STUDENT PERSPECTIVES ON TRAUMA-INFORMED CARE

by

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Abstract

Aim: This project intended to explore the perspectives of nursing students on trauma-informed care for refugees from Ukraine 2 years into the Russo-Ukrainian war.

Background: Since in February 2022 approximately 6.7 million refugees from Ukraine have sought haven in host countries. War-affected refugees from Ukraine are likely to have experienced traumatic events and research supports a trauma-informed care practice.

Methods: A qualitative description study with a focus on quality improvement was conducted Fall 2024. Faculty sought to improve and expand nursing knowledge through a global health international virtual exchange course between ECU and a university in Poland. This study reports on the reflective writing of four ECU nursing students who met virtually with Polish nursing student partners. Reflective writings were transcribed, coded, and systematically analyzed. Themes were inductively derived.

Results: The themes identified were: Long-term effects of trauma; Benefits of trauma-informed care, and Lack of nursing competence in trauma-informed care practices. Students felt prepared in only two trauma-informed care practices: creating a safe environment and empowering via translation. The use of translators was problematic in both countries but more challenging in Poland due to population heterogeneity.

Discussion: Findings suggest that physical and emotional trauma among war-affected refugees should be given equal consideration. Trauma-informed care content should be assessed and expanded in baccalaureate and graduate nursing programs to address war-affected refugees. Webinars in trauma-informed care practices could reach practicing clinicians.

Introduction

The Russian invasion of Ukraine in 2022 has quickly become one of the largest refugee crises in modern history as the ongoing war approaches its three-year mark. To date, tens of thousands of Ukrainians have perished, and over 6 million people (an estimated quarter of the country's population) have been displaced and fled to neighboring countries seeking refuge (Weiderhold, 2023). Approximately one and a half million Ukrainian refugees have registered for temporary protection in Poland, most of them women and children (International Rescue Committee, 2024) and 400,000 have resettled in the United States and Canada (U.S. Committee for Refugees and Immigrants, 2024). Brought with them to these areas of resettlement, refugees carry both physical and mental health concerns due to exposure to active war zones, displacement from their homes, leaving families behind, and resettlement in a foreign country. Experiencing psychological traumas may cause an increase in the prevalence of PTSD, depression, and anxiety (Su et al., 2022). This in turn creates difficulty in providing healthcare services for refugees, as navigating a foreign healthcare system can be highly stressful and act as a trigger, leading to re-traumatization of the refugee (Greenwald et al., 2023). Given these circumstances, healthcare providers of all disciplines need to be appraised of trauma-informed care practices.

Trauma-informed care, or TIC, is a concept developed in 1994 by the Substance Abuse and Mental Health Services Administration (SAMHSA). TIC was created by SAMHSA to expand upon prior trauma research and improve the care provided to survivors of physical and sexual violence and substance use disorders (Ashworth et al., 2023). TIC has increased in popularity as mental health needs are becoming a priority in the healthcare setting. TIC is defined as "A program, organization, or system that is trauma-informed realizes the widespread

impact of trauma and understands potential paths for recovery. The program recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" (Ashworth et al., 2023). The six key principles of TIC are: 1) ensuring physical and emotional safety, 2) maintaining transparency and building trust, 3) sharing experiences and building support with peers, 4) collaborating with all members of the care team, 5) empowering the patient by providing choices and ensuring their voice is heard, and 6) offering inclusive services for patients with cultural, historical, or gender issues (Ashworth et al., 2023).

Literature supports using a trauma-informed care approach with refugees and is viewed as being both beneficial and important in the context of care. In fact, a lack of culturally responsive care combined with a difference in language is one of the main barriers that keep refugees from either seeking care for their physical and mental health needs or getting the appropriate level of care (Im et al., 2021). In the United States, the healthcare system serves refugees of many countries, and the most recent refugees to the US are from Ukraine. While TIC is universally supported in use with the refugee demographic, there is little data or discussion on its implementation, specifically within the Ukrainian refugee population. This project aims to explore the perspectives of American nursing students on trauma-informed care use with refugees from Ukraine 2.5 years into the Russo-Ukrainian war.

Literature Synthesis

Literature reviews were conducted between June 2023 and September 2024. Relevant studies related to trauma-informed care were obtained from databases including CINAHL, PubMed, Google Scholar, and Elsevier. Overall, 12 studies were selected and organized into

three areas: Mental health of refugees, Host nation attitudes of refugees, and Other approaches of care for refugees.

Mental Health of Refugees

The literature on mental health of refugees is comprised of two quantitative studies and three qualitative studies. In a survey with 1,626 participants of varying Ukrainian, Polish, and Taiwanese origins investigators found the highest prevalence of PTSD, stress, depression and anxiety among Ukrainians (Chudzicka-Czupała et al., (2023). In addition, 52.5% of Ukrainian participants would not pursue assistance/mental health services despite their high prevalence (Chudzicka-Czupała et al., (2023). A systematic literature review evaluated the trauma-informed sexual and reproductive health care for refugee women and determined the importance of integrating principles of safety, trustworthiness, identity, culture, and context when providing care. These principles create a welcoming and comforting service environment that will act as a refuge from violence, in which women feel physically and emotionally safe (Mathis et al., 2024). The trauma-informed care principles of connection and collaboration appeared particularly vital in the provision of sexual and reproductive health care to refugee women, including between service providers and clients (Mathis et al., 2024).

One qualitative research study involved four healthcare professionals who work with Ukrainian refugees reported the prioritized needs by Ukrainian refugees were shelter, protection against infectious disease, healthcare access, and mental health services (Lee et al., 2023). Access to treatment for adults and children with severe mental health conditions and psychosocial disabilities was a concern due to the lack of established referral pathways, language barriers, and access requirements for clinical reassessment (Lee et al., 2023). In a qualitative case study conducted with eight refugees who resettled in New Zealand, authors found that refugees

were unable to communicate effectively in the host country's predominant language. This study argued that the culture and language barriers experienced by refugees in New Zealand compound the inherent ordeal of (re)settlement and increase the risk of re-traumatization (González Campanella, 2023). In the final qualitative study, the importance of TIC was found not to be given sufficient attention in nursing programs and nursing student from the U.S. and Poland reported needing more content on TIC (Larson et al., 2024).

Host nation attitudes of refugees

The attitudes of countries receiving refugees (host nations) category is comprised of four studies including two mixed-method studies, a qualitative study, and a literature review. In a mixed methods study utilizing computer-assisted interviews with native Poles, it was found that 79.2% of respondents believed that refugees should be provided with free access to medical care, and the opportunity to receive education (85%) (Babicki et al., 2023). In another mixed-methods study published from the standpoint of refugees residing in both Poland and Hungary, investigators conducted surveys with 728 Ukrainian refugees through utilization of the computer-assisted personal interview (CAPI) technique. These investigators found that a high incidence of social support of refugees in host countries provides better outcomes in negating the mental health trials refugees face when resettling. Participants reported that there was higher social support for refugees in Poland as well (Kovács et al., 2023).

Host nations have involved refugees and representatives of refugee communities in decision-making involving their care. While not specifically related to TIC, researchers in a qualitative study reported on work with 31 co-facilitators from refugee resettlement populations within the U.S. and 32 project implementors. The findings from the study indicated that involving refugee co-facilitators led to "enhanced relationships with the refugee community,

facilitated referral processes, and increased awareness and openness to emotional and mental health care" (Im et al., 2023, p. 8).

In a literature review of 23 articles that examined trauma-informed approaches for Ukrainian pediatric refugees, investigators found that community was viewed as a *"protective winter coat"* (Glazer, 2022, p. 15-20)**,** that strengthens refugees' sense of belonging and identity, which can be a powerful intervention during times of transition" (Glazer, 2022, p. 15-20).

Other approaches to care for refugees

Similar approaches of care for refugees examined the difference between these approaches and TIC. This category is comprised of a mixed methods study, a theoretical study, and a qualitative study. In Ukraine, a mixed-methods study was published involving 133 therapists and 137 of their patients. Results from the surveys of both therapists and patients show that trauma-focused health assessments can be utilized as a proactive tool to combat PTSD and other traumas (Pfeiffer et al., 2023). Thus, training for Trauma Focused-Cognitive Behavioral Therapy is well received by therapists during times of war with sufficient international and local support (Pfeiffer et al., 2023).

Snider et al. (2023) developed a theoretical model based on surveys from 22 mental health and substance abuse agencies across Pennsylvania. They found that trauma symptom screening rates were sustained, and trauma-informed care training participation improved over a three-year period (Snider et al., 2023). The data from this study is key in identifying that there is a systematic way to deliver and implement TIC using an agency-wide approach.

In a qualitative study conducted with 40 healthcare providers, investigators found that using a transcultural care approach led to more effective and culturally appropriate care plans for

immigrant and refugee families experiencing mental health disorders (Wylie et al., 2018). The themes highlighted that providers have the ability through proper assessment and the patient care environment to improve mental health outcomes among refugees, as patients have varied pathways into mental health care, including through the emergency department, direct admission, and referrals from doctors or community agencies (Wylie et al., 2018).

In summary, refugees from war-torn nations face stress, anxiety, depression, and PTSD. Seeking mental health care can be hindered by language differences, financial barriers, and stigma. The attitudes of the host country can facilitate or deter refugee health-seeking behaviors. TIC practice is lacking among healthcare providers, yet beneficial when implemented with populations exposed to traumatic events. This study intends to add to the literature by examining the perspectives of nursing students on TIC practice for war-affected refugees.

Method

Study Design

A qualitative descriptive study was conducted in Spring 2024 with a focus on quality improvement. Qualitative description studies utilize straightforward descriptions of experiences and perceptions of the individuals involved in the study, with the aim of providing theoretical context to the samples' experiences (Doyle et al., 2017). Dr. Kim Larson (KLL), an American female nurse scientist from East Carolina University (ECU) in North Carolina with expertise in qualitative research and immigrant and refugee health led the study. A male undergraduate honors student, who participated in a study abroad program in Guatemala and an international virtual exchange course with Poland, was the co-investigator of the study As this was a quality improvement project, the university IRB deemed this study as exempt from ethical review.

Sample & Setting

The lead nurse scientist (KLL) developed and taught a global health international virtual exchange course (IVE) in 2024. Four ECU and seven Jagiellonian University nursing students completed the course. This study only includes the four ECU nursing students. Inclusion criteria was being actively enrolled in a university nursing program, completion of one or more clinical semesters, and completion of the global health IVE course. Students were informed that their agreement to participate gave faculty and researchers permission to use deidentified reflection papers submitted in the class. Three of the ECU students were juniors, and one was a senior in the undergraduate nursing program. Three were female and one was male; all were born in the USA, aged 20-21 years, and two were from under-represented populations.

Data Collection

Data was generated from the reflection papers of the ECU students. ECU students met with their Polish counterparts virtually in their respective classrooms six times over the course of ten weeks. Students met synchronously for 2 hours during each virtual meeting from February-April of 2024, for a total of 12 hours. The course involved group and partner breakout room discussions. Topics relevant to caring for refugees, including trauma-informed care and nutrition were discussed. In addition, students reviewed current reports from the United Nations High Commissioner on Refugees, the UN Sustainable Development Goals, and the World Health Organization. After each virtual meeting, students wrote reflections based on class discussions and submitted them weekly through a online learning management system.

Data Management & Analysis

Reflection papers were chronologically organized and merged into one transcript for each student, creating four total transcripts consisting of 34 double-spaced typed pages. Transcripts

were de-identified and numbered 1-4 to maintain anonymity of participants. Transcripts were generated through Microsoft Word utilizing the same format. The two members of the research team read each transcript multiple times, searched for keywords in relation to trauma-informed care. A code book was created using first and second-cycle coding. First-cycle coding was applied to the initial transcript and each subsequent transcript. Second-cycle coding was applied to the transcripts following first-cycle coding, to merge codes and look for patterns or trends (Bingham, 2023).

In vivo and descriptive coding resulted in 21 code words or phrases, including trauma, health, language, and culture. Transcripts were then analyzed using the keywords in context (KWIC) approach, which relies on the distribution of key terms throughout the transcript (Khan et al., 2022). Codewords used in the same context such as barrier and language, were then merged into four main sections. During second-cycle coding, matrices were created using selected exemplars. Content analysis was used, and themes were inductively derived.

Findings

The themes identified were: Long-term effects of trauma; Benefits of TIC, and Lack of competence in TIC. Exemplars of each theme are demonstrated by nursing students (S) and participant number (1-4).

Theme 1. Long-Term Effects of Trauma

The long-term effects of trauma were characterized by untreated mental health concerns that manifested in physical signs and symptoms. These long-term effects are related to physical conditions that are influenced by factors that affect the refugee population such as language barriers, which can influence the care being received (if they decide to/are able to seek care at

all). Without acknowledging the mental health effects trauma has on an individual, no progress can be made in reducing the effects of trauma and will further promote poor health practices and outcomes. This was illustrated by a student in this way,

> Trauma is stored in the body and physically causes maladaptive learned and conditioned responses that become so ingrained in the day-to-day that we as a collective don't realize the effect it has on ourselves and the people/community around us (S3).

Students noted that refugees may experience psychosomatic effects. One student reported that the "refugee population has a high rate of stress, anxiety, depression and above all trauma, but we only review various conditions and view the solution through the eyes of pharmacological interventions" (S1). On top of the high incidence of mental health conditions associated with traumatic experiences such as war and displacement, further trauma can develop in refugees when resettling in a host country. Navigating language barriers can attribute and catalyze the already present trauma. A student noted that refugees struggle in, "That sense of not being nearly understood or heard due to a language barrier, then contributes to mental health conditions which can poorly affect physical health" (S3). The trauma of being misunderstood or not heard together completely can have detrimental effects, one student explained, "This can cause a lot of issues, because the refugees' and immigrants' health may begin to decline rapidly and they may not know who to go to, to receive the care that could save many of their lives" (S2). Going without healthcare services for any reason can negatively impact a patient, refugees consequently are at a higher risk of not receiving healthcare related to language barriers, lack of health literacy, and a lack of understanding of the new host healthcare system. One student wrote,

> when an extremely large amount of people is without healthcare…. it becomes an umbrella for a whole plethora of secondary issues that are showcased in everyday life in

regards to inequality, poverty, chronic health conditions, collective burnout, infectious disease, generational trauma, and many more (S3).

Without an identified plan or standard of care, traumatized refugees may run the risk of being further traumatized or undertreated and rapidly undergo a decline in quality of life.

Theme II. Benefits of Trauma-Informed Care

The benefits of TIC were characterized by mitigation of trauma among refugees and avoiding re-traumatization through early TIC assessment. Early assessment builds trust among the patient and provider, which helps bridge the gap between health and well-being of the patient. One student illustrated this benefit in this reflection, "Using trauma-informed care, the healthcare provider can determine that the patient is scared and experiencing post-traumatic stress from her immigration due the war in Ukraine" (S1). TIC assessment is considered a mitigation effort in a patient population where reactionary change may be made too late. TIC was noted by one student as "'upstream thinking' where healthcare providers focus on the root causes of the issues instead of waiting for an emergent effect" (S4). This technique was supported by another student who found that "addressing the trauma that many refugees face as they enter a new country is the number one way to help refugees prosper in life and in their new situation" (S2).

The students collectively identified that current practice in the U.S. addresses first principle of TIC, to ensure physical and emotional safety. One student shared this reflection, "providing comfort and safety during care promotes trust, and traumatized individuals will accept care" (S4). Students noted the benefit TIC in the refugee population and "how dramatically it decreased the trauma that refugees experienced" (S1). This decrease in trauma can be attributed to fostering an environment of safety and comfort for the patient. For example,

one student highlighted that "the patient must feel safe in the moment in their own body to face the trauma so that we do not retraumatize the patient" (S1). Adding TIC to a provider's toolkit can benefit the refugee patient and patients of similar adverse events. One student summarized this realization that, "Trauma can have lifelong effects, that can impact the way individuals see the world and interact with it, so trauma-informed care can help bridge the gap that many individuals feel between themselves and healthcare" (S2).

While most of the students had minimal experiences with TIC they were able to identify a second pillar of TIC, which is the use of translators. While interpreters and language-access technology are more prevalent in the US, one student noted problems still may occur,

> When discussing the computers which are the interpretation devices used in some hospitals in America, I talked about how there are good intentions and efforts behind it, but when put into practice, it can cause some complications furthering the stigma of why one and one's family may not want to receive care or are hesitant because of that (S3).

Theme III. Lack of TIC Competence

The lack of nursing competence in TIC principles was represented by minimal training and application in practice. Students identified this limitation in the nursing program in this reflection, "Trauma-informed care is something that is not spoken of quite often… as we are taking our psych class, and trauma-informed care has now been brought up, but it is not spoken of elsewhere" (S3). This was echoed by another student, "we are not really taught about trauma-informed care in our nursing courses throughout the two years, but we should be as it is a very big part of nursing as a whole" (S2).

When TIC is not used by health care professionals' cultural competency is not considered in the provision of quality care for refugees worldwide. A student noted,

> In any setting, regardless of any situation, trauma-informed care is something that needs to be implemented, I see an extremely large disconnect in our more Westernized medical world between the physical and mental well-being (S3).

Nurses, as frontline clinicians, need TIC skills in their toolbox. One student reflected that they "have been in situations where I did not know how to give trauma-informed care" (S4). Incorporating TIC as early as possible in nursing education creates the possibility to build nursing competence in delivering TIC at the bedside and in positions of leadership. It also provides a baseline for use to build upon for future evaluation.

Discussion

This qualitative descriptive study aimed to describe how American nursing students perceived trauma-informed care among refugees from Ukraine more than two years after the onset of the Russo-Ukrainian war. Through discourse and reflection, findings determined that emotional trauma was not assessed and thus given less attention than physical trauma among the war-affected refugee population. Benefits of TIC were found in early assessment of emotional trauma to provide comfort and safety. Assessment of trauma must be gained through interpreter or language-access technology by the health care team. Trauma-informed care was also identified as a tool to bridge the gap between refugees and well-being. A lack of TIC understanding by nursing students and practicing nurses was evident.

When considering the long-term effects of emotional trauma among war-affected populations, it is important to understand the implications of addressing only physical trauma.

Emotional trauma surfaced in this study as a prominent factor for war-affected refugees. PTSD, anxiety, and stress take time to manifest, but when ignored can snowball into physical signs and symptoms and exacerbate other previously diagnosed chronic health conditions. Ethnic and cultural backgrounds of diverse populations may present emotional distress via physical ailments or concerns (Center for Substance Abuse Treatment, 2014). Many individuals who present with somatization are likely unaware of the connection between their emotions and physical symptoms. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance (Center for Substance Abuse Treatment, 2014). Physical trauma can usually be identified and corrected more readily than emotional trauma. Without addressing emotional trauma with the physical trauma, refugees will experience diminished quality of life. Given the ability for emotional trauma to have an extended effect on the physical well-being of a person, and the time-sensitive interventions that are required, emotional trauma needs to be looked at with the same priority as physical trauma.

The two principles of TIC that were acknowledged were "ensuring physical and emotional safety" and "empowering the patient by providing choices and ensuring their voice is heard" (Ashworth et al., 2023). The practice of TIC ensures physical and emotional safety through assessment and mitigation of re-traumatization. By ensuring physical and emotional safety, nurses promote trust, respect, and cultural sensitivity. American students noted that while US health care facilities have access to translators and language access technology, it is not always effective. Students also noted that Poland had fewer resources in translators and language access technology because historically they have not been a pluralistic nation. In Poland, 97% of the population is Polish.

While TIC has been established as a priority for holistic and culturally appropriate care, in this study there was minimal attention given to TIC in nursing education. Data shows that most nursing programs do not systematically integrate TIC education (Cannon et al., 2020). Many graduate nursing programs also lack TIC curriculum and a specific framework to guide education and practice (Brown, 2023 p. 20). This can be attributed to several possible conflicts within the education sector. There is no guarantee that nursing curriculum allows space/time to implement TIC education and use, nor that there is faculty with sufficient training/experience with TIC that can effectively deliver this content. The main issue within nursing education is the focus on medical-surgical-related priorities and general nursing practice. Mental health content focuses on care behavioral disorders, such as schizophrenia and manic-depression, and TIC is not prioritized. The American Association of Colleges of Nursing lists numerous Essentials for curriculum content and competencies, at least two of which TIC is related to; person-centered care and promoting quality and safety. However, TIC is not specified within the Essentials framework (AACN, n.d.). The NC Board of Nursing requires continuing competency but does not mandate TIC content for all nurses (NCBON, n.d.). In the ECU College of Nursing, TIC is given minimal attention in reference to child abuse and neglect and military veterans (personal communication, M. Pestaner and S. Wilson, 14 November 2024).

Limitations

There are several limitations in this study. One limitation is the small sample size of four nursing students in one college of nursing of similar demographics, experience, and age. A second limitation is the geographic location in eastern North Carolina. A third limitation is the reflection papers from Polish students was not included in this study. This study does however add to the sparse literature on TIC for war-affected refugees.

Implications for Education, Practice, and Research

Studies have found that TIC can decrease symptoms, shorten stays, decrease emergency department visits and hospitalizations, reduce costs, and improve health outcomes (O'Malley et al., 2023). Thus, nursing education must assess the curriculum to ensure that TIC principles are woven throughout the professional courses and applied in simulation and clinical practice. TIC has importance in health assessment, pediatrics, women's and adult health, and population health courses. This type of pairing of physical and mental/emotional trauma would encourage a holistic approach to refugee health.

In practice, the creation and use of online TIC webinars that train practicing nurses, and new graduates, can improve effective use of TIC in the clinical and community settings. Webinars were identified as the best source to overcome this gap as it allows nurses to complete the training on their own time without the expense of travel. Research suggests that webinar content should be integrated with traditional, face-to-face teaching (Yo et al., 2021).

Research on TIC would be beneficial by identifying best practices for TIC training, in-person or online, as well as faculty preparation to deliver TIC content. Having an estimated time frame and qualified faculty to deliver TIC content can increase the likelihood that TIC is adopted in the curriculum of undergraduate and graduate-level nursing programs.

Conclusion

Refugees coming from war zones, displaced from their homeland, and after resettlement are likely in need of primary and secondary health services. Integrating TIC into clinical practice enhances the overall quality of care by promoting a holistic, empathetic, and patient-centered

approach through utilization of effective communication combined with facilitating a safe environment for refugees.

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