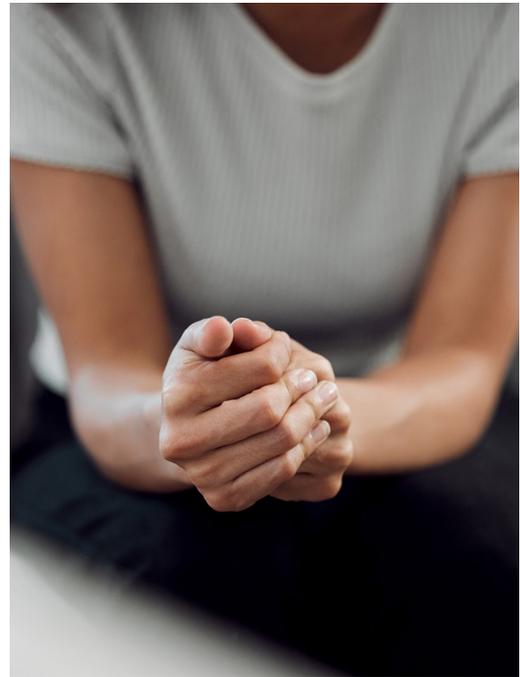


What does trauma-informed care mean in general practice? A qualitative study of general practitioners' perspectives



Eleanor Bulford, Kelsey Hegarty

Background and objective

At the frontline of the healthcare system, general practitioners (GPs) regularly see the health consequences of traumatic life experiences, yet their perspectives on what constitutes trauma-informed primary care are not well understood. This qualitative study sought to explore Australian GPs' perspectives on trauma-informed care.

Methods

Fifteen GPs with an interest in supporting patients with histories of trauma and abuse were interviewed. Data were analysed thematically.

Results

Four key themes were identified: (1) shifts in understanding; (2) it is the relationship that is important; (3) dynamics of power and control; and (4) beyond the GP.

Discussion

This study sheds light on how GPs understand and seek to practise trauma-informed care, and the factors that support and hinder them in this work. Findings support the need for greater integration of trauma-informed principles across the healthcare system, including in funding structures and training programs, and for increased support for GPs' own wellbeing.

AS A PROFESSION that has long held 'whole-person care' as a guiding principle,¹ many general practitioners (GPs) will be deeply familiar with the ways in which 'biography' shapes 'biology':² the profound impact that life conditions and events have upon physiology, psychology and health outcomes. There is strong evidence to indicate that for many individuals, exposure to trauma, violence and abuse plays a major role in shaping physical and mental health across the life course.^{3,4} Particularly when exposure occurs early in life, trauma can impact neurodevelopmental domains such as sense of self, attachment and emotional regulation.⁵ For GPs, trauma is therefore not only important as a major risk factor for poor health, but it can also have significant effects on the therapeutic relationship.

Exposure to domestic violence is arguably one of the most prevalent forms of trauma, experienced by nearly one-third of women globally⁶ and forming a leading cause of morbidity and mortality among women of reproductive age.^{7,8} In Australia, GPs are the professional group that victim-survivors most often tell about their experiences of domestic violence.⁸ At a population level, trauma is a significant contributor to societal health inequities, affected by structural factors such as colonisation, racism and gender inequity.^{7,9} Healthcare services that do not adequately understand and respond to

trauma not only fail to meet the needs of their patients and communities, but risk triggering further trauma.^{9,10} There is an urgent need to strengthen the healthcare response to domestic violence, trauma and abuse.

Trauma-informed care describes healthcare that is underpinned by a strong understanding of trauma, a recognition of signs of trauma, and a response that prioritises patients' emotional and physical safety and resists re-traumatisation.^{10,11} The Substance Abuse and Mental Health Services Administration describes six principles of trauma-informed care: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice and choice; and (6) cultural, historical and gender issues.¹⁰ Trauma-informed healthcare aims to avoid causing harm and instead draws upon patients' strengths to support resilience and healing.^{10,11}

The Royal Australian College of General Practitioners has highlighted the importance of trauma-informed approaches in its clinical guidelines.¹² However, implementing the principles of trauma-informed care in general practice remains an area of limited evidence.¹³ How GPs understand and provide trauma-informed care is not currently well understood, with a small number of existing studies including GPs' perspectives (mostly in the setting of a specific intervention),

and only two identified qualitative studies from the Australian context.¹⁴⁻¹⁷ This study aimed to address this gap by exploring the question: what are Australian GPs' perspectives on trauma-informed care?

Methods

Study design, study population and recruitment

This project was a descriptive qualitative study, conducted in 2022 and 2023, that drew on an interpretivist paradigm to enable an in-depth examination of GPs' experiences.¹⁸ We took a purposive approach to sampling,¹⁹ recruiting GPs who were currently practising in Australia and had an interest in supporting patients with a history of trauma and abuse. This aimed to achieve a sample of GPs who were well placed to share their perspectives on trauma-informed practice. We used several methods of recruitment including advertising on a GP-only social media group and directly contacting GPs and GP groups from the research team's wider network, inviting them to participate.

Reflexivity

EB is an early career GP also working in family violence research and education. KH is an academic GP with extensive experience in family violence prevention research. From the outset, both authors believed in the value of trauma-informed care and the importance of primary care in the response to trauma and abuse. A small number of participants in the study were acquainted with the authors through professional networks. The authors' backgrounds and the relationship between participant and researcher may have influenced this analysis.

Data collection

EB conducted semi-structured interviews via the video platform Zoom (Zoom Communications, San Jose, CA, USA). The interview included questions on what trauma-informed care meant to the interviewee, their experiences of the impacts of trauma in general practice, their approach to practising trauma-informed care, challenges faced, any prior training in trauma-informed care and how they felt general practice could become more trauma-informed. Interviews were audio

recorded and transcribed by a professional transcription company. EB cross-checked all transcripts. Participants received a \$50 gift voucher to thank them for their time.

Data analysis

The authors conducted a thematic analysis, informed by the methodology of Braun and Clark.¹⁸ Following multiple readings of the transcripts, EB generated and applied codes to sections of the data. After further review of the codes by EB and KH, those that shared a relationship were connected to create overarching themes through the lens of the research question. NVivo Version 12 (Lumivero, Denver, CO, USA) was used for data management.

Ethics

Ethics approval was obtained from the Human Research Ethics Committee at The University of Melbourne (reference 2022-24261-29811-3). Being mindful of the potential for an interview about trauma-related issues to cause emotional distress, a trauma-informed protocol previously developed by our research team was in place to use should participant distress arise. Participants' names have been replaced with pseudonyms.

Results

Participants

A total of 15 GPs were interviewed (Table 1). Participants were working across a range of urban and rural general practice settings including private practice, community health and Aboriginal Community-Controlled Health Organisations. Most participants were female and approximately half had been practising for over 10 years. Interviews lasted between 30 and 70 minutes.

Themes

Thematic analysis identified four overarching themes: (1) shifts in understanding; (2) it is the relationship that is important; (3) dynamics of power and control; and (4) beyond the GP. Each theme is detailed below.

Shifts in understanding: 'It gives me a framework to understand suffering differently'

Most participants spoke about different clinical presentations that they recognised could be associated with trauma.

These included common presentations such as depression, anxiety, chronic pain and substance use disorders, but also specific personality traits, difficulties with emotional regulation and chronic disease that was difficult to manage. Participants discussed ways in which some patients' histories of trauma could affect the clinical relationship; in particular, that some interactions might be difficult and that building trust and engagement could be challenging. Several GPs reflected on how their perspectives had shifted over their careers as they gained insight into the impacts of patients' life experiences on their physical and mental health. They described how recognising these interactions in the context of the impacts of trauma allowed them greater depths of understanding, patience and compassion, and informed their clinical management going forward.

It's meaningful to me because it gives me a framework to understand suffering differently. (Dr Ana)

Table 1. Participant demographics

| Characteristic | No. participants (n = 15) |
|---|---------------------------|
| Gender | |
| Female | 13 |
| Male | 2 |
| Locality of practice | |
| Urban | 8 |
| Rural | 7 |
| Type of practice^A | |
| Private practice | 10 |
| Community health | 2 |
| Aboriginal Community Controlled Health Organisation | 5 |
| Other | 2 |
| Years in general practice | |
| ≤5 | 4 |
| 6-10 | 4 |
| 11-15 | 2 |
| 16-20 | 3 |
| ≥20 | 2 |

^A Several participants were working in more than one type of practice.

I probably would have been as bad as any junior doctor talking, like referring to borderline patients, you know, as 'frequent re-presenters' on the system ... I think (understanding trauma-informed care) has definitely made it easier for me to hold space for people who might be untrusting. (Dr Hannah)

Describing a patient whom she had found challenging to work with at times, Dr Leona said:

From a trauma-informed perspective, it's important to say, okay, she's not doing this because she's a pain and because she wants to manipulate people. It's out of fear. 'Are you going to abandon me the same as everybody else has abandoned me? Let's see how far I can push you.' (Dr Leona)

Several GPs discussed times where they had also been able to draw on these insights to support patients to make connections between what had happened to them and the health issues they were experiencing. These GPs spoke about the therapeutic value this could offer the patient, with several describing 'lightbulb moments':

... just let them know that there is a link between their trauma and whatever their superficial problems are. Often that gives them empowerment, that they don't feel like they're the problem. (Dr Rowan)

It is the relationship that is important: 'As humans, that's what we need, isn't it?'

Most GPs highlighted that building a trusting relationship with patients was a central aspect of trauma-informed care. They discussed how the clinical relationship had the potential to offer a form of long-term attachment that had therapeutic value in itself, with several acknowledging that patients with histories of trauma might have experiences of disrupted attachment. Allowing appropriate time and space in consultations, listening carefully, being accountable and meeting patients with an openness, curiosity and a non-judgemental attitude were all highlighted by the GPs as crucial parts of building this relationship.

As humans, that's what we need, isn't it? We need, I think, to have long-term,

caring relationships. And I think a number of that group of people (with experiences of trauma) have not experienced that, really. They haven't had enough caring and love ... Does it partly replace that? It's a long-term, non-judgemental relationship that - they can keep coming along and seeing me and I will listen to them, and I will care for them. (Dr Peter)

I think number one is just universal positive regard and ... always feeling relaxed, never feeling alarmed or shocked, trying to be that stable and steady presence through these big ups and downs. (Dr Fatima)

For some GPs, however, the clinical relationship could also bring a personal emotional load. Several described experiences of exhaustion, emotional depletion and secondary trauma through their work.

You just take on their reality and their lives so much. And then you worry so terribly, because so many things go wrong ... You just can't hold that in your real life, you have to constantly reset. (Dr Mary)

Dynamics of power and control: 'Suppressing some ego, I suppose'

Several GPs described a shift away from seeking to 'fix' a patient's problems towards taking a longer-term view, trying to empower their patients and seeing their own role as a 'coach' or 'facilitator'.

When there are behavioural challenges that have been as a result of trauma, sometimes they'll counter your recommendations just to test you out. So to still say, okay, well, that's alright. I'm still going to treat you and I'm still going to be here. It's hard as a type A personality, someone that likes to be in control ... so suppressing some ego, I suppose, to say, okay, no, there's a reason, there's a context behind this. Just to keep coming back and we'll chip away. (Dr Leona)

When I first started off it was very much, 'oh my God I've got to fix this and let's do this, this and this'. Now it's a lot more about listening more and I think definitely in people who experience trauma, that would definitely be my approach. (Dr Layla)

As they navigated power dynamics in a consultation, GPs discussed prioritising listening to their patients, choosing their language carefully and offering patients choice and shared decision making in all aspects of care.

I've really changed my language with patients and I tend to be much more deliberately inviting to people and giving them choice in every step in a consultation. (Dr Ana)

Beyond the GP: 'It starts even before they've come into my room'

Participants discussed broader practice and systems-level factors that influenced their ability to provide trauma-informed care. Most spoke about the important role of their reception colleagues, describing how patients' experiences of feeling safe and welcome started with these initial interactions. Several also discussed the importance of appointment systems that were accessible, flexible and not unnecessarily punitive to patients who missed appointments or made last minute changes.

It starts even before they've come into my room. So that means really involving the whole staff, the whole team. (Dr Lin)

They're just two basic things about a clinic. One is access, so that traumatised people with chaotic lives feel like 'I can actually walk in and get help' and they're not struggling with, 'oh no, there's no appointment for 3-4 weeks ...'. And also, when they walk in, there's an attitude of welcome. Doesn't matter if you're smelly, or if you've got old clothes, or whatever, in some terrible situation - that you're a human being and your humanity is recognised. (Dr Mary)

Most GPs discussed a shortage of referral options to help support patients with complex, trauma-related health issues, particularly mental health support. Several spoke about experiences where they had involved other professionals in patients' care, including specialist and tertiary services, and were left frustrated at what was perceived as an approach that was not trauma-informed, describing rigid systems, limited scope for support and patients experiencing stigmatisation.

Almost all GPs described the challenges of time pressures and remuneration structures, which they felt made it difficult to allow adequate time and space in consults to take a trauma-informed approach. A small number of GPs also described a divide within their practice, between GPs who were caring for a large number of patients with complex, trauma-related histories and those who chose not to do so, and were remunerated more highly for a greater number of shorter consultations.

It's heavy lifting and the Medicare rewards are just pathetic. (Dr Hannah)

Nearly all GP participants had not received education on trauma-informed care in their medical training. Instead, several described proactively seeking out additional training and resources in their own time, and many discussed how the skills and understanding they had developed were simply through experience.

Discussion

This qualitative study sheds light on the ways in which GPs understand and practise trauma-informed care. Participants shared how a trauma-informed lens could open up a different understanding of their patients, bringing therapeutic value, greater patience and compassion. They saw a trauma-informed approach as prioritising the development of strong, trusting relationships ahead of trying to 'fix' their patients' issues, and being mindful of dynamics of power and control in their consultations. Trusting relationships with clinicians have consistently been highlighted as critical when caring for people affected by trauma and abuse.^{9,20} Importantly, in this study, GPs shared some of the ways in which they sought to build these relationships: allowing adequate time and space; being open, curious, and non-judgemental; choosing language carefully; and offering patients shared decision making. Similar approaches have been mentioned in a small number of other qualitative studies on managing trauma-related issues in primary care.^{14,15} Research seeking to define the craft of generalism has highlighted whole-person scope, relational processes and healing

orientation as among key principles of the generalist approach^{1,21} — values closely related to the established principles of trauma-informed care and themes identified in this study. Our findings arguably illustrate the importance of generalist settings like general practice in caring for people with histories of trauma and abuse.

A 'holding' approach, which has been described in limited primary care literature, might also capture these strategies: describing the development of a trusting clinical relationship, long-term support and the clinic being an emotionally safe space.^{14,22,23} 'Holding' also encompasses ongoing care and advocacy without the expectation of cure,²³ reflecting the move away from a focus on fixing their patients' problems that GPs described in this study. Embracing a shift in clinical mindset away from the role of 'fixer' has previously been found to aid clinicians in feeling more confident to address domestic violence in their practice.²⁴

The impact of power dynamics in clinical relationships has previously been highlighted in limited literature, particularly that exploring equity-oriented healthcare and trauma- and violence-informed care for First Nations communities.^{17,25}

GP participants felt supported in this work when the entire practice team understood trauma-informed care. They were frequently hindered by time pressures and remuneration structures that made it difficult to allow sufficient time and space in consultations, as well as limited and rigid referral pathways — findings that are consistent with other research on identifying and responding to domestic violence in primary care.^{24,26} When asked in the interview, most GP participants reported that they had not received formal education on trauma-informed care, though some had sought out extra training or resources in their own time. This is consistent with a known paucity of training on trauma-related issues such as domestic violence in Australian medical education.²⁷ Despite this lack of formal training, participants demonstrated an understanding of caring for people with histories of trauma that corresponded closely with the established principles of trauma-informed care. Several GPs described the emotional load of practising trauma-informed

primary care and their experiences of emotional exhaustion and secondary trauma. This correlates with other studies into clinicians' experiences navigating trauma-related issues in primary care,^{16,25,28} yet there is currently little insight into how GPs' own wellbeing can be supported.²⁹

Strengths and limitations

This study is one of the first to explore Australian GPs' perspectives on trauma-informed care in depth. Recruiting practising GPs with an interest in this field allowed a deep exploration of trauma-informed primary care from the clinician's perspective. We recognise, however, that the cohort of participants was small and findings cannot be generalised to a broader population of GPs. The understanding of, and attitudes towards, trauma-informed care among other GPs might vary widely. Time and funding constraints did not allow for further work to enhance credibility, such as triangulation of the data.

Conclusion

GPs' first-hand experiences and perspectives are essential in building an evidence-based understanding of what trauma-informed primary healthcare encompasses. These should be integrated with the viewpoints of other stakeholders, particularly patients with lived experience, and evaluation of trauma-informed interventions to develop a framework for trauma-informed general practice in Australia. For GPs to succeed in this work, there must be a shared understanding and integration of trauma-informed principles across the healthcare system, including in training programs. This also requires the unique value of general practice in caring for patients with histories of trauma to be recognised, and primary care to be structured and funded in a way that supports GPs to take the time and space required to build trusting relationships with their patients. Finally, the personal impact on GPs of managing complex, trauma-related issues within an imperfect system must be recognised. Greater understanding and implementation of structures to support GPs' own wellbeing is desperately needed to prevent clinician burnout and to ensure the sustainable, long-term delivery of trauma-informed primary care.

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Competing interests: None.

Funding: This research was supported by The Royal Australian College of General Practitioners with funding from the Australian Government under the Australian General Practice Training Program, as well as the National Health and Medical Research Council (NHMRC) through the Centre for Research Excellence in Safer Families (grant number 1116690).

Provenance and peer review: Not commissioned, externally peer reviewed.

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Acknowledgements

The authors wish to thank the participants in this study for their generosity in sharing their perspectives. They would also like to thank Kitty Novy from the Department of General Practice and Primary Care at The University of Melbourne for her support with the project.

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