Analysis

Trauma-informed care:

what does it mean for general practice?

'After trauma the world is experienced with a different nervous system. The survivor's energy now becomes focused on suppressing inner chaos, at the expense of spontaneous involvement in their lives. These attempts to maintain control over unbearable physiological reactions can result in a whole range of physical symptoms, including fibromyalgia, chronic fatigue, and other autoimmune diseases. This explains why it is critical for trauma treatment to engage the entire organism, body, mind, and brain.'

(Bessel van der Kolk)[1]

Early life adversity and trauma can have a huge impact on our long-term health. What can healthcare institutions and staff do to combat this? Healthcare institutions can improve community health including cross-sector working via integrated care systems (ICSs), but this can take time. However, in general practice, people consulting with primary care staff may have already encountered challenges in life that can negatively impact physical and mental health. This analysis looks at what can be practically done and the role of trauma-informed care (TIC) within general practice.

TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

Seeing the world through a trauma-informed lens could explain how early life challenges result in negative health and social consequences. Trauma is defined as an event (or series of events) that has long-lasting negative impacts on a person's physical, mental, or emotional/social wellbeing[2] after the event has ended. Structural, historical, and oppressive factors can all collectively contribute to trauma. One criticism is that the definition of trauma is broad, and some may use it as a catch-all term for any stressful experience. Trauma occurs after the experience whereas stress is confined to the experience alone.

> *"[Trauma] may result in difficulty forming trusting relationships, not taking up offers of care, and higher use of drugs and alcohol as coping strategies."*

Another way of seeing such challenges is through 'adversity': adverse childhood experiences (ACEs). This refers to child abuse and neglect; parental separation or death; household violence; mental illness; substance misuse; or criminality. Other examples include living in foster care; experiencing bullying; feeling discriminated against; feeling unsafe in your neighbourhood; and witnessing violence.[3] An epidemiological study demonstrated that three in ten adults had experienced childhood trauma in England and Wales.[4] In this study trauma was narrowly defined as actual or threatened death, serious injury, or sexual violence but often definitions are broader, suggesting a higher prevalence of childhood trauma.[5]

People who have experienced such adversity may see the world as a dangerous place and may have low self-worth.[6] This may result in difficulty forming trusting relationships, not taking up offers of care, and higher use of drugs and alcohol as coping strategies. The challenges that people face can result in other unhealthy behaviours such as poor sleep and decreased physical activity, as well as physical and mental health conditions such as heart disease and depression.[7] Adversity can prevent people from benefiting from protective social networks and healthy behaviours.

IDENTIFYING TRAUMA

Questionnaires were developed to identify trauma and ACEs in population health research[8] and not necessarily for use in clinical practice. Such questionnaires do not consider the context of a person's life, the duration or intensity of adversity, or the presence of a safe and supportive relationship. Furthermore, there is no clear cut-off in an ACE questionnaire where intervention may be helpful, and it may not be possible to determine risk of negative health outcomes from the scores alone.[9] Identification of those with high ACE scores but few persistent health or social concerns may divert resources away from those with low ACE scores but ongoing support needs.[10] ACEs may interact synergistically, at least in pairs, and cause a cumulative negative effect greater than the sum of an individual ACE.[11] An alternative viewpoint is that a focus on ACEs continues to medicalise social problems over which general practice has limited influence.

A trauma-informed professional may be acutely aware of the possible long-lasting mental or physical effects on an individual and manage them appropriately, for example, depression, substance misuse, or post-traumatic stress disorder (PTSD). Despite this, having symptoms of trauma may not warrant a referral to secondary care; perhaps only if treatment cannot be provided in primary care.[12]

> *"Trauma awareness is not just for healthcare professionals: reception staff ... care navigators, and community link workers may also benefit from practice-wide training."*

TRAUMA-INFORMED CARE: IN PRACTICE

TIC could be a better response to trauma by general practice. TIC is a framework by which organisations embed system-level interventions by integrating the *4Rs* into health care: Realising that trauma exists, Recognising the signs and symptoms, Responding by creating trauma-informed policies, and Resisting re-traumatisation.[2] Such an approach could shift the focus from *what is wrong with a person* to *what happened to the person*. This may provide an understanding into maladaptive coping strategies such as smoking or alcohol addiction.

Part of a TIC approach is being cognisant that trauma might be the reason for presentation to healthcare settings. One example might be: *'Sometimes difficult things from our past and our childhood can affect the*

Box 1. Purkey *et al*'s five principles for trauma-informed care[15]

1. Identify and acknowledge the patient's experiences of trauma and its persisting impact.
2. Reassure and ensure that patients are physically and emotionally safe.
3. Engage and empower patients to lead decisions around management and next steps.
4. See the patient as a survivor with strength and resilience, rather than a victim with symptoms and disease.
5. Be sensitive to those in marginalised groups who experience systemic abuse and the intergenerational implications.

way we feel, and the way our bodies react. Do you think that this might have happened to you?' Acceptability of enquiring about trauma is variable in clinicians due to perceived barriers[13,14] since clinicians doubt whether they have the right resources to refer people due to insufficient time, low confidence, and worries about causing the patient distress. However, these barriers can be overcome once clinicians are trained on how to handle disclosures.[13]

After identifying a history of trauma, what can you do within general practice? First, we should appreciate that trauma might be the cause of many illness presentations such as depression or medically unexplained symptoms. Second, we must not underestimate the importance of the therapeutic relationship, emphasising empathy, trust, and safety. Purkey and colleagues[15] provide five principles that primary care staff may consider using (Box 1):

A TIC approach does not require that a professional enact trauma therapy but that they use the principles of TIC to build trusting relationships with patients, giving informed choices and providing safety in the clinical space. This is especially important for those individuals who have faced abuses of power such as childhood abuse, political persecution, or systemic racism. At its heart, TIC is person centred and values shared decision making, an ethos that aligns with modern-day general practice. Trauma awareness is not just for healthcare professionals: reception staff (who are often on the receiving end of patients' emotional responses), care navigators, and community link workers may also benefit from practice-wide training.

TRAUMA-INFORMED CARE AT ORGANISATIONAL LEVEL

Current research around system-level TIC approaches demonstrates a large evidence–policy gap. A recent systematic review demonstrated positive but conflicting results for intervention effects on patient and provider psychological, behavioural, and health outcome domains.[16] Interventions included some of the following components:[12,16] governance and leadership including a mission statement; written quality improvement or harm reduction policies; re-designed waiting room space such as women-only spaces; advisory or co-design with service users; collaboration with local communities, companies, or organisations; mental health as well as trauma and substance misuse screening and treatment; training with staff and trauma champions; financing; regular monitoring; and mixed-methods service evaluation. However, systematic implementation is difficult to evaluate, especially as there is large heterogeneity in implementation and outcome measures.[16] An organisational transformation ultimately takes time, and requires stakeholder buy-in and political support.[17] Should this prevent us from becoming trauma-aware?

The COVID-19 pandemic also shone a spotlight on the impact of collective trauma for all members of the UK public. The strain of isolation, threat of death, and loss of loved ones took a national toll – an increase in psychological distress reported in adults that fluctuated with the series of lockdowns. Taking an intersectional approach can help us understand how trauma can have a cumulative effect on marginalised communities.

Trauma is widespread but largely ignored. The relevance to primary care is indicated by causal links between trauma and related mental and physical health changes. Empowering colleagues to uncover previous life traumas may help clinicians understand the relationship between a person's trauma and their reason for their current presentation. Furthermore, a by-product may be an improvement in clinician–patient relationships and patient healing because of their trauma being 'seen'. TIC is an emerging response to a systemic problem. It is hard to dispute that TIC *should* be implemented but it is unclear *how* TIC can be implemented. TIC could give clinicians a lens by which to understand the intersection between health and trauma.

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