CE 2.5 contact hours

Trauma-Informed

HELPING PATIENTS WITH A PAINFUL PAST

ABSTRACT: *Life trauma is highly correlated with an increased risk of mortality from chronic disease.* Trauma-informed care *(TIC) is an evidence-based approach to deliver healthcare in a way that recognizes and responds to the long-term health effects of the experience of trauma in patients' lives. Four essential features and six defining concepts delineate a TIC approach to healthcare. Nurses can realize the benefits and learn the tenets of TIC to deliver superior care to patients with chronic illness.*

KEY WORDS: *Adverse Childhood Events (ACE) Study, chronic illness, mental health, nursing, trauma-informed care*

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Care

By Cathy Koetting

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law by President Barack Obama. This legislation was designed to increase access to affordable quality health insurance for more Americans and reduce the growth in U.S. healthcare spending (Bolin, Gamm, Vest, Edwardson, & Miller, 2011). The legislation also offered new benefits, rights, and protections that are noteworthy: preventing insurance companies from denying coverage for a person's health status, expanding coverage to more Americans by subsidizing healthcare costs, and requiring all insurers to cover people with preexisting conditions (U.S. Department of Health and Human Services, 2015).

Preexisting conditions often are chronic conditions requiring treatment in primary, community, and acute care settings. According to the Centers for Disease Control and Prevention (CDC, 2015), in 2012, about 50% of adult Americans—approximately 117 million people, had one or more chronic health conditions. In addition, one in four adults had two or more chronic health conditions (CDC). Nurses treat patients with chronic illness, such as cardiac disease and stroke, depression, diabetes, cancer, obesity, smoking and tobacco use, hyperlipidemia, reproductive health issues, and drug abuse. Hence, the initiation of PPACA means that more and more people will be utilizing healthcare and present with chronic conditions. Not only does this create a strain on providers and allocation of preventative care, it focuses on the need for better patient outcomes.

With more people having increased access to healthcare also means nurses need a better understanding of behaviors that lead to chronic illness. Life trauma can lead to lifestyle practices that influence the development of chronic illness. Understanding past traumatic events in patients' lives can be key to effective care. *Trauma-informed care* is an approach to engaging people with a history of life trauma that recognizes trauma symptoms and acknowledges the role trauma has played in their lives (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015a).

A TRAUMA-INFORMED APPROACH TO PRACTICE

Trauma-informed care originated in social work, counseling, psychology, and addiction studies. Recognizing the need for a patient care approach that addresses the myriad problems related to long-term trauma effects, providers looked to research to provide theoretical underpinnings for this methodology (Marcellus, 2014). Trauma-informed care has become the basis of support programs in mental health, child services, corrections, and juvenile justice. According to the National Council for Behavioral Health (NCBH, 2014), addressing trauma has become the "expectation, not the exception." However, there is a paucity of studies showing the benefit of the trauma-informed care (TIC) approach, and nursing literature is lacking application of TIC in daily practice. For all nurses, understanding and using a TIC approach offers possibilities for improving practice and subsequent outcomes for patients, particularly those with chronic illness.

According to the SAMHSA, a trauma-informed approach is a methodology to respond to those who are at risk or have experienced trauma. The essential features of TIC must include, in both an organization and providers (Table 1): *Realization* of the widespread impact for trauma and understanding of potential paths for recovery; *Recognition* of the

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Cathy Koetting, DNP, APRN, is an assistant professor of nursing at Saint Louis University in St. Louis, Missouri, a member of the University Sexual Assault Advisory Group, and a board certified pediatric and family nurse practitioner serving underserved and vulnerable populations.

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*Names changed to protect privacy.

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signs and symptoms of trauma in clients, families, providers, and others involved in the system; *Respond* by fully integrating knowledge about trauma into policies, procedures, and practices; and seek to actively resist *retraumatization* (SAMHSA, 2015b).

The first step to embracing this approach is an understanding of the prevalence of trauma. From 1998 to 2010, the Adverse Childhood Events (ACE) study, conducted at the Kaiser Permanente Department of Preventative Medicine, in collaboration with the CDC, sought to understand how childhood events might affect adult health. The study included 17,421 participants (Felitti et al., 1998).

Why study ACEs? In 1985, physician Vincent Felitti, chief director at Kaiser Preventative Medicine, was puzzled by the over 50% five-year dropout rate in his obesity clinic. He found all dropouts had been successful in losing weight.

Table 1. Four Essential Approaches and Six Principles of Trauma-Informed Care

A Program, Organization, or System That:
1. *Realizes* the widespread impact of trauma and understands potential paths for recovery.
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others.
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices.
4. Seeks to actively resist *retraumatization*.
Six Key Principles:
1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Recognition of cultural, historical, and gender issues

Source: SAMHSA (2015b). Used with permission.

Delving deeper into almost 2,000 patient dropout records, Felitti discovered patients had all been born at a normal weight, had a history of abrupt weight gains, then stabilized. However, when they lost weight, they almost always gained it back (Felitti, 2002).

In face-to-face interviews with several hundred patients, asking standard health history questions, Felitti mistakenly asked a female patient how much she weighed when she first became sexually active. When she answered, "forty pounds," he asked again, thinking he had not heard correctly. The patient added, "It was when I was four-years-old; it was with my father," and she began to cry (Stevens, 2012). In subsequent interviews, other patients spoke of childhood sexual abuse, when asked the same question. One had been raped when she was 23 years old and gained the weight because, "overweight is overlooked, and that's the way I need to be" (Felitti, 2002, p. 44). Once she started losing the weight, she became more attractive to men. Subsequent distress ensued, and she quit the weight loss program.

Felitti asked colleagues to interview more patients, using the same questions; of 286 patients interviewed, most had been sexually abused as children. Interview results gave insight into problems related to chronic illness, such as obesity and substance abuse. Many patients had been grossly overweight but did not see their weight as a problem. Eating was their *fix*, a solution to their problem, as it relieved stress and anxiety, much like alcohol, tobacco, or methamphetamine. Not eating increased stress, anxiety, depression, and even fear to intolerable levels (Stevens, 2012). Felitti and his colleagues speculated a relationship between adverse trauma in a person's life (particularly in childhood) and health issues.

THE ACE STUDY

Felitti et al. (1998) sought to discover the relationship of health risk behavior and disease in adulthood in relation to the span of exposure of childhood emotional, physical, or sexual abuse, and household dysfunction. Data collection in the ACE study measured the impact and prevalence of trauma on physical and mental health outcomes. Patient/participant health appraisals included: a standardized health history questionnaire, demographics, family medical history, and previous medical diagnosis. A healthcare provider completed a medical history, performed a physical assessment exam, and provided and explained laboratory results.

A week after their medical visit, participants were mailed the ACE study questionnaire, composed of adapted questions from several validated instruments. This questionnaire was used to define and gain information on violence, sexual abuse, and exposure to drugs during childhood. Questions about health-related behaviors were taken from the Behavioral Risk Factory Survey and the Third National Health and Nutrition Examination Survey. Questions regarding depression were taken from the Diagnostic Interview Schedule of the National Institute of Mental Health (Felitti et al., 1998).

Childhood abuse was assessed by questions characterizing different types of abuse: psychological, sexual contact, or physical. Four categories of exposure to household dysfunction during childhood included: substance abuse, mental illness, violent treatment of mother or stepmother, and criminal behavior. If a respondent answered yes to one of more of the categories, it was defined as one exposure. The measurement of total childhood abuse and household dysfunction was a sum of all yes scores (Felitti et al., 1998).

Risk factors and disease conditions also were assessed. Researchers identified smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, oral and intravenous drug abuse, a high lifetime number of sexual partners, and a history of sexually transmitted infections as risk factors that led to the highest morbidity and mortality. Ischemic heart disease, any cancer, stroke, chronic bronchitis, chronic obstructive pulmonary disease, diabetes, hepatitis, jaundice, and skeletal fractures were chosen as the focus of the study. Lastly, the patients' own

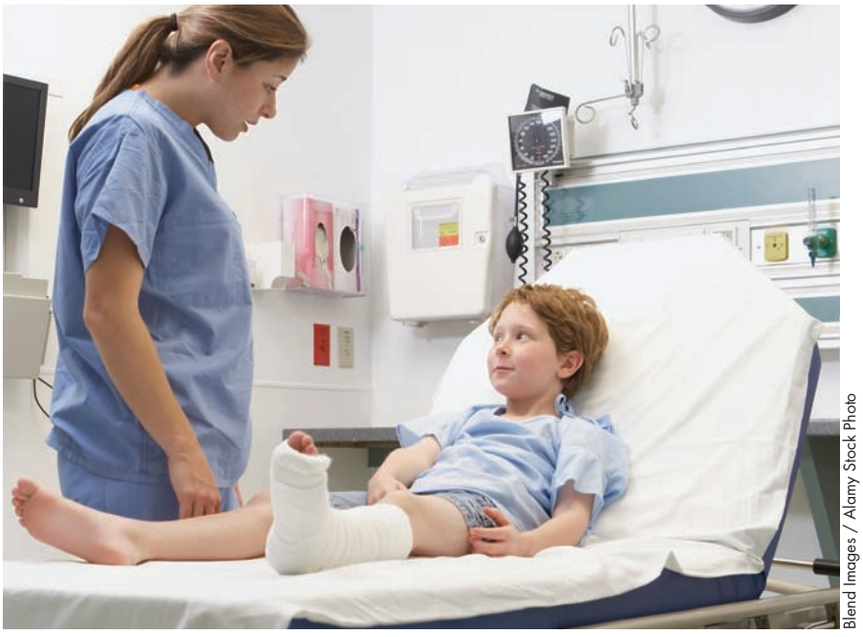
assessment of his or her health status was included (Felitti et al., 1998).

A final sample of 8,506 patients was included in the first round. The most significant results were the relationships between childhood exposures and health risk factors, and childhood exposures and disease conditions. ACEs were common; 64% had at least one. Having one ACE gave a person an 87% chance of having two or more. The more ACEs a patient had (a higher numeric score), the greater the risk for chronic disease, mental illness, violence, and being a victim of violence. Patients with an ACE score of four were twice as likely to be smokers and seven times more likely to be alcoholics. Having an ACE score of four increased the risk of chronic bronchitis by 400% and the risk of suicide by 1,200% (Felitti et al., 1998; Starecheski, 2015).

Since the original ACE study, other studies have substantiated these results (Brown et al., 2010; Chartier, Walker, & Naimark, 2010; Dube, Cook, & Edwards, 2010; Norman et al., 2006). Evidence supports that the experience of trauma in people's lives has a direct impact on their health behaviors, in particular, increasing the risk of mortality from chronic illness. For nurses, this translates into understanding the *why* behind the health behaviors of our patients, withholding judgment for negative health behaviors, and helping patients heal physically, psychologically, and spiritually.

THE NEUROBIOLOGY OF TRAUMA

A TIC approach to nursing practice is based on providing safe support for patients. Over time, persons living in an environment with the constant threat of danger physiologically adapt to survival mode. Their bodies remain in a state of constant hypervigilance. The hypothalamic–pituitary–adrenal axis (HPA) stress response causes adrenal release of cortisol. As stress continues, there is repeated HPA activation, impairing new hippocampal neuron growth and compromising the negative feedback response to the hippocampus (Sherin & Nemeroff, 2011). This results in atrophy of the hippocampus. The now deficient hippocampus has decreased memory resources available to form an appropriate reaction to stress.



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There are six specific concepts that define trauma-informed care (TIC).

By studying rat brains, Chetty et al. (2014) found that the sustained elevation of cortisol levels changed the structure of the brain, creating more myelin-producing cells and fewer neurons than normal. This myelin (white matter) excess resulted in disruption of communication within the brain. Similarly, patients exposed to chronic stress have developed stronger connectivity between the hippocampus and amygdala—the part of the brain that controls the fight or flight response. With decreased connectivity between the hippocampus and prefrontal cortex, an area of the brain that controls responses, one can imagine that the person exposed to chronic stress and trauma remains at high alert, unable to control stressful thoughts.

The amygdala, the area of the brain responsible for perception of emotions, controlling aggression, and storing memories of events and emotions, inhibits a fear extinction response (Evans & Coccoma, 2014, pp. 49–67). As a result, the amygdala treats perceived threats as real, and the individual may experience sensorimotor or bodily responses to a stimulus (Marcellus, 2014; Miehls & Applegate, 2014). Trauma survivors may appear overly defensive to a simple question, lack eye contact, or become angry from a touch on the arm. The trauma experience of survivors is linked to central nervous system disorders, cardiovascular, respiratory, and sexual health problems (Norman et al., 2006; Spitzer et al., 2009).

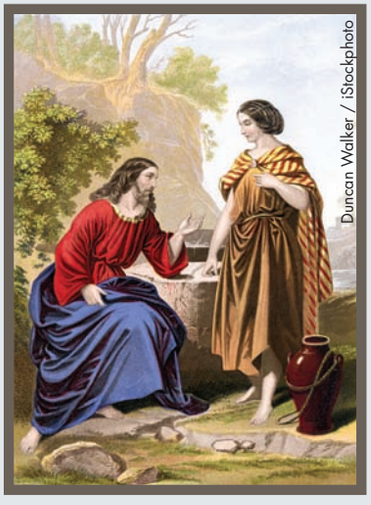
Trauma survivors may be more likely to smoke, drink alcohol, and abuse drugs. Emotionally, they may have depression, anxiety, and emotional numbness. Cognitively, they may have memory lapses, decreased ability to concentrate, and difficulty making decisions. Spiritually, they may have inner feelings of shame, self-blame, being damaged, or that they are bad (Haskell & Randall, 2009). When providing TIC, nurses need to be aware of possible trauma-related behaviors of patients, in order to decrease risk of retraumatization.

THE PRACTICE OF TIC

In TIC, healthcare providers and staff need to be cognizant that trauma is extensive and permeates the lives of many patients. Trauma-informed care seeks to change the illness paradigm from one that asks, "What's wrong with you?" to, "What has happened to you?" (SAMHSA, 2015a). Six specific concepts define TIC (Table 1) (SAMHSA, 2015b). The first, *safety*, is the feeling that healthcare staff and the patients and families they serve, feel safe, both physically and psychologically. All interactions performed within the

A Trauma-Informed Encounter at the Well

Throughout the Bible, we see people who experienced great trauma. Women were raped (Genesis 34:1-2; 2 Samuel 13:1-22), men were forced into slavery (Genesis 37:12-36; Exodus 1), and their children were slaughtered (Matthew 2:16-18). The trauma-informed approach to healthcare reminds me of God's approach to making people whole.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In John 4, we read about a woman who seems to have experienced significant trauma. Scripture does not point to a specific event in her life, but I have to wonder, *Was this woman traumatized?* She had had five husbands, was living out of wedlock with yet another man, and felt so ostracized she went alone to the town well to draw water at noon, in the heat of the day (women went together in the cool mornings). At Jacob's famous well, she encountered Jesus.

Jesus overcame two Jewish prejudices and asked the woman for a drink (men didn't talk to women, and Jews didn't talk to Samaritans because of race issues). She called him out on it. But instead of getting into a gender/race argument, Jesus deepened the conversation by offering the woman living water. *Living water* had a double meaning: either running water, like a fresh spring, or spiritual water from God (see Isaiah 12:3; Ezekiel 36:25-27). The woman thought fresh water was a great idea, but again called Jesus out because he didn't have a bucket to draw water. She challenged him, asking if he thought he was greater than Jacob, who created the well, and continued to misunderstand what Jesus was offering. But she was intrigued. Jesus asked her to call her husband, presumably to talk with both of them. She honestly answered that she had no husband.

Jesus displayed penetrating insight into her life, revealing that he knew about the trauma she had experienced. Now the woman wondered if Jesus could be a prophet. But she changes the subject from her life to Jewish/Samaritan religious arguments about worship of God. Jesus gets to the heart of *true worship*—that it isn't about who you are or where you worship; it is about *who* you worship. Amazingly, he reveals to the first person on earth that he is the *Messiah*, the promised one who will bring salvation, not just to Jews, but to all people! She is so excited she leaves her water jar, runs back to town, and brings back all who will come to check out this man "who told me everything I ever did. Could this be the Christ?" (verse 29). Her encounter with Jesus changes not only her life, but the life of her town.

I think Jesus modeled a trauma-informed approach to care in this life-changing encounter. He *realized* the impact of trauma on this woman's life and reached out to her, treating her graciously. He *recognized* her trauma and gently *responded*, with respect and insight. Instead of judging and *retraumatizing* her, he offered relationship with God. Jesus gave the woman *a voice* as he took into account current *cultural, historical, and gender issues*. He created a *safe* space to interact and proved himself *trustworthy*. He *empowered* the Samaritan woman, by being *transparent* and giving her knowledge that he was the Messiah. Jesus offers the same response to anyone who will engage him with his or her questions.

In my years of bedside nursing, especially in behavioral health, I have witnessed the horrific impact of trauma on people. There have been times I was able to probe deeper, asking "What happened to you?" and responding with a new, safer, plan of care. Sometimes it has been appropriate to introduce patients to Jesus, and guide them into bringing their questions to the one who can truly heal them.—KSS

healthcare environment should promote a sense of safety.

The second concept is *trustworthiness and transparency*. Trust between patients, staff, and management, regarding operations and decisions, is vital in building strong relationships. Traditionally, nurses are educated to use a holistic approach in their nursing care. This approach easily addresses safety and trustworthiness. Communication with patients should include acknowledgment that the setting is safe and care is accessible.

The third fundamental concept is *peer support*. Here, the term *peer* refers to individuals with similar lived experiences of trauma. Peer support helps to create safety and hope, builds trust, enhances collaboration, and utilizes survivors' stories to promote recovery and healing (SAMHSA, 2015b).

The fourth concept, *collaboration and mutuality*, addresses the issue of differences in perceived levels of power between staff and between staff and patients. All members of the organization are equal (including patients), and all are a part of the team. This means a flattening of the administrative hierarchy must occur. Every member of the organization must practice *universal trauma precautions*, the idea that every person with whom the organization comes in contact potentially has a history of trauma (Benedict, 2014). This includes caregivers who regularly assess for traumatic histories and symptoms. Organizations should develop and utilize best practice guidelines for TIC. Incorporating the use of trauma screening tools into the Electronic Medical Record (EMR), helps accomplish this goal.

The fifth concept is *empowerment, voice, and choice*. Here, individual strengths and differences are identified and used as the foundation for recovery and healing. The organization fosters a belief in the value of the people served, their resilience, and their ability to recover. Trauma can be a unifying thread woven throughout the lives of those who manage the organization, who serve patients, and for those who come to the organization for help. The entire

functioning of the organization, from workforce development to services, exists to entitle both staff and patients.

Traditionally, healthcare organizations have not allowed patients much choice or voice in their treatment. A TIC practice seeks opportunities for patients to have a say in their care. For example, many patients with a history of trauma may be afraid of having to remove clothes for an assessment, or are fearful of having a procedure. Offering patients choices and input in examinations and procedures provides a voice and sense of control (Raja, Hasnain, Hoersch, Gove-Yin, & Rajagopalan, 2015). The patient focus of care is centered on shared decision making, choice, and support, so that patients are involved in their care plan and care goals. Self-advocacy skills are modeled and encouraged, and staff take the role of facilitators of recovery, rather than controllers of care (SAMHSA, 2015b).

The sixth concept involves the *recognition of cultural, historical, and gender issues* that are important to address in patient care. Cultural stereotypes and biases are set aside in policy and practice. The organization is gender responsive, recognizing the unique value and healing power from cultural connections, and incorporates policies, operations, and procedures that are conscious of patients' racial, ethnic, and cultural needs.

For example, staff and administrators of one Northeastern U.S. state prison sought to improve the plan of care for pregnant, incarcerated women through a TIC approach. Healthcare providers, social workers, and the parenting coordinator joined with the warden to develop a consistent pregnancy treatment plan and standards of care to improve outcomes (Ferszt, Hickey, & Seleyman, 2013). This gender responsive plan also addressed secure transportation to community clinics, along with things like decreased ability of the provider to fully assess the mother and baby when a pregnant patient was shackled.

Lesbian, gay, bisexual, transgender, queer or questioning, and asexual or ally individuals (LGBTQA) are a marginalized population, particularly if they are adolescents. Many LGBTQA adolescents feel their identity is a stigma and tend to have had negative experiences, such as bullying and physical victimization (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). A gender responsive organization realizes that these adolescents readily become victims of violence. When working with LGBTQA patients, nurses should be cognizant that many do not have the developmental benefit of family acceptance, vital to physical and mental health (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Acknowledging LGBTQA patients with respect and support will make it easier for nurses to collaborate care and provide education. Many of these patients have high-risk health behaviors, receive disparate healthcare, and need excellent assessment and intervention.

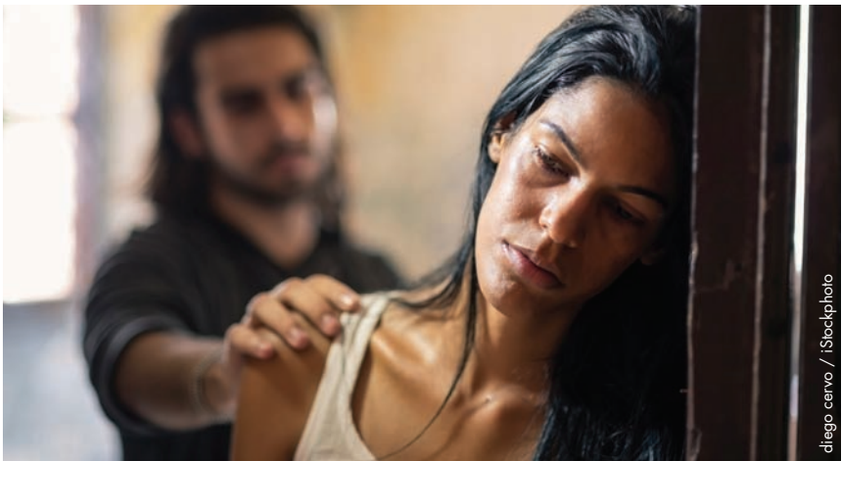
EMPOWERMENT THROUGH SPIRITUALITY

Practicing TIC is an approach that imbues empowerment. Trauma-informed care reflects patients' ability to successfully access the skills and resources needed to effectively cope and grow. One such resource is spirituality. Studying the relationship between interpersonal violence/child abuse and spirituality/empowerment, Hipolito et al. (2014) found that spirituality and personal empowerment increases mental health and general well-being, and is especially helpful after childhood and/or adult trauma. In essence, the spiritual dimension of health should be addressed by providers and management in a TIC organization, particularly one that serves victims of violence and abuse.

Providers should offer care within individuals' faith, religion, and spiritual background. Nurses are encouraged to perform a quality spirituality assessment, as an integral intervention in the delivery of TIC. This assessment must be sensitive and use nonsuggestive language, be patient-centered, and most importantly, done at a time that is most relevant to the patient (Hipolito et al., 2014), such as when they want spiritual help.

Spirituality is a resource for positive living and a fundamental dimension of health. Trauma-informed care organizations will enhance policies and practice by including the spiritual dimension of health. To accomplish this, organizations must rewrite practice standards to address spiritually competent care; education of staff, management, and providers; and the incorporation of spirituality into organizational attitude and guidelines concerning health. Providing spiritually competent care includes promotion of open, nonjudgmental discussions, and opportunities to fulfill spiritual needs. It is important to

Over time, persons living in an environment with the constant threat of danger physiologically adapt to living in survival mode.



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have such things as a Bible or holy book available, offering connections to faith communities, or having a space to pray. Nurses should plan to work collaboratively with chaplains, clergy, spiritual advisors, or religious leaders who are relevant to patient needs and qualified for supporting the services (Hipolito et al., 2014). The Sidebar, *A Trauma-Informed Encounter at the Well*, offers a biblical perspective on TIC.

TIC AT THE BEDSIDE

Carlie* is a registered nurse in a large, urban, cardiac intensive care unit (ICU). During report, she learned that the patient assigned to her, Meghan, a 26-year-old female, is scheduled for cardiac catheterization with balloon valvuloplasty to open her stenosed pulmonary valve. Meghan arrived at the hospital Emergency Room (ER) yesterday, after complaints of feeling faint, then passing out. She was transferred to the cardiac ICU for stabilization, but her blood pressure (BP) has been high. Meghan is emotionally labile, seems combative at times, and appears frightened. She will not let the BP cuff stay on her arm, for constant measurement, stating, "I don't like that feeling."

Carlie enters Meghan's room and finds a young man at her bedside. She introduces herself and learns he is Meghan's husband. He states that his wife is very worried about their eight-month-old infant, but he has reassured her the baby is fine in the care of his parents, and he is going to check on her now. Carlie pulls up a chair next to the bed so she is at eye level. She explains that she will care for Meghan before and after her procedure. Carlie acknowledges that the ICU can make patients feel anxious. She reassures Meghan of her availability to help. She explains that she wants Meghan to feel safe. She notes the difficulty of the last few hours and assures Meghan that she is in a safe place. Carlie asks Meghan about her pain level. After learning that Meghan has no pain, Carlie asks permission to do a brief assessment. Carlie makes sure that privacy is maintained during the assessment, explaining to Meghan what she is doing and why. She ends by stating, "I will only check your blood pressure when needed, and I will request your permission first." By the end of the assessment, Meghan has tears in her eyes.

Carlie gently inquiries about Meghan's discomfort and asks, "What happened to you?"

Meghan states that she was born in Srebrenica, Bosnia, and immigrated to the U.S. in 1996. She was eight when she arrived with her aunt, her only living relative. In 1995, her father and brother were killed during fighting in Srebrenica, and her mother died after being brutally beaten by a Serbian soldier.

Meghan notes that she likes living in the U.S. and realizes her life is better. Meghan says she is scared she will die, just like her mother died when she was only seven; she does not want her child to grow up without a mother.

Carlie is moved by her patient's story and now understands that the hospitalization is retraumatizing her, and Meghan fears for her life. Carlie continues to assure Meghan that she is safe and helps her feel in control of what is happening to her. Carlie asks if there is anyone with whom she'd like to speak. Meghan noted *Muslim* under religious preference on admission, and Carlie asks if she'd like to speak to a Muslim prayer leader. At this, Meghan's face brightens, and she confirms her desire to see the prayer leader before the procedure. Carlie places a call to pastoral care.

CONCLUSION

A TIC practice starts with an awareness of the event of trauma, the experience of those who have been exposed or victimized, and the effects on the individual. The six concepts of TIC, plus spirituality, are the foundations of what nurses and healthcare organizations should be addressing. Nurses need to be aware of how they can integrate these ideas into practice. Conversations with colleagues can be the start of a cultural shift in the workplace (Cleary & Hungerford, 2015). Increasing awareness of the need for TIC is vital. The goal is to guide patients from a state of trauma to one of healing; to help patients alter their family and community environment so it is less traumatic. Healthcare organizations can be stressful and chaotic places in which to work, but TIC can transform the care-giving experience for nurses by remodeling their workplace culture to one that promotes holistic recovery for all.

Web Resources

- National Council for Behavioral Health—http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/
- National Center for Trauma-Informed Care—http://www.samhsa.gov/nctic
- The Trauma-Informed Care Project—http://www.traumainformedcareproject.org

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