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## Implementation of Childhood Trauma Questionnaire in a Primary Care Setting

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## **Background**

Adverse childhood experiences (ACEs) have a significant impact on a patient in later life and research suggest these experiences have shown to cause psychological and mental issues, suicide attempts, increase in morbidity and mortality and future unhappy relationships (Hovens et al., 2010; MacDonald et al., 2015; Merrick et al., 2019; Pierce et al., 2018; Zarse et al., 2019; & Zhang et al., 2019). ACEs can range from violence, abuse, neglect, observing violence, substance use and alcohol abuse at home, having a family member attempt or die by suicide, and instability of parental separation, or household members being in jail (CDC, 2022). Rural areas are even more affected by a shortage of services and providers available. Further, patients may experience challenges in accessing the care and treatment they need based on their socioeconomic status, race, ethnicity, and demographics (Le Cook et al., 2019). It is an alarming problem when patients cannot get into a mental health provider for two to six months. Due to limited access in rural areas, the CTQ screening tool will help primary care providers identify, diagnose, and properly treat patients by questioning the patient regarding past childhood trauma events.

## **Literature Review**

A literature search using the online databases available through Lovejoy Library revealed several issues and the impact of adverse childhood experiences on overall health throughout the lifespan. These include but are not limited to mental and physical health, for example: smoking, unintended pregnancies, relationship/intimate relationship abuse, sexually transmitted infections (STI's), alcohol abuse and suicide events later in life (Dube, 2004). Chronic pathologies associated with ACEs include anxiety, depression, psychosis, paranoia, coronary artery disease,

stroke asthma, COPD, cancer, kidney disease, diabetes, dementia, obesity, and hypertension, among others (Merrick et al. 2019; Sheinbaum et al. 2020).

Evidence based research has demonstrated that administering a targeted screening tool in a primary care setting may expose relationships between current presenting symptoms and ACEs (Adverse Childhood Experiences) and adult mental health, physical illness as well as social issues (Centers for Disease Control (CDC), 2010; Felitti et al.1998; Zarse et al. 2019).

Administering a screening tool provides a guide for the care, prevention, and better understanding of certain mental health concerns.

Some screening tools widely used are the Adverse Childhood Experience's Questionnaire, Child Abuse and Trauma Scale, Parent to Child Conflict Tactics Scale, Traumatic Experience Checklist and Childhood Trauma Questionnaire. Of these, the most common tools are the Adverse Childhood Experiences' Questionnaire and Childhood Trauma Questionnaire. Both screening tools have been deemed reliable and valid (Bernstein et al. 1997, 2003; Paivo, 2001; Spinhoven et al. 2014; Zhang et al. 2020 & Zarse et al. 2019).

## **Conceptual Framework**

This quality improvement project was guided by the Biopsychosocial Model. The model demonstrates the complex interplay of the three major dimensions (biological, psychological, and social) in the development of psychiatric disorders. By applying the CTQ screening to practice, clinicians can better recognize, understand, and respond to a patient's presentation and assure them they are being understood (Borrell-Carrio, 2004).

## **Project Methods**

The aim of this project was to implement the use of a screening tool in a family practice setting to assess adverse childhood trauma and the effects in adulthood in patients who are being seen in the office. The entire staff, including the certified nurse practitioner, medical assistants, and front desk staff were educated and trained on the Childhood Trauma Questionnaire (CTQ) which screens for adverse childhood trauma including neglect, abuse (physical, mental, and sexual), parent divorce, substance abuse, death, significant injury, violence, major life upheaval). Working in a primary care setting, I have personally experienced situations in which patient's symptoms or morbidities could not be explained or the patient would never improve with treatment and after further evaluation it was noted the patient had some kind of childhood trauma. This prompted further research in the cause and effect of childhood trauma and the effects in adulthood. The project location was at a family practice office located in central Illinois. Prior to the project being conducted, there was no formal or standardized process to screen patients for any adverse childhood traumatic events.

For this project, staff were educated about the implementation of patient screening using the CTQ screening tool. The tool was provided as a paper document to the office personnel and was administered to roomed patients upon their arrival at the office. The form was given to patients that had a behavioral health diagnosis or were administered if patients had unexplained or chronic issues that would not improve without a reason why. The health care provider then reviewed the responses during the exam. Evaluation of feasibility and acceptability of this project was evaluated through staff completion of a brief, Likert-style questionnaire after the implementation period. Items included in the questionnaire are:

1. The CTQ was easy for me to understand?
2. The CTQ was easy to administer to patients?
3. The CTQ was easy for the patients to understand?

4. The CTQ is a useful tool in assessing childhood trauma?
5. The CTQ is feasible to continue to use as a screening tool in the primary care setting to assess childhood trauma contributing to a patient's current symptoms and/or diagnosis?

## **Evaluation**

Adverse childhood trauma has a significant impact on a patient in later life and research suggests these experiences may influence the development of psychological and mental issues, suicide attempts, increase in morbidity and mortality and future unhappy relationships (Hovens et al., 2010; MacDonald et al., 2015; Merrick et al., 2019; Pierce et al., 2018; Zarse et al., 2019; & Zhang et al., 2019). The aim of this project was to implement the use of a screening tool in a family practice setting to assess adverse childhood trauma and the effects in adulthood in patients who are being seen in the office. The CTQ screening tool is widely known and used in many clinical settings and have been deemed reliable and valid. (Berstein et al., 1997, 2003; Mulvaney-Day, 2017; Oral, 2016; Pavio, 2001; Spinhoven et al., 2014; Zhang et al., 2020 & Zarse et al., 2019).

The project location was at a family practice office located in central Illinois. Prior to the project being conducted, there was no formal or standardized process to screen patients for any adverse childhood traumatic events. Forty-two patients were screened during this project implementation. It was anticipated that three nurse practitioners, one physician, 4 nurses and two front office staff would complete a brief questionnaire at the end of the implementation period to obtain feedback on the screening process, share ideas on how the screening could be improved in the future, the ease of administering the questionnaire and the feasibility of continuing the project long-term.

## **Project Strengths**

Evaluation of the feasibility and acceptability of this process in a rural healthcare setting was evaluated using a brief 5-point Likert scale questionnaire. Due to dramatic staffing changes in the clinic setting, only two nurses were able to participate in the project. One hundred percent (n=2) of participants strongly agreed that the CTQ screening tool was useful. One hundred percent (n=2) of the participants strongly agreed that the CTQ was feasible to continue in daily practice. No staff reported any concerns about the implementation of the project.

The staff felt the screening could improve quality of life and assist staff in understanding patient's morbidities better (not responding to medication treatment for musculoskeletal issues, non-compliance, etc.). The implementation was considered feasible by office staff who participated, and it assisted in identifying patients who may need further evaluation. The staff had few issues with the change in protocol. There were no patient complaints regarding the screening forms. This simple questionnaire is quick to administer at no cost or burden to the facility and can explain the patient's behavior and morbidities, help further direct patients to more disciplines for treatment and give them a better quality of life.

## **Project Weaknesses**

Some of the project weaknesses were that patients who presented for follow-ups or physicals were missed with the screening process. This occurred due to staff forgetting to give the screening forms to the patient. The primary concern with this QI project was the number of staff who ended up participating in the project. Originally a total of 10 staff members were to participate in the project; however due to a change in office structure, provider schedules, and role change of nursing staff, only the project leader NP and two clinic nurses were able to

administer the questionnaire. decreasing the number to 3 participants. The decrease in the number likely impacted the study results.

### **Implications for Practice**

Implementing a screening tool could improve quality of life and assist staff in understanding patient's morbidities better (not responding to medication treatment for musculoskeletal issues, non-compliance, etc.). This was demonstrated during the study through the identification of patients who were historically non-adherent and presented with complaints and symptoms that did not improve with treatment. Applying the CTQ screening tool revealed patients' whose adult disease process may be influenced through past ACEs. Evidence based research suggests that implementing a childhood trauma questionnaire in primary care settings has shown links between ACEs and adult physical as mental illnesses, as well as social issues (CDC 2010; Felitti et al., 1998; Zarse et al., 2019). Moving forward with the CTQ in primary practice would allow the primary care provider to more quickly identify these ACEs that could be the underlying cause of the patient's complaint's, symptoms, and morbidities.

### **Conclusion**

The implementation of the CTQ in a family practice setting by the nurse practitioner and staff nurses was feasible. Future research should include replicating this QI project on a larger scale to validate the findings from this study. This project demonstrated that a screening process could be successfully implemented in a family medical practice. Future projects may focus on efforts to include more staff in the screening process as a regular part of patient care.

