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A Community-Based Trauma-Informed Care Curriculum on Women's Health for Third-Year Medical Students

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Abstract

Introduction: Trauma affects 90% of individuals and has profound impacts on health, making it essential for medical trainees to recognize its effects. Trauma-informed care (TIC) offers a framework for developing these skills. Despite its importance, no TIC curriculum integrates community feedback into its design. To address this gap, we developed a 4-hour TIC curriculum that incorporates community insight, clinical expertise, and practical communication training. **Methods:** The curriculum design followed community-based participatory research principles, engaging community members as contributors. The training included a dynamic combination of didactic lectures, video demonstrations, small-group role-play, and an OSCE, supported by a novel TIC toolkit. Community partners were trained as standardized patients (SPs). We assessed student outcomes through pre- and postsession surveys, employing 5-point Likert scales and open-ended responses. Additionally, a custom assessment tool was developed to evaluate OSCE performance, with SPs providing structured feedback. **Results:** Thirty-four third-year medical students participated, with 100% survey completion. Quantitative analysis revealed significant increases in students' understanding of TIC principles and confidence in applying them from pre- to postsession ($p < .05$ for all metrics). Students demonstrated strong performance on the OSCE, achieving a mean OSCE performance score of 31.4/38 (or overall score of 82.6%). SP feedback highlighted the students' ability to engage empathetically and effectively in trauma-sensitive encounters. **Discussion:** This novel TIC curriculum on women's health demonstrates a successful, scalable model for integrating TIC training into medical education. By embedding community voices and combining evidence-based principles with experiential learning, this program addresses educational gaps in TIC medical education.

Keywords

Communication Skills, Community-Based Health Care, Competency-Based Medical Education, Substance Use Disorders, Trauma-Informed Care, Women's Health, Family Medicine, OB/GYN, Standardized Patient, Community Engagement, Community-Engaged Learning

Educational Objectives

By the end of this activity, learners will be able to:

1. Identify common physical, psychological, and behavioral indicators of trauma exposure.
2. Recognize trauma's prevalence and its impact on women's health outcomes.
3. Use trauma-informed techniques to screen for trauma and obtain a sexual history during the OSCE.
4. Apply trauma-informed communication skills to elicit and respond to trauma disclosures during the OSCE.
5. Employ trauma-informed communication when discussing and reviewing the steps of a physical exam during the OSCE.

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Introduction

Trauma is ubiquitous in the general population, with more than 90% of individuals experiencing at least 1 traumatic event during their lifetime.[1] Although trauma is challenging to characterize, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines it as an event or circumstance leading to lasting mental, physical, emotional, social, or spiritual repercussions.[2] Examples encompass sexual abuse, adverse childhood experiences, neglect, war, pandemics, health care system interactions, and historical injustices like ableism, racism, and sexism. Trauma can impact health outcomes, medical service use, and patient–provider relationships.[3-5] Thus, taking care of patients who experience trauma requires a comprehensive, patient-centered approach to medicine.

Trauma-informed care (TIC) is a patient-centered framework focusing on realizing trauma, recognizing signs, responding empathetically, and resisting retraumatization. Studies show that fewer than one-quarter of providers feel comfortable screening for trauma histories.[6] Notably, existing research underscores the significant impact of untreated trauma on women's health, leading to various adverse outcomes such as eating disorders, substance use disorders, and chronic pelvic pain.[7,8] In the perinatal context, trauma history elevates risks of mental health disorders, high blood pressure, preterm birth, and posttraumatic stress disorder.[9] These outcomes reinforce the American College of Obstetricians and Gynecology recommendation to incorporate TIC into women's health, emphasizing the need for more training in this domain.[10]

Several published TIC curricula focus on women's health and prevalent trauma issues such as intimate partner violence and sexual assault, though most are designed for resident or attending physicians.[11-17] Medical educators have identified the need to teach and assess TIC skills early on in undergraduate medical education (UME). When we initiated this work in early 2020 with grant funding from the Association of Professors of Gynecology and Obstetrics and subsequently developed and implemented the curriculum between 2021 and 2022, very few TIC curricula were available for UME. At that time, *MedEdPORTAL* included early innovations focused primarily on first-year medical students and introductory skills such as communication and physical examination skills.[18,19] Even among recent studies, few UME curricular developments focus on women's health, and to our knowledge none have incorporated community-based research principles.

Since the implementation of our curriculum, literature on TIC in medical education has expanded substantially. Notably, the 2023 *Academic Medicine* Roadmap for Trauma-informed Medical Education calls for the meaningful inclusion of patient and community voices across all levels of training.[20] In addition, the publication of validated TIC competencies for UME reflects the increasing need for structured and developmentally appropriate approaches to teaching these skills. Here we present a curriculum that was developed during a time of rapid evolution of TIC and is very closely aligned with these principles. This curriculum fills an important gap by translating key competencies into a women's health context and integrates community partnerships as a core component of curricular design. Creative approaches to teaching TIC are needed, not only to prepare students to apply versatile skills but also to address systemic issues that may reinforce or perpetuate trauma.

We developed a novel 4-hour TIC session focused on women's health that incorporates intimate-partner violence screening and a community-based participatory research (CBPR) model.[21] CBPR is a framework for collaborative research that engages community members and applies their knowledge to project efforts. At the root of this approach is the critical need to better address health disparities and the systemic issues surrounding them. For our TIC session, we trained community members with either lived trauma experience or TIC expertise as standardized patients (SPs) for an OSCE activity designed to mirror a real patient encounter. We collaborated closely with these community members to incorporate their feedback into the curriculum. Additionally, we integrated this session into a longitudinal health systems science curriculum that teaches the science of health care delivery and spans 4 years of medical school at the Virginia Tech Carilion School of Medicine.

Our extensive TIC session for third-year medical students integrates a didactic lecture, TIC simulation videos, small-group discussions, a role-play case, a station demonstrating trauma-informed physical exam skills, and an OSCE with scoring of student performance using a TIC grading rubric. The curriculum draws from an existing training method described by Elisseou and colleagues focused on teaching adaptable skills.[18] To our knowledge, this is the first TIC curriculum to use CBPR, and is one of only a few TIC programs in women's health that incorporates several modalities of teaching.[22-25]

Methods

Curriculum Development

The TIC session spanned 4 hours and employed various modalities, including prework, a didactic lecture, a small-group role-play, a skills demonstration, and an OSCE activity involving SPs. The design drew from adult learning theory and experiential education to integrate cognitive knowledge with communication and reflective skills. A full profile of the design, or run of show, for reproduction at other institutions is provided in the facilitator guide (Appendix A).

The TIC curriculum was developed using the CBPR methodology, a framework that centers community members as partners in designing, implementing, and evaluating educational initiatives.[21] Local individuals from the Trauma-Informed Care Network (TICN) were sent invitations to participate.[26] We also contacted TIC-trained colleagues and several patients with trauma histories who had previously engaged in UME. Interested community members included several peer recovery specialists, trauma-informed professionals, and individuals with lived experience. They

collaborated with the curriculum team to shape the educational objectives, case content, OSCE design, and patient-centered communication language. Through interviews and co-design meetings, the group helped identify best practices for screening, responding to disclosure, avoiding retriggering of trauma, and supporting patient autonomy in shared decision-making. Their insights and experiences shaped the TIC toolkit (Appendix B), OB/GYN videos (Appendices C and D), and the OSCE case scripts (Appendix E). The OSCE grading group was created by the main design team based on a literature review and community interviews. The finalized grading rubric was reviewed by local experts in the TICN. A full list of the resources developed for the curriculum, including pre- and postsession surveys for data collection, is provided in Appendices F and G.

To keep students engaged, we created innovative training videos demonstrating both the need for TIC and how to implement specific skills (Appendices C and D). The curriculum team originally planned to produce 1 video modeling basic TIC communication, but community partners emphasized the importance of also showing harmful clinical interactions to help students recognize re-traumatization. As a result, these videos highlight techniques to avoid or apply when responding to trauma in clinical settings. The videos also demonstrate skills from SAMHSA's guide on implementing TIC principles, many of which have been recognized as core TIC practices for over a decade.[27,28] Videos were written, filmed, and edited by an attending facilitator and a medical student with support from residents, attending physicians, and community members.

Standardized Patient Preparation

Two training sessions were held to prepare the 13 community members who were recruited to serve as SPs. Training began with an SP PowerPoint orientation (Appendix H) and a review of the TIC toolkit (Appendix B). A character development guide was created to help SPs authentically portray a patient with a trauma history. This resource (Appendix E) detailed the patient's background, affect, triggers, and communication style to support a consistent and realistic portrayal during the OSCE encounter. Throughout the process, SPs were invited to provide feedback on case language, realism, and the accuracy of the trauma-screening questions. Recommendations were incorporated into the curriculum prior to the session day.

Session Components

The session's schedule was as follows:

- 75 minutes: Introduction, presession survey, TIC lecture, facilitator reflections, and OB/GYN videos
- 10 minutes: Break
- 45 minutes: Small-group role-play cases
- 90 minutes: OSCE with community SPs, pelvic exams, and application of the TIC toolkit
- 30 minutes: Debrief, closing, and postsession survey

Student prework: Before the session, students reviewed the TIC toolkit (Appendix B) covering definitions, communication strategies, physical exam techniques, and referral sources. Recognizing the sensitive nature of this content, students were offered an opt-out option and access to counseling resources.

Surveys: To comply with institutional review board requirements, all surveys were optional and anonymous. Students completed a presession survey (Appendix F) to assess baseline knowledge of TIC. Each student received an envelope with an animal image and corresponding number to allow for anonymous matching of the pre- and postsession surveys. To gauge familiarity with the concept, students were asked in both the pre- and postsession survey to define TIC. The session concluded with a postsession survey (Appendix G) in which students assessed changes in their knowledge, comfort, and trauma-informed awareness.

Didactic lecture and videos: The session began with a 60-minute lecture introducing trauma prevalence, core TIC principles, and practical frameworks for screening and communication (Appendix I). This portion emphasized building trauma awareness and sensitivity. Students learned person-first language, framing techniques, and the use of an adapted HITS (Hurt, Insult, Threaten, Scream) tool for intimate-partner violence screening.[29,30] The lecture concluded with an overview of practical approaches to incorporating TIC into practice, followed by the 2 short videos (Appendices C and D). Before transitioning to the next section, the facilitator reviewed the OSCE format and the associated grading rubric (Appendix J) with the students.

Small-group role-play: Students were then divided into small groups of 8–10 learners to discuss 2 cases designed to build foundational skills in trauma-informed communication (Appendix K). Faculty and several of the identified community members facilitated the session, modeling language and offering real-time feedback. This structure allowed students to practice communication strategies and screening techniques in a psychologically safe environment. Case 1 focused on a gynecology visit for sexual dysfunction, with the main objectives of practicing taking a trauma-informed sexual history as well as utilizing the adapted HITS tool and the adapted Centers for Disease Control and Prevention 5 Ps (Partners, Practices, Protection from Sexually Transmitted Infections [STIs], Past

History of STIs, and Pregnancy Intention) framework.[30] Case 2 described an obstetric patient during labor and delivery, emphasizing how to practice a continuous consent and person-first communication.

OSCE: Students rotated in groups of 10 through the OSCE suites. Each encounter began with a 5-minute review of the door note (Appendix L). Students were then given 15 minutes to complete the OSCE. When the time ended, a bell signaled the students to exit the room. SPs had 5 minutes to complete the OSCE grading rubric (Appendix J) and structured feedback form (Appendix M). Students were given their OSCE scores and structured feedback form within 2 weeks of session completion.

Wrap-up and debrief: The session concluded with a facilitated debrief and students' completion of the postsession survey (Appendix G), which mirrored the presession survey. Any remaining student questions were answered. Students were also given the opportunity to share reflections on the session day.

Evaluation and Data Analysis

To ensure rater reliability, each student's OSCE video was independently reviewed by 1 SP and at least 3 faculty members, and the final grade for the encounter was calculated as the mean of all scores. Paired pre- and postsession survey responses, collected using 5-point Likert scales, were analyzed using Wilcoxon signed-rank tests. Descriptive statistics were used for student feedback. The 3 faculty members used inductive coding to extract themes from qualitative survey responses. Data were analyzed using SAS for Windows statistical software (version 8.3.7.202; SAS 2019–2020).

Results

TIC Value and OSCE Results

A total of 34 third-year Virginia Tech Carilion School of Medicine medical students participated in the TIC session day, with both the optional presession survey and postsession survey achieving a 100% completion rate (Appendices F and G). Of the 34 students, only 2 (5.9%) claimed to be very familiar or extremely familiar with TIC presession.

The survey contained 4 questions assessing students' perception of the importance of TIC in both clinical care and medical education. A Bonferroni correction was applied to control for multiple comparisons (adjusted significance threshold $\alpha = .0125$). Responses from the pre- and postsession surveys to all 4 questions on perceived importance of TIC indicated that the students believed in the importance of trauma-informed skills both before and after the TIC intervention ($p > .05$ for each item; Table 1).

Table 1. Participant Ratings of the Trauma-Informed Care Curriculum on Pre- and Postsession Surveys ($N = 34$)

Survey Questions	Presession *M* (IQR)	Postsession *M* (IQR)	*p*[a]
Perceived Importance[b]			
Incorporating a trauma-informed approach into medical education is a critical component of medical education.	5 (4-5)	5 (5-5)	.7266
Trauma-informed approaches to patient care improve patient satisfaction.	5 (5-5)	5 (4-5)	1.0000
Trauma-informed approaches to patient care improve patient outcomes.	5 (5-5)	5 (4-5)	.5000
A trauma-informed approach to the physical exam improves care for patients who have a history of trauma.	5 (5-5)	5 (5-5)	1.0000
Comfort[c]			
How comfortable do you feel explaining to a colleague the key components of a physical exam that is sensitive to patients who have experienced trauma?	2 (2-3)	4 (3-4)	<.0001*
How comfortable do you feel explaining to a colleague what kind of language and phrasing to use during a physical exam that is sensitive to patients who have experienced trauma?	2 (2-3)	4 (3-4)	<.0001*
Frequency[d]			
How often do you think about a trauma-informed approach when meeting a patient for the first time?	3 (2-4)	4 (3-4)	.0027*
How often do you use trauma-informed maneuvers during the physical exam portion of the patient interaction?	2.5 (2-4)	3 (3-4)	.0002*
How often do you use trauma-informed language with patient interactions?	3 (2-3)	3 (3-4)	<.0001*
Confidence[e]			
How confident do you feel in your ability to use a trauma-informed approach when eliciting a sexual history?	2 (2-3)	4 (3-4)	<.0001*
How confident do you feel in your ability to create a safe and comfortable environment during the physical exam that is sensitive to the needs of patients who may have experienced trauma?	3 (2-4)	4 (4-5)	<.0001*
How confident do you feel using draping techniques that may help patients who have experienced trauma feel more comfortable?	3 (2-3)	4 (4-5)	<.0001*
How confident do you feel using maneuvers during the physical exam that may help patients who have experienced trauma feel more comfortable?	2 (2-3)	4 (3-4)	<.0001*

[a] Asterisk indicates significant change from pre- to postsession.
[b] Rated on a 5-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*).
[c] Rated on a 5-point Likert scale (1 = *not at all*, 5 = *extremely*).
[d] Rated on a 5-point Likert scale (1 = *never*, 5 = *always*).
[e] Rated on a 5-point Likert scale (1 = *not at all confident*, 5 = *extremely confident*).

In addition, we evaluated students' comfort in practicing trauma-informed principles, and confidence in their TIC skills, using 9 questions on the pre- and postsession surveys (Table 1). A Bonferroni correction was applied to control for multiple comparisons across these 9 items (adjusted significance threshold $\alpha = .0056$). Each of the 9 questions revealed a significant increase in students' knowledge, comfort, and confidence in performing TIC skills ($p < .05$ for each item).

Overall, student OSCE performance scores (of a possible score range of 0–38) were 28 or higher ($M = 31.4$ [$SD = 1.8$]; Figure 1).

Session Effectiveness

According to the survey, 78.0% of the students indicated that the overall session was effective, based on the percentage of students who rated it as very good or excellent for each item (Figure 2). When asked about specific components of the curriculum, 30 students (88.2%) felt the content was very good or excellent in defining TIC and in gaining a better understanding of how to elicit a sexual history. Additionally, 28 students (82.4%) felt the presentation was very good or excellent and effective in learning trauma-informed language. Furthermore, 26 students (76.5%) believed the OSCE with community members as SPs was very good or excellent in its ability to teach trauma-informed skills.

Qualitative Feedback

Approximately 94% of students reported plans to incorporate TIC into their future practice, even in non-OB/GYN fields such as dermatology. Students offered thoughtful responses defining TIC, emphasizing themes such as the prevalence of trauma, creating a safe environment, and using sensitive language and physical exam techniques (Table 2). Challenges in treating patients with trauma and incorporating TIC were also identified, including building trust, avoiding triggering language, managing time constraints, and coping with personal trauma histories.

Students identified strengths and opportunities for improvement, emphasizing the community SPs, videos, and presentations as highlights. Clinical pearls from the training included continuous consent practice, trauma prevalence statistics, and patient nonverbal cues. Students expressed a desire for feedback from SPs after the OSCE sessions, and discussions on TIC application in other specialties.

Discussion

Developed with robust community involvement and a focus on women's health, this curriculum provides third-year medical students with effective training in trauma-informed communication, supported by a multimodal learning structure and an OSCE to assess applied skills. Grounded in CBPR methodology, the curriculum incorporates perspectives of individuals with lived trauma experience. By combining didactic

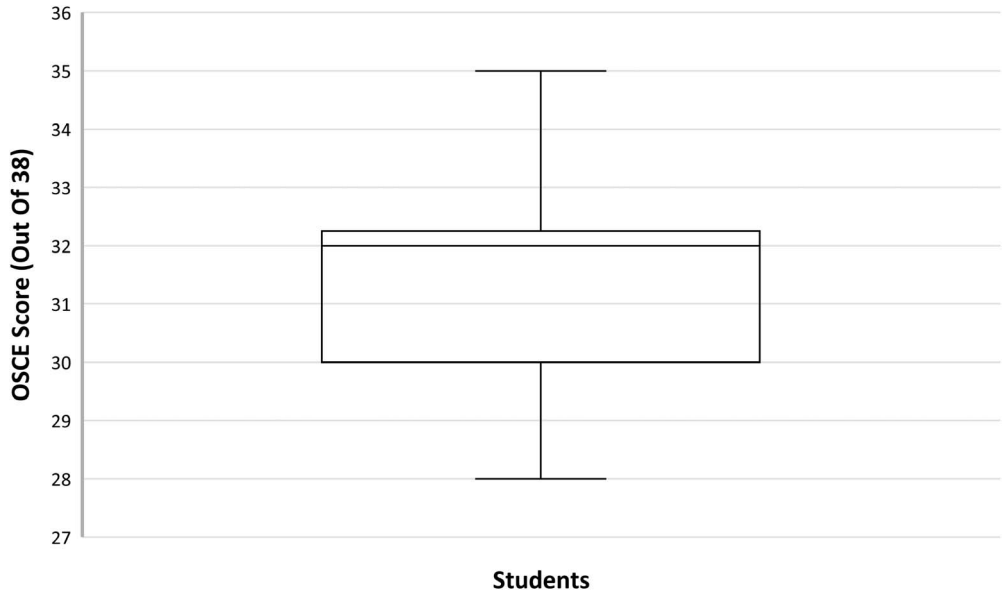

Figure 1. Distribution of OSCE performance scores among trauma-informed care session participants ($N = 34$). The grading rubric had a minimum possible score of 0 and a maximum of 38. Students achieved a M (SD) score of 31.4 (1.8), with a minimum of 28 and maximum of 35.

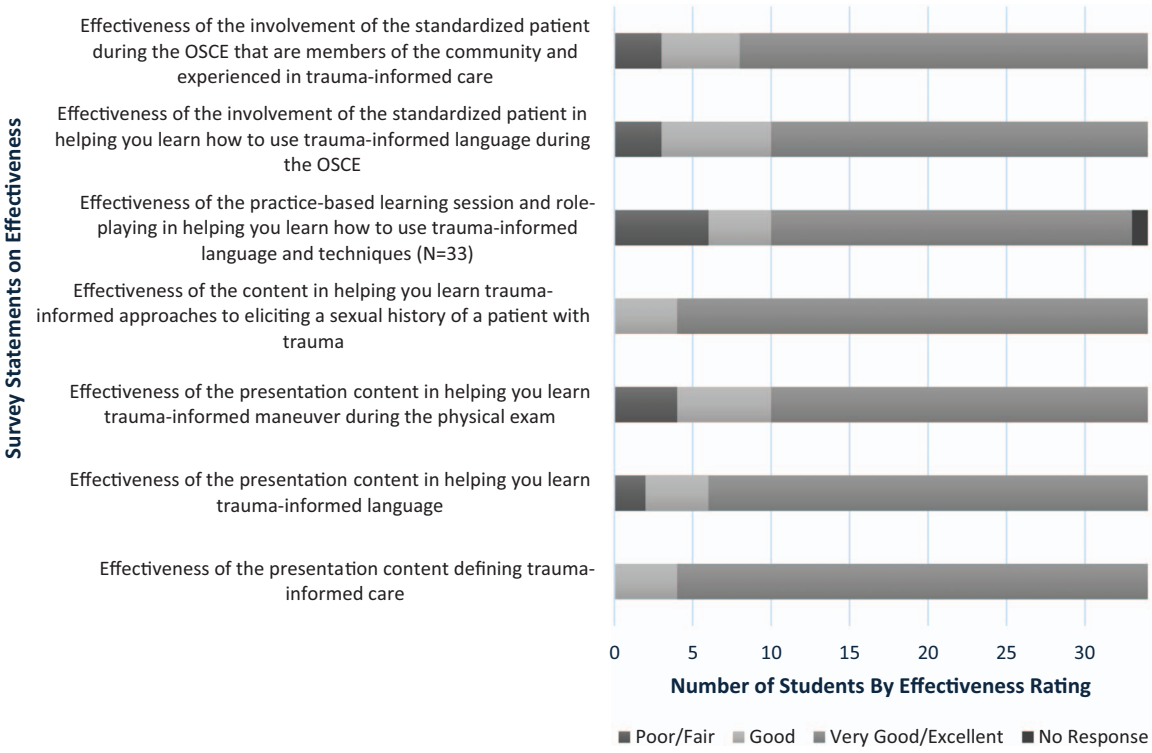

Figure 2. Effectiveness of the trauma-informed care curriculum rated by session participants ($N = 34$). Scores are on a 5-point Likert scale (1 = *poor*, 5 = *excellent*).

teaching, simulation videos, role-play, and an OSCE, this curriculum equips learners with practical, adaptable skills fundamental to TIC.

Findings and Limitations

Student self-assessments demonstrated increased comfort and perceived competency after completing the expansive curriculum. OSCE performance scores were similarly high, suggesting that learners were able to apply core TIC behaviors during the simulated encounter. However, several limitations apply to this curriculum. The training has undergone multiple refinements over the subsequent 2 years. Since no preassessment of TIC skills was conducted, OSCE scores must be interpreted independently and cannot be used to infer growth

Table 2. Participant Qualitative Responses Regarding Aspects of the TIC Curriculum ($N = 34$)

Survey	Survey Topic	Common Themes	Response Examples
Presession	Definition of TIC	Mindful of patient's lived experiences when caring for them	"Practices that take into account the trauma that our patients may have experienced and includes interactions/maneuvers that help make patients feel as safe and comfortable as possible."
	Plans for use in future practice	Universal application of TIC to all patients	"I believe many patients have trauma that we may not be aware of, so using a more trauma focused approach in general would be beneficial to overall practice."
	Common challenges	Building trust	"It is hard to establish trust in just minutes of time. Patients may not want to talk about their trauma. We may not have time or resources to adequately handle disclosures."
Postsession	Definition of TIC	Creating a safe space for patients	"Creating a space of respect for the patient to engaged with the healthcare system on their terms based on their experiences using appropriate language and actions."
	Strengths of session day	Hands-on learning with SPs	"Being able to practice with a SP."
	Clinical pearl	Continuous consent	"The practice of continual consent. Mistakes will happen and it is most important that you keep trying and learning. This helped me being confident in my abilities to implement these practices."
	Suggestions for future iterations	Individualized feedback from SPs	"Feedback directly from the SPs would be helpful."

Abbreviations: SPs, standardized patients; TIC, trauma-informed care.

in observable behaviors. Additionally, the OSCE served as a formative experience during the pilot year; beginning in 2025, a revised and validated rubric has been incorporated into the summative clerkship grade. Finally, although the involvement of community members was a major strength of the initiative, it may limit generalizability for institutions without similar partnerships. Notably, since the pilot year, we have successfully trained dozens of SPs without lived-experience backgrounds, and we believe that other institutions can similarly adapt our curriculum to broaden their SP pool while maintaining the fidelity of TIC instruction.

Student Feedback and Curriculum Evolution

Learners valued the curriculum and expressed a desire for more immediate feedback from SPs following OSCE encounters. During this pilot year, students received written feedback from SP evaluation forms (Appendix M). In later iterations, we extended the OSCE time and incorporated a brief real-time debrief between learners and SPs. Students appreciated this adjustment, noting that timely, behavior-specific guidance enhanced retention and confidence. Both learners and SPs require trauma-informed protections. We incorporated opt-out mechanisms for students, content warnings, and available on-site counseling. These features were essential, particularly during role-play of sexual histories, which students identified as anxiety-provoking.

Generalizability Across Institutional Contexts and Specialties

Although this curriculum was created in the context of women's health, the core trauma-informed skills it teaches are relevant to many fields. Skills such as framing sensitive questions, checking in for consent, being aware of power dynamics, and supporting patient autonomy translate well across the fields of internal medicine, pediatrics, psychiatry, and emergency medicine. Programs can adapt the cases and OSCE checklist to fit their own clinical needs. For settings with limited time, individual components of the curriculum, such as the toolkit, role-play activity, or SP feedback form, can be used independently. While our study focused on third-year medical students, TIC skills are equally important for residents and attending physicians. The OSCE grading rubric could easily be adapted to evaluate residents in a simulated encounter. At our institution, the OSCE now counts toward the clerkship grade, and residents participate in TIC-focused simulations to reinforce TIC concepts and enhance their own teaching skills. These experiences show that the curriculum can grow with learners and be applied across stages of training.

Future Directions

There remains a need for validated, standardized approaches to TIC training and assessment in UME and GME. We have since developed a 4-year longitudinal TIC framework that is now in its implementation phase at our institution. Validation of the revised TIC rubric will facilitate accurate measurement of learner performance and enable multicenter comparison. Our curriculum design begins with trauma awareness (preclinical years), advances to trauma sensitivity (early clinical phase), and culminates in trauma-responsive communication (advanced clinical training). We have created a corresponding TIC Arc logic model to guide this developmental trajectory, with various teaching methods and assessment tools expanding with a growing curriculum. Finally, further research should explore the impact of TIC curricula on patient outcomes, health care utilization, and learner well-being.

Appendices

A. Facilitator Guide.docx
B. TIC Toolkit.docx
C. Obstetric Video.mp4
D. Gynecology Video.mp4
E. OSCE Case Script.docx
F. Presurvey.docx
G. Postsurvey.docx
H. SP Orientation.pptx
I. Didactic Lecture.pptx
J. OSCE Grading Rubric.docx
K. Small-Group Role-Play.docx
L. Door Note.docx
M. Feedback Form.docx

All appendices are peer reviewed as integral parts of the Original Publication.

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Prior Presentations
Nunziato J, Simcox K, Lessard C, Karp N. T.I.M.E. for change: trauma-informed medical education during Objective Structured Clinical Examination (OSCE). Presented at: 2024 APGO & CREOG Annual Meeting; March 1, 2024; San Antonio, TX.

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Ethical Approval
The Carilion Clinic Institutional Review Board reviewed this project.

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