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Brief Report

Resident Physicians' Perceptions of Trauma Informed Care: Findings from a Small-scale Descriptive Study

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ABSTRACT

Introduction. Screening for adverse childhood experiences (ACEs) is a significant component of trauma informed care (TIC), as intervention can mitigate negative health outcomes. However, as few as 4% of physicians with pediatric patients screen and intervene for all ACEs. The authors of this study sought to: 1) understand resident physicians' perceptions of TIC; 2) identify areas of training needed to improve screening and intervention of ACEs.

Methods. This descriptive study occurred in a large Midwestern Family Medicine residency and involved a convenience sample of 38 resident physicians. Participants completed a survey, which included a total of 22 Likert-scale and open-ended questions. Descriptive frequencies were used to represent Likert-scale responses, and the open-ended questions were analyzed utilizing a thematic analysis approach.

Results. Participants identified screening for ACEs as useful. However, they reported a lack of confidence in their ability to screen and intervene. Barriers to screening and intervention also were noted and included lack of time, discomfort in assessment, perceived inability to help, insufficient knowledge and skills, and competing primary care recommendations.

Conclusions. Family Medicine residents identified the screening and intervention of ACEs to be important. However, lack of confidence, competing primary care recommendations, and concern for receptiveness can deter residents from screening and intervention. Based on this study's findings, the authors recommend that graduate medical education focuses on building systems of training that provide learners with the knowledge, skills, and resources to routinely screen and intervene for ACEs in primary care. ***Kans J Med 2023;16:264-268***

INTRODUCTION

Screening for adverse childhood experiences (ACEs) is a significant component of trauma informed care (TIC), as interventions can help mitigate negative health outcomes.[1-6] The American Academy of Pediatrics has called on physicians to address toxic stress as part of routine patient care.[5,6] However, a study surveying 302 physicians with pediatric patients found as few as 4% screen and intervene for all ACEs.[6,7] Physician perceived barriers to screening and intervention include lack of training and knowledge,[4,6-10] time constraints,[4,6-9] lack of resources,[4,6-8] diminishing physician-patient rapport,[4,6,10,11] and increased mandated reporting.[4,6,10] However, prior literature indicates that screening and intervention can actually improve physician-patient rapport and incidents of mandated reporting should not increase as neglect, abuse, and exploitation should be assessed regardless of ACEs score.[11-13]

This descriptive study was conducted in an 18-18-18 Midwestern Family Medicine (FM) residency program and was sought to: 1) understand resident physicians' perceptions of TIC; and 2) identify areas of training needed to improve screening and intervention of ACEs.

METHODS

In the fall of 2018, screening for ACEs became a standard practice within the embedded pediatric clinic. Children aged 4 to 18 received annual ACEs screening. Prior to the launch of the screening, all residents received training in 1) ACEs science; 2) components of TIC; 3) screening approaches; and 4) ACEs intervention methods. Training was provided by a director of BH, a pediatrician, and a TIC specialist during two 45-minute didactic sessions that spring. Incoming residents received one 90-minute training during orientation.

In the fall of 2019, study participants completed a survey questionnaire titled, "Resident Physicians' Perceptions of Screening for Adverse Childhood Experiences" during educational didactics and following resident physicians training in ACEs science. This survey was based on an original, validated tool titled "Screening for Childhood Trauma in Adult Primary Care Patients,"[10,14] which was adapted with permission from the authors. The survey consisted of 22 Likert-scale and open-ended questions. Descriptive frequencies were used for Likert-scale responses. To maintain fidelity with the methodology of the original survey,[10,14] dichotomous variables were created as follows: 1) usefulness of screening, "not at all/somewhat" versus "moderately/very"; 2) confidence in ability to screen and to follow-up, "not at all/somewhat" versus "moderately/very"; 3) behavior and medication intervention, "rarely or never/sometimes" versus "usually/always"; 4) addressing adversity at follow-up, "rarely or never/sometimes" versus "usually/always"; and 5) barriers to screening were dichotomized as "major" versus "minor/no barrier". The open-ended questions were analyzed independently by researchers (RN, RE) using thematic analysis.[15] The hosting university's Institutional Review Board approved this study.

RESULTS

Quantitative Results. Fifty-four FM residents were invited to complete the survey, and 38 elected to participate for a participation rate of 70.4%. Sample size calculations were not utilized, as all residents were invited to participate. Demographics of the participants are identified in Table 1. Sixty-two percent of participants (23/37) had not reviewed an ACEs screening. Fifty-one percent (19/37) identified screening as useful, but 62% (23/37) lacked confidence in "ability to screen" and 78% (29/37) lacked confidence in "following-up with information collected". In responding to a history of ACEs, 64% of participants (23/36) indicated they suggested a BH referral, 65% (24/37) were not likely to offer medication to relieve relevant symptoms, and 81% were not likely to bring up the adversity at subsequent visits (Table 2).

Table 1. Participants' demographic information (N = 38).

Gender	N	%
Female	21	55.3
Male	17	44.7
Post graduate year		
PGY1	13	34.2
PGY2	14	36.8
PGY3	10	26.3
Missing	1	2.6
Prior ACEs training		
None	16	42.1
In residency	15	39.5
In medical school	6	15.8
Missing	1	2.6

Only two major barriers to screening were identified by participants: "not enough time to ask about a history of childhood adversities" (70.3%; 26/37) and "not enough time to fully evaluate or counsel victims of childhood adversities" (83.8%; 31/37). All participants (100%; 37/37) indicated that their patients' ACEs history and their ability to be reimbursed by insurance did not represent a barrier to screening. Thirty-five (94.6%) indicated that a concern for re-traumatizing their patients by screening was not a major barrier, nor was a concern of offending patients (91.9%; 34/27). Additionally, 28 participants (75.7%) did not see helping patients with a history of ACEs as a major barrier. Thirty-six respondents (97.3%) noted that they were not "uncomfortable inquiring about psychosocial issues" and that "competing primary care recommendations" was not a major barrier to screening (73.0%; 27/37). Finally, 97.3% (36/37) indicated that viewing childhood adversities as a medical problem and difficulties in verifying reports of reported ACEs (89.2% 33/37) were also not major barriers (Table 3).

Qualitative Results. Participants provided open-ended responses regarding experiences of ACEs screening and intervention. Thematic analysis extracted 18 significant statements and three themes: 1) screening and intervention are important; 2) brief encounters can pose challenges; 3) increased knowledge and skills in addressing patient resistance are desired (Table 4).

Table 2. Participants' attitudes and behaviors related to screening for ACEs (N = 38).

	n (%)
Usefulness of screening for ACEs in patients	
Not at all useful	3 (8.1)
Somewhat useful	15 (40.5)
Moderately useful	11 (29.7)
Very useful	8 (21.6)
No answer	1 (2.7)
Confidence in ability to screen for ACEs	
Not at all confident	4 (10.8)
Somewhat confident	19 (51.4)
Moderately confident	10 (27.0)
Very confident	4 (10.8)
No answer	1 (2.7)
Confidence in own ability to follow-up with ACEs information	
Not at all confident	12 (32.4)
Somewhat confident	17 (46.0)
Moderately confident	7 (19.0)
Very confident	1 (2.7)
No answer	1 (2.7)
Suggested behavioral health referral	
Rarely or never	0 (0.0)
Sometimes	13 (36.0)
Usually	17 (47.2)
Always	6 (16.7)
No answer	2 (5.6)
Offered medication to help relevant symptoms	
Rarely or never	8 (21.6)
Sometimes	16 (43.2)
Usually	11 (29.7)
Always	2 (5.4)
No answer	1 (2.7)
Bring up childhood adversity at subsequent visits	
Rarely or never	8 (22.2)
Sometimes	21 (58.3)
Usually	7 (19.4)
Always	0 (0.0)
No answer	2 (5.5)

Table 3. Participants' reported barriers to screening for ACEs (N = 37).

	Major Barrier n (%)	Minor Barrier n (%)	Not a Barrier n (%)
Not enough time to ask about a history of childhood adversities	26 (70.3)	10 (27.0)	1 (2.7)
Not enough time to fully evaluate or counsel victims of childhood adversities	31 (83.8)	6 (16.2)	0 (0.0)
Uncomfortable inquiring about psychosocial issues	1 (2.7)	24 (64.9)	12 (32.4)
The minor female patients I see are unlikely to have been victims of childhood adversities	0 (0.0)	4 (10.8)	33 (89.2)
The minor male patients I see are unlikely to have been victims of childhood adversities	0 (0.0)	4 (10.8)	33 (89.2)
A history of childhood adversities is not a medical problem	1 (2.7)	1 (2.7)	35 (94.6)
Concern that asking about a history of childhood adversities may re-traumatize my patient	2 (5.4)	16 (43.2)	19 (51.4)
There is little I can do to help those patients who have revealed a history of childhood adversities	9 (24.3)	14 (37.8)	14 (37.8)
Concern about offending my patients by asking about a possible history of childhood adversities	3 (8.1)	19 (51.4)	15 (40.5)
No reimbursement to me for screening for childhood adversities	0 (0.0)	10 (27.0)	27 (73.0)
Difficult to verify reports of histories of childhood adversities	4 (10.8)	17 (46.0)	16 (43.2)
Competing multiple primary care recommendations	10 (27.0)	9 (24.3)	18 (48.7)

DISCUSSION

This study identified FM residents' perceptions of TIC and areas of needed training. It built upon relevant literature[1-13] and is unique in that screening and intervention of ACEs were standard within an embedded pediatric clinic. Findings indicated that over half of surveyed residents believed screening for ACEs is important. Despite this, less than half felt confident in screening and intervention.

Like relevant literature,[1-13] two major barriers related to lack of time for screening and intervention were identified. Conversely, resident physicians recognized the prevalence of ACEs, as well as their role to screen and intervene. Open-ended responses iterated the importance of ACEs screening and intervention and challenges posed by time limitations. Responses also indicated residents' desire for increased training on addressing patient resistance to screening. This desire may be an indication of preconceptions and inexperience as patient resistance is converse to the literature.

Table 4. Participants' reported experiences of ACEs screening and intervention.

Themes	Selected Significant Statements
Theme 1: *Screening and intervention for adverse childhood experiences (ACEs) is important.*	1. "It's good to identify [at-risk] youth and refer them to relevant support systems, such as psychotherapy." 2. "Screening is important as ACEs have [long-term] health related effects on patients." 3. "Most parents/families appreciate their doctor caring about the long-term effects of ACEs."
Theme 2: *Feasibility of screening & intervention can be challenging.*	1. "Screening extends visits when addressing [at-risk] scores... which can be challenging when other medical concerns need to be addressed." 2. "...we need to extend encounter lengths to adequately address ACEs." 3. "Screening is probably helpful but seems like just another thing we must do to check a box."
Theme 3: *Knowledge & skills are needed in addressing resistance to screening & intervention.*	1. "I am concerned we do not know what to do with relevant information once we have screened for ACEs." 2. "I have had few extended discussions based on screening results." 3. "Few families [identified at-risk] have been receptive to intervention."

From the findings of this study, the authors hypothesized the outcomes of the following training changes. First, if training was provided prior to each pediatric outpatient rotation, residents may have had increased knowledge and confidence in screening and intervention. As it was, some residents were trained over a year prior to their first rotation in the pediatric clinic. Second, a structured clinical examination would have provided residents the opportunity to practice screening and intervention in a safe yet "real world" environment. Third, if this survey had initially been given to residents prior to training, training modifications could have been made to target identified barriers.

Next steps include incorporating the changes noted above and the expansion of screening for ACEs. Incorporating pediatric and adult screening into the family medicine clinic will significantly increase screening volume. To efficiently expand screening, it is essential clerical support is provided. These steps will likely increase residents' confidence, decrease discomfort, mitigate time restraints, and normalize screening and intervention as routine care.

Limitations. There are several limitations to this study. First, findings may not be generalizable as this study included a single-center, Midwestern FM residency setting. Second, the retrospective nature of the surveys may be prone to recall bias, and there may be some social desirability bias due to the nature of some questions. Third, participants may also have been primed by the questionnaire when answering the open-ended questions. Fourth, the data from this study was collected four years ago; however, findings remain relevant.[16]

CONCLUSIONS

The FM residents who participated in this study identified the screening and intervention of ACEs to be important. However, lack of confidence, competing primary care recommendations, and concern for receptiveness were identified as barriers to screening and intervention. Although future research is needed to further evaluate training approaches, it remains pertinent for graduate medical education to focus on building systems of training that provide learners with the knowledge, skills, and resources to routinely screen and intervene for ACEs in primary care. For review of training materials currently available, see Appendix A (Available online only at journals.ku.edu/kjm).

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