

A National Survey of Trauma-Informed Care Practices in Acute Care Rehabilitation

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Abstract

Background: Trauma-informed care (TIC) is increasingly recognized as an essential component of acute care practice; however, little is known about acute care rehabilitation providers' perception of their ability to apply TIC in practice.

Methodology: This cross-sectional descriptive survey study examined acute care rehabilitation providers' self-reported self-efficacy, practice implementation, and perceived barriers related to providing TIC. A modified Trauma-Informed Care Provider Survey, adapted for electronic administration and revised to assess self-efficacy, was distributed to occupational therapists, physical therapists, and speech-language pathologists practicing in inpatient acute care settings across the United States.

Results: 41 rehabilitation providers completed the survey. Respondents reported low rates of self-efficacy in understanding the evidence underlying TIC principles, eliciting trauma-related information without re-traumatization, and assessing patients' emotional needs following trauma. Commonly reported barriers included time constraints, lack of training, fear of re-traumatizing patients, and limited organizational support. Participants also reported minimal preparedness to provide caregiver/family education about trauma.

Discussion: Findings suggest meaningful gaps in TIC preparedness and implementation among acute care rehabilitation providers. Addressing rehabilitation-specific TIC training and organizational support in acute care settings can potentially enhance rehabilitation effectiveness and improve patient outcomes in acute care.

Keywords: trauma-informed care, acute care, rehabilitation, occupational therapy

Introduction and Background

The lifelong impact of trauma is well documented. Trauma refers to events or circumstances experienced as physically or emotionally harmful and can be life-threatening with lasting adverse effects on functioning, health, and well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2026). Traumatic experiences may occur along a continuum, ranging from acute, life-threatening events such as motor vehicle accidents or interpersonal violence to more chronic or situational stressors such as food insecurity or exposure to unsafe living conditions. Whether an event or circumstance is experienced as traumatic is subjective and depends on the individual's perception of threat, loss, and control. Trauma has been associated with long-term physiological and psychological consequences, including chronic disease, sleep disturbance, mental illness, and mortality (Buckley et al., 2024; Chang et al., 2024; Eilers et al., 2023; Gu et al., 2022; Luo et al., 2022; Noteboom et al., 2021). In fact, childhood trauma (e.g., domestic violence, substance use, and physical/emotional abuse) is linked to several leading causes of death in adults (Yu et al., 2022).

Globally, nearly 70-90% of individuals report having experienced at least one traumatic event in their lifetime (Benjet et al., 2015; Olf et al., 2025). Exposure to trauma often begins in early childhood, with an estimated 60% of adults worldwide reporting at least one adverse childhood experience before the age of 18, which may include abuse, neglect, familial and/or household dysfunction (Madigan et al., 2023). Given this prevalence, trauma-informed approaches are relevant across all healthcare settings, particularly in acute care, where hospitalization may result from a traumatic

event or be experienced as traumatic itself (Stillerman et al., 2022). Patients may present with trauma histories such as serious injury or illness, violence, or near-death events, as well as prior distressing healthcare experiences, which may trigger trauma-related stress responses during hospitalization.

For individuals who have experienced a traumatic event, acute care hospitalization may heighten patient vulnerability. Although some individuals experience hospitals as places of safety, others may experience triggering sensory, environmental, or social stimuli associated with prior trauma (Peach et al., 2025). Hospitalization may also be associated with emotional distress, lack of support, and limited communication about their care (Khan et al., 2025). For patients with trauma histories, these experiences may worsen health outcomes, contribute to recurring hospitalizations, or even increase the risk of re-traumatization, thereby highlighting the need for trauma-informed care (Hennessy et al., 2023; Sossenheimer et al., 2018),

Trauma-informed care (TIC) is an approach that guides healthcare interactions and systems toward safer and more responsive care for individuals affected by trauma. TIC is grounded in the 4 R's framework: Realize the widespread impact of trauma, recognize signs and symptoms of trauma, respond to trauma with evidence-based interventions, and resist re-traumatization (SAMHSA, 2026). Within rehabilitation-based healthcare settings, the 4 R's framework is reflected in providers' ability to acknowledge the impact of trauma on patients' health and functioning, adapt communication and treatment styles to promote patients' physical and emotional safety, and identify and actively resist practices that may inadvertently re-traumatize patients by preserving autonomy and minimizing distress (SAMHSA, 2026).

In addition to the 4 R's framework, TIC emphasizes key principles of safety, trust, collaboration, support, empowerment, and humility (SAMHSA, 2026). Together, these principles guide patient-centered practices by promoting emotional safety, establishing therapeutic rapport, and prioritizing responsiveness to trauma-related needs. These principles of TIC are essential for rehabilitation providers, particularly within occupational therapy, physical therapy, and speech-language pathology, as these providers frequently engage in patient-facing interventions that require trust, collaboration, communication, and sensitivity to distress. In occupational therapy, patient care also includes addressing mental health concerns, self-care tasks such as dressing and toileting, and cognitive impairment, all of which may be re-traumatizing for some patients. In acute care settings, patients may be at increased risk of exposure to traumatic experiences. While TIC may benefit patients, rehabilitation providers report limited training in TIC principles, which may impact consistent implementation in clinical practice (Barreca & Wagner, 2024; Bruce et al., 2018; Lamberson et al., 2024).

Self-efficacy, defined as one's belief in their ability to successfully perform a specific task (Bandura, 1977), is an important factor to consider when assessing providers' self-perceived confidence in navigating complex clinical situations. According to Bandura's Social Cognitive Theory, perceived self-efficacy influences an individual's effort, persistence, and choice of action when engaging in certain behaviors, particularly in challenging situations that require sustained effort and adaptation (Bandura, 1977). In healthcare settings, providers who have greater confidence in their ability to apply trauma-informed principles may be better positioned to navigate complex patient scenarios with greater persistence. Given that rehabilitation providers report limited TIC

preparation and education, self-efficacy may also influence how providers perceive their ability to address challenging scenarios or patient needs. Therefore, assessing self-efficacy among acute care rehabilitation providers may provide insight into their perceived confidence and capability to implement TIC principles in practice.

Improving access to clear, discipline-specific TIC training has been shown to strengthen providers' self-efficacy and support more consistent use of trauma-informed approaches (Lamberson et al., 2024). When patients have a safe, supportive environment that encourages healing, the impact of TIC can improve patient outcomes, both physiologically and psychologically (Schroeder et al., 2021). Despite its relevance to practice, TIC remains underutilized in hospitals, and rehabilitation-specific implementation in the adult population is still minimally explored (Sweeney & Taggart, 2018). Therefore, the purpose of this study was to examine acute care rehabilitation providers' perceived self-efficacy, implementation practices, and barriers related to TIC.

Methodology

Study Design

An anonymous cross-sectional descriptive survey was used to collect quantitative data on self-efficacy, perceived barriers, and implementation of TIC into practice. The study received expedited approval by the Rush University Institutional Review Board (ORA#: 25090201-IRB01).

Participants

Inclusion criteria included registered/licensed rehabilitation providers (occupational therapists and occupational therapy assistants, physical therapists and physical therapy assistants, and speech-language pathologists and speech-language

pathology assistants) who provided direct patient care (full or part-time) in an inpatient acute care setting. Providers were eligible for participation regardless of years of clinical experience; therefore, no minimum experience in their respective roles was required. Eligibility was not restricted by age group served; therefore, providers working with pediatric, adult, or mixed-age populations within inpatient acute care settings were eligible to participate. Excluded from the study were non-registered/licensed providers, those practicing in non-acute care settings (e.g., outpatient rehabilitation, inpatient rehabilitation, long-term acute care), and those in non-patient-facing roles.

Measures

The study used an adapted version of the *Trauma-Informed Care Provider Survey – All Patient Version 2.0* (TIC Provider Survey v2.0; Center for Pediatric Traumatic Stress [CPTS], n.d.) with permission from the original developers. The confidence domain was modified to measure self-efficacy. The barriers and practice implementation domains used in the original survey were unchanged. Survey items were selected to assess providers' self-efficacy, practice implementation, and perceived barriers to TIC in acute care settings. The adapted survey was reviewed by providers with acute care experience and a research/data specialist prior to implementation.

The survey included two eligibility questions, six demographic questions, and 28 items across the three TIC domains. Self-efficacy items were rated as limited ability (0), moderate ability (1), or strong ability (2). Barrier items were rated as not a barrier (0), somewhat of a barrier (1), or a significant barrier (2). Implementation items assessed self-reported TIC practices within the past 6 months and were rated as no (0), sometimes (1), or yes (2). Higher scores reflected greater perceived ability, greater

perceived barriers, and more frequent implementation of TIC practices. Although psychometric properties were not established for the modified survey, the original instrument demonstrated acceptable-to-good internal consistency across domains, including self-efficacy ($\alpha = .90$), practice implementation ($\alpha = .83$), and barriers ($\alpha = .70$; CPTS, n.d.).

Data Collection

The survey was administered via Microsoft Forms and was distributed nationally to rehabilitation providers across the United States through professional networks, listservs, email outreach, word of mouth, and local flyer distribution using a QR code. The survey remained open from February 2026 to March 2026 to avoid invalid responses (e.g., survey bots). Participation was voluntary, and survey completion indicated implied consent. Survey responses were collected anonymously, as the survey did not collect names, email addresses, IP addresses, or any other personally identifiable information. Responses were stored in Microsoft Forms, with access restricted to the research team.

Data Analysis

One respondent was screened out for not meeting eligibility criteria and was automatically directed to the end of the survey. All remaining eligible respondents completed the survey in its entirety, as all survey items were required for submission; therefore, no missing data were present, and all eligible responses were included in the final data analysis. Data were analyzed using descriptive statistics in Microsoft Excel. Frequencies and percentages were calculated for demographic and categorical

variables, while averages and standard deviations were calculated for Likert-scale items. Items were grouped into subdomains to support interpretation.

Self-efficacy items were categorized according to the 4 R's framework of TIC (i.e., realizing the impact of trauma, recognizing trauma, responding to trauma, and resisting re-traumatization [SAMHSA, 2026]). Barrier items were categorized into provider-level (emotional or cognitive factors that may impact their provision of TIC), organizational, and knowledge-related barriers. Practice implementation items were organized by the content and intent of survey questions and according to their alignment with the 4 R's of TIC for the purpose of descriptive analysis.

Results

A total of 42 clinicians responded, including one who did not meet the inclusion criteria, leaving the participant count at 41. As the survey was disseminated nationally via snowball sampling, the response rate was not calculated. Participants included rehabilitation providers with varying years of experience, degrees obtained, hospital trauma designations, and geographic regions (see Table 1). The majority of participants identified as occupational therapy practitioners ($n = 27$, 65.85%), practiced in the Midwest ($n = 36$, 87.80%), had 2–4 years of experience ($n = 13$, 31.71%), and worked in a Level I trauma hospital ($n = 24$; 58.24%). Approximately 56% ($n = 23$) of participants reported having already completed or were planning to complete a TIC training, while nearly 44% ($n = 18$) had never completed or were unsure if they had previously completed a training (see Table 1 for additional demographic details).

Table 1*Demographic Information (n = 41)*

<i>Participant Characteristic</i>	<i>n (%)</i>
Professional Discipline	
Occupational Therapy	27 (66)
Physical Therapy	11 (27)
Speech-Language Pathology	3 (7)
Practice Setting (Trauma Level)	
Level I	24 (59)
Level II	12 (29)
Level III	0 (0)
Level IV	1 (2)
Level V	0 (0)
Not applicable / No trauma designation	3 (7)
Unsure	1 (2)
Geographic Region	
Midwest	36 (88)
West	2 (5)
Northeast	1 (2)
Southeast	1 (2)
Southwest	1 (2)
Years of Practice Experience	
0–1 years	3 (7)
2–4 years	13 (32)
5–9 years	5 (12)
10–14 years	8 (20)
15–19 years	6 (15)
20+ years	6 (15)

<i>Participant Characteristic</i>	<i>n (%)</i>
Highest Degree Obtained	
Associate's	2 (5)
Bachelor's	2 (5)
Master's	16 (39)
Clinical Doctorate (e.g., OTD, DPT, SLP-D)	19 (46)
Clinical Science Doctorate (CScD)	1 (2)
Research Doctorate (e.g., PhD, EdD)	1 (2)
TIC Training Experience	
Yes	23 (56)
No	9 (22)
Unsure	9 (22)

Note. OTD = doctor of occupational therapy; DPT = doctor of physical therapy, SLP-D = doctor of Speech-Language Pathology, PhD = doctor of philosophy; EdD = doctor of education.

Self-Efficacy of TIC

Self-efficacy questions were organized according to the TIC framework: Realize (understanding the impact of trauma), Recognize (identifying signs of trauma), Respond (integrating TIC principles), and Resist Re-traumatization (avoiding practices that may re-traumatize patients) (SAMHSA, 2026; see Table 2). Participants reported limited ability related to understanding the evidence/scientific basis of trauma-informed assessment and intervention, while most reported only moderate ability in educating patients on common trauma responses.

Within the Recognize domain, most participants reported limited-to-moderate ability in assessing a patient's emotional needs and support systems following a traumatic event and recognizing how trauma presents across diverse populations. The item participants rated as their strongest ability across all items was responding calmly

and without judgment to a patient's distress. High ability levels were also reported in responding to colleagues' emotional needs and engaging with traumatized patients in ways that promote comfort. However, more specialized trauma-related skills, including providing trauma-focused interventions and responding to questions about death, were more commonly rated as moderate ability. Participants, on average, reported moderate ability eliciting trauma-related details without re-traumatizing patients and modifying potentially traumatic hospital situations/environments (see Table 2).

Overall, participants displayed greater self-efficacy in the Respond and Resist Re-traumatization domains compared to Realize and Recognize, specifically with emotionally supportive interpersonal interactions, compared to completing/providing trauma-specific assessment, education, and interventions.

Table 2

Self-efficacy of TIC Practices (n = 41)

Item	Limited Ability (0) <i>n</i> (%)	Moderate Ability (1) <i>n</i> (%)	Strong Ability (2) <i>n</i> (%)	<i>M</i> (SD)
Domain: Realize				
Understanding the scientific or empirical basis behind assessment and intervention for traumatic stress	8 (43.90)	15 (36.59)	8 (19.51)	0.78 (0.77)
Educating patients about common traumatic stress reactions and symptoms	9 (21.95)	23 (56.10)	9 (21.95)	1.03 (0.66)
Domain: Recognize				
Assessing a patient's distress, emotional needs, and support systems soon after a traumatic event	13 (31.71)	19 (46.34)	9 (21.95)	0.98 (0.80)
Understanding how traumatic stress may present differently in patients of different ages, genders, or cultures	12 (29.27)	18 (43.90)	11 (26.83)	0.98 (0.77)

Item	Limited Ability (0) <i>n</i> (%)	Moderate Ability (1) <i>n</i> (%)	Strong Ability (2) <i>n</i> (%)	<i>M</i> (SD)
Domain: Respond				
Engaging with traumatized patients so they feel comfortable talking to you / comforted by you	3 (7.32)	20 (48.78)	18 (43.90)	1.38 (0.63)
Responding calmly and without judgment to a patient's strong emotional distress	0 (0.00)	18 (43.90)	23 (56.10)	1.58 (0.50)
Responding to a patient's question about whether he/she will die	13 (31.71)	19 (46.34)	9 (21.95)	0.93 (0.73)
Providing basic trauma-focused interventions (assessing symptoms, normalizing, providing anticipatory guidance, coping assistance)	9 (21.95)	19 (46.34)	13 (31.71)	1.13 (0.72)
Responding to colleagues' distress, emotional needs, and need for support	4 (9.76)	16 (39.02)	21 (51.22)	1.43 (0.68)
Managing your own work-related stress or distress	2 (4.88)	21 (51.22)	18 (43.90)	1.40 (0.59)
Domain: Resist				
Eliciting details of a traumatic event from a patient without re-traumatizing them	11 (26.83)	26 (63.41)	4 (9.76)	0.85 (0.58)
Changing or altering situations within the hospital that a patient might experience as traumatic	10 (24.39)	17 (41.46)	14 (34.15)	1.1 (0.78)

Barriers to Implementing TIC

Providers' perceived barriers to implementing TIC are presented in Table 3, categorized by organizational, knowledge-related, and provider-level. Time constraints were the most prominent barrier overall and within the organizational subdomain, and the least frequently reported barrier was providers' own personal stress. A majority of

participants ($n = 25$, 60.98%) reported that lack of organizational support was commonly endorsed as somewhat of a barrier, more so than a significant barrier.

Lack of training was identified as a significant barrier by nearly 22% of participants ($n = 9$) and somewhat of a barrier by over half of participants ($n = 25$). Confusion about TIC was frequently cited as somewhat of a barrier for half of the participants ($n = 21$). Participants expressed divided opinions on whether scope of practice constraints were a barrier to implementing TIC, with 19 individuals (46.34%) reporting they were not a barrier, and 20 individuals (48.78%) indicating they were somewhat of a barrier. Participants identified their worry about upsetting/re-traumatizing patients as somewhat of a barrier to their implementation of TIC, while their level of personal distress was mixed. Half of the participants found it not to be a barrier at all ($n = 21$) compared to those who stated it was somewhat of a barrier ($n = 17$, 41.26%) and those who said it was a significant barrier ($n = 3$, 7.32%; see Table 3).

Table 3*Barriers to TIC Interventions (n = 41)*

Item	Not a Barrier (0) n (%)	Somewhat of a Barrier (1) n (%)	Significant Barrier (2) n (%)	M (SD)
Organizational				
Time constraints	6 (14.63)	20 (48.78)	15 (36.59)	1.23 (0.70)
Lack of organizational support	10 (24.39)	25 (60.98)	6 (14.63)	0.90 (0.63)
Knowledge-related				
Lack of training	7 (17.07)	25 (60.98)	9 (21.95)	1.03 (0.62)
Confusing or unclear information about trauma-informed care	13 (31.71)	21 (51.22)	7 (17.07)	0.85 (0.70)
Scope of practice constraints	19 (46.34)	20 (48.78)	2 (4.88)	0.60 (0.59)
Provider-Level				
Worry about upsetting or re- traumatizing patients	8 (19.51)	25 (60.98)	8 (19.51)	1.00 (0.64)
Level of personal stress/distress	21 (51.22)	17 (41.46)	3 (7.32)	0.58 (0.64)

Implementation Practices

Items were grouped into three categories: family education, support for providers, and coping strategies. Providers implemented the most interventions within the coping strategies subgroup, specifically encouraging patients to leverage their social support systems and teaching patients to manage their pain/anxiety during procedures.

Providers were frequently able to assess and care for their own emotional and physical health and somewhat able to utilize support from their organization for themselves and their team. Family education practices were among the least implemented interventions,

particularly those related to supportive communication following traumatic experiences and recognizing signs that a patient may need additional support (see Table 4).

Table 4

Implementation of TIC Interventions Within the Last Six Months (n = 41)

Implementation Category	No (0) n (%)	Somewhat (1) n (%)	Yes (2) n (%)	M (SD)
Family Education				
Teach family what to say to their family member after a difficult/painful/scary experience	15 (36.59)	17 (41.46)	9 (21.95)	0.88 (0.76)
Provide information to family about emotional or behavioral reactions that indicate their family member may need help	14 (34.15)	16 (39.02)	11 (26.83)	0.97 (0.78)
Ask patients' family members questions to assess their symptoms of distress	7 (17.07)	15 (36.59)	19 (46.34)	1.33 (0.73)
Provider Supports				
Utilize support for yourself/your team available from your organization	5 (12.20)	20 (48.78)	16 (39.02)	1.28 (0.68)
Assess and care for your personal emotional and physical health	2 (4.88)	12 (29.27)	27 (65.85)	1.60 (0.59)
Coping Strategies				
Ask a patient questions to assess his/her symptoms of distress	7 (17.07)	12 (29.27)	22 (53.66)	1.38 (0.77)
Teach a patient specific ways to cope with upsetting experiences	7 (17.07)	13 (31.71)	21 (51.22)	1.38 (0.74)
Teach a patient specific ways to manage pain and anxiety during a procedure	4 (9.76)	12 (29.27)	25 (60.98)	1.53 (0.68)
Encourage patients to make use of their own social support system (family, friends, etc.)	2 (4.88)	8 (19.51)	31 (75.61)	1.70 (0.56)

Discussion

In this study, we examined rehabilitation providers' perceived self-efficacy, implementation practices, and barriers related to TIC in acute care settings. Findings provide insight into current strengths and gaps in hospital-based rehabilitation practice. The authors anticipated that rehabilitation providers would report higher self-efficacy in the interpersonal and adaptive aspects of trauma-informed approaches, due to the inherent holistic and client-centered nature of rehabilitation.

Provider Self-Efficacy in TIC

Supporting this hypothesis, providers demonstrated the highest levels of self-efficacy within the Respond domain of TIC, particularly in responding to patients' and colleagues' emotional distress. However, only half of the participants reported feeling somewhat able to manage their own work-related stress. Although TIC is primarily focused on patient-centered care, provider-level factors such as self-care and organizational support may directly influence consistent implementation of TIC in rehabilitation settings. These factors are considered contextual influences on TIC implementation from a rehabilitation provider perspective. Aligned with these findings, existing literature describes the prevalence of burnout and vicarious trauma among healthcare and human service professionals, which may occur through repeated empathetic engagement with individuals who have experienced trauma (Kim et al., 2022). When providers are unable to effectively care for themselves, their ability to provide patient-centered care may also be impacted.

Previous literature suggests that implementing TIC within healthcare systems may help reduce burnout and vicarious trauma among providers (Elisseou, 2023;

McLean et al., 2023). Successful implementation, however, requires organizational support, leadership engagement, and sufficient time for bedside application (Elisseou, 2023; Goldstein et al., 2024). These organizational constraints were also identified as barriers in the current study and have similarly been reported in prior research (Bruce et al., 2018; Huo et al., 2023; Kassam-Adams et al., 2015).

Barriers to TIC Implementation in Acute Care

Findings from the survey showed several barriers to TIC implementation, including a lack of training, unclear understanding of TIC principles, time constraints, and perceived scope-of-practice limitations. The fast-paced and medically focused nature of acute care environments may further complicate consistent implementation of trauma-informed approaches, particularly those requiring additional time for patient and family education. Collectively, these barriers highlight the importance of education, training, and organizational support to empower providers to implement TIC consistently. Providers also identified their concern about re-traumatizing their patients as somewhat of a barrier to their implementation of TIC, consistent with findings from Barreca and Wager (2024) and Bruce et al. (2018).

These findings may help explain the limited implementation of family education practices identified in this study, as providers may feel less prepared to educate patients and caregivers on trauma-informed concepts when they lack sufficient training or confidence in their understanding of TIC (Bruce et al., 2018). Similar findings have been reported among pediatric occupational and physical therapy providers (Barreca & Wagner, 2024). Given the important role family members play in care coordination and discharge planning in acute care settings, limited implementation of family education

practices may represent a missed opportunity to support trauma-informed recovery beyond hospitalization.

Relationship Between Self-Efficacy and TIC Implementation

Limited knowledge of the evidence supporting trauma-informed interventions may influence both implementation and perceived clinical utility of TIC altogether. Participants demonstrated the lowest levels of self-efficacy within the Realize domain, indicating limited ability to understand the evidence supporting trauma-informed approaches. These gaps in knowledge are further reflected in providers' self-efficacy regarding recognizing the signs and symptoms of trauma.

Participants also demonstrated lower self-efficacy within the Recognize domain, indicating limited ability to identify signs of trauma and understand its impact on functioning and healthcare experiences. These findings are particularly important, as providers may struggle to effectively implement trauma-informed approaches when they are unable to recognize how trauma influences patient behaviors, participation, and rehabilitation outcomes. Without this foundational understanding, trauma-related responses may be misinterpreted, potentially impacting therapeutic rapport, patient engagement, and quality of care (Barreca & Wagner, 2024; Bruce et al., 2018).

Responses to items within the Resist Re-traumatization domain demonstrated inconsistent levels of self-efficacy across participants. Participants reported moderate-to-strong self-efficacy related to modifying situations within the hospital environment that patients may experience as traumatic, but lower self-efficacy when discussing trauma-related experiences without re-traumatizing patients. These findings may reflect previously identified provider concerns and suggest that rehabilitation providers feel

more prepared to adapt care approaches and environments to promote emotional safety than to directly engage in trauma-related discussions with patients, potentially due to concerns of re-traumatizing patients. This distinction may reflect uncertainty regarding how to address trauma sensitively within the rehabilitation process, as well as ongoing uncertainty surrounding rehabilitation providers' perceived role in addressing trauma-related experiences within acute care settings.

Overall, findings suggest that rehabilitation providers are already integrating certain trauma-informed principles into practice intuitively, particularly through coping-focused and provider-focused supports, despite uncertainty surrounding trauma-specific knowledge, education, and implementation processes. Although participants in the study expressed concern about re-traumatizing their patients, they are already using interventions that will help build their patients' resilience and reduce feelings of distress, which are key values of TIC. This pattern suggests that providers may naturally implement certain trauma-informed interventions, such as responding calmly and comforting patients, without fully recognizing why these interventions are trauma-informed or may be suitable for their patients' needs.

Limitations

One limitation of this study is the small sample size, which consisted primarily of occupational therapy practitioners located in the Midwest, limiting generalizability to rehabilitation providers across disciplines and geographic regions within the United States. The use of snowball and convenience sampling may introduce selection bias, as providers with an interest in TIC may have been more likely to participate. Additionally, the study used an adapted version of the Trauma-Informed Care Provider Survey

(CPTS, n.d.), including revised wording, selective item inclusion, and modified response formats, which may have affected the instrument's reliability and validity. Finally, this study examined providers' perspectives and self-reported practices rather than patient outcomes or implementation effectiveness.

Future research should examine strategies to improve TIC training and reduce organizational barriers within larger and more geographically diverse rehabilitation samples, as well as evaluate the impact of TIC on adult rehabilitation outcomes. Additionally, future research should also investigate whether years of clinical experience and the culture of acute care organizations are associated with providers' self-efficacy, implementation, and barriers related to TIC.

Implications for Future Practice

This study identified several opportunities to improve the implementation of TIC into acute care rehabilitation. Some recommendations include:

- Increase access to formal TIC education through annual competencies, departmental trainings, journal clubs, and continuing education focused on trauma recognition, trauma-sensitive communication, family education, and reducing re-traumatization during rehabilitation interventions. Organizations may consider educational initiatives that include case-based discussions, simulated activities, and role-playing exercises that allow providers to practice applying TIC principles to common acute care scenarios.
- Strengthen organizational support for TIC implementation by addressing barriers such as limited training, time constraints, and uncertainty regarding billing and coding for psychosocial interventions. Hospital systems may consider

incorporating TIC education and expectations into new staff onboarding, providing protected time for staff education, developing referral pathways to interdisciplinary team members, and integrating trauma-informed documentation prompts within the electronic medical record to encourage consistent TIC implementation. Rehabilitation providers, particularly occupational therapy practitioners, may already address psychosocial needs within non-psychiatric hospital settings through interventions such as 97535 self-care retraining and 97530 therapeutic activities. These interventions may support coping, emotional regulation, and participation in daily activities impacted by hospitalization, injury, or changes in functional status (see Karr et al., 2024, for guidance on billing mental health-related interventions in non-mental health populations).

- Promote evidence-based TIC implementation strategies already embedded within rehabilitation practice. For example, interventions addressing sleep, coping, emotional regulation, and environmental modification may also support patients experiencing trauma-related distress. Increasing provider awareness of the trauma-informed value of existing rehabilitation interventions may support more intentional integration of TIC principles into patient care. Examples of trauma-informed strategies include asking permission before physical contact when feasible, providing opportunities for patient choice and autonomy during dressing or toileting tasks, and modifying the patient's environment to promote comfort and a sense of safety during their hospitalization.

Conclusion

This study explored acute care rehabilitation providers' perceived self-efficacy, barriers, and implementation of TIC practices. Respondents reported greater self-efficacy in emotionally supportive interpersonal interactions, such as responding calmly to distress and supporting colleagues, compared to their provision of trauma-specific assessment, education, and intervention skills, including assessing emotional needs, understanding the scientific basis of TIC, and eliciting trauma-related details without re-traumatizing patients. Time constraints, lack of training, concerns about re-traumatizing patients, and limited organizational support emerged as the most prominent barriers to TIC implementation. Family education practices were among the least frequently implemented interventions. Overall, findings highlight opportunities for rehabilitation-focused TIC education and organizational support strategies to strengthen trauma-informed rehabilitation practice in acute care settings.

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Appendix

Trauma-Informed Care Provider Survey

1. I provide direct patient care in the inpatient acute setting. (Yes/No)
2. I am a registered/licensed occupational therapist, physical therapist, or speech-language pathologist OR occupational therapy assistant (COTA), physical therapy assistant (PTA), and speech-language pathology assistant (SLPA). (Yes/No)
3. I have previously participated in or am scheduled to complete trauma-informed care training on behalf of my organization. (Yes/No/Unsure)
4. How would you rate your ability to... (Limited ability/Moderate ability/Strong ability)
 - Engage with traumatized patients so that they feel comfortable talking to you/ comforted by you
 - Respond calmly and without judgment to a patient's strong emotional distress
 - Elicit details of a traumatic event from a patient without re-traumatizing them
 - Educate patients about common traumatic stress reactions and symptoms
 - Change or alter situations within the hospital that a patient might experience as traumatic
 - Respond to a patient's question about whether he/she will die
 - Assess a patient's distress, emotional needs, and support systems soon after a traumatic event
 - Provide basic trauma-focused interventions (assess symptoms, normalize, providing anticipatory guidance, coping assistance)
 - Understand how traumatic stress may present itself differently in patients of different ages, gender, or cultures
 - Understand the scientific or empirical basis behind assessment and intervention for traumatic stress
 - Respond to colleagues' distress, emotional needs, and need for support
 - Manage your own work-related stress or distress

5. Please indicate whether any of the following is a barrier for you in providing basic trauma-informed assessment/intervention. (Not a barrier/Somewhat of a barrier /Significant barrier)
- Time constraints
 - Scope of practice constraints
 - Lack of training
 - Confusing or unclear information of trauma-informed care
 - Worry about future upsetting or re- traumatizing patients
 - Lack of organizational support
 - Level of personal stress/distress
6. In the past SIX (6) months, have you personally implemented the following basic trauma-informed interventions? (No/Somewhat/Yes)
- Ask a patient questions to assess his/her symptoms of distress
 - Ask patients' family members questions to assess their symptoms of distress
 - Teach a patient specific ways to manage pain and anxiety during a procedure
 - Teach a patient specific ways to cope with upsetting experiences
 - Encourage patients to make use of their own social support system (family, friends, etc.)
 - Teach family what to say to their family member after a difficult/painful/scary experience
 - Provide information to family about emotional or behavioral reactions that indicate their family member may need help
 - Assess and care for your personal emotional and physical health
 - Utilize support for yourself / your team available from your organization
7. Which rehabilitation discipline do you practice? (Occupational Therapy/Physical Therapy/Speech-Language Pathology)

8. Which level of professional education have you completed? (Associate degree/Bachelor's degree/Master's degree/Clinical doctorate (e.g., OTD, DPT, SLP-D/Research doctorate (e.g., PhD, EdD)/Other)
9. How many years of experience do you have practicing in your current rehabilitation profession? (0-1 year/2-4 years/5-9 years/10-14 year/15-19 years/20+ years)
10. What is the trauma level designation of your primary hospital or clinical site? (Level I Trauma Center/Level II Trauma Center/Level III Trauma Center/Level IV Trauma Center/Level V Trauma Center/Not applicable / My facility does not have a trauma designation/Unsure)
11. Describe the geographical location of your hospital/organization. (Northeast (i.e., ME, NH, VT, MA, RI, CT, NY, NJ, PA)/Southeast (i.e., DE, MD, DC, VA, WV, NC, SC, GA, FL, KY, TN, AL, MS, AR, LA)/Midwest (i.e., OH, MI, IN, IL, WI, MN, IA, MO, ND, SD, NE, KS)/Southwest (i.e., TX, OK, NM, AZ)/West (i.e., CA, OR, WA, NV, UT, CO, WY, MT, ID, AK, HI).