Application No. 935/24

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**Trauma matters: Development of trauma informed care framework for allied health professionals working with children and youth**

**Research Program**

Allied health professionals (occupational therapists, physiotherapists, speech therapists, and dietitians) regularly encounter children and youth in their clinical practice, providing treatment and supporting their development. Despite the high prevalence of trauma among this population, allied health professionals may not recognize the behaviors traumatized children and youth exhibit as connected to trauma because they are unfamiliar with this subject. Thus, there is an urgent need to equip allied health professionals with the knowledge and skills to implement trauma-informed care (TIC) principles in their work, ensuring they can provide appropriate, sensitive, and effective care to traumatized children and youth. This study aims to provide a TIC framework that will serve as a basis for broader TIC implementation among allied health professionals working with children and youth. A mixed-methods sequential explanatory design (qualitative followed by quantitative) will be used to identify and deeply understand the associations between knowledge, attitudes, and the implementation of TIC among allied health professionals who work with children and youth aged 0 to 18 years and the impact of emotional and organizational factors on these associations.

**Scientific Background**

According to the Ministry of Welfare, the Israel National Council for the Child, and the Haruv Institute data, approximately 340,000 children aged 0 to 18 years in Israel are at risk to experience a traumatic event. Based on the same data collected between 2017 and 2022, every fifth child in Israel suffers abuse and neglect (The Israel National Council for the Child, 2023). The ongoing challenges of the COVID-19 pandemic and regional conflicts have only exacerbated the psychological burden on children and youth. A *trauma* is an event, series of events, or circumstances that are experienced as emotionally or physically harmful and have an enduring impact on someone mentally, emotionally, physically, socially, and/or spiritually and neurobiologically (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). When trauma occurs during childhood or adolescence—critical periods for development—it can disrupt the normal trajectory of growth and maturation, leading to profound and long-lasting impacts across various domains of functioning.

*Adverse childhood experiences* (ACEs) include all early traumatic events that occur under the age of 18 years and could have lasting negative effects on a person’s health and well-being (Felitti et al., 2019). They include maltreatment (neglect or physical, emotional, or sexual abuse) and household dysfunction (parental separation, domestic violence, mental illness, substance abuse, and incarceration; Boullier & Blair, 2018; Gilbert et al., 2009). Studies have shown that ACEs and other traumatic experiences can negatively affect children's and adolescents' development and well-being, including their physical, emotional, cognitive, and social capabilities (Balistreri, 2015; Wade et al., 2018; Webster, 2022). The children and youth may face motor, sensory, language, and cognitive difficulties, behavioral issues, physical illnesses requiring medical care, and other problems, such as with sleep and appetite (Balistreri, 2015; Balistreri & Alvira-Hammond, 2016; Cronholm et al., 2015; Kan et al., 2020; Lanier et al., 2018; Wade et al., 2018; Walker et al., 2011; Webster, 2022). Healthcare professionals, specifically allied health professionals (e.g., occupational therapists, speech therapists, nutritionists, and physical therapists), can treat these children and youth according to the individual consequences these experiences leave behind (Gerber, 2019; Goddard, 2021; Layne et al., 2014; Qu et al., 2023; Webster, 2022).

The wide-ranging effects of early adversity and trauma, together with the understanding that professionals’ responses influence the long-term impact of traumatic events, have led to the development of a trauma-informed approach to care (Gerber, 2019; Matthew et al., 2022; Wilson et al., 2013). A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture (SAMHSA, 2014). This approach acknowledges that health care organizations and care teams need a complete picture of a patient’s life situation— past and present—to provide effective health care services with a healing orientation. Adopting trauma-informed practices can potentially improve patient outcomes and increase staff satisfaction (National Council on Behavioral Health, 2019; SAMHSA, 2014).

Trauma-informed care (TIC) is a framework to minimize the effects of trauma by addressing distress and offering emotional support to facilitate resilience and recovery (Marsac et al., 2016; Wilson et al., 2013). It involves creating a safe, supportive environment that empowers individuals to engage in their own healing process rather than retraumatizing them (Holmes et al., 2023) and emphasizes the importance of understanding the patient's experience and how it led to a physical or psychological effect (Gerber, 2019; Matthew et al., 2022). Trauma-informed care uses a strengths-based approach to promote resilience and recovery (Holmes et al., 2023). It aims to minimize the potential for the medical care itself to trigger trauma reactions (Marsac et al., 2016). According to SAMHSA (2014), the six key principles fundamental to a trauma-informed approach include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

While TIC has gained significant recognition in recent years, research remains primarily focused on establishing foundational principles and demonstrating the effectiveness of trauma-informed approaches in various settings, such as mental health, education, and social services (Marsac et al., 2016; Holmes et al., 2023). Studies have increasingly shown that TIC can enhance patient outcomes, reduce retraumatization, and support healing across diverse populations (Gerber, 2019; Matthew et al., 2022). However, despite these promising findings, there is still limited empirical research on the specific application of TIC principles within allied health professions, especially in child and youth services (Steen et al., 2022). Current models often lack comprehensive integration of TIC principles in clinical practice, particularly in non-mental health fields. Moreover, TIC is usually not part of the basic training of allied health professionals, thus most of them do not perceive the behaviors of traumatized children and youth as obviously connected to trauma. By providing appropriate TIC, children and youth who have experienced trauma will have the opportunity to thrive and reach their developmental potential, enabling them to actively and productively participate in the community.

Trauma informed care not only provides a framework for addressing the needs of traumatized children and youth, but also establishes best practices for protecting therapists from the consequences of exposure to trauma. It has become increasingly clear that the adverse sequelae of trauma exposure may extend beyond survivors or perpetrators (Gottfried & Bride, 2018). This indirect trauma may affect medical professionals and health care providers who care for traumatized children and youth, known as secondary traumatic stress (STS) or compassion fatigue (Gottfried & Bride, 2018; Jee et al., 2020; Newell et al., 2016). *Secondary traumatic stress* consists of behavior and emotions arising from the desire to help a person experiencing a traumatic event. It is defined as indirect exposure to trauma due to a professional relationship with individuals who experience a traumatic event (American Psychiatric Association, 2013; Bride et al., 2004; Figley et al., 1999).

Many studies point to the contribution of health professionals’ emotional characteristics to their ability to handle STS. Some suggested that *resilience*, the ability to adapt in the face of tragedy, trauma, adversity, hardship, and ongoing significant life stressors (Newman, 2005), may prevent STS (e.g., Harker et al., 2016; Ludick & Figley, 2017). Others indicated that *self-compassion*, the ability for self-acceptance, kindness, and self-understanding during times of suffering, failure, or personal inadequacy (Neff, 2003), might effectively mitigate STS (e.g., Rushforth et al., 2023; Yazıcı & Özdemir, 2023). Finally, *empathy*, the ability to understand and share the emotional experiences of those who directly experienced trauma (Gibbons, 2011), was presented as a key feature in reducing STS among health professionals, indicating that education on good empathy skills might assist as a protective factor against STS (Ludick & Figley, 2017; Ogińska-Bulik et al., 2023).

Organizational and environmental factors also play a critical role in shaping the effectiveness of healthcare delivery, particularly in the context of TIC. Successful implementation of TIC requires not only individual knowledge and attitudes but also supportive organizational structures, including leadership commitment, adequate resources, and a culture that prioritizes trauma-sensitive practices (Bowen & Murshid, 2016; SAMHSA, 2014). Furthermore, a supportive work environment that fosters continuous learning and provides opportunities for professional development has been shown to enhance the ability of allied health professionals to recognize and respond to trauma (Green, 2015; Mancini & Marek, 2004). Despite these insights, there remains a significant gap in understanding the specific organizational factors that most influence TIC adoption.

In conclusion, further research is needed to develop and evaluate a framework that systematically integrates TIC into allied health interventions, addressing the unique needs of traumatized children and youth. This framework should also focus on mitigating STS by addressing emotional factors. Additionally, it should facilitate the acquisition and implementation of TIC across diverse healthcare settings while providing comprehensive support for allied health professionals.

**Research Objectives**

The primary aim of this study is to develop and evaluate a TIC framework designed for allied health professionals working with children and youth aged 0 to 18. This framework will aim to integrate TIC into interventions addressing the unique needs of traumatized children and youth. A key component of the framework will involve addressing emotional factors of allied health professionals alongside organizational aspects, that influence the successful acquisition and implementation of TIC across diverse settings.

The proposed research will be conducted in three phases:

***Phase 1 - Qualitative study.*** This phase will deepen the understanding of the preliminary results from the initial survey done by the researchers of the current study (Ghanem et al., under review), and identify the facilitators and barriers to the acquisition and implementation of TIC among allied health professionals.

***Phase 2 - Quantitative study.*** This phase will include cross-sectional survey to assess identified factors that are related to TIC acquisition and implementation. Final study variables will be determined based on the findings from Phase 1.

***Phase 3 – TIC framework development and formative evaluation.*** This phase will include the development of TIC framework for allied health professionals working with children and youth, as a basis for future trauma informed practice. Following that, a formative evaluation will be conducted.

**Expected Significance**

This study holds significant potential to enhance TIC practices among allied health professionals working with children and youth in primary healthcare, hospitals, community services, and educational settings. Currently, there is a clear theoretical and practical gap in the clinical field: while the importance of TIC is widely acknowledged, there is a lack of a theoretical framework and tools to support its implementation (see preliminary results section). This gap leaves professionals unable to fully respond to the complex needs of traumatized children and youth. Failing to address this need not only compromises the quality of care but may also create a sense of helplessness among allied health professionals, as they are aware of the need but lack the resources to address it effectively. By developing a comprehensive TIC framework, this research will improve the ability of allied health professionals to identify and address trauma, leading to more effective care and better outcomes for traumatized children and youth. The anticipated impact of the current research will include improved training and support for allied health professionals that will lead to better long-term outcomes for children and youth. Moreover, given their ethical commitment to provide adequate support to children and youth in various contexts, it is crucial to equip these professionals with the necessary skills and strategies to meet these needs. Additionally, by addressing STS and providing coping strategies, the framework will help mitigate the emotional toll on allied health professionals. Finally, this research will drive organizational change by embedding TIC into the everyday practices of the healthcare system. By reducing trauma-related complications and addressing provider burnout, the framework will contribute to long-term cost savings and efficiency, ultimately strengthening the overall healthcare system.

**Detailed Description of the Proposed Research**

**Working Hypotheses**

***Phase 1 - Qualitative phase:***

1. Factors that facilitate or barrier the acquisition and implementation of TIC will be identified and will serve as a basis for developing a TIC framework for allied health professionals working with children and youth.

***Phase 2 - Quantitative phase:***

1. Significant associations will be found between baseline variables (demographics, knowledge on TIC, attitudes towards TIC), emotional factors (resilience, self-compassion, empathy), organizational factors, acquisition and implementation of TIC, and STS.
2. Emotional factors (resilience, self-compassion, and empathy) and organizational factors will serve as moderating variables for knowledge on trauma, TIC acquisition and implementation, and STS.

Figure 1 presents an initial proposed model describing the hypothesized associations between study variables.

**Figure 1.** *Model of Associations Between Emotional Factors, Organizational Factors, TIC, and STS*



***Phase 3 – TIC framework development and formative evaluation***

1. The formative evaluation will identify both strengths and areas for improvement, leading to the refinement of a final framework tailored to promote wider acquisition and implementation of TIC among allied health professionals working with children and youth.

**Research Design and Methods**

The proposed study will use a mixed-methods sequential explanatory design (qualitative followed by quantitative), allowing for a more comprehensive understanding of the complex factors influencing TIC acquisition and implementation. Integrating both qualitative insights and quantitative data to address multifaceted research questions is more effective than either method alone (Creswell & Plano Clark, 2018). This method captures the nuanced experiences of allied health professionals while also providing measurable evidence to inform the development of a practical, evidence-based framework.

***Phase 1 - Qualitative Phase***

**Aims.** The objectives of this qualitative phase are to: (1) Identify the facilitators and barriers for the acquisition and implementation of TIC among allied health professionals working with children and youth in various clinical settings; and (2) Identify shared needs across all allied health professions alongside the unique needs specific to each profession.

**Study design.** The study employs a qualitative research design, utilizing a reflective thematic analysis approach (Braun & Clarke, 2020) to initially explore the experiences and perspectives of allied health professionals working with children and youth. Data will be collected through semi-structured interviews and the study will follow an iterative process to ensure in-depth understanding and credibility of the findings.

**Participants.** About eight participants from each profession (occupational therapists, physiotherapists, speech therapists, and dietitians), currently working with children and youth, will be recruited through key informant connections as part of a purposeful sample. This sample size will allow us to provide sufficient diversity and depth of insights while maintaining manageable data collection and analysis.

**Assessment tools.** In-depth semi-structured interview guide will be developed for this phase. The interview guide will include questions that refer to opportunities and challenges in meeting traumatized children and youth, facilitators and barriers to TIC acquisition, facilitators and barriers to TIC implementation, general and profession-specific needs of each allied health profession, the current coping strategies to deal with trauma related situations, the response of the healthcare organization to the needs of the professionals with reference to a TIA.

**Procedure.** After receiving the ethics approval, we will contact the participants via email or phone call, present the research aims and importance, and invite them to participate in an interview. Participants will be asked to sign an informed consent prior to the interview. Interviews will be held in-person or online using Zoom platform/Google Meets in accordance with the availability and the preference of participants. The interviews will last between 45 and 60 minutes. Interviews will be taped and transcribed, while erasing any identifying details. This process will enable a complete and accuraterecord of the interviews as the basis for data analysis.

**Challenges in recruiting subjects and coping methods.** Allied health professionals often have busy schedules, making it difficult to find time for interviews. We will offer flexible scheduling options, including evenings, and provide the option for online interviews to reduce travel time. In addition, potential participants may not appreciate/understand the direct benefit of participating in the study or find the research topic irrelevant to their work. Therefore, we will clearly communicate the importance and potential impact of the research on their professional practice and the field, as well as highlighting any direct benefits, such as contributing to knowledge that could improve workplace practices or patient outcomes.

**Data Analysis.** The data will be analyzed using reflecting thematic analysis, as outlined by Braun and Clarke (2020). This approach was chosen for its reflective nature facilitates an in-depth exploration of barriers and facilitators to TIC acquisition and implementation, ensuring that findings are both descriptive and interpretative. Additionally, this approach can systematically identify and interpret complex patterns within qualitative data while allowing flexibility in capturing both shared and unique experiences across allied health professions. To facilitate the analysis, we will use ATLAS.ti (Friese, 2019) to organize and manage the data systematically. Similar codes will be grouped together to develop and refine themes. The research team will collaboratively discuss potential themes after thoroughly reviewing the dataset and noting initial ideas, ensuring a rigorous and transparent process.

***Phase 2 - Quantitative Phase***

**Aims.** To explore and gain measurable evidence of the complex associations between the emerged variables from Phase 1 in addition to: (a) baseline variables (demographics, knowledge on TIC, attitudes towards TIC); (b) emotional factors (resilience, self-compassion, empathy); (c) organizational factors; (d) acquisition and implementation of TIC; and (e) STS.

**Study design.** A cross-sectional quantitative study with a convenience sample. This phase will include an online survey of allied health professionals working with children and youth aged 0 to 18 years. This design enables to collect a measurable data from a large sample within a relatively short timeframe and is particularly suited for examining complex relationships and patterns across multiple factors, which will emerge from Phase 1. Using Structural Equation Modeling (SEM) allows for a robust analysis of both direct and indirect effects, offering a deeper understanding of how these variables interact to influence the acquisition and implementation of TIC and the experience of STS among professionals.

**Participants.** According to the calculation of sample size using G-Power based on a medium effect size (*f*2= .15), error size of .01, and power of .95, the sample will include approximately 150 allied health professionals (occupational therapists, physiotherapists, speech therapists, and dietitians) who work with children aged 0 to 18 years in Israel. All participants should have at least 1 year of experience working with this population. Participants will be recruited by advertising on social media interest groups and professional and organizational mailing lists.

**Assessment tools.** The survey will include several questionnaires in a sequence under one link. The final assessment tools included in the survey will be determined according to the results of Phase 1. The initial suggested assessment tools are:

1. *Demographic Questionnaire.* This questionnaire includes questions about gender, age, nationality, religious affiliation, professional specialty, seniority (general and with children), organization affiliation (e.g., Ministry of Health, Ministry of Education, or community services), and geographic work area.
2. *The Attitudes Related to Trauma-Informed Care (ARTIC) Scale* is a tool designed to measure the attitudes of professionals and organizations towards TIC. The primary goal of the questionnaire is to assess the readiness, beliefs, and commitment of individuals or teams to implementing trauma-informed practices in their work, particularly within settings that involve supporting individuals who have experienced trauma. The scale helps to identify potential barriers and areas where further training or support may be needed to effectively adopt trauma-informed approaches. The translation of the ARTIC into Hebrew is currently in process with the authors.
3. *Trauma-Informed Approach Questionnaire (TIAQ).* The TIAQ was developed for the current study by Dr. Adi Stern and Dr. Liron Lamash based on a survey developed by Rupert and Bartlett (2022) and a trauma-oriented organization questionnaire developed by the Haruv Institute (https://haruv.org.il). Seven professional experts on TIC from various disciplines reviewed the initial TIAQ version. The researchers developed and approved a final version according to the experts’ feedback. The final version includes four sections. The first consists of 17 items on the extent of knowledge the participants have on trauma in general, rated from 1 (*very limited*) to 5 (*extensive*). The second section includes seven items referring to the participants' perceptions of the relevance of trauma-related topics to their clinical practice with children, rated from 1 (*not relevant*) to 5 (*highly relevant*). The third section includes 11 items about the extent to which the participants apply TIC in their clinical practices, rated from 1 (*not at all*) to 5 (*consistently*). The fourth section includes 16 items related to a TIC intake interview, and participants mark whether they address each in their intake interviews. The TIAQ has shown high internal consistency (.96 for all items and .67–.96 for the occupational therapy sections).
4. *The Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003)*. The CD-RISC is a widely recognized and extensively used self-report assessing an individual's level of resilience, defined as the ability to adapt and recover from adversity, stress, and life's challenges. The CD-RISC consists of 25 items capturing various aspects of resilience, including adaptability, emotional strength, and the capacity to cope effectively with stress and setbacks. Respondents rate their agreement with each item on a Likert scale from 0 (*not true at all*) to 4 (*true nearly all the time*); higher scores indicate higher resilience. The CD-RISC has demonstrated good reliability and validity in numerous studies and has been translated into multiple languages. It also demonstrated good internal consistency reliability in various studies, with Cronbach's alpha coefficient around .85 or higher in different populations. The CD-RISC has shown strong evidence of construct validity, positively correlated with measures of positive psychological functioning and negatively with measures of psychological distress (Connor & Davidson, 2003).
5. *Self-Compassion Scale (SCS; Neff, 2003)*. The SCS is a widely used self-report instrument assessing an individual's capacity for self-compassion and self-kindness. It includes 26 items rated on a scale from 1 (*almost never*) to 5 (*almost always*) to measure the three core components of self-compassion: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification. The total score and each component score are obtained by calculating their items' average score; higher scores indicate greater self-compassion. The SCS has been found to have good internal consistency. In various studies, the Cronbach's alpha coefficient for the overall scale has typically ranged from .86 to .92. Some studies showed moderate to high stability over time, suggesting good test–retest reliability (Neff, 2003; Neff & Vonk, 2009). The SCS has content validity based on Neff's theoretical framework of self-compassion, including the three core components (self-kindness, common humanity, and mindfulness; Neff, 2003) and construct validity with negative correlations with self-criticism and self-judgment measures and positive correlations with psychological well-being and positive mental health measures (Neff et al., 2007).
6. *Interpersonal Reactivity Index (IRI; Davis, 1980)*. The IRI is a widely recognized and extensively used self-report designed to assess an individual's dispositional empathy, defined as the capacity to understand and share the feelings and perspectives of others. It comprises 28 items rated on a scale of 1 (*does not describe me well*) to 5 (*describes me very well*). The items are divided into four subscales, each targeting a different aspect of empathy. The four subscales are (a) *fantasy*, the tendency to identify with fictional characters; (b) *perspective taking*, the ability to adopt another person's point of view; (c) *empathic concern*, the degree of emotional responsiveness and compassion for others; and (d) *personal distress*, an individual's emotional discomfort in response to the suffering of others. Scoring the IRI involves summarizing responses to individual items on each subscale; higher scores indicate higher empathy dispositional. The IRI has demonstrated good internal consistency, with Cronbach's alpha coefficients ranging from .70 to .80 or higher for its four subscales (fantasy, perspective taking, empathic concern, and personal distress) and reasonable test–retest reliability over time. The IRI has strong evidence of construct validity and convergent validity with other measures of empathy and related constructs, supporting its ability to assess the intended aspects of empathy (Davis, 1980).
7. The *TICOMETER*© (Bassuk et al., 2017) is a psychometrically validated assessment tool designed to measure the implementation of TIC within health and human service organizations. Developed with input from an expert panel, the TICOMETER© originally comprised 189 items across five key domains, which were later refined to 35 items based on their psychometric strength. These domains include safety, trustworthiness, peer support, collaboration, and empowerment, all essential aspects of TIC. The TICOMETER© has demonstrated high reliability, with strong internal consistency across its domains, as well as good test-retest reliability. The translation of the *TICOMETER*© into Hebrew is currently in process with the authors.
8. *Secondary Traumatic Stress Scale* (STSS; Bride et al., 2004). A structured self-report questionnaire designed to evaluate the presence and severity of STS symptoms among individuals who might be exposed to the traumatic experiences of others, such as healthcare providers, social workers, and counselors. The STSS consists of 17 items, divided into three subscales that correspond to the core dimensions of STS: intrusion, avoidance, and arousal. Each item is rated on a 5-point Likert scale, ranging from 1 (*never*) to 5 (*very often*), indicating the frequency with which the respondent has experienced each symptom. The total and subscales scores on the STSS are calculated by summing the items’ scores, with higher scores indicating greater levels of STS. The STSS has demonstrated strong construct validity and good to excellent internal consistency of .93 for the total scale and .80-.87 for the subscales (Bride et al., 2004).

**Procedure.** Ethics approval was obtained by the Ethics Committee of the Faculty of Welfare and Health Sciences at the University of Haifa (approval number 053/23). An advertisement will be published among relevant professional interest groups on social media, including a link to the study description, its importance, and informed consent to participate. Allied health professionals agreeing to participate in the research will access the online survey. The survey is anonymous, and there is no way the researchers can identify the participants.

**Challenges in recruiting subjects and coping methods.** We do not anticipate difficulty in recruiting participants for an anonymous survey. However, we will monitor the sample during the data collection to verify enough participants from each profession. If needed, we will increase the advertising to dedicated groups on social media. We will also use relevant distribution lists (e.g., lists of academic department graduates or allied health professionals in health and education systems, professional associations, and organizations).

**Data Analysis.** Data analyses will be performed using IBM SPSS and AMOS (version 27).

Descriptive statistics will be used to describe sample characteristics and map knowledge of trauma, attitudes about its relevance, and the scope of using a TIA. SEM will be used to examine the association between the variables, with a focus on understanding both direct and indirect effects.

***Phase 3 – TIC framework development and formative evaluation***

***Aims.*** Based on Phases 1 and 2, a TIC framework for allied health professionals will be developed. A formative evaluation will be conducted to evaluate the proposed framework's strengths and weaknesses and refines various aspects (Elwy et al., 2020) to produce the final TIC framework for the allied health professionals, with specific adjustments for each profession if needed.

***Study Design.*** A formative evaluation based on descriptive qualitative methods from interviews with stakeholders recruited via word-of-mouth sampling. This approach allows for an in-depth examination of the proposed TIC framework’s strengths and weaknesses, providing rich, context-specific feedback from key stakeholders (Elwy et al., 2020). This method is particularly suitable for refining and improving the framework based on real-world perspectives and experiences, ensuring it is tailored to the needs of allied health professionals. By using qualitative interviews, the study can capture nuanced insights and identify practical considerations that may not emerge from quantitative methods, ultimately leading to a more effective and relevant TIC framework.

***Participants.*** About 10-15 participants, including a combination of professionals from relevant fields, stakeholders and policymakers. This will ensure a diverse range of perspectives on the feasibility and impact of the framework.

***Assessment tools.*** A semi-structured interview guide will be developed based on previous phases, including closed and open questions, to refine the initial TIC framework. After a short presentation of the suggested TIC framework, participants will be asked about the principles and content.

***Data Analysis.*** Descriptive statistics will be calculated for closed-ended questions and data that can be described by frequencies. For the qualitative analysis, a directed content analysis approach will be applied, guided by existing theory and research to address prespecified interview topics while remaining open to new themes that may emerge. This method improves clinical implementation and ensuring a systematic and structured evaluation of the data (Hsieh & Shannon, 2005; Elwy et al., 2020).

**Preliminary Results**

The preliminary results stem from a pilot study conducted among allied health professionals. The pilot study aimed to: (a) investigating the presence of gaps between knowledge on trauma, attitudes toward the relevance of TIC to allied health professionals' clinical practice, and TIC implementation level, and (b) exploring the correlations between knowledge on trauma, TIC relevance and implementation, and emotional factors related to STS (self-compassion, resilience and empathy).

This cross-sectional pilot study was conducted among 176 Israeli allied health professionals recruited via social media and interest groups. Sixty (34%) were occupational therapists, 62 (35%) were speech therapists, 44 (25%) were physical therapists and 11 (6%) were nutritionists. Their ages ranged from 23 to 67 years (*M*= 35 years, *SD*= 8.9), and they had a mean of 10 years (*SD* = 8.0) of experience working with children and youth. The online survey included the: (1) Trauma-Informed Approach Questionnaire *(*TIAQ, Stern & Lamash, 2023), to assess the participants’ knowledge, relevance perception, and TIC implication level in their work; (2) Self-Compassion Scale (SCS; Neff, 2003) to evaluate an individual’s capacity for self-compassion and self-kindness; (3) Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) to assess various facets of resilience; and (4) Interpersonal Reactivity Index (IRI; Davis, 1980) to measure of an individual’s dispositional empathy. Descriptive statistics, *t* tests and Cohen’s *d* were used to assess differences between knowledge, attitudes, and implementation. Pearson correlations were used to assess relationships with emotional factors.

The results indicated significant differences between trauma knowledge, TIC relevance perception, and TIC implementation among the entire sample, F(2, 352) = 127.5, p < .001, η² = 0.43. Perception of TIC relevance was higher than knowledge of trauma (p < .001) and TIC implementation (p < .001). Positive correlations were found between resilience and knowledge of trauma (r=.22, p<.01), TIC perception relevance (r=.17, <.05), and TIC implementation (r=.23, <.05). Self-compassion was positively correlated with knowledge of trauma (r=.18, p<.05) and TIC implementation (r=.22, p<.01). Perspective-taking (empathy) was positively correlated with knowledge of trauma (r=.15, p<.05), perception of TIC relevance (r=.39, p<.01), and TIC implementation (r=.31, p<.01), and empathic concern was positively correlated with perception of TIC relevance (r=.33, p<.01).

The findings from this preliminary study highlight the limited knowledge and understanding of trauma, emphasizing the absence of TIC training. However, there was a notable discrepancy: Participants expressed high perceptions of TIC's relevance for their practice. These findings further emphasize allied health professionals’ unpreparedness or lack of ability to identify and care for children and youth who may have experienced trauma, aligning with previous research findings (Jee et al., 2020; Kerker et al., 2016). The complexity of treating traumatized children and youth, and the lack of well-established TIC teaching and training models for allied health professionals in Israel underscore the need to develop a TIC framework for this population. Moreover, resilience, self-compassion, and empathy among allied health professionals can be strategies to cope with treating children and youth who have experienced trauma and prevent STS.

**Resources**

*Background and Qualifications of the Researchers*

Both researchers hold senior faculty positions in the Occupational Therapy Departments, Dr. Adi Stern at Ben-Gurion University and Dr. Liron Lamash at the University of Haifa, and both have extensive experience in supervising master's and doctoral students, which will facilitate various stages of the study. As leading occupational therapists, they possess extensive expertise in child and youth development as well as trauma-related interventions. Dr. Stern specializes in mental health, with a particular focus on trauma. She has served as a consultant for the Haruv Institute and is recognized as an expert in TIC and is currently working at a special clinic for adolescents with mental health disorders and co-morbid addictions. Dr. Stern actively trains and supervises allied health professionals. As a member of the Supreme Council of Occupational Therapy, Dr. Stern maintains connections with key organizations such as the Ministry of Health and health maintenance organizations, which will be valuable for participant recruitment and engaging experts in the study. She also leads the Laboratory for the Research of Functional Aspects in Mental Health, offering an innovative space for the research activities.

Dr. Lamash specializes in child and youth development, with expertise in assessing and addressing developmental challenges in educational settings. She has extensive experience training educational staff and developing evaluation programs for children and youth with a variety of developmental difficulties. Her background in the educational system, combined with her experience in training allied health professionals, brings a unique perspective on integrating TIC within educational settings. She is the head of the Technological Laboratory to Promote Autonomy and Participation (Tech-AP), which provides an accessible and innovative space for conducting interviews and focus groups. Together, the complementary expertise of Dr. Stern in healthcare and trauma, and Dr. Lamash in education and developmental evaluation, ensures a comprehensive approach to addressing both the clinical and educational dimensions of the research.

*Research Collaborations*

Both researchers are actively engaged in collaborations with researchers from related departments at Ben-Gurion University and the University of Haifa, such as physiotherapy, speech therapy, public health and social work. They also collaborate with researchers from other occupational therapy departments at multiple institutions across Israel. Additionally, this research will be conducted in partnership with the prominent team at the Haruv Institute, a hub for local and international professionals, clinicians, and researchers in the field of child maltreatment. This study’s researchers have well-established professional relationships with the team at the Haruv Mental Health Clinic, a multidisciplinary clinic serving children who suffered abuse and neglect and their families. The clinic operates within the Haruv Children’s Campus, a unique, innovative initiative bringing together various services for these children. The clinic director, Mrs. Stav Dekel Amir, is an occupational therapist and PhD student. The clinic’s team includes a child psychiatrist, pediatric neurologist, occupational therapist, speech pathologist, nutritionist, and social worker, each a specialist in childhood trauma. This clinic is an abundant source of knowledge to support our research efforts further.

**Expected Results**

Children and youth in Israel are exposed to trauma at a higher rate than most children in other Western countries. Thus, TIC must be an integral part of the core knowledge and training for Israeli allied health professionals working with children and youth, given the profound impact trauma can have on their development. However, many allied health professionals are not adequately equipped with the necessary knowledge to effectively implement TIC. Furthermore, the foundational academic programs for allied health professionals in Israel do not provide sufficient education or practical training on trauma and TIC principles. The findings from the current study will serve as a basis for developing a TIC conceptual model and training framework, incorporating essential elements for effective implementation in both academic and clinical settings. Future research will further investigate the application and integration of these TIC programs among allied health professionals working with children and youth.

**Pitfalls and Alternatives**

Based on our experiences conducting similar studies with high response rates, we anticipate no difficulties recruiting the sample for the survey. If necessary, we will increase advertisements for research participation with dedicated mailing lists of health care, education, and academic institutions. In case of difficulty recruiting participants for the interviews and/or experts for the formative evaluation, we will apply for assistance from the relevant authorities in the Ministry of Health and the Ministry of Education and relevant associations. Additionally, we will use our collaboration with the Haruv Institute, Israel’s leading body in the field of children who are victims of abuse and neglect.

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