Trauma Informed Care Scale: Turkish Validity and Reliability Study

Travma Bilgili Bakım Ölçeği: Türkçe Geçerlilik ve Güvenilirlik Çalışması

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ÖZ

Bu çalışmanın amacı travma bilgili bakımla ilgili bilgi, tutum ve uygulama düzeyini ölçmek için geliştirilmiş olan travma bilgili bakım ölçeğinin gerekli analizlerini yaparak Türk kültürüne uyarlamaktır. Tarama modelindeki bu çalışmaya 161 ruh sağlığı meslek çalışanı katılmıştır. Araştırmanın verileri kolayda örneklem yöntemi ile Demografik Bilgi Formu ve Travma Bilgili Bakım Ölçeği kullanılarak toplanmıştır. Veriler online veri toplama platformu surveey.com aracılığıyla üretilmiştir. Çalışmaya dahil olan ruh sağlığı çalışanlarının çoğunun (%70,2) travma bilgili bakım modelini daha önce hiç duymadığı, %87'sinin de bu modeli uygulamalarında kullanmadığı saptanmıştır. Yapılan AFA analizi toplam varyansın %50,36'sını açıklayan ve bütün maddelerin orijinal ölçekteki alt boyutlarda yer aldığı 3 faktörlü yapının ortaya çıktığını göstermektedir. Yapılan analizler sonucunda ölçeğin toplam maddelerinden Tutum alt boyutunda yer alan 3 madde çıkarılmış ve Türk kültüründe kullanabilecek 18 maddelik son hali ortaya çıkmıştır. Yapılan korelasyon analizleri toplam puan ortalamasının bütün alt boyutlarla yüksek düzeyde ve pozitif yönde ilişkili olduğunu göstermektedir. Travma Bilgili Bakım Ölçeği travma mağduru danışanlarla çalışan ruh sağlığı meslek mensupları (hekimler, hemşireler, psikologlar, psikolojik danışmanlar, sosyal hizmet uzmanları) ile travma bilgili bakım ve/veya travma duyarlı bakımla ilgili çalışmalar planlayan araştırmacılar tarafından kullanılabilecek geçerli ve güvenilir bir ölçüm aracıdır.

Anahtar sözcükler: Travma, travma bilgili bakım, ölçek uyarlama

ABSTRACT

The aim of this study is to adapt the trauma-informed care scale, a scale developed to measure the level of knowledge, attitude and practice related to trauma-informed care, to Turkish culture by making the appropriate analysis. 161 mental health professionals participated in this survey model study. The data of the study were collected by using the convenience sampling method, the demographic information form and the Trauma Informed Care Scale. The data were generated through the online data collection platform surveey.com. It was determined that most of the mental health professionals (70.2%) in the study had never heard of the trauma-informed care model, and 87% did not use this model in their practice. The EFA analysis showed that a 3-factor structure was emerged, which explained 50.36% of the total variance and in which all items were included in the subscales of the original scale. According to the results of the analyzes, 3 items in the Attitude subscale were removed from the total items of the scale and the final version of 18 items scale that could be used in Turkish culture was created. The correlation analyzes showed that the total mean score was highly and positively correlated with all subscales. The Trauma-Informed Care Scale is a reliable measurement tool with proven structural validity and suitable for use by mental health professionals (physicians, nurses, psychologists, psychological counselors, social workers) working with trauma survivors, and researchers planning studies on trauma-informed care and/or trauma-sensitive care.

Keywords: Trauma, trauma-informed care, scale adaptation

Introduction

Discussions about what constitutes a psychically traumatic event have been going on for a long time. In the 19th century and the first half of the 20th century, the use of the term "trauma" was limited except for physical trauma. The idea that traumatic events other than physical harm can also cause problems emerged after the French and Prussian war in 1870 (Çolak et al. 2010). Substance Abuse and Mental Health Services Administration (2014) define trauma as an event or series of events that are emotionally disturbing or life-threatening for an individual, or the lasting adverse effects of these events on the individual's mental, physical, social, emotional or spiritual well-being. While Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III) (APA 1980) began to describe traumatic events as 'beyond the usual human experience...' in DSM-IV (APA 1994), the experience of helplessness, fear and horror and the threat of extinction in the face of action became

the determinant of the traumatic event. In DSM-5 (APA 2013), on the other hand, the scope of all these has been expanded and the effect of the subjective experience of the person on the traumatic event has been eliminated, and the traumatic experience has been medicalized as an infectious disease and defined as a "standard" disease created by a single microorganism (Başterzi et al. 2019). According to DSM-5, trauma may occur when directly experienced or witnessed, experienced by a family member or close friend, or professionally experienced, facing death or serious injury, or being sexually assaulted (APA 2013). In DSM-5, the subjective reaction of the person is not taken into account, instead, ways of encountering events are listed in order to clarify the definition of traumatic event. According to DSM-V, the person himself may have experienced and witnessed the event or it may happen to a close friend or a close relative. The expression "physical integrity of self and others", which was in previous DSMs, was removed and for the first time the expression "sexual assault" was included (Çolak et al. 2010). The World Health Organization (WHO 1995) defines trauma as accident, natural disaster, fire, rape, harassment, exposure to blackmail, sudden death of a loved one, life-threatening illness, war, fraud, seeing a corpse, seeing someone injured or killed, home invasion, death. It has been defined through events such as being threatened, victimized by terrorism, physical violence/attack, divorce, and abandonment. This definition focuses on direct actions rather than psycho-social effects on the person.

Terr (2003) first distinguished trauma between two types: Type I and Type II. Type I single-incident trauma results from a single event, such as a rape or witnessing a murder. Type II complex or repetitive trauma results from "repeated exposure to extreme external events." Survivors of Type II trauma generally have at least some memories of their experience. Trauma can occur due to extraordinary events such as violence and harassment, or it can be caused by ordinary everyday events. Regardless of how it occurs, trauma is generally the most avoided, ignored, belittled, denied, and untreated cause of human suffering (Levine and Kline 2014). While some traumas such as physical and sexual abuse, domestic violence, exposure to partner violence, rape, abuse and death are quite obvious, chronic experiences such as emotional neglect, a careless caregiver or a parent addicted to alcohol and drugs, being threatened are subtler and insidious. Most clients may experience different types of trauma that causes toxic stress and triggers complex trauma reactions (Cloitre et al. 2009). The level of being affected by trauma varies according to the gender, age, and psycho-social development of the individual. Existing vital risks such as substance abuse, disability, mental illness, the individual's strengths, and existing social support networks also affect the level of being affected by trauma (Ogden et al. 2006).

Trauma-related disorders, previously classified under anxiety disorders section, are classified under trauma-and stressor-related disorders in the DSM-V. Related disorders according to the new classification are: Reactive attachment disorder, acute stress disorder (ASD), post-traumatic stress disorder (PTSD), adjustment disorders (Ads), dissociative disorders (DDs). Environmental risk factors, including the individual's developmental experience, would thus become a major diagnostic consideration (Friedman et al. 2011, Koç 2018). In Classification of Diseases-11, a new classification has been made under the title of "especially stress-related disorders": Post-traumatic stress disorder, complex post-traumatic stress disorder, prolonged grief disorder, adjustment disorder, reactive attachment disorder, acute stress reaction (Maercker et al. 2013). Both DSM-5 and ICD-11 have included post-traumatic stress disorder (PTSD) among trauma-and stressor-related disorders. An important group of clients at the center of trauma-informed care consists of people with post-traumatic stress disorder. Trauma-informed care argues that traditional standard treatment models can trigger trauma survivors and exacerbate their symptoms. Trauma-informed programs are designed to be more supportive and avoid re-traumatization for people with post-traumatic stress disorder (SAMHSA 2014).

Trauma, in any case, does not influence everybody in the same way. While some people are not affected even though they have experienced very terrible events, those who witness it may be more affected. Traumatic response is profoundly individualized and molded by a wide extend of components. The trauma-informed care approach of professionals determines the course of the long-term effects of the traumatic event (Wilson et al. 2013). Trauma-informed care approach to care has evolved over the past 30 years from various streams of thought and innovation. Nowadays, it is practiced in a wide variety of environments, including mental health and substance abuse rehabilitation centers, child welfare systems, schools, and criminal justice institutions (Cohen et al. 2012). Although it is so common, trauma-informed care is not a "one approach fits all". Interventions should always be determined according to the individual situation of the client. Gender and type of trauma are some of the specific requirements that will determine the type of intervention (Kelly et al. 2014).

While there are similarities between trauma-informed care and trauma resolution therapy, the two are quite different. Trauma focused interventions can be a precursor to targeted therapy for many clients. Trauma-informed care based practices help clients with traumatic experiences discuss their painful experiences and reduce their anxiety levels. This helps clients to regulate their emotions and behaviors (Cohen et al. 2012). Unlike classical theory and treatment methods, Trauma-informed care can be used by mental health professionals in

conjunction with any therapy. This method tries to understand the behaviors and coping mechanisms of traumatized clients and the problems caused by traumatic events. Trauma-informed care is a solution-oriented approach rather than a problem-oriented one (Tekin and Başer 2021). Trauma-informed care requires professionals working with clients with a trauma history to have a comprehensive knowledge of trauma. In addition, these professionals should have knowledge and awareness about the impact of trauma on the lives and actions of clients (Güneş Aslan 2022).

This study aims to adapt the Trauma Informed Care Scale to Turkish culture by conducting validity and reliability studies. Various scales (Kağan et al. 2012, Tanhan and Kayri 2013, Tekin and Kırlığolu 2021, Taytaş and Tanhan 2022) are available in the literature to be used in research on trauma in Turkey, however, there is no scale developed or adapted directly related to trauma-informed care, and of which validity and reliability studies have been conducted. Therefore, this study is very necessary and important in terms of meeting the need in the literature and the field.

Methods

Sample

This research is a survey model that aims to reveal the existing situation with a descriptive method without changing it. The population of the study consisted of mental health professionals (psychiatrists, social workers, psychologists, psychological counselors and psychiatric nurses) working with individuals with a trauma history. Since the number of the population is not known and this is a scale validity study, the sample calculation was made according to the number of scale items. For the 21-item scale study, it was planned to reach five times the number of scale items and 105 participants were determined as the minimum sample number. According to Tavşancıl (2002), the sample size should be at least five times the number of items in scale validity studies. Since the data of the study was collected through online platforms, participants from all over Turkey were included in the study. The study was completed with 161 participants by reaching more participants than the targeted minimum sample number. Inclusion criteria for the study: volunteering to participate in the study, being a mental health professional, working actively in the field for more than a year, and being able to speak and read Turkish. Exclusion criteria for the study: working in another job despite having a vocational diploma in the field of mental health, being in charge of another unit despite being a mental health professional have less than one year of professional experience. Also 17 participants who did not meet inclusion criteria were not included in the study.

Procedure

First of all, permission was obtained from the authors who developed the scale via e-mail. In addition, the opinion and approval of the author was received to replace the expression "patient" in the original items of the scale with the expression "client" used in the field of mental health. Prior to data collection, ethics committee approval was obtained from Necmettin Erbakan University Health Sciences Research Ethics Committee (Date: 06.04.2022 Number: 21/205). During the research, the rules of the Declaration of Helsinki were complied with. The participants of the study were informed that the research results could be used for scientific purposes and their written consent was obtained. This study was conducted by two competent researchers working in the field of clinical social work and behavioral psychology.

The data of the research were collected by convenience sampling method. Convenience sampling is the method that provides the easiest way to reach the sample representing the population (Gürbüz Şahin 2018). Participants representing the sample were reached through the peers of the researchers and their professional associations. In addition, research links were announced and shared in professional whatsapp, facebook and telegram groups. The data of the research were collected through the surveey.com data collection online platform. Repeated logins were blocked by setting IP and cookie control, a participant could only participate in the study once. Information about the purpose and scope of the study was given to the participants on the entrance page of the data collection online platform, and it was assumed that the participants who gave their consent by clicking the "participate in the study" button participated in the study voluntarily.

Language Validity

The translation of the scale items from the original language into the language of the culture to be adapted from the cultural adaptation studies of the scales is an important step. Therefore, for the language validity of the scale,

the scale items that were originally in English were translated into Turkish. During the language validity process, the items of the scale, originally called Trauma Informed Care, were translated into Turkish by two different sworn translators. At least two independent translators are required at the language validity stage (Aksayan and Gözüm 2002). Then, an academician translation form was prepared with the English scale items and their Turkish translations. This form was sent to a total of six academicians, three of whom are social workers and three psychologists, who have studies on trauma. The corrections from these academics were compared by the researchers and the Turkish version of the scale was created by adopting the translations that were thought to best express the item in question. This scale was applied to 20 participants for the pre-application study, the questions that were thought to be incomprehensible were reviewed and the final version of the scale to be used in the main study was created.

Data Collection Tools

The data of the study were obtained by using the "Demographic Information Form" and the "Trauma Informed Care Scale".

Demographic Information Form

The descriptive features form created by the researchers, consists of 9 questions that determine the gender, age, education, occupation, duration of professional experience, knowledge of trauma-informed care, use of trauma-informed care in occupational interventions, training on trauma-informed care, and need for training on trauma-informed care.

Trauma Informed Care Scale (TICS)

The scale was developed by King et al. (2019) and consists of 21 items and 3 subscales: knowledge, attitude and practice. There are 6 items about "Knowledge", 9 items about "Attitude" and 6 items about "Practice". There is no reverse item in the scale. The scale enables the determination of trauma-informed care related knowledge, attitude and practice levels of mental health professionals working with individuals with a trauma history.

Scoring of the five-point Likert type scale is Strongly Disagree (0), Disagree (1), Undecided (2), Agree (3), Strongly Agree (4). Although the scale does not have a cut-off score, the high score indicates the need to learn about trauma-informed care. As a result of the validity study conducted with 592 healthcare professionals, confirmatory factor analysis of the scale revealed that 21 items provided the strongest internal consistency reliability for the general tool and each factor. The Cronbach Alpha value of the scale was 0.86, the knowledge subscale was 0.84, the attitude subscale was 0.74, and the practice subscale was 0.78 (King et al. 2019).

Statistical Analysis

The data obtained in the research were analyzed using the SPSS (Statistical Package for Social Sciences) for Windows 22.0 program. Before the analysis, skewness and kurtosis values, histograms and Q-Q plots were examined to assess whether the data set was normally distributed. Skewness and Kurtosis values ranged from -1 to +1. This result indicated normal distribution. Additionally, histograms and Q-Q plots also showed each of the variables was normally distributed. Frequency analysis, correlation, explanatory factor analysis, and reliability analysis were used for data analysis. Pearson correlation coefficient was preferred because the scale was a Likert-type interval scale, the data were normally distributed, and the sample size was sufficient. In addition, Bartlett's Test of Sphericity (BTS) was used for the significance of correlation coefficients between variables. Cronbach's Alpha coefficient was calculated for the reliability of the scale. Since it was a scale adaptation study, only EFA (Exploratory Factor Analysis) was considered sufficient, and CFA (Confirmatory Factor Analysis) was not considered necessary. Possible patterns that may occur can be revealed more clearly in EFA. Structures that cannot be noticed in CFA can be discovered via EFA. For this reason, possible changes that may occur in the structure in adaptation studies can be easily understood with the help of EFA (Orçan 2018).

Results

The sample of this study consisted of a total of 161 mental health professionals, 102 (63.4%) female and 59 (36.6%) male, aged between 21 and 60 (Mean = 33.16 ± 8.72). Of the participants, 38 (23.6%) were psychiatrists, 43 (26.7%) were psychologists, 37 (23%) were psychological counselors, and 43 (26.7%) were social workers. 90 (55.9%) of the participants were undergraduates, 51 were graduates, and 20 (12.4%) were PhD graduates. When examined in terms of professional experience, the highest rate was composed of those who worked for 1-3 years (32.9%, n=53) and those who worked for more than 10 years (32.3%, n=52). When the ratio of the participants

was analyzed in terms of the institution they worked for, it was found that the highest rate was formed by the participants working in the ministry of health (37.9%, n= 61%). The findings regarding the demographic characteristics of the participants are provided in Table 1.

While 48 (29.8%) of the participants stated that they had heard of the concept of trauma-informed care before, 21 (13%) stated that they used the trauma-informed care model in the professional intervention process. In addition, 23 (14.3%) participants stated that they received training on trauma-informed care during their undergraduate education, while 101 participants (62.7%) stated that they needed training on trauma-informed care. The opinions of the participants about trauma-informed care are provided in Table 2

Table 1. Demographic characteristics of the participants			
Variables		**n**	**%**
Gender	Male	102	63.4
	Female	59	36.6
Profession	Psychiatrist / Psychiatric Nurse	38	23.6
	Psychologist	43	26.7
	Psychological Counselor	37	23.0
	Social Worker	43	26.7
Education level	Bachelor	90	55.9
	Master	51	31.7
	Phd	20	12.4
Professional experience	1-3 years	53	32.9
	4-6 years	30	18.6
	7-10 years	26	16.1
	10 +	52	32.3
Institution of employment	Ministry of Justice (Courthouse, Prison, etc.)	14	8.7
	Ministry of Family and Social Services (SHM, SÖNİM, ÇODEM, etc.)	7	4.3
	Ministry of Education (School, Course, etc.)	28	17.4
	Ministry of Health (Hospital, Universities, etc.)	61	37.9
	NGO/ Foundation (Yeşilay, Kızılay, SYDV, etc.)	8	5.0
	Private Sector (Clinic, Consulting Center. etc.)	29	18.0
	Ministry of Youth and Sports	14	8.7

Table 2. Participants' thoughts on trauma-informed care			
Variables		**n**	**%**
Have you ever heard of the concept of trauma-informed care?	Yes	48	29.8
	No	113	70.2
Do you use the trauma-informed care model during your professional interventions?	Yes	21	13.0
	No	140	87.0
Did you receive any training on trauma-informed care during your undergraduate education?	Yes	23	14.3
	No	138	85.7
Do you think you need education about trauma-informed care?	Yes	101	62.7
	Indecisive	52	32.3
	No	8	5.0

In order to test the construct validity of the Trauma Informed Care Scale, EFA with principal components method was conducted using Varimax rotation with Kaiser Normalizer. EFA is a statistical analysis method that is frequently used for social science studies to determine the hidden factors underlying the observed variables (Orçan 2018). When the results of the Barlett sphericity test was examined, it was revealed that that the data met the sphericity assumption (χ^2 (210)= 1151.34, p < .001). As a result of the analysis, a three-factor structure with a KMO (Kaiser-Meyer-Olkin) value of 0.75, explaining 44.90% of the total variance, and an eigenvalue above 1 was obtained. However, the items "Recovery from trauma is possible", "Paths to healing/recovery from trauma are different for everyone" and "Informed choice is essential in healing/recovery from trauma" were excluded from the analysis because they were not included in the original subscale and had a load below 0.32 and analyzes were repeated. The results indicated that a 3-factor structure was emerged, which explained 50.36% of the total variance and included all items in the subscales of the original scale. As a result of the analysis, 3 items in the attitude subscale were removed from the total items of the scale and the final version of 18 items scale that could be used in Turkish culture has been created. The correlation analyzes indicated that the total mean score highly and positively correlated with all subscales. The internal consistency values of the scale were also

examined. Cronbach's alpha coefficient is a reliability value that indicates whether the scale items are related to the characteristic to be measured. It provides information about how consistent the scale items with each other and how coherent a group they form (Büyüköztürk 2010). The Cronbach Alpha internal consistency coefficient of the scale was calculated as 0.81 for the practice subscale, 0.72 for the knowledge subscale, and 0.82 for the attitude subscale. The Cronbach Alpha internal consistency coefficient value calculated for the whole scale is 0.80. Findings are provided in Table 3.

Table 3. Trauma Informed Care Scale exploratory factor analysis			
Items	**Factors**		
	Knowledge	Attitude	Practice
There is a connection between mental health issues and past traumatic experiences or adverse childhood events.	0.779		
Substance use can be indicative of past traumatic experiences or adverse childhood events.	0.768		
Distrusting behavior can be indicative of past traumatic experiences or adverse childhood events.	0.754		
Retraumatization can occur unintentionally.	0.680		
Exposure to trauma is common	0.645		
Trauma affects physical, emotional, and mental well-being.	0.570		
I share my expertise and collaborate effectively with colleagues regarding the use of trauma-informed practice.		0.817	
I have a comprehensive understanding of trauma-informed practice.		0.767	
I believe in and support the principles of trauma-informed practice.		0.749	
Trauma-informed practice is essential for working effectively with our clients and their families.		0.477	
I would like to receive more training on trauma-informed practice.		0.435	
People are experts in their own healing/recovery from trauma.		0.434	
I help clients and peers to recognize their own strengths.			0.853
My interaction with each client is unique and tailored to their specific needs.			0.776
I inform all clients of my actions before I perform them.			0.764
I offer clients choices and respect their decisions.			0.689
I maintain transparency in all interactions with clients.			0.665
I practice self-care (taking care of my own needs and wellbeing).			0.474
Explained Variance	26.152	12.602	11.609
Eigenvalue	4.707	2.268	2.090
Cronbach alpha	0.809	0.717	0.819

Pearson correlation analysis was conducted to examine the relationships between the total mean score and subscales of the Trauma Informed Care Scale. The results obtained demonstrated that the total score average was positively and highly correlated with all subscales (Information: r = 0.66, p < .001; Attitude: r = 0.71, p < .001; Practice: r = 0.73, p < .001). There were positive and low relationships between knowledge and attitude (r = 0.35, p < .001), between knowledge and practice (r = 0.20, p <.001), and between attitude and practice (r = 0.20, p < .001). The findings are provided in Table 4.

Table 4. Correlation between the Trauma Informed Care Scale and subscales						
Variables	**Knowledge**	**Attitude**	**Practice**	**Total**	**Mean**	**SD**
Knowledge	1				4.47	.46
Attitude	.352***	1			4.33	.54
Practice	.196***	.201***	1		3.08	.66
Total	.664***	.709***	.734***	1	3.96	.39

***p < .001; SD: standard deviation

Discussion

The main purpose of this study was to adapt the knowledge, attitude and practice level measurement tool related to trauma-informed care developed by King et al. (2019) into Turkish and to prove its validity and reliability with scientific methods. As a result of the studies, Cronbach's alpha reliability coefficients calculated for both the total scale and subscales were found to be at satisfactory levels. The practice subscale was found to be 0.81, the knowledge subscale was 0.72, the attitude subscale was 0.82, and the Cronbach's alpha for the total scale was 0.80. The fact that the internal consistency coefficient is above 0.70 indicates that the scale has a very high reliability (Büyüköztürk 2010). Cronbach's alpha values obtained in the original study of the scale were 0.84 for knowledge, 0.74 for attitude and 0.78 for practice (King et al. 2019). According to the results of the EFA analyzes,

the KMO value was 0.75 and the Bartlett test χ^2 value was found to be 1151.34 (p < .001). If the KMO value is between 0.5 and 0.7, it is considered normal, and between 0.7 and 0.8 it is considered good (Hutcheson and Sofroniou 1999). The BTS value should meet the condition of being significant at p<.05 level (Alpar 2020). The significance level of this study was found to be p < .001. The results showed that the sample and the scale were suitable for factor analysis. It was observed that the Turkish version of the scale was three-dimensional, as in the original, and it explained 44.90% of the variance regarding the feature measured by the three-dimensional scale. A high explained variance can be interpreted as an indicator that the related concept or construct is measured well (Büyüköztürk 2007). In addition, the eigenvalue results (Alpar 2020), which can be used as an indicator of how many factors the scale should consist of, show that it may be appropriate to use a 3-factor structure. The factor loadings of the items ranged between 0.43 and 0.85. Factor loadings above 0.30 indicate a strong construct validity (DeVellis 2017). The results showed that the scale met the validity criteria. However, the items "Recovery from trauma is possible", "Paths to healing/recovery from trauma are different for everyone" and "Informed choice is essential in healing/recovery from trauma" were excluded from the analysis because they were not included in the original subscale and had a load below .32 and analyzes were repeated. The results showed that a 3-factor structure was emerged, which explained 50.36% of the total variance and includes all items in the subscales of the original scale. As a result of the analysis, 3 items in the Attitude subscale were removed from the total items of the scale and the final version of 18 items scale that could be used in Turkish culture has been created. In the final study of the 28-item scale model created in the original study of the scale, a total of 7 items were removed, 5 items from the knowledge subscale and 2 items from the attitude subscale, and the final 21-item model of the scale was created (King et al. 2019). The fact that the three items in the original of the scale were removed after the analysis can be explained with the assumption that the related items cannot find meaning in Turkish culture.

Pearson correlation analysis revealed that the correlation between knowledge and attitude sub-dimensions was 0.35, the correlation between knowledge-practice sub-dimensions was 0.20 and the correlation between attitude-practice sub-dimensions was 0.20 In the original study by King et al. 2019, the correlation coefficient between knowledge-attitude sub-dimensions was 0.55, the correlation coefficient between knowledge-practice sub-dimensions was 0.28, and the correlation coefficient between attitude-practice sub-dimensions was 0.65. Compared to the original study, the correlation values were relatively lower in this study. In particular, the correlation between attitude and practice sub-dimensions was much weaker than in the original study. However, all correlations were positive and significant as in the original study. The findings obtained from our study overlap with the findings obtained from the original study of the scale.

An important limitation of the study is that the research data was collected online. The findings obtained from the research are limited to the answers given by the mental health professionals participating in the research. Research results can be generalized to the mental health professionals involved in the study. Additionally, although all participants of the study were mental health professionals, this does not mean that they have the same level of experience with trauma. Researchers should take this into account when evaluating the study. Finally, since the original version of the scale did not have validity and reliability studies for other cultures, the comparison of the findings obtained from this study was limited to the findings of the original study.

Conclusion

As a result of the statistical analyzes, the validity and reliability of the Trauma Informed Care Scale has been proven in the light of scientific data. With this study, a scientific measurement tool that will enable the determination of the knowledge, attitude and practice levels of healthcare professionals working with individuals with trauma history has been brought to the literature. The Trauma Informed Care Scale is a valid and reliable measurement tool that can be used by professionals (physicians, nurses, psychologists, psychological counselors, social workers) working with trauma survivors, and researchers planning studies on trauma-informed care and/or trauma-sensitive care.

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Addendum-1. Trauma Informed Care Scale (Turkish Version)

Trauma Informed Care Scale Turkish Version (Travma Bilgili Bakım Ölçeği)					
Instruction: This scale measures the level of knowledge, attitudes and practices of mental health professionals working with trauma victimized clients regarding trauma-informed care. It is scored as Strongly Disagree (0), Disagree (1), Neutral (2), Agree (3), Strongly Agree (4). Please mark the most appropriate option for you.					
	0	1	2	3	4
1. Travmaya maruz kalmak yaygındır.					
2. Travma fiziksel, duygusal ve zihinsel sağlığı etkiler.					
3. Madde kullanımı sorunları, geçmişteki travmatik deneyimlerin veya olumsuz çocukluk yaşantılarının göstergesi olabilir.					
4. Ruh sağlığı sorunları ile geçmiş travmatik deneyimler veya olumsuz çocukluk yaşantıları arasında bir bağlantı vardır.					
5. Güvensiz davranış, geçmiş travmatik deneyimlerin veya olumsuz çocukluk yaşantılarının göstergesi olabilir.					
6. Travma istemsiz bir şekilde tekrarlayabilir.					
7. İnsanlar kendi travmalarını toparlama ve iyileştirme konusunda uzmandırlar.					
8. Danışanlarımız ve aileleriyle etkin bir şekilde çalışmak için travma bilgili uygulama önemlidir.					
9. Travma bilgili uygulama hakkında kapsamlı bir anlayışa sahibim.					
10. Travma bilgili uygulama ilkelerine inanıyor ve bunları destekliyorum.					
11 Travma bilgili uygulama hakkında uzmanlığımı meslektaşlarımla paylaşıyor ve onlarla etkin bir şekilde işbirliği yapıyorum.					
12. Travma bilgili uygulama konusunda daha fazla eğitim almak istiyorum.					
13. Danışanlarla olan tüm etkileşimlerde şeffaflığı koruyorum					
14. Danışanlara seçenekler sunuyorum ve kararlarına saygı duyuyorum					
15. Danışanların ve meslektaşlarımın kendi güçlü yanlarını fark etmelerine yardımcı oluyorum.					
16. Çalışmalarıma başlamadan önce tüm danışanları bilgilendiririm.					
17. Her danışanla olan etkileşimim benzersizdir ve onların özel ihtiyaçlarına göre uyarlanmıştır					
18. Öz-bakım yapıyorum (kendi ihtiyaçlarım ve sağlığımla ilgileniyorum).					

Scoring

Subscale	Items
Knowledge	1, 2, 3, 4, 5, 6
Attitude	7, 8, 9, 10, 11, 12
Practice	13, 14, 15, 16, 17, 18