Exploring How Sexual Assault Nurse Examiners Practise Trauma-Informed Care

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Background: Sexual violence is a term describing sexual acts where consent is not freely given. Registered nurses employed as sexual assault nurse examiners (SANEs) provide care to address the medical and legal needs of victims/survivors of sexual violence. Trauma-informed care (TIC) is an approach recommended when caring for individuals who have experienced trauma.

Purpose: The study purpose was to understand how SANEs incorporate trauma-informed approaches in the care of adult and postpubescent adolescent victims/survivors of sexual violence.

Methods: Eight SANEs were purposively recruited to participate in online semistructured interviews. Interview data were analyzed using qualitative interpretive description.

Results: Six themes emerged from the analysis: (a) the importance of understanding the patient’s experience; (b) personalized connection: developing a safe nurse–patient relationship; (c) choice: the framework of how we do things; (d) rebuilding strengths and skills to support healing and posttraumatic growth; (e) a wonderful way to practise: facilitators and benefits of trauma-informed practice; and (f) challenges to trauma-informed practice.

Conclusions: These findings indicate the perceived value of TIC and the need for enhanced support of providers who deliver TIC. More research is warranted to strengthen the evidence about trauma-informed practice in SANE programs and across healthcare settings.

KEY WORDS:
Experiences and perceptions; interpretive description; nursing practice; qualitative research; sexual assault nurse examiners; sexual violence; trauma-informed care

Sexual violence describes sexual acts, completed or attempted, where consent is not freely given (Centers for Disease Control and Prevention, 2018). It is a social, public health, and human rights issue that affects children, women, men, and nonbinary individuals across the lifespan (Basile et al., 2014). It is estimated that one third of adult women will be sexually assaulted in their lifetime in Canada and the United States (Smith et al., 2017; Statistics Canada, 2006). Researchers have identified associations between a history of sexual violence and impacts to physical and mental health (Jina & Thomas, 2013; Oram et al., 2017).

In North America, registered nurses (RNs) are employed as sexual assault nurse examiners (SANEs) to address the medical and legal needs of victims/survivors of sexual violence (International Association of Forensic Nurses, n.d.). The care options include, but are not limited to, documentation of the assault, medical assessment and treatment, forensic evidence collection, safety planning, and follow-up care. Such services are recognized to help practitioners provide a sense of safety, control, and reassurance for victims/survivors of sexual violence (Du Mont et al., 2014).

Trauma is a single or repeated threat or circumstance causing harm, such as a sexual assault (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The effects of trauma resulting from sexual violence may be short- or long-term and can occur immediately or have a delayed onset (SAMHSA, 2014). Trauma-informed
care (TIC) is an organizational approach ideally integrated into the care of clients, the work of frontline providers and administrators, and the workplace culture (SAMHSA, 2014) and is seen as a framework for “promoting equity and improving health outcomes” (Laughon & Lewis-O’Connor, 2020, p. 195) but requires organizational change and ongoing training (Maguire & Taylor, 2020).

The conceptualization of TIC principles has been shaped by several authors/organizations, notably Harris and Fallot (2001), SAMHSA (2014), and the National Sexual Violence Resource Center (2017). TIC principles are not hierarchical or distinct from each other and do not need to be applied in a specific order. The principles of TIC referenced in this study are as follows: trauma awareness and understanding, safety, trust, choice, collaboration, strength- and skill-building, and competence of cultural and social identities. Given the prevalence of sexual violence and resulting trauma, as well as the known benefits of TIC, better understanding if and how SANEs incorporate TIC principles is of concern to optimize the short- and long-term outcomes of survivors.

### Background

A literature search using the keywords “trauma-informed” and “nurses” and four databases (CINAHL, MEDLINE, EMBASE, and PsychInfo) was completed. TIC is described as an organizational approach meant to include all staff (SAMHSA, 2014). The existing research about TIC has included many different healthcare providers (HCPs) and health settings.

TIC is described as a universal approach of which the principles are applied regardless of the patient’s disclosure of trauma (Harris & Fallot, 2001; SAMHSA, 2014). Given this, the breadth of healthcare settings represented within the existing literature is reassuring. There is much literature concentrated within psychiatry (Beckett et al., 2017; Isobel & Delgado, 2018; McEvedy et al., 2017; Stokes et al., 2017) and pediatrics (Broughton et al., 2017; Chokshi et al., 2019; Kassam-Adams et al., 2015; Moss et al., 2019).

Researchers have investigated the applications and impacts of TIC in various settings. A subset of the literature was about understanding HCPs’ knowledge, skills, practices, and confidence in delivering TIC (Bruce et al., 2018; Chokshi et al., 2019; Kassam-Adams et al., 2015). In these studies, the authors concluded that HCPs would benefit from training about TIC. In other studies, researchers tested the efficacy of educational interventions in healthcare settings, including pediatrics (Broughton et al., 2017; Choi & Seng, 2015), emergency departments (Hall et al., 2016), and psychiatry (Isobel & Delgado, 2018). Many of the educational interventions were determined to significantly increase HCPs’ confidence in practising TIC (Broughton et al., 2017; Hall et al., 2016).

Much of the TIC literature is informational, indicating a need for studies to better understand and improve current trauma-informed practices. The empirical research provided shows the applicability of TIC to different settings; however, limitations exist. Furthermore, there is a paucity of empirical research about how TIC is practised. As TIC is a relatively new concept, research on its applications is emerging, and gaps exist in understanding SANEs’ use of TIC. Therefore, the study purpose was to explore SANEs’ experiences and perceptions of using a trauma-informed approach in the care of victims/survivors of sexual assault.

### Methodology and Methods

Interpretive description (ID), as described primarily by Sally Thorne, was chosen as the methodology because of its alignment with applied nursing research and real-world questions (Hunt, 2009; Thorne, 2016; Thorne et al., 1997). It provides a framework to generate, beyond description, interpretive accounts of phenomena that will inform the generation of new knowledge and ongoing inquiry (Thorne, 2016; Thorne et al., 2004). Researchers undertaking ID are encouraged to understand what is currently known about the topic of interest to make linkages with this knowledge, thus strengthening the results (Thorne et al., 1997, 2004). Furthermore, the flexibility of ID encourages critical thinking throughout the research process (Thorne et al., 1997).

The study setting was a Canadian province, where 36 SANE programs operate. Participants were recruited purposely based on the following inclusion criteria: RNs employed by SANE programs, trained and working independently, with access to computer or smartphone with teleconferencing capabilities, and able to provide informed consent. Ten centers were randomly selected, and recruitment was attempted using email solicitation to the most responsible person for each program. If recruitment was not possible based on lack of response or an ethics approval process exceeding 2 months, another center was randomly selected. In addition to these centers, recruitment was completed at a site local to the primary author to test interview questions. The ethical approval for the study was obtained from the primary author’s university ethics board and the affiliated hospital (NURS-461-18, #6025532) as well as three additional study sites.

Data were collected by the primary author using semistructured online interviews allowing for an in-depth exploration of participants’ views and experiences, while ensuring that the research questions were addressed. Each participant participated in one interview, which lasted an average of 67 minutes. An interview guide was developed referencing the principles of TIC and was provided to participants before the interview. Interviews were completed and recorded using online teleconferencing software, which included audio and video, and were transcribed verbatim by the primary author. A second investigator reviewed the transcripts for accuracy. The researcher’s field notes and
reflexive journals were appended to each interview transcript. To allow for member checking, participants were provided an opportunity to provide feedback about the transcript and interpretation of their interviews and the findings.

Qualitative data analysis followed the thematic analysis process as outlined by Miles et al. (2014) and was not viewed as a distinct methodology—the coding process that is acknowledged by Thorne (2016) to be “almost inevitable” (p. 159) to pragmatically manage the data and within the latitude of the methodology. In the first coding cycle, overarching labels or codes were assigned to portions of transcript text to assign meaning to the data (Miles et al., 2014). In the second coding cycle, the codes were grouped into a smaller number of themes to make the research data meaningful and manageable (Miles et al., 2014). Second-cycle coding led to the development of themes and subthemes. Strategies from Guba and Lincoln’s trustworthiness framework were implemented to improve the credibility, confirmability, dependability, and transferability of the research (Krefting, 1991; Lincoln et al., 1985; see Table 1).

### Findings

Eight individuals, each of whom was assigned a pseudonym, from three distinct sites participated in the study. Their experiences as a SANE ranged from 2 to 9 years, and most, although not all, asserted that they had heard about TIC. All participants worked on an on-call basis in some capacity.

Two participants worked as program coordinators, which involves managing community partnerships and logistical tasks, in addition to their on-call duties. One participant currently provided follow-up support for clients in addition to on-call duties, which involves ongoing medicolegal care, such as assessment and treatment for sexually transmitted infections (STIs). The six main themes and 16 subthemes are presented in detail below and summarized in Supplemental Digital Content 1, http://links.lww.com/JFN/A71.

#### The Importance of Understanding the Patient’s Experience

The experiences and perceptions of participants conveyed that they recognized that the foundation of providing TIC to victims/survivors of sexual violence is having an understanding of the patient’s experience.

#### Knowing about psychological trauma

Participants shared their understanding of psychological trauma and its importance in their practice. Riley explained, “The clients that we care for are a group that has recently suffered something very traumatic, and it’s important that their care provider understands that what they have been going through is really difficult and takes that into account.” Several participants explained that they practised with the lens of “universal trauma precautions,” and it was encouraging that every participant could articulate a rudimentary definition of trauma and its effects and that this understanding was regarded as important in the care interaction.

Participants described how the experience of trauma manifests in patients differently and how they account for this when providing care. The experience of sexual violence was noted by participants to contribute to a vulnerability in patients and often leads to victim blaming. Participants also described how they perceived that certain factors place victims/survivors at an increased risk for previous or future trauma.

#### Knowing about cultural and social identity

Participants provided examples of the cultures and identities they have encountered in practice, including transgender patients, Indigenous patients, patients requiring translation services, and racial minorities. To provide care that is considerate of different identities, the participants explained that they endeavored to make their care inclusive at baseline. Participants explained how they perceived that being respectful conveys acceptance of the patients’ cultural considerations. Shannon said, “I’m fairly culturally aware and inclusive of anybody. I say you treat any human being with respect, does not matter your color, where you came from.” Morgan provided an example of asking the patient questions, stating, “If there was a transgender patient, asking what they would like to be referred to, what pronoun they would like used.”

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**TABLE 1. Trustworthiness**

| Credibility          | Reflexivity activities (e.g., appending written reflections to each interview transcript, ongoing discussions with coauthors) |
|----------------------|--------------------------------------------------------------------------------------------------------------------------|
|                      | Triangulation (e.g., collecting the data from multiple participants in different settings)                                    |
|                      | Member checking (e.g., participants were provided their transcript via email for any corrections/ additions; online group teleconference was held to provide initial findings, and a postconference email was sent with the information for those who could not attend) |
|                      | Peer debriefing                                                                                                              |
|                      | Interviewing technique (e.g., clarifying with participants as to their insights)                                               |

| Confirmability       | Reflexivity and triangulation (as outlined above)                                                                           |

| Dependability        | Maintaining records regarding the research process                                                                          |
|                      | Describing the research methods in such detail that they could be replicated                                                |
|                      | Member checking                                                                                                              |

| Transferability      | Study procedures and findings provided in detail                                                                             |

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Journal of Forensic Nursing  
www.journalforensicnursing.com  
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Participants were forthright that their knowledge about some groups was limited, indicating their insight into personal practice improvement.

**Personalized Connection: Developing a Safe Nurse–Patient Relationship**
Participants described striving to build effective nurse–patient relationships and how connecting with patients helped to build this partnership. Morgan described it as a “personalized connection.” This theme consists of three subthemes: trust, collaboration, and safety.

**Building trust**
Building a trusting, professional relationship with the client was described as vital. Alex said, “If they did not trust me, you would not know their story, and you just would not be able to provide excellent care.” Taylor commented:

I really feel like building that therapeutic relationship is one of the most important pieces because these clients do not feel safe. When they come to you, if they can even just have an hour of feeling safe, I feel like it does a lot for their psyche.

Clearly explaining the consent and confidentiality process was noted as very important in gaining trust. Jordan explained, “I think the consent is really helpful, so going over the consent for service, I think helps to build that professional relationship, because then they know what to expect of me.” Participants agreed that building trust was inherent to nursing practice, by using therapeutic skills such as non-verbal communication. They described the importance of connecting with patients as a way to build trust. Alex explained, “Show[ing] some interest in our patients as a human being outside of the assault, and not just ask[ing] questions pertaining to the assault.” Seeing one’s humanness was perceived as vital to a trusting relationship.

**Building collaboration**
Collaborating with patients involves making decisions in partnership, having the patient lead when able, and leveling power differences. Morgan explained, “I just want them to feel as an equal so that they feel supported and comfortable in their environment.” Participants detailed how they integrated shared decision-making and collaboration into the care by guiding and supporting the patient. Morgan said, “I try to make sure that they understand that I’m there to support them. And in whatever way they choose to proceed with their care, I’m still going to support them and offer them all their choices.” The importance of supporting and guiding the patient was noted as especially important if they were unable to make decisions as a response to the traumatic incident. Participants described that their role in the collaboration of making choices was using their expertise to support and guide the patient, which may promote the victim/survivor’s decision-making abilities.

**Ensuring safety**
As communicated by participants, when patients feel safe, they are able to develop a trusting nurse–patient relationship, so they tried to promote patients’ physical safety and comfort. Jordan explained, “I try to support them in the room, like offer them things that are going to make them comfortable, whether it be food, or water, or warm blankets, or whatever kinds of supports I can provide in that way.” By promoting psychological or emotional safety, patients become more willing to share their experiences. Jordan noted: “I think she [in reference to a patient] definitely felt safe, because she was very, very open.” Completing safety planning with the patient was described as a strategy to promote physical and emotional safety after the care interaction.

**Choice: The Framework of How We Do Things**
Participants frequently discussed how they provide patients choices, conveying that it was very important in their practice. Morgan noted, “This is our framework of how we do things, you get to pick and choose what you want done.” The importance of choice in “giving patients power and control back” was the experience of several participants (Riley, Shannon, and Frances). Shannon further explained:

Everything’s been taken from them. So if they have been assaulted without consent, then they have lost that ability to control their life and their choice. And so I feel like this gives them the power to decide, “this is my body, and this is what I want to happen to it in this moment, and this is how I’m going to heal.”

Participants perceived the provision of choice as empowering to the victim/survivor. Alex reflected, “When I think of empowering my patients, I think of handing over the reins to them so that they get to be in the driver’s seat, and they make the decisions.” Participants emphasized how choices are offered at every step and that how care is performed is also a choice.

**Rebuilding Strengths and Skills to Support Healing and Posttraumatic Growth**
The principle of strength- and skill-building was described by participants as a way of building resiliency in victims/survivors to serve them after the care interaction. Many participants explained that identifying strengths can be as simple as commending the patient on seeking help. Morgan noted, “Always pointing out that they have come to the point of being in the treatment room with me and that in itself is a challenge for so many people. And pointing out their strengths in doing that and coming forward.” Participants elaborated on other ways in which they identify strengths and skills, particularly regarding how to cope with the negative implications of the assault. Alex explained how they address strengths and skills:

Talking them through, “do you do yoga? How do you usually decompress? What are your self-care habits like
already? How can you amp those up, as an adjunct to these other things that we are going to help to orchestrate for you to sort of manage with the stress and anxiety that people often experience after an assault?”

Participants described the formal and informal supports they perceived that contributed to strength- and skill-building. The act of organizing appointments with a counselor was frequently cited as an important formal support. Family and friends were described as sources of informal support. Despite the importance of this theme, participants articulated that, because of the brevity of the acute visit, time and resources do not allow for extensive strength- and skill-building.

A Wonderful Way to Practise: Facilitators and Benefits of TIC

As participants described their practices, several factors were perceived to facilitate TIC, and it was described as “a really wonderful way to practice” (Taylor). The facilitators of TIC were as follows: working autonomously, having supportive coworkers and management, and continuing competence. The benefits of TIC participants described were as follows: providing them comfort that they did the right thing and having benefits beyond the SANE role.

Working autonomously

Participants described how their role provides independence and control over certain factors of their practice and how this autonomy was beneficial for preventing role burnout. Shannon asserted that, “I think our ability to schedule ourselves helps provide care because you sign up for the shift that you can do, so you are not completely burnt out.” Shannon also explained: “One of the best parts about being a SANE is that you pick the patient up in the emergency room and we bring them to a treatment room, and from then on, it’s you and the patient.”

Supportive coworkers and management

Participants described the importance of the support of their coworkers and management. Jaime explained, “If I did not have the co-workers that I have, I do not know that I would still be in this role that I’m in, because of what we are exposed to.”

Continuing competence

Participants described ongoing learning about a variety of topics as an important priority in advancing their practice of TIC (e.g., improving their understanding and care of patients of different cultures and social identities). Participants described different forms of continuing competence, including SANE training, conferences, workshops, online courses, and informal learning, such as in-services at team meetings. Morgan said, “I think doing stuff like that...makes you feel more confident in the care that you are providing, and I think that’s kind of how I feel empowered as a nurse, when I have that opportunity to go to an education session.”

Finding comfort in practising TIC

Participants described that practising TIC provided them comfort in knowing that they had done the right thing for the patient, even when feeling dissonant with their beliefs. In describing a patient who decided against prophylactic HIV medication after a high-risk exposure, Jordan recounted:

The fact that she would not take HIV PEP really bothered me...but now it’s funny, because...providing her with the education and letting her make the decision [a trauma informed care approach]. I think I would have understood that better, but at the time being new to the role, I sort of felt like I had not done my job well enough because she refused.

Shannon explained how fostering safety was assurance that they did the right thing for the patient: “I did not know in that moment how to console her because it wasn’t going to be okay for her in that moment, and I did not want to say the wrong thing. I just felt completely unprepared in that moment. And I knew that I needed to be there with her, and I knew I needed to keep her safe. So I felt okay about that.”

Benefits beyond SANE practice

Participants communicated how knowledge about trauma and TIC has been beneficial in improving their practice in other nursing roles. Taylor explained: “Had I not been educated on TIC, would I even have recognized the practice behaviors at my other position as being problematic?”

Barriers to Trauma-Informed Practice

Participants described several barriers to delivering TIC: patient factors contributing to difficult trust-building and organizational barriers, including continuing competence, difficulty accessing patient support services, organizational changes, organizational integration of TIC, and vicarious trauma.

Factors that complicate the nurse-patient relationship

Participants’ experiences conveyed how the challenges or vulnerabilities that some patients experience, such as a previous history of trauma and mental illness, can be a barrier in building trusting relationships. The act of breaking confidentiality for patient safety was described as detrimental to trust. Shannon described: “When [I] called the physician with my concerns she maybe felt in that moment that our relationship, our trust had gone...and in those moments...they do not trust me.”

Continuing competence

Although participants described continuing competence as a facilitator to their practising of TIC, they also described the lack of educational opportunities being a barrier. Alex described how the few learning opportunities available do
not fit their learning style. They said: “I feel like we have the option to do like all kinds of e-learning stuff. And that’s just not my learning style at all. I do not always feel like I take a lot of information away from that.”

Accessing patient support services
Participants explained how, at times, it is difficult for them to assist victims/survivors in accessing services. Another perceived barrier was the lack of enough SANEs to provide care. Jordan explained how staff shortages impact patient care: “We had gaps in the schedule and could not provide care to clients that showed up as timely as would have been nice.”

Organizational changes
The perception of constant changes to program structure and staffing were noted as challenging to participants. Taylor described:

“If you quit, because you are burnt out…because of vicarious trauma, then it is an expectation that we hire anyone to fill your role. Which I feel does more damage because I feel if you are not well prepared to come into this role, then I’m setting you up for failure and for harm.”

Organizational integration of TIC
Participants perceived that a lack of organizational integration and other HCPs’ use of TIC was a detriment to victims/survivors. Alex explained, “Part of our struggle with the ER is that we kind of get incomplete reports. I think that’s because patients do not feel safe to talk about what actually happened to them.” Participants alluded to a disintegration of trauma-informed approaches between settings contributes to confusion and misunderstanding in patients and potentially suboptimal care.

Vicarious trauma
Participants were insightful regarding their propensity for vicarious trauma and burnout in the role, and they bolstered their emotional safety through self-care practices. Jordan shared:

“I knew I needed to take a step back, I was less affected by their story. You know, I was like, [monotone voice] “oh, you were sexually assaulted. Okay.” … I was happy that I recognized in myself I needed to take a step back. For me, but also for the clients, for sure.

Participants described how they bolster their emotional safety through self-care. Riley explained that they “journal and try to participate in self-care such as physical activity and eating well...to help cope with some of the difficult situations that I hear about at work.” Morgan commented on the importance of team debriefing in protecting emotional safety: “In our monthly meeting…it comes up that whenever you have had a tough case, and you want to talk about it...if something had been bothering you then I think that that’s helpful.”

Visual Representation of Themes
In ID, conceptualizing the findings contributes to a presentation of the data that are easily understood and remembered (Thorne, 2016). To make the study findings meaningful, we created a visual conceptualization (see Supplemental Digital Content 2, http://links.lww.com/JFN/A72). The image used is the act of the SANE climbing a mountain with the victim/survivor.

Discussion
The primary study purpose was to explore SANEs’ experiences and perceptions of using a trauma-informed approach in the care of victims/survivors of sexual assault. In response, four key insights regarding TIC nursing implications emerged: valuing TIC in SANE practice and beyond, choice as a paramount priority, the need for education and continuing competence, and the realities of vicarious trauma.

Valuing TIC
When interviewed about “if” and “how” they applied the principles of TIC, participants described in rich detail that they provided sensitive TIC in response to the unique experiences of the victims/survivors. The applicability of TIC to this subset of forensic nursing care was evident even in the participant with the least experience in the role. When discussing the organizational side of applying TIC, participants conveyed that this approach to care has not been integrated into all levels of the organization. Participants described the lack of trauma-informed practice by HCPs in other settings where victims/survivors are cared for, such as the emergency department and inpatient mental health, is not ideal. Participants also described organizational barriers that impede their delivery of TIC, such as the lack of ongoing education.

SANEs are not the only HCPs whose practise of TIC is relevant to the population they serve. Bruce et al. (2018) and Kassam-Adams et al. (2015) measured provider knowledge, self-reported competence, and practices of TIC in adult and pediatric medical trauma settings, respectively. The researchers discovered that most HCPs, including nurses, were knowledgeable about trauma, were “somewhat” or “very competent” in TIC, and practised TIC in the last 6 months. The obvious limitations to these results are the self-reporting nature and potential for response bias. In a study by Stokes et al. (2017), mental health nurses were interviewed regarding their understanding and experiences of TIC. Participants, although not familiar with the TIC terminology, described how TIC is fundamental to nursing practice, similar to the nurses in this sample.
Participants communicated how TIC has been beneficial in improving their practice in other nursing roles and in their lives outside work. One participant explained how their work as a SANE made apparent the unfortunate lack of TIC in a primary care setting where they also worked. Another participant described how she has applied aspects of caring for this population to her parenting. In addition, participants expressed comfort in relying on the principles of TIC, particularly choice and safety. Participants explained how practising TIC assisted them with accepting dissonant feelings when they felt as though they did not do the right thing. The HCPs in Moss et al.’s (2019) study identified in the qualitative interviews that practising TIC “makes [patients] feel comfortable and less stressed” and that “seeing positive impacts and outcomes” (p. 23) has a positive effect on themselves as HCPs.

Choice as a Paramount Priority
The principle of choice was mentioned frequently by participants. Providing choice was perceived as a vital means to support the victim/survivor in making the choices they need to promote healing and posttraumatic growth.

Given that the importance of providing choice to victims/survivors was so central and intuitive to participants suggests its natural alignment with the work of SANEs. The importance of choice has been detailed briefly within the literature and resources specific to SANEs. For example, the vision and mission of the Network includes informed choice and recognizes the importance of promoting choice (ONSADVTC, 2017). Campbell et al. (2008) developed a logic model of the “empowering care” of SANEs and surveyed victims/survivors on whether they experienced the aspects of the model in the care they received. One such aspect of the logic model was reinstating patient control and choice. It is interesting to note that, although this was not referred to as a TIC model, many aspects of TIC were embedded, such as trust-building and safety (Campbell et al., 2008). Most patients reported that the aspects of the logic model were consistently performed by the SANEs throughout the care (Campbell et al., 2008).

One important distinction in SANE programs, compared with other healthcare settings, is that care is rarely mandatory or medically necessary. Given that patients are not obligated to complete any care with the SANE program, choice becomes a means to an end in that the choices made promote their healing and posttraumatic growth. In other words, choice gives the victims/survivors what they need.

The Need for Education and Continuing Competence
The need for education and continuing competence was not a unique finding to this study. Other authors have articulated a need for more HCP training about TIC (Bruce et al., 2018; Hall et al., 2016; Kassam-Adams et al., 2015; Moss et al., 2019; Stokes et al., 2017). In this study, participants described how they have completed some TIC-specific training, including the 40-hour SANE training and self-directed learning courses. Upon review of the SANE modules, TIC is addressed in one of the 15 modules, and the content is mostly about understanding and awareness of trauma (ONSADVTC, n.d.). Participants described how ongoing training opportunities were limited in their communities, and they expressed a desire for more education about TIC, such as improving cultural and social identity competence. Furthermore, the study findings also indicated that participants perceived there was a lack of trauma-informed practices in the other HCPs whom they interacted with, for example, the providers in the emergency department, inpatient mental health setting, and primary care. As a result of this lack of consistency in trauma-informed approaches, participants described how the care of the victim/survivor was negatively affected. In addition to healthcare, participants described a need for education about TIC for other providers, such as police officers and school teachers, who are likely to interact with victims/survivors of sexual violence.

The voices of these participants and others have suggested a need for education about TIC beginning in undergraduate nursing education. Li et al. (2019) completed a literature review investigating the trauma-informed educational practices of several health disciplines and found no published theoretical or empirical findings on TIC content in nursing education. In Canada, knowledge and application of TIC is noted as an entry-to-practice competency for RNs (Canadian Association of Schools of Nursing, 2015). Whether student or newly graduated nurses are able to retain or apply principles of TIC does not appear to have been evaluated.

The Realities of Vicarious Trauma
Participants started how this type of work impacts them. The risk of vicarious trauma in HCPs caring for victims/survivors of trauma has been documented (Antai-Otong, 2016; Beck, 2011). Participants also asserted how this work affects their emotional well-being, for example, by affecting their feelings of personal safety and how they manage their emotional health. Despite being affected by this role, participants conveyed their commitment.

The emotional impact that this role has on the individuals providing care is known to cause burnout and staff turnover (Cole et al., 2007), and this was also communicated by the participants. When programs are understaffed, either care is delayed or SANEs may be pressured to work, contributing to burnout and further vicarious trauma. Furthermore, an urgent need for staff to fill vacancies can lead to hiring in haste, which was described by one participant who was also in a supervisory role. When forced to hire individuals who may not be ready for the threat of vicarious trauma, they described feeling as though new SANEs are
being set up for failure. As such, strategies to prevent and mitigate vicarious trauma are warranted in organizations where care providers frequently provide care to patients who have experienced trauma. Such strategies could include training for frontline staff to manage their own vicarious trauma, training for management to improve identification of vicarious trauma in staff, and improvement of hiring practices to ensure that staff are prepared for the realities of the role.

**Implications for Clinical Forensic Nursing Practice**

This study provided insight into how participants’ practice is trauma informed, and the findings and existing literature revealed that there are nuances among the trauma-informed practices in different patient settings. Given that the concept of choice was emphasized as very important for SANE practice but not as strongly in other healthcare specialties, adapting TIC guidelines to be setting specific is indicated. This may be more effective in improving patient care than practising general TIC.

Participants’ experiences of vicarious trauma indicate an increased need to support the emotional well-being of SANEs. It is encouraging that participants reported feeling professional satisfaction in this role. To retain these competent professionals, leaders must educate and support staff to be resilient to vicarious trauma. The literature is in support of services being in place for staff, such as peer support, policies, and staff evaluation, to prevent and mitigate vicarious trauma (British Columbia Mental Health & Addictions Services, 2013; NSVR, 2017; SAMHSA, 2014).

The voices of the participants echoed those in other studies who are in agreement that more education about TIC is desired to enable a feeling of confidence. Research to understand the education needs of SANEs is warranted and could be modeled on similar literature where HCPs have been included in the process of identifying their learning needs and evaluating educational programs.

**Study Strengths and Limitations**

This research addressed a gap of understanding SANEs’ experiences and perceptions of practising TIC. The strategies to address the trustworthiness support the findings. The method of data collection supports the feasibility of online teleconferencing. It provided a simple and low-cost option for diversifying and accessing participants from a large geographical area. A limitation was the lack of sample diversity. More diversity would improve our understanding of the perspectives of SANEs who face different challenges, care for unique patient populations, and confirm the dependability of these results. In addition, despite the assurance of confidentiality, social desirability response bias is possible. Finally, the primary researcher’s experience as a SANE and professional relationship with some participants introduced potential bias.

**Conclusion**

In this study, we addressed the nursing applications of TIC in the care of victims/survivors of sexual violence. Participants’ experiences and perceptions conveyed that they apply the principles of TIC to their practice. These findings indicate the need for improved supports for providers experiencing vicarious trauma, enhanced education about TIC for providers, and adaptations for trauma-informed approaches, which are specific to the healthcare population and setting. Further research about the applications and implications of TIC in the care of victims/survivors of sexual assault should be completed to broaden our knowledge of this important topic.

**References**

Antai-Otong, D. (2016). Caring for trauma survivors. *Nursing Clinics of North America*, 51, 323–333.

Basile, K. C., Smith, S. G., Breiding, M. J., Black, M. C., Mahendra, R. R. (2014). *Sexual violence surveillance: Uniform definitions and recommended data elements (Version 2.0)*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/sv_surveillance_definitions-2009-a.pdf

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing*, 25(1), 1–10.

Beckett, P., Holmes, D., Phipps, M., Patton, D., Molloy, L. (2017). Trauma-informed care and practice: Practice improvement strategies in an inpatient mental health ward. *Journal of Psychosocial Nursing and Mental Health Services*, 55(10), 34–38.

British Columbia Mental Health & Addictions Services. (2013). *Trauma-informed practice guide*. http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Broughton, L., Shenoi, A., Ragsdale, L., Lawrence, J., Yoder, K., Ross, C., McGar, A., Marsac, M. (2017). Promoting self-care in PICU professionals using a trauma-informed medical care framework. *Critical Care Medicine*, 46(1), s864.

Bruce, M. M., Kassam-Adams, N., Rogers, M., Anderson, K. M., Pringnitz Sluys, K., Richmond, T. S. (2018). Trauma providers’ knowledge, views, and practice of trauma-informed care. *Journal of Trauma Nursing*, 25(2), 131–138.

Campbell, R., Patterson, D., Adams, A. E., Diegel, R., Coats, S. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients’ psychological well-being. *Journal of Forensic Nursing*, 4, 19–28.

Canadian Association of Schools of Nursing. (2015). *Entry-to-practice mental health and addiction competencies for undergraduate nursing education in Canada*. Retrieved from https://www.casn.ca/wp-content/uploads/2015/11/Mental-health-Competencies_EN_FINAL-Jan-18-2017.pdf

Centers for Disease Control and Prevention. (2018). *Sexual violence prevention*. https://www.cdc.gov/features/sexualviolence/index.html

Choi, K. R., Seng, J. S. (2015). Pilot for nurse-led, interprofessional in-service training on trauma-informed perinatal care. *Journal of Continuing Education in Nursing*, 46(11), 515–521.
Chokshi, B., King, S., Schulz, T., Chen, D. (2019). Institutional assessment: Knowledge, attitudes and practices of trauma informed practices. Journal of Adolescent Health, 64(2), S94.

Cole, T. K., Logan, J., Capillo, A. (2007). Sexual assault nurse examiner program characteristics, barriers, and lessons learned. Journal of Forensic Nursing, 3(1), 24–34.

Du Mont, J., Macdonald, S., White, M., Turner, L., White, D., Kaplan, S., Smith, T. (2014). Client satisfaction with nursing-led sexual assault and domestic violence services in Ontario. Journal of Forensic Nursing, 10(2), 122–134.

Hall, A., McKenna, B., Dearie, V., Maguire, T., Charleston, R., Fumness, T. (2016). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: A pilot study. BMC Nursing, 15(1), 21.

Harris, M., Fallot, R. D. (2001). New directions for mental health services: Using trauma theory to design service systems. Jossey-Bass.

Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: A step towards mental health nurses implementing trauma informed care. Archives of Psychiatric Nursing, 32, 291–296.

Jina, R., Thomas, L. S. (2013). Health consequences of sexual violence against women. Best Practice & Research: Clinical Obstetrics & Gynaecology, 27, 15–26.

Kassam-Adams, N., Rucic, S., Campbell, M., Good, G., Bonifacio, E., Slouf, K., Schneider, S., McKenna, C., Hanson, C. A., Grather, D. (2015). Nurses’ views and current practice of trauma-informed pediatric nursing care. Journal of Pediatric Nursing, 30, 478–484.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. The American Journal of Occupational Therapy, 45(3), 214–222.

La Ronde, S., O’Connor, K. (2020). Trauma-informed nursing improves equity. Journal of Forensic Nursing, 15(4), 195–196.

Li, Y., Cannon, L. M., Coolidge, E. M., Darling-Fisher, C. S., Pardee, M., Kuzma, E. K. (2019). Current state of trauma-informed education in the health sciences: Lessons for nursing. Journal of Nursing Education, 58(2), 93–101. 10.3928/01484834-20190122-06.

Lincoln, Y. S., Guba, E. G., Pilotta, J. J. (1985). Naturalistic inquiry (Vol. 9 pp. 438–439). SAGE Publications.

Maguire, D., Taylor, J. (2020). A systematic review on implementing education and training on trauma-informed care to nurses in forensic mental health settings. Journal of Forensic Nursing, 15(4), 242–249.

McEvedy, S., Maguire, T., Fumness, T., McKenna, B. (2017). Sensory modulation and trauma-informed-care knowledge transfer and translation in mental health services in Victoria: Evaluation of a statewide train-the-trainer intervention. Nurse Education in Practice, 25, 36–42.

Miles, M. B., Huberman, A. M., Saldaña, J. (2014). Qualitative data analysis: A methods sourcebook (3rd ed., pp. 69–104). SAGE Publications.

Moss, K. M., Healy, K. L., Ziviani, J., Newcombe, P., Cobham, V. E., McCutcheon, H., Montague, G., Kenardy, J. (2019). Trauma-informed care in practice: Observed use of psychosocial care practices with children and families in a large pediatric hospital. Psychological Services, 16(1), 16–28. https://doi.org/10.1037/ser0000270

National Sexual Violence Resource Center. (2017). Building cultures of care: A guide for sexual assault services programs. https://www.nsvrc.org/sites/default/files/2017-10/publications_nsvrc_building-cultures-of-care.pdf

Ontario Network of Sexual Assault/Domestic Violence Treatment Centres. (n.d.). Get help: Find a centre near you. Retrieved from https://www.sadtv.treatmentcentres.ca/find-a-centre/

Ontario Network of Sexual Assault/Domestic Violence Treatment Centres [ONSADVTC]. (2017). Vision and mission. Retrieved from https://www.sadtv.treatmentcentres.ca/vision-and-mission.html

Oram, S., Khalifeh, H., Howard, L. M. (2017). Violence against women and mental health. The Lancet Psychiatry, 4(2), 159–170.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

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Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.

Patel, N., Walling, M., Jain, A. (2017). Exploring nurses’ knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510.