriers identified were time constraints, lack of TIC training, and limited institutional support. Though there was recognition of the importance of integrating TIC as mandatory in participants' work, there exists a gap in training and supervision supports to help workers engage in TIC. These findings, though not generalizable, offer preliminary evidence on the need for targeted interventions, such as training initiatives, leadership-driven TIC integration, and policies that reinforce trauma-informed approaches. Addressing knowledge gaps and enhancing confidence through structured education, mentorship, and institutional backing will be key to fostering a more trauma-informed healthcare environment.

Based on the findings of this exploratory case study, the team is seeking funding to explore training opportunities and launch the developed survey to a larger group of healthcare workers at RWJ hospital. The study findings would help inform TIC practice and policies in RWJ and other

healthcare institutions, thereby promoting the health and well-being of all patients and healthcare workers.

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