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Research Article

Attitudes Related to Trauma-Informed Care by Healthcare Workers Handling Rape Victims at Orogbum Government Health Center Port Harcourt and Model Primary Health Care Center, Eliozu Port Harcourt, Nigeria

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Abstract

Background: Previous studies have suggested that there are far-reaching potentials for utilizing trauma-informed care as an intervention strategy for victims of trauma such as rape and sexual abuse. This study, therefore, explored the attitude related to trauma-informed care (TIC) by healthcare workers handling rape victims at Orogbum Government Health Center Port Harcourt and Model Primary Health Care Center, Eliozu Port Harcourt, Nigeria.

Methods: The study adopted a purposive sampling was used to select the study participants, and independent t-test statistics were used to analyze the gathered data. A structured instrument-the Attitudes Related to Trauma-Informed Care (ARTIC) Scale by Baker et al., (2016), was used to elicit respondent's data. Thirty-eight healthcare workers (23 females- 60.5%, and 15 males- 39.5%) were employed for this service evaluation survey. Three hypotheses were tested. Respondents age distribution were 18-40 years (50%, n=19) and 41-70 years (50%, n=19). Years of experience as healthcare workers - shorter years (11-40 years, n 23)- 60.5%, and longer years of experience (11-40 years, n 15)- 39.5%.

Results: Findings from the study revealed that gender and age, respectively ($t=1.785$, $t= -0.014$, $p >.05$), did not significantly affect the respondent's attitude towards trauma-informed care. However, the healthcare workers who had spent shorter time ($X =207.7$) in healthcare service delivery had more positive attitudes to trauma-informed care than their counterparts who had spent longer years ($X = 222.1$) in healthcare service delivery.

Conclusion: Though underreported, Trauma-related events, especially rape, are widespread in Nigeria. The study suggested that trauma-informed care should be at the center of training for mental health professionals caring for trauma patients.

Keywords: Healthcare Workers, Trauma patients, Trauma-informed care

Introduction:

Trauma, often called mental trauma or psycho-trauma, is an emotional reaction to a painful incident or set of events, such as car accidents, rape, or natural catastrophes (APA, 2022). Traumatic experiences often elicit a physical, emotional, or psychologically stressful response, although people's subjective experiences vary from person to person, ultimately impacting individual reactions to the same occurrences. In other words, not everyone

who experiences a potentially traumatic situation develops psychological trauma, although they may feel distressed and suffer (Storr et al., 2007). However, after experiencing a significant traumatic event or sequence of events, some persons will acquire post-traumatic stress disorder (PTSD) (Forman-Hoffman et al., 2016). This difference in risk rate can be ascribed to protective traits, such as temperamental traits, and environmental traits, like resilience and a readiness to ask for help, that certain people may possess that help them deal with distressing situations (Wingo et al., 2014).

Incidences of trauma have often been reported to result in complex and extensive psychological and physiological consequences. For some people, trauma has long-lasting adverse effects on the individual's ability to function as the mental, physical, social, emotional, or spiritual well-being has been negatively impacted. In contrast, others are more likely to engage in high-risk behaviors like smoking, drinking, using illicit drugs, and having risky sex as a coping mechanism (SAMHSA, 2014). These health and well-being consequences have made it imperative for health and social service providers to gradually realize the importance of incorporating Trauma-Informed Care (TIC) principles into their practice to guarantee survivors' safety, empowerment, choice, and satisfaction of their specific needs so that they can take a more active role in their treatment and rehabilitation (Rosenberg, 2011). There is a growing awareness that many persons who use human services may have previously experienced trauma and that to respond to such incidents, service delivery approaches may need to change (Mahon, 2022). Trauma-informed (TI) approach consists of various organizational cultures and practices that evaluate the occurrences and influence of trauma on patients and the strategies employed by those healthcare services and professionals to avert further victimization (Emsley et al., 2022). Koetting (2016) described trauma-informed care (TIC) as an evidence-based integrated intervention in healthcare delivery that identifies, reflects, and understands the long-term consequences of traumatic events to the affected individual. Quadara and Hunter (2016) defined TIC as "frameworks and strategies to ensure that the practices, policies, and culture of an organization, and its staff, understand, recognize, and respond to the effects of trauma on client well-being and behavior." In essence, trauma-informed care or service is a strength-based framework that raises providers' knowledge of the effects of trauma, guiding and supervising client-care interventions, actions, and behaviors, giving survivors a chance to regain control and empowerment, and reducing the possibility of re-traumatization (SAMHSA, 2014).

A trauma-informed approach responds to people who have experienced trauma by realizing the effects of the trauma and the potential of recovery, recognizing trauma indicators, and responding to them by integrating policies and procedures that will forestall further revictimization of the said victim (SAMHSA, 2015). Five important anchor points of the trauma-informed approach are safety, trust, choice, collaboration, and empowerment (Shier & Turpin, 2017). The practice of trauma-informed care begins with a mindfulness of the traumatic event and the feeling/response of the individual towards the traumatic event, which is highly reliant on the attitudes and knowledge of service providers. This is affirmed by Baker et al. (2016) position that service providers' attitudes toward TIC are a particularly quantifiable indicator of whether a service is trauma-informed and quality-assured.

Reviews of TIC comprised cross-sectional studies that concentrated on factors connected to TIC attitudes. One such study was conducted by Jacobowitz et al. (2015) with 172 participants in a mental hospital in the United States. They discovered parameters linked to the emergence and mitigation of staff PTSD. In addition, the researchers concluded that employees with more outstanding education were more likely to have attended a recent TIC meeting. In another cross-sectional study, Sundborg (2019) examined the association between knowledge and dedication to TIC (n = 118) among people in the health sector holding clinical, administrative, and managerial responsibilities in the United States. According to the author, the relationship between understanding and dedication to TIC is substantial and partly mediated by traumatizing beliefs. However, when a human services organization in the United States was preparing for TIC, Marvin and Volino (2018) gave information regarding the knowledge and attitudes of the staff members, in which TIC knowledge and attitudes were not statistically significant.

One study conducted by Hall et al. (2016) gave 34 nurses from an Australian emergency department an 18-item tool before and after a one-day TIC teaching program. As a result, the capacity to discuss painful events with clients has reportedly increased. However, there needed to be discernible effects of education in understanding how the emergency department setting can be re-traumatizing. In a separate study, Palfrey et al. (2019) matched pre-post data for 102 allied health professionals working in an Australian service for people with drug addiction and mental illness concerning a one-day training on TIC. Along with concrete examples of how practice is expected to improve, a considerable rise in confidence and awareness regarding TIC techniques was noted. The MHNs who participated in a related study by Stokes et al. (2017) explained the relationship between trauma and challenging behavior. The discussion centered on how interactions between nurses and patients can propagate trauma. In this approach, MHNs risk re-traumatizing their patients, who re-traumatize the MHN due to their reactions. The MHN runs the risk of passing on that trauma to additional patients, perpetuating the trauma cycle.

In the United Kingdom, Emsley et al., (2022) interviewed 11 professionals from health organizations on their practice and implementation of a trauma-informed approach, and they also analyzed 24 documents containing UK health policies. Findings indicated that though trauma-informed approaches were integrated into the national and regional health policies, they needed to be represented in the National Health Service (NHS) budgetary allocation or legislation. The study concluded that trauma-informed care needed more representation and practice in the UK health sector. Factors such as leadership, service user involvement, organizational culture, and budgetary allocation were implicated to have impeded the implementation of TIC practice at the organizational level. Whereas at the professional practice level, lack of interest and the belief that TIC is "a passing trend" that lacks substance may have contributed to its weakened popularity and implementation.

Relatedly, in a combined qualitative and quantitative study, Champine et al., (2022) investigated the level of awareness about trauma-informed approach among education and community partners in a community in Pottstown, Pennsylvania. The study

was part of a community-based, trauma-informed initiative called The Pottstown Trauma-Informed Community Connection (PTICC), whose purpose is to encourage a trauma-informed community. In this longitudinal study, data from 82 participants were utilized, and paired sample t-tests were used to analyze the data. The study sought to measure if the participants understood what it meant to be trauma-informed. Results reveal that the education and community participants had a significant understanding of the positive impact and benefits of TIC and the benefit of the TIC community initiative. Their scores, however, did not indicate any change in their perception towards organizational-level implementation of TIC.

In a Nigerian study, Effiom et al., (2020) examined the impact of trauma-informed counseling as an intervention strategy for reintegrating internally displaced persons who suffer from trauma such as war, rape, torture, and natural disasters. This qualitative study observed the significant importance of trauma-informed counseling in the social integration of this vulnerable population. Similarly, Oladimeji and Olorode (2022) investigated the relationship between trauma-informed teaching and academic performance in students with special needs in Ibadan, Nigeria. This correlational research employed 150 secondary student participants, and two instruments were used to elicit responses, which included the Academic Performance Rating Scale (APRS) and a self-structured questionnaire by the researchers. Results from the study suggest a positive and significant relationship between trauma-informed teaching and academic performance ($r = .669^{**}$, $N= 150$, $p<.05$). The study concluded that trauma-informed teaching techniques can improve academic performance among students with special needs.

Theoretical Background

Systems theory for understanding trauma-informed care.

The general systems theory was expounded by an Austrian biologist, Ludwig von Bertalanffy, in the 1940's. It explores how smaller units make up part of a more complex system. Understanding the workings of the more minor components of the system may significantly affect the outcome of the whole system (Wilkinson, 2011). The systems theory enables healthcare professionals to holistically examine client-peculiar characteristics, environmental factors, and other social variables in understanding the 'hows' and the 'whys' of delivering healthcare intervention to a client. The theory emphasizes how the smaller pieces come together to influence the outcome. Trauma should be perceived from a broader lens that incorporates different contextual aspects of an individual. An interplay of the biopsychosocial, interpersonal, community, societal characteristics, and cultural values before, after, or during the traumatic event, family support, and responses of others to the incident all form the basis for the recovery of the traumatic individual (Center for Substance Abuse Treatment, 2014).

Motivational interviewing for trauma-informed care Motivational interviewing was propounded by William R. Miller and Stephen Rollnick in 1983. This model is a client-centered counseling intervention that helps clients resolve conflicting negative emotions. Positive change is encouraged in a non-confrontational manner. Motivational interviewing has been reported to have positive outcomes for psychological and physiological traumatic experiences such as sexual abuse. The significant themes in motivational interviewing are: i) Engaging- the show of empathy and openness builds trust and helps the client open up without fear of judgment or bias. ii) Focus-here the clinician helps the client to focus on change/recovery. iii) Evoking entails the healthcare professional asking probing questions that motivate the client, and they both draw up strategies to change. iv) Planning: The clinician helps the client by motivating a commitment to change (Miller & Rollnick, 2013).

Rape and sexual victimization are traumatic weapons used to exact humiliation, supremacy, and dishonor from its victims. Okeke and Ijere (2021) noted that most victims of reported rape cases in Nigeria are females below 18. This phenomenon, which seems to be on the rise, leaves psychological and physical scars with the possibility of immediate and long-term implications. Rape and sexual assault are traumatic events with permeating and pervasive consequences. Reportage of this trauma is low, and the fear of stigmatization and a culture of silence may have enabled the spread of this epidemic (Okeke & Ijere, 2021). Given the prevalent culture of stigmatization of a raped victim and the culture of silence in some cases of sexual assault in Nigeria (Okeke & Ijere, 2021), the implementation of trauma-informed care services to sexually traumatized victims in the delivery of healthcare is likely to lead to an improvement in case assessment, treatment planning, and delivery, reduction in subsequent revictimization and promote openness in the communication between the assaulted client and the healthcare provider. By embedding appropriate trauma-informed care measures into healthcare organizations, the re-traumatization of sexual assault victims by caregivers will be minimized (Wathen et al., 2023).

The potential of utilizing trauma-informed care as an intervention strategy for trauma victims such as rape and sexual abuse has been promising, consequently forestalling further revictimization (SAMHSA, 2015). Studies conducted in Kenya revealed that survivors of sexual assault had been shown to benefit from trauma-informed services (Temmerman et al., 2019). The practice of TIC promotes a sense of security in the traumatized individual and aids their recovery (Koetting, 2016), as evidenced by Muskett (2014), who found that women who have experienced sexual assault wish to get care and attention tailored to their particular needs from traumatized medical professionals. Similarly, Ward (2020) and Weiss et al., (2017) affirmed that for survivors of sexual assault, the trauma-informed care paradigm has been successfully applied in primary and mental healthcare settings, women's clinics, and maternity care settings. In the same vein, Uganda created laws and procedures to combat sexual assault, and their efficacy has been monitored throughout time (Fay et al., 2021) to prevent the effect of trauma and re-traumatizing the survivors of sexual violence. These services offered by trained personnel have thus been shown not to exacerbate pre-existing trauma or cause new trauma, thereby encouraging healing.

Statement of Problem

Despite the importance of this approach, there seems to be a paucity of relevant quantitative studies on the effectiveness of its practice. Given the inadequate number of primary healthcare providers who possess the needed expertise or experience to screen for trauma or have the capabilities to provide the much-needed psychological, emotional, social, and physical intervention, it is no wonder why trauma has been associated with adverse health outcome and behaviors (Roberts et al., 2019). Accordingly, the Center for Substance Abuse Treatment (2014) posits that the ability

of a treatment provider to recognize trauma signs, ask the right questions about trauma history, address trauma-related issues pre-emptively, exude a feeling of safety without judgment and bias, may ultimately affect the behavioral and psychological recovery and treatment outcome of the victimized individual.

From the preceding, it is essential to highlight the essentiality of trauma-informed care to patient recovery; when a system uses the trauma-informed care approach, it recognizes the direct effect trauma can have on people's ability to access services and reacts by altering practices, policies, and procedures to reduce potential obstacles. At the same time, it is essential to stress the relative qualitative research newness of the attitude of healthcare workers to trauma-informed intervention in Nigeria that this study seeks to examine.

Objectives of study

Given the reported paucity of literature on trauma-informed intervention for individuals who had experienced trauma, especially in Nigeria, the study examined the attitude related to trauma-informed care among healthcare workers who render care to victims of rape and sexual assault --at the Orogbum Primary Health Care Centre Port Harcourt and the Model Primary Health Care Center, Eliozu Port Harcourt. The study also wishes to fill up a significant lacuna in the body of knowledge regarding trauma-informed intervention and its practice in Nigeria, especially among health professionals who manage sexually abused individuals.

Hypothesis

1. Female healthcare professionals will manifest a positive attitude related to trauma-informed care than their male counterparts.
2. Younger healthcare professionals (18-40 years) will manifest a positive attitude related to trauma-informed care than their older counterparts (41-70 years)
3. The healthcare professional who has spent a shorter time in healthcare service delivery (0-10 years) will manifest a positive attitude related to trauma-informed care than their counterparts who have spent a longer time in healthcare service delivery (11-40 years)

Methodology

Study Population, area, and procedure:

The study was conducted at Orogbum Government Primary Health Center Port Harcourt and the Model Primary Health Care Center, Eliozu Port Harcourt. This included all healthcare workers (including doctors, nurses, counselors, community health workers, social workers, etc.) who volunteered to partake in the study. The inclusion criterion for participants was healthcare workers aged between 18 and 70. The study was carried out between the 5th of June to 25th June 2023. Written Informed consent was obtained from the participants.

There were no minors, as all the respondents were above 18 years of age. The hospitals are both government-owned primary care centers in Port Harcourt Rivers State, with a program dedicated to victims of sexual abuse. The hospitals collaborate with Medecins Sans Frontieres (MSF), also called Doctors without Borders, to offer medical and psychological intervention to individuals who have been sexually violated. A purposive sampling technique was employed. The sampling method was most appropriate for selecting the participants due to their knowledge and experience in healthcare delivery. Approval for the study was obtained from the Department of Planning, Research, and Statistics of the Rivers State Primary Health Care Management Board and the Rivers State Health Research Ethics Committee (Approval number-RSHMB/RSHREC/2023/018).

Instruments: -

A structured questionnaire was used for data collection, which comprised the demographics of participants and a reliable scale measuring variables of interest. Specifically, the study adopted the Attitudes Related to Trauma-Informed Care (ARTIC) Scale, which measures the attitudes of healthcare service providers toward trauma-informed care and assesses the readiness of a service provider to adopt a trauma-informed care approach. This scale was constructed by Baker et al., (2016) and had excellent Cronbach alpha's internal reliability of ARTIC-45 (a = .93), ARTIC-35 (a = .91), and ARTIC-10 abbreviated scale (a = .82). All items utilize a seven-point bipolar Likert scale. The study used the 45-item complete questionnaire, which consists of seven subscales (five core and two supplementary subscales). The subscales measure underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy at work, reactions to the work, personal support of TIC, and system-wide support for TIC.

Data Analysis:

Demographic variables and survey items were examined with descriptive statistics. The study employed a cross-sectional design. The three hypotheses were analyzed using independent t-test statistics with SPSS version 22.

Results

Hypothesis One

Hypothesis one stated that female healthcare professionals would manifest a positive attitude related to trauma-informed care than their male counterparts. The hypothesis was tested using a t-test for independent samples and presented in Table 1.

Table 1: Summary of t-test showing influence of gender on attitude related to Trauma-informed Care (ARTIC)

	Gender	*N*	*Mean*	*SD*	*df*	*t*	*P*
ARTIC	Male	15	221.2000	21.8867	36	1.785	>.05
	Female	23	207.9130	22.7634			

Results in Table 1 show that male healthcare professionals (X =221.2000) were not significantly different in attitude related to trauma-informed care compared to female healthcare professionals (X = 207. 9130), t = 1.785, df = 36, p >.05. The result implies that there is no significant gender difference in attitude related to trauma-informed care among healthcare professionals.

Hypothesis Two

Hypothesis two stated that younger healthcare professionals would manifest a positive attitude related to trauma-informed care than their older counterparts. The hypothesis was tested using a t-test for independent samples and presented in Table 2.

Table 2: Summary of t-test showing influence of age group on attitude related to Trauma-informed Care (ARTIC)

	Age group	*N*	*Mean*	*SD*	*df*	*t*	*P*
ARTIC	Young	19	213.1053	22.3505	36	-0.014	>.05
	Old	19	213.2105	24.4008			

Results in Table 2 show that younger healthcare professionals (X =213.3505) were not significantly different in attitude related to trauma-informed care compared to older healthcare professionals (X = 213.2105), t = -0.014, df = 36, p >.05. The result implies that there is no significant age difference in attitude related to trauma-informed care among healthcare professionals.

Hypothesis Three

Hypothesis three stated that healthcare professionals who have spent a shorter time in healthcare service delivery would manifest positive attitudes related to trauma-informed care than their counterparts who have spent a longer time in healthcare service delivery. The hypothesis was tested using a t-test for independent samples and presented in Table 3.

Table 3: Summary of t-test showing influence of years of experience on attitude related to Trauma-informed Care (ARTIC)

	Year of experience	*N*	*Mean*	*SD*	*df*	*t*	*P*
ARTIC	Short year of experience	23	207.3478	23.7384	36	-1.998	<.05
	Long year of experience	15	222.0667	19.5392			

Results in Table 3 show that healthcare professionals who have spent a shorter time in healthcare service delivery (X =207.7384) significantly reported positive attitudes related to trauma-informed care than those who have spent a longer time in healthcare service delivery (X = 222.0667), t = -1.998, df = 36, p <.05. The result implies that there is a significant influence of year or experience on attitude related to trauma-informed care among healthcare professionals.

Discussion of Results

With the available information, this study is the first in Nigeria to evaluate attitudes related to trauma-informed care among healthcare workers handling rape victims in the two primary healthcare hospitals- Orogbum Government Health Center Port Harcourt and Model Primary Health Care Center, Eliozu Port Harcourt. This was examined from the three formulated hypotheses. The first hypothesis, which stated that female (60.5 %, n=23) healthcare professionals would manifest a positive attitude related to trauma-informed care than their male counterparts (39.5%, n=15), was rejected at p >.05 level of significance. Although the study did not find a significant difference between men and women in their attitudes towards trauma-informed care, it did indicate that men scored somewhat higher on the scale index than women (male X =221.2; female X = 207. 9).

This may be explained by the fact that females are unusually more likely than males to experience various types of sexual assault, post-traumatic stress disorder, and longer traumatic symptoms/stressors (Makin, 2019; Segaard et al., 2021), as well as by the fact that they are more likely to project their negative traumatic experiences in the kind of care they provide the victims of sexual assault, thereby translating to negative trauma-informed care. This exposes sufferers to further traumatization when they visit medical facilities for treatment. Most trauma-informed attitude has been linked to the health worker's clinical experience. To prevent the revictimization of this vulnerable population, healthcare organizations must offer trauma-informed training (Menschner & Maul, 2016). Given the circumstances in Nigeria, where rape victims are blamed, stigmatized, and probably not believed (Okeke & Ijere, 2021), creating a safe atmosphere free from prejudice and stigma is vital to improving treatment outcomes.

The second hypothesis, that younger healthcare workers would have a more positive attitude towards providing trauma-informed care than their older colleagues, was also rejected. There was no significant difference between the attitudes of older (x=213.2) and younger (x=213.1) healthcare professionals on their use of trauma-informed approach. This implies that irrespective of the chronological age of the surveyed healthcare workers, they all displayed similar attitudes in handling victims who may have been sexually assaulted/traumatized. The weighty implication of this finding is that TIC implementation and training by healthcare providers may depend on effective training programs rather than the healthcare workers' age or other personality or demographic attributes.

In trying to understand factors that may influence a healthcare organization's competency in handling trauma-informed care (TIC), Stevens et al., (2019) acquiesced that personality traits such as lack of openness and lack of training in TIC were associated with a reduced efficacy in TIC. However, Nation et al., (2022) disagree with this assertion and posit that training is unlikely to bring about the shift in behavior needed to ingrain TIC in health care provider's service delivery.

The third hypothesis was accepted, which stated that healthcare professionals who have spent a shorter time in healthcare service delivery would manifest a positive attitude related to trauma-informed care than their counterparts who have spent a longer time in healthcare service delivery. This suggests that the healthcare workers who had spent shorter time (X =207.7) in healthcare service delivery had more positive attitudes to trauma-informed care than their counterparts who had spent longer years (X = 222.1) in healthcare service delivery. This observation may be traced to

the growing awareness of trauma-informed approaches, which may have been implemented when the new workers were employed, as against those employed earlier, when TIC was not prominent or advocated for. This implies the holistic training and retraining of healthcare providers who handle sexually assaulted victims, irrespective of socio-demographic differences.

Conclusion

Though underreported, Trauma-related events, especially rape, are widespread in Nigeria. Trauma associated with sexual abuse and sexual violence are more prevalent and, thus, most of the time, results in mental illness. Therefore, healthcare professionals who work with trauma patients must be well-informed and trained. The training and information should be trauma-informed.

As indicated in this study, there is a need for TIC training and education for professionals providing care to trauma patients. Although other factors are essential to be considered, the study suggested that TIC should be at the center of training for mental health professionals caring for trauma patients. Thus, TIC should be strongly advocated for and implemented.

Further studies are needed to investigate the influence of sociocultural factors on the attitude of professionals who provide TIC to trauma patients in Nigeria.

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