Evaluation of a Motivation-Based Intervention to Reduce Health Risk Behaviors among Black Primary Care Patients with Adverse Childhood Experiences

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INTRODUCTION

Black Americans are disproportionately exposed to major stressful events, including discrimination, community violence, and poverty, all of which contribute to increased risk of poor health. The impact of trauma on health often goes unaddressed among Black Americans due to poor access to care, stigma, and mistrust in health care. Racial biases in health care indicate the need for facilitating greater health equity in underserved communities. Health disparities can be more broadly addressed with a trauma-informed approach to health care that recognizes trauma prevalence and its impact on mental and physical health.

There is considerable evidence that greater attention should be paid to trauma screening and intervention in primary care, particularly for low-income, racial/ethnic minority patients living in urban communities. Adverse childhood experiences (ACEs) include abuse, neglect, and household dysfunction prior to age 18 years. Since the initial findings of the ACE study, the dose-response relationship between childhood adversity and a number of health risk indicators, including alcohol misuse, drug abuse, obesity, risky sex, and smoking, has been replicated in more than 80 publications. Decades later, Dr Felitti incorporated ACE questions into a comprehensive medical assessment, which led to substantial reductions in physician office visits and emergency room visits. Although this was a retrospective observational finding that did not control for confounding factors that may have contributed to the finding of fewer office and emergency room visits, Dr Felitti attributed outcomes to 3 basic characteristics of human interactions: “We realized that asking … coupled with listening and implicitly accepting the person who had just shared his or her dark secrets, is a powerful form of doing.”

ABSTRACT

Background: Considerable evidence suggests that greater attention should be paid to the impact of trauma among low-income, racial/ethnic minority patients living in urban communities. The goal of this article is to evaluate a 2-session, motivational intervention designed to motivate a change in health risk behaviors among low-income, self-identified Black/African American patients with adverse childhood experiences (ACEs).

Methods: Qualitative self-reported data described helpful aspects of the intervention and those that could be improved. Eligible participants with 1 or more ACEs being seen in a community-based clinic were interview by a mental health clinician researcher for 2 in-person sessions scheduled 1 month apart. Content analysis was performed using a general inductive approach to identify core themes.

Results: In total, 36 of 40 participants completed both sessions, with the majority reporting a high rate of satisfaction. Participants emphasized the importance of talking with a trained professional who could listen without judgment, understand patient challenges, clarify patient goals, and facilitate behavior change plans. Suggestions for improvement included modifying structure and content, enhancing clinic environment, improving linkages to behavioral health, and increasing communication and collaboration with clinicians.

Conclusion: Participant evaluation data gathered for this study suggest that through the practice of asking, listening, and accepting, clinicians can help patients who have been exposed to childhood adversity better understand themselves and promote healthy coping behaviors. This study provides preliminary data on the needs of underserved patients that can be utilized to develop and deliver health promotion interventions using a trauma-informed approach in community-based clinics.
seeks to translate Felitti’s insights of asking, listening, and accepting into clinical practice.

Trauma-Informed Care

Trauma-informed care (TIC) is a systems approach to health care that conveys an awareness of the impact of trauma on health by incorporating an understanding of trauma and resilience throughout all aspects of care.20-22 The Substance Abuse and Mental Health Services Administration (SAMHSA) outlined 4 key assumptions of a trauma-informed approach: 1) realize trauma prevalence, 2) recognize signs of trauma, 3) respond using trauma-informed principles, and 4) resist retraumatization. The 6 principles of TIC defined by SAMHSA include the following: 1) safety; 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice, and control; and 6) cultural, historical, and gender acknowledgment. These principles constitute an approach to enhancing patient engagement through relationship-building that can guide clinical practice and inform clinical decision-making with trauma survivors.24 They work in unison to effectively address the consequences of trauma while enhancing resilience and preventing retraumatization.25 An emphasis on physical and psychological safety is the basis for clear expectations, roles, and boundaries that are navigated by clinicians and patients alike.22 TIC is governed by strengths-based care, which makes use of every opportunity to provide choice, rebuild control, and promote self-efficacy. Patients’ strengths and resilience are highlighted, rather than focusing on symptoms and pathology. TIC principles can help medical practice become trauma informed by providing a basis for high-quality relationship-based care. The state of the science on trauma-informed health care suggests that TIC can improve clinician and patient satisfaction, reduce health care costs, and lower no-show rates.26

Motivational Interviewing

Motivational interviewing (MI), a collaborative, evidence-based technique, features a set of 5 guiding principles including 1) expressing empathy, 2) developing discrepancy, 3) dealing with resistance, 4) developing self-efficacy, and 5) developing autonomy.27 MI encompasses a trauma-informed approach that can enhance motivation in changing behavior within an atmosphere of acceptance and compassion.28 Previous research shows that people who express commitment for change are more likely to make behavioral changes such as reducing drinking.29-31 Clinicians can promote coping self-efficacy, which is predictive of better health outcomes, by reflecting change-talk to patients.29,32 Together, TIC and MI principles and strategies form the basis for the novel intervention featured in this study.

Objectives

A previously published study of this intervention indicated that it was feasible to implement a brief, motivation-based intervention within primary care that could help to develop healthier ways of coping with stress among trauma-affected low-income patients of color.33 A second manuscript describes the patient experience of changing a health risk behavior. The current study expands on the previous publications by evaluating the qualitative data of what helped and what could be improved about the intervention from the patient/participant perspective. This study provides preliminary data that can be utilized to develop and deliver resilience-promoting interventions, increase trauma competence for clinicians, and enhance engagement in care for low-income Black Americans with childhood trauma exposure. The intervention has the potential to help participants connect with what happened to them in childhood and how those experiences may be affecting them today.

METHODS

The intervention was administered at an urban community care clinic to Black American patients who endorsed exposure to childhood trauma. It was implemented to help participants reduce stress and health risk behaviors by making improvements in coping self-efficacy24,32 and to encourage behavioral health referral acceptance.36,37 The intervention assisted participants to explore ambivalence in making behavior changes and to create a change plan that included a measurable goal, strategies to mitigate triggers, social supports, and rewards of progress.

Clinic Setting

This study was conducted in a Federally Qualified Health Center located in the center of a large metropolitan area. The clinic predominantly serves low-income, racial/ethnic minority patients. The patient population comprises predominately Black (76%), Medicaid-insured (76%) women (60%) who are aged between 18 and 49 (44%) or 50 years or older (25%) and have a diagnosable mental health or substance use disorder (27%). All participants were recruited from a family/internal medicine setting offering primary care services. The study protocol was approved by the University of Wisconsin Health Sciences Institutional Review Board.

Participants

Eligible participants of the clinic were adults, English speaking, and self-identified as Black/African American with 1 or more ACEs. Patients were excluded if they had noticeable signs of mental instability or intoxication or if they were physically too sick to participate. Data were collected from July 2017 through January 2018. Patients in
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The waiting room of the clinic were invited to participate in a research study about Black/African American adult primary care patients whose lives are affected by stressful events that occurred when they were children or teenagers. Potential participants were told that the goal of the research was to learn whether a certain kind of counseling would help individuals to feel less stress, to be better able to cope with stress, and to do some things that might improve their health. The data could assist providers to better understand the stressful childhood experiences that affect the lives of their patients. Patients who agreed to the initial screening were advised that some of the questions were sensitive and that they could skip any question that they preferred not to answer. An eligibility screen was administered by either the principal investigator or a trained research assistant using the 10-item ACE study questionnaire, which was scored upon completion by the person administering it. Patients with 1 or more ACEs were invited to participate in the intervention study and scheduled within 2 weeks for an initial session with the principal investigator.

Of the 188 patients who were assessed for eligibility in the clinic waiting room, 162 patients had 1 or more ACEs, reinforcing the suitability of implementing a trauma-informed intervention for this clinic population with substantial trauma exposure. Of those patients who met the eligibility requirement, 55 patients declined to participate for the following reasons: not interested in research, not having enough time, not feeling well, questions were too personal and sensitive, and other (eg, does not live near the clinic, not brought up in the United States, not stressed, in good health, busy filling out paperwork). Of the 107 patients that had scheduled a first session, 67 did not show for unknown reasons. Forty patients with 1 or more ACEs participated in the study.

**Intervention Procedure**

After having participants read and sign the informed consent, the intervention was completed by the first author (EG), a licensed professional counselor and primary care researcher. Two sessions, offered 1 month apart, were privately conducted in a patient room. The first session lasted approximately 45 to 60 minutes. The session began with a probing question to elicit resilience and resource survival skills—for example, “How has early life adversity affected you today and what has helped you the most?” In this session, the interviewer used MI techniques to support participants to identify healthy and unhealthy coping skills, explore ambivalence of changing a health risk behavior (eg, pros/cons about the behavior and worst/best things about changing), and create a written behavior change plan to generate actionable steps in changing a health behavior. The interviewer asked guiding questions to help participants create an action plan that encompassed specifying a measurable goal, identifying anything that could possibly get in the way of following through with their goal, strategizing ways to mitigate triggers, choosing specific support people to hold them accountable, as well as thinking of several ways that they could acknowledge and reward progress toward their goal. Reinforcements of participant self-efficacies and strengths whenever possible were woven throughout the conversation, elicited by questions such as, “What have you successfully changed or accomplished in the past and what personal strengths helped you to achieve your goal?” The second session lasted 20 minutes and was an opportunity to report progress and troubleshoot barriers to their goal. The interviewer inquired about coping mechanisms that the participant had tried and not tried since the prior session, what worked and what was not as helpful about what they tried, how barriers to trying new coping were addressed, and any changes in the plan going forward. A trained research assistant conducted all the participant satisfaction surveys by phone a few days after the completion of sessions 1 and 2 and then 2 months postentry. Participant evaluation responses were simultaneously typed verbatim into a protected database.

**Data Collection**

To determine participant eligibility, the 10-item ACE study questionnaire was used to screen for ACE exposures prior to age 18, including emotional, physical, and sexual abuse; emotional and physical neglect; and household dysfunction such as witnessing domestic violence, growing up with mentally ill, substance abusing, or criminal household members, and parental separation or divorce. Participants’ perceptions of the most helpful aspects of the intervention and how it could be improved from sessions 1 and 2 were addressed by asking the following questions: “What was most helpful about the session?” and “What do you think could be improved about the session?” At follow-up, participants were asked about the program as a whole—for example, “What was most helpful about the program?” and “What do you think could be improved about the overall program?”

**Thematic Analysis**

Participant responses describing what was helpful and what could be improved about the intervention were extracted from the database in a deidentified format. Content analysis was performed using a general inductive approach to identify core themes. Two researchers (EG and SFB) independently performed an analysis to identify emergent themes and met to resolve discrepancies. Several procedures were used to analyze the manifest content of participant responses. Initially, responses were distributed into content analytic units by

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entering individual meaning units into an Excel spreadsheet beneath each corresponding question. Each analytic unit was coded based on the content of the response. The data were reduced by grouping similar responses into categories and assigning them to thematic domains. A third author (JT) performed an audit of the coding. The analytic team discussed and refined themes. Exemplar quotes of participant responses were selected to illustrate identified themes.

**RESULTS**

**Demographics**

Table 1 displays baseline characteristics of Black American patients being seen in a Federally Qualified Health Center within a city in the Upper Midwest. The 40 study participants had a mean age of 44 ± 13 years (range = 20-64). The majority of participants were female (27; 67.5%) with some college or higher (25; 62.5%), and they earned a household yearly income of $30,000 or less (39; 90%). Twenty-six participants (65%) reported 4 or more ACEs and 23 (57.5%) reported 3 or more PTSD symptoms. While 15 participants (37.5%) were currently receiving behavioral health services, 31 (77.5%) reported receiving past mental health counseling.

Participants identified health risk behaviors that they wanted to change, including poor nutrition (13 participants), smoking (8 participants), anger (6 participants), physical inactivity (4 participants), drug use (3 participants), risky sexual behaviors (3 participants), unhealthy alcohol use (2 participants), and stress (1 participants). In total, 36 of 40 participants completed both sessions. Two participants were unable to be contacted and 2 discontinued participation. By the 2-month follow-up, 35 of 40 participants had completed assessments. One participant was unable to be contacted for the follow-up survey. Figure 1 exhibits the participant flow diagram.

**Participant Evaluation**

Satisfaction with the program was high, with 94% of participants endorsing that they were “moderately” or “extremely” satisfied. Participants described what they found most helpful about the 2 individual sessions and the program as a whole. Key themes that reflected participants’ experience of the program included connection with other, personal development, connection with self, and professional resources.

**Connection with Other**

This theme demonstrates how much participants highly valued talking with, being listened to, and feeling understood and accepted by another person. They reported that talking with someone was one of the most helpful aspects of the program.

*Just to talk to someone, that’s what I wanted to do. I wanted to put plans into perspective, you know what I mean?*

Some people don’t have people to talk to. I have people to talk to. But you know, your family may have heard it all before; they may say, “You already said that before!” or things like that, so I find it’s just talking to somebody. That’s what I needed.

Participants found it helpful to have someone to listen to them and felt understood and accepted as they shared their personal stories.

*It wasn’t just her just talking at me and me listening, or me talking about or filling out some list and her writing something down. We communicated together and that went well for me. A lot of times, you just need to listen to people. You don’t even need to mean to ask, you don’t need to. You just need to listen.*

Many participants echoed similar sentiments of feeling heard and understood and appreciated being able to express themselves freely: “She didn’t try to dig into stuff. She just allowed me to explain and talk about what it was I wanted to talk about and come to conclusions on my own.” Another participant spoke of “being able to talk about my feelings with no judgment or feelings of judgment.”

**Personal Development**

Perceived benefits related to personal development noted by participants included creating a behavior change plan, managing stress, and focusing on themselves. It was helpful to have reflection and input to clarify personal health goals.

### Table 1. Baseline characteristics of 40 Black American primary care patients being seen in a Federally Qualified Health Center within a city in the Upper Midwest

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>43.83 ± 13.05</td>
</tr>
<tr>
<td>Range</td>
<td>20-64</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>27 (67.5)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>5 (12.5)</td>
</tr>
<tr>
<td>High school complete</td>
<td>10 (25.0)</td>
</tr>
<tr>
<td>Some college or more</td>
<td>25 (62.5)</td>
</tr>
<tr>
<td>Income, USD</td>
<td></td>
</tr>
<tr>
<td>&lt;10,000</td>
<td>19 (47.5)</td>
</tr>
<tr>
<td>10,000-30,000</td>
<td>17 (42.5)</td>
</tr>
<tr>
<td>&gt;30,000</td>
<td>3 (7.5)</td>
</tr>
<tr>
<td>ACE score</td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>14 (35.0)</td>
</tr>
<tr>
<td>≥4</td>
<td>26 (65.0)</td>
</tr>
<tr>
<td>PTSD score, symptoms (n)</td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>12 (30.0)</td>
</tr>
<tr>
<td>&gt;3</td>
<td>23 (57.5)</td>
</tr>
</tbody>
</table>

*Column percentages may not add up to 100% due to missing values. ACE = adverse childhood experience; PTSD = posttraumatic stress disorder.*

ACE = adverse childhood experience; PTSD = posttraumatic stress disorder.
She listened [and] gave helpful, unique techniques to cope with stress and help maintain whatever my goals were. Sometimes you have goals, but they’re not specific or written down, but she made them more solid and crystal clear. Participants recognized how the sessions allowed more time to focus on the issues in their lives that might be underlying their stress. It was the time to actually talk to acknowledge and give a voice to some of the trauma that might possibly impact what’s going on now and not to stress, but [the] biggest was to look at outcomes and ways to change and spend time focusing. Others shared about how the session helped them to manage stress better. It was a real nice talk to see different perspectives, and the conversation that we did have, it brought me to realize that everything I was stressing over. She showed me how to ease myself and stay relaxed and not think about it while putting my best effort doing something to accomplish my goals and to ease stress and relax.

Connection with Self

A third fundamental theme describes how the intervention helped participants better understand themselves through self-awareness and recognizing their own strengths.

Managing my stress is my own weakness, but learning that I’m strong within myself and that I have the characteristics within myself... that I do have these characteristics, and that I do have the abilities to strengthen myself, and that I do have a way to overcome all the things I am focusing on helps me. Self-understanding and self-expression are critical to the integration of the whole self. One participant commented that the intervention was, “Bringing out some feelings in me that I didn’t know I had.” Another participant shared, “That made me understand that I stress out all the time.” And a third stated, “It brought things to my understanding. It helped me put into perspective how I can get myself back together.” This theme further illustrates helping participants to recognize their struggle and to feel empowered to take action: “It helped me plan out areas I was not doing too well, and it also helped point out all the messages or ways I can go about getting help and approaching my problems head-on.”

Professional Resources

Informational resources (eg, free online resources and self-help and communication books) and the connection to professional supports (eg, counselors and mindfulness practice and substance abuse groups) were reported as being helpful and provided a sense of hope for some participants.

Suggestions for Improvement

Participants described suggestions for improvement for the 2 individual sessions and the program as a whole. Key themes that reflected participants’ experience of the program include intervention structure and content, clinic environment, behavioral health referrals and collaborative care, and the working alliance between counselor and participant. Participants mentioned increasing the length of the first session, which would allow for more time to respond to questions and delve into specific issues. Some participants suggested increasing the number of sessions, stating that they would prefer “being able to talk to her more often instead of just month to month.” Participants commented on aspects of the intervention content that could be improved such as changing the style of the questions, clarifying goals and expectations, distinguishing between research and therapy, and emphasizing the impact of ACEs on health. For example, some questions seemed limiting for some participants who may have preferred open-ended questions that allowed them to speak more freely. In addition, taking time to clarify personal goals and expectations at the onset of the meeting can be helpful to match what the session had to offer with the needs of the individual. For some participants, it was not clear how the intervention differed from a therapy session. Others expressed wanting a better understanding of the link between childhood events and how those experiences affected them today. Participants commented on wanting to talk about sensitive topics in an...
environment that was more comfortable and private as opposed to a medical setting. They also expressed the importance of increasing collaboration and communication between the counselor and clinician to support the goal of improving patient health. Several participants commented on the working alliance between themselves and the counselor. One participant observed the different perspectives and styles between themselves and the interviewer by stating, “It’s just a different way of seeing things. Some of the things she suggested were different than the things I suggested.”

**DISCUSSION**

Participant responses on perceived benefits and limitations reflected the aspects that they found most satisfying and identified what could be improved about the intervention. As a result, these findings can contribute to improving engagement in care for low-income, Black Americans with childhood trauma exposure. The intervention elements described below provide a method for the translation of TIC principles into direct and effective practice by guiding clinicians on how to ask about trauma and to respond sensitively to patient disclosures. Operating within these principles can ensure that clinicians are practicing within a trauma-informed framework and assist to protect against unintentionally revictimizing patients.

According to participants, connection with the counselor was the most helpful aspect of each session and the program as a whole. Talking with a trained professional who can listen without judgment and is able to understand the experience of another creates a sense of safety. Feeling genuinely heard and therefore valued is healing in itself and, in some cases, may be the most effective intervention a clinician has to offer. Feeling accepted when talking about difficult and sensitive topics builds trusting relationships that create the opportunity to share more. Broaching the topic of childhood trauma is more likely to be successful with an accepting and compassionate approach. A clinician’s attitude of acceptance reduces patients’ likelihood of feeling stigmatized, shamed, or blamed for what happened to them and reinforces patient stress responses as a normal reaction to abnormal and overwhelming events or circumstances.

Forming a healthy, secure attachment is the basis for healing trauma and increasing one’s capacity to cope with stress. Unintentionally revictimizing patients by giving permission and offering choice before administering procedures and protocols that may potentially be retraumatizing to trauma-exposed patients. It is not possible to know in advance the profile of every person in a clinical setting who has been trauma exposed; therefore, it is beneficial to practice universal precautions and to apply TIC principles with all patients.

Collaboration was illustrated through the opportunity to clarify and work on realistic and achievable health goals by creating a behavior change plan with a trained professional. The counselor worked collaboratively with participants to create their behavior change plan, taking into account the best scientific evidence available as well as the individual’s values and preferences. The plan helped participants to identify triggers of using health risk coping, create proactive strategies to mitigate triggers, and establish accountability with a trusted individual. The process of developing a plan provided opportunities to point out patient strengths and competence. Emphasizing inherent resilience promoted self-efficacy among participants and notably enhanced the positive connection with the counselor. Additionally, describing the impact of trauma on adult health and consequent use of health risk behaviors as coping with stressful life events helped participants to better understand the connection between their ACEs and their health risk behaviors. Furthermore, garnering insight from talking with the counselor enhanced participants’ understanding of themselves, which bolstered confidence to make different choices. The intervention has the potential to help participants connect with what happened to them in childhood and how those experiences may be affecting them today.

Participants reported developing increased self-understanding as a result of the intervention while also learning about resources that inspired new ways of coping. Many participants arrived at the sessions with a variety of coping skills; through talking with the counselor, they were able to explore new coping strategies and to connect with additional helpful resources. For example, mindfulness-based practices such as breath awareness and relaxation and grounding techniques were introduced to participants as alternatives to respond to difficult situations in new ways. Clinicians and clinic staff can reinforce TIC principles by being aware of dysregulation cues and by introducing regulation skills to counteract distress in their patients. Trauma-related symptoms can provide the impetus to resolve underlying affect dysregulation resulting from past traumas, particularly when clinicians have a trauma-informed approach to health care.

Learning new skills can help to rewire the brain, which is imperative for trauma recovery and healing. As a result,
skills practiced on a regular basis such as mindfulness-based techniques can strengthen cortical functioning and emotional regulation as well as deactivate the fear response stimulated by the amygdala’s survival response to perceived or actual threat, all of which can increase one’s capacity to cope with stress.\(^{48-52}\) Mindfulness practices can be incorporated into a patient visit as a 3- to 5-minute exercise that can assist patients with a direct experience of its benefits.\(^{53}\)

Working collaboratively to identify coping resources that are accessible, affordable, and in accordance with one’s preferences increases chances of sustaining new practices.

Gathering feedback from participant responses provided useful information that can be used to refine and tailor the intervention structure and content, clinic environment, linkages to behavioral health services, and collaboration with clinicians, in addition to the working alliance between the counselor and participant. For example, increasing the number and frequency of sessions would grant additional support and time for participants to adopt new strategies to cope with stressful life experiences. It could also enhance the experience of being heard and listened to, which appeared to make a lasting impression on participants.

Other critical areas of feedback highlighted initially creating a clear understanding of goals and expectations with participants, while inquiring about how the session is working at regular intervals to ensure that their needs are being adequately met during the session. In addition, distinguishing counseling from research would clarify the work to be accomplished and the timeframe in which to do it. A few additional comments underscored the need to provide a comfortable and soothing atmosphere conducive to discussing sensitive topics. It is likely that people attribute these types of conversations to having a therapy session. Incorporating assessments more routinely about ACEs and other sensitive topics into the medical encounter will help to normalize and familiarize patients with having these conversations on a regular basis with their clinician. An additional point was made by participants regarding the need to increase linkages with behavioral health services and improve communication between counselors and clinicians. The facilitation of linkages among diverse clinicians would ensure that connections are made by establishing a system of warm hand-offs with behavioral health providers who are embedded within the clinic or located elsewhere. Finally, increasing the counselor’s awareness and sensitivity to any differences between the counselor and the participant could enhance the therapeutic relationship.

Several limitations qualify the study. First, results emerged from a relatively small convenience sample of patients motivated to make changes in their health behaviors. There were a number of patients who did not attend a scheduled first session, resulting in a 63% no-show rate. Along with the knowledge that the majority of participants had already received mental health counseling, the no-show limitation reinforces the motivated nature of the final sample of participants and recommends potential modifications to the intervention protocol such as outreach to scheduled patients with the assistance of the host clinic and reminder calls. Any potential barriers such as childcare, work schedules, and transportation should be discussed and resolved with participants at recruitment. Adding the session to a medical encounter and having the clinician introduce and recommend the program to their patients may also increase the number of people whom this intervention can potentially reach. It is possible that the high retention rate for those attending a first session may be attributed to the particular nature of the intervention (eg, a strengths-based motivational approach that facilitated counselor-patient rapport). Participant evaluation interviews were performed by a research assistant to minimize social desirability and to maintain participant anonymity. Nonetheless, researchers collected some data through on-site surveys, which may have potentially increased social desirability. The 10-item ACE study questionnaire was normed in a sample of white, middle class, health maintenance organization-insured patients, which would likely underestimate the number of adversities to which a low-income, racially and ethnically diverse patient sample may have been exposed. Future studies testing the efficacy of this intervention should use a more ecologically valid screener that includes the myriad community stressors that underserved patients may encounter.

Future work should assess the efficacy of such interventions. If, as we expect, positive results emerge from randomized field trials, then we would recommend wider uptake of trauma-based screening and brief intervention protocols across primary care settings. Stakeholders will pose questions about how to integrate these services into the clinic workflows. To address such issues, research can explore best practices related to intervention timing, location, and personnel, and insights gleaned can inform local implementation efforts akin to widespread brief intervention implementation initiatives for alcohol and drug misuse. With accumulation of research support and policy advocacy, trauma-related screening and referral services should become reimbursable under similar codes that cover similar substance misuse services.

**CONCLUSION**

The participant evaluation data gathered for this study suggest that through the practice of asking, listening, and accepting, clinicians can help patients who have been exposed to ACEs better understand themselves and their behaviors and ultimately foster resilience-promoting behaviors. It is essential that clinicians listen to patient stories,
since what happened is at the core of trauma healing and relationships are at the core of good health care. The therapeutic qualities of relating are powerful forms of doing that confer relief for patients. The motivation-based intervention featured in this study has clinical utility to help patients change unhealthy behaviors and assist health care clinicians to become more adept at meeting the health care needs of underserved patients with childhood trauma exposure. When implemented within clinics serving low-income patients, the intervention can potentially promote health equity.

Disclosure Statement
The author(s) have no conflicts of interest to disclose.

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Authors’ Contributions
As Principal Investigator and lead author, EG, conceptualized and designed the study, and conducted participant interviews, the qualitative analysis, and interpretation of the results. As the subject matter expert, JT contributed to the conception and design of the study and interpretation of the results. SFB contributed to the analysis and interpretation of the results. As the research assistant, KS collected participant evaluation data. All authors contributed to writing and editing the manuscript in addition to reading and approving the final manuscript.

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