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Unpacking complexity: GP perspectives on addressing the contribution of trauma to women's ill health

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Abstract

Background: There is an intricate relationship between the mind and the body in experiences of health and wellbeing. This can result in complexity of both symptom presentation and experience. Although the contribution of life trauma to illness experience is well described, this is not always fully recognised or addressed in health care encounters. Negotiating effective and acceptable *trauma informed* conversations can be difficult for clinicians and patients.

Aim: To explore the experience of primary care practitioners caring for women through a trauma informed care lens.

Design and Setting: Qualitative study in the general practice setting of England, with reflections from representatives of a group with lived experience of trauma.

Methods: A secondary thematic analysis of 46 qualitative interviews conducted online/by telephone to explore primary care practitioner's experiences of supporting women's health needs in general practice, alongside consultation with representatives of a lived experience group to contextualise the findings.

Results: Four themes were constructed: you prioritise physical symptoms because you don't want to miss something; you don't want to alienate people by saying the wrong thing; the system needs to support trauma informed care; delivering trauma informed care takes work which can impact on practitioners.

Conclusion: Health Care Practitioners are aware of the difficulties in discussing the interface between trauma and illness with patients, and request support and guidance in how to negotiate this supportively. Lack of support for practitioners moves the focus of trauma informed care from a whole systems approach towards individual clinician – patient interactions.

Keywords: Communication, Trauma Informed Care, Complexity, General Practice.

How this fits in:

- Significant challenges and uncertainties reside in how best to manage the link between mind and body in communication with patients and in healthcare pathways.
- Lack of supportive resources to deliver holistic, trauma informed care risks practitioners (inadvertently) avoiding discussion of the contribution of distress in the illness presentation.
- A trauma informed *systems* level approach would support integration of psychological support within multiple care pathways and support wellbeing of practitioners providing care.

Background

As evident in the Women's Health Strategy for England¹ and its underlying public consultation², women's health is complex and embedded in historical dismissal and stigma. There is an intricate relationship between the mind and the body in experiences of health and wellbeing. One facet of this complexity includes the possible contribution of trauma to the woman's illness experience. The physical response to, and pathways of bodily damage as a result of, the hormonal environment of chronic stress, has revealed links between unresolved emotional distress and autoimmune conditions³. Trauma impacts people in different ways. Whilst some people make positive adjustments, others experience mental ill health and/or develop physical symptoms from emotional distress⁴. This can result in complexity both in symptom presentation and health experience.

Trauma can result from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening and can include past experiences of care (including in maternity), adverse childhood events (ACEs), and other life experiences as an adult. ACEs are stressful or traumatic events that occur specifically during childhood or adolescence⁵ and can include: abuse (physical, emotional, and sexual); neglect; living in a household with domestic violence, experience of illness and bereavement⁶. In a systematic review and meta-analysis of 96 studies of adult health behaviours, the risk of poorer health outcomes (including cardiovascular disease, respiratory and gastrointestinal disorders and mental ill health) increased with the number of ACEs⁴. Experiences of trauma at any stage in life can cause lasting adverse effects on health³. In the UK, women are disproportionately affected by violence (twice as likely as men to suffer domestic violence)^{7,8}, trauma^{9,10}, and ill health^{11,12} highlighting the potential complexity of women's health presentation.

Although the contribution of life trauma to illness experience is well described, Primary Care Professionals (HCPs) do not always fully address it. Potential reasons include clinician concerns about missing a serious illness in a complex presentation, or about alienating or upsetting the patient¹¹. Addressing trauma often necessitates introducing conversations about the link between mind and body, which can be difficult to navigate. Significant challenges and uncertainties reside in how best to manage the link between mind and body in communication with patients and in healthcare pathways. Qualitative research indicates that PCPs can find it challenging to navigate this mind-body presentation. Suggestions from PCPs that physical symptoms are amplified by (or a manifestation of) distress can be experienced as dismissal and invalidation by patients^{14,15}. Therefore, attempts to bridge these health needs are not always experienced as supportive. This illustrates the potential challenges of negotiating *trauma informed* conversations in ways that are experienced as acceptable and supportive by patients.

Trauma informed care is a framework founded on five core practices: safety, trustworthiness, choice, collaboration, and empowerment, to address the impact of trauma on patients and healthcare professionals and prevent re-traumatization in healthcare services¹⁶. However, definitions, guidance, practitioner training, delivery, and support for trauma informed approaches vary between healthcare

settings according to local level funding priorities with implementation described as disjointed¹⁶. Little is known about how HCPs experience trying to effectively **deliver** trauma informed care. The aim of this paper is to explore the experience of primary care practitioners caring for women through a trauma informed care lens.

Method

This study was a secondary analysis of qualitative interview data gathered to explore primary care practitioner's experiences of supporting women's health needs in primary care. Between March and September 2022, we interviewed a sample of 46 primary care practitioners across England (General Practitioners = 31, Nurses = 9, other professionals =6, with an average of 12 years' experience (1-30 years), 41/46 female), ensuring representation from practices working in areas of deprivation where health inequalities and multi-morbidity are significant challenges. Detailed methods and participant characteristics of the parent study are reported elsewhere¹⁷.

The original topic guide was developed by three authors in response to a perceived gap in knowledge about women's healthcare in primary care, and commissioned by the National Institute of Health Research (NIHR) Policy Research Programme. Data were collected through single episode, one-to-one interviews with fully informed consent. They were conducted virtually online or by telephone by two experienced qualitative researchers and audio-recorded. These were transcribed verbatim, checked against the original recording, and thematically analysed. The team then undertook a focused enquiry using secondary thematic analysis of the dataset to explore PCPs navigation of women's experiences of distress as a contribution to their symptoms¹⁸. We recoded the transcripts line-by-line where distress, emotional or psychological impact or contribution to health experience was mentioned. We discussed the constructed data categories within the research team to create interpretive themes. We reflected on these themes with representatives of three charities supporting women with significant experience of historical and contemporary trauma to add a lived experience perspective to the data.

Results

Four themes were constructed from the data: 1. you prioritise physical symptoms because you don't want to miss something; 2. you don't want to alienate people by saying the wrong thing; 3. the system needs to support trauma informed care; 4. delivering trauma informed care takes work which can impact on practitioners.

Theme 1: You prioritise physical symptoms because you don't want to miss something

Practitioners described women's health consultations as often complex and difficult to manage in a single, constrained time slot. A significant concern was the fear of missing a physical condition

requiring specific or prompt treatment, as many women's health complaints could present with similar but vague symptomatology and could suggest multiple possible diagnoses. Some participants reflected that a challenge of navigating diagnostic processes by first excluding potential causes that need specific interventions, such as cancer, meant the contribution of distress to physical symptoms was pushed down the list of considerations.

PC17: it's definitely sort of a symptom sieve to start with, and to adequately hear your patient and really hear them and really listen to what they're saying.[...] There are many things that are difficult to do in 10 minutes, but I... women's health is particularly difficult.

PC12: they're often quite vague symptoms: bloating, things like that, so you either have a very low index of suspicion and you're seeing ca-125s [blood test that may indicate ovarian cancer] and you're scanning everybody, or things get missed, and [sighs] yeah, it can be very challenging and obviously if you miss something like that it's devastating for everybody involved, but it's very difficult.

Participants described how investigation pathways move through a hierarchy of potential causes and may involve a stepped process which did not always yield a confirmatory or unifying diagnosis. This meant that you had to manage patient's expectations of diagnosis throughout this process.

Theme 2: "You don't want to alienate people by saying the wrong thing"

Some felt that a cultural shift was needed for the wider healthcare system to acknowledge the mind-body interplay as a legitimate expression of distress, to support practitioners to discuss this with their patients along their care pathway, and provide timely access to psychological support services.

PC46: perhaps some of training for staff would be about how you talk about the connection between your brain and your body [...] without sounding dismissive and actually, training individuals to become more sensitive to these types of, conversations.

However, some felt that patients were not always receptive to recognising the contribution of emotions or past experiences to physical symptoms, or the idea of an integral link between mind and body, or the offer of psychological support to cope with the distress of physical symptoms. Some participants were worried about alienating women who might interpret this suggestion as devaluing or de-legitimising their symptom experience, and were therefore sometimes unsure when or how to navigate this.

PC18: I don't think many patients like it when we end up going down that route when it comes to pain, any pain, not just pelvic pain in itself, because they want a diagnosis of some

form or another, whatever it's called, rather than being given some antidepressants or some counselling.

Participants described the essential first step to be validation of the woman's experience, emphasising understanding and genuine belief in the symptoms as 'real' (although perhaps currently unexplained) before exploring the impact of trauma or life stress in its aetiology.

PC18: it's just spending the time with them and actually acknowledging, yes the pain is real, but are we not just saying you know, 'you've got pain and we can't find any cause for it,' 'the pain is actually real,' and what we can do is maybe go down the route of psychological sort of therapy for that, that might be the best route of managing it.'

PC14: the first lady I was talking about absolutely wasn't having any of it, [...] I got her some interesting resources [...] and I just mis-pitched it [...] the fact that this is her body feeling overwhelmed and feeling overwhelmed with the difficulties in her life and how to explain that in a way that seems scientific... it's quite difficult, isn't it?

HCPs were aware and worried that exploring the contribution of trauma or distress in the physical symptom experience, and that physical and emotional symptoms can co-exist, was not always well received. Restricted time in consultations highlighted the need for resources that could support this mind-body understanding in a positive and affirming way for the patient.

PC21: often there is something organic, or something organic that has started it off, but then it often becomes this kind of complex combination of physical and then also psychological symptoms together, and I think kind of having resources to explain how psychological symptoms can impact pelvic pain, [...] I think kind of having good resources to try and back up what I'm saying would be quite helpful.

Participants described how the net effect of these considerations could result in practitioners (inadvertently) avoiding discussion of the contribution of distress in the illness presentation.

PC30: [...] I think you can shut it down easily and not get emotionally involved, but you do not actually solve any of the issues unless they are straight up, simple, physical problems that you can just treat, but for the most part it doesn't work very well.

Participants recognised the importance of a trauma informed approach in the complex and holistic care needs of women's health. Some highlighted the unique position of the primary care practitioner in a potentially protracted diagnostic or support pathway, to communicate the contribution of distress in a supportive and helpful way to their patients.

Theme 3: The system needs to support trauma informed care.

Participants described four systemic challenges to the provision of trauma informed care: Inadequate time allocated for appointments; waiting times for specialist practitioner review in secondary care; limited access to services and providing care for women returning from secondary care without a unifying diagnosis. The challenges of time were frequently reported by participants.

PC35: I already know that I can't do everything for you in 10 minutes, which isn't always like a nice feeling for me, because you know we want to be able to help and you know do that within the time... who knows when they'll be able to get an appointment again or you know you don't want it to be frustrating for them, but equally you don't want to rush yourself.

PC23: they come back two months later and say, 'I've still... I'm still... still haven't seen the hospital,' and that there's a certain amount of workload in primary care just because of... just because secondary care can't take that on.

In some areas, they reported limited access to services such as counselling or psychological support services and community gynaecology as a result of local funding models, and the challenges of providing care for women returning from secondary care without a unifying diagnosis. This often led to practitioners 'holding the distress' of the woman (see theme 4). Despite the challenges identified, participants described how they worked within the system constraints to offer the best service for their patients. For example, planning activities across multiple appointments:

PC25: in 15 minutes it's quite challenging, or if I'm trying to examine somebody [...] that's difficult, that's when I sometimes ask them [...] to come back for the examination so that I can do all the other things that are needed.

Participants spoke of the structural supports that were in place that worked well in their efforts to deliver trauma informed care, such as support networks, the 'advice and guidance' contact service to access secondary care (a system where GPs can access specialist advice before or instead of referral), and working with social prescribers (link workers who help patients to access non-medical support services in their community).

PC23: I mean advice and guidance probably helpful I think, you write and you say, "What do I do?" and they tell you, and you then say to the patient, 'this is what the specialist has said, and that's great, and that's a really good idea,'

PC16: [Access to a social prescriber] is definitely making a difference; I don't know what we did before to be quite honest. I don't know what we would do because it's just improved the quality of life for our patients, and it's just helped us cope because you know we often see mental health problems, social problems, and with such a limited time constraint, limited resources, now that investment has been put in, it is definitely making a difference.

Theme 4: Delivering Trauma Informed Care takes work and can impact practitioners.

Taking a trauma informed approach relied heavily on the practitioner-patient relationship and some felt that the impact on practitioners was not always accounted for. The work involved in taking a trauma informed approach to care impacted on clinician workload. When they were able to navigate this challenge, participants reported job satisfaction which was a positive impact. Conversely, when participants were unable to deliver the care they aspired to and believed they should, this impacted negatively. Protracted routes to diagnosis (or not getting a diagnosis), exacerbated by long waits to access specialist review in secondary care, left participants 'holding the distress' of women managing symptoms while they waited for a management plan.

PC18: I mean typically what happens is when a referral is done, the patient is waiting three, four, five months to be seen sometimes, but the patient's still got those symptoms, so what do they do?

PC46: So pain is complex. I think every pain service in the country is poorly funded and poorly accessible, [...] The challenge we have is these patients are constantly accessing us and, you know, I don't want to label anything but they do end up becoming frequent attenders, which you know... and all we are is becoming a holding person in all of this.

This increased the pressure on primary care practitioners who were operating without adequate system support. While participants knew that managing uncertainty was integral to the role of the primary care practitioner, holding distress added to the challenge of appropriately broaching or exploring the mind-body link. Participants described feeling overwhelmed and personally affected by managing the expectations of patients held in in limbo and holding their distress.

PC34: women who have complex, like intractable symptoms that have been investigated and no one's really come up with anything [...] it's more psycho-social input that's needed, and they've seen a gynaecologist and they're still struggling and there's not really a solution, and so they're... they're the ones who you think, 'oh my gosh, I... I'm... I'm not sure what I can offer... offer you.'

PC26: I mean women's health is a prime one, it causes so much anxiety, stress, impact on the family, and I think with the complexities around the referral pathways and who's doing what, which has been one of my biggest stresses, people can fall through the gaps very easily

Participants sought support from colleagues within their daily work routines to reflect on clinical questions or complex cases. However, some felt that there were limited support services for practitioners' mental wellbeing in a more formalised and structured way.

PC30: We have our annual appraisal but that is very much to make sure that we're not total lunatics, [...], but other than that [...] they do support us, but they... you know it's once a year, there's no capacity to debrief on individual challenging cases or anything like that, it's very much to check-in that we are sort of on the rails.

Participants described how not being able to deliver high quality, holistic care due to structural constraints was unsatisfying, and challenging.

PC04: I was so unhappy in my previous job really, I'd say we still had support, but the patients were a lot more demanding and it just comes with that, you know a lot more child protection issues safeguarding and it... you know, it's just a really challenging job and that, and not necessary work satisfying either.

Lack of personal and systems support for practitioners moves the focus of trauma informed care from a whole systems approach to the clinician – patient interaction.

Discussion

Summary

Our findings indicate that clinicians are aware of the contribution of trauma and distress to the presentation of physical symptomatology within women's health consultations, but that conversations about this could be difficult. Some participants felt confident and willing to discuss the role of distress in symptom presentation; others felt that these conversations were difficult, and sometimes avoided the topic. Constraints such as limited time in consultations, and training and resources to facilitate discussions about the mind-body (the interconnection of physical and emotional health) and the role of trauma and distress, could mean that clinicians did not always talk to patients about the impact of distress. This was exacerbated by system constraints such as limited support services for referral. Practitioners described building support mechanisms for themselves at work through debrief and clinical conversations with colleagues but told us that there were no *formal* supervision or support services routinely available for practitioners. The heavy work and emotional labour within an unsupportive system was described as contributing to practitioner frustration and burnout. Whilst patient relationships were framed within a trauma informed lens, the organisational configuration was not always supportive to a trauma informed approach.

Comparison with existing literature

The complexity of women's health experiences challenges a dualistic approach to care and could better respond to the continuity model of primary care¹⁹. Practitioners in our data actively enacted the principles of Trauma Informed Care (such as safety, trustworthiness and collaboration) in their personal practice with women¹⁶. However, the structural configuration of primary care services could complicate these care aspirations, including when resources were limited or services were not flexible enough to support practitioner autonomy, which could hinder opportunities for timely care or follow up. This could erode the practitioner's efforts to deliver trauma informed care, with potential consequences for both patients and clinicians. Such structural constraints in a climate of overwork are powerful sources of moral distress and burnout in studies of nurses, midwives and doctors^{20,21,22,23}. The risk of exposing practitioners to such moral distress, can lead to the experience of vicarious trauma and reduced job satisfaction as they navigate the challenge of exploring the minded-body link with patients on their illness journey^{24,25}. Primary care practitioners held women's distress whilst they waited for specific therapies or supports, and yet the practitioners did not have adequate formal support systems to take care of their own wellbeing. This finding resonates with Pereira Gray et al²⁵ who suggest that the UK shortage of GPs, erosion of continuity of care, sustained increase of remote consultation methods and lack of structural support in the system may exacerbate challenges faced by practitioners to provide high quality care^{26,27,28}.

Strengths and Limitations

The use of secondary analysis has allowed us to conduct a focussed analysis on a rich data set of PCP interviews. As this was done within the project timeline by the original research team, potential ethical concerns about the impact of the socio-political context that often accompanies secondary analysis were mitigated¹⁸. We were able to minimise participant burden and engage with a targeted group of women for whom trauma informed care and its delivery has immediate impact. The principal limitation of our study is the restrictions offered by the original interview scope and guiding questions which focused on women's health. We are unable to report on experience in other areas of healthcare or by gender of care provider as this is unexplored.

Implications for research/practice

Our findings suggest that moving towards a trauma informed *systems* level approach would support integration of psychological support within multiple care pathways. A co-ordinated systems approach should support an integrated and holistic approach, rather than encouraging a dichotomising split between physical or psychological services. Our findings suggest that this model would also support the wellbeing of practitioners delivering care, and may have an impact on staff retention, making this

a critical consideration at all system and service levels, from individuals, to practices, to funders and commissioners^{28,29}.

However, less is known about how to enact or enable trauma-informed care at a systems level¹⁶. More research is needed about how to implement and support equitable proportionate trauma-informed care in practice. This includes learning how to actively nurture equitable care within services, practices, and within Primary Care Networks. At a funding and commissioning level, autonomy and equitable work need to be valued and enabled and this requires policy attention; simplistic metrics of care like numbers seen or a narrow focus on numerically quantifiable access will not capture either the impacts on patients or practitioners²⁸. Nor will this capture the contacts and appointments that did not happen. Furthermore, critical to effective equitable care is that practitioners need meaningful access to services that they can refer into, and that will respond promptly and supportively to needs identified. Work in areas of care such as FGM and DVA demonstrate that having acceptable accessible services to refer into enabled inquiry and compassionate care^{30,31}. It is an ethical prerogative that trauma-informed enquiry is supported by trauma-informed services and support. Finally, support for staff is essential and the responsibility for this should not be devolved to individuals, but commissioned and provided for. This contrasts with current policy, such as the wellbeing Quality and Outcomes Framework (QOF) indicators that arguably devolve the responsibility for wellbeing to those in need of wellbeing support, without offering any tangible resources.

HCPs are aware of the difficulties in discussing the interface between trauma and complexity with patients³², and our work shows they are requesting support and guidance in how to negotiate this supportively. The British Medical Association Moral Injury report²² recommends systems changes which map on to the principles of Trauma Informed Care, including increased staffing, streamlining of bureaucracy, open and sharing work cultures and provision of support for employees. However, while these recommendations acknowledge the problem and offer solutions, there is no requirement for organisations to address these structural concerns. Lack of these system supports for practitioners moves the focus of trauma informed care from a whole systems approach to the clinician – patient interaction¹⁶.

A Lived Experience perspective on the findings

To seek lived experience perspectives on our findings³³, we spoke with three representatives of charities supporting survival sex workers (SSW) in different regions of England: as an exemplar vulnerable group with significant experience of historical and ongoing trauma. They told us how women experience stigma and are afraid of disclosure and confidentiality, particularly if their children have been removed and placed into social care. The charity representatives described how women engaged in SSW rarely sought medical care, or achieved registration at a general practice surgery, due to lifestyle constraints and stigmatising experiences.

We asked what trauma informed care looked like for their service and asked them to reflect on our findings. They recommended a systems level approach to the delivery of trauma informed services across the health service. Barriers to access were described as starting at the front door of the GP surgery with the reaction of the receptionist. A lack of confidentiality in the reception area, closed consulting room doors, short consultation times and the predominance of digital access methods for appointments were also cited. Beyond these, they suggested responsive, transparent pathways into support services for vulnerable women or those living in extreme circumstances would illustrate a trauma informed approach to services. Individual practitioners were credited with adopting a trustworthy, trauma informed approach but charity representatives, in consultation with the women they support, felt that the health care system could counter-act individual good practice.

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