

GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ
FREQUENTLY ASKED QUESTIONS

PODCAST WEBINAR

What To Teach Your Registrar About Identifying and Treating Patients with a History of Childhood Trauma

According to the 2016 ABS Personal Safety Survey, at least 1 in 8 individuals presenting in general practice have experienced physical or sexual trauma during childhood – a conservative figure based on proxy data from Child Protective Services, not taking into account other forms of trauma such as neglect or physical or emotional abuse.

A more recent survey investigating sexual abuse has revealed that as many as 1 in 6 men and 1 in 3 women have experienced this particular form of trauma as minors, which suggests the true prevalence of childhood trauma across the Australian population may be much greater than the 13% asserted in the earlier study.

Adverse Childhood Experiences ("ACEs") can impact a person in many different ways throughout their life. GPs who recognise this in the context of how many of their patients are likely to have suffered trauma as a child, have an advantage in delivering better health outcomes.

Supervisors who recognise that their registrars may also have had ACEs, and enable them to perceive their role as caring for a multi-layered person, not just treating a patient's symptoms, can help the next generation of GPs apply lateral thinking to complex diagnoses while playing a vital role in breaking a transgenerational cycle of abuse.

What are the opportunities associated with a focus on identifying and treating childhood trauma?

Good general practice relies on the core principles of high quality, safe and effective healthcare, regardless of the patient's background or identity.

Comprehensive, patient-centred, relationship-based primary care enhances professional skills and general practice.

Applying the key principles of **listening** and **engaging** to understand why the person is presenting in a certain way, and approaching care in a **targeted** and **collaborative** manner can alleviate emotional distress for the patient, GP and care team while providing an opportunity for your registrar to learn about:

- patient-centred, holistic, medicine
- psychiatric, psychological and social determinants of health
- management of chronic diseases and multimorbidity
- how to use Medicare and practice systems appropriately.

Relevance to exams

Domain 1: Communication skills and the patient-doctor relationship (communication skills, patient centredness, health promotion, whole person care)

Domain 2: Applied professional knowledge and skills (physical examination and procedural skills, medical conditions, decision making)

Domain 3: Population health and the context of general practice (epidemiology, public health, prevention, family influence on health, resources)

Domain 4: Professional and ethical role (duty of care, standards, self appraisal, teacher role, research, self care, networks)

Domain 5: Organisational and legal dimensions (information technology, records, reporting, confidentiality, practice management.)



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What is childhood trauma?

Childhood trauma, or ACEs, describes all types of abuse, neglect, and other potentially traumatic experiences occurring before a person reaches 18 years of age.

Trauma may be defined as the response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causes feelings of helplessness, diminishes their sense of self and their ability to feel the full range of emotions and experiences.

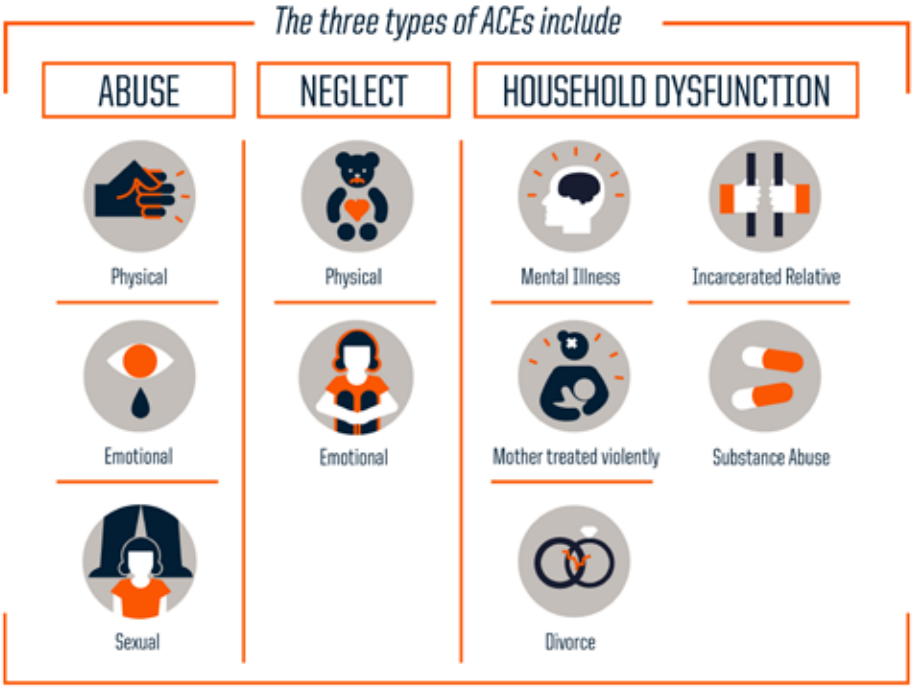
Trauma is subjective in nature and need not be deliberate or the result of mistreatment to have a lasting effect. One example is a young child with leukaemia who experiences hospitalisations as deeply traumatic despite no intent to harm on the part of the caregivers. Leaving this experience of trauma unresolved can potentially be as damaging in one individual as letting an ACE involving abuse or neglect go unrecognised in another.

Related definitions can be found on the Centers for Disease Control website (**child abuse and neglect**: www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) and the International Classification of Diseases website (**complex post-traumatic stress disorder or C-PTSD**, which was endorsed as a new diagnosis by the member nations of the World Health Organisation in May 2019, and is due to come into effect from 1 January 2022: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559).

What are the 10 ACEs GPs should be aware of?

- physical abuse
- sexual abuse
- emotional abuse
- physical neglect
- emotional neglect
- exposure to family violence
- parental substance use
- parental mental illness
- parental separation or divorce
- parental incarceration.

Contrary to widespread belief, these adversities are not experienced only, or predominantly, by certain population sub-groups. While children experiencing poverty and / or belonging to vulnerable Australian populations – for example, Aboriginal and Torres Strait Islanders, juvenile offenders, and children involved in welfare services – do have an increased risk of multiple ACEs, 20+ years of research has consistently shown widespread exposure to ACEs: across all demographics.



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The ACE questionnaire

There are several different ACE questionnaires available online.

The basic 10-question quiz (text form; online survey form) is helpful in raising awareness of the potential impact of ACEs and starting a conversation. Due to the brevity of this quiz, however, it cannot provide a full picture of the adversity an individual may have faced before turning 18.

A more comprehensive questionnaire has been prepared by the World Health Organisation. This can be downloaded (including notes / explanations for the GP) at https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq).

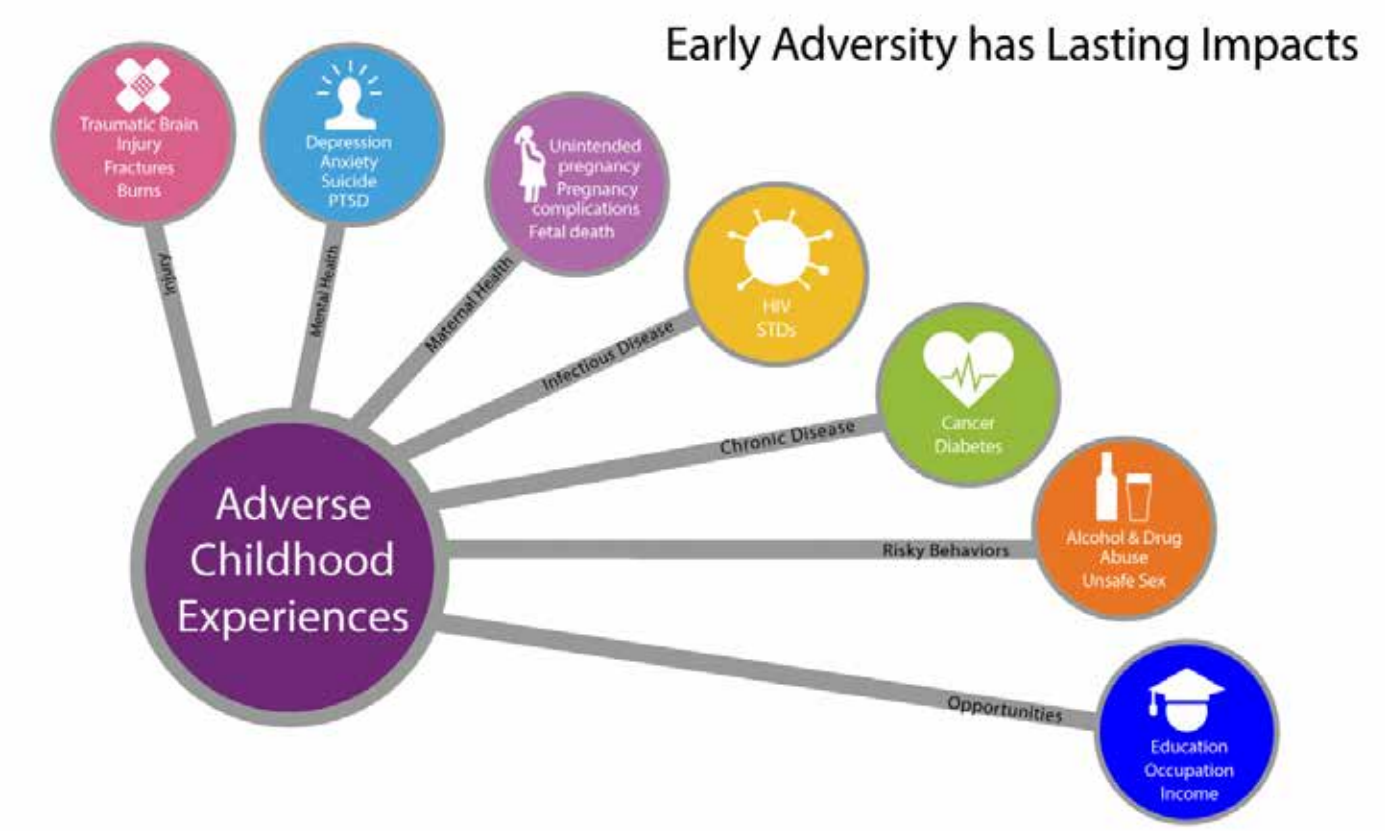
If we don't ask, we won't know.

What are the known links between childhood trauma and poor health outcomes?

Experiences of childhood trauma, or ACEs, have broadly been linked to:

- risky health behaviours
- chronic health conditions
- low life potential
- early death.

Although the presence of ACEs does not necessarily mean a child will experience poor health outcomes, it has been shown that the risk for the above outcomes increases in line with the number of ACEs.

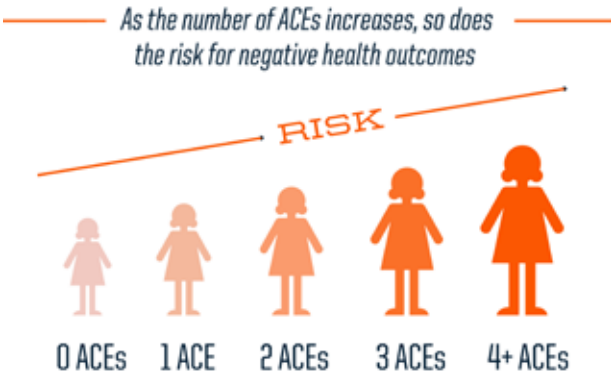


Source: Linking Adverse Childhood Experiences to health behaviors. From the Centers for Disease Control and Prevention. 2019.



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How does the number of ACEs impact on health outcomes?

Where multiple forms of trauma have occurred, cumulative trauma is markedly more damaging than single-episode trauma.

Compared to people with zero ACEs, the increased risk for an adult who scores 4 or more on the ACE quiz (ie has experienced 4 categories of Adverse Childhood Experiences) is known to be:

- depression x 4600%
- suicide x 1200%
- alcoholism x 700%
- underage sex (before 15 y-o) x 600%
- emphysema x 400%
- COPD x 250%
- heart disease x 200%
- cancer x 200%
- smoking x 200%

People with high ACE scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, more auto-immune diseases, and more work absences.

https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/

What does the GP need to take into account when managing adult survivors of childhood trauma?

- Childhood trauma is common, complex, and takes time to diagnose.
- Mind and body are interconnected so always keep this in your awareness for every patient, but especially for those who:
  - present with difficult to treat conditions (eg chronic pain);
  - present with conditions that are difficult to explain (eg chronic fatigue);
  - present with emotional issues;
  - present as guarded;
  - have compliance issues; or
  - appear to be very dependent.
- We do not need to hear their trauma story – but if they know we know something bad has happened to them, and we are non-judgmental /empathetic, that is often enough.
- The relational component of the consult is crucial. GPs do this very well. We are in there for the long haul… from cradle to coffin.
- You don't need to rush the process.
- GPs can become a very important if not integral person in helping them recover - most importantly helping them to feel safe/learn how to trust others.
- Many GPs struggle with the need to "sit with uncertainty", feeling unsettled when required to support a patient in distress without attempting to "fix the problem"… but we can learn some simple strategies to help stabilise a patient who is an adult survivor of childhood trauma.
- The therapeutic relationship can be further complicated if the GP has personal experience of childhood trauma.



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What is intergenerational trauma?

Intergenerational trauma is almost always associated with a loss of safety (emotional, psychological, physical, financial, etc).

Intergenerational trauma occurs when trauma is transferred to the next generation by people who have not had an opportunity to heal from the trauma they have experienced or witnessed in childhood.

It can be passed on through (unintentional) normalisation of toxic stress, poor parenting practices, behavioural problems, violence, substance abuse and mental health issues. A parent who has experienced trauma can impact their attachment style, which then passes down further ACEs to their own children.

Entire families and groups may become "infected" with the trauma and unconsciously perpetuate traumatic experiences for themselves and their children – most notably seen in families dealing with alcoholism or drug use.

Recent research has even demonstrated epigenetic, molecular and biochemical mechanisms for this transmission.

This may help to explain why intergenerational trauma is widely considered to be the main contributor to the collection of diseases suffered in disproportionate numbers by Aboriginal and Torres Strait islander people:

- chronic disease, including diabetes, cardiovascular disease, rheumatic heart disease, renal disease
- infectious diseases, like scabies, otitis media, STIs;
- mental health problems, including depression, psychotic conditions, and drug and alcohol problems.

How should the GP ask about adverse childhood experiences (ACEs)?

Research indicates that we don't need to directly ask or hear about the trauma experience.

The ACE quiz can be incorporated into the initial patient history questionnaire or offered as a separate form for them to complete before seeing the GP, whether in the waiting room or at home. This provides the opening to ask if they would like to "talk" about the areas they ticked. If they say no, that is absolutely ok. It is still therapeutic that they know we know and we can be a safe place to go to if needed when they are ready (often when trust has been established).

Eliciting information about trauma

With many adults who have experienced severe trauma not remembering or recognising their childhood as abusive, and / or without access to the ACE quiz, the GP needs to draw out the information through questions such as:

- 'Was your home a safe and secure place?'
- 'What were you like as a young child?' (Children who have been abused often have a highly negative self-image of themselves, such as 'My mother said I was born angry' or 'I was ugly and everyone said I was stupid')
- 'Were you asked to keep any secrets as a child?'
- 'What happened when you were punished as a child?'
- 'Did anything happen to you in childhood that hurt you?'
- 'Did anything happen around you that made you feel unsafe?'
- 'Was there someone you could turn to when life was difficult?'

Identifying a person's strengths and supports

This is crucial and can be therapeutic.

We develop this by getting to know the patient/ being curious/ getting a deep narrative of this person's life story (past, present, and future dreams).

- What coping strategies have they found helpful in the past?
- If the coping strategies are maladaptive (eg substance abuse, food restriction/purging, self-harm or other risky behaviour), then explore further until a coping strategy that is less maladaptive has been identified.

Asking about lifestyle choices can uncover clues for further exploration leading to advice. This is something we already do for our patients… SO KEEP DOING IT!

Potential coping strategies include:

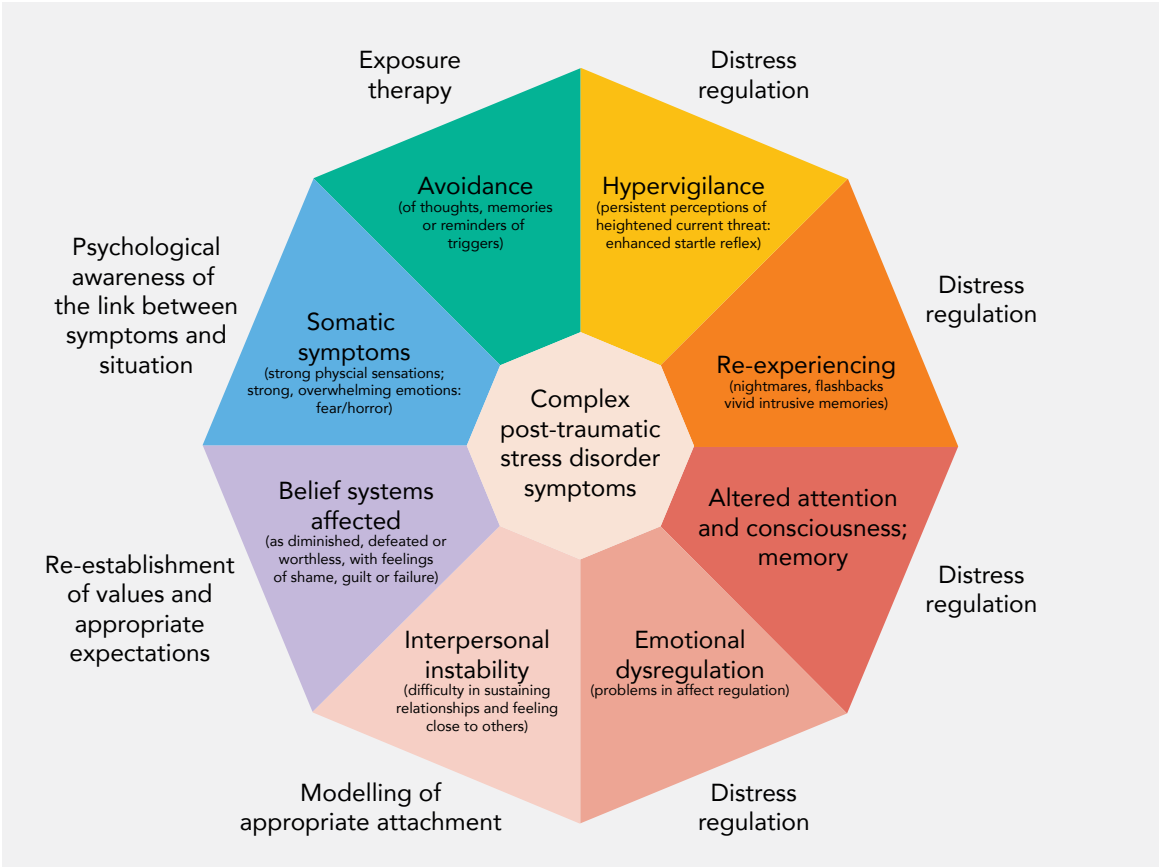
- lifestyle factors (sleep, exercise, diet)
- distraction
- connection with others
- pursuing meaning and purpose in life (eg meaningful work, volunteering, advocacy, caring for others)
- creative pursuits
- various forms of therapy.



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Diagnosing and treating complex PTSD



A model of complex post-traumatic stress disorder with potential general practice interventions Adapted from the International Society for Traumatic Stress Studies guidelines and the World Health Organization's International Classification of Diseases, 11th Revision. Su WM, Stone L. Adult Survivors of childhood trauma: Complex Trauma, complex needs. AJGP Jul 2020, 49(7):423-430 DOI: 10.31128/ajgp-08-19-5039

PTSD is complex, and takes a long time to identify and work through.

Nobody is better placed to offer the safe therapeutic relationship this requires than the GP who demonstrates to their patients that they are worthy of time, respect and empathy.

Given the complexity of symptomatology experienced by survivors, many will have acquired a raft of diagnoses, including depression, anxiety, panic disorder, psychosis and borderline personality disorder. This is confusing for patients and their GPs. However, symptoms can be clustered together to form a unifying diagnosis of complex PTSD.

This type of PTSD is 'complex' because of the developmental consequences of early trauma; a child is developing their core sense of self, learned behaviour, expectations of relationships and neurological system, and all this is disrupted by trauma.

Crossover with borderline personality disorder ("BPD")

It is important to note the crossover of borderline personality disorder and complex PTSD.

Many patients with complex PTSD will have previously been diagnosed with borderline personality disorder and experienced the stigma associated. This is a trauma in itself. Unfortunately, our current mental health system simply re traumatizes a lot of these patients.

A person with complex PTSD may have severe personality disorder or no personality disorder, where they have persistent feelings of shame or poor self-worth that do not affect functioning.



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Managing complex PTSD

This takes time, respect, validation and empathy.

Being a compassionate GP is often all that is needed:

- sensitive to suffering
- sympathetic
- empathetic
- non-judgmental
- having a distress tolerance (being comfortable with discomfort and uncertainty)
- having care for our own wellbeing.

We don't need to re witness the trauma. This can actually be harmful if we as GPs don't know how to stabilise the patient and / or don't have resources to refer them to for treatment.

Intervention

Intervention is helpful if there is functional impairment or significant distress and the patient is ready to address this.

Treatment options (if the client is willing) include:

- referral to trauma-informed specialist;
- referral to therapies such as:
  - EMDR
  - DBT
  - family-couple therapy
  - internal family systems
  - sensorimotor therapy
  - mentalisation
  - narrative therapy.
- medication.

How should the GP manage the consultation?

- Make sure you are working together, collaboratively, with the patient
- Empower the patient to work on what they can, in a way that is not overwhelming
- Slow things down
- Be respectful of time
- Set realistic expectations – for both of you
- Don't be afraid to have difficult conversations, but do learn skills to help these conversations go better (time, place, support)
- Be aware of your own self within the consultation.

Where might the registrar get into trouble?

Organisational aspects of care:

- Time/ structural constraints/ finances
- Demographics based on gender
- Lack of insight of the underlying issues
- May not be identifying that these things are linked
- Difficulty asking this question
- Responding to vs "sitting with" distress
- Registrar expectations for a "successful" consultation
- Registrar and patient alignment
- Complexity allocation
- Sitting with uncertainty
- Diagnostic overshadowing.

Self-care and awareness of interpersonal dynamics; transference and counter-transference

- Triggering
- Vicarious trauma
- Falling for the "rescuer" trap
- Boundaries
  - Loose boundaries/ over - empathising/ oversharing
  - Excessive boundary creation
- Registrars who are not empathic
- Silo-ing:
  - Not seeing mental health as 'my' problem
- Burn out



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Coping with difficult or complex cases

- Be human
- Be compassionate
- Validate, validate, validate!

Within the consultation

Give your patient time to talk, and congratulate them for trusting you enough to be vulnerable.

Offer to see them again and book a longer consult

Remember YOU don't need to problem-solve or fix the issue: it is simply enough to listen and provide a safe space

It's NOT your responsibility to:

- Diagnose
- Pathologise
- Tick boxes

Using active listening skills - OARS:

- open-ended questions
- affirming
- reflecting
- summarising

Mentorship, peer support, and managing your own stress

It's vital that you as the GP look after your own health as you would for your patients.

- Debrief with, or even organize supervision by, a mentor or peer you feel safe with
- Know your own coping style
- Avoid unhelpful strategies
- Build on relationships and support
- Access practitioner-specific support:
  - The Doctors Clinic
  - Drs4Drs
  - RACGP GP Support Program
  - AMA Doctors for Colleagues (this is a state-by-state service, eg https://amavic.com.au/assistance-for-doctors/Support-Programs/peer-support-service)

References and resources

Su WM, Stone L. Adult Survivors of childhood trauma: Complex Trauma, complex needs. AJGP Jul 2020, 49(7):423-430 DOI: 10.31128/ajgp-08-19-5039

Australian Institute of Health and Welfare 2020. Australia's children. Cat. no. CWS 69. Canberra: AIHW

Field TA, Beeson ET, Jones LK. The new ABCs: A practitioner's guide to neuroscience-informed cognitive-behaviour therapy

Koffman, Andrew et Walters, M. Grace. (2014) Introduction to Psychological Theories and Psychotherapy. Oxford University Press

https://oxfordmedicine.com/view/10.1093/med/9780199917969.001.0001/med-9780199917969

Dahlitz, Matthew. The Psychotherapist's Essential Guide to the Brain – Memory. Neuroscience, May 1 2017

Alan Schore – The neurobiology of secure attachment

The White Book www.racgp.org.au/whitebook

Blue Knot Foundation https://www.blueknot.org.au/

Project Air https://www.projectairstrategy.org/index.html

Naylor et al. The Kings Fund 2016 report: Bringing together physical and mental health. A new frontier for integrated care. March 2016. The King's Fund. Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf (This report has examples focused upon both primary and secondary care. It is UK based but can also be helpful within the Australian context. The introduction gives a helpful summary of the impact on unexplained medical illness from a public health and practice perspective.)

Stone L. Managing medically unexplained illness in general practice. Australian family physician [Internet]. 2015;44(9):624. Available from: https://www.racgp.org.au/afp/2015/september/managing-medically-unexplained-illness-in-general-practice/

Stone L. Blame, shame and hopelessness: medically unexplained symptoms and the 'heartsink' experience. Australian family physician [Internet]. 2014;43(4):191-195. Available from: https://www.racgp.org.au/afp/2014/april/blame-shame-and-hopelessness/

Emerging Minds and Australian National University. ACEs: Summary of Evidence and Impacts, January 2020 https://d2p3kdr0nr4o3z.cloudfront.net/content/uploads/2020/02/19102540/ACES-Summary-of-Evidence-and-Impacts-V2.pdf

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GPSA is supported by funding from the Australian Government under the Australian General Practice Training Program 26/04/22