Addressing Military Sexual Trauma in Women Veterans Through Trauma-Informed Care

Oregon Health and Science University

Gretchen Hillman, RN, BA, BSN

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Abstract

Military sexual trauma (MST) is a pervasive problem in all branches of the military services and disproportionately affects women. Its consequences on a woman's career, health, and well-being are deleterious and follow her throughout her lifespan. While the VA healthcare system has been diligent in its screening for MST and connection to care services for those affected by MST, trauma-informed care is a systems-wide approach and demands that the delivery of services also be rendered in a way that is sensitive to trauma. In 2020, a quality improvement study by Sierra Stuart, FNP sought to bring a training by Trauma-Informed Oregon to providers and staff at the Portland VA Women's Clinic to improve their interactions and care for patients with MST. This evaluative study aimed to assess the participation in that training and its impact on provider/support staff relationship and communication skills from the patient perspective.

Keywords: trauma-informed care, veteran, military sexual trauma, MST, women

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Introduction

Problem Description

Military sexual trauma is a term that describes experiences of sexual assault or repeated, threatening sexual harassment that a Veteran experienced during his or her military service (Department of Veterans' Affairs, 2020). For its survivors, who are disproportionately women, it leaves lasting and devastating physical and emotional effects (Calhoun et al., 2018; Creech & Borsari, 2014; Forman-Hoffman et al, 2012; Freyensteinson et al., 2018; Goldberg et al., 2019; Holliday & Monteith, 2019: Kimerling et al., 2016; Kintzle et al., 2015; Monteith et al., 2018). Although MST is reported by 32.4% of female veterans, only recently has military sexual trauma (MST) begun to receive the spotlight it deserves, and the U.S. Department of Veterans' Affairs has begun to take systematic steps to rehabilitate and compensate veterans after they experience MST (Klingensmith et al., 2014; Military Sexual Trauma Support Team, 2019).

The VA system serves approximately two million female veterans nationwide, while the state of Oregon VA system serves 28,000 female veterans and the Multnomah County VA system serves 4,900 female veterans (U.S. Department of Veterans Affairs, 2020). When 32.4% is applied to these numbers, one can see the enormity of the problem of MST both nationally and for the state of Oregon, and we also know that MST is likely underreported (Klingensmith et al., 2014). While the "one in three" statistic of MST is comparable to civilian female rates of sexual assault, one must keep in mind that MST happens within a given two to six year snapshot of a

person's life and doesn't include their whole life as the civilian rate does, making it much more prevalent within its context. Some additional aspects that make MST unique are the ongoing contact with the perpetrator, the culture of the military that supports a hierarchy of power in daily living, the military ideal of loyalty and "all for one" that is betrayed through MST, and the disconnection from social supports that occurs while deployed (Skidmore & Bell, 2020). There is also a very valid fear of negative career repercussions if an assault is reported, as 62% of those who reported their MST had negative outcomes (Cole et al., 2021).

The Veterans Health Administration (VHA) is a national leader in MST management and has built-in systems in place to provide expansive MST-related care as part of their standard for mental health services. These services include universal screening for MST, system-wide educational initiatives, and MST coordinators at each medical center who connect positive screens to care such as mental health evaluation, medication evaluation, and individual and group counseling (Department of Veterans Affairs, 2020; Kimerling, 2011). Currently the VHA has established a mandatory curriculum for any healthcare provider administering an MST screening, which provides training in sensitively assessing for MST and in assessing for comorbid conditions of MST (Pulverman et al., 2019). In 2010, in order to address barriers to care for women veterans (especially those with PTSD and MST) the VHA mandated gender-sensitive primary care for women that included separate comprehensive women's primary care clinics or a separate provider/team for women veterans within mixed-gender primary care clinics, co-location of mental health services with primary care, access to female chaperones for women-specific exams, and efficient access to gynecology care (either onsite or through referral) (Kehle-Forbes et al., 2017).

Although the Veterans Health Administration (VHA) is an organization that already has extensive policies in place surrounding detection and treatment of military sexual trauma, as well as primary care that operates in consideration of MST, that does not speak to the manner in which the screening and care is delivered. Kimerling et al. (2011) found that women veterans without MST rated their VHA care more highly than women veterans with MST and suggested that this specific population within the VA could benefit from better care coordination and communication practices between provider and patient. Additionally, studies have shown that many women veterans who establish care through the VHA later discontinue it citing mistrust of the VA, feeling triggered by the environment of the VA, and not having their needs met including OBGYN services (Cole et al., 2021). Among those who do continue, fewer than 50% believe that their mental health needs are being well met (Hamilton et al., 2013; Kimerling et al., 2015). A 2019 study by Bovin et al. found that twice as many survivors of MST were likely to report their trauma on a study questionnaire compared to the VHA screen, because the mode of assessment on the study questionnaire was changed to include more privacy and a rationale for screening. These lacking practices and other practices that would be beneficial for MST survivors can be accounted for with the adoption of trauma-informed care (TIC). TIC is a way of integrating trauma-sensitive practices into staff processes, culture, and service models that results in reducing the power differential between the provider and patient, reduces the patient's sense of vulnerability, and promotes a sense of control within the patient (Currier et al., 2017; Skidmore & Bell, 2020). For veterans in particular, adopting a strengths-based approach that reconciles their traumatic experiences and responses with their personal identities of strength, resilience, and independence is especially helpful (Skidmore & Bell, 2020).

Available Knowledge

A literature review was performed during the month of April 2021 utilizing PubMed, Medline, Ovid, CINAHL, and the digital collections of the OHSU library of DNP projects; the search was conducted using the terms "Title contains [trauma-informed] AND any field contains [military sexual trauma]". The search was limited to articles published within the last 10 years in the English language, and with full text availability. This search yielded a total of 35 articles which were further filtered to exclude "child," "maternity," "prenatal," and "correctional facility" from the title. After exclusions, a total of 16 peer-reviewed articles and e-book chapters remained. The literature review was aimed at assessing the impact trauma-informed care does have and potentially could have for female veterans who have experienced military sexual trauma. In light of a paucity of literature on current TIC impact on MST, exploration of the merits and efficacy of trauma-informed care on populations who share similarities with the target population was also included, such as veterans in general, females in general, and survivors of sexual trauma in general.

This literature review suggested benefits, both proven and potential, for TIC in MST. TIC's origination can be traced to the feminist movement and the perspectives of women, in particular "those who experienced domestic violence and sexual victimization and who called for providers to engage with them in different ways" (Burgess & Holmstrom, 1974). This value-driven theory overlapped with new discoveries in neuroscience, and led to evidence-based practice recommendations calling for TIC for any patients with history of trauma. Within the VHA population, there were no studies available on the impact of implementation of trauma-informed care practices on an MST subpopulation, and few studies of such impact on any other veteran subpopulation. There is evidence, however, that a trauma-informed program called Strength at Home aimed at male veteran users of interpersonal violence (IPV) was significantly effective at reducing IPV in domestic relationships where no other intervention had been

successful (Creech et al., 2018). A trauma-informed approach to collecting urine drug screens among veterans with trauma in substance use outpatient treatment programs also proved to effectively engage and retain those clients (Scoglio et al., 2020). Many studies advocated for the use of TIC in the military veteran population as a whole, including although not specific to those with MST (Currier et al., 2017; Gerber, 2019; Kelly et al., 2014; Scoglio et al., 2020; Skidmore & Bell, 2020). A few studies advocated for TIC in veterans of all genders with MST and another comorbidity such as homelessness, or in women survivors of sexual violence who are not veterans (Ades et al., 2019; Pavao et al, 2013). In this sense, although TIC is an organizational paradigm shift and not an encapsulated service, a TIC training for providers of MST services for women veterans appeared, based on the literature, to be very helpful, needed, and not yet attempted.

In 2020, a doctoral candidate of the Oregon Health and Science University's family nurse practitioner program named Sierra Stuart conducted a pilot quality improvement project at the Portland VA system's Women's Health Clinic in Portland, Oregon (Stuart, 2020). As part of this project, she developed an online, self-paced TIC training in coordination with certified trauma specialists at Trauma-Informed Oregon to disperse to MST providers at the health clinic for women veterans. Although her training was never completed by providers due to onset of the COVID-19 pandemic and the competing priorities the pandemic brought, her project remained a unique attempt at targeting women veterans with MST for TIC services.

Rationale

Stuart's project at the Portland VA Women's Clinic provided a 90 minute-virtual TIC training in coordination with a certified TIC trainer, then sent out an online survey to evaluate the general perceived relevance and impact of this training. Stuart writes in her study, "There

were no measures put in place to evaluate whether or not Trauma Informed Principles were implemented into the Women's Health Center clinic, or whether/how clinicians and medical staff altered their behaviors to be reflective of providing trauma informed care" (Stuart, 2020). She highlights that only one study, the Green et al., 2015 study, has evaluated these types of measures, and that this evaluative process "will need to be replicated in order to truly capture the impact and efficacy of this training." At the time that Stuart's final paper was written, it was unknown to her that providers did not complete the training.

Specific Aims

The aim of this project was to return to the site where the TIC training was developed by the Stuart, 2020 study and, by February 16, 2022, use a patient survey to evaluate patient/provider interactions before the providers complete Stuart's TIC training, to train the providers using the online TIC training, and then to evaluate the same providers again afterwards using the same patient surveys. The goal was to evaluate whether the virtual TIC training that was given altered the behaviors and practices of the providers at the Portland VA Women's Health Center clinic as measured by patient perceptions. A similar study to this, which evaluated patient/provider interactions post-TIC training in an alternate, non-VA setting, showed significant improvement in patient-centered communication and communication proficiencies immediately following the training, and at 6 months and 18 months post-training (Herlitzer et al., 2011). Measuring the project's success in this way and extrapolating from other studies about the longevity of the impact had the potential to demonstrate the sound investment of such TIC trainings to other facilities who may be considering this training (Wensing, 2003). If impact had been determined to be high, the training could have been offered to other support staff at the clinic and in other VA clinics. A secondary aim was to assess whether an individual patient's

demographics in terms of their age, race, and comorbidities were associated with a likelihood to report negative interactions with their providers.

Methods

Context

This project was conducted at the Portland VA Women's Health clinic, a stand-alone clinic serving women veterans of all ages which offered comprehensive primary care, mental health services, and routine gynecological care. The clinic was staffed by a women veterans' program manager, a women veterans' health medical director, a women veterans' mental health program director, as well as a women's health navigator who connects patients to care in the community. The clinic served as the OB/GYN consult and referral clinic for the area and had an on-site psychologist, pharmacist, and mental health team. At the time of this study there were 6 providers at this clinic, 8 support staff (nurses, receptionists) and 1300 patients. Project buy-in was established with the clinic's medical director, Brenda LaFavor, MD and a provider, Kaitlin Haws, DNP acted as the clinic project liaison. The support that was established for the TIC training by the Stuart study (2020) was felt fervently still, and indicated a dedication by all staff and providers to continue to move toward trauma-informed care for their women veteran patients. This project was tailored toward the Portland VA WHC patients and targets their responses to care received by their providers at that clinic, which improved the likelihood of local adoption of Stuart's training if results were favorable. Barriers to efficacy and large-scale adoption of this project were identified as availability of a local TIC-certified trainer to complete Stuart's training in person, verification of completion of the online training, limited number of training participants, and the specificity of the clinical setting which limits external validity. An

additional barrier that was discovered during implementation was the front desk staff's reliability in handing out the survey to the patients. While this VA clinic was especially designed and suited to serve women veterans and therefore understood the need for trauma-informed care for MST survivors, not all VA clinics may share that prioritization and care to invest resources to that cause.

Intervention

Stuart's 2020 project provided a 90-minute webinar designed and given by a TIC-certified trainer Molly Oberweiser-Kennedy of the Trauma-Informed Oregon (TIO) organization with the following learning objectives:

1) Participants will understand the principles behind trauma informed care and its relevance within healthcare settings and personal practices.

2) Participants will be familiar with the Six Principles of Trauma Informed Care.

3) Participants will be able to explain how trauma informed care will positively impact their practice and their patients.

4) Participants will be able to provide examples of trauma specific practices (Trauma Informed Oregon, 2016).

It was sent as an email to all Portland VA WHC providers and staff, who were asked to complete the training on an optional basis, then complete a survey within 8 days on the training's efficacy and usefulness. There were no measures in place to track which intended participants completed the webinar training, and no intended participants at the clinic responded to the post-survey. The first step in this evaluative project was to obtain a list of providers and staff who self-disclosed whether or not they completed the training. The result of this inquiry was found to be that no providers or staff had completed the training. This outcome provided a fortunate opportunity to begin fresh and get baseline information on patients' perceptions of the quality of their interactions with specific providers, which could then be compared to perceptions of interactions

with those same providers after the providers had received Stuarts' TIC training. The formalized webinar training was available still and had been given to this author by Stuart for use in this study.

Study of the Intervention

While the learning objectives of the Stuart 2020 intervention study were knowledge-based, the objectives of this evaluative study were to determine whether providers and staff applied that knowledge to alter their interactions while providing care to patients. For a period of four weeks, all patients were asked to complete a post-interaction survey after a regularly scheduled appointment with any provider from the clinic. This was done either on paper while still in the office or at home via an online survey format on Qualtrics. Patient questionnaires were provided in English and in Spanish and asked the patient to identify their provider by name but did not ask for the patient's name. After four weeks of baseline surveys, these surveys were collected and marked as "pre-training." Each provider then completed the TIC webinar training on their own time and reported when they had completed it. Following that, four more weeks of patient surveys commenced, using the same questionnaire to get post-training data. The questionnaires were collected and compiled for each provider and entered in as raw data for data analysis at the end of the second four-week period.

Measures

The patient questionnaire used was the same as the one which was used to evaluate patients' perceptions of their provider interactions after the providers received a trauma-informed care training in a NIH-funded study by Bonnie Green et al. (2015) at Georgetown University, and was given to this author by that author with explicit permission to use in this study. The questionnaire consisted of 20 questions aimed at assessing PCP behavior and relationships on a

5-point Likert scale. These questions covered targeted skills from the TIC training and were derived from measures assessing patient satisfaction and interactions with providers (Bertakis et al., 1991; Cooper et al., 2000; Thom & Stanford Trust Study Physicians, 2001). The questionnaire included demographics, a PHQ-2 screen for depression, a 4-question trauma screen along with one question from the ACEs study, a 4-question PTSD screen, and also assessed for chronic illness comorbidities (Kroenke et al., 2003; Green et al., 2006; Hooper et al., 2011; Felitti et al., 1998). These instruments were pilot-tested and adjusted by the Green et al. 2015 study. The primary outcome measure was the significance of patients' scoring of their provider on the Likert scale for the 20 questions related to patient relationships and communication for those who had an appointment with their provider before they had done the training compared to those who had an appointment with their provider after they had done the training. The secondary outcome measure was the prevalence of comorbidities, depression, PTSD, ACEs, and trauma screen that the patient reported regardless of provider training status.

Analysis

The patient questionnaire assessment allowed for the collection of qualitative data through statements about patient perceptions about the rapport, information, and partnership they experienced with their provider/support staff, which were then ranked on a quantitative Likert Scale allowing the data to be analyzed through SPSS. Raw data from the patient questionnaire was exported from Qualtrics to an Excel spreadsheet and sorted into "pre-training" (surveys completed before their named provider received Stuart's TIC training) and "post-training" (surveys completed after their named provider received Stuart's TIC training). All Excel data was uploaded into SPSS software and mean scores of the total items being assessed by the Likert Scale were computed for trained versus untrained samples and compared using a two-tailed,

independent variables t-test, since the same patients were not compared across two time points. Frequency charts and visual graphs were created for trauma exposure, PTSD, depression, comorbidities, and demographics. Surveys with more than two missing data points were excluded, and those with fewer than two missing data points were replaced with mean scores for the missing item for trained and untrained samples separately.

Ethical Considerations

In designing this project, there were several ethical considerations. First, patient consent to participate in the study was necessary to achieve and was obtained through a written clause on the patient questionnaire. Second, patient privacy was an important concern both to the study and to the patient. For this reason, the survey did not include the patient's name and the surveys were kept locked in a staff member's desk drawer where providers and nurses did not have access to them. The patient questionnaire was also available in an online format as an option to be completed at home to avoid any patient social discomfort.

Regarding ethical considerations pertaining to the trauma screening process that was embedded in the patient questionnaire, it was important to screen for sensitive topics such as PTSD and trauma in a way that honors patient preferences, privacy, and did not retraumatize them. As the 2019 Bovin et al. study showed, twice as many MST survivors were willing to disclose on a questionnaire that was designed for privacy and that included a rationale for screening. To that end, this patient survey was designed to be completed independently and with privacy, and a rationale for the screening was provided within the consent clause.

Results

Results

Out of six providers at this clinic, four chose to participate in the training. 21 female patients ages 22-74 at the VA Women's Clinic chose to do the survey in total; 14 pre-training and 7 post-training. The pre-training results are reflected for all six providers, while the post-training results are only representative of the providers who trained. One trained provider was excluded in the post-training results because there were no patient surveys completed post-training for that provider. Results of the pre-training surveys as an average for all untrained providers compared to results of post-training surveys as an average for all trained providers underwent an independent variables t-test and are displayed here.

T-Test

Group Statistics

	Groups	N	Mean	Std. Deviation	Std. Error Mean
TIC score total %	1.00	14	99.64	1.336	.357
	2.00	7	100.00	.000	.000

Independent Samples Test

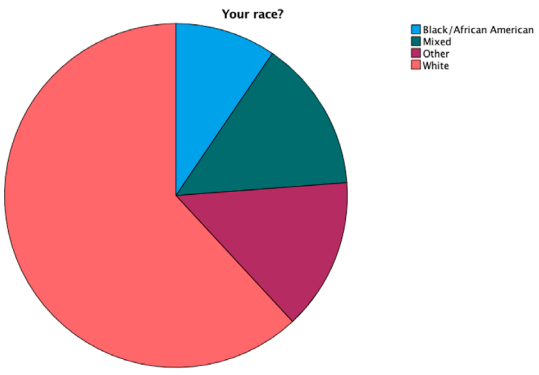
		Levene's Test for Equality of Variances		t-test for Equality of Means							
						Significance				95% Confidence Interval of the Difference	
		F	Sig.	t	df	One-Sided p	Two-Sided p	Mean Difference	Std. Error Difference	Lower	Upper
TIC score total %	Equal variances assumed	2.287	.147	-.698	19	.247	.494	-.357	.512	-1.428	.714
	Equal variances not assumed			-1.000	13.000	.168	.336	-.357	.357	-1.129	.414

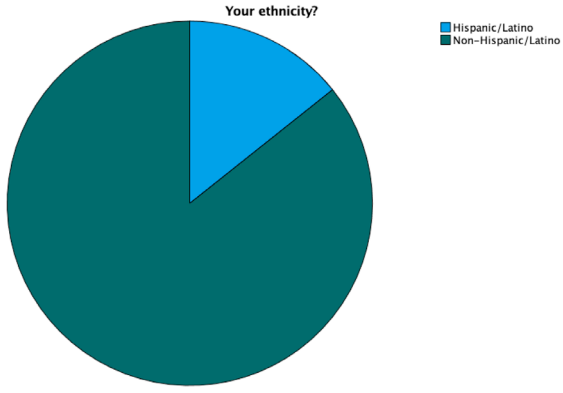
Because the mean of the pre-training surveys was so close to 100% satisfaction with their provider and mean of the post-training surveys was 100% satisfaction with their provider, the P-value = 0.494 (P-value of ≤ 0.05 was considered statistically significant), and was determined to be insignificant. CI = [-1.428 – 0.714].

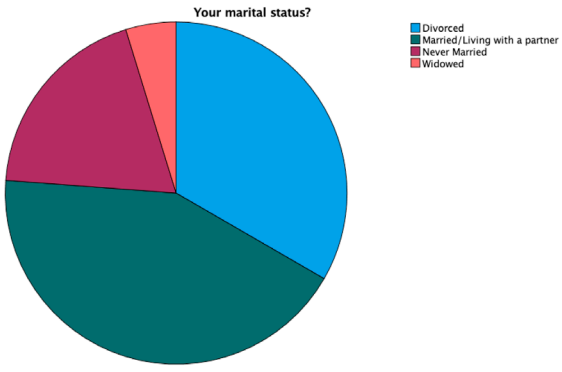
Additional graphs representing secondary aims of capturing patients' demographics and comorbidities are displayed below.

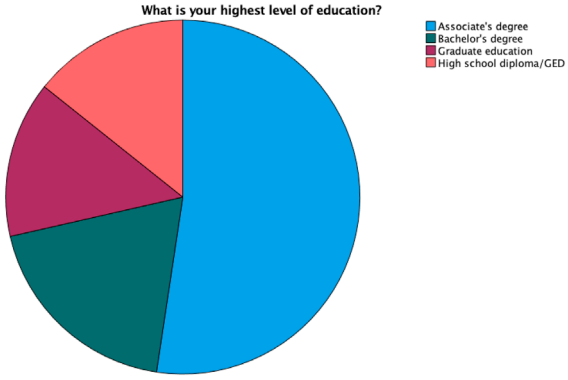
What is your age?

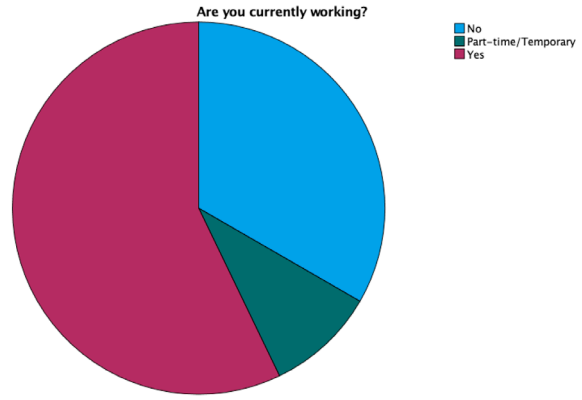
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	22	1	4.8	4.8	4.8
	30	2	9.5	9.5	14.3
	32	1	4.8	4.8	19.0
	34	1	4.8	4.8	23.8
	35	1	4.8	4.8	28.6
	39	1	4.8	4.8	33.3
	40	1	4.8	4.8	38.1
	45	1	4.8	4.8	42.9
	46	2	9.5	9.5	52.4
	47	2	9.5	9.5	61.9
	51	1	4.8	4.8	66.7
	56	1	4.8	4.8	71.4
	57	1	4.8	4.8	76.2
	61	1	4.8	4.8	81.0
	64	1	4.8	4.8	85.7
	66	2	9.5	9.5	95.2
	74	1	4.8	4.8	100.0
	Total	21	100.0	100.0	

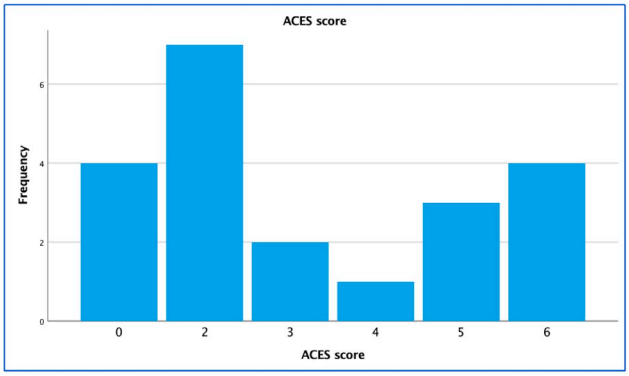


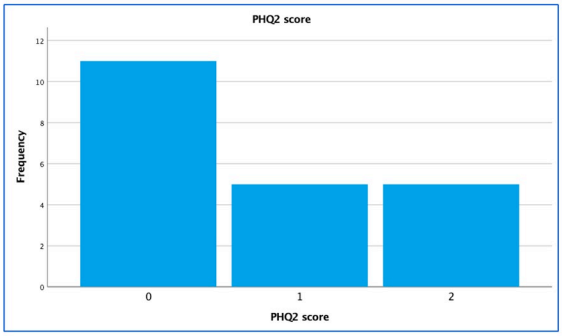


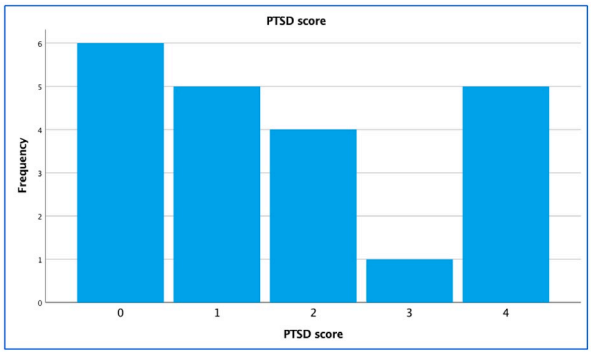


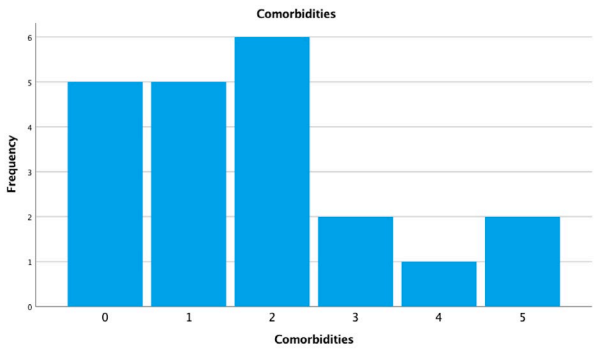












Discussion

Summary

In summary, patients' perceptions of their providers' ability to provide trauma-informed care was relatively the same before and after their provider received training, both nearly or at 100%. The sample size included 21 patients who opted to do the survey either before or after the

training date, with 14 patients completing the survey before their provider had done the TIC training and 7 different patients completing the survey after their provider had completed the training. There were 81% with trauma backgrounds, 71.4% who screened positive for PTSD, and 47.6% who screened positive for depression. 76.2% of these patients had at least one chronic illness comorbidity and 23.8% had three or more. 61.9% of the surveyed population was white, 9.5% African American, 14.3% mixed, and 14.3% other. 14.3% were Hispanic and 85.7% were non-Hispanic. 42.9% were married or living with a partner, 33.3% were divorced, 4.8% were widowed, and 19% had never been married. 14.3% had achieved a high school diploma as their highest level of education, while 52.4% had an associate's degree, 19% had a bachelor's degree, and 14.3% had a graduate degree. Finally, 57.1% were working full time, 9.5% were working temporary/part time, and 33.3% were not working.

Interpretation

A surprising finding of this study was the high level of satisfaction that patients were already feeling with their providers' TIC implementation before the training. This near-perfect satisfaction made it difficult to glean any significance out of learning that may have been accomplished with the training. It is likely, based on post-study discussions with the clinic staff, that this VA Women's Health Clinic has already made the paradigm shift to trauma-informed care, and that the providers who work here are drawn to this work precisely because trauma-impacted women is their passion population. Additionally, the providers gave this author feedback about the training itself, reporting that although it was created and presented by a trauma-expert organization, it was perhaps more motivational than practical and may be better suited for an organization that is still in the contemplative phase about whether to utilize TIC. These providers would have appreciated a higher-level training with concrete words and tools for

the clinician who has already mentally and emotionally committed to TIC. The author concludes that this training was a mismatch for this particular clinic in light of the level of TIC implementation that the Portland VA Women's Clinic is already operating with, and the training may be better utilized at an organization that has a high trauma population but little awareness of or skills around TIC. Future steps that may be taken with this project include bringing the training to such an organization, perhaps private practices such as NW Primary Care, or working with Trauma-Informed Oregon to create a higher-level training video for the Portland VA Women's Clinic that walks them through specific tools and strategies to improve the TIC they are already doing.

Limitations

Limitations of this study included a small sample size both of providers and of patients who completed the survey, as well as a small sample size of sites as it only included the one VA location. Another limitation was the omission of screening specifically for Military Sexual Violence in favor of broader trauma screening. Since this is the first study known to evaluate VA patients' perceptions of their TIC interactions with their providers, this evaluative study will need to be replicated at sites that work with high trauma populations but have not implemented TIC in order to truly capture the impact and efficacy of this training in motivating providers toward adopting trauma-informed care. At this site and others with high levels of skill around TIC, the study will need to be replicated using a more practical and higher level of TIC training.

Conclusions

This study represents a unique attempt to qualify women veterans' perceptions of their care with their providers from a trauma-informed lens. Although the findings of this study indicate that this particular training was a mismatch for this site, there is opportunity and

readiness at this clinic site for more advanced, practical TIC training with concrete tools and steps. There is also an opportunity to disperse this more basic, motivational training video at less developed sites that serve patients with trauma backgrounds and are still contemplating whether to shift their organization to a TIC model.

Other Information

Funding

This study received no outside funding to report, although the questionnaire was borrowed from a Georgetown University study that was funded with a grant from the NIH.

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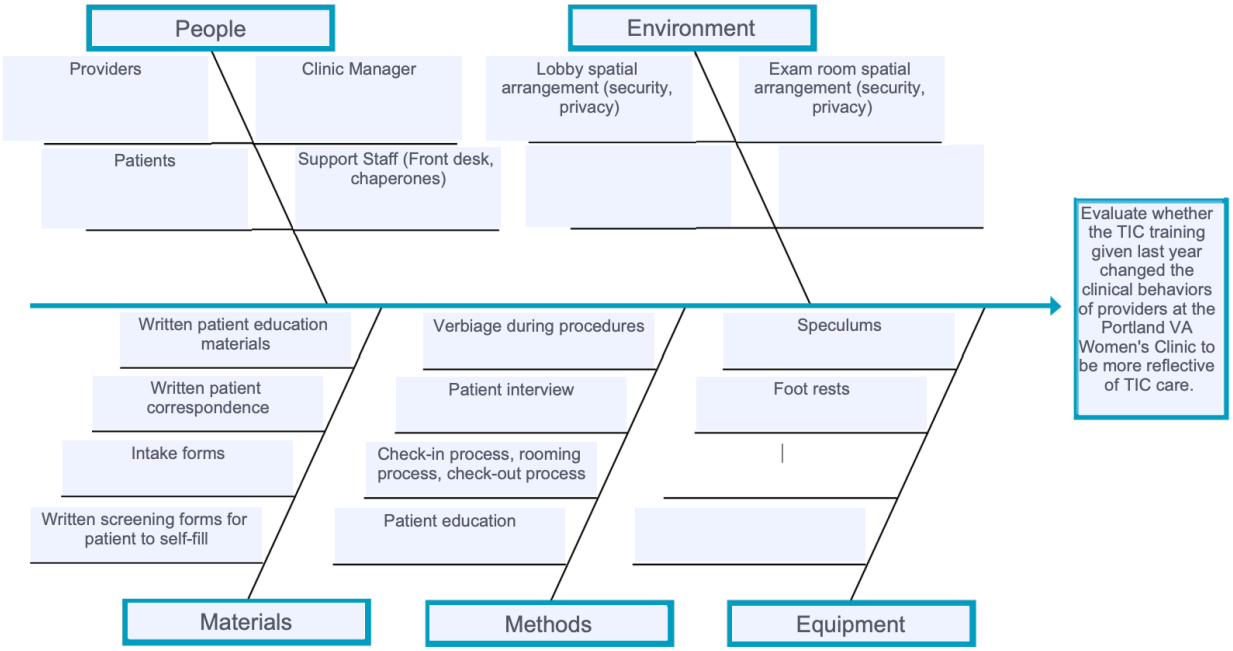
Appendices

Appendix A: Cause and Effect Diagram



Appendix B: Project Timeline

Project Timeline

	July	Aug	Sep-Nov	Dec	Jan	Feb	March
Finalize project design and approach (703A)	X						
Present Project Proposal	X						
Complete IRB determination or approval (703A)	X						
Gather baseline data from previous intervention (which providers/staff completed Stuart's training) (703B)		X	X				
Conduct pre-training surveys				X	X		
Train providers (703B)					X		
Conduct post-training surveys surveys					X	X	
Final data analysis							X
Write sections 13-17 of final paper (703B)							X

Prepare for project dissemination (703B)							X

C:

Consent page in English

You are being invited to participate in a research study titled *"Addressing Military Sexual Trauma in Women Veterans Through Trauma-Informed Care."* This study is being done by Gretchen Hillman, RN, BSN from the Oregon Health and Science University Doctorate of Nursing Practice program. You were selected to participate in this study because **you completed an appointment with a provider who may or may not have received a trauma-informed care training.** The purpose of this research study is to determine whether the training that your provider did or did not receive had an impact on the way that they interacted with you. If you agree to take part in this study, you will be asked to complete the survey/questionnaire on the next page. This survey/questionnaire will ask about your interaction you just had with your provider, along with some sensitive topics like depression, trauma, and PTSD, and **it will take you approximately 5-10 minutes to complete.** You may not directly benefit from this research; however, we hope that your participation in the study may inform this clinic about the impact of this training and potentially cause the clinic to expand the training. **Your answers in this study will remain confidential from the provider and does not require your name.** We will minimize any risks to breach of confidentiality by storing the surveys in a location separate from patient files, without patient names, and accessible only to front desk personnel. When the study is complete, these surveys will be disposed of via a shredding service. **There is an online version of this survey which you can complete at home if you would rather. The website is:**

Your participation in this study is completely voluntary and you can withdraw at any time. You are free to skip any question you choose.

As researchers we are not qualified to provide counseling services and we will not be following up with you after this study. If you feel upset after completing the study, or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance please contact Portland VA Women's Health Clinic mental health services at 503-402-2852 (Monday-Friday 7:30am-4:30pm) or connect with a Veterans crisis responder anytime day or night by calling 800-273-8255 then select option 1. You can also start a written chat by texting 838255. If you have hearing loss, call TTY 800-799-4889. In the case of an emergency please call 911.

If you have questions about this project or if you have a research-related problem, you may contact the researcher, Gretchen Hillman, at peckg@ohsu.edu. If you have any questions concerning your rights as a research subject, you may contact the Human Subjects Research manager Kathryn Schuff at irb@ohsu.edu.

By proceeding to the survey/questionnaire on the next page you are indicating that you are at least 18 years old, have read and understood this consent form and agree to participate in this research study. Please keep this page for your records and return the survey/questionnaire to the researchers. Please DO NOT write your name on the survey/questionnaire.

Appendix D: Patient questionnaire form in English

Patient Questionnaire
Relationship informed Clinical Healthcare Study

Today's Date _____Provider Name: _____

Regarding the visit you just had with your health care provider:

1. **What was the reason for your visit?**

☐ Routine exam
☐ Follow-up visit at health care provider's request
☐ Felt sick
☐ Injury

2. **About how long was the visit?**

☐ Less than 10 minutes
☐ From 10-15 minutes
☐ More than 15 minutes

3. **Were you satisfied with the outcome of the visit?**

☐ Yes
☐ Not Sure
☐ No

Please rate the following statements about your health care provider (doctor, physician assistant, or nurse practitioner) **in the visit that you just had with her or him. Put and X under the answer that best represents your opinion.**

	Disagree	Neither agree nor disagree	Somewhat Agree	Moderately Agree	Completely Agree	N/A
4. The Provider respected me						
5.The Provider asked me what I believe is causing my symptoms						
6. The Provider encouraged me to talk about my concerns about my symptoms						
7. The Provider made an effort to give me some control over my treatment						
8. The Provider discussed the pros and cons of each choice with me						
9. The Provider took my preferences into account when making treatment decisions						
10. I trusted the Provider to act in my best interests						

	Disagree	Neither agree nor disagree	Somewhat Agree	Moderately Agree	Completely Agree	N/A
11. The Provider understood my problems						
12. The Provider listened to me						
13. The Provider approached me as an individual						
14. The Provider made me feel comfortable						
15. The Provider gave me guidance						
16. The Provider encouraged me to talk about my concerns						
17. The Provider understood the problems that I wanted to discuss at this visit						
18. The Provider helped ease my mind about my worries						
19. The Provider carefully explained his or her thoughts about what was recommended						
20. The Provider asked for my participation						
21. I felt reassured after my visit with the Provider						
22. The Provider worked with me to find a solution to my health problem						
23. The Provider helped me to understand what was going on						
24. I felt hopeful about myself and my concerns after the visit						

Over the past 2 weeks, have you been bothered by either of the following?

	Yes	No
31. Little interest or pleasure in doing things		
32. Feeling down, depressed, or hopeless		

Have you *ever* had any of the following experiences happen to you?

	Yes	No
33. Been physically attacked, like being hit, kicked, or beaten up?		
34. Been threatened or put down?		
35. Been forced to have sex against your will?		
36. Ever present when another person was killed, seriously injured, or sexually or physically assaulted?		

37. Had a family member who was depressed or mentally ill?		
38. Captured, beaten, raped, or otherwise injured by the police, army, or other political group?		

During the past 4 weeks

	Yes	No	N/A
39. Have you been bothered by repeated, disturbing memories, thoughts, or images of the experience(s) you described above?			
40. Have you avoided being reminded of the experience(s) by staying away from certain places, people, or activities?			
41. Have you felt more isolated or distant from other people?			
42. Do you become jumpy or easily startled by ordinary noises or movements?			

Have you been told by a health care provider or other professional that you had?

	Yes	No
43. Arthritis		
44. Asthma		
45. Bronchitis		
46. Emphysema		
47. Diabetes		
48. Ulcer		
49. Cancer		
50. Heart disease		
51. Migraine headaches		
52. Other _____		

During the past 4 weeks, have you had? …

	Yes	No
53. Pain		
54. Headaches		
55. Dizziness		
56. Heart pounding or racing		
57. Shortness of breath		
58. Nausea or indigestion		
59. Trouble sleeping		

Now we would like to get some information about <u>your background</u>:

Age: _____

Race:

☐ Black/African American ☐White ☐Asian ☐Other ☐Mixed

Ethnicity:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Marital Status:

☐ Married/living with a partner ☐ Widowed ☐Divorced ☐ Never married

Years of Education: _____

Are you currently working?

☐ Yes ☐Part-time or temporary ☐No

Appendix E: Consent page in Spanish

Usted está siendo invitado a participar en un estudio de investigación titulado "Cómo abordar el Trauma Sexual Militar en Mujeres Veteranas A través de la Atención Informada sobre el Trauma." Este estudio está siendo realizado por Gretchen Hillman, RN, BSN del programa de Doctorado en Práctica de Enfermería de la Universidad de Salud y Ciencias de Oregon. Usted fue seleccionado para participar en este estudio porque **completó una cita con un proveedor que puede o no haber recibido una capacitación de atención informada sobre trauma.** El propósito de este estudio de investigación es determinar si la capacitación que su proveedor recibió o no tuvo un impacto en la forma en que interactuaron con usted. Si acepta participar en este estudio, se le pedirá que complete la encuesta/cuestionario en la página siguiente. Esta encuesta / cuestionario le preguntará sobre su interacción que acaba de tener con su proveedor, junto con algunos temas sensibles como la depresión, el trauma y el TEPT, y **le tomará aproximadamente de 5 a 10 minutos completarla.** Es posible que no se beneficie directamente de esta investigación; sin embargo, esperamos que su participación en el estudio pueda informar a esta clínica sobre el impacto de esta capacitación y potencialmente hacer que la clínica amplíe la capacitación. **Sus respuestas en este estudio permanecerán confidenciales del proveedor y no requieren su nombre.** Minimizaremos cualquier riesgo de violación de la confidencialidad almacenando las encuestas en un lugar separado de los archivos de los pacientes, sin nombres de pacientes, y accesible solo para el personal de recepción. Cuando se complete el estudio, estas encuestas se eliminarán a través de un servicio de trituración. **Hay una versión en línea de esta encuesta que puede completar en casa si lo prefiere. El sitio web es:**

Su participación en este estudio es completamente voluntaria y puede retirarse en cualquier momento. Usted es libre de omitir cualquier pregunta que elija.

Como investigadores, no estamos calificados para proporcionar servicios de asesoramiento y no haremos un seguimiento con usted después de este estudio. Si se siente molesto después de completar el estudio, o encuentra que algunas preguntas o aspectos del estudio desencadenaron angustia, hablar con un médico calificado puede ayudarlo. Si cree que desea asistencia, comuníquese con Portland VA Women's Health Clinic Mental Health services al 503-402-2852 (de lunes a viernes de 7:30 a.m. a 4:30 p. m.) o comuníquese con un respondedor de crisis de Veteranos en cualquier momento del día o de la noche llamando al 800-273-8255 y luego seleccione la opción 1. También puede iniciar un chat escrito enviando un mensaje de texto al 838255. Si tiene pérdida auditiva, llame al TTY 800-799-4889. En caso de emergencia, llame al 911.

Si tiene preguntas sobre este proyecto o si tiene un problema relacionado con la investigación, puede ponerse en contacto con la investigadora, Gretchen Hillman, en peckg@ohsu.edu. Si tiene alguna pregunta sobre sus derechos como sujeto de investigación, puede comunicarse con la gerente de Investigación de Sujetos Humanos Kathryn Schuff en irb@ohsu.edu.

Al proceder a la encuesta/cuestionario en la página siguiente, usted está indicando que tiene al menos 18 años de edad, ha leído y entendido este formulario de consentimiento y acepta participar en este estudio de investigación. Guarde esta página para sus registros y devuelva la encuesta/cuestionario a los investigadores. Por favor, NO escriba su nombre en la encuesta/cuestionario.

Appendix F: Patient Questionnaire in Spanish

Cuestionario para el Paciente
Estudio de Salud Clínica centrado en las Relaciones

Fecha de Hoy _____ Doctor: _____

En relación a la visita que acaba de tener con su proveedor de salud:

1. **¿Cuál fue el motivo de su visita?**

☐ Examen/ Visita rutinaria
☐ Visita de seguimiento sugerida por su proveedor
☐ Se sintió enfermo
☐ Lesión

2. **¿Cuál fue la duración aproximada de la visita?**

☐ Menos de 10 minutos
☐ De 10-15 minutos
☐ Más de 15 minutos

3. **¿Está satisfecho con el resultado de la visita?**

☐ Sí

☐ No estoy seguro (no sé)
☐ No

Por favor evalúe <u>las siguientes afirmaciones sobre su proveedor de salud</u> (doctor, asistente del médico, enfermera) **en la visita que acaba de tener con ella o él. Ponga una X en la respuesta que represente mejor su opinión.**

	En Desacuerdo	Ni de Acuerdo ni en Desacuerdo	Algo de Acuerdo	Moderadamente de acuerdo	Completamente de Acuerdo	N/A
4. El/la Doctor (a) me trató con respeto						
5. El/la Doctor (a) me preguntó qué es lo que yo creía que estaba causando mis síntomas						
6. El/la Doctor (a) me permitió hablar sobre mi preocupación acerca de los síntomas						
7. El/la Doctor (a) hizo un esfuerzo para permitirme controlar de alguna manera mi tratamiento						
8. El/la Doctor (a) discutió conmigo los pros y los contras de cada alternativa						
9. El/la Doctor (a) consideró mis preferencias al tomar decisiones sobre mi tratamiento						
10. Confié en que el/la Doctor (a) actuaría para mi mejor interés						
11. El/la Doctor (a) comprendió mis problemas						
12. El/la Doctor (a) me escuchó						

	En Desacuerdo	Ni de Acuerdo ni en Desacuerdo	Algo de Acuerdo	Moderadamente de acuerdo	Completamente de Acuerdo	N/A
13. El/la Doctor (a) me trató de una manera personalizada						
14. El/la Doctor (a) me hizo sentir cómodo (a)						
15. El/la Doctor (a) me dio orientaciones						
16. El/la Doctor (a) me animó a hablar sobre mis preocupaciones						
17. El/la Doctor (a) comprendió los problemas de los que quise hablar en la visita						
18. El/la Doctor (a) me ayudó a aliviar mis preocupaciones						
19. El/la Doctor (a) me explicó cuidadosamente las razones de sus recomendaciones						
20. El/la Doctor (a) pidió mi participación						
21. Me sentí tranquilo después de la visita con El/la Doctor (a)						
22. El/la Doctor (a) contó conmigo para encontrar una solución a mi problema de salud						
23. El/la Doctor (a) me ayudó a entender qué estaba pasando						
24. Me sentí con esperanzas sobre mí mismo y mis						

preocupaciones después de la visita						

En las últimas dos semanas, ¿le han molestado lo siguiente?

	Sí	No
31. Poco interés o placer en hacer las cosas		
32. Sentirse deprimido, o sin esperanza		

¿Alguna vez en su vida ha tenido las siguientes experiencias?

	Sí	No
33. Ser atacado físicamente, como ser pegado, golpeado		
34. Sentirse amenazado o menospreciado		
35. Ser forzado a mantener relaciones sexuales sin su consentimiento		
36. ¿Ha estado alguna vez presente cuando una persona estaba siendo asesinada, herida o atacada sexual o físicamente?		
37. ¿Algún miembro de su familia ha estado deprimido o ha tenido alguna enfermedad mental?		
38. ¿Ha sido capturado, golpeado, violado, o herido por algún miembro de la policía, las fuerzas armadas o grupo político?		

En las últimas 4 semanas

	Sí	No	N/A
39. ¿Alguna vez le ha molestado tener repetitivos pensamientos, recuerdos, o imágenes desagradables sobre las experiencia(s) que ha descrito anteriormente?			
40. ¿Ha tratado de evitar recordar dichas experiencia(s) evitando ciertos sitios, personas o actividades?			
41. ¿Se ha sentido alejado o distante de otras personas?			
42. ¿Se sobresalta o se asusta fácilmente con ruidos o movimientos?			

¿Alguna vez un médico u otro profesional le ha dicho que usted ha tenido?

	Sí	No
43. Artritis		
44. Asma		
45. Bronquitis		
46. Enfisema		
47. Diabetes		

48. Úlcera		
49. Cáncer		
50. Enfermedad del corazón		
51. Migrañas		
52. Otro _____		

En las últimas 4 semanas, ¿usted ha tenido?

	Sí	**No**
53. Algún dolor		
54. Dolores de cabeza		
55. Mareos		
56. Taquicardias		
57. Dificultades en respirar		
58. Nausea o indigestión		
59. Problemas con el sueño		

Ahora le vamos a preguntar alguna información general:

Edad: _____

Raza:

☐ Negro/Afro Americano ☐ Blanco ☐ Asiático ☐ Otro ☐ Mixed-Mezcla

Etnicidad

☐ Hispano/Latino ☐ No-Hispano/Latino

Estado Civil:

☐ Casado/viviendo en pareja ☐ Viudo ☐ Divorciado ☐ Nunca se caso

Años de Educación: _____

Está trabajando actualmente?

☐ Sí ☐ Medio tiempo/temporal ☐ No