BUILDING CAPACITY FOR TRAUMA AND VIOLENCE-INFORMED CARE AND DECONSTRUCTING OPPRESSION IN WOMEN'S HEALTH CARE

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

The Faculty of Graduate and Postdoctoral Studies

(Population and Public Health)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

May 2021

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BUILDING CAPACITY FOR TRAUMA AND VIOLENCE-INFORMED CARE AND DECONSTRUCTING OPPRESSION IN WOMEN'S HEALTH CARE

submitted by Vanessa Brcic in partial fulfillment of the requirements for

the degree of Master of Science

in Population and Public Health

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Abstract

Rationale: Experiences of oppression, trauma, daily discrimination, and structural violence are ubiquitous among people cared for within primary care. The unique impacts of these experiences on women – in particular on mothers, racialized and Indigenous women, and early childhoods – have been clearly demonstrated, including in the gendered impacts of the COVID-19 pandemic. These experiences can be perpetuated or mitigated within the health care system. Trauma and violence-informed (TVI) care acknowledges these impacts, yet its integration into the fabric of women's health care and primary care services is limited. The landscape of women's health services offers an important opportunity to learn about the implementation of TVI care across a continuum of services with variable orientations towards equity-oriented care.

Objectives: 1. To describe the environments in which TVI care is practiced within a web of interdisciplinary women's health care services centered within primary care, and the contextual, structural, and individual factors influencing the care provided; 2. To generate insights about the implementation of equity-oriented, trauma and violence-informed care at a critical time of primary care renewal in Canada, including in the COVID-19 pandemic recovery.

Research Question: How do diverse ways of enacting TVI care for women expand understandings of how to implement and scale up TVI care in primary health care more broadly?

Study Design: We conducted 23 qualitative, in-depth interviews with diverse practitioners of TVI care within a web of women's health care services centered within primary care. We engaged in collaborative thematic analysis of the data, guided by interpretive description, and conducted by three women with dual experiences as trauma survivors and providers of TVI care. This study was informed by intersectional feminism, decolonizing and critical theories, and a social justice lens.

Findings: Participants described: 1. Contextual and system-level factors influencing TVI implementation in women's health care; 2. Process knowledge of how to enact and implement TVI care; and, 3. Clinical knowledge and approaches in TVI practice. The focus of this analysis is on the first two areas, which are described as: Oppressive systems – the landscape of trauma and violence-informed practice; and, Deconstructing oppression – the work of resistance and connection.

Lay Summary

Trauma and violence-informed (TVI) care is an important intervention for people, especially women, who have experienced trauma, violence, discrimination or oppression within society and within health care. Yet this equitable model of care is not well integrated into the fabric of health care services that remains rooted in hierarchical, oppressive and colonial histories. We interviewed 23 interdisciplinary health care providers who shared professional and personal experiences implementing TVI care across a range of women's health care services that are centered within primary care. Their insights advance our understanding of the colonial and oppressive culture within women's health care, and of the acts of resistance and person-to person connection used daily by these champions of TVI care to deconstruct oppressive systems and transform health care.

Preface

In consultation with community collaborators with lived experience, community and organizational advisors, and the thesis committee, I conceptualized and designed the research study. I conducted the majority of the interviews, coordinated and led the data collection, and led the process of collective data analysis in partnership with two community collaborators (Nicole Marcia and Agnes White), in consultation with the thesis committee. All study processes and procedures were approved by the UBC Behavioural Research Ethics Board (BREB), identified by certificate number H18-00811.

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EOHC – Equity-oriented health care

SDOH – Social determinants of health

TIP – Trauma-informed practice

TVI – Trauma and violence-informed

Glossary

Equity-oriented health care (EOHC) is informed by social justice principles, and involves a multidimensional approach that explicitly addresses inequities in primary care,[1] and other settings.[2] A comprehensive understanding of EOHC has been developed by the EQUIP Health Care program of research; it includes the provision of trauma and violence-informed care (TVI care) as an essential component, together with culturally safe and antiracist care,[3] contextually tailored care,[1] and harm reduction approaches.[4]

Oppression is discrimination supported or condoned by systemic and institutionalized power, resulting in consistent denial of access to resources, deprivation, exclusion, discrimination and exploitation.[5] It is a core cause of increasing health inequities in Canada and globally, perpetuated through capitalism, imperialism, neocolonialism, neoliberalism, and unjust health and social policies.[5] Oppression is a complex and dynamic process that is amplified by its intersections with other social determinants of health, particularly sexism and racism, and it is often not clearly visible without direct exposure of, and resistance to, "the harsh everyday realities of structural power"[(p.25)] for oppressed people and groups.[5] Oppression is toxic to health, as it "creates and sustains the chronic physical and psychological stress that ultimately leads to persistent physical and mental health problems."[5 (p.34)]

Primary care aspires to provide integrated, essential, universally accessible health care through sustained partnerships with families and communities.[5,6] It often serves as a person's first point of contact with the publicly funded medical system in Canada, and refers to relationship-based, longitudinal care delivered by family doctors, nurse practitioners or allied health care providers. Primary care is a key site of health system strengthening, currently in transition towards team-based care models called "Patient Medical Homes"; these are new models of multi-disciplinary team-based primary care experiencing slow and limited implementation across Canada.[5,7] Their goal is to replace one-problem-per-visit care with a central hub of patient-centered care that aspires to be

coordinated, continuous and comprehensive, that is accessible, high quality and responsive, and that links in and across sectors of health and social services across the life course.[8]

Social determinants of health (SDOH) are the conditions in which people live, grow and age, that explain dramatically different, inequitable and unjust social gradients in health due to "the unequal distribution of power, social injustice and suffering, and their effects on people's capacity to live healthy lives."[9] Globally,[10] and in Canada,[5,11,12] insufficient policy action on SDOH perpetuates unjust gradients in health care access and health outcomes.

Structural violence includes colonial violence and any systemic conditions that perpetuate discrimination, oppression, stigma or powerlessness. It is a "major determinant of the distribution and outcomes of social and health inequities".[13]

Trauma and violence-informed care (TVI care) is an essential component of equity-oriented health care (EOHC), alongside culturally safe and antiracist care,[3] contextually tailored care,[1] and harm reduction approaches.[4] TVI care locates "the problem" in structural conditions that perpetuate oppression, not in the "the psyche of the individual";[1] thus, TVI care goes beyond trauma-informed practice (TIP) to acknowledge continuities between past experiences of trauma and ongoing experiences of structural violence.

Trauma-informed practice (TIP) is synonymous with trauma-informed care. Trauma involves a violation of a person's fundamental sense of safety, or an experience that overwhelms a person's ability to cope,[14,15] and often leads to emergence of symptoms long after the event, and poorer health outcomes throughout the lifespan.[16,17] Trauma-informed practice is a clinical approach that builds experiences of trust and safety for people who have experienced trauma.

Acknowledgements

I offer sincere gratitude to the Coast Salish peoples – including the xʷməθkʷəy̓əm (Musqueam), sḵwx̱wú7mesh (Squamish), and sel̓íl̓witulh (Tsleil-Waututh) nations – whose unceded ancestral homelands held and nourished me through the time I spent on my own healing work, and on this thesis.

I offer heartfelt gratitude for the social justice and equity-oriented work, leadership and mentorship of my thesis committee – Kim McGrail, Annette Browne, and Sabrina Wong; and for the friendship, wisdom, and meaningful collaboration of my partners in this project – Nicole Marcia and Agnes White.

I offer sincere thanks to the Women's Hospital Research Institute and Sue Harris Research Fund for supporting Nicole and Agnes' participation in this study, and in doing so, for planting a seed for future collaboration.

I offer gratitude to my mentors – Michael Klein, Gabor Mate, John Millar, Bob Woollard, Margaret McGregor, Mariah Moser, George Duffy, and Linda Filippi – who, over the years, have inspired my critical thinking and encouraged me to continue to apply it in my work in medicine.

I offer gratitude to my family, who survived forced displacement to unceded lands on Turtle Island, and whose struggles allowed me to live as the first generation in our family with financial privilege, with perspective from our past that inspires my dedication to social justice oriented work.

I also offer heartfelt gratitude for the patience, support and humour of my partner Andrew Querner and daughter Pema, which was unwavering throughout this project and through the COVID-19 pandemic.

Dedication

This thesis is dedicated to my colleagues across disciplines who are engaged in resistance, who volunteer precious time and wisdom to fight for a safer and more compassionate health care system *"out of love"*, and who are courageously doing their own healing work in the interest of both personal and health system transformation. Thank you for your dedication and inspiration to persist in our aligned work of deconstructing oppression.

Chapter 1: Introduction & Rationale

1.1 Introduction & Rationale: The landscape of trauma and violence-informed care

At the heart of primary care, longitudinal, relationship-based, compassionate, and consistently safe health care encounters can support healing through ongoing experiences of trust, connection, and wholeness.[18–22] Experiences of trauma, daily discrimination, and structural violence are ubiquitous in society and in populations cared for within primary care.[13,17,23,24] A systemic environment that perpetuates discrimination and oppression is referred to as structural violence,[13] and is a "major determinant of the distribution and outcomes of social and health inequities."[25] This requires capacity in primary care to respond, particularly in the context of substantial unmet needs due to persistent health inequities in Canada,[11,12,26] and the COVID-19 pandemic that has exacerbated inequities and amplified the impact of marginalizing conditions and policies.[27,28]

Ongoing experiences of adversity and oppression[5] – including within health care[24,29–32] – can compound past experiences by re-traumatizing patients and contributing to toxic stress with "lasting and intergenerational impacts on everyday life and health."[5(p.26),17,23] Ongoing stress compounds the long-term effects of trauma by perpetuating a chronically activated fight/flight/freeze response as a person struggles to meet basic needs due to poverty, discrimination, low health literacy, poor health, lack of support, and/or other stressors.[33,34] Trauma-informed practice (TIP) has been increasingly adopted in mainstream health care as a clinical approach that builds trust and safety for people with past experiences of trauma.[14–16] However, within health care systems and policy, a lack of action on the inequitable distribution and health impacts of social determinants of health (SDOH), structural violence, and toxic stress can perpetuate the medicalization of social problems, and the neglect of upstream interventions that can contribute to more appropriate, person-centered care, and better health outcomes for people living "under threat"[5 (p.32)] and in "marginalizing conditions".[1,11,12,29,35,36]

Trauma and violence-informed care (TVI care) goes beyond TIP to act on intersecting social and structural conditions as causes of trauma and related health issues, through strategies that "mitigate the health effects of both interpersonal and structural violence".[4] Characteristics of organizations that deliver TVI care are described in a substantial body of research that describes TVI care as an essential component of equity-oriented health care (EOHC),[1,4,35,37] with potential to improve health outcomes in primary care.[38] The context for EOHC can be further understood in related work on intersectionality,[5,26,39] structural violence,[13,40] and trauma-informed practice[15,24,41].

The integration of TVI practices into the fabric of health care services is limited, with a scarcity of appropriate TVI services available outside of dedicated centres providing care to people living in marginalizing conditions.[35,42,43] Knowledge is limited both about TVI approaches within systems that are not equity-oriented, and how primary care encounters or environments may exacerbate the health impacts of trauma and structural violence. Understanding how health care systems may perpetuate or mitigate structural violence is essential to developing capacity for TVI care. Further research has therefore been called for: 1) that studies "intervention delivery" and the implementation process of equity-oriented practice, inclusive of TVI care, "in order to understand the intricate human processes that are integral to uptake, delivery, and impact,"[4] and, 2) that seeks to understand TVI care in "varied settings and populations," including "mainstream" health care services that have less emphasis on health equity.[38]

Women's historic and present experiences of trauma and structural violence within society, and when accessing health care, are known.[30,44–48] The impact of experiences of toxic stress, trauma, sexism, misogyny and other forms of structural violence – in particular on mothers,[49,50] early childhoods,[17,51–53] and Indigenous women[30,54–56] – has been clearly demonstrated; and, gendered health and social inequities are deepening in the COVID-19 era. Women are also more likely to seek primary care services than men,[57] and the majority of women's health care services are provided by primary care providers. Thus, the landscape of women's health services offers an important opportunity to learn about the

implementation of TVI care across a range of connected services with variable orientations towards equity-oriented care.

Understanding diverse TVI practices may enable the adoption of "different theoretical perspectives and methodological approaches to address dynamic issues, problems, and inequities through various lenses… [working] together under an umbrella of respect for various approaches."[58 (p.283)] Through our own experiences both seeking and practicing TVI care, we observed that the diversity of TVI practices – in this case led not by organizations,[1] but rather by individuals within systems entrenched in historic patterns of structural violence – are not well known. We hypothesized that these islands of safety are critical for the people they serve, however within structurally violent systems without sufficient orientation towards health equity, they cannot provide sustainable TVI care. An in-depth understanding of the TVI work of people *"fighting"* to provide better health care in their workplaces can inform TVI implementation across a diverse range of primary care and women's health services.

1.2 Conceptualizing the study

This study was conceptualized in partnership with community collaborators. From the outset, I engaged in discussion about project development and conceptualization with women with dual experiences as trauma survivors and professionals working in health and helping professions with principles of TVI care. I was grateful to receive a small grant (WHRI Sue Harris Research Fund) that supported hiring two women (NM, AW) to contribute to the data collection and collaborative analysis; it is this core research team of three women (VB, NM, AW) that I refer to as "we" throughout this thesis.

Trauma and violence-informed (TVI) care is one essential component of equity-oriented health care (EOHC), along with contextually tailored care, cultural safety, and harm reduction.[1,4] In the context of varied levels of commitment and organizational orientations towards EOHC, we chose to focus our inquiry on TVI care, to invite specific reflection on the intersection of trauma-informed practice with a structural violence lens. Drawing from our personal experiences seeking health care, we understood that the presence (or absence) of

TVI care was a critical determinant of safety, care continuity, and potential for healing. Drawing from our professional experiences, we decided to center the terminology of TVI care as a relatable and identifiable concept to practitioners to ground our inquiry. Participants who have diverse understandings of what equity looks like in practice may be more familiar with principles of trauma-informed practice – with or without the specific component of structural violence – rooted in a wide range of perspectives and disciplines. Throughout the paper we also use the term "TVI practices" to describe varied approaches integrating trauma-informed practice and attention to structural violence. The term "practice" also implies that a trauma and violence-informed lens is applied not only in the care that participants provide, but also in a broader approach to inter-professional relationships, advocacy, and their own healing.

Informed by decolonizing and de-pathologizing approaches,[41,59] we avoid using the term "patients", and instead use the term "people seeking care".[60,61] The purpose of this language is to position people first, in response to the structural and often marginalizing conditions in which they live, and to avoid narrowing our focus of attention on biomedical needs often prioritized in patient care.[62]

1.3 Objective, Research Question & Approach

The objective of this study is to understand the landscape of diverse, multi-disciplinary practices of TVI care within women's health care services. Understanding TVI care across various settings, professional lenses and practices, can help inform "intervention delivery"[4] and the implementation of TVI care across a broad range of primary care settings and services that provide women's health care. Our aim is to describe the environments in which TVI care is practiced within a web of women's health care services, primarily consisting of primary care services, and the contextual, structural, and individual factors influencing the care provided. We also hope that this study will expand understandings of TVI practices, and provide new insights about how equity-oriented, trauma and violence-informed care for women can be practiced and implemented at a critical time of primary care reform in Canada, including in the recovery from the COVID-19 pandemic.

The **research question** guiding this work is: How do diverse ways of enacting trauma and violence-informed care for women expand understandings of how to implement and scale up TVI care in primary health care more broadly?

We sought to answer the research question by conducting qualitative, in-depth interviews with diverse practitioners of TVI care within a web of women's health care services that are centered within primary care. We engaged in collaborative thematic analysis of the data, guided by interpretive description, and conducted by three women with dual experiences as trauma survivors and providers of TVI care.

This study is based on the premise that aspects of TVI care exist in diverse disciplines and settings with variable orientations to equity and structural violence. TVI approaches are provided by diverse multi-disciplinary professionals, and can provide greater safety, person-centeredness, and holistic care than what is usually offered in "mainstream"[4] Western biomedical care. We propose that in-depth descriptions of multi-disciplinary approaches to TVI care will enhance our understanding of equity-oriented, TVI care across a diversity of women's health care settings, and in doing so, identify opportunities for implementation within primary care.

1.4 Self-Contextualizing & Reflexivity

Multiple authors describe the importance of situating the researcher's position and perspective in the study process.[58,63–65] Reflexivity is particularly important in the context of diversity among the study participants and within the study team. The core study team included three women with dual experiences as trauma survivors and providers of TVI care within health care or community support services. From an intersectional lens, we acknowledge our collective experiences of gender, disability, and financial security/ insecurity, and our privilege resulting primarily from our white appearances, educational privileges, and "political and relational layers" of past engagement with social justice issues.[64] These intersecting identities also informed our experiences of healing, while seeking (and struggling to find) safe and supportive health care services for ourselves.

We have all worked in Indigenous health services, however as non-indigenous people (settlers and people displaced from other nations), we acknowledge important distance from the genocide that includes normative violence and "systemic misogyny"[p.38] experienced by Indigenous peoples in Canada,[66] that also contributed to the lack of safety in colonial systems, including medical care. At the beginning of the project we described our varying backgrounds differently: Two of us identified our position as allies of decolonization, one as "an advocate for anti-racism and anti-patriarchy", and one as a feminist. We agreed that these lenses – in particular the feminist lens – were strengthened throughout the project, as we deepened our understanding of the unique contribution of each to individual and systemic capacity for TVI care.

Since I transitioned from work in the non-profit sector to medical school, and carried forward my work in the non-profit sector throughout my career, I have reflected extensively on the conditions and people that we turn away from in health care. There is so much need and pathology right in front of us, easy to see, desperate for attention, that it becomes easy not to look any deeper. It might even burn us out to look, when our capacity is stretched to see and respond to what is already in front of us. However, the conditions and people that we do not see are often those that are systematically not seen, and are silenced or oppressed through practices, conscious or unconscious, of prescribed invisibility.[5,67–69] These people and conditions are often those who need our help the most, as described by the inverse care law.[37,70] Becoming attuned to those who are silenced or excluded immediately shifts one's perspective. We may no longer see straight through the lenses of our discipline, our professional interests, or our history, and those viewpoints are re-contextualized in a broader and more critical view of our practice and environment.

Throughout the study, we drew upon our past experiences to consciously inhabit a non-hierarchical stance, with specific attention to invert the "power relations of postcolonial spaces",[64] and to seek both critique and curiosity about diverse TVI practices and the systems in which they are applied. In this study, our gaze was broadly towards trauma and violence-informed primary care and women's health care services, recognizing through personal and professional experiences the inadequacy of current services in providing safe,

attuned, and de-pathologizing approaches. As non-indigenous researchers working with diverse participants including Indigenous peoples, we continually asked: *Who does this study privilege?* [65] and *"Who wins and who loses in this research?"* [71] while maintaining our focus on understanding the potential of system transformation towards greater safety and equity. Thus our research posture resonates with Chenail's "cultural critiques"[72] of environments we have encountered in our own healing, professional learning and practice. In social justice research, self-reflexivity is a critical recommendation that resonated with us. According to Parry and Johnson, "in that uncomfortable place is where a space imbued with official academic discourses meets a space of testimony and witness"; thus researchers working for social change must engage in the risky process of "privately and publicly unpack[ing] the very real, but constructed dichotomies between our personal and professional lives,"[58 (p.285)] a practice that can be supported through "bridling"[(p.106)] as a more integrated form of bracketing researchers' experiences.[58] Kvale further offers that "hanging out in the environment where the interviews are to be conducted,"[(p.108)] can contribute to depth of findings by including considerations of language, routines, and power structures.[73] Our process of collaborative analysis and member-checking – including re-engagement with participants to enhance trustworthiness and reliability – also "help[s] ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher."[74] Further reflections on reflexivity in relation to our study findings are offered in Chapter 6.

1.5 Scope of findings & Focus of thesis

In this study, we ask how a diversity of TVI practices within women's health services can inform the implementation of TVI primary care services. Deepening our understanding of the landscape in which TVI practices are currently being implemented is important to inform TVI implementation. Experiences and perspectives of participants reflected three general content areas:

1. Contextual and system-level factors influencing TVI implementation across a continuum of women's health services;
2. Process knowledge of how to enact and implement TVI primary care; and,
3. Clinical knowledge and approaches in TVI practice.

Following a review of existing knowledge and theoretical frameworks informing this study (Chapter 2), and a detailed description of the study methods (Chapter 3), the focus of the analysis presented in this thesis is on the first two content areas listed above. Findings that describe contextual factors in TVI care and process knowledge of how to implement TVI care are provided in Chapter 4 (Part 1: Oppressive systems) and Chapter 5 (Part 2: Dismantling oppression). A summary of findings, study limitations and implications for research and primary care, are provided in Chapter 6.

Chapter 2: Background, Theory & Literature review

2.1 Background: Existing knowledge & Practice

In this study, we sought a deeper understanding of the environments in which TVI practices are being implemented, through in-depth interviews with diverse professionals working in women's health care. It is important to situate the landscape of existing TVI practices within theoretical frameworks and an existing knowledge base that together can help us understand the root of our inquiry, that is the lack of action to address "unfair" and "disturbing" inequities in health.[11,12] This inquiry is informed by critical theory, a social justice lens, feminist intersectionality, and decolonizing practices.

A substantial body of existing knowledge referenced in Chapter 1 describes chronic and toxic stress, structural and systemic violence, trauma-informed practice, and equity-oriented approaches including TVI care. In this study we focus our inquiry on the language and practice of TVI care, while acknowledging the intersections among multiple frameworks and knowledges that inform the findings and analysis. Theoretical frameworks guide our use of existing knowledge and the new knowledge generated through the present work, and help identify the role of patient/person-centered care, and how primary care environments can support TVI practices, including in the COVID-19 pandemic recovery. These theoretical frameworks, existing knowledges, and policy contexts for TVI care implementation are outlined in this chapter.

2.2 Theoretical frameworks

Our inquiry and analysis are informed by interconnecting theories, which informed pragmatic methodological choices, and the lenses through which we conducted the analysis. Theories are "extensions of researchers' subjective experiences… values, belief systems, and worldviews,"[75 (p.230)] inevitably informed by "philosophical, ideological, ethical, and political assumption[s]".[76] Intersecting theories can contribute to "creative approaches to science from an interpretive perspective",[76] and may reflect a post-positivist

"paradigm proliferation",[58 (p.281)] in which multiple premises, paradigms and theories are like a net in which the researcher can be bound, and which guides action.[63]

These theoretical frameworks also influenced our choice of interpretive-descriptive methods, which reflects Denzin and Lincoln's conceptualization of research as inherently interpretive, guided by the paradigm and position of the researcher, and the "artistic and political" practice of making sense of findings.[63] Thus we also acknowledge the importance of techniques such as bridling,[58] self-reflexivity,[64] and self-contextualization,[65] that can help correct the harmful historic trend of subordination of identities in pursuit of impartiality,[77] and situate rather than deny the researcher's perspective (1.4, 6.2).

2.2.1 Critical theory

Critical theory represents a family of theories that offer an important framework for our inquiry into the lack of integration of equity-oriented care in the dominant reductionist biomedical and neo-liberal domain.[62,78,79] Critical theory challenges dominant "Euro-American" approaches[80] in which knowledge uptake is influenced by privilege and "social and historically situated power relations," and wherein values and facts cannot often be separated.[81] In the context of *"invisibility"* of the need for TVI care in mainstream health care services (4.2.2, 4.4.1, 4.4.2), critical theory is relevant as it attempts "to get behind the curtain, to move beyond assimilated experience," with the potential to produce "information and insight that upsets institutions and threatens to overturn sovereign regimes of truth."[81] Lyons offers that "critical-ideological research" may be "the most obvious execution of research that is socially just."[82] It is aligned with other frameworks described below, that together with a critical theoretical approach can challenge colonial, Eurocentric assumptions and support turning towards the "root causes" of health and social issues.[29] Critical theories are "useful for drawing attention to the political and moral concerns arising from the legacy of colonialism, and how this shapes people's everyday experiences."[29]

2.2.2 A social justice lens

Applying a social justice lens involves consideration of human rights, including not only the equitable distribution of health in society, but how research and health care services privilege some people over others.[5,12,39,77,78] Denzin and Lincoln describe the interconnection between social justice and other theories that can be "radical, democratic, and interventionist,"[63 (p.11)] finding new ways of moving forward, exploring new discourses, and "connecting persons and their personal troubles with social justice methodologies"[(p.281)] oriented towards social change.[58] Lyons and colleagues describe social justice as an action-oriented practice informed by four principles – access, participation, harmony and equity.[82] There are "numerous points of confluence" between these approaches and qualitative research methods, including emphasis on the importance of context and environment, the acknowledgment of cultural diversity within study populations, the encouragement of healthy reciprocal relationships between researchers, participants and communities, and the recognition of the influence of the researcher on these relationships.[82]

A social justice perspective[58,82] interacts with the equity focus in other frameworks, by assigning shared responsibility for change that is oriented toward fostering a more equitable society.[58] An equity lens acknowledges the ethical implications of policy work "since it involves decisions that affect populations who have little involvement in policy decision-making."[35] Social justice perspectives are also inherently linked with intersectional approaches that consider the multiplicative impacts of health determinants,[39] in particular for people who encounter "constraint, discrimination, marginalization, oppression, and violence in their everyday lives."[58 (p.282)] Parry and Johnson cite Charmaz' description of social justice inquiry that "attends to inequities and inequality, barriers and access, poverty and privilege, individual rights and the collective good, and their implications for suffering."[58 (p.12)] To attend to these injustices through research, the authors call us to "move beyond academic discourse" and practice research within a social justice paradigm as "a moral, ethical, and political task that challenges traditional notions of universal truth, scientific neutrality, and researcher dispassion."[58 (p.12)]

2.2.3 Feminist intersectionality

Intersectionality is a critical concept informing our inquiry that builds upon the social determinants of health (SDOH)[9,83] to explain the unique impacts of intersecting identities and oppressions.[5] Together, SDOH and intersectional approaches describe social and structural impacts on a person's health, differential outcomes across the life course, and the impact of inequitable access to appropriate care on these outcomes.[26,84,85] Intersectionality also offers opportunity for innovation and greater action on social determinants of health,[26] by disrupting linear thinking and the isolation of dichotomous variables, and addressing "the inadequate methods of constructing determinants, capturing their relationships, and understanding the wider context of structural inequities in which they are embedded."[39] When considering equity-oriented health care reform in the context of historic oppression and violence in women's health care, and when broadening trauma-informed practice to include action on structural violence in the implementation of TVI care, feminist intersectionality offers an important framework from which to consider systemic oppression, violence and power dynamics in the context of women's health care.

Feminist intersectionality draws upon feminist ethics, an intersectional paradigm, and the shared goal of social justice,[39] to address "pervasive and inexcusable gender inequality underpinned by bias and sexism… [including] in research and health care".[48] It avoids privileging gender as a single, primary determinant of health that can lead to assimilation by "treating all women the same... overlooking the ways in which economics, race, ability, geography… sexuality and other influences shape and intersect with gender; and diverting attention away from differences among women."[26] Thus an intersectional feminist approach seeks to address the lack of recognition of power differentials and intersecting axes of discrimination on women's health, that without consideration leads to the secondary marginalization of many women whose needs are dismissed by simplified or assimilated perspectives of gender.[26,84]

Feminist intersectionality thus seeks to understand "what is created and experienced at the intersection of two or more axes of oppression… on the basis that it is precisely at the intersection that a completely new status, that is more than simply the sum of its individual

parts, is formed."[39] In the work of "gender justice activism," Indigenous feminisms focus an intersectional lens on colonialism and patriarchy, "to examine how race and gender systems overlap to create conditions in which Indigenous women are subjected to forms of social disempowerment that arise out of historical and contemporary practices of colonialism, racism, sexism, and patriarchy leading to social patterns of 'discrimination within discrimination'."[56] An intersectional approach therefore places at the centre of inquiry "the multidimensional and relational nature of social locations and places, lived experiences, social forces, and overlapping systems of discrimination and subordination."[84] This requires "explicit attention to power,"[39] and questioning structures that maintain power relations through privileges that disproportionately benefit "normative or non-marginalized" groups.[84]

In practice, intersectionality includes a commitment to social justice, and is aligned with social accountability practices in medicine,[86] and anti-oppression approaches originating from the social sciences.[5] These approaches seek to address discrimination entrenched by structural or "institutionalized power", inviting active resistance to oppressive systems.[5,56] This work embraces diversity, including collaboration and "strategic alliances" that explicitly avoid assimilating "otherness" into existing processes and structures, while encouraging reflexivity to ensure authenticity.[84]

2.2.4 Decolonizing practices

Decolonizing theories[80,87] further our critical engagement by bringing forward issues of race and racism to "interrogate" the colonial past and its ongoing presence,[88] including the "complicity" of institutions in unjust structures.[77] Our study procedures were inspired by a diverse study population inclusive of Indigenous and non-indigenous peoples, that required us to question what knowledge we privilege throughout our inquiry,[65] and to "consider our socio-historical and professional locations, our motivations for seeking out collaborative research relationships, and the power relations that position us."[88] Building capacity for TVI care within institutions implicated in historic practices of colonization,[89] particularly in the context of mounting evidence of ongoing, pervasive discrimination and

racism in health care,[31,32,77,90–92] can be informed by the wealth of scholarship describing decolonizing practices and the critical work of deconstructing oppression within health care systems implicated in maintaining systems of dominance, oppression and colonization.[5]

Decolonizing approaches provide a framework for "identifying, framing, and solving problems, and understanding and explaining social reality,"[93 (p.293)] particularly from the impacts of colonization on Indigenous peoples. The work of decolonizing begins by overcoming oversimplified "binary distinctions"[88] that often do not serve people seeking care (for example, able/disabled, compliant/noncompliant, whole/broken); it also broadens our perspective[94] to understand individual experiences within relational, social, political and historical contexts, and the intersections between them.[29,65] Post-colonial theory adds critical perspective on the impacts of imperialism and neo-colonialism[81] that are essential to understanding ongoing oppression in society,[94] indicative that we have not moved past colonization but rather towards "new configurations" of inequities that have distinctive effects.[88] Over time, impacts of colonization accumulate when "overt subjugation is replaced by racism, discrimination, and social and economic disadvantages."[80] Despite an emphasis on acknowledging ongoing impacts of colonialism, Kovach and Smith dispute the use of the term "post-colonial"[87,65(p.75)] as it invites the assumption that colonization is in the past; thus in this paper we acknowledge decolonizing "as a verb" – an action required in health care to undo colonial "conditioning" and achieve decolonizing "outcomes".[65,94,95]

Ta7taliya Michelle Nahanee offers an example of present-time neocolonialism as the "intention" of "free" health care in Canada, that results in ongoing "racialized" experiences and worse health outcomes for Indigenous people.[95] The "active maintenance, through consistent action and inaction, of a system of barriers that create limited [health and] health care access for many Canadians, including Indigenous people, persons with disabilities and families who live in poverty," is also described by Elizabeth McGibbon as a key oppressive practice in Canada contributing to the "deterioration of the principles of the Canada Health Act."[5 (p.24)] Decolonizing practices thus invite us to question the culture and

origins of our beliefs, and to ask "Why do I believe what I believe?" and "What is the right way of doing things?"[94] These questions informed both our study objectives and interview guide as we question deeply entrenched normative practices in primary care and women's health. In the work of decolonizing (before helping or harming), Nahanee also proposes a practice of contrasting colonial and de-colonial approaches, and dominant and non-dominant perspectives;[94] this informed our presentation of findings in Chapters 4 and 5, in which we consider both oppressive systems and the work of deconstructing them.

2.3 Existing knowledge

TVI care is a key element of equity-oriented health care (EOHC), and builds on preceding and related knowledge on the neuroscience of stress, experiences of structural violence, and trauma-informed practice (TIP). An overview of these knowledges is offered here to contextualize our findings and analysis.

2.3.1 Chronic & Toxic stress

A psycho-neuro-immuno-endocrine response to stress[51] has been described in which multiple body systems are implicated in an integrated physiological response to stress and "allostatic overload".[96,97] Understanding the stress response as the result of a "chain of causation in oppressive practices"[(p.31)] creates an imperative for TVI practices that acknowledge the persistent toxic effects of systemic oppression on mental, physical and spiritual health for oppressed people, and in particular, for women.[5] Ongoing stress can compound long-term effects of trauma exposure through sensitization of the nervous system[51,97] and a chronically activated fight, flight or freeze response.[33] When in "survival" mode due to past or ongoing stressors, activity of the brainstem and limbic system overpower executive functions of the neocortex.[96,98] In "survival" mode, a person's ability to engage in coping, long-term planning, and navigation of day-to-day needs (including health care) is limited.[99] Impacts of chronic stress are cumulative over the life course,[33,51,96] with clearly described impacts of "toxic stress" on the health trajectories of children and

through adulthood. However this does not prescribe a "fixed trajectory"; resilience is possible with adequate support.[33,100]

Chronic stress can be perpetuated by discrimination and difficulty accessing essential services,[34,101] resulting in a "direct and often devastating relationship between these intersectionalities and inequities in access to healthcare."[5 (p.83)] The ongoing impact of chronic stress on Indigenous people has also been described,[32,41,102] however, "few evaluations of interventions to reduce stress, or its ill effects for Indigenous peoples, are documented in the published literature."[5 (p.96)] Chronic stress is a direct and indirect mediator between social and environmental circumstances (including oppression and colonization) and health outcomes;[5] yet the impact of chronic stress is often under-recognized or "over-simplified" in epidemiology, and warrants further attention in health research.[5,103] Maladaptive coping behaviours, such as smoking and other addictions, have been described as sequelae of the chronic stress response;[104] further morbidity may therefore be avoided and more appropriate care may be provided where appropriate supports are available that address the behavioural sequelae of chronic stress.

2.3.2 Structural violence

Structural violence can be understood as any condition that perpetuates oppression, stigma, or discrimination,[13] including "policies and practices embedded in systems such as social welfare, economic[s], justice, and health care [that] operate to produce inequitable distribution of the determinants of health."[37] Farmer writes about health inequities perpetuated by "an erasure of historical memory" and ongoing structural violence that is commonly accepted as "both 'sinful' and ostensibly 'nobody's fault'".[71]

Structural violence in health care is embedded in the institutional nature of health services,[5,24] and the historical trauma and racism associated with colonial and institutional practices,[92] for example within TB sanitoriums.[68,89] This has led to health care services that do not address disparities, but that are instead "innately unjust,"[29] perpetuating inequities through unequal treatment,[39] and processes within health care that are static, insidious, obscured, silent, and taken-for-granted.[29,77,92] Structural violence also contributes to care

fragmentation through under-resourcing, and the phenomenon of inverse care, in which those who are most marginalized have less access to appropriate care.[1,35,37]

The history of colonialism in Canada is an important example of structural violence that persists today, with devastating impacts on Indigenous peoples.[31,32,92,102] This includes the eradication of culture and language, the apprehension of children through residential schools and foster care, the inadequacy of reserve lands, limited educational and employment opportunities on reserve, "persistent and multifaceted forms of racial discrimination" including race-based violence, and "the ongoing lack of access to the social determinants of health."[37] Discrimination in everyday life is "continuous" with discrimination experienced in health care, "despite efforts within the health care sector to promote cultural safety and sensitivity."[29]

2.3.3 Trauma-informed practice

Trauma can be understood as a "violence that overwhelms,"[66 (p.2)] involving a violation of a person's fundamental sense of safety, often leading to emergence of symptoms long after the event, and poorer health outcomes throughout the lifespan.[16,17,98] Experiences of trauma are "multidimensional," straddling biomedical, social and societal realms, impacting mental and physical health, and interacting with most social determinants of health "in an increasingly brutal world."[14,34,66] Trauma can also perpetuate invisibility, as fear and denial are coping mechanisms that can amplify "the rule of silence".[100,105] Trauma-informed practice (TIP) is therefore founded on experiences of validation and the creation of safety in the present time.[15,44,98] Emotional centers of the brain can re-organize past trauma through ongoing experiences of safety and connection,[99,98] in which flight/flight/freeze survival responses can diminish over time as human connection and belonging are restored.[99,98]

However, trauma-informed approaches that focus solely on the work of individual practitioners and neglect organizational and structural engagement "are likely to have limited success."[1,15] The term "trauma" can be problematic when it simplifies experiences of extreme stress (often presumed to have occurred only in the past) and the responses to

such events (often presumed to be only psychological). Judith Herman's formulation of complex trauma (cited by participants in this study) goes further to acknowledge how political ideologies and public policies create and sustain complex trauma, which can be understood as "embedded in a social structure that permits the abuse and exploitation of a subordinate group."[5 (p.137)] Thus we must "actively work to dismantle structures of inequity… in addition to increasing our own trauma responsiveness as providers."[106]

In 2013, a trauma-informed practice (TIP) guide was developed for mental health and substance use care in British Columbia, that describes strengths-based practices of building trust, choice and collaboration, and enhancing attunement and safety in clinical environments.[14] This frequently referenced clinical tool (including by participants in this study) acknowledges historical trauma, and the unique trauma of colonization impacting Indigenous peoples in Canada, while framing TIP in the context of supportive, "non-violent"[(p.24)] organizational policies and procedures.[14] Despite its relevance to clinical practice, acknowledgment of the importance of addressing structural violence is lacking in this and other clinically oriented guides to TIP.[44,107,108] Such omissions can further pathologize people with normal responses to adversity, and situate practitioners as "part of the legacy of colonialism… simultaneously eras[ing] the naming of the structural acts of violence, while creating and exacerbating the psychological symptoms, through a form of colonial recognition or misrecognition."[36]

Dian Million describes "a trauma economy" in which "the colonized subject became a trauma victim."[66 (p. 6,9)] Natalie Clark further explains that "the dominant discourses of 'trauma' continue to define violence within normative neo-colonial constructions, thereby functioning to obstruct and erase the naming of certain kinds of violence such as experiences of racism [and] structural violence enacted through state policy".[36] However, the landscape of trauma scholarship is evolving. The "Indigenist Stress Coping model" cited by Duran and Walters situates trauma-informed practice within multiple social and ecological determinants of health, and describes the importance of approaches that permit, include and legitimize – rather than pathologize – expected post-traumatic stress responses.[59] Haskell and Randall call for an expanded "social context complex trauma

framework" and interventions across the spectrum of influence of trauma on the individual, family and society.[41] They cite Kirmayer's rejection of the narrow biomedical description of post-traumatic stress disorder that gives "insufficient attention to the other dimensions of experience that may be profoundly transformed", including "secure attachment and trust, belief in a just world, a sense of connectedness to others, and a stable personal and collective identity".[41]

A recent book describing trauma-informed primary health care goes farther to describe TIP as an "ecosystem" of "whole culture" support [(p.31-2)] that includes cultural humility practices, acknowledgment of structural violence (given the transmission of trauma through "adverse power dynamics")[(p.27)] and resilience-focused approaches to care.[24] CAMH's 2012 guide to "Becoming trauma informed" also applies an equity lens throughout and identifies interventions to address "systemic disadvantages".[15 (p.62)] Thus, a more holistic and structural lens within TIP is emerging within broader conceptualizations of trauma-informed practice.

2.3.4 Equity-oriented care

A comprehensive understanding of equity-oriented health care (EOHC) is offered by the EQUIP Health Care program of research, which informs the conceptual and practical basis for this study, and provides a deeper understanding of the complex health and social needs of people living in marginalized conditions, and appropriate interventions.[1,4,29,35,37,38,109]

Inequities can be situated culturally, historically and politically, as a result of "common global colonialism and neoliberal forces"[29] that impact health through "unequal distributions of power, money, and resources."[78] Inequities are perpetuated by "neoliberal economic reforms and social spending cuts over the past three decades"[29] and the multifaceted and ongoing impacts of imperialism.[78,87] Addressing inequities is thus "grounded in the principle of distributive justice."[78] Given extraordinary disparities in health outcomes experienced by Indigenous peoples,[31,32,92,102] equity-oriented services must also be "conceptualized in ways that take into account the historical and ongoing

forms of discrimination and structural violence that continue to shape Indigenous peoples' health, well-being, and access to resources."[29]

Equity-oriented health care (EOHC) is informed by social justice principles,[78] and involves a multidimensional approach that explicitly addresses inequities in primary care,[1] and other settings.[2] EOHC includes the provision of trauma and violence-informed care (TVI care) as an essential component, together with culturally safe care, contextually tailored care,[1] and harm reduction approaches.[4] Within the framework of EOHC, TVI care takes into account the continuities between interpersonal and structural forms of violence, and acknowledges both past experiences of trauma, and systemic conditions that perpetuate chronic stress, oppression or powerlessness.[1,29,37,110] On a practice level, TVI care involves "respectful, empowerment practices" that address power differentials and discrimination through team-based education, extensive clinic engagement, organizational policy change, and attention to reducing the risk of re-traumatization through health care.[37] In TVI care, an individual is witnessed within their structural context; a person is "not inherently marginalized", and practices support the development of resilience.[37,100] As an intervention, it can mirror social and political "tensions" through disruption of the status quo – for example confronting discrimination and racism in health care – however, this disruption is necessary to catalyze innovation and change "deep-seated patterns and conditions".[4]

2.4 Policy Contexts

This inquiry into the landscape of TVI practices can be situated in two main policy contexts defined here. There is critical opportunity presented within ongoing primary care reform and movement towards aspirational models of primary care including "Patient Medical Homes",[8] as well as the de-centralizing of power and re-centering of services towards the needs and contexts of people seeking care. The importance of both primary care reform and patient/person-centered care has been amplified during the COVID-19 pandemic, which has exacerbated inequities in wealth, health, and access to essential supports (including technology and health care); this calls for a shift away from "average-

population" approaches,[28] towards care that acknowledges the disproportionate health and socio-economic needs of marginalized populations.[27,28]

2.4.1 Primary care reform

In Canada, primary care currently aspires to greater patient-centeredness, team-based care and comprehensive care, to better meet patient needs and address increasing complexity of care.[111,112] Primary care is also an important site to address health disparities, SDOH, and improve health outcomes for marginalized groups.[1,5,37,113,114] In the context of "neoliberal health and social policies," and "mainstream" clinical practice that is insufficiently equity-oriented,[4] primary care has potential to mitigate impacts of chronic stress and structural violence through patient- and person-centered services,[61] that are equity-oriented and trauma and violence-informed.[1,37,114] Neglecting the impact of trauma and structural violence as determinants of health and an element of patient complexity in primary care services, perpetuates structural violence in this setting,[31,32,41] and the downstream treatment of illness, which is not cost-effective or patient-centered.[5,12]

Browne and colleagues have described an equity oriented primary care framework (EOHC) to address health disparities[1] and improve health outcomes[38] for people seeking care in this important site for intervention.[35,37] Key principles of EOHC resonate with characteristics of high performing primary care systems[113,115,116] and goals of primary care reform[117] including a focus on relational continuity, tailoring of approaches to unique community and clinic contexts, and universal approaches to creating safety and accessibility such as cultural safety and harm reduction practices. The relational core of TVI care is mirrored by the relationship-based principle of family medicine[21] and other health disciplines, including nursing,[118] which aspire to build trust with patients while providing whole person care within the care environment and the social context.[6,60,119] High performing primary health care systems put the full scope of patient needs and priorities at the heart of service delivery: For example, the NUKA model in Alaska has demonstrated transformative outcomes in delivering interdisciplinary patient-centered primary care services to Indigenous communities, and is a gold standard globally for a high performing Patient Medical Home.[115]

Despite the "limited uptake" of approaches to primary care renewal,[5 (p.161)] and slow progress towards the Patient Medical Home (PMH) in Canada,[7,120] progressive new models of primary care aspire to be coordinated, continuous, comprehensive, accessible, high quality and responsive, linking in and across sectors of health and social services throughout a person's life course.[112,120] However, impacts of these aspirational models have yet to be seen, with insufficient orientation towards equity oriented health care.[35] Principles of EOHC offer substantial alignment and potential to inform clinic and team design, for example in partnerships with patients and communities, commitments to anti-racism and cultural safety,[3] adequate skills and resources amongst all team members to address patient needs, and mechanisms to ensure service is high quality and person-centered.[1,121] Knowledge contributed by this study and other research that identifies opportunities for implementation of EOHC can support greater integration of equity-oriented principles in the context of ongoing primary care reform.

2.4.2 Patient & Person-centered care

In response to "oppression and inequality within society at large," primary care is in transition away from "prevailing bio-medically oriented and paternalistic" care, towards "another way of medical thinking" that is more empowering and patient-centered.[61,122] To contextualize study findings that describe movement away from institution-centered care to person-centered care, a brief exploration of concepts of patient and person-centered care is warranted.

Patient-centered care (PCC) is widely advocated for, placing the person, and their experiences of collaboration and empowerment, at the centre of health care delivery,[60] as well as "a carer holistically… understand[ing] the patient as a unique human being before forming a diagnosis."[61] Key characteristics include care that prioritizes the patient's concerns while seeking a holistic understanding of the patients "world", finds common ground about both the problem and management, enhances prevention, and builds upon a longitudinal relationship with the health care provider.[123,124] PCC can also be understood "for what it is not – technology centered, doctor centered, hospital centered, disease

centered."[123] However, understandings of the concept remain diverse, implementation is limited, and benefits remain inconclusive.[61] PCC has also been critiqued as "narrowly conceptualized"[(p.642)] and insufficiently equity-oriented.[38]

Person-centered care emerged from patient-centered care, stepping farther away from the biomedical lens, not only towards bio-psycho-social care, but even farther towards patient empowerment and a de-emphasis of "the sick-role".[61,122] Person-centered care demonstrates alignment with patient-centered care, however it acknowledges that "patient empowerment appears to be broader than patient-centeredness, and may place greater demands on caregivers and the organization of healthcare."[122] Although it lacks an explicit orientation towards equity, person-centered care emphasizes "the need to know the person behind the illness, in order to engage the person in his/her own care",[61] taking into account "the interdependence between dimensions" of a person.[61] It also emphasizes "the importance of carers knowing their own views," including awareness of how these views can impact patient interactions and decisions.[61] Person-centered care demonstrates some alignment with intersectional approaches and contextually tailored care by expanding on patient or "client" centered care, and shaping services "explicitly to the populations served and local contexts."[4]

2.5 Assembling the evidence & Knowledge gaps

In the current landscape of primary care reform, widespread acknowledgment and implementation of equity-informed, and trauma and violence-informed (TVI) care, is lacking. Health disparities and gaps in appropriate services persist for people affected by structural violence, and action is needed to reduce disparities in health outcomes and access, and eliminate experiences of structural violence and oppression that can be perpetuated within health care services. This presents an important opportunity to further understand the contexts and practices of champions of TVI care who are working towards equitable primary care and women's health care.

Critical and intersectional perspectives of the systems in which TVI care can be implemented support the questioning and challenging of oppressive, colonial and neo-colonial norms in an active attempt to decolonize primary care services. This study also draws upon social justice theory to re-centre power relations, a practice that is especially important in the context of hierarchical and patriarchal influences on women's health. To build capacity for TVI care is also to appropriately integrate the neuroscience of stress, and the social and historical contexts of structural violence and colonization that influence the majority of primary care encounters.

Chapter 3: Methods

3.1 Study design: Overview

Foundational literature has conceptualized equity-oriented and trauma and violence-informed (TVI) health care,[1,37] described implementation in community health centres,[4,35,125] and demonstrated improved health outcomes and increased comfort and confidence in health care for people living in marginalizing conditions.[38] However, trauma and structural violence are upstream determinants of health that remain insufficiently integrated and addressed in primary care and women's health services in Canada.[5,126,127] Understanding the individual work of health care professionals who integrate trauma and violence-informed (TVI) care in primary care settings, and across a web of disciplines providing women's health care, can enhance our understanding of the implementation process and context of TVI care. We conducted a qualitative descriptive study that sought a deeper understanding of the landscape of trauma and violence-informed (TVI) practices in women's health care, informed by decolonizing and critical theories, and intersectional and social justice approaches described in Chapter 2.

We completed semi-structured, in-depth interviews with 23 participants. Interpretive-descriptive methods are appropriate to understand process and perspectives while reflecting diverse voices of participants.[128–130] Thematic analysis was iterative, including ongoing revision of the interview guide and purposive recruitment throughout the data collection process.[131] Our analysis process included a detailed coding process, memoing, and constant comparative analysis done collaboratively by the core research team. Opportunities for member-checking and ongoing consent included follow-up questions to clarify sections of the transcript, opportunity to review draft findings, and follow-up interviews that helped to clarify themes, fill gaps, or offer opportunity to participants who expressed an interest in re-contextualizing perspectives in the context of the COVID-19 pandemic.

Three women with dual experiences as trauma survivors and providers of TVI care (VB, NM, AW) comprised the core research team involved in the analysis. We engaged in collaborative, self-reflexive practices through the study design, data collection and analysis; details of our collaboration are provided below, and in Chapter 6 (6.2).

Research Question: How do diverse ways of enacting TVI care for women expand understandings of how to implement and scale up TVI care in primary health care more broadly?

3.2 Interpretive description

We used a qualitative descriptive study design[129,130] with an interpretive descriptive approach to both data collection and thematic analysis.[128,131] This methodology is well suited to understanding the context and practice of TVI care across diverse settings and professions within women's health care.

Qualitative research is appropriate in health services to meet "clinical, organizational, and policy decision makers' need for knowledge and information in new and rapidly evolving areas."[132] Qualitative description is well suited to practice-based research questions in the health disciplines, and can be "of special relevance to practitioners and policy-makers".[129] Interpretive description is described as being "of practical importance to the applied disciplines within the context of their distinctive social mandates. It responds to the imperative for informed action within the admittedly imperfect scientific foundation that is the lot of the human sciences."[128 (p.29)] In this context, interpretive description is appropriate to critically examine the context of TVI practices that in many settings represent mainstream biomedical care. Interpretive description is a naturalistic method for understanding the "who, what, and where" of practices, generating "broad insights and rich information",[133] and relying upon a "practical, analytical 'so what might this mean?' form of interpretation that extends description… into sense-making."[128 (p.56)]

Through in-depth interviews, this study sought empirical information about characteristics and experiences of TVI practices. Kvale writes: "Interviews are particularly suited for

studying people's understanding of the meanings in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspectives on their lived world."[134 (p.105)] Interviews also support dialogue, whereby researchers can learn from "nuanced descriptions of the phenomena being investigated… [and] attempt to clarify and interpret the descriptions together with the subject."[134 (p.27)] Given the particular language and policy orientation of this study, we employed Kvale's method of briefing to explain the study subject, situate the interview, introduce context, and invite examination of the language of TVI work.[134 (p.27,55)]

A descriptive study design avoids "re-presentation" of expert perspectives, however it is also interpretive and constructivist by nature, given that descriptions are offered through the lens of participants' "perceptions, inclinations, sensitivities, sensibilities,"[(p.335)] and analysed through the researchers' lens.[129] Interpretive description can comprise a complete and valuable end point where description is sought, facilitating translation of "a comprehensive summary… when straight description of the phenomena is desired".[133] This study seeks not to uncover the unknown nature of a phenomenon, but to understand characteristics and meaning associated with the practice and implementation of TVI care in diverse settings and disciplines, and produce descriptive narrative of challenges and best practices that may inform broader implementation of TVI practices in primary care and other health care settings.

Interpretation is necessary to contextualize descriptions,[128] in this case, in the context of literature describing theory and principles of TVI care, opportunities within primary care reform, and more broadly, structures and systems of oppression that contribute to ongoing marginalization and barriers to the provision of TVI care. Themes served to frame and organize the presentation of the descriptive data, wherein recurring or contradictory patterns were identified.[74,128] Descriptions of TVI practices with Indigenous peoples are presented within the broad spectrum of TVI practices described by participants; however there is rich opportunity for further analysis of Indigenous TVI practices described in this study.

3.3 Diversity in sampling

Women's health services are centered in primary care, and situated within a web of interdisciplinary health care services described by participants in this study. Maximizing the diversity of people, backgrounds and experiences included in the study contributes multiple perspectives of people providing (and receiving) TVI care in this context. This section draws upon the methods literature to support our choice to maximize diversity in this study.

Denzin and Lincoln describe the "multiparadigmatic" focus of qualitative research shaped by different tensions, sensibilities, "ethical and political positions," which can be embraced in one project.[63 (p.6)] A diverse study population includes "multiple voices, exhibiting characteristics of similarity, dissimilarity, redundancy and variety… sought in order to gain greater knowledge of a wider group."[74 (p.65)] Sampling in qualitative research should therefore focus on appropriateness and adequacy of the group of participants included, who "best represent the research topic", and who can provide "richness of information" sufficient to answer the research question.[135] We therefore sought different and potentially divergent perspectives in this study to deepen our understanding of the landscape and context of TVI practices.

In addition to generating "information-rich" description,[129] Shenton describes research with a diversity of informants as embedding a form of triangulation in the study process, yielding a rich picture based on diverse contributions, and citing Dervin, "a better, more stable view of 'reality' based on a wide spectrum of observations".[74 (p.66)] Similarly, "site triangulation" – including people in different organizations (or disciplines) – can "reduce the effect on the study of particular local factors peculiar to one institution… Where similar results emerge at different sites, findings may have greater credibility in the eyes of the reader."[74 (p.66)]

In a diverse study population, interpretive-descriptive methods can preserve the voices of participants, and do not require researchers "to move as far from or into their data".[129] Braun and Clark argue that it is "naïve" to view the goal of qualitative analysis as "giving

voice" to participants.[136] However, "low-inference" interpretation is possible that does not seek to "re-present events in other terms" and that is "especially amenable to obtaining straight and largely unadorned (i.e. minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers."[129]

Parry and Johnson describe the implications of diversity from a social justice lens, through which we view the work of equity-oriented, and trauma and violence-informed care. Interdisciplinarity in research is an appropriate match for social inequities that are both complicated and complex, by enabling researchers "to adopt different theoretical perspectives and methodological approaches to address dynamic issues, problems, and inequities through various lenses… [working] together under an umbrella of respect for various approaches."[58 (p.283)] Interdisciplinarity does not need to be exhaustive, but acknowledges that diversity is an important part of complex systems that are "too mercurial to be viewed by a single way of seeing."[58 (p.283)] However in a diverse study population, declaring who was not represented is important to acknowledge any sampling bias or presentation of a false concept of diversity.[67] Implications of diversity in our study are discussed further in Chapter 6.

3.4 Inclusion of Indigenous people

The core study team members do not identify as Indigenous, however all three of us have worked with Indigenous peoples in different settings providing TVI care. Given the significance of past and ongoing trauma that Indigenous peoples in Canada have experienced,[32,41] and the imperative of cultural safety and anti-racism approaches in the provision of person-centered TVI care,[29,31] it was important to include participants working in the field of Indigenous people's health in this study (which included people who identified as Indigenous and non-indigenous). This decision was made in consultation with the thesis committee, community advisors from the First Nations Health Authority and the SFU Faculty of Health Sciences, and in a rounds presentation and discussion at Vancouver Native Health Society (6.3). A focused exploration of the perspectives of Indigenous people, and people working in Indigenous people's health care, is outside of the scope of this thesis.

However, it is an important area of further research that we identified during study development and that we will follow up in collaboration with our community advisors.

Allies at all levels of health care service and policy must advocate for a gold standard of TVI care for Indigenous peoples that includes adequately resourced, self-determined, culturally safe care that includes traditional healing and shared care with Elders.[29,137] Islands of cultural safety within the health care system are insufficient, given the majority of Indigenous peoples live off-reserve, access a diverse web of medical services, and may experience re-traumatization in health care given its colonial roots. Through understanding the landscape of implementation of TVI care in diverse areas of practice, we hope to contribute to a greater understanding of the capacity for allyship and safety in health care for Indigenous peoples.

Translating a diversity of perspectives without assimilating ideas is important when including voices of diverse professional backgrounds and ethnicities in this study, including Indigenous peoples who may "consider themselves distinct."[80] Nicholls advises that "the goal of collaborative work should not be to dissolve/ consume/ soften/ erase difference, for Indigenous peoples – as a matter of political, practical and identity survival, as Indigenous peoples – insist on a profound difference at the Self–Other border. The hyphen is non-negotiable."[64] Thus our study process was inspired by Ermine's description of the possibility of an "Ethical space of engagement" between world views (described in section 3.9.2) and Parry and Johnson's reference to dialogue "across the expanse that lies between our world-views", that creates "space for important generative dialogues and collaborations… contributing to the potential of positive social change."[58 (p.283)]

In this context of diversity, we considered participants' orientations and world views throughout our analysis, which is described further in Chapter 6. Disclosure of our research posture to participants was also an important choice for us given the representation of survivors / practitioners on the study team. Renert and colleagues advocate for interviewer self-disclosure as a reflective process that can support "empowering participants, encouraging reciprocal sharing of intimate experiences, and overcoming barriers related to race and culture".[138] This aligned with our practice of self-reflexivity throughout the

analysis (explicitly recognizing our own perspectives and assumptions), and associated caution about both assimilation and silo-ing of participant experiences in the write-up.

3.5 Recruitment

The primary inclusion criterion in this study was self-identified experience providing TVI care for women; a minimal level of experience was identified defined as having pursued some independent reading or formal learning on TVI care or a related subject. A definition of TVI care and related concepts was provided to each prospective participant with additional support offered by the thesis student by email or phone if needed to clarify eligibility. Additional inclusion criteria were: self-identified familiarity with primary health care (see below for further detail); the ability to conduct the interview in English; and professional practice experience in British Columbia.

We recognize that patients and survivors are the true experts on TVI care, however given the sensitivity of topics related to trauma, structural violence and marginalization, we chose to exclude patients as experts who did not also work as professionals, able to bracket and contain personal experiences to create safe clinical and research environments. Potential participants were provided with one-page summary documents describing key terms and definitions together with informed consent, prior to participating in the study (Appendix A & C), in keeping with Kvale's process of briefing.[134] The definitions (of TVI care, structural violence, SDOH, and primary care) served as discussion prompts for related terms and concepts, and resonance or discordance with related concepts across disciplines; these also ensured consistency and familiarity in language amongst participants.

In this study, practice experience with TVI care included a range of levels of experience. A minimal level of knowledge was identified in consultation with the thesis committee, and defined as self-directed reading or independent learning about TVI care or related concepts, including, for example, rounds or CME presentations, webinars, or journal article reading. Self-identified familiarity with primary care was required, however we did not require professional experience working in primary care in order to acknowledge the breadth of disciplines contributing to women's health care. Familiarity with primary care

also did not distinguish between knowledge gained as primary care provider, caregiver, patient, or a combination thereof, so as not to undervalue the experience of users of primary care. To ensure a baseline understanding among all participants, we included a definition of primary care in the key terms and definitions document, however early in the interview process we removed this reference as it was unnecessary to generate discussion of TVI practices and opportunities in primary care settings.

Informed consent was collected prior to participation, including consent for audio-recording of data and preferences regarding identification or de-identification of data. Recruitment was done through networks of the core research team, including the funder (Women's Health Research Institute), professional networks of study team members, and through snowball sampling. Two recruitment letters were approved by the UBC BREB (for direct and snowball sampling). In consultation with the thesis committee, our initial goal was to recruit 15-20 professionals with varied experiences in trauma and violence-informed practice. No correct sample size can be calculated in qualitative research, but researchers must balance needs for a sample small enough to facilitate sufficient depth of exploration of individual cases, and large enough to facilitate diversity, and inform KT or further research.[134,139] We thus recruited 23 participants in this study; a description of our study population is provided in Chapter 4 (Table 1).

3.6 Data collection

Prior to recruitment, we conducted a pilot interview with one of the study team members, testing the preliminary interview guide and summary documents. This interview was transcribed and analyzed collaboratively by the three core research team members (VB, NM, AW), informing our transcription process and revisions of the key terms document and interview guide (Appendix A & B) for clarity. The pilot interview also contributed to our first exercise in self-reflexivity by initiating discussion amongst the research team about how our own perspectives, interests and priorities were reflected in the interview guide. We completed two additional revisions of the interview guide during the period of iterative

data collection and analysis, and each revision was done in a collaborative, self-reflexive process with the core study team members and in consultation with the thesis committee.

After informed consent was obtained, 23 semi-structured, in-depth interviews were conducted by two of the core research team members (VB conducted 17 interviews; NM conducted six interviews). All interviews followed the semi-structured interview guide (Appendix B), using probing questions when needed to clarify or deepen our understanding of participants' stories. Interview length varied between 60-100 minutes for most interviews. If a lack of clarity or understanding was perceived during transcription or memoing, or if demographic information was missing from the interview, we requested permission from the participant to ask clarifying follow-up questions; this was done with eight participants as part of member-checking. Given close-knit networks of practitioners, we also developed a protocol whereby participants who were personal contacts of the interviewer would be offered a follow-up interview with another team member to reduce participant or response bias. Two participants with shorter interviews (interviewed by NM) were offered and accepted this invitation for 30-minute follow-up interviews; this additional transcribed data was added (with separation) at the end of the previous transcript. During member-checking, six participants expressed interest in sharing additional thoughts or re-contextualizing previously shared ideas in the context of the COVID-19 pandemic; this data was analyzed by the thesis student and is presented separately in Chapter 5.

All participants consented to the audio recording and transcription of interviews. All transcripts were cleaned of identifying data to permit document sharing in keeping with our ethics protocol; this was done by the transcriptionist (VB or medical student volunteers), and anonymization was verified by a second team member who read each transcript during the iterative analysis and memoing process. Audio files and transcribed data were stored according to guidelines for privacy and security in data management[140] using UBC workspace to store all files.

3.7 Participants

The study included interviews with 23 participants; approximately 72% of people contacted agreed to participate. We contacted 36 people during the recruitment process; 26 people agreed to be interviewed (3 interviews with family physicians were declined or cancelled by the research team as saturation was reached); 1 person was not eligible, 2 declined, and 7 were contacted once only (no follow-up contact was made as further recruitment was not pursued).

Given the anticipated diversity of TVI practices, saturation was not an objective.[135] However after 17 interviews were completed, we began to observe repetition and "intensity" in content;[(p.1782)] our learning from participants exceeded our expectations and we were curious about possible theoretical saturation at this point.[141] We reflected on what was not being spoken about in the interviews, and identified roles or perspectives that were referenced more than once by participants, but not included in the study. An additional six participants were then purposely recruited to fill gaps in the diversity of the sample, ensuring that key perspectives were not missing (we recruited an Indigenous Elder, an expert in adverse childhood experiences, a male and female psychiatrist, and a male and female OB/GYN). This led to our total study population of 23 people. We generally experienced ease and enthusiasm throughout recruitment, with interest demonstrated by everyone we corresponded with.

In a diverse sample, declaring who is not represented, who could not be interviewed or refused participation is important.[67] Not surprisingly, we had particular interest amongst family physicians working with marginalized populations, and amongst people interested in nervous system (somatic) approaches to treatment as part of trauma-informed care. After speaking to several participants describing this knowledge base, we declined or cancelled subsequent interviews with people with similar practice experiences and knowledge backgrounds, and pursued targeted recruitment as described above, seeking under-represented views, in particular those referenced by other study participants. Of note, we did not receive a reply from a complex chronic diseases program for women, nor from two organizations providing crisis support for women experiencing violence;

however other participants described working with populations served by these programs, so we did not pursue further recruitment with these groups. The demographics and disciplines of study participants are presented in Table 1.

Preferences for de-identification varied: 11 participants chose de-identification, 10 preferred "that my thoughts/ideas/comments are attributed to me and appropriately cited," and 2 participants expressed no preference, entrusting choice of identification or de-identification to the researchers. In the final analysis, upon re-confirmation of participant preferences for identification of information during member-checking, appropriate citations were added back in to transcripts of the participants who wanted their views and ideas attributed to them.

Table 1: Participant demographics

ID	Name/Role	Gender	Years experience	Professional roles	Main area of practice	Primary practice population	Works with Indigenous peoples	TVIC related education
CF	Midwife	Female	21	Midwife, Counsellor/therapist	Primary care, private practice	Socio-economically disadvantaged women	Yes	Indigenous studies, Indigenous health & cultural safety; Trauma therapy & TIP
CV	Casey Vickers	LGBTQ2S	20	Director/Coordinator, Peer support	Primary care & allied health, community non-profit	Street-wise women	Yes	College degree & community-level training; Indigenous health & cultural safety; TIP
DF	Obstetrician	Female	4	OB/GYN, Research	Hospital, specialist consult service (urban)	Mixed demographic	Yes	Indigenous health & cultural safety
DJ	Donna Jepsen	Female	30	Director/Coordinator, Nurse (community health), Research	Primary care, Nurse Family Partnership (provincial program)	Socio-economically disadvantaged women	Yes	Master's Degree; SDoH/equity-oriented training; Indigenous health & cultural safety; TIP & Women's health
EC	Elder	LGBTQ2S	24	Director/Coordinator, Elder, Peer support	Primary care, community non-profit	Mixed demographic	Yes - Indigenous health as primary practice	Indigenous health & cultural safety, Traditional healing
GT	Psychiatrist2	Female	6	Psychiatrist	Hospital, specialist consult service	Mixed demographic	Yes	Trauma therapy, TIP & Women's health
HI	FP Addictions	Female	43	Director/Coordinator, Family physician	Primary care, hospital service	Women with addictions	Yes	Social sciences degree; Feminist studies, Women's health
JLK	Jennifer-Lee Koble	Female	18	Indigenous therapist, Social Worker	Primary care (mental health), private practice	Mixed demographic	Yes - Indigenous health as primary practice	Master's degree; Indigenous studies, Indigenous health & cultural safety; TIP & Women's health
KN	Program Director	Female	17	Director/Coordinator, Social Worker	Primary care & specialty services, hospital	Mixed demographic	Yes - Indigenous health as primary practice	PhD, Indigenous health & cultural safety
KQ	Physiotherapist	Female	8	Physiotherapist (pelvic floor), Manual therapist	Primary care (rehabilitation), private practice & hospital	Mixed demographic	Not as a significant part of their work	Community-level training; TIP & Women's health
MJ	Marcia Jacobs	Female	50	Counsellor/therapist, Social Worker, Teaching	Primary care (mental health), private practice	Mixed demographic	Not as a significant part of their work	Master's degree, Social sciences; Trauma therapy & TIP
MV	FP Forensics	Female	17	Director/Coordinator, Family physician, Teaching	Primary care, community & hospital	Street-wise women	Yes	Community-level training; TIP
ND	Psychiatrist1	Male	34	Director/Coordinator, Psychiatrist, Teaching	Primary care (mental health), community non-profit	Street-wise women	Yes	Community-level training; Feminist studies, social sciences, women's health
NM	Norissa Mongrain	Female	15	Indigenous counselor/ therapist, Social Worker	Primary care (mental health), community non-profit	Mixed demographic	Yes - Indigenous health as primary practice	College & Master's degree, Social sciences; SDoH/equity-oriented training, Indigenous health & cultural safety; Trauma therapy & TIP
NY	FP Refugee health	Female	10	Family physician, Teaching	Primary care, community non-profit	Refugees	Not as a significant part of their work	Community-level training, TIP, Women's health, Indigenous health & cultural safety
PD	Nurse	Female	23	Director/Coordinator, Nurse (community health), Harm reduction	Primary care, regional program	Women with addictions	Yes	Bachelor's Degree & Community-level training; SDoH/equity-oriented training; TIP
RA	Ron Abrahams	Male	35	Director/Coordinator, Family physician, Teaching	Primary care, community & hospital	Women with addictions	Yes	Women's health
RM	Ruth Martin	Female	34	Family physician, Research, Teaching	Primary care (prison health), community & institution	Street-wise women	Yes	Master's Degree & Community-level training; Indigenous health & cultural safety; TIP
S	Sekani	LGBTQ2S	6	Peer support, community leadership	Allied health (peer support), community non-profit	Street-wise women	Yes	Community-level training; SDoH/equity-oriented training; Indigenous health & cultural safety; Trans & LGBTQ2S health
SC	Sarah Holmes de Castro	Female	14	Director/Coordinator, Addictions & violence support, Yoga therapist	Allied health (addictions & violence), community non-profit	Socio-economically disadvantaged women	Yes	SDoH/equity-oriented training; Trauma therapy & TIP; Women's health
SD	Sheila Duffy	Female	25	Director/Coordinator, Peer support	Allied health (mental health), community non-profit	Mixed demographic	Not as a significant part of their work	Community-level training; TIP & Women's health
TN	Obstetrician	Male	17	OB/GYN, Teaching	Primary care & specialist consult, hospital (non-urban)	Mixed demographic	Not as a significant part of their work	Women's health
VE	Manual therapist	Female	6	Body worker/manual therapist, Yoga therapist	Allied health, private practice	Mixed demographic	Yes	Community-level training, Trauma therapy & TIP

ID = Identifier in text; TIP = Trauma-informed Practice; TVIC = Trauma and Violence-informed Care; SDoH = Social Determinants of Health

3.8 Data analysis

Iterative, thematic analysis began following each interview, guided by Thorne's process of interpretive description,[128,130] borrowing from the method of constant comparison from grounded theory.[142] This iterative approach involved simultaneous data collection and analysis that is appropriate in this descriptive study to support ongoing purposive (theoretical) sampling, focusing of the interview guide, greater depth in the data, and validity of findings after a period of immersion.

In our study, the three core study team members (VB, NM, AW) were involved throughout the recruitment, interviews, coding and analysis (NM contributed to study development from its outset; AW joined at the start of recruitment), with support provided by the thesis committee throughout. Consistent involvement of community members (NM, AW) was supported by a small grant (SHRF/WHRI), ensuring continuity throughout data collection and analysis. Consistency throughout the research process is recommended by Shenton to enhance researchers' abilities to identify "possible contextual meanings" in the analysis, and ensure alignment of the processes of data collection and analysis, such that analysis is not an afterthought, but "something one brings forth with them from the field."[74 (p.69)]

Our choices in the analysis were also guided by Lyons and colleagues' description of analysis procedures that support socially just qualitative research: 1) by involving a diversity of data coders "in terms of community membership, access to power, and cultural background"[(p.13)]; 2) by acknowledging researcher inputs and influence on analysis and interpretation; 3) by improving trustworthiness through the use of participant quotes and member checks; and 4) through ongoing "process consent" throughout the analysis phase,[(p.17)] in which participants can choose to opt out or remove their data at any time.[82] We followed these guidelines in our study development, particularly in the collaborative process of study design, data collection and analysis, and in the member-checking process described below (3.7.3, 3.8).

3.8.1 Data coding

The coding process was developed by the thesis student (VB) in consultation with the thesis committee, using both deductive and inductive codes (from participants' stories and interview guide content). Development and testing of the code book began mid-way through data collection. Codes were initially generated from memos of the core research team (VB, NM, AW) that reflected on the content of eight interviews, at which point no substantial new content areas emerged to be added to the code book. The coding framework reflected participants' words wherever possible, and we later added broad topic headings to capture important additional content areas (for example, Indigenous people's health and teaching/learning practices). Two substantial revisions were made to the code book; one after testing the preliminary code book in the coding of five transcripts (and then re-coding these transcripts to test the revisions), and another revision was done midway through coding after consultation with the thesis committee (this involved combining and deleting sub-codes, and few additions; we then re-reviewed previously coded transcripts to add new codes).

We chose a fine-grained coding structure that would allow for subsequent data analysis of the large and rich data set. VB trained both collaborators (NM, AW) in data coding using NVIVO software, which was used by all three team members who coded at least one transcript each. We used printed copies of the code book for visual reference and to facilitate note-taking during coding (to inform further revision and the analysis), and at all meetings to guide discussion. VB reviewed all coding done by the two collaborators in detail, and revised the coding as needed to ensure reliability and consistency in coding, as an alternative to determining inter-coder reliability (although the alignment between our respective codes improved throughout the coding process). Thus, each transcript was reviewed in detail by at least two study team members. Agreement, discrepancies, and consistency were discussed during team meetings and one-on-one between the thesis student and collaborators, using the coding and memos as prompts. Relationships between codes, sub-codes and emerging themes created a bridge to thematic analysis.

3.8.2 Focus of analysis

At the completion of coding, the three core research team members met in person to speak freely about what stood out to us, what descriptions were particularly rich and stuck with us, which coding areas were related, and what patterns we observed in the interviews across diverse participant backgrounds and experiences. Detailed notes were taken by the thesis student in this and all meetings from study development throughout the analysis; these notes were used to identify three content areas from the interviews, generated from relationships emerging between codes. These were: 1. Contextual and systems-level factors influencing TVI implementation (system dysfunction and reform); 2. Process knowledge of how to enact and implement TVI care (knowledge and practice development, ways of working within systems); and 3. Clinical knowledge and approaches in TVI practice (principally described in one-on-one encounters with people).

In consultation with the thesis committee, and in seeking alignment with the research question (learning from diverse existing TVI practices to inform the development of TVI primary care services), we decided to focus the analysis for the thesis on the first two content areas: Contextual and systems-level factors affecting the practice and implementation of TVI care within a web of women's health care services that includes but extends beyond primary care, and implementation knowledge. We then started the process of thematic analysis, which involved detailed study of data coded under two primary parent codes: *Biomedical care as an unsafe space*, and *Reforming colonial systems*. We use the detailed memos written by the three core study team members and medical student volunteer transcriptionists, to support the analysis of coded data and to help us make links with related evidence and theory. At this point, we conducted the analysis in word processing software, using groupings of data coded under these headings, and returned to NVIVO to consult sub-codes under these headings and related narrative coded otherwise. Our goal was to focus the reporting of results on these contextual and systems-level factors, while explaining and situating descriptions within the broader scope of knowledge reflected in the interviews.

3.8.3 Thematic analysis

Thematic analysis involves classifying discrete concepts and conceptual labels present in the data.[143] It aims to provide a detailed and complex account of perspectives shared by participants, through adaptable procedures that are appropriate for our goal of sharing low-inference and unadorned descriptions of diverse perspectives.[131,136] Interpretation is guided by the researchers' thoughtful judgments about representing patterned responses and meaning within the data.[136,143] The goal of thematic analysis, through a trustworthy and immersive process, is therefore to identify themes as "significant concepts that link substantial portions of the data together".[131] Thematic analysis does not include strict procedures, but guides the research process and choices made to enhance trustworthiness and authenticity in treatment of the participants' perspectives and experiences.[131]

In keeping with the process of interpretive description (3.2) and previously described guidelines for honouring diverse perspectives in interdisciplinary research (3.3), we sought to interpret findings "without moving too far" from participant narratives.[130] Data analysis has potential to "strip contextual richness away", fragmenting meanings and making it difficult to identify the individual experience and meaning within the analysis.[144] Kvale cautions that "well-polished eloquence and coherency may… gloss over more contradictory relations to the research themes."[134 (p.146)] Ayres thus recommends a form of within and across-case analysis for a diverse group of participants that respects individual narratives and common themes, facilitated by a process of "intuiting" through identification then critical reflection on themes found in accounts of multiple respondents.[144] We also considered where our thematic structure may have "failed to portray" any individual experience,[144] a process which benefited from member-checking and further analysis in which we could "ask and re-ask" what accounted for similarities and differences in perspectives.[74]

In our analysis, the three core research team members read at least one set of coded data. Two team members (VB, AW) re-read all of the memos (2-4 memos were written for each interview) to extract comments relevant to contextual and systems level factors, to check inclusiveness in reporting of results and ensure that no unique, important or contradictory

views were omitted in our translation of the results. Given important existing research on TVI care, we remained open to emergence of inductive or deductive themes, made links to existing research and knowledge of the study team, and reflected upon which descriptions were most true to the data.

Agreement on themes was made by consensus, and evolved throughout data analysis and member checking. We began with an inclusive "more is better" approach to identifying themes, recommended by Ryan and Bernard,[143] and then asked questions of the narratives represented therein, principally: *How is this expression similar or different to others?* And, "*What is this expression an example of?"*[143 (p.87)] We used additional headings in this process ("unique or contradicting ideas" and "recommendations") to ensure that contrasting, divergent or marginal views were not lost or misrepresented. Final review of themes involved examining our theme structure to ensure it was both "discrete and broad" while reflecting a "coherent pattern,"[131] and alignment or congruence with the research question, as suggested by Chenail and Whittemore.[76,145]

Once a long-form results section was drafted by the thesis student and reviewed by all three core study team members, we circulated these draft findings to participants for member- checking. Kvale[134] and Lyons and colleagues[82] describe the importance of ongoing consent, (which we embedded in our process of member-checking) to support the rights of each participant to see and inform various stages of research, and consider future use of data and ongoing implications on confidentiality.[134] Shenton cites Guba and Lincoln, describing member-checking as "the single most important provision that can be made to bolster a study's credibility,"[(p.68)] including an emphasis on whether words matched participants' intentions, and verification of any inferences that were formed during dialogue with participants.[74] This additional opportunity to review excerpts from their interviews in the context of other participants' perspectives was described on the consent form. Themes and findings were revisited by the core research team after member-checking, and in the context of related research and policy contexts. Additional context offered by six participants in reference to the COVID-19 pandemic were considered and described separately. The results of this work are presented in Chapters 4 and 5.

3.9 Trustworthiness & Validity

In the context of qualitative research that is "contextual and subjective", validity describes research that is "sound, just and well-founded", and that balances rigour with the subjectivity and creativity inherent in the research process.[76] Legitimacy and validity of findings can be examined using multiple approaches; a "gold standard" is the practical application of Guba and Lincoln's criteria for trustworthiness in naturalistic inquiry.[76]

Whittemore and colleagues argue that criteria for evaluating qualitative research must match the fluidity of emerging ideas in the research process, and that an ethical obligation exists to demonstrate not only integrity and rigour in process, but an "artfulness associated with discovering meaning in context"(p.528) as described by Sandelowski.[76] Authors propose a synthesis of validity criteria, including primary criteria necessary for all good research (credibility, authenticity, criticality, and integrity), and secondary criteria as complementary "benchmarks" of quality that are adaptable to different methodologies (explicitness, vividness, creativity, thoroughness, congruence, and sensitivity).[76]

Thus, this study elaborates on Guba and Lincoln's criteria to guide this discussion of trustworthiness and validity. The rationale for choices and details of methods have been described, and the key actions that demonstrate alignment of our process and methodological choices are as follows:

1. *Credibility and authenticity* (Do we believe the reflected experience of participants? Does our portrayal of research appropriately reflect "the meanings and experiences that are lived and perceived by participants"? Have we considered our intensiveness of engagement in the field, persistence of observation, opportunities for triangulation, peer debriefing, negative case analysis, and member checking?)
2. *Dependability, confirmability and integrity* (Is detail of the methodological process described, including an audit or decision trail? Did "findings" emerge from the data rather than the researchers "predispositions"? Did the researchers engage in reflexive practices? Have ambiguities and alternative hypotheses been considered?)
3. *Transferability* (Is sufficient context provided, while preserving thick and "vivid" description to allow judgment to be deferred the reader?)[74,76,146]

3.9.1 Credibility & authenticity

The three research team members' dual experiences as survivors of trauma and practitioners of TVI care were disclosed to participants in the consent form, and we believe this contributed to respectful relationships with participants, authenticity of conversations during the interviews, comfort demonstrated by participants who disclosed personal experiences, and ease of recruitment given mutual interests of researchers and participants. These dual lenses, strong collegial relationships amongst the study team, a rigorous member-checking process that included follow-up questions and an opportunity for participants to review collective findings, also contributed to trustworthiness of the results.

Careful reflection on diversity in research has been described (3.3), and offers an important contribution to credibility by elucidating perspectives on the landscape and context of TVI practices "from a variety of aspects", contributing to "richer variation of the phenomena under study."[147] In the analysis, our goal was an "unadorned" portrayal of participant perspectives in the reporting of results. We centered participant narratives, engaged in ongoing reflexivity practices in our identification of a thematic structure, and actively sought out unique, discordant, or missing views throughout iterative data collection and analysis. These choices are supported by literature emphasizing triangulation through diversity, and ongoing member-checking; both of these are tools that support reciprocity, which we experienced throughout the study.[87,148]

3.9.2 Dependability, confirmability & integrity

Dependability and confirmability were demonstrated through "conscious and deliberate" intentions throughout, and an audit trail of documents and decisions.[29] We engaged in detailed, free-form memoing that included notes from the interview, transcription, transcript reading, and perspectives of the researchers; two to four memos were written for each of the 23 interviews completed in this study. The audit trail included: note-keeping during team meetings; preservation of all document versions during revision (interview guide and code book); and accessing coded data through the master project in NVIVO.

Practices of self-reflexivity were embedded throughout the project; we created space in each team meeting to discuss each person's interests, biases or related experiences, and we discussed how our lenses shaped the choice of final themes (1.4, 6.2). Integrity was demonstrated by strong collaborations between team members, consultation with supporting organizations and the thesis committee during the study development, and ongoing engagement with participants through the write-up; integrity was also supported by working in a collaborative manner with the thesis committee throughout data collection and analysis. Funding for the project supported payment of collaborators (NM, AW), which helped to equalize power dynamics and preserve appropriate time and attention to the project.

3.9.3 Transferability

Nowell and colleagues position the analysis as the most complex phase of the study, with the researcher and their lens acting as the instrument of analysis, and the method, thematic analysis, as translator.[131] Translation, transferability and relevance of the results were supported by the core research team's tight collaboration, dual experiences as trauma survivors and providers of TVI care that provided baseline insight and experience about the study subject, and engagement of participants in a rigorous member-checking process. Building strong relationships between the study team allowed us to communicate openly by email, text, and telephone to clarify process, share ideas, trouble-shoot, and rely upon each person's views. Trustworthiness and reciprocity were experienced amongst the team, which made the process enjoyable and built strong relationships that we will carry forward. Although funding was exhausted, both collaborators volunteered for knowledge translation activities and further research. Involving each study team member in each key step of the analysis (transcription, memoing, coding, and thematic analysis), deepened immersion in the data and trust in choices made. In team meetings, collaborators (NM, AW) reflected that although this was not efficient, involved a steep learning curve for some steps, and a substantial time commitment by the thesis student to train the team members (in particular in transcription, and coding in NVIVO), it was valuable in its contribution to

trustworthy and transferable results, and as an investment in learning and future research engagement.

3.10 Ethical considerations

UBC BREB approval was obtained prior to beginning the study, and revised interview guides and study materials were reviewed by the thesis committee and received ethics board approval throughout the study. Two important ethical considerations in this study relate to the subject matter and study population.

3.10.1 Considerations related to trauma

The core study team straddles both personal and professional experiences providing and receiving (or being denied) TVI care, and in this project we experienced a felt sense of safety and wholeness by considering and integrating both lenses. To separate personal and professional experiences can be an artificial distinction that denies the research team's "positioning" and "consequent angle of interpretive inquiry".[128 (p.78)] We had no intention of inquiring about participants' personal experiences receiving (or not receiving) TVI care, however we (correctly) anticipated that some participants would choose to disclose their own dual experiences, as we did as researchers.

Despite the potential risk of emotional distress disclosed to participants during recruitment (Appendix C) we also acknowledge that safe and attentive spaces in which experiences related to trauma and structural violence can be heard, can help avoid harm through unintended silencing. This has particular implications for experiences of secondary traumatic stress or moral injury. Thus, the disclosure of the dual perspectives of the research team served an unexpected but ultimately critical purpose in this study, creating safety in our conversations about the landscape and contexts of TVI practice, and through that offering implicit permission for some participants to share personal experiences that influenced their professional work. Further discussion of dual experiences is offered in Chapter 6 and presents an interesting opportunity for further research.

We also recognize that trauma is a sensitive subject matter irrespective of our focus on participants' professional experiences with TVI practices. We recognized the value of dual experiences in the inclusion of personal or professional experiences of primary care, however we chose to exclude patients as experts in this study who did not also work as health care professionals. We relied upon the ability of professionals delivering TVI care to appropriately bracket or contain personal experiences, as they would to create safety in clinical environments in which they work, and we disclosed this assumption on the consent form. This contributed to a safe and abundant research environment in our study that resonates with Ermine's description of an "electrifying" and "ethical space of engagement",[149] in our case with skills contributed by both interviewer and interviewee.

3.10.2 Considerations related to diversity

Despite widespread experiences of "inverse care" and "fragmented care", primary care aspires to achieve "health for all" and tackle "politically, socially and economically unacceptable health inequalities."[70] In primary care, a diversity of patients can benefit from TVI practices. Safe and accessible health care environments must be widely available, and not restricted by diagnosis or identity in a way that excludes or privileges certain people or pathologies.

A diverse study population that includes diverse discplinary and cultural perpectives, including Indigenous and non-indigenous perspectives, invites consideration of ethical principles outlined by Castellano,[150] and in Chapter 9 of the TCPS.[151] Risk is present in the research if individual perspectives are inaccurately recorded or transcribed, distorted, reframed, repurposed, assimilated, or re-presented. Our aim was therefore to translate the perspectives of participants as they wish it to be heard, respecting individual choices for identification and confirming participant contributions and choices through member-checking (including ongoing opportunity to re-confirm preferences for identification or de-identification – Appendix C). In this way, consent was revisited and ongoing. A focus on structural and contextual factors influencing TVI practices also avoids identifying distinct

cultural histories by focusing on description of work and practice experiences, and factors related to implementation of TVI care.

Ermine's "Ethical space of engagement" offers further perspective on the inclusion of diverse identities in research.[149] Ethical spaces are moulded from distinct histories, knowledge traditions, social and political realities; the space can be unstated and unseen, but it also invites seeing, as it can be disruptive or "electrifying".[149] When beliefs of Western universality are so deeply ingrained in the context of ongoing "hype and glory of European colonialism",[149148147] an ethical space of engagement offers an alternative "field of convergence for disparate systems", a meeting place with co-operative spirit, where we can engage in human-to-human dialogue.[149] This requires affirmation of diversity, and explicit consideration of dominant and non-dominant views, whereby it "can become a refuge of possibility..."[149] This conceptual definition inspired our process and affirms the decolonizing and social justice approaches that informed this work. Questioning and challenging systems was also a central theme in our findings and was given explicit consideration throughout the analysis.

3.11 Methods summary

To answer the question – "How do diverse ways of enacting TVI care in the provision of primary care for women expand understandings of how to implement and scale up TVI care in primary care more broadly?" – we collaboratively developed an interpretive-descriptive study that was conducted by a core research team of three women with dual experiences of personal healing and professional practices of TVI care. The approach to data collection and analysis was guided by interpretive description and inspired by the diversity of our study population. A total of 23 interviews were completed with participants who reflected a diversity of identities, professions, and settings in women's health care. Iterative thematic analysis occurred throughout data collection, and included a rigorous member-checking process. Three content areas emerged in the analysis, including: 1. Contextual and systems-level factors influencing TVI implementation; 2. Process knowledge of how to enact and implement TVI care; and, 3. Clinical knowledge and approaches in TVI practice. The focus of the analysis for this thesis is on the first two areas; findings are described in Chapters 4 and 5.

Chapter 4: Findings – Part 1

Oppressive systems: The landscape of trauma and violence-informed care

Understanding the diverse environments in which TVI care is practiced sheds light on the multiplicity of ways that structural violence manifests across health care services. Knowing this landscape is an important first step to understanding the implementation of TVI care and the work of dismantling ongoing oppression in health care. Historical, cultural, social, inter-professional and inter-personal environments that surround TVI work were described in depth by participants, and are presented in this chapter.

Health care experiences occur in a complex web of services including primary care, community care, peer support, uninsured services, hospital and other institutional services. This web is often in service of persistent unmet needs. An understanding of practice experiences in these settings, and their influences on a person's care experience, is important to situate TVI practices in primary care, and within the broader web of services that people access. This chapter also situates TVI practices in the context of past and present influences on TVI practice, and future possibilities.

4.1 The system as perpetrator: Biomedical care is not a safe space

"Not safe" were words spoken by several participants in this study when describing mainstream biomedical care. Unlike the altruistic but superficial vision of a helping or healing profession that can alleviate suffering,[152–154] participants described biomedical care as well-intentioned but strained, dismissive, oppressive and potentially re-traumatizing, due to its history and colonial origins, and rigid institutional structures. A baseline lack of safety in health care for Indigenous people,[31,32,92,155] women,[48,84,126] and other groups[12,156] is well established, and requires urgent action; this was emphasized by Dr. Alika Lafontaine upon his election as 2021 President-elect of the Canadian Medical Association.[157]

4.1.1 Colonial systems: Biomedicine in a historical context

Throughout their stories, participants described *"a very dark history" [GT, Psychiatrist]* in the work of doctors and across biomedically-oriented health care services, which act as hierarchical and oppressive systems that are not separate from the legacy of colonization in Canada.[89,92]

> *"The system that I was working in [was] the tiny little micro system within the bigger system." [JLK]*

> *"The other piece that's often missing in trauma informed care, is they don't actually talk about how traumatic it can be to go through a system that's based on systemic racism… Communities still remember the stories of their parents and grandparents, who were admitted to Indian hospitals… And so there's this legacy that exists where there's still that fear of hospitals and institutions… oftentimes people will come to hospitals and say it reminded them of residential school. And then even that dynamic of listening, no matter what, to the person in authority. So if the doctor says you need to do this, then they just do it without asking questions… or challeng[ing] what they're being told. There's all these historical dynamics in place..." [KN]*

Substantial evidence describes the connection between historic, colonial practices and ongoing racism and oppression in health care, in particular towards Indigenous peoples in Canada.[55,68,89,92,155]

4.1.2 Oppression and marginalization: Institutions have caused harm

Participants shared many stories of people who experienced oppression, marginalization, or re-traumatization in health care encounters:

> *"What's good for the institution is not necessarily good for the patient… we have women who are pregnant show up homeless and in trouble. And they're kicked out and back on the street. We have women who are pregnant and in a garbage bin trying to get some food or something. And they're certified, because they're pregnant… So that's violence [at the hands of the health care system.]" [RA]*

> *"I've even gone away from doctor's appointments, just frozen and paralyzed… this sort of unseen authority of the 'doctor' saying this thing to me, how it just stopped me in my tracks, for a long time. And it made me feel really ashamed. And… she was just saying the*

thing that she learned in medical school to say… But when I think about people who that happens to over and over and over again, by all the different systems of authority… it hurts my heart. And it felt like she knew nothing, but I felt so ashamed and condescended to for a long time. And I mean it's kind of embarrassing that I had such a strong response, but it is like [that] when women are very vulnerable." [VE]

Participants further described how experiences of isolation can be amplified by inaccessible care or a lack of *"belonging" [EC]* in clinical environments, which can further marginalize people:

"We're kind of doing what everyone else has done to them their whole life. We're essentially just going to keep shutting doors on them because they're not acting right...

…I hear a lot of people talking about wanting to fit in, like they were… beaten and abused at home, and they were never wanted. But then once they found a crowd that wanted them and included them, those people also included drug and alcohol into that inclusion, and that's trauma, right? Feeling like… you don't belong anywhere." [S]

"…their way of coping, is to use drugs, as opposed to reaching out… If they have been traumatized in the past, and if any people that they trusted in the past are no longer there, then they have themselves. And that's it. Or they lack the ability to… access the service. Whether… they're just unable to understand and navigate the system, or just don't feel comfortable or safe to access the service…. We're hoping to identify those folks who feel alone, and are using alone, and then are at risk of dying alone." [PD]

Participants' descriptions of harmful health care encounters align with Rogers' and Kelly's call for a feminist intersectoral approach that sees women in the context of their environments, and addresses the harm done by neglecting this view.[39] Prioritizing practices of inclusion and safety is critical in health care to counter a repeating cycle of exclusion and trauma.[14,158]

Participants described the common practice of "negative labelling" and "marking"[159] of people seeking mainstream health care services (arguably inherent in the practice of "*diagnosis"*) that can amplify feelings of powerlessness, judgment, and lack of safety for people seeking care. This aligns with the medicalization of people and their problems described by McGibbon as "the medicalization of oppression" driven by "biomedical

dominance",[5 (p.19)] and Biderman and colleagues' concept of "somatic fixation", in which "people become more and more entangled in and dependent on the medical apparatus".[160]

Participant stories referenced people of varied demographics, including participants' own experiences of feeling judged and treated poorly. However for people with past trauma, especially those struggling with addictions,[161] the impact of judgment and "extreme stigmatization" can be especially harmful and further marginalizing, perpetuating a pattern of "harm upon harm".[162]

> *"Their perception is that you're there just to get some drugs, and you're a drain on the system, and you're all of these things... which then affects their care from the moment that they give their name up at the front, where they'll get flagged as, you know. Because say they ten years ago went in and were upset because they weren't being treated well… it's put in their chart and it stays there forever… People have been clean for years, they've left the life, and they still have difficulty accessing health care because of this history of addiction." [CV]*

> *"[Hospital] used to be called the "baby snatch hospital"… if you were pregnant, you wouldn't go to the hospital because they would take your baby away... from between your legs… It was the clinical standard of care [for moms with addictions], to put the baby in a separate room, in a quiet room, because they didn't want to stimulate the baby too much... And basically the mums were felt not to be capable of looking after babies. So really what you ended up with was a baby that was withdrawing. But it was withdrawing from the mother. But it was treated as withdrawal from the opiates… babies in those days were sent up to [children's centre] for two or three months to be treated… And the moms weren't allowed to see the baby. So they ended up on the street... the mortality and morbidity amongst the moms was huge. And the babies would end up in foster care... with, in retrospect, social attachment problems, incapable of social attachments because they were never bonded with the mother. So basically we had a generation of Romanian babies [babies left in isolation in orphanages, without contact]… There's nothing more violent than taking somebody's kid away from them, their baby." [RA]*

In her work with the Pacific Postpartum Support Society, Sheila described the importance of *"externalizing myths"* that are harmful to mothers *[SD]*. For marginalized mothers this includes pervasive negative judgments embedded in the "crack baby myth" and other stereotypes that neglect the influence of prejudice, violence and poverty on mothers with

substance use, and that has entrenched discriminatory views of "irreparably damaged" mothers and babies.[39]

Screening for Adverse Childhood Experiences (ACEs) was also described by several participants as a case example of well-intentioned work that can cause harm without a TVI practice lens informing the work:

> *"My understanding is the purpose of ACEs is to help the client or the patient make the connection between what's happened to them in the past and the impact on their health, and how they can increase their resiliency. [However] in some of those [guidelines] for physicians, it looks to me like the purpose is for the physician to know what trauma a client has experienced, to kind of open it up, and to learn more about the trauma. And that's not the point… there's more benefit for that 'aha' moment for the client… Or it'll say, "Ask the client the [ACE screening] questions." You would never do that unless the client had a literacy issue. You would never ask the client, "Have you ever been sexually abused? Did your parents ever divorce?" That's the complete wrong reason of why we use a tool. A tool is on paper typically to divorce the client from having to disclose to a care provider something that's happened to them. There could be shame. So just like with the Edinburgh Postpartum Depression survey, you don't ask the questions, you give the client the questions in most cases." [DJ]*

> *"I think it can be harmful… Going through the motions and just getting that ACE score. Saying, "You have a higher ACE score and that means you're going to have a 20 year shorter life expectancy than your friend who doesn't have any trauma." That is potentially harmful. If all I can say is, "Here's your ACE score and I've got nothing for you, I have no trauma informed services for you," that can definitely be harmful. This is what makes me nervous… We actually don't use the ACE [Adverse Childhood Experiences] questionnaire at [correctional facility], or at [outpatient] clinic. But I use my trauma informed knowledge all the time and it has absolutely changed the way I approach all of my relationships." [MV]*

Participants from all disciplines emphasized the importance of re-conceptualizing mainstream, biomedical care from its superficial label as a helping or healing profession to one that can cause further oppression and marginalization due to historical and institutional influences. In this recognition, one can begin to alleviate suffering, create opportunities for safety, and implement TVI care.

4.2 Unique experiences of structural violence and oppression in women's health care

Participants cited fundamental learning about TVI care principles from practice experience, feminist studies and social sciences, before TVI care was named and described in the literature: "*Now way down the road, there's names for it… But we were talking about this way back… [laughter] Being involved in some of these committees, I'm like "you could have asked me [laugh] 20 years ago"…" [SD]*

Participants described the necessity of acknowledging the impact on women of embedded, *"dehumanizing"* practices in medicine *[NO, Family Physician]*, and of "*unique marginalization and oppression, that's systemic" [CF, Midwife].* Women bear a disproportionate burden of violence and inequities, and have throughout history.[48,84,126] Understanding the manifestation of this oppression on women's health care today is a critical starting point to providing TVI care to women and families.

4.2.1 Historical and patriarchal influences in women's health care

The lack of acknowledgment of the roles of women within family and community systems, and as primary caregivers, represents the historical neglect and *"privatization"* of women's work *[NM, Social worker & Counselor],* and Western ignorance of impacts of structural determinants of health on women and families. When providing TVI care to both men and women, participants called for *"a feminist lens embedded," [NM, MB]* that acknowledges the unique impact of oppressive and patriarchal systems on women.

> *"Women... disproportionately bear the weight of violence… and particularly Indigenous women, certainly in this country… The contributing causes to that are structural rather than the individual family unit… not recognizing that or taking it into account, we [in health care] are a band-aid… there's not going to be any forward shifts or gains, really… [because of] the individualizing of that one person's experience without taking into account, and without continuing to look for those wider causes, and addressing them." [SHC]*

> *"Women-identified people are disproportionately impacted, especially [by] interpersonal violence… and it's built into our institutions. So this is where I get to talk about the heteropatriarchy [laugh]… In one of my OB/GYN interviews, I talked about like this exact*

idea, the history of women's health, the concept of the patriarchy and how that informs medical training and practice, and I really wanted to change that. And there were, like, literal crickets [in the room]. And then they were like, "Well, we've never heard that answer before," which is never good, right, when you're in that kind of setting. And then I left and I was… asking [the other candidates], "What did you say to that question?". And they were like, "Well, I said I wanted to be a surgeon…" [NY]

A lack of acknowledgment of structural influences on women's health unfairly individualizes the pathologies of patriarchal and colonial systems.[47,84] Without an intersectional approach embedded in policy and services, societal patterns of misunderstanding, externalizing or dismissing women's needs can be mirrored in health care, which often does not meet women's needs.[39,163]

4.2.2 The invisibility of women's needs

Participants described an invisibility of women's needs that is perpetuated by reductionist and exclusionary practices in the health care system. This mirrors patriarchal and colonial systems that have perpetuated the exclusion and mistreatment of women.[30,84,163] Hawke cites Harkness and Cheyne, who emphasize that "Childbearing is an inherently female experience, yet male oriented scientific and medical research tradition prevails, meaning that women and midwives navigate a maternity system whose foundational epistemology and ontology are based on methods that are inherently sexist."[164] "*History-informed care" [JLK, Indigenous therapist]* helps us understand experiences of invisibility.

"If we don't acknowledge that we have not provided care to people who at whatever point in our cultural histories were considered lesser than, then we don't understand why we do healthcare the way it is now. If we think about women as the minority group who weren't provided equitable care, we need to consider that until recently, they haven't been studied… We don't look at the culture around the needs of someone being a mother, and how that role may lead to a different presentation of symptoms. Someone… caring for young children may [de]prioritize their needs… acute pain may transition into a sensitized system, your symptoms begin to look different when compared to [men]. Because you have a different role with different responsibilities, by the time you get around to taking care of your symptoms they look different. Add on top of that women of racial minorities who have trauma around accessing healthcare…" [KQ]

"The allopathic medical system is extremely conservative. And even the history… the history of how it developed. I remember learning that there was a concerted effort by the American Medical Association to take women's health care away from midwives and other traditional birth attendants and other people who traditionally worked with women. And I will never forget taking this history of medicine class and seeing… a drawing of how the new doctors were trained, shortly after this kind of takeover. And basically, there was a woman, and there was a sheet draped over her, because culturally at the time, men couldn't look at a woman undressed. But as their physician, they had to examine them. So literally there's a man's hand under the sheet, just, like, 'examining' [laugh] [gesture of reaching, poking/probing]… There's just so much, even in that picture, that demonstrates the way our entire system is constructed, is predicated on dismissing or undervaluing or minimizing women's experiences… dehumanizing them really." [NY]

Whitney Wood offers an important description of "abusive" practices in the history of women's health care in Canada, in which "the appropriation of the body and reproductive processes of women by health personnel… is expressed as dehumanized treatment, an abuse of medication, and [the conversion] of natural processes into pathological ones".[165] Participants in our study described women feeling like they are having an abnormal reaction to a normal system, without a safe place to disclose feelings otherwise. This perpetuates invisibility:

"*Our system isn't set up to teach people about their bodies and how to care for themselves or seek further support. I often have clients who have never been told that penetration shouldn't hurt, and it never gets addressed by their primary care provider. Clients will have an uncomfortable pap, to the point that they are white-knuckling through the procedure to get the examination done and there's no conversation about that experience, that it shouldn't look like that or feel like that. People will presume normalcy and an assumed brokenness. They accept their brokenness and don't disclose or ask for support because they don't realize it shouldn't hurt and that it could be any other way." [KQ]*

Sheila described the external position of peer support provided by the Pacific Postpartum Support Society (PPPSS) as creating safety for women to talk about birth trauma in a way that is not permitted inside the system:

"I remember feeling violated just by the nurses coming in and yanking on my breasts… just the way that they were shoving the baby on me or whatever. It felt like a violation. But there was no place- where am I going to talk [about this]? Who am I going to say that to?

There just wasn't any room for that at that time. Nor did I understand what was happening… That's the system right there, is that the nurses, okay, they've got to get you breastfeeding. This is how they do it, right? And… it can feel violent… So [at the PPPSS], when we look at postpartum depression and anxiety, there's all these different contributing factors, or risk factors, and certainly the hospital experience is going to be a big piece for a lot of people." [SD]

Participants described having an expectation of invisibility of women's needs in society and in medical care, characterized by a lack of understanding of needs, and mirrored by a lack of comprehensive care.

4.2.3 Systemic violence in women's health care

Participants cited experiences of lack of safety and systemic violence in health care encounters:

"We get a lot of women that have experienced sexual violence at the hands of primary care providers." [CV]

"I [had] been working in this clinic and I felt that politically, it was impossible for a man to do a pelvic examination on a woman that wasn't abusive... …the power imbalance between men and women is so strong…" [HI]

"There is one doctor… for example, that trans women have to kind of 'grin and bear it'… This doctor will fondle their breasts and be like, "Oh, these are coming in nicely," and there's nothing they can do about it because they depend on this person to give them care." [CV]

"In the last few months I've had a couple of women call me right after a visit to the doctor wanting to debrief, and even cry about how they were treated or how painful it was…" [VE]

Although experiences of unsafe touch in health care are minimally examined in the medical literature,[166–168] practices that avoid re-traumatizing people seeking care (including the judicious use of touch) are part of trauma-informed practice and TVI care.[14,125] However, participants described inappropriate touch, and touch without consent, as "*super*" prevalent in medical care *[CV, Program director]*, particularly among sexual and gender

minority patients, and people who have experienced trauma.[24] Participants described informed consent that is not practiced appropriately, which can re-traumatize patients:

> *"In just regular interactions, like, learning pelvic exams… you know, people will say, "Oh, you might be uncomfortable". And they'll just continue working [laugh]…. they're still pushing the speculum forward, and sometimes I think the clinician will know, "Okay, this whole thing is going to take me like two minutes. This person is kind of crying and I'm just going to get it done. Because it just should be done fast and then it'll be over with and everybody will be fine and she'll probably forget about it…" And I feel like [the patient] might forget about what happened, but they won't forget about how they feel. And also, [the doctor] can still get consent for how to proceed… I don't need to finish this procedure in three minutes otherwise this person's going to die. I can always stop, and I can even say to this person, "We don't have to do this today if it's not working for you". And I think even that level of control… often, almost 100% of the time, works for people, where they'll [then] be like, "Okay… I can decide if I want to do this or not, [and] I really can"… It's always ongoing assentive consent." [NY]*

> *"From a complex trauma perspective, there can be certainly the potential for people to be… within a more dissociative kind of experience. So then suddenly incorporating touch into that makes things potentially complicated, if not unsafe, for many of the folks that I see. And we know that one of the outcomes of the complex trauma for some people is a real difference in how touch is received by a body and… the more sort of system-wide kind of protective or alarm kind of bells that might sound [while] receiving touch." [SHC]*

Health care providers may be unaware or lose perspective of historic influences or patient vulnerabilities, and can become blind to the impact of normative institutional practices and culture (4.3),[5,169] which perpetuates systemic violence within health care.

4.2.4 Birthing in biomedical care: "One more level of oppression"

The experience of birthing was an important example of structural disempowerment enforced by normalized systems and cultures of practice, particularly in biomedically-oriented care. Participants described harmful and disempowering *"power imbalances"* [CV, NM, HI] amplified in the unique time of birthing.

> *"I would love to have a radical feminist sociologist have a go with obstetrics. Because sometimes you can see it as just a usurpation of this incredible power that women have to*

bring forth life, and so much of obstetrics is questionable, really… where the statistical difference is so small and yet technology takes over and we have to induce, and we have to do this, and we have to do that, when really, the difference in outcomes [is] not that great... Labor is an amazing thing, because on the one hand, she's doing the most powerful thing a human can do, creating another human. My God. But she's so vulnerable… and she needs the space to be strong. And all of our little… "take off your clothes", and "put on this gown", and…"do this", "do that". Everybody is so bossy toward her, and everything [has] almost minute, diminishing [benefit]… just putting her in such a strange context and expecting her to figure out how to behave at the time that she wants to scream and yell, and shit on the floor, and cry... Like she's just [growl!]. And yet she's expected to do this among strangers… In other words, I feel like obstetrics might be the axis of evil… I mean really it's a place that I'm not sure is for women…. Very interesting to take it from the point of view that all of obstetrics is structural violence on women's health. I think I'm going to take my name off that [laugh]." [HI]

"Even [women] who've had a good birth, a problem-free birth, a healthy child… [birthing] can be quite traumatizing for the body to go through. So when agency is taken away, there's that layer… I see a lot of people basically who have been to the doctor… and clearly, for me, [the doctor visit] feels like just one more level of oppression that's going to happen to women. Women not being allowed to have agency over their own bodies… It's like the way they were treated needs to be healed." [VE]

Stories of "obstetric violence" in Canada emerged from the routine and "unnecessary medicalization" of natural labour (an event that was labeled by male physicians as "painful and terrifying" leading to "permanent invalidism" of women, thus requiring aggressive intervention), that was coupled with the self-serving "necessity to lift the status" of the new profession of obstetrics.[170,171] This *"takeover"* of traditional labour and midwifery care *[NY]* through the prophylactic and violent use of surgical interventions, built upon a pre-existing cultural practice of biomedical interference in birth that was advanced by DeLee and Williams in the early 20th century. Practices of "obstetric violence" have been described by women as "evil from the ground up", and "more damaging 'than actual sadism'", and these stories should not be overlooked in the context of developing capacity for TVI care in the present.[165]

Obstetric violence in Canada includes a history of "degrading or painful preparatory procedures, rough treatment or physical abuse, and psychological or emotional cruelty

inflicted by health care professionals … anaesthetisation without consent and the use of physical restraints… that [women] were regularly forced to endure at the hands of medical professionals".[165] For Indigenous women in Canada, this experience extends to erasure, incarceration, forced sterilization, child apprehension, physical and sexual abuse and other forms of colonial, race-based violence.[31,55,92,155] In the birthing experience, control is "placed unquestionably into the hands of medical professionals… [and] women are no longer considered experts of their own needs and become bodies that have things done to them rather than full participants in the birthing process."[163] The field of reproductive justice, including movement away from "obstetric violence" towards de-medicalized birth, advocates for equitable access to appropriate medical care alongside the empowerment of women.[163,172] Wood and Shaw thus describe the importance of recognizing underlying inequality and "structural power differences" in the context of women's bodies "appropriated through patriarchal ideology".[163,165][163,165]

Two obstetricians offered a different perspective, describing individual efforts to embed safety in the context of a system in which they acknowledge that patients *"oftentimes… get shut down." [TN]* In the context of urgent or emergent obstetrical care: "*We're trying to establish a therapeutic relationship pretty quickly about something that… can be pretty intimate." [TN]* In this context, both described constant attention to the potential for health care that can be traumatic, "*[given] the nature of this discipline." [TN] "Because I do a pelvic exam on just about everyone… [and] since 20-30% of women have experienced some unwanted sexual encounter in their lives, that is pervasive in my daily existence as a good GYN." [DF]* Thus they seek opportunities *"to maintain their human dignity, the patient's dignity, despite the fact that this sometimes might be challenging." [TN]* Understanding that experiences of trauma and violence will show up in the intimacy of the clinical examination is *"part of how I interact with patients routinely… I just ask them if they're particularly concerned, [if] they're worried, just to tell me. They don't have to have a pelvic exam that day. You just sort of try and create an open environment." [DF]*

Varcoe and colleagues also acknowledge the challenges of providing TVI care in urgent or emergency care environments that are often operating at over-capacity, and that

perpetuate "inadequate and inequitable treatment" in that context; these are important sites for history-informed,[165] and equity-oriented interventions.[2]

4.3 Institutions over people

Participants described care that is not-person centered, but institution-centered. This is care oriented to what the institution can afford and provide, and it is often dismissive of needs that do not fit within the package of services offered, particularly under the limitations of budget and resource constraints. Emmons writes, "We can define the toxic medical culture as one that puts perpetuation of an organization, or the aggrandizement, financial and emotional, of a few individuals, ahead of the interests of individual patients and physicians."[173] Zigmond describes "the medical model itself… [as] a major vehicle in this authoritarian circus. We collude together to minimise, conceal or deny these problems… It is ubiquitous, and played extremely hard, particularly in hospitals."[174] In this strained environment, power imbalances and rigid institutional structures dictate the work of health care professionals who struggle to provide safety to people seeking care within the constraints of the systems they work within.

4.3.1 Institution-centered care

Participants observed – and personally experienced – practices of institution-centered care oriented to what the system can provide, rather than to what a person needs:

> *"'Care to' [vs. 'care for'] a person… is when I found myself just hours after having given birth, and a care provider walked into the room, pulled back the sheets, opened my underwear while I was asleep to look at my sanitary pad without saying, "Hello. It's important that we check how your bleeding is going, can you tell me how often you are changing your pads, could you show me what your pads are looking like?" This is the foundation of basic informed consent to care and it is completely missing. Once you are in the hospital setting it seems like there is an implied consent so providers just stop asking. There is an amnesia around the idea that consent should be ongoing and often. That people have a right to options and to be a participant in their own care… This was a constant struggle I had when I worked with [nurses] and the time constraints they are under. I would have a patient who was preparing to go home, working on mobility goals towards*

independence, and [they] would be so much better at making that transition safely… if we would stand beside their bed for a minute while they sit themself up and walk themselves to the washroom. Too often I would find patients lying on bedpans because that's the most time-efficient thing for their care providers.... Our system is so burdened that fostering people's independence only comes if there is time for it, because we fail to recognize that… it is a critical piece in their autonomy and ability to confidently recover." [KQ]

In addition to *"amnesia"* about the history and culture of biomedical professions, this example illustrates how institutional rules, policies, time pressure, distraction and overwork can limit the presence and attunement required in TVI care. Lokugamage and Pathberiya describe the impact of these limitations on patient-centered care and the quality of care; insufficient time with patients and other "pressures" on providers reduce expressions of empathy and the ability to understand patient perspectives and preferences.[175] Health care workers thus make compromises and patients aren't offered sufficient support, space, or time to disclose their needs *"in a safe way" [NM, Social worker]*.

"My client said she had filled out a urology report and she found it to be incredibly sexual... As a care provider… I want to make sure that I am not a trigger to unearthing traumatizing experiences that you have had, if I am not equipped to support you with disclosing that information. If I am not aware of the potential impact I have and [if I am] not prepared to correct that harm, then I have done you a greater disservice." [KQ]

The needs of people seeking care often extend beyond *"finite resources" [DJ, Program director]* available for standard health care delivery that is not designed for people with complex health and social needs. Participants described "*advocating for program sustainability and recruiting related programs and services to provide access and fill gaps." [PD, Nurse].* Particularly in resource-strained environments, people working in institutions are required to contain their work, set limits or boundaries, which can be an exclusionary practice mirroring the exclusion experienced in trauma. Under-resourcing has also been described in the literature as a form of structural violence.[29,35,89,126,176] In this context, a person seeking care could easily believe that they are too much for the system:

"You don't want to have to tell them, and look at them and feel like, you know what, you're facing a lot of fucked up shit, but I have to go. You know?" [S]

"…like, you got a 20 minute appointment. You have to be really specific about what you're talking about. [For example] someone who's wanting to go and speak about an STI or get a pelvic exam… and [has] anxiety. They have to separate those things. So that in itself to me feels traumatizing, as someone who works with the whole body. It's erasing or dismissing. [It's] more of that same sort of allopathic method of chopping up the body into pieces. It's perpetuating the authority model, this idea that doctors have all the authority, that they have the answers. When actually, I think most people actually can figure out what's wrong with them in a way, or they have the ability to name what's going on for them. And sometimes it can be nuanced or it takes more time. [Biomedical care] implies that there's a problem and a solution. And actually, just one problem one solution. But the solution is only for the symptom, not the [whole] issue…" [VE]

Patient- and person-centered care are often compromised by rigid and "innately unjust" institutional procedures and "incongruent helping paradigms" that are further strained by resource and time limitations.[29,36,169] This kind of institution-centered care can be exclusionary and re-traumatizing.

4.3.2 The glorification of "unsafety"

Participants described institution-centered care that glorifies productivity, martyrdom, overwork, unhealthy coping behaviours, and bypassing of self-care. This manifests most commonly as time pressure, and creates a culture of *"unsafety" [NY]* for people accessing care and health care workers themselves. It is particularly evident in the context of obstetrical and gynecological care, where systemic pressures intimate a link to historic practices of "obstetric violence":[165]

"We would have these cancer [cases]… you know, we'd have thirty patients booked in an afternoon where we probably should have only had ten. We're getting called out to the OR, and we're getting called out to the emergency department, and we have patients on the ward who were crashing. It was just nuts all the time. And I'm not making excuses for his behavior. But, I said… I truly feel like… if someone said to [a rude physician], "What the heck did you just do? That's terrible." He would say "No." He wouldn't even have any recollection of that encounter. He'd be like, "No, I told her. I believe in being honest with patients, and I told her what her prognosis was, and we don't have anything left to offer her, so she needs to prepare to die…" Certainly doctors behaving badly has historically been tolerated in surgical disciplines, because those bad doctors oftentimes produce really good

clinical results, though sometimes… they're drug addicts and drunks and other things that they hide behind." [TN]

"If I've come off a week of call or [if] I've done four days of call in five days, or some stupid [schedule], I'm going to be tired, for sure… and you're shorter with everything at that moment in time, and your tolerance becomes less… I try not to do that as often as possible… but it's not realistic, basically. But I do do some things, for example, if I'm post call, I won't book my private office, because I see a lot more patients in that office. I won't do that post call. But I don't mind doing the [accessible clinic] care, because I'll see two or three patients, way less… and I have much more time basically… I don't find this particular population that exhausting for the most part." [DF]

"In the [bio]medical system, medical training and midwifery training - less so but still - all of the trauma [coping] responses that we know, are glorified through that training. Things like overwork, things like poor, porous boundaries, things like not listening to your own needs. Things like seeking validation by caring for others at the expense of yourself. All of these things that we know have origins in trauma, those things are celebrated, not just tolerated, they're actually celebrated, they're rewarded by our society at large, but also by the medical system. So if you live and work in that kind of context, then it can be really challenging to even claim the space that you might need to deal, or to attend to your own pain, as it comes up. Because it's not something that's encouraged or invited. And yet, if it was, of course, everyone would benefit. Patients would benefit, of course, enormously. But so would the care providers, so would the system, the running of the whole system would be so much more efficient, and I really think would improve outcomes." [CF]

Participants described the importance of understanding and de-stigmatizing unhealthy coping behaviours that are rampant, particularly in mainstream, biomedically oriented professional cultures. The normalcy and acceptance of unhealthy coping in health professional cultures perpetuates toxicity in workplaces that is harmful to health care workers and people seeking care. Substantial alignment exists between participants' descriptions of toxic cultures that "would be considered unsafe, unprofessional, and even illegal in other safety-critical industries",[177] and literature that describes risk factors for burnout, as well as ineffective or harmful responses to burnout that "individualize and decontextualize the concept of resilience".[177–179]

4.3.3 The problem of hierarchies

"Hierarchies don't work anymore, morally or even legally." [HI, Family physician] However they are entrenched in health care systems, in which some people have more power than others, and some people enact power over others. Participants described biomedical professional cultures as oppressive to those labeled as *"less than" [CV, Program director].* Reinforced powerlessness further perpetuates *"unsafety" [NY],* and can lead to re-traumatizing experiences.

> A health care encounter *"infers a power imbalance right off the bat… but there are ways that you can work with people… where we're not just another person that's removed their agency and are controlling their lives… …[however] when you look at organizations that are very structural and… hierarchical, that there's too much ego to really let that [patient-centered] work happen." [CV]*
>
> *"Especially for people who have come from structurally marginalized communities and then come into healthcare, it's always this struggle with being part of a system that has also been this system of oppression, and what your role in that is. And you can see people taking a number of different roles at different points, like sometimes they're enforcing the health care system, even on people from their own community. And sometimes they are understanding and they're trying to help someone through the system…. I think of that as its own kind of violence, being forced to try and mediate the system in some way, either by enforcing it or working around it...*
>
> *…I think you can work within a hierarchical system, and try to have modes of interaction that demonstrate that you understand everyone's value. But whenever there [are] power differentials, there's always the potential for unsafety. And so I think it's always going to have to be a struggle to work to minimize that. Yeah, I don't know if it's possible…" [NY]*

Participants observed the familiarity and comfort that comes with power, yet described how this is often enacted as power *over* others, as the skills to *em*power elude us. CAMH's guide to "Becoming trauma informed" emphasizes the importance of power in this context, as trauma-informed systems explicitly avoid re-traumatizing people through authoritarian or "power over" relationships that can perpetuate discriminatory practices and harmful power dynamics.[15]

"*I think what's unsafe is how we work with people… it becomes about power and control, and when it starts to get into power and control, then there's always exploitation, and there's always trauma…" [CV]*

"I felt like he had all the answers, and like my experience wasn't really regarded as part of it. [the harm] it's right there, I don't have a voice… or feel like I don't." [SD]

Practices of cultural safety and continuous attention to power differentials can provide alternatives to hierarchical and authoritarian systems, and can dismantle racism through "explicit attention and action to address power relations… charging the service provider with the responsibility to consider and address the role of their professional and institutional power in contributing to culturally safe or unsafe care."[29,155] Contrarily, neglecting action that can dismantle power differentials can perpetuate racism and disempowerment.

"I've seen different care providers unconsciously, or consciously abuse their power specifically. A great example is calling the ministry. I'll never forget, I had a woman who lived on the Downtown Eastside. Indigenous woman. Previous babies were apprehended. She was using drugs at the time when she was with those children, and she was not anymore. She was in a new relationship, really hoping to keep and parent this baby. And I had no concerns about her. I thought this is going to be a great situation. I was trying to help her get her access to her previous children… to get them back. And… I was trying to help her get ready for prenatal home visit from the ministry. And she had a totally sufficient home setting. She was poor, but she had everything that you would need for a baby. Everything. Diapers. She had clothes. She had everything you need. And she said, I really want to co-sleep with my baby, I don't want to use a crib… or at least use a bassinet. And I remember thinking to myself, that's not going to fly, you have to get a crib… If you don't have a crib and the ministry comes to your house, they're going to see it as a fault. Whereas if she was a privileged white woman who said 'Oh I want to co-sleep, I read about it in mothering magazine, and I'm not going to buy a crib…' There would be a completely different dynamic. And I remember… in that situation, the recognition of the power dynamics that existed." [CF]

"I think a lot about the ways in which people deputize themselves… in defense of the system… I was involved with supporting a family who needed a service at the hospital. They got it – it was around pregnancy – but then, were unable to pay one of the bills, and then got a message on their answering machine from the treating physician, threatening to call immigration if they didn't pay. So [this is an example of health care providers] deputizing

themselves… Giving themselves the authority to determine someone's immigration status, even though it's completely outside of their authority [laugh]… and I think they actually think that they are the right people to make those judgment calls." [NY]

4.3.4 Administrative violence & Resistance to change

Participants described administrative violence as a type of structural violence that refers to procedures and protocols entrenched within institutions, "which when left unchecked provide the substance for which the status quo is maintained."[92] Card and Taylor describe a type of administrative violence that perpetuates "poor working conditions and unreasonable expectations", and neglects the "hard work required to address systems failures."[178] A lack of action to address structural violence is inexcusable, representing "moral cowardice" and ignorance of evidence demonstrating harm to health care providers and patients.[177] However, participants in our study described systems as difficult to shift and resistant to change:

"Often in a health authority… we can't keep seeing folks for that long. Knowing the context of the history, that's not Indigenous Peoples' reality, right? 6, or 8, or 12 sessions [in], you are still working on healing attachment disruption, right? We're not even touching on trauma at that point… the room, the walking in, the clinical chart-taking kind of aspects, of requiring certain notes, and tick boxes. Clients did find that… challenging, at times." [JLK]
"Now the problem is institutionally… providing that care… rooming in [mothers with substance use and their babies]. "Well, we don't have time, we don't have the beds…" [But] we know it works. Now we have to develop the infrastructure to make it happen. An example, [hospital], 10 minutes down the street. Doesn't room in. Because they haven't got the resources and the nursing power... [it's] a lot of excuses... But now we have a standard of care, so you have no excuse. It's like saying we can't provide [a] cardiac care standard. Well if you can't do it, then you transfer the patient to where it can happen. But… they're saying "we can't do it". So they either transfer her or want to transfer her to [maternity care program], or they kick 'em out in the street, or they separate the baby from their mom." [RA]

Acknowledgment of TVI approaches often happens on a superficial level – for example by focusing on "diversity" rather than racism[77] – and is not supported by intentional reforms, sufficiently funded services, or meaningful change. This "imperils" high quality health care:[179]

"I see the ways in which [TVI] can sometimes be co-opted by institutions… as a way of either promoting their own services without doing the work, or of doing it incompletely, and so not seeing it as an ongoing process, but seeing it as a checkbox to be filled. I think that there is a danger in that. Talking about having a trauma- and violence-informed approach also necessarily means thinking through the process of implementation and then ongoing assessment of how it's working." [NY]

Participants described the survival of institutions competing with the unmeet needs of people seeking care within them. Limitations on services allow institutions to sustain themselves, thus the incentive to change is lacking:

"There's a 'blame the victim' mentality, which is systemic. It's not about a specific person's way of being, as a culture we're a 'blame the victim' culture. This may manifest in bureaucracies, as making services difficult to access. The underlying function of bureaucracies is to maintain themselves, and one way of maintaining yourself as a bureaucracy is not being becoming overwhelmed with clients. So, there are certain hoops erected that people have to jump through. And then you get into things like, "okay, but there's funding [issues]"… They're just trying to keep the organization going with insufficient funding. So keeping people away, sending them elsewhere, or just making the environment… non-hospitable is maybe how they're keeping their organization going." [MJ]

Service limitations can also be adopted as a practice by people within institutions, as they bear inappropriate individual burden for lack of organizational support. Lavoie describes "relationships that depend on the will of individuals [acting] as short-lived patches across gaps in the system".[35] This can perpetuate stigma and exclusion of people seeking care:[180]

"Lots of folks that work with refugees… [believe] that there are some migrants that are deserving of being here and some are undeserving, and somehow we are in a position of judging which ones those are… And you see that sometimes, like when [patients] don't perform gratitude appropriately, that [threatening position] can really come into force… They [health care providers] won't necessarily go through as many lengths to support them or they may say, "You know what, that's outside of this group of people. I help refugees, but I don't help people who came here some other way, and are not making a refugee claim". I think it's saying, "That's just… not our group of people"… it's a pragmatic approach, it doesn't mean that they're not informed by trauma. They do have an understanding of how people's trauma informs their health… but they're not applying it broadly." [NY]

Participants described scientific approaches – like evidence-based medicine (EBM) – that can also be used to reinforce harmful practices or service limitations. Although the goal of EBM was to move away from "authoritarian practice as the norm," authors "argue that it has 'become subtler and harder to detect' evidence bias and the vested interests" in an EBM era that is driven by "a technocratic model where complex health, social, political and economic elements are protocolised, guided by risk, cost and fear, at the expense of personalised care."[175] Lokugamage and Pathberiya identify a critical role for "#realEBM" and other movements that address the lack of guidelines and medical recommendations that are based on high quality, consistent evidence. Ford-Gilboe and colleagues also call for flexibility and adaptability in the application of clinical guidelines as important in the provision of patient-centered, equity-oriented and cost-effective care.[38]

> *"There's also a systemic [sigh], partially understandable thrust in paying people cheaper… and to do strictly what's evidence-based. It's very hard to evidence-base some of what we're talking about [TVI care], right? …But administrators, the [health authority], people who are funding this and who are creating templates, they don't really want to hear about open-ended therapies..." [ND]*

> *"We want to just follow the evidence, to be able to hang our hat on care that has validity behind it, but the evidence is behind. Research is always delayed, and it definitely does not keep up with cultural changes… When I use evidence exclusively, without allowing for the art of clinical decision making and trauma-informed care, I'm going to use all these words to describe what's going on, but in a year from now, this evidence is going to get thrown out of the window. If I tell you things that are so concrete that they don't leave space for the evolution of the evidence or the evolution of the person, a client may hold on to the story I gave them about their body indefinitely, always believing they are fragile, weak, discoordinated, etc. It doesn't leave space for the possibility of the one thing we know to always take place, [that is] change." [KQ]*

4.4 Blind spots & Exclusionary practices

Participants described the pressures and restrictions of a biomedical lens, which can be "*erasing or dismissing" [VE, trauma-informed yoga therapist]* when compared to whole person, biopsychosocial care that is trauma and violence-informed. Exclusion and dismissal of the stories and needs of people seeking health care is perpetuated by a blindness to what

health care providers don't know or do not provide. This perpetuates a cycle of exclusion and neglect of the needs of people seeking care, especially for those with complex needs who would benefit from inclusive, whole person TVI care.

Participants' stories align with substantial literature describing "areas of ignorance" [127] in biomedical care. Einstein and Shildrick describe biomedical care as the product of embedded and unexamined normative assumptions, and reductionistic thinking "caught in the clutches of the Cartesian dichotomy".[127] Biomedical care is also problematic because it considers the health care "consumer" as a "free, rational, self-determining subject… such an assumption can 'disappear' political influences and pressures of power".[127] Farrer and colleagues describe the narrow biomedical perspective hindering health equity approaches because of its pervasive influence "across the political spectrum and supported by the pharmaceutical and health care industry… [biomedicine thus] crowds out arguments concerning the SDoH… to improve health equity [is] a competitor for scarce resources."[78]

4.4.1 "We're blind to our own omissions"

There is little space to look for blind spots in an overburdened health care system busy attending to an unending supply of biomedical needs. *"We approach things in such a biomedical... way, that we are missing people's needs. We are missing people." [KQ]* This leads to neglect of people or conditions that don't fit the mold of the system.

> *"We are so blind to even the idea of our privileges that we have told ourselves that we don't treat race differently or that we don't discriminate [based on] socioeconomic status. We believe that we treat a person because they are a person in front of us. We fail to even recognize that for somebody to get to the hospital they have to have a certain amount of resources in place in order to move themselves there. When you are serving the patients you have and feeling like you are doing a good job, it's easy to forget about how many people you're not seeing, how many people you're not getting care to because they can't even get to your care. We can become so wrapped up in our own endless care that we are blind to even taking a step back to see how many other people aren't there who need help. I've had colleagues in their private practices justify to me that they don't need to do trauma training or psychological training because they don't treat people who have those*

problems… Comfort and our desire for confirmation bias keeps us in the dark… [We have] blinders, big blinders… [KQ]

Blinders are exacerbated by competition for scarce resources, in particular for people living *"at the margins… hanging on by their fingernails", [CV]* who are vulnerable to further oppression*:*

"[Advocates] were saying things [about access to shelter space] like: Oh well, if a woman has to share a room with a trans woman, and if that woman [feels uncomfortable] because she perceives her as a man, then the woman should leave. And I'm thinking no – my freedom and my inclusivity [as a trans person] shouldn't come at the cost of someone else's oppression… [But] they're starting to raise things like, as a trans woman accessing services, it's okay to have a beard, it's okay to look like a man, because you don't have the resources to make yourself look like a woman… And that space is supposed to be safe for both people? …trans women don't have to look like women to say they're women, you know, which impacts women." [S]

Layers of disadvantage signal multiple unmet health and social care needs; in this context a focus on downstream treatment of symptoms can occupy resources and limit what can be dedicated to other approaches, including building capacity for TVI care. Participants described TVI care as lower on the hierarchy of needs, in particular within *"very biological"* models of care *[ND, Psychiatrist]*. TVI care is not prioritized, and dismissed as "*soft skills" [PD, Nurse]* relative to treatment and intervention: *"They don't say it's not important, but it's just not getting [prioritized], it's not on the top of the pile." [PD]*

Participants described blinders as an indicator of closed-mindedness, leading to costly and inappropriate care, particularly in women's health, and particularly in response to trauma:

"[We] in essence ignored the issue of trauma as the "driver" for self medication compounded by relatively poor social determinants of health. [This] clinically meant that patients were never asked if they had any trauma in their lives! And/but were treated pharmacologically for a mental health diagnosis… So… you would have a 15 year old woman, a teenager, come into the office... she's labeled with oppositional behavior, borderline behavior, bipolar, she's off the wall. The first thing you do is say, "Oh, we've got to treat her manic [depression], or her depression, we have to treat her borderline [personality]... [Or,] we can't treat her because she is borderline…" And over the years, the treatment would have been loxapine or antidepressants and now it's risperidone and

Seroquel and gabapentin and it's a whole compendium of pharmacology, and nobody ever talked to her about "Have you had trauma in your life?" …And if you watch the Me Too movement now, and women coming forward, a lot of them talk about their PTSD and being treated for anxiety and stuff, when they finally realized that it was post-traumatic, and it was a normal reaction to the rapes and all the stuff that they were experiencing. And it's important to make that distinction because all the medications that has been thrown at them, never worked. And it never worked because pharmacology does not work for PTSD." [RA]

"When people are labeled as difficult… in my experience that's a potential marker of people having trauma… I once had a client who had very severe hyperemesis gravidarum. She was in the ER frequently needing IVs and she also had this abdominal pain associated with it. The local ER thought she was drug seeking… I saw her in one of her admissions, it was the first time I met her, and I did a [psychotherapeutic] session with her in her room as she was getting her IV, and she accessed emotional pain about her father having abandoned her. She had a huge cry, a huge emotional release, and her hyperemesis gravidarum essentially resolved. Within a week. It was better the next day and then almost completely resolved in a week. And this is someone that had been on Ondansetron for two pregnancies. I just I would like to see there be some openness within the system to other methods of dealing with physical complaints or disease, that incorporate a mind body connection and acknowledge the benefit of psycho-spiritual attention and care." [CF]

4.4.2 Neglect of structural violence

Participants described a lack of understanding and acknowledgment of structural violence across health care services. This prevents systems and programs from recognizing their own implication in systemic violence, and finding opportunities for violence-informed system reform in response. Elizabeth McGibbon describes the health care system as "instrumental" in the perpetuation of oppression through inaction: "The clinicians who are perpetrating this discrimination are not likely to identify their individual lack of action as discriminatory, nor are they likely to identify that they are practicing within a system of ruling relations that condones their individual discrimination."[5 (p.30)] Card labels this as "an unethical abdication of duty" on behalf of leaders, that sends a message not only to people seeking health care but also those providing it, "that they are the problem, that they need to do better at 'absorbing negative conditions,' and that failure to 'tough it out' is a sign of weakness."[178] This neglect perpetuates the pathologizing of people responding to

experiences of systemic oppression and marginalization,[1] and limits possibilities for person-centered and *"history-informed"* care [JLK], and system reform.

> *"There seemed to be this understanding… that somehow trauma-informed care… could be the everything that we need to know to do things better. But from our perspective in practice, we felt there's limitations [in TIP compared to TVI care], because again, it doesn't get to the system and structural issues when they're only focusing on trauma informed care. And it always has this connotation of going back to the individual that we need to fix them, rather than the bigger picture, which cultural safety looks at, which is the system that's creating a lot of this trauma." [KN]*

Beginning to correct the pervasive neglect of structural violence in the health care system begins by acknowledging this neglect as both difficult to see, and crippling to system efficacy:

> *"Addressing systemic violence is acknowledging that we have shortfalls in the system, that we have failed, that we understand that we have not done it right, and that we need to change and that we are striving to do it differently. [But] structural violence is so deeply ingrained that we often can't even see it… we don't necessarily see the system that set someone up to experience [structural violence] or to perpetuate it. As Canadians we hold a pride in our public health and access to "free" care, but… it is a broken system. We are really short sighted with our resources. We are trying to fix the sinking ship we are on, while it's on the ocean moving forward with all of us on board. Health care to me feels like we are just throwing money to try and plug holes here and there to keep our ship above water, but what we really need is to a new boat and a way for us to all get onto it [laughs]." [KQ]*

4.4.3 Power dynamics perpetuate oppression and marginalization

Hierarchies perpetuate powerlessness among people seeking care, and among people working in hierarchical systems. Herrick and Bell identify the role of "hierarchical power structures in the creation and reproduction of inequality," and central to the definition of structural violence.[9] McGibbon explains that "privilege occurs at the expense of those lower in the hierarchy of power",[(p.100)] impacting everyone exposed to "exercised dominance" inherent in "ruling relations".[5 (p.25)] Browne and colleagues describe challenging hierarchical structures within the EQUIP intervention, which "concurrently exposed power

inequities and strained dynamics among staff related to professional hierarchies as well as societal inequities," and when challenged, "provok[ed] defensiveness and efforts to minimize conflict, and sometimes provoking renewed engagement in efforts toward equity."[4] Participants in our study described the challenge of elevating voices with less power (including people seeking and providing care); if people are not heard or don't speak up, they can be blamed for it, which reinforces power differentials and leads to further marginalization. In the context of decreased access to care and support during the COVID-19 pandemic, blaming a person for not speaking up about their needs can cause re-traumatization in a time of heightened stress and uncertainty (5.3).

> *"When you have a hierarchical structure, you have a pilot or a surgeon who… thinks they're the boss. Oftentimes when things… start going off the rails, the other people in the room, or the cockpit notice... Somebody with less power in the system might notice that… [for example] the patient is bleeding over here, and you didn't know, you're over there, so you didn't notice... And because of the power structure, the mistake doesn't get fixed. Either the person who notices it isn't heard, or maybe they were afraid to speak up. And so a principle that institutions called "Stop the Line" was invented… if the cleaning man notices there's blood on the floor, [he] gets to say, "Wait a minute, your patient's bleeding". Anybody should be able to stop the line. And when… bad outcomes are analyzed, one of the questions that the computer asks as you're reporting a bad outcome is "Did you stop the line?" And I find this very interesting, [because] nurses are being blamed now for not stopping [the line], and blamed - that's a very hot word, I'm not supposed to use that word, but… here it is. If the nurse doesn't stop the line… there is a criticism of her… And I find myself saying, "Wait a minute here." Yes, now we're all supposed to "stop the line", but that's really hard to do, in fact. When you're in a situation [where] it's hard to trust your own judgment when the expert is saying [differently]… you know, three nurses knew what was happening… but the surgeon didn't hear them and so the whole thing went [wrong]…" [HI]*

Without acknowledging structural violence and power dynamics at play, efforts of inclusivity can cause further harm. This is also demonstrated in the context of increasing attention to Indigenous cultural safety:

> *"Students are inherently in the lower [end of the] hierarchy, to then put them in a position where they're supposed to know, [or] speak with authority, or power that they don't have, there's no safety for that. And that's not their role either. There is an unfairness to put that on them, and then… a very uninformed expectation. They might be called upon to speak about anything and everything Indigenous or to represent all Indigenous peoples. And*

you're almost setting them up for failure because if they don't know, then… [you've] had the expectation that they should, when in fact, that's not their role, but then you're displaying them as somebody that's not knowledgeable. So a safe process would be… bringing Indigenous peoples together… so it becomes the organization providing supports in place to create the change." [KN]

Within professional cultures, participants described a lack of awareness of the limits of disciplinary knowledge and the inherent narrowness of biomedical practice. This reflects an "entanglement in the medical apparatus" that is "largely ignored"[160] and restricts opportunities for collaboration with people seeking care, and across disciplines, as it is harder to find common ground or share power with others:

"I think healthcare professionals have so much ego around the idea that "I'm going to fix you", that we can't let things go when we don't do it right, or acknowledge that we don't have all of the answers… A piece that's fundamental to the way that I work [with TVI care] is that I know I won't ever have all of the answers and that the person I am working with has more knowledge about themselves than I do." [KQ]
"When I have clients that come to me that have been given steroids for their pain… or been given this or that from their doctors, it never really feels like the patient has wanted to do that, but they've done it, because it's the only thing their doctor could offer them. A little more humility on the part of the doctor, and a little less investment in Big Pharma, would have gone a long way… I feel like it's the tough and the rebellious ones that do better [navigating medical care], because they're like, 'I'm not going to believe the doctor'. That's what happened to me, that's how I healed my back. I was told when I was 21 that I would never get [back to] a hundred percent, "you have to live with the pain, and you have to take painkillers". And I didn't know what my options were, but I knew that wasn't an option for me, and I was just like, "screw that". And I found [solutions], figured it out." [VE]

However, people who challenge power dynamics can be further marginalized:

"I couldn't imagine many Indigenous people, in that way, having any sense of entitlement to [ask for more time]. And if they do, what ends up happening, is it's often those prickly people, who have a lot of push in the system, and then they get targeted, as now they're the 'problem people' or they're the 'aggravated people'." [JLK]

"Within the Nurse Family Partnership, we work with clients so that they feel more comfortable in their healthcare interaction, to ask more questions. Sometimes, with some healthcare providers, they can see that as being threatening, and the NFP is maybe teaching clients to be anti-doctor… [but] we're not trying to teach them [laugh] to be anti-

doctor, we're just maybe asking them to be open and bring questions to their appointment… empowering themselves…" [DJ]

Participants offered many examples of how empowerment is limited when time and space for people is limited. Making space for a person can support healing by providing safety through a disconfirming experience in which a person's experience isn't perceived as too much for the supporter:

"We're a community based organization and it's not as scary for a lot of people. I think we do have that catchment of people that won't reach out, or won't talk to their doctor, because that's somehow more scary... If you only have like an hour, or if you're a doctor, 10 minutes… it's really hard to build any kind of relationship… even just knowing that [you have time]… I think gives somebody a feeling of, 'Oh my God, like I have somebody as part of my team here'…" [SD]

4.4.4 Inaccessible & Inequitable care

Health care is *"not really meeting the benchmarks" [DJ]* for people who are marginalized, people *"coping with socio-economic disadvantage" [DJ],* and people at the margins "*hanging on by their fingernails" [CV]*. For many people in Canada barriers to care are widespread, care is inaccessible, and inequities in health outcomes result.[11,12,37] To address inequities, Hankivsky advocates for intersectional approaches to balance the biomedical approach that persists in its "absence of reference to these social dimensions," and ongoing "biomedical emphasis on measurement and quantification [that] can impede the elimination of hierarchies of health."[62]

Participants shared diverse descriptions of inequitable care:

"We have a very… [noticeable] under-representation of the aboriginal population, I would say, throughout all the clinics… There's an intergenerational aspect to it, in terms of a lack of trust in the system per se. Because coming into an institution or meeting an "expert", and in terms of the trauma that's happened with that population [in institutions in the past]... having families that are not in [foster] care coming in [just doesn't happen]." [GT]

"…we have [had] higher rates of deaths of birthing mothers and babies in the last two months, where we knew… pregnant women were not getting the care at any hospitals… not going to the hospital possibly due to their fear of not getting appropriate care, not having

access to harm reduction services, fear of poor treatment and stigma, fear of leaving their home…" [PD]

"…by the time someone sees me in my office, I'm at the end of a very long pipeline, where people have had to leap over a number of different barriers just to walk into my office at that particular time. And sometimes those barriers are just part of the appointment-making process and sometimes it has to do with their inability to get childcare, or the fact they can't put their children in school because the school won't take kids without documents, and they're just sitting at home with their kids, but they can't leave them unsupervised. There's all these different ways in which people already have to overcome structural barriers, many of which are triggering for them, in order to just even walk in my door. And so it's great if I have a trauma- and violence-informed practice, but if [they] had to experience violence all along the way to get to me, there's a limit to how much I can do... the amount of work that we ask people to do to get to the front line of the healthcare system… it's a lot, and sometimes they just don't make it." [NY]

Experiences of being unsafe in health care are common, and can worsen inaccessibility, while understanding these experiences helps identify steps towards safer and more appropriate care:

"I believe, that if a person is trauma and violence-informed that their implicit bias or those kind of unconscious biases, start to get a little more light shone on them so that we could be more likely to be proceeding a little more potentially free from stereotyping or assumptions… I think that the amount of confidence a patient has in their health provider is going to weigh into their outcomes, you know, how likely are they to want to return to that space? …how many small symptoms might they sweep under the carpet and ignore if they don't have a positive interaction with that person?" [SHC]

"Their lives are so challenging, disordered, they've experienced either trauma from the system, or trauma in their lives, or are just [facing adversity]. Particularly with substance use disorders, making it into the hospital is an impossible thing…. Lacking [specialized] programs is going to create… barriers. Because you need some flexibility in what you do, and you need multidisciplinary care. You need them to be able [to drop in] - if they're booked for Monday and they show up Tuesday - to just be seen… Go get them, go drive them… we'll go pick them up and bring them in." [DF]

4.5 Surviving unsafe spaces: Coping strategies

Participants described a strong culture of compliance imposed on health care providers and people seeking care, involving an unconscious "constriction or moulding into the required role."[174] Janelle Taylor describes a need to understand "what is uncontested as well as what is contested" in biomedical care, given the often stressful "acculturation" process to disciplines identified with "confidence in the *truth* of medical knowledge".[169] She describes medicine in particular as blind to its "one-sided" nature; it values only "real knowledge" attributed to its own discipline, leaving little opportunity to challenge normative practices and understand other knowledges.[169] This culture of compliance described by participants in our study enmeshes people within unhealthy workplace cultures, and can re-enforce power imbalances and the pathologizing of people that are inherent in biomedical culture.

4.5.1 People seeking care: Fitting the system's mold

Participants observed people consciously or unconsciously fitting their needs to what the system offers in order to access care. Hawkes describes a pressure for compliance amplified in "the restrictive context" of mainstream health care (and midwifery) practices.[164] In this context, health care providers are implicated in constructing a myth of the "good" patient, who conforms to the practitioners "preferred context of practice, aligning with the ideological framework" of care.[164] Link and Phelan reference concepts of "stigma consciousness" and "rejection sensitivity" in their description of stigma resulting from both structural discrimination and "covertly" through the pressure to conform.[180]

> *"There is… unconscious and some conscious reward, for buying into the system. Now as they say, if all you have is a hammer, everything looks like a nail... So if you [the doctor] use a lot of medications… and you don't really do very much therapy, to keep seeing that doctor, [the patient] can't say, 'Listen, no more meds. But I still want to see you.' You can ask for that, but you may be discharged pretty quickly… The currency is buying into the system, and in some sense, feeding what the doctor wants to hear and see, and wants to treat you with… The currency is taking their meds, and being their patient, and having those symptoms, or getting better from those symptoms because of those meds... The medical system is going to favour that type of treatment, and it's going to streamline that*

person. And they can go very far downstream and not really [get better]… well, maybe get better, we hope, or not." [ND]

"They [patients] end up having to adjust their own perspectives to interact with the healthcare system, [perform or show up in a certain way]… That's definitely true, at least in my experience with immigrants and refugees. There is very much a way in which they have to perform gratefulness that kind of subsumes their other experiences…" [NY]

Resisting streamlined norms is difficult in a system when a person seeking care has less power and compliance is encouraged. This makes self-advocacy difficult:

"It's very frustrating [laugh]… I understand why the systems are set up the way they are. But I'm one of those pesky people that will advocate and educate the people I'm working with... a lot of it has to do with the language, and how to interact with the systems. So it's about what are the needs of the system, to make it seem like it's all their idea [the people providing service], and [to make it sound that] they're like, [ahhh! sound of praise] "the best"… It's crazy that you have to do that, but you do." [NM]

"This is in the days when if you were pregnant, you were on methadone, but you also had to go up on your methadone, because there was a fetus in there... The guideline is you're pregnant, you have to go up on your methadone. "No, no I don't want to go my methadone, this is my opportunity to go down because I'm pregnant now, I'm motivated, I don't want my baby to withdraw." "No, you have to go up on your methadone." So she doesn't come back, she tries to wean off her methadone [by herself. She] goes into withdrawal, shows up in withdrawal, and then she's blamed for using and withdrawing and being non-compliant." [RA]

4.5.2 Health care workers: Internalizing institutional approaches

In the context of entrenched institutional practices and protocols, participants described a related culture of norms in which health care workers are also pressured to fit the mold of the system.

"They put so much effort into policies and procedures and "this is how we do things", and it all has to be very structured, that they don't realize that all of that structure is just another barrier and… you know, it's another layer of that oppression." [CV]

Dysfunction is normalized and the impetus for change often falls upon health care workers to compensate for the broken system they work in – or to challenge it, uncovering

"unexamined normativities, simplifications, and idealizations" that obscure the "real" complexities, impasses and misunderstandings inherent in health care.[127] This is a substantial burden for health care workers but it can also foster resilience.

> *"Without a doubt, the vast majority of clinicians and nurses I've ever worked with were decent, good human beings that were committed to quality care… [But] certainly, in a high-volume, high-acuity teaching centre like [city], the nurses were super stressed all the time because it was like crisis 24/7. And so I think the nurses sometimes were being felt to be dehumanized. Dehumanized by their managers and the amount of overtime they have to work. And certainly an OB residency is pretty dehumanizing [laugh]. To some extent, I think all of us were sort of in that same environment, so one had to make a conscious effort to maintain your humanity, so to speak, despite the fact that we're doing this momentous thing which is bringing people's babies into the world." [TN]*

A lack of recognition of the impact of dysfunctional structures on the people working within them reinforces a pathologizing approach in which people, rather than the system, are seen as broken:

> *"[There is] discomfort… acknowledging that these harms are happening. I think some people take it very, very personally, rather than looking at the system… Understanding where people are coming from [when they are] not wanting to admit or state that [violence] is happening in this system... we hear that they're taking it personal[ly]: "You're saying I'm doing something wrong in my practice." …It's been difficult [to work with]…" [KN]*

> *"…the source of the problem being located in the psyche of the client is a huge problem in all therapies... We take mindfulness into organizations like Google, so that their worker bees can use mindfulness to calm their minds as though there was something wrong with their minds, as opposed to something wrong with the organization and the society, and the way it is driving people. 'So we're going to get you more mindful, so you can keep working here and keep making money for us.' And, you know, this McMindfulness is also used extensively in the US Armed Forces, and it's used to help make better snipers, better killers... instead of supporting people and rallying against these organizations where the dysfunctionality of the organizations is the issue, not the people in them." [MJ]*

Enacting or internalizing institutional approaches can also perpetuate powerlessness and set the stage for the system to re-traumatize people:

"…what happens a lot in the Western systems, is we want to just diagnose and treat, as a way of caring for, but that's not going to access all the needs, and that's what ends up leaving the Indigenous person feeling, "You didn't take care of me. You haven't supported me [at] all in this way." So, knowing… that [it's the] whole system, is knowing that it's not about you... It would be very challenging for a care provider to have the intentionality of doing [TVI work], and work in a system that is always on their back, that they're doing it too slow, or they're not getting paid enough, or there's a waiting room full of people, or all of that. That's how we as individuals absorb that stress, that's not even ours." [JLK]

"Somebody came in swearing on me, and threatening violence toward me. And because I'm trauma-informed, I get where that's coming from. But I wasn't allowed to speak back, so what I was told to do was to close the door, and to tell them that they can't speak to me that way. And I'm thinking, that doesn't really solve anything. I mean I shouldn't attack them of course, but… You should be having a real conversation with them, like "this is not cool, you shouldn't be doing this to me [in a kind tone], but I have to close the door now because I feel like it's becoming unsafe." That's okay to do and to say [in that way]. But just being very transparent with that, instead of just closing the door. And then I often notice that they would get more angry when you shut the door, and I'm thinking no, no - why can't we talk to them like they're people? … But there's… a lot of policies and stuff in place that really separate us from treating each other like human beings…" [S]

Participants described the expression of systemic violence within organizations,[177,178] in particular towards workers who are "*lowest on the status pole*" [JLK]:[165,181]

"…at that time of my life, there wasn't this cultural component or those things available, right? And so I would bring smudge and whatnot to work, but I was told by the higher-ups not to work in the way that I was working." [EC]

"I was tokenized or [given] this really menial position… we had two different staff rooms. So there was "staff" [air quotes], and there was us [outreach workers]. And we never went to the staff meetings… We were separated, and there was very much a difference, especially with the way that they talked to us… I spoke up about [inappropriate organizational procedure], but the response I got was… "Oh well you know you women… you aren't at the same level of the staff and I don't think you'd be able to grasp or understand these complex kinds of issues." [S]

4.5.3 "Betraying what I was here to do": Moral distress & Burnout

For some participants, adopting institutional approaches led to experiences of moral dilemmas and burnout. Pauly and colleagues describe substantial negative consequences of moral distress on health care providers, because the experience challenges a person's ethics while forcing a choice "between following rules or following their conscience."[182] Responses to moral distress include attrition or withdrawal from the offending environment, or objecting and voicing concern – however the latter is difficult because of "institutional constraints" and pressures to uphold "professional values, responsibilities and duties."[182]

> "*…if you use a chemical restraint… it's just so much simpler to get this done or to get that done… [It's easier for the health care provider and] never better for the patient [laugh], yeah… they'll even go so far as to try to control food to get the behaviour that they want… I basically couldn't work there anymore because there was just so much that I was not comfortable with… I don't even put it on my resume." [CV]*

> *"I got to a point where a bunch of things were happening, and that's when I decided just to leave the clinic. And that was terrible because I had to let down my colleagues… So I felt terrible guilt… The system wasn't addressing these people because it wasn't designed [for them]… it was designed for people who know how to keep appointments, fill in questionnaires, respect your time as a professional. It fails that way. [My colleagues] weren't like, "Glad I don't have to see any poverty." They weren't like that. They were more like, "If they're here I'll see them, but if they don't come and my time isn't filled and they keep canceling, then I can't." But that's what people do who are disconnected and marginalized… the first thing on their list isn't their appointment. I saw that people were being excluded that needed help, and that I was… accidentally betraying what I was here to do."* [ND]

The culture of health professional education – including socialization through the "hidden curriculum… what is implicitly taught by example day to day"[183] – does not create an adequate environment of safety and support for staff. Disputing the "host of rationalizations" for lack of safety, and overcoming the "expectation of automatic resilience" is essential to avoid burnout and vicarious trauma.[178,184] Participants in our study called for greater support, and new "social norms that obligate organizations to

recognize the inevitability of vicarious/secondary exposure to trauma in [health] professions, and to provide resources proactively to prevent… deleterious effects":[184]

> *"…through the lens of vicarious traumatization, if you work with traumatized people, you will be traumatized. It's a fact. And so how does that system that you're working in, support you to deal with your own issues of trauma? And this is where, as institutions, I think we really fail, to support people working in our institutions… Peer support is a huge one. They say the biggest determinant of healing from traumatic injury is the social milieu that you're surrounded with, the social support system that you have. And so that has to become the workplace in these cases. And so often workplaces neglect that aspect [vicarious trauma and stress] so much… It's only in isolated situations that we have this." [MJ]*

> *"[During] the original RCTs in the US, nurses were starting to talk about, "I don't know if I made a difference", "I don't know if I helped", "Things aren't going well"… [The founder] started reflecting with the nurses, realizing that there is a need to build that form of reflection into the program, so that [weekly reflective supervision] became a mandatory core element of the program... The Nurse Family Partnership is… challenging work. Absolutely. And there can be high attrition rates for a nurse, so we don't want her to leave and we don't want to traumatize her. And in the US, they found that when a nurse leaves, 50% of her clients will leave the program. We saw it happen here when nurses moved on to other programs… If you want the clients to stay, we want the nurses to stay." [DJ]*

Although the "ethical climate" of an organizational culture can be "a powerful driver of change",[38] Pauly and colleagues raise concerns that "a relatively unexamined area is that of the impact of structural inequities on the development of moral distress."[182] Browne and colleagues describe the importance of "disruption as opportunity", and in the context of equity-oriented interventions, tension can catalyze change and lead to innovation.[4]

4.6 Part 1 – Oppressive systems: Summary

"*There are so many ridiculous barriers and the system is so broken." [CV]*

Western biomedical care – practiced in primary care and throughout a complex web of services that people access to meet their needs – is not a safe space. Trauma and violence-informed care is the work of active resistance to the colonial history of medical care, and to often unexamined, default practices that cause oppression and marginalization of people seeking and providing health care, especially women. This environment of "*unsafety"* is deeply established and difficult to change, with overlapping systems of administrative and systemic violence, entrenched hierarchies, unhealthy power dynamics, and a strong drive for health care providers and people seeking care to comply with the status quo, which leads to burnout and re-traumatization. In this dispiriting context, participants described many years of critical questioning of the systems they have worked in, and resistance. Finding space for TVI practices was often an independent path towards safer health care experiences for themselves and the people they work with. As we move forward to understand their work of dismantling oppression in health care, we acknowledge their critical practices of resistance, and of dismantling hierarchies by restoring connection and allyship, and finding power and opportunity in one-on-one relationships.

Chapter 5: Findings – Part 2

Dismantling oppression: The work of resistance and connection

The work of dismantling oppression begins with healing ourselves as health care workers so that we can be strong in our resistance to oppression. This trauma and violence-informed work is amplified by connection. Participants described the power of bottom-up, grassroots, collaborative, and deeply inspiring TVI work. The power and possibility of this work is greater than the coercive force of entrenched hierarchies and the drive to maintain the unhealthy and unsafe status quo. Thus, change happens, as described in this chapter.

This exploration starts by describing the work of resistance and connection (5.1). In the context of entrenched cultures of oppression within health care services, possibility for healing exists within the strength of collaborative relationship-based care, and restorative practices of compassionate attunement to the present moment, where change can happen. Section 5.2 then begins to apply these learnings in the context of primary care, and section 5.3 describes participant experiences in relation to the COVID-19 pandemic.

Of note, clinical knowledge and approaches to TVI care are inextricably linked to the work of dismantling oppression, which "is activated and perpetuated through human relationships"[5 (p.27)] – this person-to-person work is arguably its foundation. However it is beyond the scope of this thesis to describe TVI clinical skills and approaches, which will be analyzed separately in the Master's (MC) work of my collaborator in this study, Nicole Marcia. In this chapter, clinical approaches are situated within process knowledge shared by participants about how to enact and implement TVI practices in the context of systemic oppression and structural violence, which will support our understanding of the role (and power) of healing relationships to restore safety in primary care.

5.1 The work of resistance and connection

5.1.1 "We need to be ok": Healing the healer

Participants described TVI practice as inclusive of work they were doing for themselves. Understanding *"what's going on under our own hoods" [MV]* informs the care we provide, and is thus a critical starting point in TVI care, described in substantial detail in our interviews. We present this discussion in some depth to situate the research team members' dual identities, and to honour the emphasis participants placed on their own healing as a critical prerequisite to providing TVI care.

The emphasis placed by participants on their own healing work aligns with descriptions of "the wounded healer" and "the patient within".[174,185] In the "helping profession syndrome", health care professionals can be "hardened and petrified" with "a kind of emotional anaesthesia or woodenness"; these behaviours are reinforced in health professional cultures in which "the ethos of the stiff-upper-lip and coping-at-all costs is learned (by imitation and taboo) early in our training."[174,185] Internal struggles can be associated with an "exemplary persona" that outwardly remains intact, but that inwardly experiences substantial suffering, psychopathology, patterns of "compulsive care giving", or "unconscious neurotic drives and unresolved conflicts". [174,185] Repression of caregiver needs can lead to poor quality care provided, and a "malignant symbiosis" between doctor and patient as we "seek out and look after the part in other people that we disown or suppress in ourselves."[174]

However, turning towards healing increases our capacity for attunement in that "it is probably not possible to develop a humane and compassionate resonance with another unless we have some identification with them. We have to have faced similar pains, losses, conflicts or needs ourselves. The important point is that we are both aware, and in control, of these forces within us. By doing so we convert a liability into a gift."[174] Participants thus emphasized the importance of their own healing:

"If we haven't done our own work, we're bringing more of what we know, including our trauma, into the workplace… It's going to allow us to begin healing if we understand what has happened to us, and we do our own inner work. Then we can truly start to help people." [MV]

"My mom just passed away from an overdose in September… So when I'm in session with people, and they bring up loss of a parent, or an overdose death, before I go into the session, I have to think about that... Because I know that it can be triggering. And I'm like "Okay, so how do I get through this moment with people?"… Because I'm a human being, there are some times where I'll go into a session, and I'm like [sigh] I just, I need this to end. I wish all of the violence in the world [would] just end. I'm tired. The compassion fatigue sets in. And it's not because of the people I work with. This work is hard – the constant reaffirming, validating, and hearing traumatic stories hurts my heart, which can get emotionally exhausting. Once I start feeling that way, I'm like okay, what can I do to bring myself back and 'practice what I preach' for self care. I find it is important to know when to ask for help, and know when I need a break. Knowing when it is time to recharge is a necessary skill that involves a lot of reflection. Without this skill, I wouldn't be able to survive this long this field. Sometimes one just needs to create space for solitude, to process and recharge." [NM]

Participants described self-awareness and self-care as particularly important in the context of the discomfort and resilience required to fight "toxicity in the medical workplace" and resist unsafe norms.[173] This is also important in the context of research describing "defensiveness" of people and institutions in addressing systemic discrimination, and "implicit prejudice and stereotyping" that is worse in male health care providers, and that often increases throughout training, alongside cynicism and "decreased patient-centeredness" in care.[153,183,186]

"I found obstetrics very traumatic. I did obstetrics, I kept repeating it, and going into electives in it, because I just found it really [challenging]... I'm old enough that I remember when women had… buckles, and their arms were strapped down. It was really bad… I felt like I couldn't learn [obstetrics], because I was so busy resisting… feeling like these people [in obstetrics] were nuts, and… I would just get so upset." [HI]

"I was really hesitant at first… I started educating physicians, but I was very nervous about how they would accept this information. It's probably one of the most nerve-wracking things I do, because I don't know how [physicians are] going to take it. I'm talking about parenting, compassion, caring and empathy, and how this fits into patient care and our own self-care. This was not something that was a focus [in my] formal medical training…

As a group of people, I think we have a very long way to go. In order to do [TVI work]… we really have to take a look at ourselves. We all come into healthcare with our own backgrounds and experiences and it subconsciously shapes the way we interact with patients, with each other and with the systems in which we work… the work of trauma-informed care requires that we are have insight into what we bring to each encounter we have with patients and with each other." [MV]

To create safety and sustainability in TVI practice, participants described emerging from the "patriarchal mould",[174] separating from the culture of institutions by recognizing biases, and "*very important critical self-reflection that I don't know an institution is capable of" [NY]:*

"You're navigating all of the potential judgments that people have. You're navigating all of the biases… implicit, explicit biases… all the unconscious beliefs that people have… All the things that we know are directly related to [their own] trauma." [CF]

Implicit and *"unconscious"* bias *[NM]* contributes to systemic resistance that participants encountered to TVI approaches. Research demonstrates that implicit bias among health care providers "operate[s] to the disadvantage of those who are already vulnerable",[187] "playing [a] role creating or maintaining health disparities" through impacts on judgment and behaviours that contribute to inequitable medical care, and compromised relationships with people seeking care.[92,186] Participants in our study advocated for directly addressing implicit bias, judgment and stereotyping as part of TVI practice. This aligns with the EQUIP equity-oriented health care interventions that support providers to "deal with" bias, prejudices and discrimination in their workplaces,[4] and the "Stigma Model" that addresses bias as part of institutional actions to address stigma and build inclusivity.[159]

"You can't force anyone to change their approach. They really have to buy in. If you're trying to force somebody to do something, you're also not coming with a trauma informed lens. Because often [an] approach to interpersonal interaction has been learned outside of the medical system. Their approach has often come from their own upbringing, their own experience with relationships. So if they were taught that the only way to get somebody to behave is to punish them, chances are, without some conscious inner work, that's what they're going to bring into the workplace. So when I'm educating people about TIP, it becomes very personal. This information doesn't just affect our patients. It affects us as well. Everyone has been through some sort of trauma or suffering: emotional, physical, or

spiritual. With enough exposure to [something] new, people may slowly begin to see that there could be a different way to treat people that works. But again, we need to create safe spaces for everyone, not just our patients, in order for this work to evolve. As the saying goes, 'You cannot give, what you do not got!'" [MV]

Understanding the role of implicit bias in our own conditioning supports the work of addressing structural violence as part of TVI practice:

"I think the biggest thing is the cultural humility piece, and the cultural safety piece, because even if you have done a lot of work around understanding how inherently racist our healthcare system is, and so on, there's always unconscious bias, and implicit bias that's going to be there, just because in this part of the world, those of us who don't come from marginalized backgrounds, how we've been conditioned and raised." [CF]

Participants described *"the lived experience" [S]* of healing oneself (and often interacting with structural violence in the process) as an important resource in TVI work, inviting *"a different perspective" [S],* and a source of *"innate" [NM]* knowledge and expertise that participants described as undervalued:

"I was assaulted there. So that was… a difficult time… I can see my transformation as a physician since then, because when I started there… I was much more judgmental. And learning about trauma informed care has really changed the way I see myself and our patients." [MV]

"The thing about stories is that we've all got one, and sometimes our stories intersect with other people's stories… Personally, I found that it's helped me to reframe my story, like when I realize all the assumptions that are made about people and realize that I made those same assumptions about myself as a 15 year old… and I can look at it through a different lens because my clients have taught me to do that." [CV]

Participants also described a practice of externalizing bias and labeling people seeking care as *"difficult" [CF]*. This can happen when a care provider has not been seen themselves, or has adapted to an environment that required them to conform, "'blocking-out', or at least controlling to an extreme degree, natural feelings and actions that would otherwise emerge."[174] Zigmond writes, "There is a tacit and severe conspiracy of silence regarding this painful area. Traditionally, and still prevalently, the lack of emotional rapport and support within the caring professions is paradoxical but gross."[174] Conforming to a system

that is blind to trauma and structural violence perpetuates blindness and burnout in health care providers if they are not supported to do their own work. It is difficult to bear witness to another without the lived experience of being witnessed:

> *"Part of the reason why I think it's hard for them to hold other people in their pain or to provide that safe container, is because their own trauma, their own unintegrated pain is getting activated, and they don't know how to handle it. And again, the system is not set up for them to do that…." [CF]*

> *"I also want to make sure that someone feels that they can be unburdened and… to do that they need to know they're not burdening me."* [NY]

However, working in biomedical professions serve as a way that people can hide from their past and *"get accolades" [MV]* for doing so:

> *"Because the harder we work and the more recognition we receive, the more we can advance our careers and push down that gnawing feeling, the core belief that as we are, we are not good enough. Where did this wound come from? The answer is, more often than not, a wound that was experienced early in life and never dealt with. If we can heal this wound, everyone around us benefits: our patients, our co-workers and our families." [MV]*

In keeping with literature describing implicit bias,[92,186] participants described health care workers as susceptible to projecting their own judgments and biases into the clinical setting and onto patients. Difficulty recognizing one's own emotions and triggers can cause a person to exhibit judgmental and dismissive behaviours, shut people down, and perpetuate blindness and exclusion previously described. People seeking help may also shut down because they know intuitively that either the health care provider can't handle it or doesn't want to know.

> *"One of the things that we all know, is that there are plenty of people who seek out caring professions as a bypass right? As a bypass of their own pain, of their own unintegrated trauma. It's rampant. And then we see ourselves getting so burnt out and having high attrition rates, and wonder why… And if you haven't done any work on yourself, in terms of your own pain, your capacity to help other people in theirs is going to be diminished. That's just the way it is. And if you continue to compartmentalize your own pain, or suppress your own pain, or dissociate from it, or do whatever coping you do, to get yourself through, eventually there's an outcome from that that's not good for you." [CF]*

"If I'm an overworked, stressed out physician, neglecting my own needs, my family's needs, or the patients around me, I'm not employing my own trauma informed care. As human beings we pick up on all of these emotions subconsciously. Our patients will know. And that's what I'm concerned about… if we don't embody the principles, we cannot pass them on. We can't teach it, we can't spread it. So I'm hoping that along with the dissemination of this knowledge there's also deep understanding that we may need to do some healing of our own if we are going to take this approach. This may seem daunting but in the big picture, I can only see benefits to healing the healer. We matter too. Have I done counselling? Yes. Has my partner done counselling? Yes. Have my kids done counselling? Yes. Because of this, I know the power it has and the transformation it can bring to people's lives… It can only increase our own ability to relate to our patients and effect change with those we are working with. To be clear, I'm also speaking about healing our system. Our current system reinforces these feelings and sadly contributes to moral distress many of us feel when we find our beliefs out of sync with what we can accomplish." [MV]

Participants spoke with passion about the paramount importance of self-work in providing safe and attuned relationship-based care, and being *"able to connect with another person on a human level, as opposed to the helper" [NM]*. To support sustainability in practice, and build capacity for *"human-ness" [NM]* in health care, they emphasized TVI approaches that should be "*embodied" [MV]* by people providing care, with self work as an essential ingredient, such that they are practiced in applying "the notion of embodiment as lived medicine"[127] to themselves and to people seeking their care.

5.1.2 "We held hands": A story of deconstructed oppression & shared power

TVI practice can originate from the intersection of a rejection of structural violence as the status quo, and what participants described as an innate human capacity to know that healing is possible, "*going back to the time where the misogyny, and the patriarchy wasn't their knowing." [JLK]* We offer Ruth's story here to situate TVI work as deeply personal work that arises from a fire of possibility, and builds on the strength of connection.

"I invited a number of academics to come from [university] and I picked [mentor] up from the airport that morning, and we drove there [to the prison]… Basically what we were doing is giving back to the women who we'd interviewed, and the correctional officers, the findings [of the research]. And so that forum, the serendipity of it… I still get goosebumps when I think about it. The serendipity of it was just amazing. There was a storm that day

and the power lines had gone out, so they had the emergency generator going. The gym was sort of half-lit, you know, it was just gloomy. And I'd invited the Aboriginal Elder to come, because I really felt that she needed to be there. And I hadn't heard from her… but she showed up. And the Chaplain came, and there were a number of healthcare staff from the prison, and some correctional officers.

Anyway, when we got there, all the women were there and they pulled all the gym mats on the floor and so they're all sitting on the floor waiting, and the Elder, I asked her to open. What she had us do was stand around the gym and hold hands. So here we were, academics from [university] – I'm going to start crying – incarcerated women in their prison suits, [mentor] from Saskatchewan, who had just flown in. We stood around the gym, we held hands, she pulled the Chaplain into the middle of the circle with her and she opened in prayer, in Cree, and then translated to English, and then she asked the Chaplain to open in prayer, and she basically set the stage for spiritual health as part of this…

…They didn't have a microphone… so we used the karaoke machine [laugh]. So I explained the themes that had emerged from the interviews and then I asked women if there [was] anything else they wanted to add to this… [Elder] basically facilitated it. It was like this karaoke machine was a talking stick. She had them come up to the microphone one at a time. So women from prison were coming up, talking to this mic and saying, "Well, we need to research this. We need to research this. We need to research this." It just went on and on and on. There was no saturation of data. It just went on and on about all the things they thought were really important to research: "We want to do this, and we want to go into the schools and speak to the children… and we want to have better relationships with our [children]," on and on and on.

And then every so often, we'd have to have a smoke break… and they'd do some drumming. Then we'd come back, and then we have pizza for lunch, and… we basically formed [small groups]… put the chairs into five circles, and after lunch said, "You can choose which theme you'd like to go to." The idea of the smaller group is to focus on… the topic of the research. We had HIV, Hep C, and infectious disease... One was relationships with family and children… one was healthcare delivery and mental health in prison, and one was reintegration into the community... You can imagine which one most of them went to… it was family relationships, and relationships with their family and their children. The second one was reintegration into the community. And the thing that I thought we should be focusing on, which is HIV and Hepatitis C, there [were] hardly any [people there]… It just wasn't for them.

… [the] women didn't need to stay the whole afternoon. They stayed the whole afternoon. They were so buzzed and so excited about this potential to get involved in this research. That was a Friday. The next day… we said at the end of the day, "Look, this has been a really long day but we actually now need to get to the task of writing this application.

Whoever would like to come on Saturday – we know Saturday's your day off – if you'd like to come to the gym on Saturday, we'll actually get to the work." And on Saturday, 27 women showed up to help… and then they went to the warden and said, "We've got two weeks to get this funding application [done]. Doing this research is too important to us. We want to do this instead of our job, like laundry or horticulture. Can we make research a work placement?" And the warden said yes. So 27 women worked with us for two weeks putting the funding application together. And they would write the stories… I explained what sort of things they would do. And they said, "Oh yes, it's like writing an impact statement. We know how to do that." So they would then go around and interview everybody in the prison and get their impact statements for this research to go in with a CIHR application. But they would talk about how when they went back to the unit that night, they were just buzzed, because they were just so excited by the sorts of things that they could get involved in to try and improve the situation for them.

That was really the beginning of the transformation. It kind of gave them hope in a way that they hadn't had before. And… everything was unpredictable. It could have been all shut down because of the power outage, right? And… I mean if the Elder hadn't been there, it wouldn't have happened the way it was. The fact that she pulled the Chaplain [in], it wasn't an Indigenous vs. Christian thing… Sorry, now I'm emotional [laugh]. I'm going to cry [laugh]… it was transformational for me. But it was for the women as well, and you know, they'll still refer back to that time…

It was an amazing experience to be part of a prison at that time where you've got a warden who has a therapeutic kind of mindset in recognizing that women in prison are – honestly, I don't think the word trauma was ever used back then, it was so long ago – but recognizing that they've had terrible childhoods, and terrible lives, and this is an opportunity for them to actually kind of help [themselves]… so that when they leave they're in a better place to be reintegrated…

We ended up not getting the CIHR funding… I kind of went, "Right, now I can relax until we get funding news." But the women went to the warden and said, "We don't need funding, we can keep doing this." [Laugh] I went, "Okay." …They'd book these research forums and invite these community agencies in to come to the gym… all people in the prison were invited to these research forums. Then the women gave their presentation that they prepared and then they'd facilitate the question and answer [period]. So they developed public speaking skills, and answering questions, and organizing these forums. It was just… I couldn't have [predicted], there's no way… it just happened… And if we'd got funding from CIHR, it would have been [prescriptive] "you have to do this and this and this," right? [Laugh.] We would have had a research assistant or coordinator telling them what to do, because this is what you do… [but the] women just carried it… I couldn't keep up with it [laugh]." [RM]

5.1.3 Fighting the system

Where oppression is deeply entrenched,[5] uptake of advocacy is "weak",[77] and TVI practices are unsupported, participants described a choice: Advocating one-on-one through each encounter with a person seeking care, or through system-level advocacy, or both. Making – and often forcing – change as "inadvertent activism on a daily basis within routine care",[164] is the routine work of many participants who shared stories of active resistance and protest as a fundamental part of their practice. Hawke cites Lordeonce who situates this work: "Sometimes we are blessed with being able to choose the time, and the arena, and the manner of our revolution, but more usually we must do battle where we are standing."[164]

> *"They came in, my first audit, went through the charts, sat down with me after and said, "We don't like what you're doing." I said, "What don't you like?" …"You're prescribing methadone to heroin smokers." I said, "yeah". "It's not in our guidelines, it's only for IV users." I said, "Excuse me but... methadone is an opiate substitute treatment?" "Yeah." "Smoking heroin is an opiate." "Yeah." "That's why I do methadone." Five years later, they change the guidelines. So every five years, they come into my office, they say, oh, they don't like what I'm doing, and then five years later, they're doing what they didn't like. So that's the truth. God's honest truth…. Every time they come in, I said, "Have you got a complaint about me?" "No." "Can you show me where I've done harm?" "No." I said, "Well piss off." [RA]*

> *"If you're really, really coming from a place of harm reduction, then… you're doing what's best for the patient, compromising sometimes what you would see as a standard of care. So… for an IV drug user, you would not ideally put a PICC [venous central line] in, and I get that. But if the choice is, put a PICC line in that they may occasionally use to inject narcotics, versus having them walk around with a staph aureus bacteremia… I've been in those rooms where they're injecting drugs through their IV lines that you've put in. Yeah, ideally, that's not really an awesome medical standard of care. But for me, that beats them delivering their baby on [the street]. It creates tons of provider angst… Like, "is she going to OD in front of me?"… but it just feels better than the alternative." [DF]*

Participants reflected on the role of harm reduction embedded in their work. They described a commitment to acting in the best interests of the people seeking care, even if that created conflict within institutions.

"It was a battle... for every patient… I'd have patients who were on the street, they delivered, had nowhere to go… She needed care, the baby needed care, supportive care. I keep them in longer than two days. The administrators [would] come down and say we want the patient out. I said no, they kept coming down, and I said no. And I said, you want the patient out, you discharge the patient. And administrators can't discharge the patient… When we started [maternity care program], I said I will never discharge a baby to foster care simply because the mother doesn't have housing." [RA]

"There is a lot of pressure, especially when managers attend rounds, that we have to get patients out of the hospital because they need to hit a target dollar amount… a target number of discharges, a target length of stay average, a target turnover of care… I had to learn to push back on those pressures, to continue to hold accountability for making sure that health and safety of the person… was the only reason I would sign off. I had to learn how to put my foot down, until things were in place for patients to actually go home successfully… I learned to say, "not safe!" and "If you want to discharge for financial reasons, go ahead, but I am not going to say that they are okay to go because you have a dollar that you need to sign off on." [KQ]

The urgency of need, intolerance of violence, and the mobilizing strength of anger also motivates speaking up to power, as described by an Elder:

"I continued to work in the way I worked, regardless of how they wanted me to work… I've been at risk of being arrested, many times, for advocating for women out on the street, that have been arrested… those police, [forcing her to be] leaning against their car, while she's not even dressed properly. And I've gone and blanketed them and said, "At least let them sit in your car, instead of kneeling on the ground." And so, being that advocate, being that voice, and reminding some of those people that they're not doing things in a good way. I think my Elders that have guided me and supported me, and my counselor, who's my helper, that they've given me that confidence and strength." [EC]

Several participants described a long history of resistance to the particularly violent *"birth alert"* system in Canada that was responsible for separating marginalized mothers and their babies – a practice that "*was super-traumatizing for everyone involved," [DJ, Nurse, Program director]*:

"One of my young [physician] colleagues, I said to her, "wait till you have your baby." So then she had her baby. And then she actually said to me, "You told me I would see it differently when I had my baby and I can tell you now, if somebody tried to take my baby away from me after I delivered, I would have killed them." Now when a woman has her

baby taken away from them, and they're from the street, and they're fighting these doctors, and the social workers, saying "you fucking can't take my kid away, you can't take them away," they're seen as a problem behavior, they're seen as violent, they're seen as everything other than what's happening, which is that their baby was taken away from them…

…We just showed that these mothers could be loving mothers and the babies were not needing treatment for withdrawal. We have published data. When we did the first study at [maternity care program] for our outcomes, I sent it to the Canadian Medical Association Journal... I got a letter back in two days saying thank you very much for your submission, but we've decided not to send it out for peer review. What we showed was babies didn't need treatment. Babies could breastfeed. And more babies went home with the mother. [The next month] the editorial article was: The foster care system was broken. And basically, what the editor said was, we know the foster care system is broken, we know it's overloaded. And I would have said, I just sent you a paper saying that we can have less babies going into foster care. I would have thought he would say, we have an example here of how we can unload the foster care system. Instead, he said the answer to it is to increase the capacity of foster care system, because these moms are incapable to look after these kids." [RA]

Several participants also described a gentler strategy of "*nudging"* the system towards TVI processes, "*planting seeds all over the place" [MV, Family physician]*, and employing *"curiosity instead of resistance as a way of making change" [KQ, Physiotherapist]*. Hawke describes the important contribution of feminism in this work, which "helps to cast a gentler lens… leaving judgement and condemnation for the system rather than the individuals within it."[164] Participants in our study described transformation invited by action and also by who they are in their work, knowing that they are leaders, and the contagious power of their unwavering "*integrity" [KQ]*:

"…if we don't speak out, then how are things going to change? [laugh] And so the language that we use, the opportunities that come available matter, that, "Oh my goodness, we've met each other for a reason," or "We've crossed paths for a reason... We learn by experiences, and the holding of space is so important, and informing people that… you know what, if you come back to a space and there haven't been many changes, gently let them know, "Wow, what's still going on, eh? How come nothing's changed?" [Laugh] "What can we do to make it a little bit better?" [EC]

5.1.4 Resistance to change & The persistence of opposition

Participants described needing to overcome tremendous momentum of the status quo, *"the system marching on without thinking and without feeling," [ND, Psychiatrist]* with the implicit message that "*You've just got to keep doing it. This is the way we're trained." [GT, Psychiatrist]* Richard Tillet lists rigidity and resistance to change as important symptoms of burnout,[185] ubiquitous in health care professions and "toxic organizational cultures".[173] Zigmond writes: "Our armour of assumed omniscience and omnipotence has taken years to develop and is hard to discard."[174] In this context of strong systemic resistance to change, *"a lot of persistence" [SD]* is necessary in fighting for change.

> *"[Laughter]… [Doctors] generally will bring up that they only have this much time [gestures with fingers close together]. What we're talking about is screening… and they don't see it as important to ask about risks for postpartum depression - it's just another thing, right? [They say:] "And then what do I do?" And, you know, excuses." [SD]*

> *"Change takes time. People feel time is very, very hard to find, and so to change something when we don't want to prioritize the time is a big struggle. We also have to be uncomfortable enough with something to want change it. Having to change something [comes] with the admission that you might have been doing it wrong [laughs]. We don't like to be wrong, we don't like to be uncomfortable, we don't like shifting our priorities, we don't like making time, which all makes change very hard." [KQ]*

Challenging the system requires confrontation with practices of "women's subordination in a hierarchical male dominated society"[69] and the silencing and suppression of opposing views. Sheila observed that "*overall, women are speaking out more, and there's more numbers." [SD]* However, like oppression in society, health care professionals can also be "worn down by the insidious trauma involved in day after day living [or working] in a sexist, racist, classist, homophobic, and ableist society."[69] Similarly, "EQUIP's attention to inequities including racism and poverty concurrently exposed power inequities and strained dynamics among staff related to professional hierarchies as well as social inequities".[4] Speaking out is especially challenging in hierarchical environments:

> *"I just thought medical school was so damaging. I thought that I would never survive it. I thought it was so brutalizing… [In my previous job in a community clinic] the professor*

took us on rounds at the [city hospital]… We were nobody, we were these women who worked in a clinic, and they treated us like students… and I was just, I was just appalled. I saw five men do a pelvic exam on one woman… I was just appalled. I had my feminist point of view, and I got trashed. Within two weeks [as a med student]… the professors were mad at me, I wasn't supposed to be saying these outrageous things, like men shouldn't do pelvic examinations on women [laugh]. And I thought, wait a minute. They admitted me." [HI]

"Part of it is the fear of the systems admitting that they've contributed to the structural violence, and the outcomes that we see… And it's not something I feel like I can actually speak about openly… I don't know, if the day will ever come to have this conversation… and I think it would be somebody external to say it to feel safe, but… when we're talking about the national inquiry on missing and murdered Indigenous women, what role did [hospital] play that perpetuated that? Because [health care] creates vulnerabilities with Indigenous women, removing them from communities, perpetuating that pattern, the racism that they received in care while they're here… [hospital] was explicitly mentioned among all these other [systems], that Paige, this young girl, fell through the cracks of all the systems, and how each system washed their hands of any responsibility or accountability of her on her journey through each of them, when they in fact were supposed to be there to protect her, and support her… when I've dealt with communications before, and even mentioning Paige's story, [an organizational leader] actually told me later, don't talk about that." [KN]

A person's status, gender, and role within the hierarchy impacts their ability to advocate for change. A male participant attributed his ability to fight the system to *"stubbornness"*, although gender and relative power were important implicit influences:

"VB: You as a man doing advocacy. Do you think that has impacted your success in this? RA: No, no, I think it was my stubbornness. But also showing that we had data, we had published work. Once you've published, people have to pay attention to it… They said, "Oh, that's nice. I really like that." But once you show them that it's cost effective, they're doing it the next day. I had a choice, either I put my hands up in the air and say I can't deal with this, or I decide to deal with it. And [my patients] were getting treated like shit. They couldn't get treatment… So I was fighting the institutions, all the time." [RA]

A woman in a leadership position, contrarily, described the difficulty of challenging power:

"[Challenging the system], it's a fine line to walk, because I still have someone I have to report to. And depending on who I'm reporting to, and where they're at, will create the openness that I can have with them, and how direct I can be. There's still this chain of command that I have to follow… we can only push as far as the system and people are ready. And that's the constraint we have to work within." [KN]

5.1.5 Collaboration: Top-down & Bottom-up change

In the context of systemic violence and systems resistant to change, deconstructing oppression is often *"a ground-up, grassroots situation" [CV]* where everyone's voice matters. In EQUIP's health equity intervention, Browne and colleagues describe increasing "efforts to limit the dominance of biomedically-based discourses… [so that] community and socio-historical contexts might be discussed and factored into decision-making", because "ongoing dialogue and accounting for inter-professional power dynamics are key to converting abstract ideas about health equity into meaningful, concrete actions".[4] Ford-Gilboe and colleagues explain further that resistance emerges where agency – a person's "capacity to exercise their power" – is limited, often by constraining organizational and structural forces.[38]

Two participants described working within community-based organizations that rely on wisdom of volunteers with lived experience, and in which "*shared knowledge is one of the founding principles" [CV]*:

> *"From the top-down, it's not going to [change]. It really has to be the people. Front-line providers that are educating themselves. Because obviously it's not going to come from the health system. If it does, it's going to be very ineffective and probably very expensive… [The system] it's so bureaucratic, that something like trauma-informed care can't be scripted like that. It can't be. It doesn't mesh. You can't use a colonial system to address the oppression that is the result of that colonial system…*
>
> *Even here at the [organization], as hard as we try, we identify ways where we realize that we're participating in that same system of oppression by doing things the way that we do. And whenever we identify that, then it's our responsibility to address that and be like, "Okay, that's not what we're about here"… I am so grateful for all of the volunteers that I have… because I don't share their experiences. I don't have [all the expertise] I need… we need all the voices, so that you can identify where the system [needs improvement]… things that I maybe would never have considered, because I am white, or because I'm middle-class, I get to hear about because I am surrounded by people who want the same thing that I want, [who] are willing to share their stories..." [CV]*

Disruption of colonial and patriarchal systems require *"synergy"* between bottom-up change that can "*trickle upwards,"* and top-down change that can be mandated and

supportive *[MV, Family physician]*. From both sides, participants described willingness and permission for change that helps outweigh resistance.

> *"The fact that the CEO of the Health Authority signed that declaration, that gives a lot of backing to then move forward, because it's no longer just Indigenous people saying this is what we need. But it's the leader of the Health Authority, making that declaration and commitment. And so now that that's been in place, in the last four years now, I would say within my practice, I've seen that awareness increase. But there's still a lot of resistance and a lot of system barriers that's preventing it from moving at a faster pace... It feels like with how the system is designed, nothing's going to change unless you work with how the system works. So because it is top down, until we had that declaration of commitment from the CEO, it was very hard to get any type of initiatives going without being either dismissed or resisted, [or] tokenized in the system. And with a declaration being a place, it was like an order from the person in charge, that this is what we need to do now. And then… whomever is going to work within this Health Authority now, it's a part of... how things are going to be done here now, that they have to be aware of." [KN]*

Gains towards safety and healing within colonial systems can easily be reversed when power shifts back towards hierarchy, removing agency from people providing and seeking care within organizations. This illustrates the critical potential of a single person either to create change, or to reverse it; it is a disheartening conclusion to Ruth's story told in 5.1.2 *"We held hands"*:

> *"In a [prison] system that is in essence, controlling and punitive and colonial… it's oppressive, so there's all those challenges. And when you've got a warden that mitigates that and is trying to do a different paradigm, then it works. But when you've got a [conservative] warden, and then correspondingly once you've got a change in leadership at the top, then that filters down to all the correctional officers who are [now] about control and punishment. So then [TVI work] becomes really difficult, and in the end I couldn't stay. It just was too challenging. It undermines what you're doing. When things got bad and the warden changed, everything [changed]… the paradigm shifted. You felt as a physician working in this environment, that you weren't actually being supported in any of the initiatives or direction that you wanted to go… I know that prisons are colonial structures… [But] this is crazy-making!" [RM]*

5.1.6 Inclusivity & Intersectionality

Participants described TVI work in complex terrain of inclusivity and intersectionality:

> "*[TVI care] means understanding how systems of oppression will interact with different types of people… [What is safe for each person is unique] and sometimes that clashes with what you need to do to make another person feel safe." [CV]*

Inclusion is the opposite of competition (for scarce resources, time, or attention) that can happen when layers of oppression intersect and overwhelm available resources. Inclusion can be *"messy" [S],* but it is an important part of TVI practice, particularly in the work of redistributing and sharing power. Participants described broadening the scope of TVI care to create inclusive systems of safety instead of isolated services based on specific identities.

> *"In order for any real true work to be done, we have to be able to get messy with each other. That's one thing we've learned through our speakers bureau, is that a lot of people haven't had any meaningful conversations, like surrounding drug use, or even sex work… they've never had the conversation, so how do they know what's safe? Sometimes, with these conversations that need to happen, things will get messy, and I think that's where being trauma-informed and being violence-informed really comes in play, and helps... [like] for really intense conversations like the one we're talking about… changing policy and rules to be more inclusive… How is society set up differently for each of these people? …What kind of spaces of oppression do they share? And then how does it look different for each of them?" [S]*

> *"I got to a place of thinking, we need to bring the men in because we need to heal together. And again, nothing changes if nothing changes. There's lots of amazing women's drumming circles, so it's really important for women to have that space. But there's also an importance to create another space for families, for uncles, for brothers, to come and hold space with the women. And sometimes the men want to take over. But as women, as aunties, we'll bring them outside, give them a piece of tobacco, and say, "Hey, this ain't your show." [laugh] …It's changing to [women holding the power]. So, the matriarchs are coming. The grandmothers are coming. And that's exciting, right? And as life givers, we share those teachings. It's great…. those boys need good models. And those models need to do things in a really good, respectful way, so that when they grow up, they're going to treat Mother Earth, our women, our families, in a good way. And so, we have lots of laughter… the men are coming and we're singing together. Teachings, Cree teachings, are women aren't allowed at the big drum, [but] I've learned through our beautiful Elder friend [name] that everyone can sit at that drum. And so we do that here, men and women sit at this big*

drum. It's beautiful. We get to model that for our youth, for those little ones. And so… as they grow, they'll be the ones leading. They'll be the ones looking after us. They'll be the ones showing that next generation." [EC]

Inclusive practices are equally important to model among health care workers and within institutions:

"You can't make this about left brain, "You have to do this, you have to do that, you have to do this." You cannot make it like that or it won't work... The only thing that I can do is live out what I'm talking about. Treating patients the way I know they need to be treated. Treating staff the way I know that they deserve to be treated. Even if they aren't doing what I think they should do, I still need to respect them. So, I'm showing them, in a way, that's leading by example. And I think that is… what's going to change things." [MV]

"I think we have a very low hierarchy system, so we have a great deal of communication between the nurses and midwives and GPs and myself and my specialist colleagues, so I think that also helps to sort of democratize the nature of the care that we provide… I think we're also…reasonably good at looking at where our faults have been or where we've potentially made mistakes with patients… so that we're okay to hear back from the nurses, or hear from the midwives who are telling physicians about things that they may have picked up on that were missed." [TN]

Practices of inclusivity protect against harms of hierarchies, and sustain more balanced power:

"There's moments when we are at a steering committee meeting, and invited people with lived experience there, and… the person with lived experience either shuts down completely and doesn't engage, or, they have to leave [because] something had happened suddenly that was triggering, possibly [because of] that hierarchy… the type of language they're using… Since then, we are really aware of it, so we always check ourselves in the beginning, and say, this is what we're doing, this is why we're here, we're all here as equal… We don't lead it, we're there to kind of provide support, but that's also important that we're not here because we're either educated, or have more income, or we have this professional status, but we're there to really appreciate their input. And one great thing that we do is that we actually compensate, so we're not just using them for tokenistic purpose… their time and input is valued." [PD]

Inclusive and intersectional approaches are especially important in a historical and biomedical cultural context in which "experiences of systemic oppression are not included

in what is defined as trauma because the victims are typically oppressed groups and their voices are silenced by the universality of the white, middle-class and heterosexual experience that dominates the treatment and research literature."[69]

5.1.7 Integrating Trauma-informed practice & Violence-informed care

Many participants referenced principles of trauma-informed practice (TIP) – in particular those outlined in the BC MHSUPC Guide[14] – that informed their TVI work (Table 1). Clark suggests how a broader conception of trauma creates a bridge to addressing structural violence: "Constructions of trauma shape what we consider as violence, what kinds of violence are erased, and the kinds of supports and access to services that flow from this."[36] Participants in our study identified validation as an important starting point to undo this erasure and provide a corrective experience for people whose exposures to structural violence have not been seen or heard, for example in which "*everybody just shuts the door on my anger, then… I internalize it into my body and hold it within me." [S]* Participants described TVI care as a fresh start:

> "*Those Elders, those old ones, they don't want to walk through that door because of what's happened in our societies, because of colonization… that trust is [eroded]… they're so afraid. So, sometimes meeting them outside the door and saying, "Hey, come on in, let me put some tea on," and [we] start there." [EC]*

> *"When we first go in to meet them, [we assume] that they may [think], this is just another person that they can't really trust. Because they've not had necessarily the most positive experiences [in health care]… So, trying to acknowledge that, even to voice that, because sometimes there might be kind of an abrasive response, or hostility, or defensiveness… acknowledging that that's there, acknowledging the fact that they may mistrust the system, [and] bringing that into the room, so that they can feel validated…" [GT]*

Participants used de-pathologizing approaches that educate and empower people seeking care by normalizing responses to adversity (5.1.8). De-pathologizing within TVI care "mitigates the potential to locate 'the problem' of trauma primarily in the psyche of those who have experienced violence, rather than also in the acts of structural violence and the conditions that support those acts."[1]

"We often get stuck in our trauma because we haven't been informed what it actually is. So when we start understanding that we may be suffering from intergenerational trauma and these are the symptoms, it's so validating for an individual. It's like, okay, now there's that space to heal." [EC]

"People have to know they're not crazy, that the way they're feeling is a normal reaction. So for a 13 year old girl who was diddled by her brother or father, grandfather, when she was 8 to 10... she doesn't know the way she's feeling is normal reaction. She thinks it's an abnormal reaction, because everybody is telling you, "Why are you acting out, why are you being so oppositional?... why are you not listening? Why aren't you going to school?" [RA]

Normalizing harmful impacts of structural violence and the potential for re-traumatization in health care, creates a bridge from TIP to TVI care, broadening participants' approaches to building safety, and inviting more appropriate diagnosis and care.

"A lot of Indigenous women don't actually experience… postpartum depression, it could actually be something like post traumatic stress disorder. Because it's more encompassing of… all the social determinants of health they're facing in their communities, having to travel to another location to receive health services… the isolation that they're forced to encounter. There's all these forms of trauma that often don't get considered when it's a direct diagnosis like postpartum depression. That just puts the focus on the woman as an individual with something biologically happening to her. Rather than looking at everything that is happening in her environment that could be rephrased to understand her challenges better." [KN]

"The enactment of something like white supremacy, for example, is not really captured in the trauma terminology, and use of the word 'violence' goes some distance to being able to capture those experiences a little more adequately... Within white supremacy there's this unspoken, often unacknowledged centering of white experience, which then results in power very often being hoarded and not shared with people of color, or people who are racialized in some way. And it's almost invisible that by default, there's whiteness, and we don't allow space for people who carry other identities to hold power or to move as freely in society, or for there to be equity. There are continually various forms of harm being perpetrated – significant, obvious harms and violence, as well as microagressions which can accumulate over a person's lifetime to cause very tangible health outcomes through the stress of this type of oppression." [SHC]

A lack of acknowledgment of the implications of racism, discrimination and intersecting forms of stigma "in a constantly morphing colonial system",[36] translates "over centuries

into gaping health disparities… [while maintaining] systems of wealth, power and privilege."[92] This ongoing "colonial narrative of cultural hierarchy and white supremacy"[92] perpetuates *"unsafety"*, and requires comprehensive system-level advocacy to address social determinants of health, structural violence,[9] and stigma,[159] to accompany one-on-one clinical work:[188]

> *"Their current life situation is reactivating [their] trauma, because of it being so challenging… because of issues like racism and poverty and colonialism, and so on… You can help people with really good psychotherapy, and with attunement, and these sorts of approaches, but there's going to be a limitation of what you can do for them if the very things that have contributed to their trauma, are ongoing. And are systems based. And are rampant and are way bigger than you or them… they go home to that same pain, because it's never going away, because they're so marginalized. And that's something that I can't solve, individuals can't solve… we would require massive, massive systems overhaul. Overhaul of institutions." [CF]*

5.1.8 De-pathologizing care: Undoing stigma and shame

The importance of de-pathologizing and de-stigmatizing work within TVI care is described in the work of the EQUIP team,[1,29] anti-stigma[159,189] and anti-oppression approaches,[5,190] intersectional feminism,[127,164] and Indigenous methods[36,59]. Participants in our study described active de-pathologizing as another critical starting point in TVI care that supports empowerment and person-centered care.[122] This involves dismantling structures and processes that perpetuate blame, shame and stigma – concepts that are under-reported but significant in their contributions to inequitable health access and outcomes.[159,180,191]

Lyons and Dolezal describe shame and stigma as "intimately bound".[191] While "*shame* is the primary emotion of politics and conformity particularly… for those who have the 'wrong' bodies or the 'wrong' desires… Those who deviate from entrenched social norms are frequently subjected to *stigma*—a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation".[191] Shame has deep roots in a "*society [that] is inherently violent and oppressive" [NY]*, in which "profound or cumulative aversive life experiences can instill negative core beliefs [and] attitudes".[192] Shame manifests in health

care encounters as "unseen" experiences contributing to "a less effective therapeutic alliance."[192] Stigma, similarly, is "a social, emotional, political and clinical issue of enormous significance" and includes discrimination,[159] for example where "the suffering brought on by the disease process may be outweighed by the impact of stigma-induced social rejection."[191] Miles proposes that shame is inherent in the "medical professional identity", however it can be healed as practitioners, and people seeking care, move away from "repression"[193] towards greater compassion and connection.[191]

> *"When people come in around sexual issues, rape, sexual assault, abuse, incest… they often blame themselves. This is very common, all you have to do is look on Facebook …or [at] the Me Too movement. So it's really an educational task. I have the benefit of working with lots of women, and being around for lots of years, and I can say, you know, "let me tell you about this other person who wore a short skirt to a dance. Do you think that woman would deserve to get raped?" Well, no. "Well, how come you think you do?" And to help people look at how they've become inculcated in the systemic beliefs that they're the bad ones. What really needs to shift is the systems in which these beliefs are embedded." [MJ]*

> *"Nobody has [been] telling patients that their behavior is a normal reaction to the bad shit. And as soon as you say that to somebody, you can see them just relax, you can see their shoulders go down, you can see all the defenses go down… you've entered into a therapeutic relationship with them... de-pathologizing for the patient, their behavior… …Not only in the patient physician relationship, but in society, [we need] to normalize the trauma of war, normalize the trauma of being bullied at school, normalize the trauma of being a nerd, [of] being judged. People need to be able to walk into their physician's office and say, I've had trauma in my life. This is what it's like… What do I need to do to deal with it? Instead of being afraid to say it because the judgment will come down hard on them, where they'll be blamed… women who've been sexually exploited, or guys will be treated as, you know... you deserved it." [RA]*

Participants described attuned, relational, and nonjudgmental practices as essential to a de-pathologizing approach:

> *"Say there's… an angry parent, or a parent that we maybe label as, "This parent's so defensive," or "This parent's so…" Looking at it through a trauma-informed lens is to see - and this is where that trauma plus attachment [lens] is intertwined - is to see it that of course this makes sense, their reaction. It makes sense, because through whatever experience that they've had with the system, with other individuals, with medical*

professionals… they're just doing the best they can, even the parents that hurt their children… they're doing it from a place of, that's just what they know." [GT]

An Elder describes nonjudgmental and relational work shared between people giving and receiving support in a healing circle:

"…reminding [people], who do we want to be today, and acknowledging that we have this opportunity, that [violence] stops with us and that we have that power to do that. And sometimes we have experienced such negativity that we've lost our power. So, [for example] by reintroducing that [medicine wheel teachings]… you have all those ancestors behind you, supporting you, cheering you on. You have your support circle cheering you on… sharing that sisterhood, that compassion with one another in a safe, safe space. Nobody judges one another." [EC]

"The way I work is how I would like my family to be looked after… These are families. You know, I would want my family to be able to walk in somewhere and be able to receive the best care possible, and the kindest care. I would like my daughter to be able to walk into a space, and feel safe and valued." [EC]

Participants described nonjudgmental and de-stigmatizing care as spacious and respectful, so it is not only a consultation, but also a *"therapeutic intervention" [GT]*. TVI practices can also foster empowerment within health care teams through strength and safety embedded within supportive organizational structures that drive change; although within rigid systems that are "out of step" with equity-oriented care, "organizational integration and tailoring" can be slow and difficult.[4,38]

"We're trying to extend time with patients, to make sure that their needs are met, their stories are heard, and without judgment… We're trying to get away from that numbers game that people have for funding, and focus on the quality of work. Indigenous folks have experienced rushed services and poor quality of care in mainstream healthcare. We're trying to do the opposite of that. We're trying to show them that they're a part of a family. Our relationship with the people we serve is important to us, and is a homogenous value in all Indigenous cultures... [We value] permanency with staff and little turnover - there's such high turnover in healthcare and social services - this is a trauma-informed approach to account for the experiences of the patients who jumped from foster home to foster home, transient housing situations, and severed attachments due to Indian Residential Schools, foster homes, Sixties Scoop, and incarcerations, for example. The services need to reflect the needs of the clientele, based on their history and experiences. There are so many complex layers to think about when providing culturally safe care." [NM]

5.1.9 Reducing fear through attunement

Understanding how safety is established for people seeking care was another practice central to TVI care for our participants. A felt sense of physical, psychological or emotional safety is compromised in experiences of trauma and structural violence, which requires a synergistic and system-wide response.[159] In Gerber's guide to trauma-informed primary care, authors emphasize the importance of "infusing an entire organization or system with a guiding set of principles that reorders the environment to promote safety, empowerment, and healing for both patients and staff."[24 (p.vii)] Ford-Gilboe and colleagues describe how this can lead to greater "comfort and confidence" in care, which in turn is linked to better health outcomes.[38]

In the context of systemic marginalization and oppression, a family physician in our study described TVI work as "*aggressively, aggressively trying to reduce fear." [NY]* A psychiatrist described the work as intuitive and relational: "*not left-brain, so much, and it's not… you know, ivory tower." [ND]* Creating safety involves compassionately and reliably holding space for pain and vulnerability, as experiences of attunement and connection can provide a corrective experience for people who have experienced adversity. It is hard work, however *"it's a very traditional way of helping others, and being there for others, in a non-violent way." [NM, Social worker]*

> *"Humanity and respect goes a long way… a little bit more of that for someone who is on the daily experiencing structural violence, what they would learn from that." [VE]*

> *"The antidote to trauma is security... you're not going to start healing if you feel unsafe and scared… Security [is] referring to secure attachment relationships with other people. When I feel safe, seen and secure I can let down my defensive walls and begin to trust. When I do this, I will be much more open to learning a new set of skills that I never knew about before. A healthy, secure attachment means building the embodied knowledge that I can actually trust and rely on other humans. In order for this to happen though, I need to have trustworthy people around me who can see that I'm more than just my externalized behaviour. I don't have to keep coming forward with aggression, and with threat. I can… be different, because somebody is showing me that I can be different." [MV]*

Participants reflected on practices that supported their early TVI work, describing attunement, slowing down time, not entering encounters with an agenda, understanding their role within a person's *"circle of care" [NM],* and principally, *"witnessing and listening, and supporting people in their experience" [SD]:*

> *"Quite honestly, I think it's probably the biggest piece, seeing people as they start to get better, is that they start to be able to talk about the real, real experience. Because in that process, I think you start to accept it." [SD]*

> "*Listening [laugh] and curiosity can be our secret weapons… Shockingly, because each human brings… their own uniqueness, they need to be treated differently. Once you are able to figure that out and give individualized support, then they can succeed in almost the same timeline." [KQ]*

In her 2019 annual report on stigma and health, Canada's Chief Public Health Officer advocates for holistic and culturally competent care as part of a crucial process of system transformation towards safety.[159] Investing in understanding a person's experience supports a transition from doctor and institution-centered care to person-centered care, which embeds principles of empowerment and restoration of safety through power.[122] Lokugamage and Pathberiya write about the importance of compassionate, whole-person care, in which "nuanced, humanised, patient-centred care is key… to avoid unintentional blindness of any health provider to dehumanised aspects of industrialised healthcare."[175]

> *"You can't do trauma-informed and structural violence-informed care unless it's personal. [What is safe for each person is unique] and sometimes that clashes with what you need to do to make another person feel safe." [CV]*

> *"Once you've listened, then you can act… That is so important, right? Because once you've listened and you've been still – and …that's not always easy for me, it hasn't been, and I've learned – then they [open up], "This is what's going on, this is what's going on, this is what's going on..." And then you realize they came here for a reason… But sometimes, the way we're trained we almost feel like we need to know all the answers. And they [the patient will] give you a lot of answers… …I've learned to shape my assessment. Safety first, and then their agenda, and… I've just dropped a lot of questions... because it's an hour, and because I want them to feel welcome, and because I want the pace [to slow down]… So you have to let something go…" [ND]*

All participants described feeling inspired by the potential of attuned, relationship-based care to transform outcomes:

> *"I'm just so proud of the Nurse Family Partnership… that touches on all the social determinants of health. I've not come across a program that is able to do that in all of public health so well, and for nurses to have the time to do that. I just think it's really amazing, that level of intensity of the program to support clients, and I do think that it does take that level of intensity if we're trying to change behavior and we're changing generations of people that have dealt with trauma and violence and adversity. I think that this is what it takes to change a life and to change a future." [DJ]*

> *"If you are aware of the foundational principles of being trauma informed, that can be enough… That can really, really make a huge difference for people… Even just a simple intervention like that, of asking [ACE scores], and not necessarily having this huge wide psychotherapeutic skill set; that alone made a difference for people. We know that that's true, so if there's even just the capacity to learn how to attune to people. Attuning to someone doesn't necessarily take you any more time, it doesn't necessarily affect your ability to achieve all the clinical responsibilities that you need to achieve. It doesn't detract from your ability to take care of yourself. Even if people learn the principles of attunement and just started approaching their patients in alignment with these principles, it could set the stage for development of profound trust relationships and healing. It could be so huge, in fact." [CF]*

5.1.10 Women in power & Restoring the matriarchy

TVI environments are safe spaces for both practitioners and people seeking help.[4,24] Participants shared stories of health care that is moving forward from its colonial and patriarchal history, increasingly aligning with principles of restorative justice,[175] and moving towards care that is person and family-centered, supports empowerment, and helps people *"speak their voice" [NM]*.

> *"We have drumming that often happens, and it's just that safe space for people to let go. We honour their hard work, their tears. We keep the tissues and put that in a sacred fire, because they've worked so hard on releasing that and… [it's] that place where an individual can come to, and know it's a safe space, where they're going to be looked after in a really good way... I see these little ones growing up, little babies hitting that little drum or holding that rattle, or little five-year-olds after they're drumming, [I ask], "How do you feel?" "I feel awesome!" And so they get to associate that ceremony with an awesome*

feeling, and that's the biggest reward. I have a little eight-year-old boy that stands up [in circle], and I have the songs printed out, and he stands up in front of [us in] that strong women's song, and he leads us. It's so powerful, that that little boy has that confidence… another little boy, the same thing. He leads the water song. And he has ADHD, and has an older sister, [and he] has no voice at home. But when he comes to drumming, he has his voice, and he gets to sometimes smudge us. And so what he's witnessing are things done in a good way. And so that little guy's confidence… And he's going to be one of those men out there looking after his aunties [laugh], because of what he's experienced... And our little ones sitting around that drum, smiling and laughing… And so, the hope, that intention, those prayers that are put out there are so strong. Look what's happening with our amazing land defenders right now. They're working so hard. Our youth are out there because of what they've learned, right? And so that's exciting, even though it's sad. But they're standing up, saying, "No, step down." They have their voices today. Boy, if I was thirteen-years-old right now, I'd be so happy, because of those voices that are being heard, witnessed, right?" [EC]

This work also restores the power of youth, women, and people who identify as LGBTQ2S.

"I do have clients who identify as Two Spirit… so I'm always going back to when this was not a problem… going back to the time where the misogyny, and the patriarchy wasn't their knowing... I always think about it as a gift, that we have these knowings, and these Elders who have been able to support the knowing of how history was, before contact. To understand that this wasn't you ever being wrong… For women in Canada right now, we are seen as the lowest on the status pole. But at one time we were the matriarchs, we were the leaders, we were the voices. And that's where the healing is actually happening in Indigenous communities right now, is through the women's voices, and the women coming forward." [JLK]

Sheila described the Pacific Postpartum Support Society as a *"matriarchal model" [SD]* in which staff are supported in the same way as new mothers seeking help, by a strong, democratic organizational culture. Sharing power between health care workers and people seeking care is restorative, and an essential part of TVI work.

"We can acknowledge misogyny within obstetrics too… So coming from a feminist place of wanting there to be other options for birthing people, and recognizing that the impact of people birthing with people that they trust, who are approaching their care from a place of viewing them [the patient] as primary decision maker and autonomous and empowered…It's going to have a great impact on their pregnancy, on their birth, on their

baby by extension, and therefore help them develop stronger families, which then leads to stronger communities and so on." [CF]

"[TVI care is] giving [power back to the woman]… I've got some [expertise], but I don't want to take power away from a woman… This is her baby. This is her body. This is her life. And I want to keep her… integrity, power, locus of control. I want that to be hers. And I want to say, maybe I can tell you if your baby's going to be born in the next hour, or the next twelve hours, or maybe I can tell you if the baby's breech or not - I might have something to contribute. But that doesn't mean I want to turn you into something passive and unfeeling. [TVI care] is more that than saying, "I think you might have been sexually abused, so I'm going to be careful". It's not that." [HI]

Supporting women in leadership is also important in TVI practice:

"[In] the teams… the ways these things have been structured, the ways people have embraced [TVI care], and the fact that they're women-based, a lot of them, that's a big part of it. There's no getting around that… the truth is, that who's moving and shaking and making these things happen in a good way, in my life experience, is… a lot of women… with a few men... It's not patriarchal… these [TVI care] teams are… health-oriented, they're dedicated, they're not always highly paid, and they're mostly women. Any way you look at it, that's the fact. That's the truth." [ND]

"What [female leader] said was so moving, and so kind, and… guess what? She was a lactating female. Think about that… I think she had like an 18-month old … I felt, wow…. We're going to think about how we all get along, and who we all are together, and how to support each other… [Her words were] so powerful, and then I thought, oxytocin, it's the hormone of love. And we're all just biological, and maybe we need more of it. You know, we let these testosterone-fueled maniacs run the place. Well, that's not a very nice drug. It makes people angry, and aggressive, and what if…" [HI]

5.1.11 TVI care as ongoing practice: Build process not only policy

Participants described TVI care as "*an ongoing journey that is never going to end." [KN]* It is a practice of building new processes within history-entrenched organizations in which *"sometimes things get forgotten, and then we get reminded". [PD]* The challenging and slow nature of transformative processes is acknowledged by Browne and colleagues, who describe equity-oriented change unfolding "in slow, non-linear ways".[4]

"*A lot of people are incredibly overwhelmed by this new lens to look at. So it takes them a very long time to integrate that into practice." [KQ]*

"We make the changes as we go. It's a learning process. We've all been steeped in systems of oppression for so long that… the layers, and layers, and layers… and it takes a lot of time, a lot of self-reflection, and a lot of voices." [CV]

Participants described challenging the institutional status quo, and the familiarity that people in the system have adapted to, described by Einstein and Shildrick as an "intertwining of self and system"[127]:

"It can be very easy to be a part of the problem, because… everything is almost rote. Like, how ingrained everything is, it's just almost automatic. And it's just how you do things, and nobody questions every little detail of how we do things. That's why it's this process. That's why we're like, "Oh, look what I just did. I need to think about that. Why did I do that? Why do I make that assumption?"" [CV]

Participants also described finding meaning in the gradual and restorative process of implementing TVI practices from the patriarchal and colonial origins of biomedical care:

"Acknowledging structural violence shows that we are aware, that we are evolving… not stuck in a system that can't move with changing needs and individuals… I have watched the speed at which things change in the health care system. [Laugh] Sometimes I wonder… Why are we going backwards? I've watched a new person come in and reshuffle the way things are done. They get excited about something, they change everything around, and people adjust. Then, that person moves on, and the next person comes in, and they think they are doing something miraculous and change everything back [laughs]… Without having the perspective of where we've been in the past makes it impossible to make meaningful changes for the future." [KQ]

"It's an ongoing process. I don't think we'll ever reach a point where we can proclaim every system in BC to be trauma and violence informed as much as I would love for that to be the case… I still think it's possible, but I think it's always going to be a process. And I think part of that [is] being in a space of humility, and ongoing learning… I think we'll probably look back in another 20 years [and say], "Oh my God, we didn't we didn't see that piece, and we didn't see that piece…" I hope we don't think we figured it all out and stop being in a space of learning and understanding and then growing together." [SHC]

5.2 The potential for primary care to be trauma and violence-informed

Primary care has been clearly identified as a key site for the implementation and integration of TVI care,[1,37,194] however primary care reform initiatives including the "Patient Medical Home" do not go far enough to support equity or intersectionality beyond a call for increased collaboration.[8,101,112] In their article "Disruption as opportunity", Browne and colleagues reference critiques describing primary health care reforms as "too conservative, and not disruptive enough of the factors that entrench health inequities".[4] Ford-Gilboe and colleagues similarly describe reforms directed towards patient-centeredness as too "narrowly conceptualized" when compared to TVI care that has demonstrated better outcomes, especially for people living in marginalizing conditions.[38]

However participants in our study described *"a spark" [JLK]* for TVI care within systems in transition towards greater compassion and safety, and away from a *"rudimentary approach" [NY]* narrowly focused on biomedical and pharmacologic treatment of disease. Moving towards equity-oriented and trauma and violence-informed care involves a gradual disruption of the status quo and "deep seated patterns and conditions" that inform "the way that care is conceived and provided".[4,38] Some participants described inspired experiences at this point of transition:

> *"I have to believe that [the biomedical system has capacity for TVI care] because I have seen change in the amount of time that I've been working… I've seen baby steps. Like I said, no one was even talking about trauma when I was training… I didn't hear about it at any obstetrics conference, or in any [teaching]." [CF]*

> *"[TVI care in addictions medicine] kept me alive. It kept me alive professionally. It was so exciting... it was always demanding of the best parts of your brain, your imagination, your sensitivity. You always had to have your antennae out trying to figure out what was going on because it wasn't obvious. It wasn't rote." [HI]*

Some participants also referenced the potential of TVI practices to contribute to more efficient and effective primary care, as demonstrated in the research of Ford-Gilboe and colleagues:[38]

"Bodies hold your story. If we are approaching somebody in a framework where we are not understanding how their system has formed over every single exposure that they've had through their life, then we are completely missing the mark, just continuing to pass them through a system that doesn't meet their needs and doesn't give them empowerment to care for themselves. I think people have an assumption that going to their primary care provider is going to be a shitty engagement, and that they're just there to make the next step to the next thing that they need. [But if we are] looking at the person in a way that is very individualized, we can still be as efficient with our time in that primary care model, and actually direct somebody to the service that they would most benefit from, instead of going through 14 services before they reach the one that actually works for them. I believe that when we don't listen and we don't practice like this, we are… overburdening our system, and it costs us greatly." [KQ]

Primary care aspires to provide comprehensive, longitudinal care, with further potential to create new realities and disconfirming experiences that, over time, can build experiences of safety and connection. Egnew writes: "The success of biomedicine requires contemporary physicians to connect personally with patients to heal the illnesses their technology can so forcefully sustain."[152] This aligns with Tousignant and Sioui's description of building resilience that is relationship-based and structurally situated: "Resilience is a long process of interactions between an individual and his or her environment to face adversity, and can lead to the emergence of moral strength and a sense of optimism."[100] The majority of participants in our study described "small shifts"[38] over time towards primary care that is well positioned to provide TVI care as a *"universal precaution" [NY],* overseeing a person's journey through health care with coordination and stability.

"I think there can be multiple points of contact and each point of contact needs to be trauma- and violence -informed…we're all kind of on the same team. [A crummy interaction] can just permeate to their whole healthcare experience. It's from the point of entry into the system to the point of exit for them."[DJ]

"[In] primary care, you can never know everything. So for me it's all about having the right approach… [It's] not just me knowing five things about trauma-informed care, but it's about understanding why we do it, and then understanding how it might look in different settings. And for me, that's where the universal precautions comes in. It's where I… interact with my MOA, and I recognize that she has her own history, and she's working in a hierarchical system where she's lower on the hierarchy, and that may have its own trauma associated with it, in terms of how she feels valued by the organization, and that I can try

and work to minimize the difference in our positions… Or recognizing everyone's role and really valuing it for what it is. I think that is really important… it's not just something I reserve for patients…" [NY]

Several participants described potential within primary care to provide corrective experiences in the context of "macro-level" barriers and exclusionary practices in the "cultural system" of biomedical care.[180] In primary care, teams have the opportunity to deconstruct typical hierarchies and power dynamics, and deliver care in a less oppressive way, over time, especially for women who comprise the majority of most practice populations.[57] Holmstrom and Roing describe a relationship-centered approach as supportive of patient empowerment; it emerges from an understanding of cultures of oppression, relies on a "joint culture and language", and "emphasizes the need for caregivers to surrender their need to control the patient and determine what may be best for patients".[122] Participants described aspirations of accessibility and person-centeredness in primary care as good starting points from which to offer TVI care, which includes saying yes to people's experiences and needs.

"My job is advocating for the patient in front of me… I remember the first night I was on call, getting the phone call and thinking, "I've got to deal with this"… You don't get to say no… you got to give her what she needs. That's your responsibility. And I don't think you get to say no. That's what I believe. That's what primary care is… we take care of her until we find her someplace better. There might be some place better for her [laugh]. But [until then] she's ours. And we will do everything she wants, or she allows us to do, or that she needs, until then. We won't say no." [HI]

Rebuilding safety also *"has to"* happen over time *[NY],* thus longitudinal primary care is well positioned to provide TVI care that can both address and prevent experiences of "unsafety" or crisis:

TVI care is "long[itudinal care]… it really is about being a safe place, building trust, and having people come to [care] earlier in the process of a relapse or crisis." [ND]

"It brings in the structural piece a lot more… when you're in a relationship with someone, you have accountability in a way that you don't when it's just like a one-time interaction." [NY]

Participants described a key role of TVI primary care as avoiding replicating the exclusion that patients have experienced previously in their lives, including through unsupportive systems. Primary care providers are not inherently incapable, and can provide a corrective experience to help repair past harms. For example, Egnew calls for "metamorphosis" of the role of the doctor "from doer to helper, from expert problem solver and fixer to servant and companion" skilled in "empathetic witnessing".[152] This supports "continuity of caring relationships through time and the patient's feeling of being known… being heard and accepted… [and] the development of a relationship that links the patient, at a minimum through the doctor-patient relationship, to a community that turns toward a new future".[152] The foundation of this repair work is a safe and understanding relationship with good communication "*that could have a huge impact." [SD]*:

> *"[Some] medical professionals… and perhaps some of the alternative practitioners are providing [TVI] care which might be felt to be more healing, but it's because of these factors we're talking about, that they [patients] feel more understood… because [in medicine] we're so busy in a way that they may not be getting that [sense of understanding]… Because there's been a lot of mistrust with physicians and what's happened over [history]… so I think that how to bring that back, might be to remember how to listen to people… It's possible." [GT]*
>
> *"You're listening and you're being touched by it. And… they haven't had many people listen to them. And they haven't had very good experiences of healthcare, or their healthcare is so disjointed… That kind of relationship building… happened in a way that maybe they hadn't experienced before." [RM]*
>
> *"Our women's sharing circle is great, relationships get formed… last Thursday, there were 14 of us and five little ones. And I've got this nice big drum built right beside me here [touches drum covered in cloth], and we bring out that big drum and those little ones get on there, and it just warms my heart in witnessing that, like, wow, these little ones, they don't have to fear. We're all standing behind them, allowing them to feel and be in their culture. It's really exciting." [EC]*

5.3 TVI practice in the context of the COVID-19 pandemic

We completed our interviews and the bulk of our analysis as the COVID-19 pandemic began to emerge, and people – as well as most of our ideas and aspirations – were paused or pivoted in a forced re-direction of attention towards this transformative global issue and the tremendous uncertainty that accompanied it. Months later as we settled uneasily into adjusted routines, we reached out to participants to review findings for member-checking. Six participants shared additional thoughts about the rapidly changing context that was *"quite confirming what we all know clinically" [RA]* about the importance of TVI approaches, particularly in primary care, particularly during a time of stress, overwhelm, and inaccessibility of care.

COVID-19 is an "inequality virus" that is amplifying pre-existing disparities and magnifying vulnerabilities due to increased isolation and deprivation during the pandemic response.[28,195] Scholars across disciplines are recognizing the "prolonged and compounded" impacts of the pandemic, and the pandemic response, especially on children, women and caregivers who are experiencing "highly disturbing impacts" and "horrific effects" on mental health.[196] This is in addition to tragic increases in overdose deaths and increased substance use since the start of the pandemic, especially among Indigenous people and others who are isolated, lack social support, or who are suffering from "a history of mental health concerns, substance use disorder, trauma, and stigma".[196,197] As Canada's Chief Public Health Officer described in her 2020 annual report, "the COVID-19 pandemic has jolted our collective consciousness into recognizing that equity is vital for ensuring health security." Dr. Tam highlighted the imperative to address "the structural determinants of health", the contributions of "stigma and discrimination [that] are embedded in these systems and influence who has power and privilege", and the role of intersectionality to help us understand "overlapping and compounding risks", for example related to the intersection of racialization and employment in predicting differential COVID-19 exposure, susceptibility and treatment.[197]

Participants' descriptions of working through the COVID-19 pandemic referenced themes previously identified in our analysis, including the entrenched status quo of institution-

centered care, the problem of hierarchies and oppressive power dynamics, the invisibility of people living in marginalizing conditions, the neglect of structural violence, and the importance of healing moral distress and burnout to restore relationship-based care. They also echoed Dr. Tam's aspiration that "crisis can lead to opportunities for long-term and high-impact change."[197]

They described this overwhelming experience as a time of immense struggle for people both providing and needing support, in a context of significant amplification of "the things that frighten us":[196]

> *"…the fear that people have… in themselves, throughout the pandemic, plays out in different ways when they're trying to navigate their healthcare… [they] feel very powerless… it's a lot… at once… and at the same time, there's inherent challenges for people, when they're trying to simultaneously follow the rules, feel the feelings that they have, get access to the care that they need, and find support." [CF]*

> *"I see people digging so deep, gritting their teeth and hanging on for dear life, trying so hard… every little thing is overwhelming – just one extra thing [stress or bad news] – like hearing about a family member in another [country] or… people they relied on before withdrawing support because everyone is really stretched thin… [and] I feel dread, or maybe the same thing… I'm just trying to hang in there so we can also keep some semblance of going forward while time passes. I feel like we're just trying to get through the days, and I don't know what that's going to look like when the days are different... now we've experienced this collective trauma and [TVI care] should underlie everything we do. There's lots of talk right now about how we're redesigning care... but trauma and violence-informed care doesn't necessarily seem to be there." [NY]*

Two participants described the impact of COVID restrictions on the therapeutic connection, referencing the nuanced work of TVI care, and expressing concerns about the impact of limited face-to-face contact with essential support persons, and the challenge of assessing safety and providing accessible care in the context of inequitable access to technology. This references emerging literature describing how pandemic experiences can compound previous trauma as well as ongoing deprivation, discrimination and stigma, resulting in "harm building upon harm, reducing the 'shock absorbers' available to cope at times of stress"[162]. Lockdowns are also experiences that can mirror abuse, amplifying feelings of entrapment, loss of control, and loss of trust:[162]

"I'm still navigating COVID and its effects on trauma-informed care… [and] how to navigate the 'recommendation' to wear a mask… I think I had a more difficult time than the more traditional manual practices… because of where I land in [touch-based] trauma-informed-bodywork. I did have some clients say that because they have had PTSD they wouldn't come to me if I was wearing a mask [and] I tell new clients that I will greet them from a distance without a mask so they can see my face. Even still, I find it difficult to connect to newer clients… because the way I work is so much about connection, I have my doubts about how well that is going. At the same time my practice is incredibly full right now... [It's] hard to come to any conclusions yet as to whether it's fuller than ever because of anxiety levels being higher, or people needing more touch than ever for nervous system regulation." [VE]

Participants described how the impact of the COVID-19 virus as well as the social and service restrictions during the pandemic are disproportionately affecting marginalized populations. Dr. Tam,[197] as well as Flood and colleagues,[27] provide extensive descriptions of the inequitable impacts of the pandemic due to pre-existing structural inequities, in which "layers of vulnerabilities, including existing vulnerabilities, the new vulnerability to COVID-19, and further new vulnerabilities created by the varying national pandemic responses, are all socially created, through certain kinds of policies, or… due to wilful or benign neglect."[27] (p.319)

"I've found universally across my practice, that the people struggling with mental health, and mental health and trauma, it all got worse during the pandemic. At the same time my ability to support them has also gotten worse, like synergy in a bad direction. I'm worried about people… I can hear when I'm talking to them that they're not coping super well, but they don't feel free to let their tears fall, or express how they're really feeling, because there's a child in the room or another person, and they don't really have that kind of safety. [And] the way in which I can create that sense of safety in my clinical environment just isn't there. [Appointments are] often by phone because internet is often spotty if they have internet at all… I can't assess the safety of an environment any more. Sometimes they're in a one bedroom apartment… and we can't talk about what we need to talk about, and I can't provide the same amount of support that I need to. That part is really hard." [NY]

"[Health authority] had to pull back from NFP [The Nurse Family Partnership] as they had to redeploy nurses into their maternal health program and then the maternal health nurses were redeployed into COVID-19 contact tracing. They have been overwhelmed. The Supervisors are taking urgent calls but [it is] still very difficult. The other health

authorities are continuing and overall, NFP had more clients in 2020 than in 2019 so hopefully [these program restrictions are] are short-term only." [DJ]

However participants also described the increased attention to systemic injustices during the pandemic inviting potential for equity-oriented change in health care delivery and policy. Could this global pandemic be an experience of "disruption as opportunity"[4]? A family physician raised a concern about current implications of the *"historical precedent"* for research to be used as a way of delaying action in the context of government and communities that both already *"know what to do" [NY].* Whether sustained action results is thus a source of uncertainty, anxiety and dim hope:

"Broadly, this is a time when we should be relying on all of our systems and safety net to come through and… it hasn't. The way in which people, structures, government, health authorities or institutions have rolled out a lot of their work has not felt like 'care', [especially] for people who already experience a lot of administrative violence… and if it wasn't already clear to people, it's made it clear [now] where the government's priorities are… they aren't thinking about people. Even though we have all the resources to do it. Everything is so controlled, means-tested, doing the bare minimum to protect the system. It's flawed [logic] to think that protecting systems is protecting people... We are seeing the limits of the ways we have conducted our systems. Instead of trying to reframe and do something different, we are doubling down on doing what we did [before], and it is definitely not to the task of what we need." [NY]

"COVID has certainly further highlighted the inequities in our system and I am very grateful for the exposure it has given, and that our media has picked it up and is reporting on it. I'm entirely certain we are not doing enough to CHANGE [inequities,] but in the corners of the world where I intake and exchange my information, I feel less alone in the conversation. I have reserved but restored hope in the… clear awareness and sensitivity to the gravity of the choice of words used [by leaders] and the way in which British Columbians have been encouraged to participate in the efforts of the pandemic but without blanket fear-based rules that don't allow the space for the variance of individuals needing to make choices that are the safest for them within the context of their lives. I am encouraged… [that] decisions [are made] with the sensitivity in mind of the impact that stigmatization creates and what information is truly required by the public at a time of uncertainty. With all of that hope, I am still waiting to see true and meaningful action to bring about systemic reform on equitable and culturally safe healthcare…. I can see that there is now a dream of a new boat starting to take shape. I think we have made it to the pre-contemplative or maybe even contemplative stages of change… we have perhaps

started to step into the game and can hear the conversations happening. I hope that we are at a time with enough unrest and exposure that we may actually start to… make change happen." [KQ]

One participant shared a story of increased administrative violence and re-traumatization from a lack of attentiveness due to burnout, compounded by a narrow focus on COVID prevention. In this story, we acknowledge the layers of systemic resistance to TVI practices, and the *"huge amount of work"* deferred to individual providers and champions of TVI care to support and humanize people who are marginalized, especially in this context of a "mono-dimensional" focus on "contain and control" approaches to COVID-19 mitigation:[27] (p.313)

"In my hospital recently… we failed [someone] in the context of COVID… which was very troubling to me… She was a pregnant woman who was going in for a procedure… and had significant anxiety, that she had been endeavoring to address throughout her pregnancy… There was a plan in place for her partner and myself to support her through this procedure that was going to be performed by an obstetrician. And the patient arrived to our obstetrical unit, she was in the waiting room with her partner, and I said, "Okay, we're going to call you in when we're ready for the procedure." And we had a plan that… we could both hold her hand through the procedure. And she was teary, but she felt that that level of support was what she needed. And I had advised two nurses, and also the unit clerk, that I was to be called for the procedure when it happened, and there was also a note put on her chart… And there was a wait, an unanticipated wait, and so I answered a page... And while I was answering that call, the woman was called in for the procedure, [and] her partner was not allowed to come in, even though I had made a plan for him to be allowed to come in - and the reason why he wasn't allowed to come in is because of the COVID restrictions that had been put into place… Although we had planned that there would be a relaxation of this restriction given this patient's unique needs… The procedure was performed without myself or her partner present. It was very scary for her… I came back from answering my phone call, and I noticed that she wasn't sitting in the waiting room. And her partner was there, and I said, "What's happening? Where is she?" And he said, "I don't know, they took her in." And then one of the nurses said to me, "I'm so sorry, we forgot to call you. It's been really busy here. And we just forgot to call you." And I went into the room to find her by herself, crying, and shaking…

I explained to her the situation, that it was simply a mistake, that we hadn't been called. I apologized that she hadn't received the care that we had so carefully planned for her. And the obstetrician had… noticed that the patient was crying, and didn't ask about it. But I

said, "There was a plan in place for myself and this woman's partner to be present for this procedure. And we weren't here. And that was really challenging and scary for this woman. And as you can see, she's visibly upset." And the obstetrician looked at the woman and said, "Well, you didn't tell me that you wanted those people here. So I didn't know." …basically putting the onus on the woman to share the care plan with him. And then he left the room. And then both the patient and her partner became really angry. Because there was no recognition [in] the moment of [the woman's response of] fight flight or freeze…

In the context of the inherent power dynamic within the patient-doctor relationship, there's an unrealistic expectation that a potential patient would be able to say, in that moment, "Oh, could you please wait, busy doctor, my partner and my midwife are meant to be here with me." And so she was not only upset and scared, and feeling a breakdown of trust around what had happened, she also felt that she was blamed for her reaction, because she hadn't spoken up for herself. And to me it was devastating, because it took this opportunity that we had to help someone build trust in our institution, and build trust in the care team, and unfortunately, it turned into… a fracture in that trust, that needn't have happened. And there are very simple things that we could have put into place, to ensure that that didn't happen. And it was a missed opportunity… it caused harm… There are situations such as this one, where it's reasonable to have a relaxation [of protocol], if it means that it's going to help a patient have an experience where their mental health is intact afterwards… Given that we're working in an environment where thankfully, our COVID numbers are quite low… to me it is not something that precludes us having an individualized approach to these restrictions. And a plan had already been put in place for the partner to attend.

…it's one thing when something unexpected happens to someone, and you try to you endeavor to repair or you support them through the cost or the fallout… But when you have a plan in place that's very clear, in response to someone's anxiety, that is intended to be a corrective experience, that is intended to be an opportunity to build trust, and when that breaks down, the effect of [the injury] can be even more profound... the repair afterwards is even more important, and has to be even more prioritized. And in this case, that's what we did. We spent a lot of time on repair… It is a huge amount of work to make up for the deficiencies that are in the system. And at the same time, it's critical that we do that. Because our priority at the end of the day is our patients, and their wellbeing, and that our trust relationships with them are intact, and their safety. And if that means that we need to take extra time, in order to achieve that, we will. But that's because we're motivated to do so. And not everyone that works in healthcare is either motivated, or has the awareness, or has the capacity, frankly." [CF]

5.4 Part 2 – Deconstructing oppression – Summary

> *"You can't use a colonial system to address the oppression that is the result of that colonial system." [CV]*

Thus, deconstructing systemic oppression in health care is the collaborative work of repairing and rebuilding safety *"on a human level" [NM],* through the strength of collaborative and highly attuned relationship-based care. The work begins with our own healing as health care providers so that we can practice applying TVI approaches in our own lives, dismantle the power dynamics inherent in service relationships, and build capacity for sustainable, reliable and embodied safety in care partnerships. In the context of a narrow lens focused on the COVID-19 pandemic, and widespread fear and anxiety, this work is critical and timely to restore safety, refocus on the systemic causes of inequitable outcomes, and rebuild strong, person-centered, relationship-based care in the pandemic recovery.

TVI practice involves ongoing resistance to the unsafe status quo in a health care system implicated in colonization and structural violence. TVI practice re-conceptualizes patient safety in a broader context that is critical to prevent iatrogenic harms. It requires long-term commitment through a slow process of transformation and restoration of power – especially in women's health care – to women, and also to communities and all people as experts in their own wellbeing. The challenging work of TVI care is supported by a combination of intolerance to injustice, witnessing and directly addressing structural violence, and collaboration among allies. Change is most effective when it acknowledges the complexities of intersecting vulnerabilities and the voices of the greatest possible diversity of experts from the grassroots through organizational and political leadership.

TVI practices are ideally positioned in primary care as a critical point of longitudinal contact with the health care system, and can contribute to more effective and efficient primary care, especially in the context of tremendous need during the COVID-19 pandemic recovery. TVI primary care disrupts the status quo by building capacity for impactful, trusting, and empowering environments for people seeking and providing care; no one is

left out. With its aspiration for universal and equitable access, and orientation to longitudinal care, important opportunity exists in primary care to build safety and connection over time. Primary care is therefore a critical site in which TVI practices can slowly rebuild experiences of safety, and repair harm done through pervasive impacts of oppressive and colonial systems.

Chapter 6: Discussion & Conclusion

6.1 Summary of findings

Through this interpretive descriptive study, we have grown our understanding of the diverse environments in which TVI care is practiced, within primary care and across a network of services that provide women's health care. We learned that knowing this landscape is also about knowing the culture in which it is embedded – a culture with deeply embedded historic, violent, and colonial roots, in which women and their care providers are steadily reclaiming power to restore connection and repair harms and abuses still prevalent across the landscape of women's health care services. The restorative work of trauma and violence-informed care is richly described by participants in our study, who shared personal and professional experiences of resistance and empowerment. These care providers are deeply compassionate leaders who embody empowerment and a sense of justice that is sufficient to reverse entrenched institutional norms through TVI care not only as a practice, but as a way of being.

This study also provides a deeper understanding of the role of people working in relation to institutions and various parts of the health care system. We witnessed a collective story emerge that described the impact of hierarchical, patriarchal, institution-centered care that continues to oppress people underneath colonial systems with a dark and entrenched history of blinders and exclusionary practices that perpetuate marginalization and repudiation of women and "*the feminine*" *[CF]*. Participants described nudging and fighting for change as an imperative part of their work, extending themselves for advocacy *"just out of love." [CF]* As Casey eloquently summarized, *"You can't use a colonial system to address the oppression that is the result of that colonial system." [CV]* The result of doing so within systems ill-equipped for intersectionality could be, as Sekani told us, "*at the cost of someone else's oppression." [SD]* However, you *can* use the power of the people, which is at the heart of trauma and violence-informed practice, and person-centered, relationship-based primary care.

Marginalization can be perpetuated by reductionist biomedical practices, and is disrupted by trauma and violence-informed care. For our participants, TVI practice is bottom-up, grassroots work done by people, many of whom are fighting unjust and unsafe norms, many of whom are women, and many of whom have done their own healing work which has equipped them with resilience that they can then fight for within systems. This perspective differs from existing research that has implemented and studied organizational shifts towards equity; participants in our study acted as champions – or individual "sentinels" – of TVI care within their respective disciplines. Their practices of TVI care were often independent, sometimes within small teams of allies, and always in a context of structurally violent systems. These findings build on the work of Levine and colleagues, demonstrating how both the concepts and people invested in TVI care across a spectrum of health care services "can challenge the dominant paradigms of biomedicine and individualism in primary health care."[125] This also resonates with Thomas Kuhn's description of "scientific revolutions" in which efforts to incorporate new approaches into an existing paradigm are "met with frustration, [and] the field enters a state of crisis. Resolution comes only with a revolution, and the inauguration of a new paradigm",[198] which leads to changes in perspective and gradual adoption of new knowledge.[199]

6.1.1 Part 1: Oppressive systems – Important findings and key themes

With insufficiently acknowledged colonial and patriarchal roots, biomedical care is both a site and practice of oppression, impacting people both seeking and providing care. Trauma and violence-informed care resists this harmful status quo in which default practices that cause oppression and marginalization are perpetuated by institutions and people who continue to be privileged by them and within them. This environment of "*unsafety"* is deeply established and difficult to change, with interlocking systems of administrative violence, entrenched hierarchies, unhealthy power dynamics, and a strong drive for health care providers and people seeking care to comply with the status quo, which leads to burnout and re-traumatization.

Belonging is a determinant of health that is also compromised through "dynamic processes of inequality" and associated social exclusion,[p.99] and the erosion of social safety nets and "the collective ways that we treat each other".[5] [p.27] In this oppressive, capitalist, neoliberal society,[5] we commodify traditional ways of supporting one another in community under a "capitalized" notion of mental illness.[200] In this context that overvalues individual agency and results in increasing class differences and inequities,[9] people may seek belonging in health care environments in which they have relative permission to seek support or connection, despite the general lack of time and "structural competency"[9,189] in these settings.

A family physician described community support as the true first-line health service, situating primary care *"at the end of a very long pipeline"* of barriers, social and structural determinants of health, and informal but critical community supports that bridge gaps *[NY].* Particularly for women and caregivers who de-prioritize their needs in favour of their children and families, women's health care systems (and research supporting many medical interventions) are not designed for them *[KQ],* with systems of biomedical knowledge and practice *"predicated on dismissing, undervaluing or minimizing women's experiences" [NY]*. For primary care to become trauma and violence-informed, action on both social determinants of health and structural violence is critical,[9] to avoid medicalization and downstream treatment that is ineffective and expensive *[ND, KQ].*

A characteristic of biomedical and institution-centered care is its culture of compliance, described as a hierarchical, inflexible, protocolized environment that is part of a complex and deeply established system with colonial roots, driven by outdated concepts of professionalism,[77] and in which reform is difficult. Participants described primary care in close relationship to its institutional partners: It is similarly inaccessible, inflexible, hierarchical, and *"not set up to attune to people" [CF]* due to a similar system-oriented culture (further strengthened by primary care's struggle for sustainability), in which mainstream norms are difficult to shift, and in which *"doctors have all the authority" [VE]*. Voices of people *"lowest on the status pole" [JLK]* are excluded from health care reform initiatives, and where they are included, it is under the condition that the status of the

system and current practices are not threatened. The experience of being entrapped in institutional approaches underneath a *"chain of command" [KN]* that is ubiquitous in biomedically-oriented disciplines, leads to moral distress and burnout in which health care providers may find themselves *"betraying what I was here to do." [ND]* The acculturation process of people into institution-centered practices feeds power imbalances,[77] and pathologizing practices (for example, the "medicalization" and "psychiatrization" of the consequences of oppression),[5 (p.123)] and is worthy of further research as a barrier to implementation of TVI care.

6.1.2 Part 2: Dismantling oppression – Important findings and key themes

TVI practice is the work of dismantling oppression embedded in the dominant, reductionist biomedical culture, in which advocates fight for a broader, universal lens inclusive of social and structural determinants of health.[9] The challenging work of TVI practice is supported by a combination of intolerance to injustice, witnessing and directly addressing structural violence, and collaboration among allies. Change is most effective when it acknowledges the complexities of intersecting vulnerabilities and the voices of the greatest possible diversity of experts from the grassroots through organizational and political leadership. Ruth's story of building empowerment in prison health illustrates the tremendous potential of collaborative and creative TVI work (5.1.2: *"We held hands"*), although the disheartening conclusion to this story illustrates the deep entrenchment of structural violence and destructive hierarchies that can quickly stamp out beautiful work (5.1.4). This study sheds light on how TVI care is learned and practiced outside of the mainstream of biomedicine; within it, participants described systemic "erasure" of structural violence and institutional accountability for harms.[56] However, TVI practice opportunities can evolve from grassroots movements informed by diverse knowledges, as well as from formal interventions. In the context of multi-directional influences that build momentum and capacity for TVI care, change happens gradually.

Participants described at length the importance of gathering momentum for TVI work by humanizing workplaces and healing ourselves as health care workers, so that we can be

strong in our resistance to oppression, and build capacity for safety that is sustainable, reliable and embodied. Participants also described this work as active resistance to unhealthy behavioural norms hidden from view within medical institutions and the people working within them.[201] People (primarily doctors and nurses whose practice is at the heart of biomedical care) are traumatized in their workplaces, and bring their trauma into their workplaces, where implicit biases, personal struggles and repressed histories are re-enacted in relationships with colleagues and people seeking care. These toxic patterns demand *"critical self-reflection" [NY]* and personal healing to avoid their contribution to the perpetuation of "malignant" helping practices,[174] health disparities,[92,186] stigma,[191] and racism.[3,77] Equity-oriented interventions support such reflection,[4,125] however may not go far enough to dismantle the incongruous stigma experienced by "the wounded healer", and the "armour of assumed omniscience and omnipotence" that doctors, in particular, have developed over time.[174] Participants described leading by example, creating and expanding a culture of TVI practice within organizations. The role of individual "sentinels" and champions of TVI care emerged in this study, and their important role in amplifying organizational initiatives is worthy of further exploration.

Finally it is important to emphasize the unique set and setting of TVI practices within women's health and maternity care. Much of women's health care reflects a medicalization of normal transitions in a woman's life, and dismissal of opportunities for empowerment. Section 4.2 describes the exclusion and invisibility of women's needs perpetuated by "inherently sexist"[164] scientific paradigms and a shocking history of normative practices of disempowerment and abuse in biomedical care that have been characterized as "obstetric violence".[165,172] Participants described TVI care in this context focused on the imperatives of *"repair" [CF],* de-stigmatizing and de-pathologizing approaches that normalize rather than pathologize women's experiences. This includes repeatedly and persistently challenging institution-centric care that can default to an amnesia about this important history, and perpetuate re-traumatization within health care.

This work is especially important in the care of marginalized women who experience trauma *"at the hands of primary care providers" [CV]* due to inappropriate consent

procedures, through the ongoing violence of child separation and apprehension in multiple forms, and through ongoing oppression by the *"heteropatriarchy" [NY]*, including cumulative *"microaggressions" [SHC]* within health care and society (4.2).[69,164] However, several participants observed the potential of both trauma-informed practice and TVI care to invite substantial shifts in the empowerment of women through experiences of safety and connection in health care. The nuances of one-to-one clinical approaches are outside of the scope of this paper, however it is important to acknowledge the critical first step as the constant critical examination of institutional norms, in which small but essential windows of opportunity for relationship-based TVI care can emerge.

6.1.3 TVI care in the context of primary care reform & the COVID-19 pandemic

The conservative approach to primary care reform in BC neglects the importance of equity-oriented care that can improve health care quality, effectiveness, and efficiency. "Deliberately modest" and "minimally disruptive"[202] primary care reform initiatives in BC emerge from established hierarchies that preserve existing structures of power and privilege, and a biomedical tradition in which psychosocial aspects of illness, social histories and emotional responses are "largely irrelevant… [and] regarded as inadmissible evidence."[169] This exclusionary approach is mirrored in the pandemic response with its "mono-dimensional" focus on mitigation of viral spread that is widely understood as inevitable despite unintended consequences.[27 (p.313)] "Shadow pandemics" and secondary effects of both the COVID-19 virus and the pandemic response[203,204] are creating "highly disturbing impacts"[196] – especially on women, families, caregivers and people already marginalized by structural inequities[27,196] – yet the prolonged and compounded impacts of increased inequities and marginalization of many groups are also understood as inevitable. This paints a falsely disempowering picture of the potential for equity-oriented health care and policy to address inequities and injustice in a time of crisis.

The narrowness of this approach and the need for equity-oriented action is amplified on the world stage by the COVID-19 pandemic, in which increased attention to the marginalizing impacts of the pandemic and the pandemic response[27,204] evoked strong

feelings among participants in our study who shared their experiences of the pandemic. They described looking for hope that this crisis can lead to change and feeling *"less alone" [KQ]* in conversations about inequities, however they also expressed despair about health care and social safety nets that have not sufficiently *"come through"* for people suffering immensely during the pandemic *[NY, CF].* In the context of systems in incremental transition towards equity-oriented, TVI care, we must honour the *"huge amount of work" [CF]* deferred to individual providers and TVI champions to create safe and human spaces in this challenging time. Section 5.3 concludes with CF's story that highlights the unique knowledge brought by TVI approaches, the layers of institutional resistance to the work, and the enormous amount of time and persistence invested by TVI champions to repair harms done in biomedical care.

6.2 Reflexivity notes

As a team of three women (VB, NM, AW) with dual experiences as trauma survivors and providers of TVI care, the stories shared by participants resonated deeply with us. We shared experiences of overwhelm and motivation for action as we deepened our witnessing of the extensive roots of structural violence embedded in health care services for women. Yet we also emerge with feelings of inspiration from "electrifying"[149] time spent reflecting on powerful stories of resistance and activism. However, the intensity of experience witnessing both sides – oppressive systems and the work of deconstructing them – is amplified by the critical time we are in, during the COVID-19 pandemic. Inequities and injustices are increasing globally, and most people are experiencing *"a common felt sense experience of being insignificant, helpless, and overwhelmed" [AW]* in addition to widespread psychological distress in response to unprecedented lockdowns.[205] In this context, many people – especially those marginalized by ongoing expressions of colonialism and the heteropatriarchy – are also rising up against oppressive, sexist and racist norms, fighting for justice and equitable access to health, and pushing all sectors towards intersectionality. We can see the connections between these broader trends, the work that participants generously described in this research, and our own fire ignited by witnessing this in depth.

All of us on the core study team (VB, NM, AW) are non-indigenous women who have several years of experience learning and practicing decolonizing approaches, Indigenous health, and cultural humility. Agnes is a descendent of settlers on Treaty 6 territory and the traditional lands of the Cree, Blackfoot, Dene and Metis people. Nicole and Vanessa are uninvited settlers whose ancestors came as political, religious and economic refugees to the unceded traditional territories of the Musqueam, Squamish, and Tsleil-Waututh First Nations, and the traditional territory of the Haudenosaunee and Anishinaabe peoples that is protected by the Dish With One Spoon Wampum agreement. As a group we identify as allies in decolonization and advocates for anti-racism, with these identities strengthened throughout this study. We agreed on the importance of naming institutional, medical and economic systems as *colonial* systems wherever possible, to emphasize the link between current institutions in Canada and the history of genocidal violence and ongoing enactments of colonization that are, in our view, the most important marginalizing forces to be understood and repaired, and that include experiences of trauma (of the colonizers and colonized) and harms of patriarchy within them.

Our relationships to feminism differed: NM entered the study with a strong feminist identity, whereas AW and VB acknowledged the influence of widespread overvaluing of masculine traits and identities (especially in medical training) that influenced our identities as feminists entering this study; however we emerged *"more feminist" [AW]* after growing our understanding of the influence of the heteropatriarchy, and the importance of matriarchal structures and female leadership in the deconstruction of oppressive practices. Our perspectives on our own trauma experiences shifted in the study as well, with renewed awareness of the *"common experience" [AW]* of trauma and associated *"experiences of dismissal and being unheard." [VB]* We also recognize the privileges we experienced as survivors due to our social locations; Nicole, for example, described recognizing *"that my attacker was an immigrant in a country where he was experiencing extreme racism and marginalization; he had also come from a country of extreme poverty…" [NM]* Finally, we shared a sense of integration and respect for our different identities that allowed us to make space for our own needs as they arose throughout the study process, and that

strengthened our friendship and our ability to remain authentic and present throughout the study.

While completing this thesis, I was also in the process of re-entering medical practice after a period of healing, learning and parenting. These concurrent experiences led me to seek belonging for all of these critical parts – myself as student, scholar, parent, advocate, doctor, and patient. I understood personally how when a whole is compromised, people are left seeking belonging; where it doesn't exist in neoliberal, capitalist societies entranced in the myth of individualism, we seek it in health care institutions; where it doesn't exist internally, we "professionalize this problem by working in one of the caring professions."[174] However, where biomedical practice had failed me personally and professionally, I found inspiration and meaning in the momentum I experienced in conducting this research, and more broadly in momentum towards equity-oriented health care and policy. This – in addition to other personal resources and supports – carried me.

After spending too many years healing each of my injured body parts one by one (like any good patient steeped in a reductionist biomedical model), throughout the stops and starts of this thesis, I continued putting myself back together as a whole. It took time to find space for the skills I earned through my healing, and for sufficient clarity and empowerment to claim that openly as one of my greatest assets. Throughout the project, I witnessed increasing energy that I could redirect from my interior path, to authentic and meaningful engagement with participants in this study. I could see myself able to equally witness the despair of injustice (particularly harms perpetuated by the "old boys club" in medicine[201,206,207] that seems blind to its own existence and gives me substantial grief), alongside energy for focused advocacy to fight it (particularly in my well supported and connected work in the non-profit sector), with sufficient energy left to grow and enjoy my own wellness (and that of my partner Andrew and daughter Pema). I could effectively read and reflect on the stories I heard in this study only from a place of wholeness, which is the theme that resonates most with me upon completing this paper. This is also the place from which I continue to witness the silent harms perpetuated by the health care system, hidden by those who do not wish to see it, and neglected by those biased towards preserving the

status quo, who dismiss the need for change as outside of the space and scope of biomedical care.

In the context of the current pandemic, I have also felt a renewed cycle of grief, not only for the losses we have experienced in the last year and the injustice and inequities that underlie them, but also for the implications of the medical profession in causing these harms. In the last year I have witnessed escalating suffering: among patients I have seen in mental health crisis and those relying on self-soothing and suicide prevention through substances; among elders I saw in hospital admitted as a respite from living in conditions of extreme neglect and filth due to lack of support; among parents and young children in my community struggling to survive and parent during prolonged isolation. These tragedies are all a result of the excessively narrow focus perpetuated by a biomedical culture whose ethos of separation and reductionism is applied to the body, social and service systems, and the environment.

At the time of writing, many countries including Canada have been living in one full year of lockdown, in which we are isolated from the very core of what it is to be human – that is social connection. Beyond the magnification of inequities, racism, sexism and injustice perpetuated by the pandemic, I do not believe that we can any longer thrive or be healthy by dividing our bodies and societies into siloed systems and reductionist solutions. We have now ventured far enough from a semblance of wholeness, that lifting the lockdown will not be a sufficient solution. Our society and relations must be restored sufficiently such that health (including physical, mental, community, societal and ecosystem health) can emerge from renewed engagement and investment in healing environments, rather than more work placed on individuals and overburdened systems to heal wounded parts. When burnout and vicarious trauma are widespread throughout the health care system and society, we must grow conscious of the burdens placed on individuals in systems stretched thin, and instead rely on the processes in which we find inspiration and strength, including the collaborative and restorative healing practices described in this study. I find inspiration in Dian Million's description of the Okanogan word *naw'qinwixw* as a metaphor for seeking diverse view; listening and hearing one another creates more clarity, and offers

us “a chance at a better understanding of what it is we need to do”.[66 (p.27)] She cites Elder Brown’s description of the Canoe Journey that also resonates: “Preparing to welcome each other, voyaging on the ocean, we find what is similar to us all. That is called healing.”[66 (p.168)]

6.3 Limitations

Strengths of this study are outlined alongside measures of trustworthiness and validity in Chapter 3 (3.9). This study builds on a growing body of research describing trauma informed practice,[14,15,24] and TVI care as part of a broader process of equity-oriented organizational transformation.[1,35,125] Here, I will focus on what was not heard in our study; I will discuss four principal limitations, including implications of isolating TVI care from broader equity interventions, a lack of personal tension or dilemmas expressed by participants, the limited role of dual experience as a substitute for patient/client perspectives, and a lack of focus on Indigenous views and methods in the analysis.

Although we chose to focus our discussion on practices of TVI care, we recognize the limitation of omitting explicit inquiry about TVI care in the context of intersecting elements of equity-oriented practice, including cultural safety and explicit antiracism approaches, harm reduction, and contextually tailored inequity interventions. Several participants in this study referenced practices of cultural safety and harm reduction as intimately related to TVI care. However we sought to understand critical perspectives and themes in TVI practices across disciplines, and thus did not explore approaches to cultural safety and harm reduction in detail, nor did we explore practices of contextual tailoring of inequity-responsive care within individual disciplines. We can contribute to a growing knowledge base of interprofessional and cross-disciplinary TVI practices, however we may have “failed to portray” the unique experiences in each discipline, differences between TVI approaches within diverse disciplines, and varied opportunities for implementation in different settings.[144]

Ryan and Bernard describe themes as emerging, interrelated, from different cultural systems, professional definitions, “local, commonsense constructs”, and the values, theoretical orientations and personal experiences of the researchers.[143] In the context of

diverse experiences, themes can indicate the frequency and pervasiveness of experiences "across different types of cultural ideas and practices", including "the degree to which the number, force, and variety of a theme's expression is controlled by specific contexts."[143] However, Linda Tuhiwai Smith argues that knowledge is not a product that can be isolated from its social context, or from its site of struggle.[87] Thus, further analysis of our data and ongoing inquiry is required to understand differences, challenges, and opportunities in TVI care implementation in different disciplines and settings.

Another limitation is the limited exploration of tensions and dilemmas that participants expressed in their experiences of TVI practice. Participants in this study generally represented non-dominant views in cases where the context of their practices were disciplines oriented towards biomedical care. They described tensions related to implementation of TVI practices in the context of structurally violent systems; this aligns with Levine and colleagues' descriptions of the disruption of "pre-existing tensions" as inherent in the implementation of TVI care within dominant paradigms.[125] Participants in our study expressed no overt reluctance or resistance to TVI approaches; they represented a group of TVI champions, expressing relatively uniform endorsement of, and familiarity with, TVI care. However, it is worth noting that interviews with most participants were punctuated by laughter, that we believe signaled some unspoken tension. We interpreted this laughter as a coping strategy when faced with the absurdity of structural violence that is ubiquitous in health care – that was also my experience of the laughter that I shared as an interviewer. However it could also signal under-explored frustration, challenges or barriers in the work of TVI care that were not openly discussed underneath more prominent experiences of "'momentum,' 'acuity,' or 'focus' to take on structural inequities".[125]

All participants demonstrated an orientation away from narrow biomedical practice, towards whole-person, biopsychosocial care inclusive of social and structural determinants of health; none explicitly described tensions or "dilemmas" related to their TVI practices that have been described in other research.[4,125] However, divergence was evident between the perspectives of two obstetrician/gynecologists when compared to the primary

maternity care providers in our study who described an entrenchment of violence within the culture of maternity care that was not conducive to people simply doing the best they can within violent environments. These findings may "reflect multiple realities",[74 (p.71)] in which obstetrician/gynecologists experience greater sympathy and orientation towards biomedically oriented care, and a more flexible understanding of appropriate engagement with TVI care, given limitations inherent in their discipline. This difference in perspective was likely due to their roles within an urgent care and consultation-oriented specialty, however more research is needed to explore further differences, especially given the unique role of specialty care in the history of "obstetric violence",[165] and the presumed difficulty of avoiding reductionist approaches in specialist medical disciplines. In summary, the cohesion of the study population allowed us to learn about principles of TVI care implementation from the lens of TVI champions who act as "sentinels" of TVI care[35] within a broader network of services. However, further research is needed with more participants from each discipline to understand disciplinary practices informing TVI implementation within different knowledges and settings, and to explore opportunities and challenges in individual disciplines.

It is important to consider the perspectives contributed by several participants, and the core study team members, from dual experiences as survivors and practitioners. Despite the orientation of TVI care towards patient- and person-centered care, we acknowledge that survivors of trauma and violence are the true experts in TVI care; apart from dual experiences providing and seeking care, this direct lens was missing in our study. It is important to further explore perspectives of people seeking care in the context of organizational interventions that aspire to create sufficient safety for these views to be heard. Dual experiences represented in this study (including those of two peer support workers purposely recruited) provided an important window into participants' experiences of inadequate care within biomedically dominant systems. This generated a deep and unexpected understanding of the importance of supporting the healing work of health care professionals as part of TVI practice. Some participants also described accessible spaces for inclusion of those with less power in health system design. However, these experiences warrant further exploration in the spirit of dismantling hierarchies and

decolonizing health care environments. As speakers emphasized in the Trauma Research Foundation's Social Justice Summit this year, "as long as inequalities persist, trauma will be re-enacted"; thus equalizing power is a critical TVI intervention that also serves to decolonize the appropriation of "mental illness treatment" by health care workers, whose power is amplified in models that under-recognize the role of community and peer support in healing.[200]

Finally, in the context of what was not heard in our study, it is important to revisit considerations related to the inclusion of Indigenous people and practices in our study (3.10.2). Risks of misrepresentation are present if individual perspectives are distorted, repurposed or assimilated in the presentation of findings. Although our methodological choices were made with this potential risk in mind (3.3, 3.4, 3.8.3), we did not conduct a separate analysis of TVI Indigenous health practices, and we acknowledge that the combined TVI approaches of participants are presented in a dominant cultural context of Western, colonial values that are "simmering, unchecked, enfolded"[149] in the social and professional contexts of people reading this research. Despite necessary processes of aggregation in qualitative analysis,[147] we revisited Ruth Nicholls' important statement that a diversity of perspectives must not involve assimilation (3.4): "The goal of collaborative work should not be to dissolve/ consume/ soften/ erase difference, for Indigenous peoples… insist on a profound difference at the Self–Other border."[64]

Thus a more detailed analysis of Indigenous peoples' perspectives on TVI care, including the possibility of comparison between Indigenous and non-indigenous peoples' perspectives, will be considered in further analysis and in a purposeful exploration of how to treat varying world views that are represented in this data. Omitting this step could potentially implicate us in an imperialist, trickle-up, knowledge "stealing" process,[87] whereby everyone benefits from Indigenous health knowledge while access to culturally safe, trauma and violence-informed care is still out of reach for many Indigenous people in Canada.

During the study development, I consulted with community advisors,[1] who expressed interest in methodological learning that could be gained from a data set reflecting diverse world views by including Indigenous and non-indigenous perspectives. We believe that further analysis is warranted to deepen our understanding of Indigenous health perspectives offered in this study, and to learn from the inclusive analysis and presentation of findings that represent divergent world views. Acknowledging Levine and colleagues' call for further research "to explore how practitioners and organizations manage TVI care in the context of different worldviews and approaches",[125] upon completion of the thesis, it is our intention to follow up with these community partners and explore this area of further learning.

6.4 Implications for research

In this study, we sought a greater understanding of the landscape of TVI practices across diverse disciplines providing women's health care. This inquiry led us to a deeper understanding of the social and professional *cultures* informing the implementation of TVI care. Despite existing literature describing practices of discrimination, racism, colonization and stigma, and a growing body of work describing the violent and abusive history of medical practice in Canada, knowledge is limited that describes the implications of biomedical culture in these trends. This emerged for us as an important area of further inquiry: to understand challenges and opportunities for implementation of progressive, people-centered health care reforms, the reaches of neo-liberal policies into the health care domain, the lack of progress towards better quality primary care despite substantial evidence guiding system transformation, and the role for a paradigm shift to contextualize necessarily disruptive reforms that "subvert the existing tradition… [and] lead the profession at last to a new set of commitments".[199 (p.6)]

[1] Dr. Lyana Patrick (Assistant Professor, Indigenous health and community-engaged research, SFU); First Nations Health Authority (FNHA) Research and Knowledge Exchange team (Jennifer Murray, Darius Pruss, Research Analysts; Dr. Charl Badenhorst, Medical Director); College of Family Physicians of Canada (Artem Safarov, Director, Health Policy and Government Relations, Indigenous Health Working Group member).

Although saturation of perspectives is impossible in a diverse study population, we experienced saturation in our themes, whereby throughout the study we observed an increasingly stable and consistent view of the landscape of TVI practices from a diversity of knowledges and experiences. However, we appreciate that more depth of exploration is possible on some themes, particularly those that were not explicitly asked about in the interview guide.

An example that stands out is the theme of invisibility, referencing cultural blindness, "unseen" elements of professional cultures that influence TVI care, and beliefs or practices that have been subjected to "systematic erasure" in the mainstream context that oppresses non-dominant views.[56] We observed participants in this study using their privilege and relative power to disclose the frequency of unsafe practices in biomedical care, and we acknowledge the importance of understanding the experience of working in oppressive professional cultures. Further research to understand experiences of patients receiving unsafe care is also important. Stories of *"unsafety"* shared by participants are likely the tip of an iceberg, in which knowledge of unsafe and harmful clinical practice is far more plentiful, diverse and commonplace. Some literature explores this – for example, descriptions of "obstetric violence",[165,172] and ongoing racism experienced by Indigenous peoples in health care[29,31,47,92,155] – however this knowledge has insufficiently penetrated mainstream clinical practice. Where this knowledge is recognized, it is not effectively acted upon due to active neglect and (conscious and unconscious) bias towards the status quo that continues to privilege those in power. This perpetual blindness to harms perpetuated within health care may contribute to substantial systemic resistance to TVI practice described in our study and in the work of the EQUIP team.[4,35,125] Further research and knowledge exchange about implementation is required for successful movement towards equity-oriented and TVI care in the context of ongoing ignorance and harm perpetuated by systems that aspire to help.

Professional experiences with trauma and structural violence cannot be fully isolated from personal experiences, however to protect safety of participants, we inquired about professional experiences only. Yet all participants shared some personal experiences

navigating their own self-care, wellness, sustainability in practice, or personal healing; clear agreement was demonstrated about the importance of a person's own practice informing embodied TVI work (5.1.1). However, limited research exists that parallels these stories of personal healing. There are descriptions of the role and archetype of "the wounded healer", instructions to "heal thyself", and mounting evidence that describes the prevalence of burnout, secondary traumatic stress, and vicarious traumatization experienced by health care workers. However, literature is limited that describes the cultural environment surrounding these experiences, *risk factors* for burnout and secondary traumatic stress, as well as systemic predictors of resilience that do not rely excessively on individualized strategies and a neglect of structural and cultural influences. The topic of healing the healer is taboo in the context of the myth of "omnipotence" of doctors and other health care "providers"; further research and attention to this important lens may facilitate a more integrated practice of structural competency that acknowledges the influence of systemic violence on people seeking care, and on people working within biomedical models of care.

6.5 Implications for primary care & the COVID-19 pandemic

In the context of reductionist biomedical approaches focused on the COVID-19 pandemic, and widespread isolation, fear and anxiety, trauma and violence-informed health care is critical to restore safety, refocus on the systemic causes of inequitable outcomes, and rebuild strong, person-centered, relationship-based primary care in the pandemic recovery. However this work is challenged: by the current context of primary care reform initiatives that usually exclude equity-oriented approaches, by burnout that is mounting among health care providers (especially women), and by a pandemic response that reflects an ever-narrowing biomedical lens in which inequitable consequences of the pandemic response on conditions that perpetuate marginalization are unacknowledged and under-reported. Paul Farmer writes that to avoid acknowledging structural violence is to be complicit in it; oppression can "reside in consciousness", and is "exerted systematically—that is, indirectly—by everyone who belongs to a certain social order: hence the discomfort

these ideas provoke", and the importance of addressing structural violence in this time of increased need.[71]

In the context of the COVID-19 pandemic, a body of literature on Indigenous peoples' health also helps situate the precarious position of the health care system in a time of amplified marginalization and increased need. The compounding impacts of ongoing viral and overdose pandemics have had a devastating impact on Indigenous peoples and communities in Canada.[27,197] Some Indigenous communities that were "on the cusp of renewed connection" have now been "pushed back into a state of fear".[196] We must consider the explicit contribution to First Nations genocide made by viral and bacterial diseases through history, and the medical response of both "benign neglect" and residential treatment that has exacerbated disease.[87] In this context, we can expect heightened mistrust in systems that have not been able to meet "Aboriginal needs for real social security or safety."[66 (p.105)] Biomedical and public health approaches pathologize a condition or experience to bring it into the sphere of what is seen. However in a historic context of colonization and ongoing "cultural chaos or anomie",[(p.84)] people become stigmatized and pathologized as more prone to problems.[66] Million writes in relation to Indigenous peoples and human rights: "Increased surveillance, monitoring, and imprisonment without changes in respect and value for women do not produce safety".[66 (p.39)] Yet we believe the space of primary care, based in relationship, with integrated TVI care, may offer a site of possibility.

This study describes TVI practice as a "paradigm shift"[125,198,199] and a *"universal precaution" [NY]* that can be applied in primary care, and across a wide spectrum of women's health care services, to meet increased need due to increased marginalization and inequities, and to restore *"human-ness"* and opportunities for healing in health care *[NM].* This trauma and violence-informed system transformation is presently being led by organizations,[4,35] and individuals, generating a collusion of top-down and bottom-up change in response to crisis that, with greater integration and implementation, can support a "fundamental paradigm shift"[(p.89)] and "reconstruction of the field from new fundamentals"[(p.85)].[199]

Stories shared by participants in our study are relevant across a diversity of health care settings and disciplines, resonating with Dian Million's description of healing as a "process

of removing barriers… overcoming the legacy of past oppression and abuse", and supporting "the transformation of our inner lives… relationships, and the social and environmental conditions" in which we live and work.[66 (p.143)] Participants in our study described more than a process of TVI care implementation; rather, it is an embodied cultural shift that supports stronger relationships among interprofessional health care teams and with people seeking care. It is a tool of "metamorphosis" of the system and the people within it,[152] creating opportunity for restored relationship-based care, and through this, repair of past harms.

6.5.1 Key recommendations

A summary of recommendations from the study are as follows:

- Primary care is founded on principles of community orientation and accessibility, in which *"you don't get to say no… that's what primary care is." [HI]* In this context, it is important to direct inquiry and action in broader professional and policy contexts towards who is excluded, and systemic factors complicit in this oppression, including how power and privilege may perpetuate inaction. To avoid doing so perpetuates superficial, downstream, cost-intensive solutions while violating these principles of primary care; contrarily, to do so may require a paradigm shift towards equity-oriented and TVI practice as a *"universal precaution" [NY]* in health care.
- A culture shift away from the narrow and reductionist biomedical approach is required to reclaim practices of person-centered, bio-psycho-social care, integrate intersectional approaches, and avoid doctor- and institution-centered care that can re-traumatize people and perpetuate toxic workplace cultures, exclusion, and prescribed invisibility of people and their needs. Inaction or lack of change within biomedical settings (including primary care) can perpetuate a dangerously narrow understanding of patient safety, and harm that impacts both people seeking and providing care.
- In research and clinical work, we can expand opportunities for TVI practice and intervention through increased attention to chronic or toxic stress as a mediator between outdated, individualistic, behavioural models of care prevalent in biomedical practice, and experiences of structural violence, colonization, and ongoing oppression.

- We must consider both deliberately insufficient primary care reforms and proposed shifts towards TVI practice within the context of a system currently experiencing widespread burnout and amplified fear during a global pandemic. COVID-19 presents a fork in the road: We may be amplifying discomfort with the status quo sufficiently to precipitate transformation, or, people and systems who are "*just trying to get through the days*" may hold ever more tightly to their power and privilege (and the status quo in which it is embedded) as they are *"hanging on for dear life, trying so hard." [NY]* On either path, it is critical to implement TVI care as an embodied practice that includes support for healing among people providing care and in the relationships and environments in which they practice. As health care providers, we cannot offer to others what we do not also practice ourselves.

- Change must begin with the difficult work of witnessing experiences of oppression, structural violence, stigma, discrimination and racism perpetuated in health care systems, particularly on women. If colonial and patriarchal roots are insufficiently acknowledged, biomedical care (including primary care) remains a site and practice of oppression, impacting people providing and seeking care. A structural lens in this work is critical to avoid the over-reliance on individuals to compensate for the broken systems in which they work, and to avoid perpetuating blame and resistance among people working (and inevitably enmeshed in) systems with which they are pressured to comply.

- *"It's flawed [logic] to think that protecting systems is protecting people." [NY]* Dismantling inherently oppressive hierarchies and *"democratiz[ing]" [TN]* health care addresses the problem of trying to *"use a colonial system to address the oppression that is the result of that colonial system." [CV]* The redistribution of power is a critical element of TVI practice, supporting bottom-up change that honours the resilience and resources of people both seeking and providing care from a variety of roles and knowledges. An act of repair to consider in this context is actively de-medicalizing and de-colonizing mental health services by resourcing community and peer supports as an approach to TVI care. This is a particularly important consideration in the context of violence, mental health, and substance use crises burgeoning in the shadow of the COVID-19 pandemic.

6.6 Conclusion

At the heart of primary care, tremendous potential exists for implementation of trauma and violence-informed care. This potential builds upon ongoing movement towards longitudinal, relationship-based and person-centered care, and explicitly acknowledges the impacts and intersections of ongoing oppression and structural violence on the lives – and health care experiences – of people both providing and seeking care. This work is critical in the context of the ongoing COVID-19 pandemic, its "shadow pandemics", and the opiate crisis, which are amplifying experiences of marginalization, deprivation and loss, especially for women, families, and caregivers. (There I am too, across all three of those groups.) Reflecting on the overwhelm we have experienced as women, and as health care providers, invites us to rally a more urgent, human and whole response to the need for trauma and violence-informed care.

After a full year of living through a global pandemic, most of us are sharing an embodied experience of overwhelm and desperation for change, which affects the writing and reading of this thesis. In this common experience, we can come together across professions and communities to build a stronger, better quality, and more person-centered primary care system that adopts the lens of trauma and violence-informed care as a universal precaution, and in doing so, actively resists the ongoing neglect of the impact of structural violence perpetuated in society and within health care. Building on momentum to address systemic racism and understand intersectionality as an alternative to reductionist biomedical care, allows us to align this compassionate transformation towards TVI practice with ongoing primary care reforms, such that we can redress the harms we have perpetuated in the past and present.

This study sought to understand the landscape of trauma and violence-informed care across the diverse web of women's health care services, at which primary care is at the centre. Looking out at the landscape, we learned about the culture in which TVI care fights for recognition. Deepening our knowledge of reductionist and hierarchical professional cultures, and colonization practices that are perpetuated by health care institutions,

mobilizes a social justice oriented response that will contribute to better health and wellness for people providing and seeking care.

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Appendices

Appendix A Key terms & definitions (participant briefing document)

Trauma and Violence-informed (TVI) care is care that is both trauma-informed, and mindful of structural conditions (social determinants of health) that impact a person's health. TVI care has been conceptualized by Varcoe, Browne and colleagues to describe a "safe and trusting" health care environment that acknowledges the continuities between past experiences of trauma, and systemic conditions that perpetuate chronic stress, oppression or powerlessness:

"Trauma-informed care (TIC) prioritizes the need to create an emotionally safe environment based on an understanding of the health effects of trauma. The insertion of violence into the notion of TIC is intentional to emphasize that (a) interpersonal and structural forms of violence (e.g., poverty, racism) intersect and (b) such forms of violence are often ongoing as well as historical, compounding the negative impacts.

… The emphasis on violence-informed care also mitigates the potential to locate 'the problem' of trauma primarily in the psyche of those who have experienced violence, rather than also in the acts of structural violence and the conditions that support those acts. In contrast to more specialized 'trauma therapy and trauma treatment' such as psychotherapy, trauma and violence-informed care is a more general approach which aims to mitigate the potential harms and traumatizing effects of seeking health care or other services by creating safe and trusting environments."

Reference: "EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings," Varcoe et al. (EQUIP Research Team) Intl Journal for Equity in Health, 2015, v14.

Structural Violence includes colonial violence and any systemic conditions that perpetuate discrimination, oppression, stigma or powerlessness. Structural violence is a "major determinant of the distribution and outcomes of social and health inequities".

*Reference: "Structural Violence and Clinical Medicine," Farmer et al. PLOS Med **3**, 2006, e449.*

Social determinants of health: Experiences of trauma and structural violence can be understood as determinants of health (SDOH). SDOH are defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age". SDOH are mostly responsible for health inequities – the unfair and avoidable differences in health status between different groups and populations. The Canadian Medical Association states that "SDOH can have a larger impact on individual and population health than the health care system... any actions to improve health and tackle health inequity must address the social determinants and their impact on daily life."

Reference: "Health equity and the social determinants of health," https://www.cma.ca/En/Pages/health-equity.aspx

Primary Care aspires to be the first point of contact with the publicly funded medical system in Canada, and commonly refers to Family Medicine services delivered by family doctors or nurse practitioners. Primary care in Canada is in transition towards team-based care models called "Patient Medical Homes" or "Primary Care Networks" that aspire to provide a broader range of services under one roof.

Reference: College of Family Physicians of Canada (CFPC). "A Vision for Canada: Family Practice - The Patient's Medical Home," The College of Family Physicians Canada, 2011.

Appendix B Interview Guide (Key questions)

Understanding of TVI Care:

1. Can you describe any training or education you have had about trauma and violence-informed care, or related concepts?
2. What does trauma and violence-informed care mean to you?
3. What does trauma-informed, and structural violence-informed care look like in your day-to-day work?
4. What challenges have you encountered in your practice of TVI care?
5. What enables or supports you to practice TVI care?
6. *[If not already answered:]* What is your understanding of why "violence" is included alongside trauma-informed care? *OR,* Can you describe how you incorporate a structural or systemic lens in your work?

TVI care in greater depth:

7. How has your experience providing TVI care impacted you personally or professionally?
8. Can you describe how your personal or professional experiences have influenced your choice or ability to provide trauma and violence-informed care?
9. Can you describe how or why TVI care is important in women's health care? *OR,* How does your practice of TVI care *["your work"]* look different when working with women, compared to men (or people of other genders)?
10. How do the systems that you work in impact your ability to provide trauma and violence-informed care?
11. From your perspective, how feasible is it for primary care to be trauma and violence-informed?
12. We are interested in the limits, or edges, of trauma and violence-informed care. Can you describe any examples in your *[work/practice/organization]* where the care could have been better, or where a trauma and violence-informed approach would have been helpful? *OR,* Can you describe any limits to your practice, or experiences where you were unable to provide trauma and violence-informed care?
13. Can you describe how your personal or professional experiences have influenced your choice or ability to provide trauma and violence-informed care? *OR,* How does your own wellbeing, professionally or personally, impact your ability to provide trauma- and violence-informed care?

Appendix C Consent form

Expanding safe spaces:
Practices and perspectives of trauma and structural violence-informed care

Information & Consent form

University of British Columbia – Faculty of Medicine – School of Public & Population Health
Suite 300, 5950 University Boulevard, Vancouver, B.C. Canada V6T 1Z3

Principal Investigator: Kim McGrail, Associate Professor, SPPH, UBC
Co-Investigator & Thesis student: Vanessa Brcic MD CCFP; Registered Therapeutic Counselor (ACCT); Clinical Assistant Professor, Department of Family Practice; MSc candidate, SPPH, UBC;
Collaborator: Nicole Marcia MA C-IAYT TCTSY-F Trauma Informed Yoga Therapist, Fine Balance Yoga
UBC Advisors: Sabrina Wong & Annette Browne (School of Nursing)

Dear Colleague,

This letter contains information about the qualitative study: "Expanding safe spaces: Practices and perspectives of trauma and structural violence-informed care". It also will ask for your preferences should you choose to participate in this study.

Study Purpose: To understand diverse types and levels of experience of professionals providing "trauma and violence-informed (TVI) care" for women. *Please see the document entitled "**Definitions & Key Terms**" for definitions of terms and more details about the study.*

Experiences of trauma (physical, attachment-emotional, developmental, intergenerational, or social-structural) are important determinants of health that can be amplified by structural violence – social and structural experiences that perpetuate discrimination and oppression. Health care that recognizes patient experiences of trauma and structural violence has the potential to be safer and more appropriate than standard medical care. In this study, we would like to learn about your professional experiences delivering care that is in some way informed by structural violence and trauma, so that we may build our capacity to provide this type of care in primary health services.

Participants: We hypothesize that diverse language and approaches are used in this work. We hope to interview people with varied experiences; a minimal level of expertise required to participate in this study is having pursued some self-directed reading or other learning on trauma and structural conditions that interact with trauma.

The Interview Process: We invite you to participate a 60-90 min. interview with Dr. Brcic or Ms. Marcia. We may request a follow-up interview if more time is needed, or if it would be helpful to go into greater depth. We will also invite you to review the transcript, analysis and write-up, to ensure that we are accurately transmitting your views. The total time commitment could be up to 4 hours.

Prior to the interview we ask that you spend approximately 10 minutes reviewing a document outlining terms and definitions "***Definitions & Key terms***", which can be discussed in the interview. This is to ensure you feel comfortable with the terminology, and also to invite discussion about different terms used to describe TVI care.

We will schedule the interview at a convenient time and place for you, and questions will be open-ended. With your permission, **the interview will be audio-recorded** and the comments will be typed, and analyzed. You will receive a $50 honorarium in appreciation for your time.

The study team involved in the analysis includes health providers who are also trauma survivors, to allow for representation of a broader lens including patient experiences, in the analysis. Only the interviewer will have access to audio files and original transcripts; de-identified transcripts will be stored in NVivo software on encrypted, password-protected computers of the study team members, which includes those listed at the top of the document.

Confidentiality: The transcripts of all interviews will be de-identified (i.e. will not contain names of the participants, nor any details that will identify individual persons), unless you prefer otherwise (see below).

Voluntary Participation: Your participation in this study is voluntary and you may withdraw at any time (or choose to have your interview removed from the results/analysis prior to completion of the study). You may choose not to respond to any questions. We will send you the results so that you can provide feedback and corrections on how your contributions are represented in the analysis, write-up, and materials for knowledge translation (i.e. infographics). Including the interview time and these additional opportunities for feedback, we anticipate the total time commitment over the course of the study could be up to 4 hours (~1.5 hrs for preparation/interview + up to 2.5 hrs for follow-up).

Risks & Benefits: Participants may benefit from the opportunity for inter-professional dialogue, and from results of the study that will engage community and partner organizations to build capacity and support for TVI care within the health system. A potential risk of emotional distress always exists in discussion of a sensitive topic (trauma, oppression/violence, extreme stress), however the purpose of the interview is to discuss professional (not personal) experiences in TVI care; furthermore, the professional experiences of both experts and the interviewer in this study will allow everyone involved to set appropriate boundaries and practice safety within the professional dialogue.

Contact for information about the study: If you have any questions or would like further information, please contact the thesis student, Dr. Vanessa Brcic, at (phone) or (email).

Contact for concerns about the rights of research subjects: If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598, or if long distance, e-mail RSIL@ors.ubc.ca or call toll free at 1-877-822-8598.

☐ **I consent to audio recording** of the interview to ensure accuracy of transcription.
☐ **I prefer no audio recording**; I consent to the use of the interviewer's notes for write-up & analysis.

☐ **I consent to de-identification of data** (my name and any identifying information will be removed).
☐ **I prefer that my thoughts/ideas/comments are attributed to me, and appropriately cited.**

Please indicate preferences for identification & citation (i.e. name, affiliation, community, etc.):

_____

Your signature indicates that you have received a copy of this consent form and that you consent to participate in this study.

_____

Participant Signature Printed Name Date