

Survey of General Hospital Healthcare Staff Assessing Their Insight, Comprehension and Confidence When Encountering Patients with A History of Childhood Trauma

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Received: September 08, 2025; **Accepted:** September 18, 2025; **Published:** September 25, 2025

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Introduction

Childhood psychological trauma before the age of 18 has increasingly been recognised by health policymakers as a widespread public health issue. Felitti et al. first introduced the term ‘adverse childhood experiences’ (ACEs) to describe various aspects of such experiences [1]. This study surveyed 13,494 adults to assess their childhood experiences of maltreatment, including abuse and neglect, as well as a broader range of experiences related to family and household circumstances, referred to as ‘household dysfunction’, which encompassed a detailed analysis of living conditions, such as witnessing domestic abuse or drug misuse by adults. Felitti and colleagues demonstrated that half of the surveyed individuals reported at least one ACE and established a positive correlation between the number of ACEs reported and the presence of physical health issues. These health issues included ischaemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The study was further expanded by Campbell et al, whose research indicated that an ACE score of ≥ 4 was linked to psychiatric problems, substance abuse—including heavy smoking—and physical illnesses such as strokes [2]. Campbell and colleagues’ findings also emphasised how different ACEs impacted the risk of developing comorbidities to varying degrees.

NHS England has started to recognising the impact of such trauma early in life as a key factor for higher medical costs and increased population comorbidity, prompting the development and implementation of guidelines for trauma-informed care [3,4]. However, the education and training of medical and other healthcare students, junior staff, and foundation doctors still lag

behind, leaving many feeling ill-equipped to manage patients with childhood trauma [5-7].

Methodology

A survey assessing the comprehension and confidence of hospital healthcare staff was carried out at a district general hospital. Two externally validated questionnaires were combined and customised to meet the study’s objectives: the Adverse Childhood Experiences (ACE) questionnaire, as described by Ramadurai et al [7, Appendix A], and the 21-item Scale to evaluate staff knowledge, attitudes, and practices related to trauma-informed care, designed by Abdoh et al [8, Appendix B] and validated by King et al [9].

A small-scale preliminary test was conducted using all questions from the two questionnaires. It seemed that the questionnaire was too long and did not elicit many good responses. Therefore, this was reviewed with the clinical librarian, and items from these questionnaires were selected to create a shorter, more manageable version. Questions were chosen based on their relevance to the understanding and confidence of junior healthcare professionals in managing patients with a background of childhood trauma or ACE. A total of 20 questions were selected—12 assessing comprehension and 8 assessing confidence—and included in the survey. Respondents were asked to indicate their level of agreement with each statement, from strongly disagree to strongly agree, and could also write a response in a text box. Six inpatient units were randomly selected: four general medical and two surgical wards. The questionnaire link was distributed electronically via a QR code displayed on posters across the wards, enabling anonymous participation.

Citation: Samr Dawood. Survey of General Hospital Healthcare Staff Assessing Their Insight, Comprehension and Confidence When Encountering Patients with A History of Childhood Trauma. J Clin Med Health Care. 2025. 2(3): 1-4. DOI: doi.org/10.61440/JCMHC.2025.v2.39

The verbal qualitative responses were analysed using narrative analysis. Inductive coding was employed to identify and break down different themes and messages conveyed by all responses per question, creating a core narrative and categorising responses into good, neutral, or bad comprehension/confidence levels. The data was also analysed quantitatively by examining the proportion of participants who strongly agreed, agreed, were neutral, disagreed, or strongly disagreed with each question. A mean score was calculated by assigning numerical values to each response: strongly disagreed at 1, disagreed at 2, neutral at 3, agreed at 4, and strongly agreed at 5. These scores were used to determine the overall mean-agreement-score for the comprehension questions (questions 1 to 12) and the confidence questions (questions 13 to 20). Demographic data for each respondent was recorded, including age, role, gender, ethnicity, experience in their current role, as well as experience and length of practice in emergency medicine or psychiatry, and whether they had prior training in adverse childhood events and the type of training received.

Results

Out of 52 healthcare professionals surveyed, 24 completed the questionnaire. Among these, five were foundation year 1 doctors, four were foundation year 2 doctors, six were nurse band 5, four were nurse band 6, two were pharmacy band 5, and three were pharmacy band 6. Eight respondents (33.3%) had prior training in Adverse Childhood Events (ACE) (see table 1).

The Likert scale responses to each question are visualised on Graph 1 using a stacked bar.

Supplement 1 provides inductive coding of verbal responses per question, categorised as good, neutral, or poor in comprehension or confidence.

Table 2 shows the percentage of participants who strongly agree, agree, are neutral, disagree, or strongly disagree, along with the mean-agreement-score for each question.

Overall mean score for the respondents' agreement to the comprehension questions (question 1 to 12) is 3.573 out of 5.

Overall mean score for the respondents' agreement to the confidence questions (question 13 to 20) is 2.662 out of 5.

The three questions with the highest mean-agreement-score are all comprehension related questions:

Q9 – Trauma affects physical, emotional, and mental well-being — 4.500

Q11 – There is a connection between mental health issues and past traumatic experiences or adverse childhood events (ACE) — 4.167

Q3 – Trauma is distinct from everyday stress — 4.167

The three questions with the lowest mean-agreement-score are all confidence related questions:

Q13 – I can identify when re-traumatisation has re-occurred unintentionally — 2.250

Q17 – I am confident in identifying the different paths people will need to recover from trauma — 2.125

Q16 – I can confidently identify if re-traumatisation has occurred in the community or institutional setting — 2.083

Note that Q5 (patients are personally responsible for the trauma they experience (e.g., substance use)) actually had a lower mean-agreement-score than Q13, but this points to good comprehension as they disagree with the statement of the question.

Discussion

The UK Office for Health Improvement and Disparities states children's social and physical environments impact their health, risking trauma or re-traumatisation. Trauma-Informed Care helps ACE patients feel safe. The guidance recommends Psychological First Aid training for healthcare workers and references resources such as Health Education England e-learning and Home Office-funded ACE training [10].

This study highlights a discrepancy between healthcare professionals' comprehension and confidence in managing patients with adverse childhood experiences (ACEs). While participants demonstrated a general awareness of trauma's long-term psychological and physical impact, they reported significant uncertainty in identifying re-traumatisation, particularly in non-mental health settings. These findings reflect a wider issue in healthcare systems, where trauma-informed care has not yet been universally integrated. Frameworks such as SAMHSA's "4 Rs"—Realize, Recognize, Respond, and Resist re-traumatization—have been developed to address this gap and guide professionals toward more sensitive and effective care delivery [11].

Most participants recognised childhood trauma's prevalence and lasting effects ("exposure to trauma is common" – mean-agreement-score 3.75), especially its impact in shaping mental health outcomes. Despite awareness, many noted a lack of systemic support in hospitals to identify or address trauma. There was a clear recognition that trauma differs substantially from common stressors ("trauma is distinct from everyday stress" – mean-agreement-score 4.167), and that individual thresholds and responses to experiencing trauma vary according to factors such as resilience and coping mechanisms [12]. The respondents who expressed confusion on how to differentiate trauma from everyday stress highlighted the need for more robust training in this area.

Most participants rejected the idea that individuals are solely responsible for their trauma, emphasising external factors like poverty, abuse, and social environments ("patients are personally responsible for the trauma they experience e.g., substance use" – mean-agreement-score 2.208). This aligns with trauma-informed principles recognising trauma as a complex interplay of personal and systemic factors [13]. A small group believed patients might bear some responsibility due to personal choices.

Participants linked adverse childhood experiences to poor adult mental health—mean-agreement-score 4.167—supported by clinical observations and literature showing early life factors, including socioeconomic status, abuse, and neglect have cascading consequences during the adulthood of patients [14]. The participants and literature also cited links between childhood trauma and increased risk for psychiatric conditions like anxiety, psychosis, OCD, and bipolar disorder [15]. However, several participants cautioned against assuming causation, emphasizing trauma's multifactorial nature.

Exploring patients' trauma histories is sensitive and often neglected ("I am comfortable inquiring about physical, emotional, and sexual abuse in my patients" – mean-agreement-score 3.292). Childhood trauma is diverse and common, so healthcare professionals should routinely use open-ended questions to build trust and empathy [16,17]. Participants described barriers including time constraints, lack of training, role boundaries, and environment concerns; this is reflected in research showing some patients decline disclosure due to limited time (12%) or discomfort (4%) [18]. Additionally, under time pressure, clinicians tend to focus more narrowly on presenting symptoms, potentially neglecting broader psychosocial contributors to illness [19].

Although participants wanted to provide holistic care, many said their roles didn't support exploring emotional coping or trauma histories ("I routinely encourage patients to disclose what traumatic experiences they feel comfortable sharing" – mean-agreement-score 2.667). Most felt unprepared to discuss these topics and unsure how to respond to disclosures. Despite this, there was broad consensus that trauma recovery is possible ("I am confident that recovery from trauma is possible" – mean-agreement-score 3.667) and best achieved through evidence-based therapies like trauma-focused CBT, EMDR, systemic therapy, and psychodynamic psychotherapy [20,21].

Most participants felt supporting trauma recovery was outside their role, seeing their job as guiding patients to specialists, with 25% disagreeing and 20.8% strongly disagreeing that they can help patients make informed choices regarding their healing and recovery from trauma. A gap in awareness of pathways connecting physical and mental health service further underscored the fragmentation of trauma-informed care across sectors. Despite this, they showed empathy for trauma survivors and disagreed that these patients over-utilize healthcare, believing they might actually need encouragement to engage more with available services resources - "patients who experience trauma frequently over-utilise health care resources" – mean-agreement-score 2.958.

Views on trauma's impact on treatment adherence vary: "patients who have experienced trauma may have difficulties adhering to medical therapies as prescribed" – mean-agreement-score 3.5. Some believe trauma impairs adherence through psychological or behavioural effects, supported by evidence linking childhood trauma to poorer adherence and higher relapse rates in substance use disorders [22]. Others report positive experiences with motivated patients engaging proactively with their recovery. Overall, trauma's impact may differ based on individual circumstances.

There was unanimous agreement that participants lacked adequate training to identify or respond to re-traumatisation ("I can identify when re-traumatisation has re-occurred unintentionally" – mean-agreement-score 2.25; "I can confidently identify if re-traumatisation has occurred in the community or institutional setting" – mean-agreement-score 2.083). Many also said their clinical environment—especially in acute or specialised settings—did not support such exploration. This underscores a key area for future workforce development to implement trauma-informed approaches in healthcare.

A review of the literature assessing comprehension and confidence of healthcare staff and ACEs, showed that while ACEs are recognised as common and linked to many illnesses, they are not routinely screened for—less than 10% of adults were screened in one study [23]. Another found 62% of patients were at risk of ACEs, yet in-depth discussions only more likely occurred with the 22% considered high risk of experiencing ACEs, despite acknowledgements that these discussions provided a complete picture into the social determinants of health [24]. Tink et al. found only 45.5% of family medicine residents had formal ACE training, correlating with low confidence in screening for and following up on ACEs including physical and sexual abuse [25]. Similarly, Nutting et al. assessment of 38 physicians reported that although they understood the value of ACE screening for Trauma Informed Care, they lacked confidence due to discomfort, limited knowledge, and time constraints [26]. This all indicates that, similar to the results seen at the study's District General Hospital, healthcare professionals tend to have more comprehension than confidence in dealing with patients with Adverse Childhood Events, and that training in this area is suboptimal- subsequently, efforts need to be implemented to promote routine screening for ACE [23,25,26]. Implementing this change early in the training pathway of healthcare professionals has been recommended, with education on ACE comprehension and confidence beginning prior to graduation and continuing throughout professional development [25,26]. This training should focus on addressing barriers known to hinder routine ACE screening, including issues with comprehension and confidence [23,26].

Conclusion

This study finds a gap between comprehension and confidence among junior healthcare workers in managing patients with adverse childhood experiences (ACEs). Confidence was notably lower than comprehension, findings that are consistent by the wider literature. While many understand trauma's effects, many feel unprepared to identify, discuss, or respond to trauma in clinical settings. This reinforces the need for early, ongoing trauma education in healthcare training. National strategies should promote accessible training to boost knowledge and confidence, integrating trauma-awareness from undergraduate to postgraduate levels. This can help overcome barriers, improve patient outcomes, and strengthen clinician resilience.

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