A QUALITATIVE EXPLORATION OF DOCTOR-PATIENT RELATIONSHIP
EXPERIENCES IN TRAUMA SURVIVORS AND PRIMARY CARE PHYSICIANS

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By
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Seint Kokoky, candidate for the degree of Master of Arts in Clinical Psychology, has presented a thesis titled, *A Qualitative Exploration of Doctor-Patient Relationship Experiences in Trauma Survivors and Primary Care Physicians*, in an oral examination held on August 26, 2016. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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ABSTRACT

The Diagnostic Statistical Manual of Mental Disorders, fifth edition, defines trauma as “any event or events that may cause or threaten death, serious injury, or sexual violence to an individual, or his or her close family member or close friend” (American Psychiatric Association, 2013, p. 830). As a result of trauma exposure, there may be a change in the ways survivors think, behave, and relate to others. Survivors’ ability to trust others may be distorted such that they may be unwilling to trust others, including professionals who can provide help. Trauma survivors are also at risk for developing multiple medical and psychological problems. This often results in multiple trips to medical clinics as survivors often depend on primary care physicians as the first line of treatment. Research shows that survivors of childhood abuse, sexual assault, and intimate partner violence have positive and negative experiences with their healthcare providers. Preliminary research suggests that the negative thinking and behaviours as a result of trauma exposure may transfer into survivors’ interactions with healthcare providers. In turn, many physicians report they do not have adequate time or training to address the multiple physical and mental health complaints of trauma survivors, due to the perceived complexity of such problems. It appears that both trauma survivors and physicians who treat them perceive difficulties in their interactions. This study was the first to examine healthcare experiences of trauma survivors and primary care physicians’ experience when interacting with these individuals. Fifteen trauma survivors from Saskatchewan were interviewed to inquire about their healthcare experiences and 11 family physicians (nine practicing physicians and two medical residents) from the province were asked about their professional experience with trauma survivors.
Interviews were digitally recorded and transcribed. The data were analyzed using thematic analysis (Braun & Clarke, 2006), which is an iterative process of reading and coding qualitative data for themes. Trauma survivor and physician participants discussed the importance of trust, connection and communication in the doctor-patient relationship. Physician’s approachable nature, compassion, and competence were all necessary to build trust. When there was trust, patients were more likely to comply with their physicians, and thus leading to better health outcomes. However, when trust was lacking, patients were less likely to adhere to treatment plans, and their health condition remained unchanged. Both participant pools expressed difficulties when interacting with each other and made recommendations on what would be helpful towards a good doctor-patient relationship. Results have implications for policy changes in patient care and health care administration.
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### ABSTRACT


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### DEDICATION


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The Diagnostic Statistical Manual of Mental Disorders, fifth edition (DSM-5) defines traumatic stressors as “[a]ny event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend” (American Psychiatric Association [APA], 2013, p. 830). Similarly, the International Classification of Diseases, tenth edition (ICD-10) defines a traumatic stressor as a “stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime)” (World Health Organization, 1991, p. 120). Traumatic stressors can be classified as either interpersonal trauma, which involves a malicious perpetrator who intentionally harms another human being, or non-interpersonal trauma, which lacks a malicious perpetrator (Lilly, Valdez, & Graham-Bermann, 2011). There are a number of ways to assess for traumatic events (Carlson et al., 2009; Goldberg & Freyd, 2003; Nader, 1996; Weathers et al., 2013a; Weathers et al., 2013b), and there may be different response rates depending on how trauma is defined. The purpose of this research was to explore trauma survivors’ experiences with healthcare professionals and systems and primary healthcare physicians’ professional experiences treating trauma survivors.

1.1 Interpersonal trauma

Interpersonal traumatic stressors may include rape and sexual assault (in childhood or adulthood), physical assault, and intimate partner violence (IPV; Briere & Scott, 2006). Childhood sexual assault includes acts involving a child with the intention
of sexual gratification for the perpetrator. Similarly, these acts of abuse can occur in adulthood and the perpetrators may or may not be spouses or partners (APA, 2013).

1.1.1 Betrayal Trauma Theory. Betrayal trauma is defined as a traumatic event whereby a person’s trust is violated by another person on whom they depend (Freyd, 1997). Betrayal trauma typically occurs when abuse is inflicted on a person by someone who is close to the victim (Freyd, 1997), and the perpetrator is usually someone on whom the victim relies for survival (e.g., parent/caregiver or partner). When this happens, the victim’s trust is broken (Freyd, 1997; Gobin & Freyd, 2009), and as a result, there may be a tendency to distrust those who may be helpful and/or to trust those who may be harmful (Gobin & Freyd, 2013). Moreover, fear and distress are often associated with betrayal trauma, regardless of whether post-traumatic stress disorder (PTSD) develops (DePrince & Freyd, 2002).

1.1.2 Prevalence. The proportion of individuals exposed to an interpersonal traumatic event ranges from 37% to 62% (Breslau et al., 1998). The estimated global prevalence rate for childhood sexual abuse is 20 percent in women and five to ten percent in men (World Health Organization, 2014, January), and for violence against women (including IPV and sexual assault) is 35% (World Health Organization, 2014, November). In North America, the prevalence of childhood sexual abuse is 14.2% in men and 32.3% in women, and of childhood physical abuse is 22.2% in men and 19.5% in women (Briere & Elliot, 2002). In Canada, six percent have reported being abused by their spouse or partner (Statistics Canada, 2011).

1.1.3 Medical and psychological problems for survivors. A large body of research has demonstrated that survivors of interpersonal trauma develop multiple
psychological (such as depression, PTSD, and anxiety disorders) and medical problems (such as headaches, physical injuries, and stomach ulcers; Bonomi, Anderson, Reid, Rivara, 2009; Edwards, Freyd, Dube, Anda and Felitti, 2012; Felitti et al., 1998; Freyd, Klest and Attard, 2005; Goldsmith, Freyd and DePrince, 2011; Walker, Katon and Russo, 2003). PTSD is characterized by experiencing all of the following symptoms for more than one month after exposure to a traumatic stressor: presence of intrusion symptoms (such as distressing memories about the traumatic event and recurrent dreams); avoidance of situations that remind the survivor of the traumatic event; negative thoughts and emotions associated with the traumatic event; and dramatic changes in arousal and reactivity associated with the traumatic event (such as hypervigilance and exaggerated startle response; APA, 2013). Drossman, Talley, Leserman, and Barreiro (1995) found a relationship between abuse history and gastrointestinal (GI) illness. When they examined literature published on abuse history in GI clinic settings, they discovered that individuals abused in the past reported more physical symptoms than those without an abusive past. These individuals, particularly survivors of sexual abuse, were also more likely to seek medical attention for psychosomatic symptoms (e.g., abdominal pains, headaches, and dizziness). Moreover, survivors reported more GI, respiratory, and neurological symptoms than those without any history of past abuse. Drossman and colleagues (1995) concluded that perhaps survivors of abuse experience psychological distress, which activates autonomic pathways in the central nervous system which, in turn, causes GI symptoms. Felitti and colleagues (1998) also made similar observations when they investigated the effects of adverse childhood experiences (e.g., abuse and household dysfunction) in adulthood. When they examined adults who were part of their Health
Maintenance Organization study, they found that having adverse childhood experiences was associated with health risks, such as smoking, severe obesity and suicide attempts.

The relationship between the perpetrator and survivor may be a factor in health outcomes for survivors of abuse. In a study by Edwards, Freyd, Dube, Anda, and Felitti (2012), childhood sexual abuse was characterized as being either low in betrayal (when the perpetrator was a stranger, friend or relative not living at home) or high in betrayal (when the perpetrator was a relative or non-relative living at home). Results showed that mental health outcomes (e.g., depression, suicide attempts, anxiety, panic attacks) were markedly higher in survivors of childhood sexual abuse who experienced high betrayal than in those who experienced low betrayal.

It has also been documented that female survivors of IPV seek medical attention for many reasons, including mental health disorders, sexually transmitted infections, lacerations, broken bones, female reproductive problems and neurological diseases (Bonomi et al., 2009). It has been estimated that in the U.S. alone, survivors of IPV use healthcare services significantly more frequently than those without past abuse. These healthcare services include visits to primary care providers, emergency physicians, specialists, pharmacy, mental health facilities, and inpatient care (Walker, Katon, & Russo, 2003). Based on previous studies, it appears that trauma survivors have more medical and psychological problems than individuals who have not experienced trauma.

1.2 Non-interpersonal trauma

There are several ways in which individuals may be traumatized in the absence of a malicious perpetrator: natural disasters, large-scale transportation accidents, domestic fires, and motor vehicle accidents are some examples. Natural disasters are large-scale adverse
environmental events that cause injury or death (such as earthquakes, floods, hurricanes, and tornadoes). Large-scale transportation accidents (such as airline crashes and train derailments) often result in injuries to or deaths of many individuals. Domestic fires, including house fires, may lead to physical injuries and may be traumatizing for survivors. Motor vehicle accidents (MVA) are traffic accidents as a result of a vehicle colliding with another vehicle, a living being or a stationary obstruction (such as a utility pole), and may result in injuries or deaths to the individuals involved (Briere & Scott, 2006).

1.2.1 Prevalence. Twelve to sixty percent of individuals may be exposed to traumatic non-interpersonal events (Breslau et al., 1998). WHO reports that approximately 90,000 individuals die and 160 million people are affected worldwide each year as a result of natural disasters (World Health Organization, 2015). In Canada alone, over 47,000 fires and approximately 226 deaths as a result of these fires have been recorded between 2003 and 2007 (Council of Canadian Fire Marshals and Fire Commissioners, 2007). In regards to MVAs in Canada, there are 2,077 to 3,615 deaths and 165,172 to 247,593 injuries annually resulting from MVAs (Transport Canada, 2014).

1.2.2 Medical and psychological problems for survivors. Survivors of non-interpersonal trauma may develop psychological problems in addition to physical injuries as a result of trauma exposure (Blanchard, Hickling, Taylor, Loos, & Gerardi, 1994; Briere & Scott, 2006; Gilboa, Friedman, & Tsur, 1994). Survivors of natural disasters may be traumatized by the extent of physical injury, fear of death, and property damage (Briere & Scott, 2004). They may also continue to experience psychological distress several years following the disaster (Bland, O’Leary, Farinaro, Jossa, & Trevisan, 1996).
In addition to skin injuries, burn trauma survivors may experience shock and have infections, depending on the severity of the trauma (National Institute of Health, 2015). Some may also experience inhalation injury if they breathe in smoke (National Institute of Health, 2015). Many survivors are traumatized during the burn incident and hospitalization period, and some continue to experience psychological distress (Gilboa, Friedman, & Tsur, 1994). Survivors may also develop PTSD, anxiety disorders, and major depression (Willebrand, Andersson, & Ekselius, 2004). The majority of MVA survivors have physical injuries, such as cuts, bruises, whiplash injury, and in some cases, severe head injuries leading to a loss of consciousness (Blanchard et al., 1995, 1996). Forty-six percent of MVA survivors develop PTSD, of whom 48% also meet criteria for major depression, and 20% show sub-clinical levels of PTSD (Blanchard, Hickling, Taylor, Loos, & Gerardi, 1994).

1.3 Sequelae of trauma exposure

1.3.1 Changes in cognition. Research shows that exposure to trauma and the development of PTSD are influenced by cognitive distortions such as pre-trauma beliefs (e.g., pre-existing perceptions about themselves and the safety of the world), negative appraisals of the traumatic event, negative views of the world, and self-blame (Bennett, Beck, & Clapp, 2009; Dunmore, Clark, & Ehlers, 2001; Ehlers & Clark, 2000; Moser, Hajcak, Simons, & Foa, 2007). This type of cognitive processing has been observed in survivors of sexual assault (Resick, 1993), crime related trauma (Resick, 1993), motor vehicle accidents (Bennett, Beck, & Clapp, 2009), and refugees (Ssenyonga, Owens, & Olema, 2013). There exist individual differences in appraisal of trauma and its sequelae, and individual differences in the way traumatic events are stored in memory. However,
compared to those who recover from trauma exposure, individuals with persistent PTSD appraise traumatic events as a continual threat rather than a specific past event (Ehlers & Clark, 2000).

Ehlers and Clark (2000) outlined in their cognitive model of PTSD that it is the negative persistent appraisal of a traumatic event that perpetuates the symptoms of PTSD. Individuals with PTSD perceive a greater probability of further catastrophic events occurring, such as “bad things always happen to me” (Ehlers & Clark, 2000, p. 321). Initial symptoms of PTSD (e.g. flashbacks, mood swings, lack of concentration) that are common immediately following a traumatic event are not seen by the individuals as part of normal recovery, but as negative evaluations of themselves.

Other research demonstrated results that are in line with this cognitive model of PTSD (Dunmore, Clark, & Ehlers, 2001; Elsesser, & Sartory, 2007; Resick, 1993). Sexual assault trauma survivors, who endorse self-blame and accept responsibility, are more likely to have more psychological distress (Resick, 1993). When Dunmore, Clark, and Ehlers (2001) followed individuals who have been physically or sexually assaulted, they found that mental defeat, negative appraisal of initial symptoms, negative appraisal of other’s responses, and negative beliefs after assault were significantly associated with PTSD severity. Individuals with PTSD compared to recent trauma survivors had higher perceived threat of trauma, more intense and persistent dissociation, and more intrusive symptoms (Elsesser & Sartory, 2007). In short, negative cognitive processing following a trauma exposure may put individuals at risk for developing PTSD.

Many trauma survivors experience shame and guilt (Jonsson & Segesten, 2004; Lee, Scragg, & Turner, 2001; Leskela, Dieperink, & Thuras, 2002; Street & Arias, 2001).
Shame can be understood as negative beliefs or evaluations of the self (such as feelings of worthlessness) or beliefs that others will see the self as inferior (such as stigma; Lee, Scragg, & Turner, 2001; Leskela, Dieperink, & Thuras, 2002). Guilt is felt when there are beliefs that one has done something wrong or has caused harm to others, and is often associated with a sense of responsibility (Lee, Scragg, & Turner, 2001; Leskela, Dieperink, & Thuras, 2002). For instance, paramedics may experience guilt when they are unable to save a life, especially if a promise of a positive outcome was made to the patients and/or their relatives (Jonsson & Segesten, 2004). These feelings of shame and guilt have been observed in different trauma survivor populations (such as prisoners of war, paramedics, and intimate partner violence survivors; Jonsson & Segesten, 2004; Leskela, Dieperink, & Thuras, 2002; Street & Arias, 2001).

Trauma survivors may also endorse certain cognitive schemas about safety and trust. A negative schema about safety related to the self is “the belief that the self is uniquely vulnerable to future harm, injury, or loss or the belief that one is incapable of protecting oneself from future harm, injury, or loss” (McCann, Sakheim, & Abrahamson, 1988, p. 561). For example, an individual who previously believed the world was a safe place may no longer hold this belief after a criminal victimization. A negative schema about safety related to others is “the belief that other people are dangerous or can be expected to cause harm, injury, or loss” (McCann, Sakheim, & Abrahamson, 1988, p. 562). For instance, individuals who survived repeated abuse may expect others to hurt them. In regard to trust, individuals may doubt their own perceptions or judgements and/or may develop mistrust towards others. These negative cognitive schemas will then
affect the way survivors adapt to their traumatic experiences (McCann, Sakheim, & Abrahamson, 1988).

1.3.2 Changes in behaviour. There are two main behavioural strategies that trauma survivors use to cope with their distress. The first is problem-focused coping whereby the survivor seeks information about the stressor and attempts to resolve the stressor. This coping strategy results in lower levels of distress (Littleton, Horsley, John, & Nelson, 2007) and increases resilience of the individual (Stratta et al., 2015). The second is avoidance, where the survivor actively attempts to minimize intrusive symptoms (Asmundson, Stapleton, & Taylor, 2004), and is the more commonly studied of the two coping strategies (Fuerer, Nishith, & Resick, 2005; Lawrence, Fauerbach, & Munster, 1996; Shapiro, Kaplow, Amaya-Jackson, & Dodge, 2012; Littleton et al. 2007; Van Minnen & Hagenaars 2010).

Reviewing memories after a traumatic event is part of normal recovery, and avoidance hampers recovery (Lawrence, Fauerbach, & Munster, 1996). The DSM-5 describes the avoidance criteria for PTSD as persistent avoidance of internal (such as distressing memories, thoughts, or feelings) or external (such as places or people that arouse distressing memories, thoughts, or feelings) stimuli associated with traumatic events occurring after the traumatic event. In burn trauma survivors, avoidant behaviour was significantly correlated with intrusive thoughts upon discharge from the hospital and at four month follow-up (Lawrence, Fauerback, & Munster, 1996). Turning to alcohol or substance use may also be considered as a form of avoidance (Chung, Walsh, & Dennis, 2011). Substance use may be associated with psychological ailments as a result of trauma exposure (Bonomi et al., 2009; Edwards et al., 2012; Tucci, Kerr-Correa, &
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Souza-Formigoni, 2010), and is also a form of behavioural coping strategy used by trauma survivors (Carver, 1997; Chung, Walsh, & Dennis, 2011; Potter, Vujanovic, Marshall-Berenz, Bernstein, & Bonn-Miller, 2011). Survivors may use substances as a way to manage and escape from guilt and other unpleasant emotions associated with exposure to trauma (Lee, Scragg, & Turner, 2001).

Survivors use avoidance so that they are not reminded of the traumatic event and any accompanying distressing thoughts or bodily sensations associated with it (Dunmore, Clark, & Ehlers, 2001; Morina, N., 2007; Plumb, Orsillo, & Luterek, 2004). Ironically, avoidance coping is likely to lead to impairment in psychological functioning, such as feeling distressed or numb (Plumb, Orsillo, & Luterek, 2004). Avoidance has also been shown to be positively associated with future depressive symptoms, dissociative symptoms, and PTSD symptoms (Shapiro et al., 2012). Van Minnen and Hagenaars (2010) found that avoidance behaviour maintained PTSD symptoms. In a meta-analysis (Littleton et al., 2007) examining the association between coping strategies following traumatic events (including assault/abuse, robbery, and severe injuries) and distress, avoidance was strongly associated with distress, whether it was general distress, depression, or PTSD symptoms. Similarly, avoidance was found to be strongly associated with greater PTSD severity (Dunmore, Clark, & Ehlers, 2001). Avoidance has also been shown to be negatively associated with quality of life (Morina, 2007). In conclusion, although survivors use avoidance to escape from trauma-related distress, it may in turn increase the distress from which they are trying to escape.

1.3.3 Changes in trust. Healthy adult relationships rely on trust, having a secure sense of self, and knowing when and how to rely on another person (Cole & Putnam,
Trust is also related to secure attachment and the ability to depend on others (Hazan & Shaver, 1987; Mikulincer, 1998). However, when there is mistrust or a lack of trust, individuals are not able to form healthy adult relationships (Cole & Putnam, 1992). Lack of trust may also lead to distress in the relationship and its dissolution (Mikulincer, 1998). Individuals, who have been abused, including children, have reduced trust of others (Cole & Putnam, 1992; DiLillo & Long, 1999; Gobin & Freyd, 2009; Gobin & Freyd, 2013; Jurgens, 2005).

DiLillo and Long (1999) examined relationship functioning in childhood sexual abuse trauma survivors by studying 167 female college students who were in relationships that were six months or longer at the time of participating. The study required participants to complete questionnaires on childhood sexual experiences, marital satisfaction, interpersonal trust (using the Specific Interpersonal Trust Scale-Female Form; Johnson-George & Swap, 1982) and communication patterns in monogamous relationships. They found that abuse trauma survivors reported lower reliable (perceptions of others as reliable) and emotional (perceptions of others as emotionally trustworthy) components of trust than women without a history of abuse. When Gobin and Freyd (2009, 2013) investigated trust in undergraduate students, participants who had experienced high betrayal trauma reported lower trust in others compared to those who did not report any high betrayal trauma.

As previously mentioned, trauma survivors may have negative cognitive schemas about trust (McCann, Sakheim, & Abrahamson, 1988). Similarly, there are interpersonal schemas that are “generic cognitive representation[s] of interpersonal events” (Safran, 1990, p. 89). Safran (1990) describes that interpersonal schemas are subjective for
individuals to allow them to establish interpersonal relatedness and proximity with others. Individuals may plan activities to maintain interpersonal relatedness that are congruent with their interpersonal schemas. However, interpersonal schemas may, in turn, bias individuals against remembering events that are incongruent with their schemas. For example, if an individual believes relatedness relies on being warm and kind, then they may fail to remember times when they have been uncaring (Safran, 1990). Memories of trust and betrayal may be more accessible in trauma survivors, but memories of positive events may be less accessible (Mikulincer, 1998). When Jurgens (2005) investigated the relationship between interpersonal schemas and interpersonal problems in 61 women who were child abuse survivors, results showed that women with more negative interpersonal schemas had a greater number of interpersonal problems.

Attachment may be understood as a deep emotional bond between two individuals (Bowlby, 1969). It may be related to trust, as the kind of attachment style an individual identifies with is related to their views of the self and of others. Having a secure attachment would indicate the individual harbours positive self-views and positive views of others. On the other hand, a combination of positive and negative views of the self and of others, or negative views of both self and others, is associated with insecure attachment (Bartholomew & Horowitz; 1991). Negative views of self and/or others can lead individuals to be demanding and dependent on others, compulsively self-reliant and often downplay the importance of intimate relationships, or dependent on others and avoiding intimacy in fear of rejection (Bartholomew & Horowitz, 1991). Attachment styles may then influence relationship dynamics such that partners may want to increase or decrease emotional and/or physical closeness (Allison, Bartholomew, & Mayseless, 2008).
Much of the research on trust in interpersonal relationships has been discussed in the context of sexual abuse and betrayal trauma. This may be a limitation in the literature and it is unclear how non-interpersonal trauma survivors process trust in the wake of their trauma experience. In spite of this, the literature suggests that trust is an important aspect in interpersonal relationships and, in turn, can be affected by interpersonal schemas.

1.3.4 Power differential. Finkelhor and Browne (1985) define powerlessness as a dynamic process where an individual’s “will, desires, and sense of efficacy are continually contravened” (p. 532). In the case of child sexual abuse, for example, there is a basic sense of powerlessness for the child during the abuse itself, as the child’s body and space are invaded; and any further coercion and manipulation adds to the feeling of powerlessness (Finkelhor & Browne, 1985). As a result of feeling powerlessness, there may be a need to control or dominate others (Finkelhor & Browne, 1985; Gartner, 1999) that may then result in aggression towards others or appearing fearsome (Finkelhor & Browne, 1999). Conversely, individuals may want to appease authorities if they are feeling vulnerable as a result of past powerlessness experiences (Gartner, 1999). Much of the research on powerlessness has focused on abuse trauma (Coffey et al., 1996; Finkelhor & Browne, 1985; Freyd, 1997; Gartner, 1999; Kinzl & Biebl, 1992; Volpe, Hardie, & Cerulli, 2011), but Finkelhor and Browne (1985) argue it can be generalized to other types of trauma. The role of powerlessness on interpersonal relationships as a result of other types of trauma is understudied.

1.4 Patients’ contributing factors in doctor-patient relationship

1.4.1 Patient satisfaction. Patients can be viewed as consumers of healthcare systems and patient satisfaction can be understood as fulfillment of their expectations of
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Factors that influence patient satisfaction include accessibility, quality, availability, continuity, and efficacy of care (Cleary & McNeil, 1988; Pascoe, 1983; Sitzia & Wood, 1997); however, patients’ personal preferences and expectations may affect the way they interpret the aforementioned factors (Sitzia & Wood, 1997). In a study by Like and Zyzanski (1987), whether patients’ desires were met explained significant variance in patient satisfaction. The more healthcare providers meet their patients’ expectations, the more satisfied patients will be (Sitzia & Wood, 1997). Aspects of care may be further broken down into technical and interpersonal aspects (Cleary & McNeil, 1988). Technical aspects of care include competence and qualifications of the physician, and patients’ perceptions of their physicians’ skills. Interpersonal aspects of care include accurate and complete communication between physicians and patients, how patient preferences are taken into consideration for treatment plans, and the level of empathy and care expressed by physicians.

How physicians approach and communicate with patients affects patients’ feelings and behaviours, and satisfaction with the care they receive (Korsch, Gozzi, & Francis, 1968). Physician empathy facilitates exchange of information—which in turn increases patients’ perceptions of physician expertise—and builds partnership and interpersonal trust between patient and physician (Kim, Kaplowitz, & Jonston, 2004). Five hundred participants were asked about characteristics of themselves and their physicians, and satisfaction with healthcare immediately following their visit and two to twelve weeks post-visit. Patient expectations and doctor-patient interaction (such as receiving explanations of symptom aetiology) were predictors of satisfaction immediately following the visit (Jackson, Chamberlin, & Kroenke, 2001). Like and Zyzanski (1987)
found that patients’ perspectives on whether their physicians liked them was a significant predictor of patient satisfaction. Quality of care and of encounters with physicians appear to have substantial influence on patient satisfaction.

Clinical outcomes, patient’s perceived health, and patient characteristics also impact patient satisfaction. Patients who perceive themselves as healthier are more satisfied with their healthcare experience (Young, Meterko, & Desai, 2000). In a study by Jackson, Chamberlin, and Kroenke (2001), patient functioning predicted patient satisfaction immediately post-visit as well as two to twelve weeks following the visit, and whether symptoms improved predicted patient satisfaction in the follow-up period. Those with better functioning rated higher satisfaction, and those whose symptoms improved also rated higher satisfaction (Jackson, Chamberlin, & Kroenke, 2001). How knowledgeable patients are about their presenting problems also affects their satisfaction (Like & Zyzanski, 1987). Older patients and female patients tend to report better patient satisfaction after accounting for all other factors (Jackson, Chamberlin, & Kroenke, 2001; Like & Zyzanski, 1987).

1.4.2 Patient expectations. Patient expectations may be understood as the patient’s anticipation of events that are likely to occur in the context of medical care. Patients may communicate their expectations to their physicians either verbally or in writing (Ulmann, Inui, & Carter, 1984), and their expectations can be observed through the responses they provide and the questions they ask (Korsch, Gozzi, & Francis, 1968; Street, Makoul, Arora, & Epstein, 2009). Patient expectations may also be communicated through facial expressions, language, and tone of voice (Ulmann, Inui, & Carter, 1984). Specific patient expectations may include physical examinations, medical
tests, referrals, information about their symptoms, counselling, and discussion about what the patient had in mind for managing symptoms (Bell et al., 2002; Kravitz, Cope, Bhrany, & Leake, 1994). In emergency departments, patients expect staff to listen to their concerns and provide reassurance as they are anxious, nervous and in pain. They also expect frequent updates, explanations for their symptoms, a diagnosis, and immediate treatment (Watt, Wetzler, & Brannan, 2005). When patients’ needs are met, they become more attentive and accepting of physicians’ advice (Bell et al., 2002; Korsch, Gozzi, & Francis, 1968). They are also more likely to have higher patient satisfaction than those whose expectations were unmet (Bell et al., 2002; Watt, Wetzler, & Brannan, 2005).

1.4.3 Trust in physicians. Patients’ trust in physicians may be due to trust in physicians in general, trust in the healthcare system, or positive experiences with individual physicians (Gordon, Pugach, Berbaum, & Ford, 2014). Hall, Dugan, Zheng, and Mishra (2001) postulate that trust in physicians is comprised of four components: fidelity (i.e., physicians having the best interests for their patients), competence (i.e., physicians not making mistakes and achieving the best results), honesty (i.e., physicians telling the truth, admitting mistakes, and not providing any false hopes), and confidentiality (i.e., proper use and protection of sensitive information). They also posit that there is an emotional and non-rational component of trust, such that when expectations are not met, patients may feel betrayed. For patients who have been severely injured, informational support (such as assistance with knowledge, information, and skills patients can use to address the problem) and emotional support (such as empathy, care, and concern) from physicians are important for these patients to develop or maintain trust in their physicians (Ommen et al., 2008). Moreover, patients who
reported having good communication with their physicians also reported having higher trust in physicians (Gordon et al., 2014). It is important for patients to have trust in their physicians as it affects their adherence to treatment and their satisfaction with the service they receive (Bell et al., 2002; Hall et al., 2001).

**1.4.4 Help-seeking behaviours.** An individual’s help-seeking intentions are associated with gender, severity of their symptoms, and any stigmatizing beliefs surrounding their disorders (Barber, 2008; Barney, Griffiths, Jorm, & Christensen, 2006; Galdas, Cheater, & Marshall, 2005; Mojtabai, Olfson, & Mechanic, 2002; Oliver, Pearson, Coe, & Gunnell, 2006). In a large survey study of general health and help-seeking behaviours, men were less likely than women to seek help, and help-seeking behaviour was positively associated with age and worsening health (Oliver et al., 2006). Male survivors of intimate partner violence trauma who develop injuries (such as severe bruising, lacerations, and injuries to genitals) are less likely to seek treatment than female survivors (Barber, 2008). In a literature review on men’s health-related help-seeking behaviour, there was a delay in help-seeking behaviours in men compared to women, and men were less likely to report psychosocial problems and distress (Galdas, Cheater, & Marshall, 2005). Some women may also be reluctant to seek help, especially if they are survivors of interpersonal trauma (such as intimate partner violence or sexual assault; Campbell, 2005; Campbell & Raja, 2005; Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Liang and colleagues (2005) found that intimate partner violence trauma survivors’ decision to seek help was based on whether the survivors recognized their problems as undesirable and whether they saw their problems as unlikely to go away without help. Those who perceive their problems as undesirable (such as escalating
violence) and/or those who believe their problems will not go away without help are more likely to seek help (Liang et al., 2005). In a community sample examining help-seeking intentions associated with depression, respondents reported feeling embarrassed about seeking help as they expected negative responses from health professionals (Barney et al., 2006). This expectation was in part due to perceived stigma (i.e., their perception of others’ negative response) and self-stigma (i.e., negative attitudes about themselves; Barney et al., 2006).

1.5 Physician contributing factors

1.5.1 Communication. Physician communication with patients is vital for dissemination of medical information such as diagnoses, test results, treatment plans and treatment alternatives, and medication side effects (Heisler, Bouknight, Hayward, Smith, & Kerr, 2002; Street et al., 2009). It has been shown to be associated with better patient self-management, adherence to treatment, and better physical and psychosocial health (Zolnierek, & DiMatteo, 2009; Heisler et al., 2002; Street et al., 2009). There are two main types of communication styles physicians may adopt: patient-centered and biomedical. Patient-centered communication includes developing an understanding of the patient, conveying empathy, and finding common ground with the patient; whereas physicians who adopt a biomedical communication style are direct and focus primarily on biomedical issues (Swendon et al., 2004).

In a classic study by Bensing (1991), videos of physician consultations with patients who had hypertension were evaluated for quality of psychosocial care, doctor-patient communication, and physician behaviour. The videos were assessed by experienced general practitioners, psychologists, and the physicians’ own patients.
Components of doctor-patient communication examined included affective behaviour (such as showing interest, nonverbal attention, encouragement, and verbal empathy), systematic and purposive behaviour (such as clarification, structure, and purposive probing [or willingness to discuss psychosocial aspects of the presented problem]), and patient-centered behaviour (both in diagnostic and therapeutic phases). Results showed that nonverbal attention, verbal empathy, encouragement, and purposive probing predicted patient satisfaction.

In a study by Swendon and colleagues (2004), patients were shown videotaped vignettes of patient and physician communication on complementary and alternative medicine, wherein half the videos, physicians used patient-centered communication and in the other half, biomedical communication. The videos only differed in physician communication style—both had the same recommendations and information about associated risks. The majority of patients in this study preferred patient-centered communication. They appreciated that the physician listened more in the patient-centered communication, and that the physician was more open minded, took the patient’s problem seriously, and gave the patient full attention.

Rhodes and colleagues (2007) conducted a study where they examined audio recorded sessions of emergency physicians with women who were intimate partner violence trauma survivors. Results showed that the trauma survivors were more likely to disclose abuse when their physicians asked open-ended questions and probed for information about abuse with at least one follow-up question. The physicians’ response to disclosure was also important to the patient. Trauma survivors reported feeling empowered when physicians were empathetic and supportive, and provided
encouragement. Results also showed that some physicians responded to abuse disclosure with awkwardness, changed topics, or failed to acknowledge abuse.

1.5.2 Empathy. Physicians showing empathy towards their patients affect their relationship with their patients in a positive way (Hojat et al., 2002). Empathy has a cognitive and an affective aspect (Hojat et al., 2002; Kim, Kaplowitz, & Johnston, 2004). The cognitive aspect is the physicians’ capacity to understand their patients’ mental states and points of view, and the affective aspect is the physicians’ ability to have joint emotional experience with their patients and to respond such that their patients’ emotional states are improved (Hojat et al., 2002; Kim, Kaplowitz, & Johnston, 2004). Physician empathy has been shown to positively influence patient satisfaction and compliance with treatment (Kim, Kaplowitz, & Johnston, 2004; Pollack et al., 2011; Steinhausen et al., 2014). In patients with cancer, for example, surgeons’ behaviour during a cancer diagnostic interview (where the surgeon informs patients of their cancer diagnosis and available treatment options) predicts psychological adjustment to the diagnosis and medical condition (Roberts, Cox, Reintgen, Baile, & Gibertini, 1994). Additionally, surgeons who appear caring and empathetic have a positive influence on their patients’ psychological well-being (Roberts et al., 1994).

Hojat and colleagues (2011) investigated the relationship between family and community physicians’ empathy and the blood sugar and cholesterol levels of their patients with diabetes in a U.S. hospital. Physician empathy was measured using the Jefferson Scale of Physician Empathy (Hojat et al., 2001) and was further characterized as high, moderate, and low. High physician empathy scores were associated with a lower proportion of patients with high blood sugar levels and high cholesterol levels compared
to physicians with low empathy scores, above and beyond physician and patient demographics and the type of insurance patients had. The authors concluded that physician empathy has a positive influence on patients’ clinical outcomes. This study was replicated in Italy by Del Canale and colleagues (2012) and they obtained similar findings. In addition, high physician empathy scores were associated with lower rates of patients with metabolic complications due to diabetes.

Steinhausen and colleagues (2014) examined trauma surgery patients’ judgements of their treatment outcomes and physician empathy behavior. Physician empathy behaviour was rated by patients by answering how much they agree with statements regarding their physicians’ behaviour (such as, “did the physician behave in a manner that made you feel completely at ease”; p. 55). Patients also evaluated their medical treatment outcome, quality of life, psychosocial care, and satisfaction with the care they received. Results showed that patients who indicated their physicians as having higher empathy also rated better perceived medical treatment outcome, higher quality of life and greater patient satisfaction.

1.5.3 Experience with trauma survivors. Physicians may classify patients who are trauma survivors as “difficult patients,” and feel frustrated and overwhelmed when interacting with them (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Chung et al., 2012; Green et al., 2011). They often do not discuss patients’ trauma histories due to their perceived complexity and their discomfort with the topic (Beynon et al., 2012; Williamson et al., 2004). Common barriers for physicians when treating trauma survivors are lack of time and lack of training (Beynon et al, 2012; Green et al., 2011). As a result, they feel inadequate in working with trauma survivors (Green et al., 2011).
When physicians were asked about their attitudes and knowledge about IPV, the majority reported having poor to fair competence in treating IPV trauma survivors. Moreover, some felt that IPV was a social problem and not a medical one (Williamson et al., 2004). Conversely, when physicians were asked about trauma in general, they associated trauma with physical injury but not emotional problems. In this way, trauma is normalized, as it is not understood as a mental health problem. There are factors (such as a trusting relationship and the physician’s comfort with mental health issues) that facilitate physicians’ relationships with trauma survivors (Chung et al., 2012). When physicians are given training on how to understand and effectively respond to trauma survivors, they demonstrate better patient-centered communication.

**1.6 Doctor-patient relationship summary**

Doctor-patient relationships are affected by both the patient’s and physician’s perspectives and other factors (such as trust and experience). Patients expect their physicians to provide them with certain information about their symptoms and treatment available to alleviate these symptoms, and whether these expectations are met affects their satisfaction with healthcare. Patient satisfaction is also influenced by the physician’s communication style and whether the physician is empathetic towards the patient’s suffering. This in turn impacts patients’ trust in their physicians, and having trust in physicians leads to better compliance with treatment. Given that trauma exposure affects trust in interpersonal relationships and trauma survivors (particularly interpersonal trauma survivors) may be less likely to seek help, the disassociation of the aforementioned factors may explain the link between trauma exposure and poor health. Furthermore, research demonstrates that physicians label their patients who are trauma survivors as “difficult
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patients” because of the complexity of the problems these patients present. Better understanding of the doctor-patient relationship between trauma survivors and physicians who treat them will help towards explaining the link between trauma exposure and poor health and towards creating better healthcare interventions for trauma survivors.

1.7 Current study and Research impetus

Past studies investigating healthcare experiences of trauma primarily studied women and interpersonal trauma. Additionally, most of the studies on physician experiences with trauma survivors utilized questionnaires or focus groups, and mainly addressed IPV. In contrast, one of the aims of this study was to examine healthcare experiences of individuals, both men and women, with varied types of past trauma. This study addressed the following research questions in relation to trauma survivors: 1) what are the common characteristics of positive and negative healthcare experiences for trauma survivors? 2) Have they talked about their traumatic experiences with a healthcare provider? 3) What are some of the difficulties they experience when visiting a physician? 4) What would they find helpful in dealing with physicians and nurses?

The second aim of this study was to interview primary care physicians to inquire about their professional experience when encountering trauma survivors in their practices. Similar research questions for the physicians were raised: 1) what are the common characteristics of positive and negative interactions for physicians with their patients who are trauma survivors? 2) Have they talked to their patients about their patients’ traumatic experiences? 3) What are the difficult aspects of talking to patients who have a history of trauma? 4) What would they find helpful in dealing with trauma survivors? To date, this study will be one of few to investigate both trauma survivors’
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patient experience and physicians’ perspectives on these individuals. It was expected that while many participants with past trauma will have positive and negative experiences with their general physicians, there will be distinct features (such as care and empathy, or lack thereof) that distinguish the two kinds of relationships. Similarly, primary physicians will also have positive and negative experiences when managing patients with a history of trauma, and distinct features of these interactions will distinguish positive from negative experiences. By asking these questions, it was expected that in-depth information about doctor-patient relationships would emerge.

I was surprised to discover the lifetime prevalence of experiencing a traumatic event is 89%, of which 60% is exposure to interpersonal trauma. Many trauma survivors seek medical services, but many see the physician just for the presenting medical problem. Sometimes these medical problems are deeply rooted in their traumatic past, but their traumatic experiences are infrequently discussed. For example, a woman with a history of child abuse and sexual assault may repeatedly visit a physician for her GI problems, headaches, and insomnia. After performing several medical tests and referring her to a GI specialist, the physician concludes there is no medical cause to explain her symptoms. However, if a conversation about her traumatic experiences does not take place, the physician may not know the underlying reasons for the symptoms the patient is presenting with. Although it may be beneficial to rule out any medical causes to the patient’s symptoms, it may also be more cost-and-time effective to have a conversation about the patient’s traumatic experiences. Furthermore, once a discussion about the patient’s traumatic past has taken place, the physician can provide her with the appropriate care, referrals, and resources. I am invested in discovering the reasons why a
trauma survivor may or may not have a discussion with their healthcare provider about their trauma experiences in the hopes of imparting this knowledge to physicians on how to initiate a conversation about their patients’ traumatic experiences in order to investigate whether their patients’ traumatic past is the root of their current medical symptoms.

There is a more important reason for conducting this research project. Trauma survivors experience several changes following exposure to trauma, many of which have been discussed earlier in this thesis. What I believe to be one of the more damaging consequences of trauma is how it affects relationships with others. Some may lose trust in others and some may no longer feel safe. When many have to seek medical attention for their problems, their relationship with healthcare providers becomes important. It may be possible that changes in the way trauma survivors interact with others affect their relationships with healthcare professionals. I would like to learn about what it has been like for them to seek help. Whether or not trauma survivors discuss their traumatic past with their providers, they still have to discuss sensitive or personal concerns with the providers. I would like to learn what would make them feel comfortable sharing these concerns.

My motivation to explore physicians’ experiences stem from my past work experience. I worked for a neurologist before embarking on my graduate studies, and I had the privilege of discussing many of his patients’ cases with him and the clinical team. I witnessed how the way he interacted with his patients affected how comfortable they were with him. I remember when a sick woman lying on a hospital gurney just broke into a smile when my former supervisor took her hands in his and told her he will be with her soon. I also remember when he took the time at the end of his day to listen to a
patient tell him about the troubles she had adjusting to her neurological problems. Conversely, there were patients towards whom my former supervisor felt frustrated and exasperated. Examples of these patients included those who did not follow through with their treatment plans, demanded particular medication (particularly pain medication), or persistently called the office. Although the doctor fulfilled his medical duties, he did not spend any more time than necessary with these patients. His perception of- and feelings towards his patients influence the amount of time he spent with them and his desire to help them. Because of my past work experience I felt compelled to learn about providers’ perspectives as well. It was not enough to simply learn about the healthcare experiences of trauma survivors given that healthcare providers also contribute a significant portion to their experiences. Therefore, I must also investigate providers’ experiences with trauma survivors. At the end of this research endeavour, I hope to learn from personal accounts about what it has been like for trauma survivors to seek care and similarly what it has been like for physicians to treat trauma survivors.
2.1 Overview of Thematic Analysis

Qualitative research “allows researchers to get at the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables” (Corbin & Strauss, 2008, p.14). Researchers are expected to be curious and to trust their instincts (Corbin & Strauss, 2008). Although there are several different forms of qualitative research (such as phenomenology, grounded theory, and ethnography; Creswell, 2012), I chose thematic analysis because I needed a method to identify, analyze, and report patterns within the data, while accurately presenting participants’ experiences and stories in a comprehensive manner. However, I did not necessarily need to be guided by specific theoretical approaches or philosophical ideas (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Braun & Clarke, 2006). The methodological framework for thematic analysis is a combination of methods and techniques from grounded theory, interpretivism, positivism, and phenomenology, while drawing epistemological learning from positivist and interpretive perspectives (Guest, MacQueen, & Namey, 2012).

“Ontology refers to our most basic beliefs about what kind of being a human is and the nature of reality. This is the basis for developing an epistemology which defines the nature of the relationship between enquirer and known, what counts as knowledge, and on what basis we can make knowledge claims” (Grant & Giddings, 2002, p. 12). The interpretivist researcher is a realist who interprets the significance of self-understanding that participants may not have seen or realized. The researcher is both a listener and interpreter of data (Grant & Giddings, 2002). The positivist researcher values objectivity
and objective reality through systematic and detailed observations while testing hypotheses. “The positivist researcher is the ‘expert’ and is expected to maintain an objective stance in relation to the subjects of the research” (Grant & Giddings, 2002, p. 14). This combination of interpretivism and positivism epistemologies allow assertions to be supported with evidence and quantification of these assertions (Guest, MacQueen, & Namey, 2012). This framework allowed me to examine experiences of my participants. I was able to highlight the strengths and weaknesses of the healthcare system from patients’ and physicians’ perspectives while quantifying how many participants shared these experiences and viewpoints. An overview of thematic analysis, as described by Braun and Clarke (2006), will be paraphrased below.

The researcher in thematic analysis plays an active role in identifying the patterns and themes, choosing which are of interest. The themes capture important points, patterned responses or meaning as they relate to the research question. The analysis can be inductive (i.e., data-driven) or theoretical (i.e., theory-driven). In inductive analysis, the themes are strongly linked to the data set and the data is not coded using pre-existing coding frame or using the researcher’s analytic preconceptions. In theoretical analysis, the themes are influenced by the researcher’s theoretical or analytic interest in the area (Braun & Clarke, 2006). Rivas (2016) assert that it may sometimes be useful to use a combination of deductive and inductive coding. For example, when the researcher has a general idea of what (s)he is looking for, deductively determined codes used alongside inductive coding to tease out the details. For the purpose of this thesis, I used a combination of inductive and deductive analysis. The codes were derived from the data and the categories were broadly informed from the interview questions and from previous
The themes may be semantic or latent in nature, and the analyses may be conducted within the essentialist, constructionist, or contextualist paradigms. In the semantic approach, the themes identified have explicit or surface meaning, and do not extend beyond what the participants have said. In contrast, the latent approach uses themes to examine underlying ideas, assumptions, and conceptualizations. Due to time constraints, I chose the semantic approach to develop the themes. The essentialist perspective reports experiences, meanings, and realities of participants, whereas the constructionist examines how those factors operate within society. The contextualist view lies between essentialist and constructionist perspectives (Braun & Clarke, 2006).

Given that the purpose of my thesis was to investigate the healthcare experiences of trauma survivors and physicians’ professional experiences with patients who are trauma survivors, I was interested in understanding the subjective reality of the individual participants and what those experiences mean to them. As such, the essentialist perspective was one that fit best with the goals of this thesis. In order to understand participants’ experiences, I asked them to explain their experiences in as much detail as possible and I sought clarification as needed to ensure I interpreted their responses as they intended to be understood. Moreover, I did not question the veracity of what participants shared with me nor did I investigate how their self-perceptions may be different from those with whom they interact. This may be a limitation and it will be further discussed in Chapter 5.

Coding of the data set depends on whether the themes are data-driven or theory-driven. There are codes for as many potential themes or patterns as possible, and the
codes are of extracts of data inclusively. The individual extracts of data may be coded into as many different codes as they fit into (i.e., they may be coded as many times as needed). Once all the data is coded and combined, the list of codes is sorted into different themes. During this process, the researcher is thinking about the relationships between codes, between themes, and between different levels of themes (Braun & Clarke, 2006). Once the themes have been developed, they need to be reviewed. Some themes may need to be combined, while others may need to be broken down further into sub-themes. Themes need to be reviewed for coherent patterns based on the coded data extracts, and they also need to be reviewed in relation to the entire data set. This review process can hypothetically take place indefinitely; therefore it is important to define clear guidelines for the refinement process (Braun & Clarke, 2006).

Lastly, Braun and Clarke (2006) provide guidelines for defining and naming themes. Naming themes is not simply paraphrasing the content of the data extracts, but needs to highlight what is interesting about the data extracts and why it is interesting. The name itself captures the “essence” of what each theme is about (Braun & Clarke, 2006, p.92). The researcher then conducts and writes detailed analyses about each theme, how it fits into the entire data set and how it relates the research questions. The process of coding, creating and naming themes in the current study is described in detail in the results section.

2.2 Participants

This study included samples from two different populations: trauma survivors and primary care physicians. Trauma survivors were Saskatchewan residents. Primary care physicians were practicing general physicians in Saskatchewan and medical residents
who have received clinical training from the College of Medicine at the University of Saskatchewan, and who were familiar with the Saskatchewan healthcare system.

Trauma survivors were first recruited using online classified sites (such as UsedRegina.com and Kijiji-Regina) and social media sites. On October 15, 2015, a journalist from PA Now (an online and radio news company from Prince Albert) featured a story about this study, and provided a link to the online screening questionnaires (Sterritt, 2015). This helped me recruit half of my trauma survivor participants. Prospective participants completed a set of online screening questionnaires including demographic and contact information, healthcare utilization, the Brief Betrayal Trauma Survey (BBTS; Goldberg & Freyd, 2006), the Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013a), and the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013b). They completed the online screening questionnaires on Qualtrics (Qualtrics LLC, Provo, Utah). The BBTS and LEC-5 assessed whether participants had experienced any traumatic event, and the PCL-5 assessed whether participants endorsed any symptoms of PTSD. The BBTS and LEC-5 were used to identify participants who had experienced at least one traumatic event, and participants were at least 18 years of age and had experienced at least one traumatic event in their lifetime. Participants were selected such that there was diversity in demographics, utilization of healthcare, traumatic experience (as indicated by their responses to the BBTS and LEC-5), and PCL-5 scores. Out of 21 individuals who completed the online screening, 15 participants were invited to a 60-90 minute telephone interview where their experiences with healthcare providers and systems were explored. The first seven were interviewed within a week of the online survey being launched. After which point, there were fourteen individuals from
which I had to select eight participants to interview. They were chosen such that their demographics added to the diversity (i.e., age, ethnicity, education level, and employment) of the sample. They were compensated $40 for their time.

Primary care physicians were recruited using general purposive and snowball sampling methods. The head of the Department of Family Medicine at Regina Qu'Appelle Health Region (RQHR) circulated an email about the study to all family physicians with hospital privileges. I also had colleagues who knew practicing physicians and medical residents and I asked them to refer people who could potentially participate. The second phase of recruitment included advertising the study (Appendix M) on online classified sites, sending an email to all the physicians who had participated so far, asking them to forward information about the study to colleagues they thought may be interested in participating, and another email to all family physicians affiliated with RQHR was circulated. Participants were asked a set of demographic and contact questions, and were invited to a 30-minute telephone interview to explore their professional experience with trauma survivors. Participants were told that interviews would take 30 minutes with the option of extending it if they wished to discuss more. Eighteen practicing physicians and medical residents were interviewed and they were each given a $100 honorarium. However, only interviews from 11 were analyzed.

2.3 Data collection

Following ethics approval (Appendix A), recruitment, and general screening, all interviews were audio recorded using a digital telephone-recording unit, and files of the recordings were uploaded and saved onto a computer. Participants were made aware of this and provided verbal consent for recording prior to the initiation of the interview.
DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA (Appendices K and P). The Healthcare Experiences Interview (HEI; Green et al., 2012; Appendix L) was used as a guide while interviewing trauma survivors, and questions were modified to ask physicians about their professional experience with patients with past trauma (Appendix R).

2.3.1 Demographic and contact questions. Trauma survivors were asked for their full name, age, ethnicity, city/town of residence, email address, and telephone number (Appendix D). Primary care physicians were asked the healthcare region in which they practice (or the healthcare region in which they had their longest training for medical residents), number of years of practice (or training for medical residents), and their work mailing address. (Appendix Q) Halfway through data collection, providers who had already participated were sent an email asking them about the setting of their practice or training and the average time they spend with a patient, and those who were interviewed after this point were asked these two questions as part of the demographic questionnaire.

2.3.2 Brief Betrayal Trauma Survey, Expanded Version (BBTS-14; Goldberg & Freyd, 2006). This is a 14-item self-report measure of trauma exposure (Appendix E). Participants are asked whether they experienced each of 14 types of traumatic events before the age of 18 and from the age of 18 or older. The BBTS addresses both interpersonal (e.g., childhood abuse, IPV, sexual assault) and non-interpersonal (e.g., natural disasters, motor vehicle accidents) trauma. The BBTS items may be categorized into two subscales: trauma with more betrayal and trauma with less betrayal. Trauma with more betrayal is characterized as having been deliberately attacked, sexually assaulted, or emotionally or psychologically mistreated by someone with whom
participants were very close, or having witnessed someone with whom participants were very close commit suicide, be killed or deliberately attacked. Trauma with less betrayal is characterized as having experienced natural disasters, having been in a motor vehicle accident, or having witnessed someone with whom participants were not so close undergo a similar traumatic event or having been deliberately attacked or sexually assaulted by someone with whom participants were not close.

2.3.3 Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013a). This is a 17-item self-report measure to screen for potentially traumatic events in a participant’s lifetime (Appendix F). It assesses exposure to 16 events that may result in the development of PTSD or distress and one additional item that may not have been captured in the first 16 items. Participants have to respond to each item and rate it as either “Happened to me,” “Witnessed it,” “Learned about it,” “Part of my job,” “Not sure,” or “Doesn’t Apply.” Since LEC-5 is a recent revision of the LEC, psychometric properties are currently not available; however, psychometric properties for the Life Events Checklist (LEC) include good inter-rater reliability (mean kappa for all items was 0.61) and retest reliability ($r = 0.82$; Gray, Litz, Hsu, & Lombardo, 2004).

2.3.4 PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013b). This is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD (Appendix G). Each of the items is rated on a 0 to 4 scale, where 0 is “Not at all” and 4 is “Extremely.” Preliminary psychometric properties of the PCL-5 show that it has a high sensitivity (0.78) and specificity (0.98), and factor analysis shows four factors with high internal consistencies for each of the PTSD symptom clusters (Criterion B [re-experiencing], Cronbach's $\alpha = 0.89$; Criterion C [avoidance], Cronbach's $\alpha = 0.91$;
Criterion D [negative alterations in cognition and mood], Cronbach's $\alpha = 0.91$; and Criterion E [hyper-arousal], Cronbach's $\alpha = 0.87$; Cohen et al., 2014).

2.3.5 Healthcare utilization questionnaire. This measure was created for the purpose of this study, and asks participants how frequently within the past year they have received medical treatment from healthcare professionals (Appendix H). For each healthcare professional, participants must rate whether they have received medical treatment “not at all,” “once,” “2-3 times,” “4-5 times,” “5-10 times,” or “More than 10 times.”

2.3.6 Healthcare Experiences Interview (HEI; Green et al., 2012). This is a semi-structured qualitative interview originally developed to examine healthcare experiences of low-income women with past trauma (Appendix L). It asks participants about positive and negative interactions with healthcare providers, discussions about trauma with healthcare providers, and suggestions for the healthcare system. The questions were modified slightly to better suit the populations that were examined in this study. (See Appendices L and R).

2.4 Interviews

I used the HEI as a guide to learn about my participants’ experiences as they relate to the research questions (Appendix L and R). The HEI was designed as a semi-structured interview guide and I used it as such for all the participants. W. Smythe recommended the following when conducting qualitative interviews (personal communication, September 9, 2015). It is important to establish rapport, which includes trust, mutual respect, amiability, courtesy, professionalism, and openness. Before the start of the interview, I first obtained verbal consent from all the participants and it was
during this period that I established rapport by following-up on what they had previously written in their emails. I also emphasized the importance for them to only talk about what they felt comfortable sharing. During the interviews, I mirrored their emotional responses. For example, I laughed when they laughed or I made verbal statements on how their stories had impacted me. The interviewer may seek elaboration by asking for specific examples and by asking about similar experiences. After each interview, the researcher should record in their research journal their overall impressions, any non-verbal and contextual information, their evaluations (such as what went well, what could have gone better, and what could be done differently next time), and whether changes should be made to the interview guide. After the first few interviews with the trauma survivor participants, I noticed participants indicated the importance of trust with their physicians. In subsequent interviews, I began to ask them what trust looked like to them and how physicians may gain their trust. As for the physician participants, I asked them instead how they build trust with their patients.

Bird (2005) argues transcription is a key phase in qualitative research as it is an act of representing oral language in written form. Transcription allows the researcher to become familiar with and make sense of the data, develop further understanding of their research, and reflect on what is useful for their research (Bird, 2005; Braun & Clarke, 2006). It is an interpretive act (Bird, 2005) as “researchers locate within the context of their assumptions about language, culture, and discourse practices” (Green et al., 1997, p.173). If transcription is done by an individual other than the researcher, it is important for the researcher to review the data and check the transcripts against the original audio recordings for accuracy (Braun & Clarke, 2006).
Due to the limited time available to complete my thesis, all the audio recordings were sent to Transcript Divas Canada to provide verbatim transcription. I checked the transcripts against the audio recordings for accuracy, and anonymized the transcripts at this point. Although I could not partake in the “interpretive act” of transcription, I was still able to reflect on the experience of the interview. I was able to listen to the tone of voice of the participants as they provided their responses to the interview questions, allowing me to understand how those particular experiences affected them. I was also able to identify the moments when I took on the identity of a clinician rather than a researcher. For example, I was validating the participants’ experiences during the first few interviews. I noticed I was also rephrasing what the participant said to clarify their responses instead of asking them to clarify their statements.

2.5 Theoretical sampling

Theoretical sampling is “a method of collecting data based on concepts derived from data” (Corbin & Strauss, 2008, p.144). It is an iterative process of data collection and analysis, followed by more data collection and analysis until saturation is achieved. The data that will subsequently be collected is guided by analytical leads derived from analysis in the previous step(s). Saturation is achieved when no new categories, relevant themes, or relationships between categories and themes are emerging. Corbin and Strauss (2008) state that although total saturation may not be achieved, sufficient sampling may occur when there is depth and breadth in the major categories to adequately understand the phenomena. Theoretical sampling may still occur when all the data is collected before analysis; however, it may be more challenging when gaps are discovered as there are no opportunities for further exploration (Corbin & Strauss, 2008).
I had originally intended to conduct one or two pilot interviews, followed by their analyses before interviewing more participants. However, within a week of launching and advertising the online survey for trauma survivors, there were several prospective participants who completed the survey. As this is a challenging population to recruit, I interviewed them as they became available. Similarly, I interviewed physicians and residents as they contacted me, regardless of whether I had had a chance to analyze the preceding interviews.

2.6 Data Analysis

2.6.1 Coding. The purpose of coding is to develop themes. The process of coding itself is an iterative process of coding, categorizing, then recoding and re-categorizing as necessary (Saldaña, 2009). There may be several cycles of coding; moreover, codes from the first cycle may be rearranged, reclassified, or even dropped in subsequent processes of coding and categorizing. For this study, the second analyst and I coded all the data. We used the interview questions as the categories to sort the codes during the first cycle of coding. In the first cycle of coding, descriptive, emotion, or values coding were the methods of coding I used. According to Saldaña (2009), descriptive coding is summarizing in a word or short phrase the topic of a passage; emotion coding is labelling emotions recalled or experienced by the participant or inferred by the researcher about the participant; and values coding reflects the participant’s values, attitudes, and beliefs. Pattern coding was used during the second cycle of coding. “Pattern Codes are explanatory or inferential codes, one that identify an emergent theme, configuration, or explanation” (Saldaña, 2009, p. 152).
Saldaña (2009) stated it is possible to have multiple analysts coding the data collaboratively. In this case, it is suggested the analysts build together a list of codes and a list of themes, with one member responsible for maintaining a master list of codes ("codebook editor"). The researchers must check for inter-coder agreement or participate in group discussions to come to a consensus or agreement. This step is necessary as each analyst is bringing in another way of interpreting the data. I had a second analyst (Miranda Reid) to help me with analyzing the transcripts. Ms. Reid is an undergraduate psychology student at the University of Regina, who had previous experience in qualitative research. She coded the transcripts independently of me using the methods described above. I assumed the role of "codebook editor." Once all the transcripts were coded, Ms. Reid and I independently employed pattern coding to develop themes. Only the codes that correspond to interview questions, which help answer the research questions were analyzed in the second cycle of coding. Following this process, we met several times to discuss the codes and themes and came to a consensus on the themes to be reported.

2.6.2 Scoring. The total BBTS score for each trauma survivor participant was obtained by tallying the number of “yes” responses. Any participant who indicated they experienced a trauma with more betrayal were included in the tally for this scale, and similarly, anyone who indicated they experienced a trauma with less betrayal were counted in tally for this scale. The number of participants for all the items on the LEC-5 were a tally of participants who checked off each of the events on the online screening survey. The PCL-5 total symptom severity score was obtained by summing the scores for each of the 20 items for each of the participants.
2.7 Reliability and Validity

It is important for qualitative research to instill reliability and validity to ensure rigor is attained (Morse, Barrett, Mayan, Olson, & Spiers, 2002). “Research is only as good as the investigator” (Morse et al., 2002, p. 17). Investigator’s responsiveness (e.g., creativity, sensitivity, flexibility, and openness) at every stage of the research ensures validity of the research (Morse et al., 2002). The stratification during the recruitment process allowed me to maximize the options available to ensure I had sufficient sample size. I was open-minded during the interview process, allowing participants to share with me what they felt comfortable disclosing and centering the interviews on their experiences. I did not discuss any ideas that were poorly supported. There was methodological coherence in that the research questions matched the methods used, and the methodology matched the data and analytic procedures (Morse et al., 2002). As discussed earlier, thematic analysis was the methodology employed to guide the development of the research questions, the data collection, and the analysis process. “[T]he sample must be appropriate, consisting of participants who best represent or have knowledge of the research topic” (Morse et al., 2002, p. 18). Two different questionnaires (BBTS-14 and LEC-5) were used to screen for whether trauma survivor participants had previously experienced trauma. There was diversity among the trauma survivor participants to attain a representative sample. Reliability of the analysis was also established by having a second analyst, as described above. I believe the datum collected was reliable to the extent that participants were provided with opportunities to refuse to participate, and were encouraged to share what they felt comfortable discussing. There was frequent debriefing between Dr. Klest and me to draw any attention to any
biases I may have harboured and to develop ideas and interpretations from the participants’ interviews. A reflective commentary will be further discussed in Chapter 5 of this thesis.
3.1 Trauma Survivors

3.1.1 Demographic Information. Fifteen adult trauma survivors residing in Saskatchewan were interviewed. Table 1 illustrates the demographics of the trauma survivor participants. The average age was 39 years old (22-75). There were seven females and seven males, and one identified as “other”. Ethnicities included White/Caucasian (11), Aboriginal/First Nations (2), Asian/Pacific Islander (1), and mixed race (1). Seven were employed and eight were not working, of which two were retired. There was a diverse highest level of education, which included less than high school diploma (1), high school diploma (2), some college or post-secondary credit (no degree; 3), associate or technical degree (2), bachelor (2), and graduate or professional degree (3). The majority of the participants were from the Prince Albert Parkland (9) health region, and the rest were from the Saskatoon (3), Regina Qu’Appelle (2), and Cypress (1) health regions. As shown in Table 2, the average total BBTS score was 4.4 (0-8). Ten participants experienced at least one trauma with more betrayal, while 12 participants experienced at least one trauma with less betrayal. There was diversity in the kind of traumatic events, and many of them experienced multiple traumas as a result of the trauma having happened to them directly, witnessing it, learning about it, or as part of their jobs (see Table 2). The average PCL-5 score was 33.9 (0-70), suggesting moderate levels of PTSD.
Table 1. Trauma survivor participant demographics.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of participants or Average (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>39 (24-75)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>11</td>
</tr>
<tr>
<td>Aboriginal/First Nation</td>
<td>2</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
</tr>
<tr>
<td>Mixed race</td>
<td>1</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Currently employed</td>
<td>7</td>
</tr>
<tr>
<td>Not employed (not retired)</td>
<td>6</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
</tr>
<tr>
<td>Health region</td>
<td></td>
</tr>
<tr>
<td>Prince Albert Parkland</td>
<td>9</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>3</td>
</tr>
<tr>
<td>Regina Qu’Appelle</td>
<td>2</td>
</tr>
<tr>
<td>Cypress</td>
<td>1</td>
</tr>
<tr>
<td>Highest level of education</td>
<td></td>
</tr>
<tr>
<td>Less than high school diploma</td>
<td>1</td>
</tr>
<tr>
<td>High school diploma</td>
<td>2</td>
</tr>
<tr>
<td>Some college/post-secondary credit, no degree</td>
<td>3</td>
</tr>
<tr>
<td>Associate/Technical degree</td>
<td>2</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>2</td>
</tr>
<tr>
<td>Graduate/Professional</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 2. Past traumatic experiences reported by trauma survivor participants.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of participants or Average (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Betrayal Trauma Survey Scores</strong></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>4.4 (0-29)</td>
</tr>
<tr>
<td>Trauma with less betrayal</td>
<td>12</td>
</tr>
<tr>
<td>Trauma with more betrayal</td>
<td>10</td>
</tr>
<tr>
<td><strong>Life Experiences Checklist for DSM-5</strong></td>
<td></td>
</tr>
<tr>
<td>Natural disaster</td>
<td>4</td>
</tr>
<tr>
<td>Fire or explosion</td>
<td>8</td>
</tr>
<tr>
<td>Transportation accident</td>
<td>9</td>
</tr>
<tr>
<td>Serious accident at work, home, or during recreational activity</td>
<td>7</td>
</tr>
<tr>
<td>Exposure to toxic substance</td>
<td>3</td>
</tr>
<tr>
<td>Physical assault</td>
<td>9</td>
</tr>
<tr>
<td>Assault with a weapon</td>
<td>5</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>5</td>
</tr>
<tr>
<td>Other unwanted or uncomfortable sexual experience</td>
<td>7</td>
</tr>
<tr>
<td>Combat or exposure to a war-zone</td>
<td>3</td>
</tr>
<tr>
<td>Captivity</td>
<td>1</td>
</tr>
<tr>
<td>Life-threatening illness or injury</td>
<td>10</td>
</tr>
<tr>
<td>Severe human suffering</td>
<td>8</td>
</tr>
<tr>
<td>Sudden violent death</td>
<td>5</td>
</tr>
<tr>
<td>Sudden accidental death</td>
<td>9</td>
</tr>
<tr>
<td>Serious injury, harm, or death you caused to someone else</td>
<td>3</td>
</tr>
<tr>
<td>Any other very stressful event or experience</td>
<td>10</td>
</tr>
<tr>
<td><strong>Posttraumatic Stress Disorder Checklist for DSM-5</strong></td>
<td>33.9 (0-59)</td>
</tr>
</tbody>
</table>

* Number of participants who selected either “Happened to me,” “Witnessed it,” “Learned about it,” or “Part of my job” for each of the items in the Life Experiences Checklist for the Diagnostic Statistical Manual of Mental Disorders, fifth edition.
† Diagnostic Statistical Manual of Mental Disorders, fifth edition.
Figure 1. Hierarchy of themes that emerged in positive and negative healthcare experiences for trauma survivors.
3.1.2 Common characteristics of positive and negative experiences. Fourteen of the participants gave detailed accounts of positive experiences with healthcare providers and systems. One trauma survivor said, “I can't really attest to any positive experiences I've had with doctors”. Twelve participants provided descriptions of negative experiences with healthcare providers and systems. Three had no negative experiences with healthcare providers as a patient; however, two reported negative experiences when they were involved with their parents’ healthcare. In this section, I will describe the common themes that emerged from the interviews. Figure 1 illustrates the hierarchy of themes, which emerged in the discussion surrounding participants’ healthcare experiences and Table 3 provides a list of themes and subthemes for positive and negative experiences.

3.1.2.1 Trust. Trust was a recurrent theme in the majority of the participants’ experiences. In their positive experiences, there was mutual trust between physicians and the participants, and the physicians kept their word or promise. One participant described an encounter when he was diagnosed with diabetes and was placed on diabetic medication; his physician said if he was able to lose weight and reduce his blood sugar level, his physician would discuss discontinuation of that medication. After three months, the participant was able to lose 40 pounds and reduced his blood sugar level back to normal. He described the following:

I said to him, I said so I can go off my pills and I had expected that he would say no. Here's talk about a positive experience but he actually kept his word. So I went off them and then we've had, every three months, you know, another A1C test and it's still within normal range - it's normal for the normal individual - not even a person with pre-diabetes. So, um, so that's a positive experience, that your physician actually keeps his word.
As a result of established trust, the participants felt comfortable with the physician and they felt hopeful. Many described that they were hopeful of the outcome as there was a plan and this in turn made them feel empowered. In their negative experiences, on the other hand, there was distrust. They reported their physicians making errors or quick inaccurate diagnoses, leading them to feel betrayed or violated by their physicians. One participant was referred to a urologist to examine his swollen prostate and the physician diagnosed him with cancer based on a physical finger test. He described the following:

He says, “You need to have a biopsy done because this is cancer.” He actually made the diagnosis there. He did the finger test and he says this is cancer. I said, “Well I can't have it because I just had a stent done and my physician wants me on Plavix and wants me on aspirin and he wants me on this blood thinner at least for six months.” So they decided after six months that I would go off Plavix and then they did the biopsy and the biopsy was negative… It was negative; at least I'm not dying from prostate cancer. So, but you understand I was waiting for six months thinking it was cancer because the guy, based on a finger test, thought it was cancer. You know, and why would you do that? If you say well do a biopsy first and then I'll tell him its cancer or not.

Participants described situations where their physicians provided some form of reassurance, and subsequently, they felt reassured or relieved. These situations were also associated with hope and participants feeling at ease, calm or relaxed. One participant said she had hypochondriasis. Her physician reassured her that she was not the only one with this condition, and provided her with support. She said the following:

Relief knowing that I- I'm not the only one that - you know I thought I was crazy, um, and hearing from him, being a physician, having many patients, hearing from him that there are other people out there that, you know, feel the same and have the same issues, I think that just kind of made me feel a little bit of relief that, you know I'm not going crazy and that, you know, this can happen.

In their negative experiences, there was uncertainty, no reassurance, or clarity in the negative experiences described by the participants, leaving them confused about a given situation. A participant had a pregnancy test performed by her family physician
when she was a teenager. It was her first time visiting the physician on her own and she described the following:

The physician asks you, “What are you going to do about it?” You know and it’s like I have no f–ing clue. First I got to find out if I’m pregnant but you’re not—you know, and it was called back for the results and that was it. And this is how if I had stayed with him it would probably always been. But it wasn’t, “Here’s some people to call, here’s some resources, here’s anything”, you know what I mean? “Talk to my receptionist.” Nothing, it was asking me what I was going to do about it. Yes, he knew my dad was a sickbed dying and was friends with my mother, first time going on my own. You know but nothing and I left there saying, “Now what the f– do I do?”

3.1.2.2 Connection with physician. Participants had good relationships or good connection with their physicians in their positive healthcare experiences. One participant described having a spiritual connection with his physicians and they would pray for each other. Another participant expressed the importance of shared experiences with his physicians. Participants also discussed how well their physicians knew them. A sub-theme that emerged in the positive experiences was long-term relationship—participants had the same physician for 20 to 30 years and their physicians were familiar with the participants’ entire medical history. The following is a description from a participant about her connection with her family physician.

I was 16 or 15 when he took over the practice from another physician and he was a new physician and I stayed with him and (pause) I don't know if it sounds silly to say but because it's been so long, I feel like we've been through a lot together, you know through the birth of all my children and, you know, various illnesses and stuff, and- and he's always been a confidante.

Conversely, participants were either disconnected or had no closeness with their physicians in their negative experiences. One participant described her family physician as a stranger and as somebody who did not try to get to know her. Another participant said “it just seemed like he wasn’t, um, either didn’t have kids or didn’t relate to
children” when describing the physician on service at the time her baby daughter was admitted to the hospital.

3.1.2.3 Physician’s compassion. Physician’s compassion is an evaluation of a physician’s level of sympathy and empathy towards his or her patients. Participants who had positive interactions with physicians described the provider as compassionate, sympathetic, and empathetic. They felt that their physicians understood their feelings. In scenarios where they had negative interactions with physicians, participants said the providers lacked compassion and empathy. They provided examples of when the physicians were insensitive or inconsiderate, and when the physicians were not caring. A participant reported he went to a walk-in clinic to seek treatment for his tonsillitis and said the following:

This is the ninth time I had had them. “No, just don’t worry about it. You won't get - if you get them again just come back for more penicillin.” And not listening to the concerns you have, explaining that we've already tried that drug. It's not working. We need to try a new family. And, yeah, it was very like kind of brush you off.

Physician’s authenticity is an attribution about whether or not the physician is genuine or sincere. Participants described their physicians as genuine or authentic in their positive experiences, and as not sincere in their negative experiences. The following is an example of a participant’s negative experience.

Like it was, uh, there was other people in the room as well and those people he would speak to in a regular tone and in a regular voice. And then when it came to me it was, uh, it was more like, he kind of had a, not, uh, not genuine smile on his face. And it just, the tone, I wish I could describe it more but it was just a, a, not a sincere tone to it. It was just kind of a, a, I guess I would say it would be, just put on, like it was forced.

Participants commented about whether their physicians were caring or not caring. When physicians were caring in participants’ positive experiences, they were described
as being attentive, paternalistic, supportive, and eager to help. For example, when a participant’s baby daughter was in the intensive care unit (ICU) she recalled the physician staying “over 24 hours beside her [daughter] without, le-leaving her side. It was pretty intense. It was like he felt obligated to see her condition resolve or at least get to a point where she wasn’t so severe.” The physicians in participants’ negative experiences were described as not caring or did not bother to care. When asked what physicians could have done, one participant stated, “with a physician, as a patient, um, that I know they’re – that they’re looking out for my best interests.”

3.1.2.4 Physician’s communication. The subthemes that can be grouped under physician’s communication include physician’s approachability, physician’s understanding, whether there were adequate explanations, and whether physicians spoke the same language as the participants.

Approachability. Several participants attributed traits to their physicians that described how approachable the providers were. The three main traits in participants’ positive experiences were warm, comfortable, and physician’s calm demeanor. Participants spoke of how their physicians were warm (such as warm voice, and warm body language), how their physicians spoke lovingly, their physicians’ welcoming demeanor, and their physicians’ friendliness and kindness. Participants also discussed how their physicians made them feel comfortable either by how easy they were able to talk to their physicians or by their physician’s comforting tone of voice. They also commented on how calm their physicians were, particularly in regards to their mannerisms. There were other factors such as the physicians’ availability, ample eye
contact, and how close they sat to the participants. The same participant whose daughter was in ICU said the following about her daughter’s physician.

[I]t felt like he had cared for her like you would your own child and that’s kind of what he would say too. He, he would mention things like that, like, um, uh, “I love children,” and I don’t know exactly what he said at the time but he was, I still remember his, the way he looked and he just remained calm and even at the time where I had to sign a form that if they injected her with this stuff she might die and he’s basically make me sign this form. He still made me feel like, “oh, I would do this for my kid and this is perfectly normal and we do this all the time” and don’t, you know, um, he just made us feel a little bit calmer.

In their negative experiences, participants described their physicians as rude and impersonal. One participant recalled a visit to a walk-in clinic where the physician simply entered the room and started discussing the participant’s presenting problem without any introductions. Another participant described his physician’s body language as “very shut down, you know, it wasn’t – it wasn’t inviting.” Many participants recalled interactions with their physicians that were clinical or impersonal in nature. There were several accounts where they felt the physician did not treat them as a person. One participant described the following about her daughter’s care team.

I saw some specialists in there that would just come in and treat the person as though it was, uh, they were, say the eyes, throat and nose specialist or whatever - only come in and look at that one area of the body and do a diagnosis without actually considering that this is a whole human being and not interacting with us as though we were human but more like a medical textbook kind of thing, you know.

Another participant recalled his physician as “incredibly” condescending, where he felt his physician treated him as “just another number.” He also described the interaction between him and his physician as “more of like going into a business” than receiving healthcare.

Understanding. Participants expressed different ways in which physicians either understood them or were non-judgmental in their positive experiences; or physicians did
not listen to them, or were dismissive, impersonal, judgmental or accusatory in their negative experiences. One participant said, “[My physician] took what I said as true and very... [S]he acknowledged what I was saying as true.” The participant whose adopted mother was diagnosed with late-stage cancer recalled the family physician “just said that she needed to, um, be more grateful for what she has in her life and to be, when she feels sad, to just project happiness and she'll be happy.” Another participant recalled several visits to the emergency room following his heart attacks. He recalled that the attending physician did not believe him and he said, “Every time I went in there, after they had taken blood, they say there's nothing wrong with you.” Two of the participants with a history of substance use felt that they were stereotyped by their physicians when history of their addictions surfaced. The following is a description from one of these participants.

I was having suicidal thoughts, I was feeling very depressed... I went to see the psychiatrist about that, um, he had - he accused me of, um, basically, uh, lying about-about my symptoms into try and get, um - to try and get a prescription which was not that case at the time. Um, I was very discounted by this in the sense that, you know I was genuinely having these, these thoughts of suicide and thoughts of, um, like self-harm and all this kind of stuff. And-and when I acknowledged that yes, I had in fact had a history of substance abuse, then it was automatically, um, in his mind, it was like I was there to exploit the system, um, which I was not there to do at all.

Adequacy of explanations. In their positive experiences, participants commented on situations when their physicians explained the medical procedures before they were performed and when the providers kept them well informed. However, in their negative experiences, several participants discussed how inadequately the physicians explained their respective medical situations. One participant recounted a visit to a psychiatrist where “there wasn’t a lot of explanation, or um, tsk, or communication.” Another
participant said she received conflicting information and diagnoses from several different specialists who examined her daughter in ICU.

Language. One participant said it was helpful for his parents that their family physician spoke the same language as them. A different participant said there were physicians where she lived that were of different ethnicities, and she said, “So you’re still having that little bit of you know trouble understanding them and that, it’s just a language barrier kinda thing.”

3.1.2.5 Physician’s competence. A physician’s competence is the ability of the physician to provide medical services successfully and/or efficiently. The subthemes that emerged in participants’ positive experiences included thoroughness, physicians’ efficiency or organization, physicians’ ability to provide timely referrals and treatment, and physicians’ knowledge. Participants described that their physicians were thorough when investigating their ailments and that their physicians checked everything before making conclusions. Many praised their physicians for being efficient and organized. One participant commented that “[his physician] did a good job.” Several participants said their physicians either provided appropriate referrals or sought opinion from another physician as needed.

The subthemes that emerged in the negative experiences were irresponsible, unethical conduct, and unprofessional behaviours. A participant described a visit with a cardiologist where the physician did not adequately examine him, and the physician talked about unrelated matters with the participant’s wife for the majority of the consultation. He said at a later time, the same cardiologist provided false information in
the consultation letter to his family physician. The following is an account of his situation.

According to the consultation of this cardiologist, and I got a copy of it - my physician gives copies of everything. So according to the consultation, the guy did a full physical exam on me. Well I saw his nurse for five minutes, I saw him for 10 minutes and six minutes he talked about these motorcycles with my wife. So I saw him for a total of four minutes and then he claimed that my abdomen were palpable and that my lungs sounded okay - he didn't even listen to my lungs.

The participant expressed that he should have complained to the College of Physicians and Surgeons about this cardiologist’s unethical practice. One participant described her biological and adopted mothers’ family physician as a “liar,” “murderer” and “criminal.” Her adopted mother had been complaining of her ailments and symptoms for a year; but each time her mother (accompanied by the participant) went to her family physician, the physician dismissed her symptoms. After a year had elapsed, at the mother’s request, a blood test was done and the results showed she had stage four cancer. She said, “that's when her physician realised, um, well because of the tests, she saw how far along this cancer was.” She also shared that three years prior, her biological mother experienced the same situation with the same family physician.

3.1.2.6 Power. There was equal power between the physicians and participants in the positive experiences described by the participants; however, there was a power difference in their negative experiences. A few of the participants explicitly mentioned “equal power relationship” and “equality” when describing their positive interactions with physicians. Other participants spoke of the collaborative nature of their interactions with physicians. There were several accounts when the physicians engaged the participants in discussions or provided opportunities for participants to make informed choices. One participant commented on the open-mindedness of his physician to try
treatment options the physician had not previously considered. The power difference between the participants and their physicians included situations when the physicians exerted their authority or when they refused to help the participant. One participant shared an experience that took place in the emergency room. He had gone in to seek treatment for kidney stone. After the kidney stone had passed, the participant recalled the physician ordered a catheter to be inserted, provided him with oral pain medication and discharged him. He said the following about an emergency room physician.

He just, you know he told me he's (laughs) in charge and that's what he's obliged to do for his job and it was quite clear that he was in charge and I was not, by me saying he - I gotta stay here. No, he had authority, he's sending me home. He's got authority, not me.

Two participants described instances when nurses and care aids followed particular procedures because they were obligated to follow the physicians’ orders. One recalled a time when he was strapped to the bed for not following orders and he said, “I was just pretty much like pissed off because of the fact that they - they were tying me to the bed and like it just felt like I was in jail.”

3.1.2.7 Time. The majority of the participants commented on time as it related to the consultation duration, physician’s patience, and wait time. In both their positive and negative experiences, participants expressed too short of a visit with the physician. One participant commented that the healthcare system does not allow for longer visit. Physicians were described as being patient or “not rushed” in the positive experiences. Examples included physicians taking time to properly discuss medical issues, to know the participants, and to answer any questions. Conversely, in the negative experience, physicians were described as being impatient or “rushed.” Examples included physicians not taking the time to become acquainted with the participants, for making quick
diagnoses, and for providing “band-aid solutions.” In regards to wait time, one participant said she was surprised to have an appointment with her surgeon quicker than anticipated; however, most of the comments about wait times were about long they were. For example, one participant said he sought services in another province because the wait time in Saskatchewan to get medical tests performed was too long.

3.1.2.8 Expectations. The term expectations best describes whether the participants were satisfied with their healthcare, whether they received any relief from their ailments, and whether they found their physicians helpful. The following is a description from a participant when her experience with her physician was better than she had expected.

The efficiencies in the office that I go to is - was really surprising compared to – I guess what I’ve heard from others and what I had seen in the past. Um, it was just done a lot quicker and what I felt was more efficient.

Two participants recalled receiving either medication or resources for pain relief. One participant commented that she felt relieved when her physician told her she was not the only one with her ailments. Three participants expressed how helpful their physicians were. Two participants explicitly said they were either disappointed or expected better healthcare. This then led them to describe their experiences as surprising or unbelievable.

3.1.2.9 Other providers. Interactions with nurses, psychologists, and counsellors were discussed by several participants. Nurses were described as kind and helpful in participants’ positive experiences, but were described as judgemental and unprofessional in the negative experiences. Two participants expressed the helpfulness of psychologists in their positive experiences. One participant recalled a “very dry” conversation with a psychologist where she felt the professional “lacked a genuine – a genuineness and
empathy in the session.” Another participant commented on his good relationship with an addictions counsellor because of shared experiences and what they had in common.

3.1.2.10 System. Any accounts that did not involve direct contact with a healthcare provider were placed under this theme. These accounts include negative experiences with healthcare facilities, the provincial healthcare system, and social support. One of the participants commented the bathroom in a hospital in which her baby daughter was admitted, “was, um, very dirty and had, like, um, disinfectant for people that have HIV.” She also described that there was no place for her to stay or a bed to sleep on. She said, “Um, at one point, I slept lying down in, like, a broom closet because I wouldn’t go home. Um, the physicians were like, ‘you need to go lie down’ and the nurse showed me this little closet area.” Another participant shared her opinions regarding the inadequate care her father received at a mental health facility in a city. When her father had to be certified, she requested the physician to admit him to a facility in a different city.

Three participants expressed the need for more healthcare specialists (in particular mental health) to be available. One participant said the wait time to receive treatment from a provincially-funded addictions treatment facility is six weeks. He said:

[I]f I had to wait six weeks to find a bed in a treatment facility, (sniff) then it would - then there was really no point. I couldn't wait that long - if I could stay - if I could stay healthy for six weeks then I wouldn't have needed the treatment facility in the first place.

Another participant said there were no cardiologists in the city he lived in. The following is what he shared.

Then I was told you have to see a cardiologist but first of all, the bad experience is, there is no cardiologist in the city and the city has like 45,000 people. There's not one cardiologist here. So- so then an appointment was made with a cardiologist in [another city].
3.1.2.11 Participants’ affect. When asked how they felt, participants said they were happy, calm or exuberant in their positive experiences; however, said they were angry, anxious, frustrated, or upset in their negative experiences. Additionally, their anxiousness included fear, feeling scared, or nervousness.
## Table 3. Themes and subthemes of positive and negative experiences of trauma survivors with primary care physicians and other providers.

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3.1.3 Talking about traumatic experiences.

3.1.3.1. Conversations about trauma. Ten participants had discussed their traumatic experiences with a healthcare provider; of these, five had disclosed their traumatic past to multiple providers. The providers they talked to included their family physicians, general physicians, psychiatrists, psychologists, and counsellors.

3.1.3.1.1 How the conversation came up. Conversations about participants’ trauma experiences were brought up either during check-ups with their physicians, as a means to an end, or because they volunteered.

During a check-up with their physicians, three participants said their physicians instigated the conversation about their past trauma. One remembered her physician checked-in with her after she had been in a car accident; another said his physician knew his family’s situation and followed-up; and one remembered she was forced to talk about her trauma that was ongoing at the time. There was incidental disclosure of past trauma
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during a physician’s visit for three participants. Three participants recounted incidentally disclosing their traumatic experiences during a consultation with a physician. The family physician of one of the participants had received a report from the hospital and discovered what had occurred to the participant. The traumatic past of another participant unravelled in a general discussion with her family physician. One participant visited a general physician to be examined for abdominal pain, and it was then she disclosed her girlfriend sexually assaulted her.

Five participants disclosed their traumatic past as a means to an end. One participant wanted resources to cope with his depression and anxiety. Another participant was feeling depressed and she said it was “more sadness than just post-partum.” Subsequently, she made an appointment with her family physician to discuss ways to cope with her depression. A different participant wanted to discuss with her family physician alternatives to pain medication. One participant had to disclose any past trauma before he could receive prescription for medical cannabis. Another participant needed to share her traumatic history as part of documentation to receive additional support for school.

One participant voluntarily (i.e., without any prompting) shared her traumatic past with her healthcare provider. She said “I’ve always wanted to talk to somebody about what it really means for someone to have an experience where really both negative and positive kind of happened at the same time, and I just was curious to see what she'd have to say about it. She, uh, she just says I'm very lucky.”

3.1.3.1.2 Positive outcome. Six participants found their conversations with their healthcare providers about their traumatic experiences to be positive. The major themes
that emerged were trust, collaboration, compassion, acknowledgement, and ease of opening up. Some participants described there was mutual trust. There was collaboration between the participants and the physicians. Two participants commented that their physicians were receptive to their suggestions about their mental symptoms which precipitated from their past trauma. The participant who sought medical cannabis said the physician with whom he disclosed his traumatic experiences collaborated with his family physician to pursue the matter further.

Three described that their providers showed compassion after they had disclosed their traumatic experiences. One participant said his physician’s voice and eyes softened, and was concerned about his wellbeing. Another participant said her counsellors had compassion and were caring. Two commented that their physicians were attentive and sympathetic.

Participants said their providers acknowledged their situation by either validating their experiences or acknowledging their experiences as traumatic. The following is one participant’s account.

Well she - she - she - she couldn't - you know she tried to write things down as I was talking to make sense of it all, the key words and all of that, and, um, at the end it was more like - she says, “You, I think you have a feeling that people just don't believe you.” Because I've actually had my son who had said to one of my brothers that “mum - is mum fake-happy,” you know, like they don't - they don't understand why I could possibly be genuinely happy in my life.

In regards to ease of opening up, one participant commented that it was good for her to verbalize her concerns. Another participant remembered her physician asking questions, making it easier for her to share her experiences. A different participant said it was easy for her to discuss her traumatic past with her psychologist.
All six participants were satisfied with the outcome of their conversations and received what they had expected or hoped for. One participant commented it was helpful for her to learn more about herself and would want to see her psychologist again. When asked whether the conversation was helpful, one participant responded “100%.” Four participants either received medication for pain relief, treatment for their mental health symptoms, resources to cope with their problems, and/or referrals to see specialists to manage their symptoms.

3.1.3.1.3 Negative outcome. Four participants indicated they had negative encounters with healthcare providers when they disclosed their past trauma events. The major themes that emerged were physician’s ignorance, lack of compassion, impersonal, and power difference. The following is a participant’s account of how her physician was ignorant.

I said that I had been sexually assaulted by my girlfriend and he- he just - he couldn't get it. He was like, “No, not a girlfriend, your boyfriend.” I said, “No, by my girlfriend.” He's like, “No, you don't have a girlfriend - you have a boyfriend.” And I - and, um, and I'm like, “I'm sitting here right in front of you, I'm telling you I'm in a same sex relationship and she sexually assaulted me.” He's like, “No that's impossible.”… And so I was telling him and he just kept telling me that it was impossible… And, um, and then when I- when I was done, then he apologised. He apologised and he said, “You know I didn't think it was ever possible” and he - and he was new to this country as well (sigh) but he didn't know how to help me.

A lack of compassion can be attributed to healthcare providers to whom two participants disclosed their traumatic experiences. Two participants said there was no reaction from their providers. One said, “I think just there’s not a lot of relating on a level.” Another commented, “I think she lacked a genuine - a genuineness and empathy of - in the session.” The same described her provider’s reaction as “almost a-a scripted session. As like she- it’s like- it’s like almost everything had its perfect little place even
right down to the sheet and the pen – it was very routine for her.” Another participant said, “I felt forced into everything,” and added that the physician kept probing her more than she was comfortable sharing; a reaction from the provider which would be best described as a difference in power.

All four participants found their conversations about their past trauma to be counterproductive. One said she refused to return to her physician and subsequently did not seek medical services for the following three years. Another recalled, “I would leave feeling very unvalidated and- and she’d leave me in more of a mess than when I walked in.” She added, “I wanted somebody to - who I could connect with, somebody who- who could understand where- where I'd been or who could relate to the experiences that I was expressing.” Two commented that their physicians only considered the medical aspect surrounding their traumatic events.

3.1.2.1 No conversations about trauma. Seven trauma survivors had not disclosed their traumatic experiences with their physicians, of whom five had not shared their traumatic past with any healthcare provider. The main themes that emerged are no trust, deal with it personally, no compassion, hopelessness, fear, and time.

3.1.3.2.1 No trust. Three participants listed lack of trust as a reason for not informing their physicians about their past trauma events. One participant commented, “But sometimes going into a physician it’s a total stranger.” Another said, “I just don’t trust a physician.” The third participant expressed he liked to keep information about his trauma to himself; however, he added, “if one of the physician – if somebody – you know, somebody if I trust him enough, maybe I will tell him.”
3.1.3.2.2 Deal with it personally. Three participants responded that they had not discussed their trauma with their physicians because they felt they were able to manage on their own. One participant expressed the following.

I just didn’t feel that any of them were to a level in which I needed to involve a physician… Um, it doesn’t really affect like my - my day-to-day life. And it's - I just don’t think it's an adequate place, I guess.

Another participant had a previously unsavory experience with crisis volunteers and now preferred to “deal with stuff on your own.” He added that he had “multiple friends in social work and psychiatry background. So I've done lots of therapy, um, with them, I guess you could say.” The other participant said she did not see the significance of sharing her past with her physician as “it doesn't seem like, um, you know it's not - it’s not keeping me awake at night.”

3.1.3.2.3 Lack of compassion. Two participants felt that their physicians did not care to know about their past trauma. One said, “So like if - if they don't care then why should I?” Another said if his physician cared and asked, he would disclose his traumatic experiences.

3.1.3.2.4 Hopeless. One participant’s response may be described as hopeless as he believed it is pointless to share with his physician his traumatic past. The following is what he expressed.

I don't see a point… Um, I- there's nothing that they can do to change - change my past… I don't think that there's anything that a physician could do to, um, get you - to make me feel better or to change the way I feel, or to eliminate those events from having happened… just still going to be alone and I'm still going to be, you know, hopeless, uh, when I leave this physician's office.

3.1.3.2.5 Fear. One participant was concerned about her self-esteem and worried about being re-traumatized if she were to discuss her traumatic experiences with her physician. She said, “If something triggers a memory and then I start thinking too
much—because when I start thinking too much, then that’s when the anxiety comes and
the panic attacks come.” As a result, she added, “I didn’t want to think about it.”

3.1.3.2.6 Time. Two participants commented about the lack of time as a reason
why they have chosen not to share their traumatic past with their physicians. The
following is a response from one of the participants.

I find that if you start talking about certain things and they start looking at their
watch and they’ll, you know, leaving knowing that they have another appointment
coming, well, I guess that's my issue though because I-I'm already aware that he's
busy and he's got a roomful of patients out there.

The following is a response from the other participant.

[Y]ou know the physicians the way it is with our medical system now, all I find is
that they want to put a Band-Aid on whatever it is that you’re coming into the
office to see them about and that's it. No more. (Very crackly line) It's like a
crisis centre in a way, they just deal with the crisis and send you on your merry
way. There's - there's no unravelling what the underlying reasoning or symptoms
or causes might be.

3.1.4 Difficulties while visiting a physician. Eleven participants expressed
difficulties when visiting the physician’s office while four said they did not experience
any difficulties when going to the physician’s. In this section I will describe the nine
themes that emerged.

3.1.4.1 Time. Participants reported the visits with the physician were too short.
They felt it was not enough time to adequately express any problems they were enduring
at the time. This in turn made them feel like they are being rushed. One participant said,
“Because when I'm rushed I get flustered and ... and I -- I'm not able to explain
everything. And if there was something else that I really wanted to mention, I usually
end up forgetting it.”

3.1.4.2 Lack of trust and connection. Many of the participants commented on
the distrust they had in their physicians as a difficulty. One participant said he did not
seek healthcare for several years because of the lack of trust and faith he had in physicians. Some participants were not willing to share sensitive information with physicians whom they had no connection or no established relationship with.

3.1.4.3 Discouraging. Four participants said one of the difficulties they faced was feeling discouraged because the physician dismissed their concerns. One participant indicated, “one of the biggest things, uh, about that is being downplayed, uh, my concerns being dismissed or, or them trying to justify how it’s not as big of a deal as I think it is.” Another participant said, “I guess speaking your own opinion if you do end up disagreeing with something. Sometimes they don’t really want to hear it.” Another said he felt discouraged as a result of being dismissed by multiple physicians. The following illustrates this.

Um (pause) being discouraged… Um, I, I work very hard to, uh, essentially fight what’s going on in my body, make, make necessary changes and improvements to try and better, uh, what little abilities I have left… And, and just being told that I can’t do things… Yeah, it, it comes back to, you know, downplaying and being discouraged, happens quite often with most of the specialists that I see.

3.1.4.4 Discrimination. Three participants said they were subject to discrimination by their physicians; two because of their history of addictions and one because of her race. The participant who was discriminated for her race indicated the following.

The biggest difficulty I face these days when seeking medical attention for myself or for my kids or my grandsons, is the wait time. We can sit waiting for a physician - even my own physician sometimes, (intake of breath), um, we can sit there waiting for two/three hours - four hours sometimes. And- and it's like - it's really obvious or like there'll be our family then other First Nation families in the waiting room and yet all the white people don't sit there and wait even half the time that we wait - they go in right away.

3.1.4.5 Fear and anxiety. Five participants expressed fear or anxiety as a difficulty when visiting a physician. One participant commented she is “just the type of
person that always worries about what everybody else thinks.” Another participant disclosed she was afraid of physicians and said “I hate going to the physician’s office.” One participant, who was a paramedic, was concerned about physicians’ expectations of him to know his medical conditions. The following is his account.

I think for me it would be more that - to do with my profession because I am another healthcare provider. So I begin to think I’m stupid for being here, asking this question or do they assume that I should know this because I am a paramedic. And me being here right now is it really important or do you think they’ll be like, “he's a paramedic. He knows this could have waited. He didn’t need attention now.”

He also expressed that at his workplace, “You have to be the strongest emotionally and mentally.” He struggled to tell his physician about any PTSD symptoms he experienced in fear that others may discover this and may think he is “weak.” Another participant worried that if she told her physician her concerns, her physician might think she was “crazy.”

3.1.4.6 Self-consciousness. Three participants provided difficulties surround their self-consciousness. One participant said, “I think it’s self-esteem. It’s just everything. It’s like opening up and letting somebody in.” Two participants commented it was easier for them to advocate for a family member’s health than their own.

3.1.4.7 Denial. Three participants commented that verbalizing their mental health problems makes their problems appear real. For example, one said “I think it's partially the realisation that you're unhealthy, um, and verbalising it just makes it that much more real, right?” One participant expressed difficulties telling his physician his mental health symptoms.

3.1.4.8 Lack of transportation. One participant said not having adequate transportation prevented her from visiting the physician during the periods she lived in
poverty. She said she could not afford to take the bus to transport her to the physician’s office. The following is her account.

[A] big one would have been the transportation barrier when I didn't have, uh, a vehicle or when I was unemployed and I was living in poverty - I had a lot of transportation barriers and difficulties then, uh, which a lot of times I just ended up suffering wherever I was - suffering it out or medicating it away with, um, with alcohol or drugs, or a combination of both.

3.1.4.9 No difficulties. Four participant said they had no difficulties telling a physician what is bothering them. They all commented that they are open to their physicians about any health concerns they may have. One disclosed she had difficulties when she was younger because she was shy to talk about them. Another expressed the importance of letting her physician know what is bothering her and she provided, “the reason being is that I know, I believe that if you don't talk about the things that are bothering you, you're going to get some horrible disease (laughs) I really do believe that.”

3.1.5 What is helpful in dealing with physicians and nurses. Twelve participants provided answers to what they thought might be helpful in dealing with physicians and nurses. Three said they were uncertain or did not know. Table 4 depicts the responses from participants when presented with suggestions that may help them feel more comfortable and confident in their interactions with healthcare providers.

3.1.5.1 Compassion. Four participants suggested that physicians show more compassion, care, and empathy. They wanted to be respected and cared for. The following is a response from the participant who is a paramedic.

Um, but I guess maybe between physicians and nurses and us, so we all have different ideas of what each other do. So I mean, we work by each other side by side every day. But I mean some nurses think that all medics do is drive. Some of us think that nurses are overpaid like just some very stereotypical examples. Um, so I guess maybe like for them if they really wanted to know and they really wanted to come and help, support to come on a ride along with us and then fully understand the job.
3.1.5.2 *Equality.* Three participants’ responses fit best under the theme “equality.” One commented he would like “to discuss as opposed to being told what to do.” Another said it would be helpful “if they would assess me based on the symptoms that I’m telling them rather than my appearance.” The third participant talked about power differences that arise from differences in pay between physicians and other professions and below is what he shared.

> I think it really comes down to money. I think that if physicians made the same amount as teachers, that made the same amount as city employees, that made - um, etc, etc, that we wouldn't hold them in such high esteem. I think that it's very easy for somebody who makes as much money as many physicians do, um, to feel that they are, um, superior to their patients and that disconnect in my opinion that is - that they're - that you're not viewed as an equal in a - in a physician's office format, that you are, like I said - and now I'm sounding repetitive too - but more of a number than - than you are.

3.1.5.3 *Good communication skills.* Three participants highlighted the importance of good communication skills either on their part or on the part of the providers. One expressed that “it's really important for a patient to be able to describe exactly what they're feeling or what's going on. Because otherwise there's no way for a diagnosis to be made.” Another suggested listening and being attentive. Another said it would be helpful if “[physicians and nurses] paraphrased back to you what they thought the problem was just so you knew, like, you’re both on the same page.”

3.1.5.4 *Physicians know patients better.* Three participants expressed they would like their physicians to get to know them better. One said he wanted his physician to speak with him for half an hour instead of five or ten minutes. Another commented it would be helpful to have a conversation about how past experiences have impacted an individual as it may help explain individuals’ “fears, anxieties, um, losses about, in- in life.” Another said, “If at all possible, uh, the follow-ups did help. So if those -- if more,
uh, if more were able to do that, I think that would definitely make a difference in a lot of people's lives.”

3.1.5.5 Physician training/education in mental health. One participant discussed how physicians are not trained to deal with PTSD or addictions. His suggestion was to have physician education on these two areas.
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Table 4. Suggestions made to trauma survivor participants regarding ways of helping other trauma survivors feel more comfortable and confident in their interactions with healthcare providers.

<table>
<thead>
<tr>
<th>Suggestions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information/pamphlets on symptoms and health concerns that trauma survivors might have and what to do about them.</strong></td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>11</td>
</tr>
<tr>
<td>Not helpful</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
</tr>
<tr>
<td><strong>Educational groups covering how stressful and traumatic experiences affect the body, physical health, and relationships with others.</strong></td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>12</td>
</tr>
<tr>
<td>Not helpful</td>
<td>2</td>
</tr>
<tr>
<td>Depends on the group</td>
<td>1</td>
</tr>
<tr>
<td><strong>Tips about how to prepare for a doctor visit or exam.</strong></td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>12</td>
</tr>
<tr>
<td>Not helpful</td>
<td>3</td>
</tr>
<tr>
<td><strong>Being able to talk with a nurse in the doctor’s office before or after you meet with the doctor, to help you explain your concerns or answer any questions.</strong></td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>11</td>
</tr>
<tr>
<td>Helpful before a visit</td>
<td>1</td>
</tr>
<tr>
<td>Helpful at follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Not helpful</td>
<td>2</td>
</tr>
<tr>
<td><strong>Other suggestions:</strong></td>
<td></td>
</tr>
<tr>
<td>Mobile coaching application</td>
<td>1</td>
</tr>
<tr>
<td>Support groups</td>
<td>1</td>
</tr>
<tr>
<td>Online support</td>
<td>1</td>
</tr>
<tr>
<td>Breaking down barriers to stigma</td>
<td>1</td>
</tr>
<tr>
<td>More public awareness</td>
<td>1</td>
</tr>
<tr>
<td>Groups to help children deal with grief</td>
<td>1</td>
</tr>
<tr>
<td>Public awareness for LGBT and IPV in LGBT community</td>
<td>1</td>
</tr>
</tbody>
</table>

*LGBT = Lesbian, gay, bisexual, and transgender.*
3.2 Healthcare Providers

3.2.1 Demographic Information. Eleven physicians from Saskatchewan were interviewed. Table 5 illustrates the demographics of the provider participants. The average age was 44.5 years old (28-65). There were eight females and three males. Ethnicities included Asian/Pacific Islander (6) and White/Caucasian (5). Nine were practicing family physicians and two were medical residents, both of whom were in family medicine. Seven of the participants went to medical school in Canada. The average number of years the physicians have been practicing was 19.5 (3-40) and both the residents were in their first year of residency training. The practice or training information for the provider participants is shown in Table 6. The majority of the participants were from the Regina Qu’Appelle (8) health region, while the rest, were from the Five Hills (1), Mamawetan Churchill River (1), and Prairie North (1) health regions. Nine of the participants were either practicing or receiving their training in urban settings while two were in rural settings. On average, participants spend 15 minutes with their patients; however, the time they spend can range from 10 to 60 minutes.
Table 5. Provider participant demographics.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of participants or Average (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>44.5 (28-65)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>6</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>5</td>
</tr>
<tr>
<td>Physician or Resident</td>
<td></td>
</tr>
<tr>
<td>Practicing Physician</td>
<td>9</td>
</tr>
<tr>
<td>Resident</td>
<td>2</td>
</tr>
<tr>
<td>Medical school training</td>
<td></td>
</tr>
<tr>
<td>In Canada</td>
<td>7</td>
</tr>
<tr>
<td>Outside of Canada</td>
<td>4</td>
</tr>
<tr>
<td>Experience</td>
<td></td>
</tr>
<tr>
<td>Years practicing</td>
<td>19.5 (3-40)</td>
</tr>
<tr>
<td>Years in residency</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6. Practice/training information of provider participants.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of participants or Average (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health region</td>
<td></td>
</tr>
<tr>
<td>Regina Qu’Appelle</td>
<td>8</td>
</tr>
<tr>
<td>Five Hills</td>
<td>1</td>
</tr>
<tr>
<td>Mamawetan Churchill River</td>
<td>1</td>
</tr>
<tr>
<td>Prairie North</td>
<td>1</td>
</tr>
<tr>
<td>Population in setting</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>9</td>
</tr>
<tr>
<td>Rural</td>
<td>2</td>
</tr>
<tr>
<td>Average time with a patient</td>
<td>15 (10-60)</td>
</tr>
<tr>
<td>Practice/Training setting*</td>
<td></td>
</tr>
<tr>
<td>Community clinic</td>
<td>6</td>
</tr>
<tr>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Family clinic</td>
<td>2</td>
</tr>
<tr>
<td>Private clinic</td>
<td>1</td>
</tr>
<tr>
<td>Occupational health clinic</td>
<td>1</td>
</tr>
<tr>
<td>Walk-in clinic</td>
<td>1</td>
</tr>
</tbody>
</table>

* Numbers do not add up to 11 as some participants work in multiple settings.
3.2.2 Common characteristics of positive and negative experiences. All the participants provided detailed descriptions of their positive and negative experiences when treating trauma survivors. Their experiences may be categorized at the level of the physician, patient, and system. Four participants also spoke of experiences which can be attributed to problems at the system-level. I will describe the common themes that emerged from my interviews with the participants. Figure 2 illustrates the hierarchy of themes, which emerged in the discussion surrounding participants’ professional experiences with trauma survivors.
experiences and Table 7 provides a list of themes and subthemes for positive and negative experiences.

3.2.2.1 Physician Level. Themes that emerged for the physician level were attributable to the physicians themselves—i.e. their opinions on the subject matter, the way they behaved towards their patients, and their own reactions to the situation.

3.2.2.1.1 Compassion. In positive and negative experiences with trauma survivors, seven participants commented on the compassion they showed their patients. One participant said, “[A]s a physician, I am always worried about what [the] physical and emotional wellbeing of my patients.” Another participant recalled that her patient had a workplace accident and became a single parent to his children after his wife’s death. She said, “I feel badly for what he went through; he's been dealt a bad hand in terms of life events.” She commented that she has to be sensitive to the issues surrounding his wife’s death and his family situation. She also added that she related to him as she had similar demographics. One participant empathized with a patient who thought he was misunderstood by professionals in the healthcare system. One of the participants disclosed that she experienced a similar traumatic event to one of her patients as she fled the same war-torn country which she and her patient were both from. She said this helped her understand her patient’s experiences. Two sub-themes that emerged in participants’ negative experiences were “distressing” and “vulnerable.”

Four participants were distressed or upset after hearing their patient’s traumatic experiences. One participant described it as “upsetting” and “demoralizing” to hear situations where parents who are survivors of child abuse perpetuate abuse on their own children. Another participant said she “just about burst into tears” after hearing her
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patient’s traumatic history. The third participant commented, “So what left me distressed about it is one thing, that it's ongoing.” A fourth participant had a patient who was a survivor of sexual abuse. The following is her account of the situation.

I mean (sigh) with this patient I just spoke about, it was distressful because it just, she kind of was very graphic about kind of what had happened and who it was and how often it happened, so it was just the details, um, and it was distressing to me because she was very upset obviously. Um, distressing to me because I couldn't, at that point, calm her down and so, um, in that instance I was quite - quite distressed - I almost had to leave the room for a bit to try- try to take a breath and come back…. [Y]ou almost could feel it physically, like when a patient is reliving their trauma, um, and they're kind of telling you all these details, you- you physically feel distressed - you have like your heart rate beats faster, your - you're almost like sweating, you're like having trouble focussing because you're listening to all this stuff. So I- I think the best word is distressed because it's hard to not be, if they're - if you're really engaged with your patient and that's how they're feeling, you also start to feel it.

The same participant shared that hearing about her patients’ past abuse “makes you feel like that could happen to anybody,” resulting in her feeling vulnerable. She added, “I don't think people select to have bad things happen to them - I think just bad things happen to people.”

3.2.2.1.2 Hopeful/Helpless. Four participants’ positive experiences can be described as hopeful, resulting in them feeling inspired and having personal learning. One participant found hope when she was able to help her patient “in the areas which were harmful to her and which were, uh, the source and the cause of trauma.” One participant said, “I think it's really important to look for successes and to find the times when things got better… I think having it on your mind and remember those wins, is really good because it re-motivates you.” He added that “if you never see that win… it's really hard to stay positive as a caregiver, if you think that the person is never going to get better.” He described his positive experience as “instrumental,” “encouraging,” and “eye-opening,” and commented it was a reminder of “the ability of just like the body
heals, the mind can heal just as effectively.” Through treating his patient, he learned “how trauma can be survived and how it can be handled and how it can be done well.”

A different participant said, “I think it's a great privilege to be able to help uh-help patients in a way that physicians are able help, understand or hear about the problems.” As a result of treating his patient, he furthered his communication skills and developed “a set of skills that might be able to help them like unravel their problems or um help identify you know this is maybe the next step that might be able to help them kinda thing.” The fourth participant realized that “we're all prone to experience kinds of fear or suffering and, um, you know our - our emotions and our reactions are often, uh, sort of universal.”

There was a sense of helplessness in eight participants’ negative experiences, and the sub-themes which emerged were frustration, powerlessness, and guilt. One participant said she felt helpless that she was not able to help her patient. She added, “[I]t was very hard because any time he comes to see me about this, I got really down because I don’t know how much more I can do to help this person.” One participant attended to a patient with laceration wounds, and he suspected his patient was a survivor of ongoing intimate partner violence. He expressed concern for his patient; however there was not anything he could do to protect her as he said, "There's no platform that I'm aware of that allows me to mandate or charge- I wasn’t there, it was unwitnessed and there's no way for me to charge or to protect this- this person from another person.”

Six participants expressed frustration after describing their negative experiences with trauma survivors. One participant said she could “just cry out of what - I don't know if the cry is feel sorry, or the cry is frustration” because she was “just at the kind of - the
end of your rope.” Another said she was “frustrated as it is not going the way they had planned.” A different participant said it is frustrating when patients try to manipulate her to obtain prescription for opioid pain medication. Another participant found her experience with a patient frustrating as the situation “starts to feel futile as time goes on and there's no progress.” The following is one participant’s account of his frustrations as a family physician.

[I]t's frustrating, because I have a very short time window to see it and I feel like nothing's changed and I try to get inspired by talking to people who've been here 30/40 years, and I'm like do things get better? Has like all the things we're doing making a difference, are they changing - and you want to hear yes, because you're like well if I do this every day, sure, like day-to-day being a physician is about, you know, fixing - fixing little things and medical problems, but the big picture things, you hope that over time communities heal. Now that's about being a family physician, you're not just - oh you hope that the legacy of your life's work is you've uplifted a whole community, not just a bunch of little patients. And - and- and you want to know that you're - you're doing all these things that are slowly going to have an effect and improve the quality of life for all these people. And that's - that's why I care about it, because I look at this every day in the emerge, and you sometimes get desensitised or whatever, but, currently in my training, as you've asked me these questions, yeah, I've seen it and I really question and wonder how many times I won compared to how many I lost.

Two participants expressed their experience as impotent. One participant (the same one who treated a patient with laceration wounds) said “I'm really powerless to- to act in her service, cause you know she's making an informed decision for herself I suppose... I felt a little bit powerless in terms like what more can I really do.” The other participant said he felt powerless against the cycle of abuse, whereby survivors of childhood abuse later become perpetrators of child abuse themselves, and he felt frustrated at the situation. The following is his account.

[T]hese are the people who are at the raw end of it and they should know better, but somehow the only ability to - to process it or whatever, is to do it to somebody else. And as much as you try to teach them or talk to them, they get angry, and aggressive and defensive, and you try all these strategies, but most of the time,
people who abuse people - you know the abusers - it's a pattern that's hard to break, and most of the time they're both the victim and the abuser.

One participant expressed profound guilt for not previously understanding that her patient’s health anxiety and need for reassurance was due to the patient’s past traumatic experience. The following is her explanation of why she felt guilty.

So I felt incredibly guilty about that and I told her that (sniff) - that I felt like I'd failed her. Had we had these discussions 20 years before, (teary) it probably would have been much easier for me to talk her into doing an anti-depressant, because she was in obvious post-traumatic disorder. So, that one, I still feel guilty about it because she had (sniff) about, uh, four really good years before she died of cancer when, in my opinion, she should have had 24 good years.

3.2.2.1.3 Services provided. Seven participants made reference to the kind of service they provided to their patients. Two only mentioned prescribing medication; another two only spoke of referrals to counsellors, psychologists or psychiatrists, while another two participants provided examples where they prescribed medication and provided referrals. The seventh participant said she utilized motivational interviewing to help a patient overcome their challenges. In their positive experiences, participants talked about how their patients received appropriate treatment and how they were able to connect their patients to professionals who can provide mental health services. When asked why an experience was particularly positive, one of the participants said “[t]he fact that we could connect her to the resources that she needed help with.” In contrast, participants recalled offering to prescribe medication and recommending referral which their patients rejected in their negative experiences.

3.2.2.1.4 Approach. Approach is the style or manner in which participants communicated with their patients. One participant said she speaks to her patients in a “practical” and “matter of fact” manner while reassuring them and being “maternal.” The following is an example of a dialogue she provided.
Um, just saying, you know, um, “here's why you don't remember this. You're saying you had a couple of drinks, but you're - you're this big, you hadn't eaten, you had roughly x-number of drinks, um, this is probably your limit” - you know you go - because they always want to know, “what did I do wrong?” “Okay, you didn't do anything wrong, this isn't sin, this is you need this information so you can better protect yourself in the future.”

In their positive and negative experiences, participants provided explanations either about their patients’ health conditions or medical procedures. One participant recalled saying to her patient, “I think what you are, you know, presenting is symptomatic problems of a more and more deeper emotional problem that you have, which you’ve been through all those difficult life and all the trauma and your husband being killed in front of you.” The same participant tried to explain to another patient the somatisation of their traumatic experience. Another participant mentioned that she explains to her patients, who are sexual assault survivors, how she physically examines them to investigate any physical injury. A different participant said he explained to his patient why they do not have a particular medical disease.

3.2.2.1.5 Power. Two participants shared experiences where there was a power difference between them and their patients. One participant said she was more forceful than usual in telling her patient to try anti-anxiety medications, and another participant commented there was a “struggle” with his patient to take antipsychotic medication.

3.2.2.1.6 Bias. Two participants’ description of their experiences may be categorized as their bias towards their patients. One of the participants had a patient who was an Aboriginal male who used alcohol and substances, had hepatitis C, and was taking pain medication. She said the patient failed a urine drug screen and requested prescription for a controlled substance. When asked to choose three to four words to describe her experience, she chose “stereotyped” and “judged” because of her patient’s
The other participant described her patient as “hypochondriacal and, um, you know needy - the kind of patient that you always - oh you see her name and you cringe because you know you're going to be doing the same discussion about the same thing”. She discovered after 20 years that her patient’s symptoms were trauma related.

3.2.2.2 Patient Level. Themes that emerged for the patient level were attributable to the patients—i.e. how the participants remembered their patients’ behaviour and reactions to the situations they described.

3.2.2.2.1 Compliance. Compliance is whether patients adhered to the treatment their physicians recommended. Five participants provided accounts of when their patients were compliant in their positive experiences, of whom two also provided examples of patient non-adherence in their negative experiences. One participant recalled that a patient of hers developed itchy skin, which she suspected was somatization of the patient’s traumatic past. When a dermatologist prescribed a medication—which the patient initially thought was specifically for his skin condition—he took the medication. However, the patient stopped taking the medication after he discovered it was to treat anxiety and not his itchy skin. One participant recounted that his patient who complied with the treatment was optimistic that the medication would work. The following is an example of a dialogue provided by a participant between him and his patient who did not adhere to the treatment plan.

I have a patient actually, she diagnosed with a personality disorder and she had, uh, schizophrenia. And she's, uh, advised by the psychiatrist to take, eh, some medication. She take it a few days and she quit and she come and – with the symptoms of mania and that. “Why you don't take the medication?” And she did not – “which is not helping. And uh, I seen the, um, I need the, uh, smaller dose.” “But the psychiatrist prescribed you this dose” and – and she kept to the emergency many times with the same symptoms and she didn't like to take the medication.
3.2.2.2 Help-seeking behaviour. This theme describes whether patients were willing to seek help from their physicians to address their difficulties and whether they accessed resources which their physicians recommended or referred them to. Seven participants provided accounts of when their patients wanted to make changes to get better or accessed further resources. One participant described a patient who was in search of a healthier lifestyle and engaged in discussions with the physician regarding healthy and balanced lifestyles. This patient had children and expressed a desire to change for their sake. Another participant spoke of a patient who was motivated to overcome her challenges and motivated to participate in activities that may help her heal from her traumatic past. A third participant said, “So she sought care and, uh, I think that's the best part of it.” The remaining four participants’ accounts of their patients’ help-seeking behaviours fall into a sub-theme “accessed resources.” One participant recalled a patient who participated in all post-treatment plans and sought care from a psychologist. Another participant described a similar experience where her patient received care from a psychiatrist and counsellor. A different participant said her patient became more independent and “accessed vary- various resources for counselling to try to move on from her childhood.” The fourth participant explained that individuals in some the cultures, in which her patient identified, “they don’t believe of emotional problems, you know? Depression and anxiety, post-traumatic disorder.” However, after the participant explained this to her patient, her patient accepted her advice to receive counselling.

Three participants provided negative experiences with their patients’ help-seeking behaviour. One participant said “even after I convinced him there was something
happening and he needed help, we could arrange counselling for him, of course he didn’t go for the counselling.” Her patient was not accepting of her help and subsequently did not return for follow-up visits. Another participant recalled her patient “seemed to have his own agenda, which was to not go back to work and sit back and let everybody else do all the work for him.” The third participant had experience with two patients who consulted the internet for their healthcare management. One of his patients stopped taking medication because of the side effects she read on the Internet. His other patient, who had back pain, was convinced he had ankylosing spondylitis because of what he read on the Internet. The following is the participant’s account with his patient.

He reads that ankylosing spondylitis, it's autoimmune disease. It's coming with the back pain. So he'll come in, he want to do the investigations. There were x-rays, uh, the special blood tests to follow this anklylosing spondylitis. You don't have a family history, you don't have the restriction in the back movement, you don't have anklyosing spondylitis, but he insists that he, eh, eh, read and he, eh, sure that he has like this disease.

3.2.2.2.3 Health outcome. Seven participants described experiences when their patients’ health improved, of whom four also provided experiences where there was no progress in regards to their patients’ health. For four of the participants, the improvement of their patients’ health was what made their experiences particularly positive. Similarly, three participants expressed that the lack of improvement in their patients’ health was what made their experiences particularly negative.

One participant said, “[I]t was like - like we handed him a lifeline and he grabbed on and took it… [H]is marriage was healing, he had good relationship with his family, he was going back to work feeling like he was doing a useful job.” She added she was relieved and happy when her patient was better. Another participant commented that her patient was “feeling better and when she comes, she’s more smiley and I think she
Another participant said one of her patients “had come in quite, um, you know, focussed on what had happened to her and then it - and not to say that it went away completely but it wasn't as distressing to her on a day to day basis.” One participant commented that after physically examining sexual assault survivors, “when the girl says afterwards, uh, ‘I'm glad that's over but it wasn't as bad as I thought.’ Then I know that I've - I've helped and not done harm.” Another explained the progress of her patient’s health after her patient shared with her his past trauma. One participant had a patient who had severe psychosis and anxiety but after treating her, “the girl’s functional.” It was a particularly positive experience for one participant when his patient recovered from a motor vehicle accident. He said, “Yeah, and, uh, he's working perfectly since. And he's self-employed now, managing his business really good and, eh, he's ... in a good mood most of time or his morale is, uh, good, uh - now but not usually.”

One participant said it was frustrating when she was “not seeing any result” and she felt the situation “starts to feel futile as time goes on and there's no progress.” Another participant expressed, “you can describe that as a situation like here you can get a person that is never improving.” For another, her patient’s conditions were “very chronic and growing, you know, more worse and worse every day.” One other participant had a patient who was a survivor of IPV, and who initially sought care for head wounds, bruises, and fractures. She said her patient returned three to four months later with similar symptoms, but with a different partner. The patient’s condition did not ameliorate.

3.2.2.4 Trust. Six participants’ responses may be categorized under “trust,” with sub-themes “connection” and “physician reassuring.” One participant said after
several visits her patient shared with her his traumatic experience and he trusted her 
“enough to tell [her], um, you know, how - how intense and scary it had been for him and 
how it had affected him.” Four participants described having a connection with their 
patients. Two of these participants had “long standing” relationships with their patients. 
The other two participants spoke of how they bonded with their patients. One said her 
patient congratulated her on her pregnancy and shared with her his experience as a 
parent. She added, “[S]o we sort of bonded over that.” One participant commented that 
“there were moments where we can make a joke, have a laugh” and that it is important to 
have “some kind of personal connection with the person.” Two participants said they 
were able to reassure their patients. For patients to feel reassured by their physicians, 
there must be some kind of underlying trust for them to feel relief. It is a “good 
experience” for one of the participants when they are able to calm their patients who are 
sexual assault survivors and when their patients feel relieved and relax at the end of the 
visit. This participant tried “to convince them and reassuring them that they're normal, 
that the trauma is mostly psychic and emotional and that we're going to get them help for 
that too.” The other participant validated her patient’s symptoms by telling her patient “I 
know they are real.” For this patient, the participant said “there wasn’t many people for 
her to talk to and express what she went through and what she had, you know? And 
when they talk about it, then they feel much better.”

3.2.2.2.5 Outlook. Four participants commented on their patient’s positive 
outlook. One said, his patient is “happy most of the time, it’s helpful.” Similarly, 
another commented her patient had “a fairly good outlook.” A different participant 
explained that her patient refocused on the positive aspects of her life, refocused on her
children, and was in the process of identifying people who can provide her with support. The fourth participant explained that patients with PTSD lose hope; however, “lessening of their symptoms gives them hope that life can, you know, that life can be pleasurable”

3.2.2.2.6 Resiliency. Three participants described the resiliency of their patients. One labeled her patient as a “survivor” because “he seems to be doing fairly well for himself despite a lot of hardship in life.” Another said his patient was a “fighter.” The third participant explained her patient had resilience for “moving forward” after surviving repeated traumatic events.

3.2.2.2.7 Affect. Patients’ anger was present in participants’ positive and negative experience. One participant said, “Probably the most difficult piece about dealing with him is the anger.” The same participant had another patient who was angry at her and at the service she provided, and blamed others for everything that was negative in the patient’s life. Another participant described a patient who “started to have problems and anger issues and causing problems with neighbours get mad at teachers at school.” A different participant had a patient whose daughter died in a motor vehicle accident, and this patient was “angry at anyone and everyone that she could, uh, direct her anger at,” including the participant (her physician). Two more participants spoke about situations during the visits when their patients expressed anger.

3.2.2.2.8 Psychological barriers. Seven participants provided descriptions that may be psychological barriers preventing their patients from maximizing the healthcare they receive. As mentioned earlier, one of the participants spoke of the loss of hope as a result of PTSD. Another participant explained how trauma affected the lives of her patient and his wife. Three of the participants’ accounts may be characteristics of their
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patients’ “self-worth.” In one participant’s negative experience, her patient had a sense of entitlement as “he just sort of sits back and, uh, you know tells us how ineffective we are and, um, you know we've let him down, we haven't provided the service, we haven't done this, that and the other thing.” Another participant said she found her patient to be “a little manipulative” and self-pitying as “he was one of those people that sort of blamed their whole lives on what happened.” Four participants provided examples of their patients’ behaviours which may be harmful coping mechanisms that they engage in. For example, two participants mentioned their patients had a history of substance use and substance use disorder. One participant explained that her patient self-medicated himself to ease his itchy skin. “He started to take out different type of creams and even injections that he got when he was in the refugees in that country when before he came to Canada.” The fourth participant commented that it appeared to him the parents’ “only ability to - to process it (childhood abuse) or whatever, is to do it to somebody else.”

Three participants alluded to their patients’ denial of their psychological ailments in their negative experiences. The participant whose patient presented with lacerations said his patient insisted her wounds were accidental. The following is his account.

I saw a lady with a head laceration and she stated that she had fallen off a- he'd [sic] been drinking with her friends and she had slipped and she'd hit her head uh on the corner of a table, but she had like a massive, massive laceration, it looked like someone had inflicted that with like a broken bottle of like a knife or something like that and it turns out she had a really large history of um abuse from her um common law partner.

Another participant had a patient who sought care multiple times for chronic headaches; however she said, “It is physical, but I am sure there is an element of emotional and mental trauma that's ongoing.” For one participant, the patients she described in both her positive and negative experiences were in denial of their emotional
problems. One of her patients persistently presented with physical symptoms (e.g. lower back pain, leg pain, headaches), made several trips to the emergency room, and had multiple medical investigations performed; however, there was no medical origin for any of the patient’s physical symptoms. Her other patient was the gentleman who had itchy skin. She recounted the following.

[T]he minute he knew this is not something really for the skin, he just went and stopped... But because of his- his ego, he was not saying, “okay I’m sad and depressed. I’m feeling traumatized about what happened in my life” and he was expressing it, this itchiness in his face that he was not convinced this is totally physical. It’s psychological, nothing physical. He was asking me, “No you have to send me to see, um, an allergy special. I’m sure I’m allergic to something.”

3.2.2.3 System Level.

3.2.2.3.1 Support for patients. Two participants commented on the lack of adequate support for trauma survivors. One commented that he is able to address the medical issues that abuse survivors present with but he is not able to stop the cycle of abuse or “fix their households.” He added, “[W]e don't have enough money or we don't have enough resources - we just don't - there's no good system out there in the world right now, other than strong communities and strong families to fix these cycles.” The other participant was resentful and angry that some children had to endure abuse and that “nobody protected them.” “[W]hen it comes to children having been abused, that it feels like nobody protected them, so not nobody, but protect, somebody did not protect them and something happened.” She also said the following.

[A] lot of the Aboriginal women I- I talk to, um, who grew up with some form of abuse, either sexual of physical, um, felt that, like they- they weren't taken out of that situation, or they weren't, um, like nobody recognised that this might be happening to them. And so they were left to their own devices in these situations that were very, um, traumatic to them... somebody could have noticed and then it wouldn't have continued to happen
3.2.2.3.2 Regulations. Two of the participants spoke of regulations in place for dispensing controlled substances. One said she felt defensive and agitated as she has to decide to whom she can and to whom she cannot prescribe these controlled substances in accordance with these regulations.
Table 7. Themes and sub-themes for participants’ positive and negative experiences with their patients who are trauma survivors.

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<tr>
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<th>Major Themes</th>
<th>Positive Experiences</th>
<th>Negative Experiences</th>
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<td>Empathetic</td>
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<td>Understood patient</td>
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<td>Inspirational</td>
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<td>Personal learning</td>
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<td>Cycle of abuse</td>
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<td>Services provided</td>
<td>Appropriate treatment</td>
<td>Offered prescription</td>
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<td>Made referrals</td>
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<td>Approach</td>
<td>Communication style</td>
<td>Provided explanations</td>
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<td>Power</td>
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<td>Bias</td>
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<td>Patient</td>
<td>Compliance</td>
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<td>Accepted treatment</td>
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<td>Help-seeking behaviour</td>
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<td>Health outcome</td>
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<td>Trust</td>
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<td>Physician reassuring</td>
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<td>Outlook</td>
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<td>Resiliency</td>
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<td>Affect</td>
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<td>Psychological barriers</td>
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### Major Themes

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<tr>
<th>Factors</th>
<th>Positive Experiences</th>
<th>Negative Experiences</th>
</tr>
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| System  | Support for patients | Lack of adequate support for patients  
          |                      | Physician resentment |
| Regulations |                     | Controlled substance  
                |                      | Physician resentment |

### 3.2.3 Talking about patients’ traumatic experiences.

All eleven participants had discussions with their patients about their patients’ traumatic experiences. However, three only discussed their patients’ past trauma in certain situations. One of the participants would gauge whether they patients want to talk about their past trauma or whether “they [will] shut me down.” From her practice, she found that many patients do not want to share their trauma history. Another participant only discusses her patients’ past trauma when she conducts fitness for duty assessments and when employers request assessment of their employees’ medical condition. The third participant does not “routinely screen for trauma.” He broached the topic with his patients only when he thinks the discussion will benefit them, when he has “the ability to provide them insight” or “a resource to discuss it,” or when there is “somebody available to talk with them.”

Table 8 outlines all the themes and sub-themes that emerged in regards to participants talking about their patients’ traumatic experiences.

### 3.2.3.1 How it came up.

How conversations about participants’ patients’ past trauma were initiated may be categorized in terms of physician or patient factors.

#### 3.2.3.1.1 Physician factors.

All eleven participants had previously initiated conversations about trauma with their patients. Four major themes emerged in this
Physician’s approach describes the manner in which participants initiate conversations about trauma and how they proceed with the conversations. Two participants reported they ask their patients directly. Three participants said they asked open-ended questions in an effort to get to know their patients. Examples include: “Have you had anything that's difficult to talk about?” “How do you like your work?” “Tell me a bit more about what things were like when you grew up?” One of these participants explained that she asked open-ended questions so her patients “don’t feel obligated to talk about their traumatic events.” She added, “I don't press patients to disclose, I just kind of give them the venue to do it if they want to.” Another participant practiced in a rural community where she would sometimes learn about her patients’ traumatic incident after it had occurred, and she “would walk into the room and immediately acknowledge that that has happened.” A different participant allowed her patients to guide the conversations. One said he brings up the topic in a manner his patients are comfortable with. For example, he said he is blunt with teenagers, uses euphemisms with his elderly patients, and utilizes play with children. A sub-theme which emerged is physician attentive, which highlights the physician’s attentiveness to the conversation. Two participants mentioned they actively listen to their patients. Another said he asks follow-up questions. One explained she lets her patients “them feel, like you want them to know that you're only asking them in a - so that you can help them.”

Two participants provided responses that indicated they initiated conversations with their patients in considering an appropriate treatment. One participant explained she
explored her patients’ traumatic past with them in “trying to figure out if they should try a medication for their anxiety or their depression” or “considering a diagnosis of PTSD.” Both participants spoke of whether their patients would benefit from talking to a counselor.

For eight of the participants, discovery of their patients’ traumatic past surfaced through discussing other health issues. Four participants said it came up through discussions about their patients’ physical symptoms or concerns (e.g., lack of sleep, headaches, unwanted pregnancy). Medical investigations (e.g., blood tests) were performed to rule out any medical causes (e.g., high blood pressure); however, one said, “we know if I find nothing, refer it to the post-traumatic or psy – psychological, mm, problem.” Conversations about trauma also surfaced when participants explored their patients’ general health, anxieties, and alcohol use. Of the eight participants, four provided responses that were best characterized under a sub-theme further exploration as these participants persisted in their talks with their patients to discover the cause of their patients’ ailments. One participant explained she continued to have discussions with her patients until “they will accept the message that, okay these are all physical things from something much deeper, something emotional, and emotional pain, which present as physical symptoms.” Another participant had conversations with his patient about how the patient is coping with her symptoms and investigated “the reason for the anxiety and uh how are the manifestations after the anxiety, what are things that make it worse, what are things that make it better.” The third participant was concerned that her patient was stuck in his depressive state, and in trying to understand her patient’s behaviors, there was a discussion on her patient’s experience as a survivor in a hostage situation. The
fourth participant shared she had conversations about her patients’ traumatic past when discussing contraception and sexually transmitted infections (STI). With one of her patients, she explored how her patient contracted STI. The following was her experience with this patient.

[W]e’d just treated her for Chlamydia and I asked her, “okay, hon, tsk, how many partners have you had in the last year? And - and how many lifetime partners have you had?” And that sort of - or trying to explain to women the risk for be it cervical changes, cervical cancer, whatever, it - how many viruses have you been exposed to. So it's not a judgemental thing, it's a I need to know what your risk is of this or that. (Sniff) And this young woman told me from Grade 9 to Grade 12 she'd had 17 or 18 partners I think. And I went “why do you think you had that many partners?” I said “you couldn't have been in - in love with all them, you know, you couldn't have even necessarily (laughs) been dating them for very long?” (Sniff) And she, right off the bat, said “I had sex with my first boyfriend because he wanted it and I loved him. And then, when he dumped me, um, I was at a party” and, um, one of his good friends, um, was sort of pushing her - pushing her for sex, and she said “I didn't feel like I could say no to him because he knew I wasn't a virgin.” And - and so when I - it just like dumfounded me, and I said “what made you think that, um, you didn't have a right to decide about your own body simply because you'd had sex once.” Um, and of course that's when she told me about her brother and cousin molesting her when she was younger.

Five participants said they discovered their patients’ traumatic history while collecting information about their patient’s history for a new patient or during routine assessments for existing patients. Examples of patient history include collecting background information about the patient, asking patients about their social history, or screening questions to provide prescription of controlled substances. Two participants explained they discovered their patient’s traumatic past while conducting a complete physical examination.

3.2.3.1.2 Patient factors. Themes that emerged in patient factors describe conditions under which patients disclosed their traumatic experiences or the behaviours patients displayed that prompted participants to instigate the conversation about their past trauma. The three themes that emerged were patient initiates, trust, and patient signals.
Four participants said they had patients who disclosed their past trauma out of their own volition. Examples of responses include, “it was actually her that brought up that- the traumatic” and “they start to talk to you how hard their life was and how things would happen.” Five participants provided responses which were best categorized under trust. Three commented that the majority of their patients do not discuss their past trauma during their first visit with their physicians. “Some, some of them just, you know, just look at you and, and, doesn’t say much in the beginning.” However, they said their patients disclosed their past trauma after several visits. “So she opened herself to us over, like I said, about three to four visits.” Four highlighted the importance of building rapport and a trusting relationship with their patients in order for their patients to feel comfortable discussing their past trauma. One said, “[B]ecause I developed that trust and that rapport with these patient that they started to open to me.” Another stressed, “[Y]ou're not going to get that the first time you meet someone, you're going to have to establish a relationship with them”

Two participants described situations when their patients communicated with them non-verbally, which made them suspicious of possible past traumatic experiences. One of the participants commented that some of her patients seemed upset and “then they'll often burst into tears if it's a female.” When patients became tense during physical examinations, one participant would ask her patients, “Was there a bad, um, unwanted sexual experience, was there, you know, molestation or child abuse when you were younger?”

3.2.3.2 Outcome. Themes which emerged were from responses to questions about patient reactions to participants asking them about their past trauma, participants’
own reactions to their patients’ responses, participants’ hopes or expectations about their conversations, and whether participants thought these conversations were helpful.

Themes were further categorized into physician and patient factors.

3.2.3.2.1 Physician factors. Themes under physician factor described participants’ comfort (or discomfort) with discussing their patients’ past trauma, their approach in navigating the conversations, and under which circumstances they would find the conversations unhelpful. Two participants addressed how comfortable they are with these conversations. One said in the past he was not prepared for his patients’ emotional reactions. At present, he commented he is now prepared; however, he expressed the importance of being careful and prepared “because you might have just totally up - you’ve destroyed this world that allowed them to function normally.” The other participant said, “it's more about you - the physician's comfort with learning how to be okay with the reactions” and added this is “why physicians don't ask, 'cos they don't want that.”

Five participants spoke of their approach to the conversations. Two participants set aside time to have these conversations. One said she talks to her patients in a practical and reassuring manner. Four of the five participants’ approach may be described as patient-centred. One said “I usually don’t pry them.” Another provided her patients with the option to talk; if her patients were not ready to discuss their traumatic experiences, she said she acknowledged their experiences and told them “it doesn't seem like you're ready to talk about this and maybe nothing's happened, but maybe something has and if you want to talk about it in the future, we can.” One commented that she does not pressure her patients to disclose and said “I usually don’t pry.” One of the participants
“try to let [his] patient tell their story within the constraint in order to best serve them,” and similarly another participant “let the patient guide the conversation.”

Three participants commented that sometimes conversations about patients’ past trauma are not helpful when there is no direction for treatment or when there is no continuous care. All three participants said it is not helpful for patients to simply relive their trauma. For example, one said, “I don't find that I've found it very useful to be the physician sitting in the room talking to someone about their trauma.” One of the participants also expressed the following in regards to not having continuous care.

I don't think it's helpful if you're not going to be, um, you know, seeing them longitudinally, um, to kind of talk about all these traumatic experiences because you can't help them that way, I don't think... Yeah, you're not going to follow up and you're not going to be part of their care, you know, you're not going to be their care provider, you're - you're not going to be part of their care on a long-longitudinal basis, having one visit and discussing traumatic events is probably not helpful.

3.2.3.2.2 Patient factors. Participants provided responses that indicated the benefits to their patients after discussing their patients’ traumatic history, their patients’ emotional reaction to these conversations, and situations where these talks were unhelpful for their patients.

Four participants commented that these conversations provide their patients with opportunities to develop insight. “[I]t's all about like the ability for patients to identify self-reflect.” Two of the participants expressed hopes that talking about their past trauma will help their patients to think more about their past and to help them connect more deeply with their feelings. These talks also helped to reduce patients’ anxiety as “they can identify the triggers that cause them to have the anxiety or the panic attack or the behaviour that they exhibit.” One participant hopes that his patients will be motivated to make changes to their troubled situations.
Four participants said that their patients were relieved following these discussions. They had patients who told them, “I've never told anybody that before, so thank you so much, I feel so much better.” One said, “Some of them seem to just, like I say, like to get it off their chest every once in a while.” Another compared their patient’s relief to “lancing a boil and letting the pus out - sorry, gross simile but they are - they are almost all relieved that it's known.” Their patients find relief in knowing that they are not the only ones who experienced trauma or that “they're not, uh, worthless or damaged or dirty or whatever.”

Five participants spoke about their patients receiving care following their discussions about their patients’ past trauma. One participant said, “[I]t is very positive because [the] patient keeps getting engaged in care.” The same participant had several patients who continue to return to seek more help. Two participants’ responses may be grouped into a sub-theme (compliance) as their patients were welcoming of any suggestions, they were cooperative, or they were “very compliant with the therapy.” One participant was able to refer her patient to a psychiatrist and counsellor, and provided her patient with more resources. She said, “I think that's the best part of it, so we could connect her to a psychiatrist immediately, made sure that she was safe, and had the crisis response team visit her home.” Three participants mentioned their patients received continuous care as a result of these discussions. One said, “You know, at least once a month and they counsel up with me and make sure they are okay and they-they are on treatment and make sure the treatment is working. So it’s the continuous support.” She explained that this continuous care is needed as the improvements are gradual. Another
commented that she follows up with her patients “very regularly, sometimes it’s twice in a week” and added that this allows her to know they are safe.

Four participants expressed hopes that their patients acknowledge their physicians care for them. One said, “I think as a practitioner you feel like you want to let people know that you care.” Another commented, “If they feel that, uh, I have the time to give them and I'm listening, I'm usually seeing them come out very positively about their experiences.” One of the participants hoped her patients will think that their physician understands them and will be encouraged to be honest about any situation. The fourth participant made the following comment.

You know - they might not admit to me, they might not say it to me, they might get angry at me, but it's not like they didn't hear me - they definitely heard I thought that there was a concern and this was something to think about and there might be something going on.

Two participants made comments that describe their trusting relationships with their patients. One said, “[W]e enjoyed our time with each other.” Another explained that she built a relationship first with her patients before she discussed her patients’ traumatic experiences with them. Three participants responded that these conversations were helpful because their patients felt “slightly more positive” and their symptoms reduced. One participant was able to help her patient find housing after she discovered her patient’s living conditions.

Ten participants made reference to their patients’ negative emotional reaction to discussing their past trauma. Two participants commented that “most people are embarrassed initially” and initially express negative emotions. Six of the participants had patients who were upset following these conversations. “[M]ost people I think - most people, in my experience are upset when we talk about it.” A participant had patients
who “will just come in crying,” and others had patients who were “quite tearful.”

Patients express “a flood of emotions,” including “break down.” Three participants commented on the anger with which their patients react. “[S]ome of them are angry because they're hurting and- and nobody's done anything.” One participant explained the following about his male patients’ anger.

> [T]he next step is usually they get angry. “Wow, what are you saying - you think it happened to me?” Guys get super angry, especially when it comes to sexual abuse, it's a - it's a - I don't it's foreign to them but that you think that somehow they could have had some moment of weakness like that.

Three participants described their patients’ negative reactions, which were neither upsetting nor angry. Some patients became agitated and spoke at a faster pace, some became anxious, while others became depressed. The following is one participant’s account of their patient’s feeling bewildered and ashamed.

> [W]e have some of those that are quite bewildered that they can't believe after 15 years, um, that this is happening to them. They're quite bewildered. Um, the, um, some of them are, oh, I'm just trying to think, what's the other reaction that we get. Well they're ashamed - some of them are very much ashamed. A lot of them, um - some of them are like, um, “oh I'm not that kind of person, you know bring it on, I can take anything.”

Three participants addressed their patients’ denial of any past trauma. After one participant asked whether her patients had experienced past trauma, she said “sometimes people look you - look at you and say no-no-no, but their eyes say yes-yes-yes, you know something happened but they're not ready to talk about it.” Some patients become defensive, while others may dissociate. One participant said, “And some people seem too dissociated from the whole, like this girl who was raped. She talked about it like it wasn't her and she was just telling a story about someone else, without emotion really.” Another participant commented that his patients respond with “a lot of denial. No one ever wants to admit it - even people who have been viscously abused.” The same participant
described an incident where a young female patient came into his clinic with fecal matter in her hair because she had not been taken care of for what he suspected “in months, if not weeks - uh, weeks if not a- a year.” His young patient had such an aversion to men that “she wouldn't look guys in the eye - it classic signs of sexual abuse.” She had to be examined by a female physician. After this young patient was provided with care and proper hygiene, the participant said there was “denial, denial, denial - we never got - she's either mentally not ready to admit and we all know that her behaviour tells us classically to something that's happened, but she's not going- denies it.”

Three participants found there were situations when having a conversation with their patients about their past trauma was not beneficial. One said, “It doesn’t work the first time.” Another participant had a patient where she thought “perhaps nothing would ever be helpful- it was not helpful, it never would be helpful and that - that was tough, but that's a very unusual.” The third participant explained that these discussions can make the situation worse for her patients as it can cause them to become more upset.

3.2.4 Difficulties with trauma survivors. I will discuss in this section themes which emerged from responses to the difficulties participants encounter when treating trauma survivors and when discussing their patients’ traumatic experiences. These are also illustrated in Table 8. The themes are categorized as physician, patient or system factors.

3.2.4.1 Physician factors. Themes were grouped into physician factors when they related to what the participants felt and what they were thinking when faced with these difficulties.
3.2.4.1.1 Sensitivity. This theme describes how sensitive four of the participants were and why their sensitivity was a challenge for them. One felt “overwhelmed for the patient because that’s how they come to you feeling.” This triggered an emotional reaction for the participant because it made her realize “we’re all vulnerable to things happening that are traumatic” and “it can make you think about your own stuff that might have happened to you.” Two participants acknowledged “the huge intensity” of what happened to their patients. They both added if their patients’ traumatic events were similar to something that had previously happened to them, they may self-identify with their patients’ experiences. The following is an example provided by one of the two participants.

I think it's difficult because it can, you know, it can make you think about your own stuff that might have happened to you or like, you know, if you were bull-like if I were bullied in school, like that, you know, being - talking to a patient that's suffered from a lot of bullying, like it brings that up too. So if you're a self-reflecting individual, it - like some of your own experiences, it will come in- into light, um, when you're talking to patients that have gone through like traumatic events.

Due to their sensitive and caring nature, participants may feel anxious about responding appropriately to their patients. One expressed that “any time you're talking about extremely negative event it can't be easy to do.” Another said she fears saying “something that's not entirely appropriate.” She added that she worries about “making things worse” for her patients when exploring these sensitive issues and feelings with them. The third participant was constantly concerned that she might re-traumatize her patients as she may “bring it back for them and make it real for them again in - in the moment today... bring back those feelings.” The fourth participant remarked, “I think I do a decent job of like being nonjudgmental of the patient, but you know it's sometimes not super easy to do that.”
3.2.4.1.2 Cannot relate. One participant’s response captured the difficulty physicians have in trying to understand their patients who are trauma survivors. She explained that “a lot of physicians themselves haven't lived through a lot of trauma,” and “they've had a very different life than the patients that they're serving.” She suspected part of the challenge for physicians is “trying to find common ground, well when you haven't had that happen to you, it's really hard to - to understand what they might be going through.” She disclosed that she herself was sexually assaulted as a child. The following is her understanding of what physicians who have not experienced a traumatic event may think.

I think sometimes people, the idea of trauma and its effects on people, it's so much worse than actually - like when you think about it all at once, cumulative, it's so much worse than actually living through some of it. I-I don't - it's - I don't want to say that trauma doesn't do anything to people, but I do think that sometimes the idea of trauma is worse than - because you put it all together, its cumulative effect over time. And so people are afraid when they - when they bring it up, it brings up it altogether as opposed to, um, you know, when you live through it I guess.

3.2.4.1.3 Preparedness. Three participants expressed that part of the challenge is being prepared to treat trauma survivors and being prepared to have a discussion about their patients’ traumatic past. Two participants remarked that preparedness includes knowing what to say and knowing how to proceed in a way that is beneficial for patients. Another participant explained he asks himself, “What are you going to do next with it? Those are probably the hardest things. So great now you did it - now what?” He expressed frustration that physicians are not well equipped to deal with this. Similarly, one of the participants said, “As a GP takes a while to discuss and break down and we're not really geared appropriately or healthcare systems aren't geared appropriately to set up to break down these issues appropriately like they might deserve.”
3.2.4.1.4 Uncertainty. Four participants expressed uncertainty in managing trauma survivors. One was not certain on aspects about bringing up conversations about his patients’ past trauma. For example, “what is the appropriate situation, not only the appropriate patient - but what's the appropriate time?” He added that another difficulty is that “it's not obvious that they're trauma patients, right - they don't come with a sticker... I think that's probably the hardest thing is that figuring out which one of these people has encountered trauma.” Another participant commented “it's wondering what their reaction is going to be” and was concerned whether she will cause harm to her patients by discussing their past trauma. A different participant said, “I don't have any solid firm guidance on how to help them through it usually.” A sub-theme emerged from the fourth participant’s response. Much of the uncertainty for her is the psychosomatic symptoms with which her trauma survivor patients present. The following is what she described.

[Y]ou start second-guessing every symptom they have and you have to go okay, now is this part of the somatization, is this part of the anxiety, is this part of the depression - is it part of the PSTD, or is this a real problem and you're - you don't want to over-investigate or give too much importance to what might be a benign symptom, um, or - or a psychological symptom, and at the same time, you're going but, you know, sh– what if I'm missing something? What if I don't do this test? So, the high anxiety that they have leads to so many difficult symptoms that you're always afraid you're going to put something down as psychological when they actually have a cardiac arrhythmia or hypothyroid, you know, or whatever. So that's actually a big part of - of dealing with trauma survivors - dealing with the aftermath and how to separate, um, psychological from physical.

3.2.4.2 Patient factors. Participants’ responses included difficulties which may be attributed to their patients and themes that emerged from these responses will be discussed in this section.

3.2.4.2.1 Reluctance to accept treatment. Four of the participants had difficulties with their patients’ reluctance to accept help or treatment. They expressed disappointment that trauma survivors do not regularly follow-up with their physicians as
needed and many of their patients only visit their physicians to receive prescription medication (e.g., opioid). One of the participants commented that medication is only part of the treatment and that “[t]here's a lot more that has to be done psychosocially for them and making sure that the other social determinants, uh, which may be affecting their health, ah, are taken in to consideration.” A sub-theme, engagement in care, emerged when considering two of the participants’ responses. One participant found it challenging to move her patients past their emotional states so that she can encourage them to participate in treatment. The difficulty is “having them in a mental state so they're willing to have the insight to change.” The second participant commented that male patients are the hardest to engage and hardest to convince that they need help. He said, “So how do you convince that person that 'hey, buddy, the reason you're such a violent, you know, offender is because you're actually hurting.’ (Laughs) That's - that's really hard.” He added male trauma survivors are also the ones who need the most help. Another sub-theme, mentality, emerged in reviewing responses from two participants. One participant asked herself “are they ready to look at this” before initiating any conversations about her patients’ past trauma.

3.2.4.2.2 Difficult to connect with. Three participants responded they have difficulties connecting with their patients. Trauma survivors were described as being “distant,” not having good eye contact, and “they're preoccupied with something.” Even though one participant said she tries to connect with her patients, sometimes she is not able to, especially when her patients are homeless or do not have a stable residence. She opined, “I wish there was - if there was a way of having them connected to one particular case worker who would connect them with us on ongoing basis - I think I would be able
to help them more.” This same participant also discussed her patients’ drug use, a sub-theme which emerged in this section. Some of her patients came to their appointments while under the influence of substances (i.e., they were intoxicated), making it challenging for her to connect with them properly. The following is a description she provided.

Then suddenly, these people with, um, tsk, substance use disorders, are there with it one day and then it depends on what's going on in their life and how much or what they are still using, continuing to use as, um, these recreational drugs are concerned, and then they are not with it the next time they come.

3.2.2.3 Expectations. Two participants had difficulties managing their patients’ expectations. One participant said, “Some patients expect that you're the physician, you have, uh, the magic prescription, he feeling really good soon. Yeah, and uh, it was not, uh, reality. The reality is some – some stuff that take longer time.” The other participant commented that perhaps trauma survivors had a previous negative experience where they may not have “been taken seriously” or received no help; and so she suspects “so they feel like they can't, if they give information it will come of no avail anyway.”

3.2.4.2.4 Sensitivity. Two participants made comments which described their patients’ sensitive nature. One commented that inappropriate remarks “makes them feel worse” or “makes them not trust my motivation or intention.” The other participant said, “I find it difficult when I see somebody who, um, needs to be in control and, um, I'm going to ask them a question that's going to make them vulnerable.”

3.2.4.2.5 Negative reaction. Participants spoke of their patients’ negative reaction as one of the difficult parts of talking to patients about their trauma-related issues. They experienced their patients becoming agitated or upset. One said, “[Y]ou're trying to deal with their emotional state,” whether it was fear, anger or bitterness. Another commented
that patients often misdirect their negative feelings towards her and added, “I'm not surprised when people put it to places where it doesn't belong.” Patient’s anger, which was a sub-theme that emerged, was frequently discussed by four participants. One had patients who were “so abusive, so angry with everybody else in the clinic.” Another described in detail the difference in anger expression between his female and male patients. He said his female patients “act out on themselves. They'll overdose, they'll cut themselves, they'll - they'll do violence upon themselves.” On the other hand, his male patients “act out on others.” He explained they are often mistaken as “oh, you know he’s violent, he's a dick, he's a bully” when in fact they are aggressive because “they're just scared or hurt.” He added there is a higher rate of suicide in men than in women.

3.2.4.2.6 Non-communicative. Six participants addressed their patients’ reticence as a difficulty when treating trauma survivors. One participant described a patient who was “very quiet” and who “neither says yes or no” when questions were directed at her. Another participant remarked that trauma survivors “can be a bit guarded.” She added “they obviously have reservations” and are “not willing to answer a lot of questions.” A different participant said trauma survivors “don’t express their feeling. They don’t express their feelings to their children because they are worried about them. They don’t express their feelings to their, you know, close family members.” Four of the participants also found their patients’ reluctance to share information extended to discussions about their past trauma. Their patients would tell them, “I don't want to talk about it. I just want to forget about it.” Two commented that male trauma survivors feel less comfortable discussing their trauma-related issues. The following is an explanation provided about a participant’s male patients.
[T]hey don't feel comfortable talking to anyone and they don't feel comfortable talking to their buddies or their mum or anyone, so - and that's always why you see such high rates of suicide in men. Like women will try more times, but men will do it more times. They'll actually do it, and they will not tell anyone and they'll suddenly be dead.

3.2.4.2.7 Trust. Two participants mentioned the lack of trust as a difficulty. Patients may not trust that they will receive help. One commented “trying to get to a point where they trust you enough to talk about it” is a challenge.

3.2.4.2.8 Comorbid factors. One participant remarked that trauma survivors’ comorbid mental health illnesses pose a challenge for physicians. She said, “A lot of mental health challenges take a while- as a GP takes a while to discuss and break down.”

3.2.4.2.9 Difficulties letting go. Two participants commented that trauma survivors perseverate on their trauma. One said, “Sometimes moving them forward is very difficult.” The following is the other participant’s explanation of the difficulty for trauma survivors to let go of their past.

I think it's really important when the trauma happens to you, like in terms of brain development and, um, you know, I see a lot of patients who were traumatised when they're young and they don't really move forward maturity-wise beyond a certain point because of the trauma. I think it changes them.

3.2.4.2.10 Cultural factors. One participant noted cultural differences between her and her patients as a barrier to providing care for trauma survivors. Her patients may speak a different language and their English may be poor. She also explained that some cultures discourage expression of mental health illness as they believe there is only treatment of physical symptoms. These cultures also view expression of feelings as a weakness and “they don’t believe in the word depression or the word anxiety or the word posttraumatic disorder.”
3.2.4.2.11 Denial. Two participants remarked on their patients’ denial of their past trauma as a difficulty when providing care for them. One of the participants observed that some of his male patients denied any past trauma as “they don't see themselves as weak or somebody who's been abused or attacked or dealt with trauma - they see themselves as strong, and the way they demonstrate that strength is through their violence.” As mentioned before, some patients have different culture-bound beliefs about mental health illnesses. As a result of these cultural beliefs, some patients from different cultures are in denial of their problems. The following is an example provided by one of the participants:

Because I can tell you about patients who had mental problems back in their countries and when they came and I start to ask them. And all the husbands and the wife were in denial because, uh, the guys were telling me, yes she was sick. My wife was sick before. She will go and disappear and she cannot find her way back. And her sister was the guardian giving her the medication because we couldn’t trust her if she takes her medication and that. But when I told them about the diagnosis, they were totally in denial that I have to send them to specialist and re-diagnose their mental illness.

3.2.4.2.12 Avoidance. Two participants provided responses that are suggestive of avoidance behaviours in which their patients may be engaging. One of the participants commented that one of the challenges is “trying to get to a point where they trust you enough to talk about it and deal with it.” Another participant said, “So you explain to them that, um, avoiding - avoiding the memory, avoiding dealing with it, it's like when you're anxious about something, avoiding it builds the anxiety up.”

3.2.4.2.13 Psychosomatic symptoms. Three participants expressed that trauma survivors’ psychosomatic symptoms present as difficulties when treating them. “[I]t can be hard to get to the bottom of.” When survivors are from different cultures, “they don’t know how to express their psychological symptoms.” One participant said she believes
once “they have no other real, you know, daily, life stuff to worry about, then they start to come present with psychosomatic symptoms.”

3.2.4.3 System factor. Two participants voiced the lack of support available for trauma survivors as a difficulty in managing their health issues. One opined, “I feel I want more of community resources to connect them to.” Another explained while it is beneficial for trauma survivors to seek healthcare, there needs to be more community involvement for them to overcome their personal challenges. The following is what this participant recounted.

Okay, great, and then they’ve gone - went and saw mental health twice a week, so they see mental health for an hour - that's three hours a week. Okay, great. And so what do they do the other 146 hours or whatever - you know like 140 so hours, that's where community comes in.

3.2.5 What is helpful in dealing with trauma survivors. All 11 participants provided suggestions on what they believe would be helpful in dealing with trauma survivors. Their responses may be categorized as physician, patient or system factors. I will describe the 12 themes which emerged. These themes and any sub-themes may also be found in Table 8. Participant responses to suggestions to developing ways of helping trauma survivors feel more comfortable and confident in their interactions with healthcare providers can be found in Table 9.

3.2.5.1 Physician Factors. Suggestions that pertain to what physicians may do or may or what physicians need are categorized under this section.

3.2.5.1 Appropriate treatment. Two participants expressed that it would be helpful to take care of their patients’ needs and to provide them with appropriate medication and treatment. One of the participants commented, “[G]etting the medication that allows their brain to function so that they can start coping again.” The same
participant also explained that appropriate treatment for trauma survivors would be evidence-based therapy such as cognitive behavioural therapy and dialectical therapy.

3.2.5.2 Time. Five participants alluded to time. Two of the participants were able to book patients at 30 minutes intervals, which they found to be helpful. One said, “I spend quality of time with them... I have enough time. I don’t have to run and see one patient after another and at least have time to listen to them.” The other participant said her patients have complex needs, and “that’s good” to have 30 minutes. For participants who are not able to set aside 30 minutes per patient expressed that “15 minutes is not enough” especially “when we take some time explaining.” One said “enough time is the biggest thing probably for me.” Another participant commented “sometimes it goes long - much longer than you anticipate” when patients become upset following disclosure of their past trauma. Three of the five participants explained that time may take the form of follow-up or regular visits. All three highlighted the importance of regular visits as one or two visits may not be helpful enough for their patients. Moreover, one added, “[W]hen you know the patient and this patient is seeing you regularly in your practice, then you understand them more. You know that it is nothing physical out there, it is something deeper going on.”

3.2.5.3. More education. Two participants spoke to receiving more training and education. One said it would be helpful to have more training in mental health, while the other participant expressed the need for education on different cultures. The second participant said it was helpful for her to know about the residential schools and cultural trauma that her Aboriginal patients experienced. Similarly, she commented it would be helpful to know of risk factors and shared trauma for different ethnic groups. She added,
“[T]here's certain immigrant health stuff that I - that I wouldn't feel very comfortable working with immigrants if I didn't know some of their shared traumas.”

3.2.5.4 More experience. One participant said gaining competency in dealing with trauma survivors comes with experience. Through her own experience, she was exposed to the emotional responses from trauma survivors and she learned to sit and listen to them. She explained that learning to manage that emotional response may be difficult for physicians, especially when “sometimes the best thing to do is just be there.” She expressed the need for this kind of exposure in training.

3.2.5.5 Understanding. One participant explained in depth the importance of understanding his patients. “Understanding someone's context is probably the most important thing.” He found it difficult sometimes to understand his patients, and so he believes “it's the best for physicians from the place to care for a place.” He explained that when physicians care for a place they come from, “they know what people went through, they understand that - you don't have to have lived through it but you have to have an understanding of it.” He added it would have been helpful to integrate himself into the community to understand their patients’ historical traumas and health context. For example, for him “it's a new encounter, but to them it's their 50th encounter with healthcare, and trying to remember what - what that might mean to them.”

3.2.5.6 Use of reflection. One participant found it helpful to use reflections, whether simple or complex, to empower his patients. He provided the following as an example to a simple reflection. “So uh if someone said uh- ‘So that person hit me’ and I’ would say so you were hit by the other person.” The following is an example of a complex reflection. “So if um ‘I wanna- I want to improve my drinking because I wanna
be there for my children’ and you said something like, ‘[O]h you're someone that really care- I can tell you're a very caring person.’”

3.2.5.2 Patient Factors. The two themes that will be discussed in this section are related to what participants thought their patients could do.

3.2.5.2.1 Trusting relationship. Three participants commented it would be helpful to have trusting relationships with their patients. One said, “[I]f you can have a relationship with someone where you actually like them for even a little while, that helps a lot too.” Another highlighted the importance of her patients to trust her, to “open up more,” and “to develop that trusting and, uh, respectful, uh relationship.”

3.2.5.2.2 Communication to a supportive person. A response from one participant was consistent with having a supportive person to whom their patients may communicate. She said, “[I]'s really important if they're identified, they let it out - secrets are just so overwhelming - they let it out, they told someone, they weren't judged, their world didn't fall apart... then they can start dealing with it.

3.2.5.3 System Factors. Themes classified under this section were related to suggestions which are outside the control of the participants and their patients. The themes include resources, having a third party present, and having a multidisciplinary team.

3.2.5.3.1 Resources. Three participants suggested that it would be helpful to refer patients to counsellors and to have more mental health resources to which they can refer their patients. One said, “Make sure you, you have good counselling services with those people because still they need to sit out an hour with the counsellor.” Another participant
also suggested having free or affordable counselling so that they are more accessible to patients.

3.2.5.3. Third party present. Having a peer, a case worker, or some other form of third party personnel was suggested by two participants. One participant recalled a “peer-to-peer” program that used to exist at her workplace. This program allowed for a peer who “could accompany the patient, be supportive for the patient, validate what the patient is saying, and validate what [the physician is] saying to the patient.” This participant added that this program is “very useful especially when we have somebody who's a little reluctant to proceed with treatment.” The other participant would find it helpful “if there was a way of having them connected to one particular case worker who would connect them with us on ongoing basis.”

3.2.5.3. Multidisciplinary team. Two participants responded that working with a multidisciplinary team would be helpful when dealing with trauma survivors. Both suggested having counsellors, psychologists, and nurses with whom they can work with closely. One said having a pharmacist on the team would also be helpful.
Table 8. Themes and sub-themes which emerged when participants had discussions with their patients about their patients’ traumatic experiences, and when they were asked what they found difficult and what they found helpful when dealing with trauma survivors.

<table>
<thead>
<tr>
<th>Factors</th>
<th>Discussions about patients’ traumatic experiences</th>
<th>Difficulties</th>
<th>What is helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How it came up</td>
<td>Outcome</td>
<td>Sensitivity</td>
</tr>
<tr>
<td>Physician</td>
<td>Physician’s approach</td>
<td>Physician’s approach</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Attentiveness</td>
<td>Patient-centered</td>
<td>Cannot relate</td>
</tr>
<tr>
<td></td>
<td>Routine assessment</td>
<td>Physician’s comfort level</td>
<td>Preparedness</td>
</tr>
<tr>
<td></td>
<td>Through other health issues</td>
<td>Not helpful</td>
<td>Uncertainty</td>
</tr>
<tr>
<td></td>
<td>Further exploration</td>
<td>If no continuous care</td>
<td>Psychosomatic symptoms</td>
</tr>
<tr>
<td></td>
<td>Considering treatment</td>
<td>If no direction</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Patient initiates care</td>
<td>Receives care</td>
<td>Reluctance to accept treatment</td>
</tr>
<tr>
<td></td>
<td>Trust</td>
<td>Seeks help</td>
<td>Engagement in care</td>
</tr>
<tr>
<td></td>
<td>Patient signals</td>
<td>Compliant</td>
<td>Mentality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referrals and resources</td>
<td>Difficult to connect with drug use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop insight</td>
<td>Expectations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trust and connection</td>
<td>Sensitivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relief</td>
<td>Negative reaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knows physician cares</td>
<td>Anger</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative emotions</td>
<td>Non-communicative trauma talk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Initially negative</td>
<td>Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upsetting</td>
<td>Comorbid factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anger</td>
<td>Difficulties letting go</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denial</td>
<td>Cultural factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not helpful</td>
<td>Denial</td>
</tr>
<tr>
<td>System</td>
<td></td>
<td>Lack of support for patients</td>
<td>Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Third party present</td>
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<td></td>
<td></td>
<td></td>
<td>Multidisciplinary team</td>
</tr>
</tbody>
</table>
Table 9. Suggestions made to physician participants regarding ways of helping trauma survivors feel more comfortable and confident in their interactions with healthcare providers.

<table>
<thead>
<tr>
<th>Suggestions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/pamphlets on symptoms and health concerns that trauma survivors might have and what to do about them.†</td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>6</td>
</tr>
<tr>
<td>Not helpful</td>
<td>3</td>
</tr>
<tr>
<td>Educational groups covering how stressful and traumatic experiences affect the body, physical health, and relationships with others.‡</td>
<td></td>
</tr>
<tr>
<td>For patients</td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>7</td>
</tr>
<tr>
<td>Not helpful</td>
<td>2</td>
</tr>
<tr>
<td>For physicians</td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>7</td>
</tr>
<tr>
<td>Not helpful</td>
<td>2</td>
</tr>
<tr>
<td>Tips about how to prepare for a doctor visit or exam.</td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>5</td>
</tr>
<tr>
<td>Somewhat helpful</td>
<td>1</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
<tr>
<td>Not helpful</td>
<td>2</td>
</tr>
<tr>
<td>Being able to talk with a nurse in the doctor’s office before or after you meet with the doctor, to help you explain your concerns or answer any questions.</td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td>5</td>
</tr>
<tr>
<td>Helpful before a visit</td>
<td>1</td>
</tr>
<tr>
<td>Depends on patient</td>
<td>1</td>
</tr>
<tr>
<td>Depends on the healthcare provider</td>
<td>1</td>
</tr>
<tr>
<td>Not helpful</td>
<td>1</td>
</tr>
<tr>
<td>Other suggestions:</td>
<td></td>
</tr>
<tr>
<td>Support groups</td>
<td>1</td>
</tr>
<tr>
<td>More public awareness</td>
<td>1</td>
</tr>
<tr>
<td>Counsellors trained in mental health, refugees and immigrants</td>
<td>1</td>
</tr>
<tr>
<td>Consultation team</td>
<td>1</td>
</tr>
<tr>
<td>Trauma support helpline</td>
<td>1</td>
</tr>
<tr>
<td>Physician training on how to deal with trauma survivors</td>
<td>1</td>
</tr>
<tr>
<td>Physician training on mental health</td>
<td>2</td>
</tr>
<tr>
<td>Healthcare providers to spend adequate time</td>
<td>1</td>
</tr>
<tr>
<td>More mental health professionals and resources</td>
<td>1</td>
</tr>
</tbody>
</table>
Two participants were simply asked to provide suggestions and were not provided with the list of suggestions. Participants recommended these pamphlets be available in different languages, in picture form for patients with low literacy, and electronically for ease of use through the electronic medical record. One participant responded that a seminal paper outlining care for trauma survivors would be more time efficient.
4.1 Trauma survivors

The purpose of interviewing trauma survivors was to explore the common characteristics of their positive and negative healthcare experiences, to investigate whether they disclosed their traumatic experiences with a healthcare provider, to inquire about the difficult aspects of visiting a physician, and to inquire about what they find helpful in dealing with physicians and nurses. The major themes that emerged in participants’ positive experiences included the following. Participants had trust in, and a good relationship with, their physicians that was collaborative in nature. Their physicians demonstrated compassion and genuine care. They described their physician as approachable, understanding, and competent. The opposite was true in participants’ negative healthcare experiences.

In regards to disclosing their traumatic experiences to a healthcare provider, the majority of the participants had discussions some of which resulted in positive outcomes while others were negative. There was trust, collaboration between provider and patient, compassion from the provider, acknowledgement, and ease of disclosure in experiences participants found helpful. Participants who found these disclosures counterproductive had providers who were ignorant, insensitive, and impersonal, and there was a power differential between providers and patients. Participants who chose not to discuss their traumatic past with a healthcare provider felt hopeless about their situations, fearful of being retraumatized, they could not trust the provider, they could manage their problems by themselves, or there was not adequate time to have these discussions.
When asked about difficulties they encounter at a physician’s visit, trauma survivors discussed a lack of time, a lack of trust and connection with their physicians, discrimination, fear and anxiety of what others might think. What they found to be helpful was when their physicians showed compassion and took the time to get to know them better, there was equality, there was good communication between physician and patient, and physicians were trained to deal with mental health issues. In the following sections, I will discuss the major themes with respect to four main sections: patient contributing factors, provider contributing factors, relationship factors, and system factors.

4.1.1 Patients’ contributing factors.

4.1.1.1 Expectations. According to past research, patients expect to receive information from their physicians (particularly concerning their disease and treatment), to be included in the decisions concerning their care (the right to choose or deny treatment), to receive medical services, and to be shown necessary care (Bostan, Acuner, & Yilmaz, 2007). Patient satisfaction can be used as an evaluative measure of patient expectation such that patients, whose expectations are met, are more satisfied than when their expectations are not (Bell et al., 2002; McKinley, Stevenson, Adams, & Manku-Scott, 2002; Sitzia & Wood, 1997). Patient satisfaction has been associated with physicians’ communication abilities (e.g., their listening skills, their ability to extract pertinent and important patient information, providing medical explanations), interpersonal skills, professional knowledge and expertise, compassion, and sensitivity (Boquiren, Hack, Beaver, & Williamson, 2015). The availability and accessibility of physicians, and wait
In this study, participants were asked whether their conversations with their healthcare providers about their traumatic experiences were helpful and whether these discussions were what they had hoped for or expected. Participants whose discussions had positive outcomes were satisfied with the conversations, described their physicians as compassionate and understanding, and had a trusting and collaborative relationship with their physicians. On the other hand, participants who experienced negative outcomes following their discussions described having physicians who were ignorant, impersonal, and indifferent. Furthermore, their conversations can be described as counterproductive. Although participants were not asked about their expectations or satisfaction in regards to their positive or negative healthcare experiences, we can make the following associations. Physicians in participants’ positive healthcare experiences were viewed as compassionate, approachable, understanding, and regarded as competent, all of which are factors associated with high patient satisfaction (Boquiren et al., 2015). Conversely, physicians in participants’ negative healthcare experiences were viewed as indifferent, not approachable, not understanding, insensitive, and regarded as incompetent.

4.1.1.2 Deal with it personally and Denial. Research shows that men are less likely than women to seek help for their health problems, particularly those psychological in nature, and when they do, there is generally a delay (Barney, Griffiths, Jorm, & Christensen, 2006; Galdas, Cheater, & Marshall, 2005; Mojtabai, Olfson, & Mechanic, 2002; Oliver et al., 2005; Wrigley, Jackson, Judd, & Komiti, 2005). For both men and women, there are stigma attitudes associated with seeking help for mental health
Many find it difficult, embarrassing, or frightening to seek help for their mental health problems, and they expect health care providers to respond negatively to their problems (Barney et al., 2006; Wrigley et al., 2005). A survey conducted by Komiti, Judd, and Jackson (2006) reported that stigma beliefs and attitudes influence individuals’ willingness to seek help from a general physician for their mental health problems. Examples included beliefs that other people will gossip about individuals with mental illness, strong character is required to overcome mental health conflicts, and individuals should work out their own problems.

While all the participants in this study had previously sought help for their medical problems, four of the five participants who had not previously disclosed their traumatic experiences to any healthcare provider were men. Given that there was a near equal ratio of males to females in this study, the majority of the men had not previously sought help for their trauma-related problems. The observation that men are less likely to seek help than women may apply to trauma survivors as well.

When participants think that they can manage the consequences of their trauma experiences on their own, it inhibits them from seeking help from physicians or mental health providers to help them cope with their posttraumatic stress symptoms. One commented that her past trauma does not affect her daily functioning; however, her PCL-5 score of 21 suggests she experienced some posttraumatic stress symptoms. Although it was not addressed during the interview, it is questionable whether this participant was aware or recognized how her posttraumatic stress symptoms may affect her day-to-day living. The other participant continued to be affected by the traumatic events he endured;
however, he refused to see a healthcare provider to address his posttraumatic stress symptoms as he felt he should be able to deal these symptoms on his own.

The participant who identified as Asian said he kept these sensitive matters to himself and only sought healthcare services when it was an emergency. He also found it difficult to tell his physician about his mental health symptoms. He dealt with his emotional problems as a result of his traumatic experience by building physical strength and by isolating himself from everyone, including his family. I speculate that his reluctance to seek healthcare regularly, particularly professional psychological healthcare, was due to his cultural identity as Asian. The more individuals of Asian descent adhere to Asian culture values, the less likely they are to seek professional psychological help or to see a counsellor (Kim & Omizo, 2003). Examples of Asian culture values include, “following familial and social expectations is important,” “one should have sufficient inner resources to resolve emotional problems,” and “one should consider the needs of others before considering one’s own needs” (Kim, Atkinson, & Yang, 1999, p. 345).

Two other participants found it difficult to verbalize their mental health symptoms with their physicians as admission of their symptoms would indicate they have mental health problems. Their denial of their mental health symptoms may be their way of coping with stress or distress. Out of the two modes of coping with stress, they were engaging in avoidance of stressors, which in their case may be trauma. Being in denial removed anything that reminded them of their stressors from their consciousness (Roth & Cohen, 1986). However, this in turn trapped them in their stressful situations as they were not taking action or seeking opportunities to remove themselves from their stress.
Consequently, this denial of their problems impaired their judgment about the need for treatment. I suspect their unwillingness to seek help could also be stigma attitudes associated with mental health. More exploration is needed in future research to support this speculation.

4.1.1.3 Fear, anxiety, and self-consciousness. Fear, especially socially related fear, is associated with posttraumatic stress symptoms and PTSD (Amstadter & Vernon, 2008; APA, 2013; Collimore, Asmundson, Taylor, & Jang, 2009). This can be expressed as anxiety sensitivity (whereby an individual fears anxiety-related physiological sensations, cognitive changes, and social consequences), fear of negative evaluation (which occurs when an individual is distressed about being negatively evaluated by others), and intolerance of uncertainty (IU, where the individual views the probability of a negative event occurring as unacceptable and threatening; Collimore et al., 2009; Collimore, Carleton, Hofmann, & Asmundson, 2010).

In this study, five participants reported having fears and anxiety when interacting with physicians. Two of the participants’ fears are rooted in how others might negatively judge them, i.e., they have fears of negative evaluation. One participant had not disclosed her traumatic past in fear of being re-traumatized, and she likely had anxiety sensitivity. This participant’s fear of negative evaluation and anxiety sensitivity inhibited her from seeking services from physicians as a result of her worries. Her fear of negative evaluation and stigma attitudes may in turn be explained by stigmatisation aspect within the four traumagenic dynamics model of sexual abuse (Finkelhor & Browne, 1985). As she had indicated past sexual assault, she may have received stigmatization and negative
messages from the perpetrator during the abuse. This may have distorted her sense of value or self-worth.

The other participant, who was a paramedic, was worried about what his physicians might think and about being discovered by others for seeking mental health services. Not only did he have fear of negative evaluation, but also believed he would be stigmatized. There are stigma attitudes associated with seeking help for mental health problems, and this makes it difficult, embarrassing, or frightening for individuals to seek help for their mental health problems as they expect health care providers to respond negatively to their problems (Barney, Griffiths, Jorm, & Christensen, 2006; Wrigley, Jackson, Judd, & Komiti, 2005). For this paramedic, his fear of negative evaluation and stigma attitudes prohibited him from seeking services for his posttraumatic stress symptoms.

Three participants’ difficulties with their physicians were categorized as “self-consciousness.” A possible explanation for this observation is the sense of powerlessness as a result of participants’ past traumatic experiences (Finkelhor & Browne, 1985). When survivors of repeated abuse feel powerless, they are unable to advocate for themselves (Fallot & Harris, 2002). Even though one of the three participants did not report past interpersonal trauma and it is unsure whether the remaining two had experienced repeated abuse, this phenomenon may still apply to them. Another possible explanation may be that they are uncertain or worried about what their physicians may be thinking. One was concerned about sharing sensitive information and perhaps this participant may also have fear of negative evaluation. The remaining two stated it was easier to advocate for a family member’s health than their own. What makes it more
difficult for them to advocate for themselves? As I did not explore this with the
participants, I speculate that perhaps they may harbour some uncertainties about what
might happen if they stood up for themselves, and perhaps they may be experiencing IU.
Bardeen, Fergus, and Wu (2013) stated that IU moderates the relationship between worry
and posttraumatic stress symptoms, and thereby maintains posttraumatic stress
symptoms. Similarly, Fetzner, Horswill, Boelen, and Carleton (2013) found IU to be
associated with three of the posttraumatic stress disorder clusters of symptoms
(avoidance, numbing, and hyperarousal). Given that the PCL-5 scores for these three
participants ranged from 10 to 35, it is possible that their posttraumatic stress symptoms
were associated with their IU through their “self-consciousness.” However, this too is a
speculation and an area for future research.

4.1.2 Providers’ contributing factors. Although several participants discussed
their experiences with nurses, psychologists, and counsellors, the main focus of this
discussion will be on physicians, as the majority of participants described experiences in
relation to their physicians. Additionally, there has been extensive past research on
physicians to which this study may be compared.

4.1.2.1 Compassion. Physician’s compassion encompasses empathy and a desire
to help or to relieve suffering of their patients (Fernando & Consedine, 2014).
Physician’s compassion has been associated with lower state anxiety (Fogarty, Curbow,
Wingard, McDonnell, & Somerfield, 1999). The ability for physicians to understand
their patients’ perspectives and to effectively communicate this understanding led to
more information exchange and patient’s perception of physician expertise (Kim,
Kaplowitz, & Johnston, 2004). Similarly, the ability for physicians to respond and
improve their patients’ emotional state led to increased partnership and interpersonal trust (Kim, Kaplowitz, & Johnston, 2004). Patients whose physicians demonstrated higher levels of empathy also rated higher satisfaction (Kim, Kaplowitz, & Johnston, 2004; Pollak et al., 2011). Participants in this study who described their physicians as compassionate, empathetic, and caring said they felt their feelings were understood and felt they were cared for and supported. They also described feeling calm, happy, and exuberant in their experiences with their physicians. Participants who described their physicians as not compassionate, insensitive, and non-caring described feeling anxious, scared, angry, and frustrated. They did not feel cared for or reassured, nor did they have any trust or connection with these physicians. It appears that trauma survivors’ reactions to physicians’ compassion or indifference are similar to non-trauma survivors’ from past research.

**4.1.2.2 Communication.** There is a large body of research on doctor-patient communication (Del Piccolo & Goss, 2012; Johnson Thornton, Powe, Roter, & Cooper, 2011; Pincus et al., 2013; Street et al., 2009; Verilnde, Laender, Maesschalck, Deveugele, & Willems, 2012). Del Piccolo and Goss (2012) proposed three functions for doctor-patient communication: 1) gather data to understand patients’ problems and concerns, 2) develop relationship and respond to patients’ emotions, and 3) educate patients and negotiate towards treatment plan. However, Street and colleagues (2009) identified six: 1) information exchange, 2) managing uncertainty, 3) enabling self-management, 4) responding to emotions, 5) fostering the doctor-patient relationship, and 6) making decisions. Whatever the physicians’ intentions may be, they can communicate to their patients verbally and/or non-verbally (e.g., eye contact, tone of voice, facial expression,
physical distance; Verilnde et al., 2012). Through verbal communication physicians can provide information and reassurance that is aimed at influencing patients’ beliefs about illness and treatment, and this in turn promotes treatment adherence and self-management (Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001; Pincus et al., 2013). By using a combination of verbal and non-verbal communication, physicians have the ability to lower patients’ fears and thereby improve patients’ satisfaction (Di Blasi et al., 2001; Pincus et al., 2013).

Examples of physician’s communication provided by participants in their positive experiences are consistent with past research as described above. Participants spoke of situations when their physicians provided opportunities for information exchange by explaining medical procedures and keeping them informed. Participants also provided examples when their physicians communicated to them non-verbally. Participants who spoke of their physicians in this positive way also expressed feeling reassured and relieved, being listened to, and described having good relationships with their physicians.

Past research has shown there are patient characteristics that elicit negative responses from physicians, some of which are due to physicians’ implicit biases (Chapman, Kaatz, & Carnes, 2013; Cooper et al., 2012; Najam, Klein, & Munro, 1982). Physicians negatively stereotype patients who challenge their competence, who are uncooperative, who ask too many questions or who are not sufficiently grateful (Najam, Klein, & Munro, 1982). They may have implicit bias against one group of people, resulting in unintentional or unacknowledged discrimination for one group over another. For example, physicians may implicitly stereotype against a particular race or patients who struggle with obesity (Chapman, Kaatz, & Carnes, 2013). In Canada, there are health
disparities and inequities for Aboriginal Canadians compared to non-Aboriginal Canadians (such as higher rates of suicide, injuries, and substance use; Adelson, 2005). There is also discrimination and marginalization of Aboriginal individuals by healthcare providers (Towle, Godolphin, & Alexander, 2006).

One participant, who identified as a First Nations individual, experienced much of the discrimination described in this thesis. She said she and other First Nations individuals in her family physician’s office were subject to longer waiting periods than Caucasian patients. When asked what would be helpful in dealing with physicians and nurses, she responded that she wanted to be judged by what she is telling them rather than by what she looked like, suggesting she may have experienced more situations of discrimination than she shared during the interview. Although the subjective reality of this participant was discrimination based on her identity as Aboriginal, there were insufficient Aboriginal participants in this study to support the claim that they were discriminated against or marginalized.

Physicians also negatively stereotype patients who abuse alcohol and substances and perceive them as more lazy, forgetful, and unreliable (Najman, Klein, & Munro, 1982). A survey on illicit drug users showed 81.7% had experienced at least one form of discrimination from a physician (Young, Stuber, Ahern, & Galea, 2005). The same study reported that illicit drug users were discriminated against for drug use, jail time, poverty, race, age, sex, and sexual orientation. Moreover, discrimination was associated with poorer mental health and depression (Young et al., 2005). Two participants in this study recounted events when their physicians negatively stereotyped them because of their substance use. One of the participants described how a psychiatrist accused him of
feigning his symptoms to receive prescription medication instead of believing he was seeking treatment for his depression and suicidal ideations. This encounter led the participant to feel discouraged from seeking any additional treatment in the following six or seven months. Consequently, he said he became more ill than when he saw the psychiatrist.

Patients may not reveal sensitive information unless their physicians show interest in discussing them (Helitzer, LaNoue, Wilson, de Hernandez, Warner, & Roter, 2011). Contrary to this finding, five out of the 10 participants who discussed their traumatic history with their physicians did so out of their own volition in order to receive treatment, resources, or documentation. Two participants’ physicians initiated the conversation about their trauma, following their respective traumatic experiences; this suggests these physicians must have had an interest in discussing this.

When patients do disclose sensitive information (such as IPV), their physicians’ response to the disclosure is important (Rhodes et al., 2007). It is helpful when physicians show empathy and concern, and provide referrals for counselling. However, it is discouraging when physicians fail to acknowledge disclosure of abuse or fail to provide patients with information on available resources (Rhodes et al., 2007). Participants who found disclosure of their traumatic experiences helpful had providers who acknowledged their experiences, responded with compassion, and/or received further services. Conversely, participants whose disclosure resulted in negative outcomes had physicians who were either coercive, impersonal, or responded with indifference. This finding shows that physicians’ response influences patients’ perceived outcome of the discussion (whether it was helpful or counterproductive). Rhodes and colleagues
(2007) examined disclosure of IPV; however, this study included participants who were survivors of interpersonal and non-interpersonal trauma. Therefore, physicians’ response can be discussed within the context of any trauma and can affect survivors of trauma of any nature.

4.1.2.3 Time. The amount of time physicians allocate for consultations affect several domains of patient healthcare (Davidoff, 1997; Dugdale, Epstein, & Pantilat, 1999). Physicians who have shorter consultation durations are more likely to skip essential medical history (Davidoff, 1997), to spend less time talking and listening to patients, and to address or deal with psychosocial problems (Hutton & Gunn, 2007). Physicians who allocate longer consultation durations are more likely to ask questions and provide more explanations to their patients (Hutton & Gunn, 2007), and are more likely to recognize and deal with long-term problems and psychosocial problems (Wilson & Childs, 2002). These physicians are also more likely to offer preventative care and to request follow-ups (Wilson & Childs, 2002). Patients ask more questions and provide more statements when their physicians provide more time (Hutton & Gunn, 2007).

Patient satisfaction has been shown to be associated with activities that are time-intensive (such as wanting health-related information and participatory decision-making styles from their physicians; Dugdale, Epstein, & Pantilat, 1999). Ogden and colleagues (2004) reported that patients who requested more time were less satisfied with their healthcare and had less desire to comply with their physicians’ recommendations. Wilson and Childs (2002) found perceived consultation length (but not actual consultation length) was associated with consultation satisfaction.
Participants in this study described their visits to the physician as “too short” in both their positive and negative healthcare experiences. Although the duration of the visit was not quantified, there was a difference in the physician style in participants’ positive experiences compared to their negative ones. In their positive experiences, participants described their physicians as “not rushed” and said their physicians took the time to properly discuss problems, to get to know them, and to answer any questions. These are the physician behaviours described in the literature for physicians who took longer consultation durations (Hutton & Gunn, 2007). In participants’ negative experiences, participants said their physicians rushed the visit, did not get to know them, and made quick diagnoses; all of which are traits attributed to physicians who took shorter duration times as described by Hutton and Gunn (2007). Taking into consideration findings from this study and from past research, the brevity of consultations is a common complaint among trauma survivors and non-trauma survivors. Moreover, trauma survivors in this study were partial towards physicians whose style is to take their time however long or short the consultation duration.

4.1.3 Relationship Factors.

4.1.2.1 Trust. Some of the commonly described dimensions of trust in physicians include competence, compassion, reliability and dependability, communication, and acceptance (Burkitt Wright, Holcombe, & Salmon, 2004; Pearson & Rake, 2000; Skirbekk, Middelthon, Hjortdahl, & Finset, 2011; Thom, Kravitz, Bell, Krupat, & Azari, 2002). A qualitative study investigating trust in the doctor-patient relationship discussed five themes associated with trust (Skirbekk et al., 2011). First, physicians showed an early interest in their patients, such as expressing interest in their patients’ wellbeing.
Second, physicians demonstrated sensitivity to their patients’ emotions through emotional cues and by displaying calm understanding. Third, physicians took time to get to know their patients and for the doctor-patient relationship to develop; whether it was time spent in each consultation or time passed through continuity of care. Fourth, physicians worked with their patients against common adversaries (e.g., patient’s disease). Fifth, physicians showed instances of normal behaviour.

Many participants spoke of trust (or distrust) in their physicians. Participants who had trust in their physicians spoke of being reassured by their physicians, feeling relieved and hopeful of their situations, and feeling comfortable with their physicians. Several participants discussed experiences where there was mutual trust. Participants who had trust in their physicians also discussed the themes stated by Skirbekk and colleagues (2011). They discussed how the physician took the time to get to know them and to properly discuss their problems. They spoke of the physician’s calmness and calm mannerisms, which in turn made them feel reassured.

Hall and colleagues (2001) stated that when patients trust their physicians, it is because the patients believe their physicians’ motivations and intentions consist of benevolence and caring. Distrust towards physicians may develop when patients have anxious or pessimistic views of their physicians’ motivation and expected results in their healthcare. Physician’s competence and honesty are taken into consideration. Trust is lower when physicians make mistakes—whether they are cognitive (errors in judgment) or technical (errors in execution) in nature—and when physicians are dishonest (e.g., failing to admit to mistakes, giving false hope; Hall et al., 2001). Participants who had distrust in their physicians provided examples of errors made by their physicians, and
feelings of betrayal, confusion and uncertainty. The physicians in these situations were irresponsible by not providing their patients with the best care possible. For example, one of the participants said her mother’s physician was not attentive to her symptoms until a blood test revealed late-stage cancer. The participants described their physicians’ conduct as unethical and unprofessional.

Since the factors associated with having trust (or distrust) in their physicians from this study are consistent with those from previous research, this observation may be universal. It may not matter whether an individual is a trauma survivor. When physicians show compassion, express interest in their patients, and are reliable and dependable, it is likely patients will develop trust in those physicians. Conversely, when physicians make errors and are dishonest, it is likely patients will feel distrust towards them.

Betrayal trauma theory asserts that survivors of betrayal trauma may have altered tendencies of trust and distrust towards others (Gobin & Freyd, 2013). This is a result from the trust that is broken when someone who was close to them abused them (Freyd, 1997). In this study, 10 participants experienced at least one event of trauma with more betrayal (see Table 2). While trust or distrust in physicians may be a universal observation as previously stated, this observation may be skewed in survivors of betrayal trauma, especially when taking into consideration that trauma survivors may endorse negative schemas about safety related to others and may expect others to hurt them (McCann, Sakheim, & Abrahamson, 1988). While I am not able to compare how trust looks in non-trauma survivors, I speculate perhaps it may take more effort for patients who are trauma survivors to develop trust with their physicians. For example, participants who had trusted their physicians often had long-standing relationships with
their healthcare professionals. It was important for them that their physicians were authentic and compassionate. The physicians with whom they had trusting relationships were approachable, understanding, and provided adequate explanations; indicating that perhaps these are the qualities trauma survivors need in order to have trust in physicians.

4.1.3.2 Power. The paternalistic model of care, which has been the most commonly used model by physicians (especially in the emergency room), places the physician in a position of power whereby the provider makes the medical decisions and the patient is then expected to accept them (Kaba, 2007; Quilt & Brody, 1996). There is now a move towards patient-centred style where there is shared power and responsibility (Kaba, 2007; Quilt & Brody, 1996). Recent research (Del Piccolo & Goss, 2012; Helitzer et al., 2011; Street, Majoul, Arora, & Epstein, 2009) highlights patients’ empowerment and agency, involving patients in the decision-making process. Patient satisfaction has also been associated with physicians who engage in a participatory decision-making style and who provide patients with the right to choose treatment plans (Bostan, Acuner, & Yilmaz, 2007; Dugdale, Epstein, & Pantilat, 1999).

Participants from this study experienced physicians who used the paternalistic model of care and physicians whose style was patient-centered. Physicians who asserted authority were discussed within the context of negative healthcare experiences. Trauma survivors may already endorse a sense of powerlessness resulting from their past trauma (Finkelhor & Browne, 1985). In the wake of their traumatic experiences, the sense of their ability to control their own lives may be distorted. As such, the paternalistic model of care may enhance this sense of powerlessness.
In the doctor-patient relationships where there was collaboration and equal power, participants recounted there were discussions with their physicians, their physicians asked what they needed, their physicians provided them with opportunities to make informed decisions, and they were involved in the decision-making process. This led them to feel valued and understood. Three important components of patient-centred care are “communication with patients, partnerships, and a focus beyond specific conditions, on health promotion and healthy lifestyles” (Bauman, Fardy, & Harris, 2003, p. 253). This “partnership” along with patients feeling valued and understood, may lead trauma survivors to feel empowered; and therefore less powerless.

4.1.4 System factors.

4.1.4.1 Facilities. Patients expect to have adequate management of services when in hospitals. The factors that contribute towards management of services include patients being informed clearly, medical exams performed in a short time, patients’ right to complain, places for patients to rest, and patients’ ability to request cleaning services (Bostan, Acuner, & Yilmaz, 2007). Hospitals that receive high patient satisfaction ratings provide patients with adequate nursing services, open communication with physicians and nurses, information about their medications and pain control, clean and quiet rooms, and discharge information (Jha, Orav, Zheng, & Epstein, 2008). Participants from this study expressed grievances about the lack of cleanliness, space, and care in the healthcare facilities in Saskatchewan. There was no adequate place to rest or clean bathrooms according to one participant when her baby daughter was in ICU. One participant in the current study preferred one mental health facility over another because there was better care and better access to healthcare providers. It may not matter whether
individuals have had past trauma; they have the same expectations for healthcare facilities as individuals who have not experienced past trauma. Since not all participants discussed their expectations of- or satisfaction with the healthcare system, the aforementioned statement is only a speculation and no further analysis can be made at this point in time.

4.1.4.2 Lack of specialists. The healthcare in rural and remote regions in Canada is underserviced (McBain & Morgan, 2005). More than half the residents in Saskatchewan do not live within 30 minutes of medical facilities and the province has difficulties recruiting and retaining healthcare staff (McBain & Morgan, 2005). Additionally, 600,000 residents (aged 15 or older) across Canada reported unmet mental health needs and 1,000,000 had partially met mental health needs (Sunderland & Findlay, 2013). There is a higher prevalence of mental health needs among individuals who have mental health conditions (Sunderland & Findlay, 2013). The need for more healthcare specialists (especially those who can provide mental healthcare) voiced by participants in this study is consistent with these statistics.

When there are not sufficient medical specialists in the province, the wait time for patients to see a physician becomes longer and physicians may be less available in less populated areas. A similar statement may be made about mental healthcare providers and mental health facilities. Since individuals are more likely to seek help for their mental health problems from general physicians than any mental health professionals (such as counsellors, psychologists, and psychiatrists; Barney et al., 2006; Komiti Judd, & Jackson, 2006), having general and family physicians who are trained in mental health
and addictions may shorten the wait time due to the shortage of mental health specialists in Saskatchewan.

4.1.5 Proposed Pathway. To understand the doctor-patient relationship from the patients’ perspective, I propose a pathway through which the themes discussed are related. As shown in Figure 3, patient’s contributing factors (e.g. their fears and anxieties, any denial of their problems, and help-seeking behaviours) affect their motivation to seek healthcare. When they do seek help, how their physicians respond to their disclosures and the way physicians communicate with them may affect how much they choose to disclose. Time mediates the relationship between patient’s contributing factors and provider’s contributing factors. Provider’s contributing factors (e.g., communication, competence, compassion) affect patient satisfaction, patient affect, and how much information a patient is willing to disclose. However, these factors affect outcomes through a mediated route involving relationship factors (e.g. trust, collaboration, connection). For example, a patient whose physician is approachable, understanding, competent, or compassionate develops trust in that physician. That physician is more likely to use a patient-centered approach, which fosters a collaborative doctor-patient relationship. This trust and relationship allows the patient to feel satisfied with their healthcare, to feel relief, and to encourage further disclosure of their health problems. When a patient encounters a physician who is rude, not understanding, incompetent or indifferent, they begin to distrust the physician. That physician is less likely to use patient-centered approach, but a more paternalistic style, leading to a power difference within their relationship. This distrust and power difference leads to the
patient to be disappointed, angry, and frustrated, and may inhibit the patient from sharing
sensitive information.

Street and colleagues (2009) proposed a similar pathway for non-trauma
survivors. In their pathway, physician’s communication functions (e.g., information
exchange, responding to emotions, managing uncertainty) leads to patient health
outcomes (e.g., survival, cure/remission, less suffering). These communication factors
affect health through an indirect route through proximal outcomes of interactions (e.g.,
understanding, satisfaction, clinician-patient agreement), which then influence
intermediate outcome (e.g., quality of medical decision, commitment to treatment, trust in
system).
Figure 3. Pathway for doctor-patient relationship in trauma survivors.
4.2 Healthcare Providers

The purpose of interviewing primary care physicians was to explore the common characteristics of their positive and negative professional experiences when treating trauma survivors, to investigate whether they have had discussions with their patients about their trauma-related issues, to inquire about the difficult aspects of treating trauma survivors, and to elicit suggestions for what they find helpful in dealing with trauma survivors. The major themes that emerged in participants’ positive experiences included the following: In both their positive and negative experiences, participants were compassionate and empathetic towards their patients. While it was not surprising to discover that physician participants had positive as well as negative experiences with trauma survivors, it was puzzling that they still experienced unpleasant moments with their patients in spite of their compassion and empathy. Their compassion led them to understand their patients’ situations in their positive experiences, while they felt distressed or vulnerable in their negative experiences. Similarly, they provided explanations to all their patients in both their positive and negative experiences. Patients in their positive experiences trusted their physicians, were compliant, sought help, and had a positive or hopeful outlook. This in turn resulted in better patient health and in the participants feeling hopeful and inspired. On the other hand, patients in their negative experiences were described as non-compliant and not accepting of help. The participants were not able to establish any connection with these patients, and they were left feeling helpless, frustrated, and powerless in these situations.

All the participants had previously discussed trauma-related events with their patients. They responded that sometimes they initiated the discussions (through routine
assessments, while exploring their patients’ other health issues, and when considering
treatment) by using patient centred-approach and asking open-ended questions.
Participants also described situations when their patients instigated the conversation
(either voluntarily or provided non-verbal cues). A few expressed that physicians may
not be comfortable talking to their patients about their trauma-related issues, and in
certain situations it may not be helpful—especially if care is not continuous and if there is
no clear treatment plan. They recalled many of their patients reacting negatively (some
became upset and others expressed anger) to these conversations, and some of their
patients were in denial of their traumatic past. Overall, many of the participants
commented that their patients benefited as a result of these conversations. Compared to
those who have disclosed past trauma, individuals who had not expressed their thoughts
and feelings about their traumatic events had increased long-term illness consequences
(Pennebaker, 1985). Fewer health problems and fewer ruminative thoughts about death
had been associated with disclosing details about one’s traumatic events (Pennebaker &
O’Heeron, 1984). Veterans found discloses about their past trauma to healthcare
professionals to be helpful, even though some had initial negative experiences (Jeffreys,
Leibowitz, Finley, & Arar, 2010).

Participants encountered numerous difficulties when treating survivors and when
discussing their trauma-related issues. They voiced uncertainties about the discussions
and had troubles distinguishing trauma survivors’ psychosomatic symptoms from
medical ones. They were concerned about being prepared to have these conversations
with their patients. Many of the of the participants expressed being sensitive to their
patients and being able to relate to their patients as challenges they faced when treating
trauma survivors. Trauma survivors themselves presented with factors with which the participants struggled. They may be reluctant to accept treatment, and hence difficult to engage in care. Some of the participants were not able to connect with their patients, either because their patients were under the influence of substances or had other mental preoccupations. Participants had to be careful of what they said as trauma survivors were sensitive and reacted negatively to discussions about their trauma-related issues. Trauma survivors may have issues with trust and may be not forthcoming with their physicians. Some engage in avoidance, while others are in denial of their issues.

Participants listed suggestions that they would find helpful when treating survivors, of which the most commonly recommended was more time, followed by having a trusting relationship and having more resources. Participants also found it helpful to provide appropriate treatment, to work within a multidisciplinary team, to receive more education on different cultural issues, and to have a third party present. Other suggestions included more experience with trauma survivors, understanding of survivors’ circumstances, using reflection, and support person(s) for survivors. I will discuss in the following sections the most salient themes that emerged in my interviews with the primary care physicians.

4.2.1 Physicians’ contributing factors.

4.2.1.1 Approach and compassion. The way healthcare providers interact with patients can affect their patients’ way of thinking and feelings towards an illness (Di Blasi et al., 2001). Providers can influence their patients’ beliefs about their illness and treatment by providing information and reassurance. They can lower their patients’ fears by providing support, empathy, reassurance, and warmth (Di Blasi et al., 2001).
Physician’s empathy can also lead to increased patient compliance and satisfaction through increased interpersonal trust (Kim, Kaplowitz, & Johnston, 2004). Physicians can provide patient-centred care by showing interest in their patients and by addressing their patients at the level with which their patients are comfortable (Burkitt Wright, Holcombe, & Salmon, 2004; Helitzer et al., 2011). Particularly when interacting with trauma survivors, physicians can ask open-ended questions and follow-up questions for their patients to disclose sensitive information (Rhodes et al., 2007).

Participants in this study used patient-centred communication by asking their patients open-ended questions and by speaking to their patients at a level their patients are comfortable with. While the participants did not explicitly mention they followed-up on these issues because they were interested, it still demonstrated the same to their patients. They showed compassion and used patient-centred approach in both their positive and negative experiences; but the outcome was variable depending on the patient. In their positive experiences, their patients felt relieved after having discussions with their physicians about their health- or trauma-related issues. Moreover, patients with whom they had positive interactions better understood their health situation and received further care. On the other hand, patients with whom they had negative interactions did not show up for follow-up appointments, refused help, and were non-compliant. For these patients, it did not matter the amount of compassion shown or the amount of information they received from their physicians. It is possible there was little to no trust between patient and physician in the negative experience situations. This in turn may have reduced patient satisfaction, and thus resulted in less compliance. I did not ask the participants whether they thought their patients were satisfied with their
healthcare and how this may have affected their patient-doctor relationship. Having this information would have helped to further explain why what patients described in their positive experiences had different outcomes than in their negative experiences.

Physicians’ compassion emerges from the physician’s willingness to share the emotions and sufferings their patients are experiencing (Rakel, 2000). This can evoke emotional secondary stress and grief in the physicians who make themselves empathically available to trauma survivors (Figley, 1995; Stebnicki, 2000). In this study, participants’ empathy and compassion towards their patients came at an emotional cost to them. Two participants described conversations they had with patients when they were able to relate with their patients. One said she shared similar demographics as her patient, allowing her to relate to her patient, while the other commented about her patients discussing similar events that had happened to her. The latter said that these self-identifying situations triggered some of her own emotions and memories associated with her experiences. It is not uncommon for healthcare professionals helping trauma survivors to revisit some of their own experiences and their associated emotional, mental, and physical reactions (Stebnicki, 2000). Several of the participants were upset or distressed in the wake of learning about their patients’ traumatic past. They became emotional following the “flood of emotions” expressed by their patients. Some were also anxious about responding to their patients in an appropriate and non-judgmental manner. One expressed guilt because she felt she could have provided better care for a patient had she investigated her patient’s traumatic past. Consequently, she said, “I felt like I’d failed her.” Green and colleagues (2011) reported that primary care providers in their study
described having emotional reactions (e.g., being overwhelmed, worried, discouraged) when treating trauma survivors.

While physicians may recall unpleasant memories after hearing their patients’ traumatic experiences, it may help them to better understand their patients. Two participants self-disclosed they had previously been exposed to trauma. This allowed one of the participants to connect with her patients and utilize this to influence their engagement in treatment. The other participant commented that it may be difficult for physicians to relate to trauma survivors if they hadn’t experienced trauma themselves. Physicians are often different from their patients—different demographics and life experiences. Physicians sharing their experiences with their patients allow their patients to see their physicians as individuals and this leads to increased interpersonal trust (Burkitt Wright, Holcombe, & Salmon, 2004; Skirbekk et al., 2011).

4.2.1.2 Time. Past research (Tai-Seale, McGuire, & Zhang, 2007) shows that primary care physicians allocate on average 17.4 minutes per visit, with little variation across physicians. With more consult time, physicians are able to spend more time talking and listening to patients (Hutton & Gunn, 2007). According to a study by Hutton and Gunn (2007), physicians believed time was the major barrier for the management of their patients’ psychological problems; they have the necessary skills but lacked time to properly address these issues. Other studies (Beynon et al., 2012; Green et al., 2011; Roelens, Verstraelen, van Egmond, & Termmerman, 2006) similarly reported physicians’ perceived lack of time as a barrier when treating trauma survivors. The majority of the participants in this study spend on average 15 minutes with their patients and not having enough time was one of the most commonly expressed difficulties when treating trauma
survivors. Even the two participants who were able to book 30 minutes appointment times believed time to be a major barrier. Some remarked that it takes time to deal with trauma survivors, and two even set aside time to discuss their patients’ trauma-related issues. Based on the participants’ accounts in this study, it takes time for trauma survivors to develop trust in their physicians and to feel comfortable disclosing sensitive information. Once they share their traumatic past, patients may have strong emotional reactions. One participant recalled a visit when she spent 40 minutes with a patient who was a childhood sexual assault survivor. Although the participant said, “I gather she wanted to talk about it,” I suspect there was a deeper reason why she was compelled to spend that amount of time with her patient. I had not thought to ask the participant why, nor did I ask the other participants why they set aside time for their patients who are trauma survivors; however, one participant explained that the visits are longer than anticipated when patients become upset. I speculate that it may not be appropriate for participants to end an appointment when their patients are distressed or upset.

Three participants commented that having enough time means time to provide continuous care for patients over a longer period. This is consistent with findings from Skirkbekk and colleagues (2011) where physicians reported they need to give patients time, not only time spent in each consult but also time passed through continuity of care. Participants from this study added that it is important to follow-up with patients grappling with trauma to inquire about how they are coping, especially when their patients have ongoing trauma. This would require them to actively follow-up and contact their patients and not rely on their patients to set up these appointments. This may be a challenge when
patients do not have a stable residence, and this may be why one participant suggested having a case worker to connect her with her patients on an ongoing basis.

4.2.1.3 Uncertainty, preparedness, and experience. Many of the participants faced challenges about being uncertain and prepared to deal with trauma survivors. They do not know—unless they ask or unless their patients disclose—which patients have been through traumatic events. One participant expressed uncertainty about knowing with which patients to initiate conversations about their trauma-related issues, and knowing when and how to bring up the topic. He highlighted the importance of being prepared to have this conversation. Disclosing their past trauma places patients in a vulnerable state and how they may react may be unpredictable. Some may be in denial, others may become angry, while some may “break down.” A study (Rolens et al., 2006) showed that physicians do not have conversations about their patients’ IPV as they are fearful of offending or insulting patients. In this study, three participants remarked that re-traumatizing patients by discussing their past trauma may be harmful. This may be why some participants expressed they needed to ensure either their patients were ready to have these conversations and/or they had the necessary resources to follow-up with.

Physician participants in past studies (Beynon et al., 2012; Green et al., 2011; Lorenzetti, Jacques, Donovan, Cottrell, & Buck, 2013; Roelens et al., 2006) addressed the perceived lack of self-efficacy in dealing with trauma survivors and lack of training as barriers when treating trauma survivors. Similarly, having the necessary experience was a difficulty expressed by participants in this study. One participant shared that she learned to manage trauma survivors from experience through her own practice. She suggested it may be beneficial for physicians to have some exposure to treating trauma
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survivors while in training. Another participant spoke of “physicians from a place for a
place” (i.e., physician from a particular region to work in that region after receiving
medical training) so that they understand any existing historical or community trauma.
He worked in a rural Aboriginal community with which he had no prior experience.
Having prior knowledge about residential schools and historical trauma may have
benefitted this participant in treating his patients more effectively.

4.2.1.4 Culture and further education. A participant suggested it would be
helpful to receive education on different cultures. Education programs on cultural
competence for physicians improve their knowledge, attitudes, and skills in managing
patients from diverse ethnic backgrounds (Beach et al., 2005). Physicians can reduce the
racial disparities that exist in the provision of healthcare by acknowledging,
understanding, and managing sociocultural variations in their patients’ health beliefs and
health behaviours (Beatancourt & Green, 2010). The same participant who suggested
this cultural education had previously mentioned she judged and stereotyped a patient
based on his lifestyle and race. She remarked later in the interview that it would be
helpful to be knowledgeable of risk factors in different ethnic groups. Gaining cultural
competency may help this participant to understand and appreciate the differences that
exist for her patient because of his race, and what led her patient to use substances.

Physicians who received cultural competence training or have high self-rated
cultural competence are better able to ask questions that elicit patients’ understanding of
their illness (Betancourt & Green, 2010), especially since patients may harbour health-
related cultural beliefs (Fernandez et al., 2004). Understanding of their patients’ health-
related beliefs may lead to responsiveness from patients regarding their conditions
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(Fernandez et al., 2004). Patients whose physicians were more culturally competent sought more help and shared more information regarding their health (Paez, Allen, Beach, Carson, & Cooper, 2009). One participant was from a similar culture as two of the patients she described during the interview. This allowed her to understand the cultural presentation of mental health issues in the form of physical symptoms. She explained that some cultures believe it is a weakness to express emotional feelings and therefore reject the existence of mental health illness (e.g., depression, anxiety, PTSD). She added that part of this is due to the conceptualization that there is treatment only for physical symptoms. She was able to explain this to her patients and use her knowledge to influence changes in her patients’ health behaviours.

Earlier I discussed one participant’s remark that it would be helpful for physicians from a place to care for that place, in the context of knowing about the community’s historical and cultural trauma. I will discuss here another interpretation of this remark, whereby the participant believed these physicians would have an understanding of the norms within that community. He worked in a rural community with a strong Aboriginal identity and he said he regretted not integrating himself into the community as he is not from the community nor was he an Aboriginal individual. Culture in his case may be understood as differences in race (i.e., Aboriginal) or in population (i.e., rural). There exist disparities in health seeking behaviours and health beliefs between Aboriginal and Western cultures. Aboriginal individuals consult traditional healers and utilize traditional healing methods (e.g., sweat lodge; Graham & Stamler, 2010; Thomlinson, McDonagh, Crooks, & Lees, 2004). They believe it is important to have a holistic perspective on health, which includes physical, mental, and spiritual wellness. They also experience
economic, environmental, and political barriers that may hinder their access to healthcare (Graham & Stamler, 2010). Rural communities also express different health beliefs. Individuals in rural communities only see physicians after three days of feeling ill; they draw support from family, friends, and neighbours; and they desire physicians who know their patients’ history and who are in turn known by the residents in the community (Thomlinson et al., 2004). However, as Thomlinson and colleagues (2004) only examined individuals in rural communities in Canada, a comparison could not be made to urban settings. The participant commented that he could have better integrated himself into the community he worked in at the time. Cultural competence education may help physicians develop the tools to assess the role of family and the use of alternative medicine, and to bring awareness to issues about prejudice (Betancourt & Green, 2010). I postulate that this participant would benefit from cultural competence training, and he may then use this knowledge to bring about change in his patients.

4.2.2 Patients’ contributing factors.

4.2.2.1 Help-seeking behaviour and compliance. Approximately 32% of individuals have sought help for their psychological problems, and they are more likely to have sought help from a GP than any mental health professionals (Barney et al., 2006; Komiti, Judd, & Jackson, 2006). In this study, seven participants had patients who sought and accepted help for their problems. Although not explicitly discussed, it may be inferred that these family physicians were the first health professionals their patients consulted for their problems. Some of the patients were then referred to mental health professionals as needed. For these patients, their health and quality of life improved. As for the participants, their patients seeking or accepting help was what made their positive
experiences particularly positive. One participant had a patient who refused help and did not return to the participant’s office. Although information about this patient’s final health outcome cannot be ascertained, there was no improvement in his health during the time he was under the participant’s care. Furthermore, the participant retold her experience with this patient with chagrin and sadness. Another participant had a patient who was not motivated to get better. She became frustrated at this patient and his “laissez-faire” attitude and commented that “there [was] no reason for him to get better except just to get better.”

Two of the difficulties participants encountered when treating trauma survivors were their patients’ reluctance to accept help or treatment, and their patients’ non-communicative nature. Some of the participants experienced difficulty engaging their patients for treatment, and this made it challenging for them to provide the necessary care for their patients. Others had patients who were non-communicative. When their patients were not willing to answer questions, participants were not able to ascertain information to properly assess their patients’ ailments. This then led to poor provision of care, treatment and resources.

Patient compliance or adherence to treatment depends on numerous factors, including characteristics about the patients, their illness, and medication (Kane, Kishimoto, & Correll, 2013). Patient characteristics include sex, age, race, socioeconomic status (SES), their insight into their illness and need for treatment, motivation, beliefs about treatment risks and benefits, and stigma (Kane, Kishimoto & Correll, 2013). Patient adherence rates are lower when they have low education, have low income or low SES, or live in poverty (Kane, Kishimoto, & Correll, 2013; Kardas,
Such detailed demographics were not available for all the patients described in this study to compare with previous research.

Past studies (Kane, Kishimoto, & Correll, 2013; Karads, Lewek, & Matyjaszczyk, 2013) have shown that patients who are non-adherent to treatment may not have sufficient knowledge or comprehension about their disease and treatment, may have unrealistic expectations about their medications’ benefits, or may question the efficacy and effectiveness of the medications their physicians prescribed. They may have experienced adverse effects of the medication, thereby reducing their quality of life (Kane, Kishimoto, & Correll, 2013; Karads, Lewek, & Matyjaszczyk, 2013). One of the participant’s patients stopped taking her medication because it was not helping her and she requested a smaller dose. As I did not follow-up with the participant on his experience, it is unknown how informed the patient was in regards to her treatment. The amount of time that elapsed since the patient was prescribed her medication to when she believed it was no longer helping was not available; however, I speculate that her request for a lower dose may be attributed to her unrealistic expectations about the medication’s benefits. She may have also experienced side effects that either she did not voice or the participant did not mention during the interview. Co-existing alcohol or substance use or other comorbid illnesses may also reduce patients’ compliance to treatment (Kane, Kishimoto, & Correll, 2013; Karads, Lewek, & Matyjaszczyk, 2013). In this study, one of the patients who was non-adherent to her medication had comorbid personality disorder and schizophrenia. The other patient who was described to be non-compliant had undiagnosed depression.
When patients sought help and were compliant, the participants (i.e., their physicians) were able to provide more care and services and the patients’ health subsequently improved. The participants also described feeling hopeful and satisfied with the care they provided. Conversely, when patients did not seek or refused help, or were non-adherent to treatment, their health did not improve. This left the participants feeling frustrated and helpless. Similarly, past research (Grander, Sandelowski, Tahshjain, Swedberg, & Ekman, 2009; Wens, Vermeire, van Royen, Sabbe, & Denekens, 2005) has shown physicians become frustrated when their patients do not adhere to the treatment regimen. Physician participants in a study by Wen and colleagues (2005) also expressed feeling powerless when their patients did not attain treatment goals.

4.2.2.3 Negative reaction. There are several types of patients with whom physicians have difficulty, and they include patients who are angry, aggressive or argumentative, seek secondary gains, or are manipulative, demanding, entitled, or exploitive (Lorenzetti et al., 2013; Steimetz & Tabenkin, 2001). Several of the participants encountered patients who presented with anger, and some patients were also angry at their physician—however misdirected participants felt it may have been. Anger is common among trauma-exposed individuals (Whiting & Bryant, 2007). Among individuals with PTSD, anger is present across diverse populations (McHugh, Forbes, Bates, Hopwood, & Creamer, 2012), and occurs in both male and females at equal ratios (Worthen et al., 2014). When participants were faced with angry patients, some began to feel angry themselves.

A participant had a patient who felt entitled, and who was not motivated to be actively involved in getting better. Furthermore, this patient made remarks that devalued
the service that was provided at the time. This resulted in the participant feeling exhausted at trying to remain professional and frustrated at trying to provide adequate care to her patient. Another participant had a patient who she felt was manipulative and tried to take advantage of her and the medical system. She said, “[H]e was trying to get things from me that he knew I wouldn't give him” and added that he was not genuine or honest about his conditions. Her experience with this patient left her frustrated. In their review, Strous, Ulman, and Kotler (2006) stated that these types of patients can be exhausting for the physician and can lead to self-devaluation of the physician.

The negative emotions expressed by patients may be due to their trauma exposure, comorbid psychiatric disorders, unrecognized personality disorders, and/or subclinical behaviour traits (Strous, Ulman, & Kotler, 2006). It may also depend on their ability to manage their emotions; however, physicians can help them manage their emotions as these negative emotions can impact their emotional and physical wellbeing (Street et al., 2009). Physicians who participated in past research (Steinmetz & Tabenkin, 2001) said they managed such patient emotions by being empathic, non-judgemental and patient, and referring their patients to various consultants and mental health services as needed. Physicians do not have to be proficient at mental health to provide effective care. By understanding their patients’ experiences, physicians can begin to understand that their patients’ behaviours may be a manifestation of their fears or may be an attempt at compensating for their perceived loss of control as a consequence of trauma (Strous, Ulman, & Kotler, 2006).

Several of the participants shared that they started feeling angry when their patients’ emotions were directed at them. One participant had a patient who was angry at
everyone, including the participant. Although it was hard for her not to “feel angry back,” she understood that her patient’s anger was misdirected. I suspect that this understanding, along with acknowledging what her patient experienced was “a horrible thing that had happened,” allowed this participant to maintain her professional demeanour. Another participant had a patient who on occasion became upset and angry with the staff in the physician’s office. Because the participant understood her patient’s situation, she was able to placate him by explaining the procedures for releasing opiate medications. One of the participants understood that some of his male patients are aggressive and “act out” on others because “they're just scared or hurt;” as such, he was able to state, “I don't mind if they get angry.”

It is not surprising that participants encountered patients with past trauma who presented with anger. According to the traumagenic dynamic model (Finkelhor & Browne, 1985), the sense of powerlessness following traumatic events, especially those interpersonal in nature, may cause trauma survivors to have a need to control or dominate others, resulting in aggression towards others or appearing fearsome. When considering the cognitive model of PTSD (Ehlers & Clarke, 2000), trauma survivors may perceive their surroundings as dangerous or may feel that others are violating them or treating them unfairly. These perceptions and appraisals can lead to anger. For example, for the participant whose patient became angry when denied opiate medication, this patient may have thought he was treated with unfairness and may have felt betrayed as his physician did not provide him with the care he thought he deserved. Consequently, his frustration was expressed through anger.
When another participant said, “[S]ome of them are angry because they're hurting
and- and nobody's done anything,” it demonstrated that she knew about her some of her
patients’ experiences. I suspect this allowed her to be empathetic towards her patients.
When participants understood their patients’ experiences and behaviours, I speculate it
allowed them to overcome their own emotions in order maintain professionalism and to
influence the course of action with their patients.

4.2.2.4 Psychosomatic symptoms and denial. Past research (Afari et al., 2014;
McCall-Hosenfeld, Winter, Heeren, & Liebschutz, 2015; Taycan, Sar, Celik, & Erdogan-
Taycan, 2014) has shown an association between somatic symptoms and traumatic stress.
Higher somatic symptoms have been observed in interpersonal trauma survivors
(McCall-Hosenfeld et al., 2014). Trauma exposed individuals are nearly three times
more likely to have functional somatic syndrome (such as fibromyalgia, chronic
widespread pain, chronic fatigue syndrome, temporomandibular disorder, and irritable
bowel syndrome) compared to non-trauma exposed individuals. These conditions have
no understood physical or biological cause, nor do they present with laboratory
abnormalities (Afari et al., 2014). Many of the participants in this study had trauma
survivor patients who presented with psychosomatic symptoms and these patients
repeatedly visited their physicians’ office for treatment of their symptoms. For example,
a participant had a patient who developed itchy skin. This patient visited her office
several times and insisted on a referral to a dermatologist. For this particular patient, as
he was from a war-torn country, it may not be acceptable to display emotional problems
in his culture. Kirmayer and Young (1998) stated that somatisation occurs across diverse
ethnicities and it could be an index of disease or disorder. For example, somatisation
may be an indication of psychopathology where it is an expression of psychological conflict or emotional distress, or it may also be cultural expression of sickness or distress. The participant in the example above suspected her patient’s itchy skin was a manifestation of his past trauma.

Somatisation has been associated with high levels of healthcare utilization (Duddu, Isaac, & Chaturvedi, 2006). The absence of a known or understood underlying biological cause presents a challenge to physicians. The number of somatic symptoms has been shown to be correlated with perceived difficulty for physicians (Hahn, 2001). Participants in this study experienced similar levels of difficulty. The statement, “[I]t can be hard to get to the bottom of,” provided by one of the participants exemplifies the difficulty physicians experienced when patients presented with somatic symptoms. Participants did not want to investigate needlessly if it is psychogenic in nature, but they concurrently worried they may overlook a medical disease. Not only were patients with somatic symptoms difficult for her, she also experienced high anxiety when managing these patients.

Individuals’ awareness of their mental health illness is impacted by how they conceptualize the illness and their experience with it. This awareness and identification with having an illness (or illness identity) affects their self-esteem. For example, if they consider having a mental health illness as a weakness, then being aware of their illness may lower their self-esteem. Their self-esteem in turn influences their social interactions and coping strategies (Yanos, Roe, & Lysaker, 2010). Individuals’ conceptualizations of mental health illnesses are also impacted by any associated stigma, which then affects their adherence to treatment (Sirey et al., 2001). This pattern is supported by the results
in this study. When patients accepted their situation (however reluctant they may have been initially), they sought more help from the participants—who were then able to provide treatment and referrals to mental health professionals—and were more motivated to change. Conversely, when patients were in denial of their psychological problems, they only sought help for their somatic symptoms and were not motivated to explore any underlying possible conditions. In the case of the patient who had itchy skin, he stopped visiting the participant’s office and his health condition remained unknown. A few of the participants addressed the denial harboured by their patients who were interpersonal trauma survivors. It was frustrating for the participants as they wanted to help but were unable to when their patients refused help. One participant said, “[W]e are just putting Band-Aids.”

4.2.3 Relationship factors. For there to be therapeutic alliance or a good physician-patient relationship, there needs to be mutual trust between physician and patient, and the patients must feel respected and cared for (Street et al., 2009). Other factors, such as compassion, understanding, and time as discussed earlier, also influence the relationship. In their positive experiences, participants spoke of their patients having trust in them and of having a good relationship with their patients. Having trust and relationship also allowed participants to have a positive influence over their patients. For example, a participant described a patient who was initially reluctant to explore her trauma-related issues. After establishing a relationship with the patient, the patient eventually felt comfortable to disclose her past trauma. The participant was able to use this opportunity to explain to the patient her situation and recommended treatment and counselling. The patient was accepting of the same. Participants also commented about
their patients feeling reassured or relieved after their discussions with their physicians. I suspect that this relief and reassurance can only occur when patients trust their physicians. In their negative experiences, participants described having no connection with their patients. Some of the participants remarked that their patients were distant and preoccupied and some attributed this to their patients’ substance use, which limits their mental capacity to connect with their physicians. In the absence of connection, the participants had little influence over their patients. For example, patients did not make or keep their follow-up appointments, and did not accept the help their physicians offered. There was no mention of trust; however, I speculate their patients were distrustful towards their physicians.

It is important to have trust in any doctor-patient relationship as it influences patient compliance and satisfaction (Bell et al., 2002; Hall et al., 2001). However, trust may be a more critical component of this relationship between trauma survivors and their physicians resulting from the misappraisals of their surroundings and betrayal from past trauma (Freyd, 1997; Gobin & Freyd, 2009). While the participants acknowledged the need to build trust and rapport especially surrounding disclosures of past trauma, I wonder whether they recognize the cognitive changes resulting from traumatic experiences that causes trauma survivors to have distrust in others. Only two physician participants addressed the difference in power that exist between their patients and them. Since trauma survivors may have a sense of powerlessness, care should be given to help them feel empowered. While patient centred-care will address ways to build trust and collaboration with patients, trauma-informed care will specifically target these factors when caring for patients with past trauma. Trauma-informed care recognizes the impact
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of trauma, aims to empower survivors, maximizes survivors’ choices and control over their recovery, and highlights the importance of collaborative relationships (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Future research is needed to investigate how this kind of care may help physicians better interact with patients who are trauma survivors.

4.2.4 System factors.

4.2.4.1 Support for patients. A lack of support for trauma survivors was a difficulty two of the participants faced when treating these kinds of patients. One explained while it is beneficial for trauma survivors to seek counselling an hour each week, the community may help them effectively spend the remainder of the time during the week. He opined that it is not enough to simply rely on physicians, especially in rural areas where “they have physicians who are not [there] for long periods of time.” Two other participants recommended some form of peer support for trauma survivors. One described that the peer support personnel may act as a liaison between the patient and the physician. Another described a peer support that would help patients stay connected to their physicians on an ongoing basis. Research on peer support programs for mental health services (Badger & Royse, 2010; Lawn, Smith, & Hunter, 2008; Repper & Carter, 2011) has shown these programs are helpful and consumers benefit greatly by participating in these programs. These programs offer informational peer support, emotional and practical support, and can assist with developing relapse prevention and self-management strategies. Since peer support workers (PSW) had previously lived through similar experiences as the consumers, they can offer authentic empathy and validation and consumers can better relate to them (Repper & Carter, 2011). Consumers
expressed a sense of belonging and affiliation when working with their PSWs, and this gave them hope and confidence (Badger & Royse). Moreover, these peer-run programs provide improved care that the healthcare system cannot provide (Lawn, Smith, & Hunter, 2008).

4.2.4.2 Resources. Thirty percent of family physicians in Saskatchewan see between 11 and 20 patients with mental health problems per week. Although 46% of them reported they are satisfied with the mental health care they are able to provide, satisfaction was higher among those who had on-site mental health providers. The three most common areas for improvement in regards to provision of mental health care voiced by family physicians in Saskatchewan were access to specific mental health professionals, enhanced mental health resources, and timely access to specialty mental health care (Clatney, MacDonald, & Shah, 2008). Community resources and professional supports were also listed as a facilitator for physicians treating trauma survivors (Beynon et al., 2012). Participants in this study suggested that having more mental health resources would be helpful for them when treating trauma survivors. They recommended having more counsellors and psychologists to whom they can refer their patients. One participant said, “I spend more of my time counselling people than I do actually treating medical conditions.” Another participant shared a similar remark. Having mental health resources will allow these physicians to refer their patients to mental health providers so that they may have more time to treat patients with medical conditions. As mentioned previously, past research (Hutton & Gunn, 2007) found that physicians listed lack of time as a barrier for treating psychological problems. When
there are more mental health providers available to refer their patients to, physicians need not spend as much time treating their patient’s psychological problems.

4.2.5 Proposed pathway. The patient-doctor relationship from the physicians’ perspective mainly comprises of two factors, patient and physician characteristics, and it is the interplay between these factors that influences the outcome of the relationship, as shown in Figure 4. I propose the following pathway based on the interviews with the participants. When a patient visits a physician’s office, their illness perception, expectations, and communication level determine how much they are willing to share with the physician. The physician’s approach, and how compassionate the physician is, and how much the physician understands of the patient’s situation impact how much the patient is willing to trust the physician and the level of connection they will have with the physician. They can be trusting towards their physician during the visit or it may take time over several visits to establish that trust. When there is established trust and connection between patient and physician, the patient is more inclined to seek help, to comply, and to disclose more information. This in turn helps them feel reassured and their health is more likely to improve. The physician feels satisfied that they have done their part to help their patient and is hopeful for a positive patient health outcome. On the other hand, the patient may be distrustful towards the physician and may have no connection with the professional. This increases the probability that the patient will refuse help, will not adhere to treatment and will be reticent. It is unlikely the patient’s health will improve and the patient will feel angry because they believe the physician had not helped. This leaves the physician feeling frustrated and helpless at the situation.
Figure 4. Pathway for doctor-patient relationship in primary care physicians.
4.3 Integrated Discussion

I will discuss in this section the themes that are integral to the doctor-patient relationship as observed from my interviews with trauma survivors and primary care physicians. There were some notable differences between the trauma survivor participants and the patients who the physician participants described in their interviews. Some of the patients described by the physician participants were either experiencing recent or ongoing trauma and/or actively using substances. These factors may have impaired patients’ ability and motivation to engage in treatment. One of the physician participants noted that patients who had recently experienced traumatic events were less willing to discuss these events, but patients were more likely to disclose these events much later when evaluating their lives. None of the trauma survivor participants disclosed any recent or ongoing trauma. In their negative healthcare experiences, trauma survivors described physicians who showed little compassion, were rude, and dismissive. On the other hand, all the physician participants each described situations when they demonstrated compassion and understanding. Trauma survivor participants often recalled experiences over the span of one to two visits for their healthcare experiences, but a few described physicians whom they had known for several years. Physician participants retold experiences over the span of several visits, and some over a longer period of time. Due to these differences there were themes that emerged in discussions with trauma survivor participants that were not discussed with physician participants and vice versa.

Trauma survivor participants’ healthcare experiences highlighted numerous physician factors but few patient factors. Conversely, physician participants’
professional experiences included numerous physician and patient factors; however, there were more patient than physician factors. Examples of patient characteristics which were brought up by physician but not trauma survivor participants included non-compliance, patient anger, and psychosomatic symptoms. None of the trauma survivor participants discussed times when they may not have adhered to their treatment plan. Several described experiences when they were frustrated with their physicians and at their situations; however, none remarked explicitly any anger they may have shown to their healthcare providers. One participant commented about her health anxiety; however, no one else mentioned any psychosomatic symptoms they may have been experiencing. It is possible that they did not experience many of the patient characteristics noted by the physician participants; however it is also a possibility that they may not be aware of such factors.

Examples of physician characteristics spoken by trauma survivors but not physician participants included being judgemental, having little compassion, and being unprofessional. Only two physician participants discussed times when they were judgemental and they acknowledged this may be what led to their negative experiences with their respective patients. It appeared that in both positive and negative experiences, physician participants showed compassion, remained professional, and tried to be understanding. It is possible that they may not be the kind of individuals to be judgemental, indifferent, and unprofessional; however, like the trauma survivor participants, they may not be aware of times when they may have appeared to be so. For example, one participant said it was a “struggle” with a patient who refused to take her anti-psychotic medication. Although the physician may have had the best intentions to
encourage his patient to take the medication, he may have appeared overbearing to his patient. These differences in patient and physician characteristics reported by the participants may hint at participants’ lack of self-awareness and how these characteristics may have contributed to negative doctor-patient interactions.

Self-serving bias may be another possible explanation for these differences. Self-serving bias is a psychological strategy to preserve or protect one’s self-concept or self-image (Heider, 1958; Campbell & Sedikides, 1999). Participants may not want to discuss traits that may them appear unfavourable. In particular for the physician participants, when I asked them about negative experiences they have had with patients who are trauma survivors, they may have felt that their self-image was threatened especially if they perceived the question as a challenge to their competency as a physician. However, since some of the physician participants admitted to the mistakes they have made in the past, this phenomenon may have occurred at an unconscious level. Further research is needed to support these claims. In light of these differences, participants from both populations discussed similar essential components to the doctor-patient relationship. Figure 5 is an illustrative summary of this relationship.

Both trauma survivor and physician participants discussed the importance of trust and connection towards a positive doctor-patient relationship. Trauma survivors were more likely to trust physicians who were approachable, compassionate, and competent. They also trusted physicians who did not rush the appointment and took the time to get to know them. They appreciated physicians who included them in the decision-making process. When their physicians had the aforementioned characteristics, trauma survivors were more likely to seek help, disclose sensitive information, be compliant, and feel
reassured or relieved. Physician participants echoed similar remarks. Additionally, they commented that it takes time over several visits to develop a trusting relationship with their patients.

When there was no trust or connection, trauma survivor and physician participants experienced negative doctor-patient interactions. Trauma survivors did not trust physicians who were rude, indifferent, incompetent, and unprofessional. They also reported connecting less with physicians who rushed visits, were dismissive, and asserted their authority. Furthermore, they were less likely to return to physicians whom they did not trust or did not connect with. Physician participants, on the other hand, described patients who were not compliant and reticent even when they were compassionate and understanding. This created a power struggle between physician and patient. In the case for physician participants, patient non-compliance and reticence may be attributed to patient characteristics such as denial and substance use. Trauma survivor participants did not discuss compliance to- or refusal of treatment offered by their physicians. They did discuss denial as well as fear, anxiety, and self-consciousness as difficulties they encountered in their healthcare experiences.

Trauma survivor and physician participants made similar suggestions for what would be helpful when interacting with each other. They suggested more resources for patients with past trauma experiences, whether it was in the form of more support in the community, more mental health professionals, or more medical specialists. Community support may provide survivors with appropriate environment for recovery. Available mental health professionals will lessen the time physicians need to spend on counselling their patients and will provide patients with another avenue to receive counselling. More
medical specialists will lessen the wait time for patients to seek specialized healthcare.

Participants from both populations also recommended that physicians be better educated in mental health, addictions, and trauma care. This further education may allow physicians to better detect mental health ailments their patients may be experiencing, and to better triage their patients’ care. Implications of this study will be discussed in the next chapter.
Figure 5. Pathway for doctor-patient relationship as observed in trauma survivor and physician interviews.
5.1 Implications

Results from this study will add to the existing literature about trauma survivors and their interactions with healthcare and about healthcare providers’ interactions with trauma survivors. These findings highlight the importance of a trusting doctor-patient relationship for both trauma survivors and physicians. Components that contribute towards this relationship include open communication between patient and physician, manageable patient expectations, and physician’s approach, compassion and understanding. Positive experiences shared by trauma survivors and physicians included numerous examples of patient-centred care; thus underscoring the role of patient-centred care in helping trauma survivors feel comfortable. Physicians also expressed the kind of support and resources they need to provide care and treatment that are appropriate for trauma survivors. Results can be used to develop guiding policies in patient care in order for trauma survivors to receive care that is comfortable and appropriate for them and policies in healthcare administration to help physicians provide the kind of care trauma survivors need. Results will be used to develop a research questionnaire that assesses trauma-related aspects of patients’ interactions with healthcare providers and healthcare systems. With further research, there may be a better understanding of doctor-patient relationships between trauma survivors and primary healthcare providers.

5.2 Strengths, Limitations, and Future Directions

There were several strengths and limitations of the current study. While past studies have investigated healthcare experiences of trauma survivors, the scope has been
limited to female survivors of interpersonal trauma (namely, childhood abuse, sexual abuse, and intimate partner violence). One of the aims of this study was to examine healthcare experiences of individuals who have experienced any kind of trauma (interpersonal and non-interpersonal), and in both men and women. This study was the first to look at doctor-patient relationships from both the patients’ and physician’s perspectives. It was also the first of its kind conducted in Canada, with a focus on the Saskatchewan healthcare system. Since the trauma survivors were receiving healthcare within the same system in which the physicians work, it increased the internal validity of this study, and highlighted any strengths and deficits of the healthcare system.

Although doctor-patient relationship experiences were examined, the participants (physicians and trauma survivors) were not matched dyads. As such, I was not able to investigate how physician participants’ behaviours were perceived by their patients and vice versa. For example, when physician participants claimed they were compassionate or described behaviours that make them appear the same, their patients may not have perceived it as such if they and their patients do not share similar definitions of compassion. From their perspectives, their intentions may have come from a place of compassion but if the ways they communicated betrayed those intentions, their patients may not necessarily have seen them as compassionate. Additionally, as I took the essentialist approach, I took what the physician participants shared with me at face value. I did not ask them how they behaved and communicated with their patients such that they had the self-perceptions of themselves as compassionate or whether their patients appreciated and perceived the same. I did not consider how participants thought their behaviours may have been perceived by others or how these behaviours may have
influenced the way they interacted with others. These are issues that may be addressed with further research.

The qualitative research design can be both a strength and limitation of this study. As inductive or in vivo analysis was employed, new themes that have yet to be explored came up during the interviews. Deductive analysis was also used (i.e., what has previously been shown in research was used to inform the second cycle of coding). Some may find the subjective nature of qualitative research as a limitation. My previous experiences and my worldview influenced the way I conducted my interviews. Someone else with different experiences and perspectives may have elicited different responses from the interviews. Similarly, the second analyst’s and my perspectives coloured the way we analyzed the data.

Since the sample was collected from Saskatchewan, Canada, this limits the generalizability of the results to the population at large. Canada’s healthcare system operates at a provincial level. Since only consumers and providers of the Saskatchewan healthcare system were interviewed, findings from this study may not be applicable to other provinces and territories within Canada, or to other countries. One of the aims of this study was to examine healthcare experiences of trauma survivors, and so their experiences may not apply to consumers without a history of trauma.

Trauma survivor participants were initially recruited through an online survey. This already limited participation to individuals who had access to a computer and Internet. Of those who filled out the online survey, eligible participants were invited to a telephone interview, further limiting participation to individuals who had access to a telephone. Provider participants were mainly recruited from Regina; thus the geographical
representation is limited and the experiences shared by these participants may not extend to physicians practicing across Saskatchewan. Internal medicine residents also participated in this study, but their interview responses were not used in the analysis of the results. The limitations of not using those interviews will be discussed later in this section. Some of the physician participants were distracted or had distracting background activities during parts of the interview. For example, one participant had her baby grandson playing with chimes and on occasion she had to pacify the baby. Other participants had dogs barking or people talking in the background. This all affected the flow of the interview, my ability to understand them clearly, and their ability to understand me.

Bird (2005) reported, in her experience transcribing interviews she conducted, that she could hear over again the same few seconds of recording until she could make sense syntactically and held contextualized meaning. Many of the participants in this study used cell phones, and there were background noises during several of the interviews. When I received the transcripts from Transcript Divas Canada, there were several sections in each transcript that were unintelligible for them to transcribe. Although I was able to make sense of most of these “unintelligible” audio segments, there were many audio segments where I could not make sense of what the participants were saying after numerous replays. While I do not believe this had any major impact on the results of this study, it is nonetheless a limitation.

Not all the interviews or all parts of the interviews were included in the analysis. Eighteen physicians were interviewed for the study, but responses from 11 were discussed. The original intent and plan for the study was to interview practicing family physicians, and nine such physicians were interviewed. Because of initial recruitment
concerns, seven internal medicine residents and two family medicine residents were also interviewed. Due to time and resource constraints, only interviews from nine practicing family physician and two family medicine medical residents were discussed in this thesis. Since I used responses from preceding interviews to inform areas I needed to explore in subsequent interviews, there may have been information in the unanalyzed interviews that was not discovered and therefore not presented in this paper. For all 15 trauma survivor and 11 physician interviews, only the categories that answered the research questions were used for the second cycle of coding. In order to finish this thesis study on time, other parts of the interviews that may have added to the understanding of participants’ experiences were not analyzed. Additionally, besides the aforementioned questionnaires in the online screening and the HEI, other information was not collected. This may limit the richness of background information about the participants that was available.

The data was collected before analysis. Corbin and Strauss (2008) stated there are no opportunities to explore any gaps in the analysis when data is collected first. There were gaps in the analysis that I was not able to address and I made speculations on what the situations might have been for participants. Examples of these gaps included exploring whether Asian values affected the way one of the trauma survivors coped with his trauma, whether IU is a possible explanation for the ease of advocating for another but not for oneself, and whether physicians perceived mistrust that their patients may have towards them. These could be areas to explore further in future research.

Future research should be an extension of the current study. Although Saskatchewan’s population consists of 16% Aboriginals (Statistics Canada, 2013) and the
proportion of Aboriginal participants in this study reflects the provincial statistics, there needs to be more trauma survivor participants who identify as Aboriginal to explore racial disparities in the provision of healthcare. Including more trauma survivor participants who identify as Asian may be beneficial to investigate whether Asian values affect the way individuals cope with trauma. In regards to physician participants, seven interviews have yet to be analyzed. Analysis of these interviews may add depth to the current themes and/or may result in new themes. There could also be more ethnic diversity in the physician sample. This further qualitative exploration may provide better insight into the experiences of doctor-patient relationships for trauma survivors and primary care physicians.

5.3 Personal Learning

5.3.1 Interviews with Trauma Survivors. Before I started any of the interviews, I thought I would be prepared to listen to trauma experiences. I used to volunteer at a child abuse evaluation and treatment center where I read reports from psychiatrists and psychologists, and I worked with families whose children were referred to the centre. At my former job, I was working with individuals newly diagnosed with terminal illnesses and with patients who were gravely ill. I thought I would be unfazed by the interviews that I would have to conduct for my thesis project; however, none of my experiences prepared me for hearing the stories from the trauma survivors directly. Speaking with them gave personal meaning and connection to the concepts discussed earlier in this thesis.

Many of the trauma survivors shared with me in detail their experiences with healthcare providers and in some instances, the healthcare system. Even the participants
who were initially guarded and uncertain allowed me into their personal space and told me their stories. For two of the participants, I was the first person with whom they had ever shared some of their traumatic experiences. It was a humbling experience that they trusted me enough to share their stories with me.

There were two participants who left lasting impressions. One was a paramedic, whose traumatic experiences stem from his work. He had not sought healthcare for his trauma in fear of losing his license. This was a man whose career involved saving lives, but he did not seek services to better his own health. I felt helpless and a deep sense of sadness for him. Another participant identified as a First Nations individual and was a teaching assistant and public speaker. She described in detail her traumatic experiences and her encounters with healthcare providers and the healthcare system. With the exception of one experience involving her family physician, her interactions with physicians were described in terms of betrayal, injustice, insensitivity, and/or racism. I remember crying after the interview and every time I reviewed her experiences in the analysis process. I could not believe how callous and insensitive some healthcare providers can be, and I could not imagine how devastating it must have been for her to endure those experiences.

There were a few challenges I encountered. One of the most difficult was to be a researcher and not a clinician. Many times I felt I became a clinician by asking my participants how they felt or what they thought about the situation, and reflecting back to them what they told me. Many of them shared with me their traumatic experiences, even though I had not asked. I could hear the change in their voices (for example voice cracking and increased sniffing) as the subject matter became more emotional and sensitive, and I
found myself not knowing how to respond to them. Even after supervision with Dr. Klest, I still struggled with this process. There were two participants who talked at length about events which were loosely associated with the interview questions. I found it difficult to interrupt them and to bring their focus back to the interview.

Overall this has been an educational and personal learning experience. As an aspiring clinical psychologist specializing in trauma, this experience is the beginning of learning how trauma affects individuals. I also learnt different perspectives of trauma survivors, particularly as they relate to their healthcare experiences. Interviewing trauma survivors for this thesis has strengthened my aspiration to apply the results in ways that will be practical for them and to embark on future research that will help this population.

5.3.2 Interviews with Providers. I started the project expecting physicians to describe events that were congruent with the concepts discussed in the introduction of this thesis. For example, I was anticipating them to all tell me how trauma survivors were “difficult” patients. I had already interviewed seven trauma survivors by the time I interviewed my first physician participant. Based on the different healthcare experiences trauma survivors shared with me, I was no longer certain what to expect from the physicians.

I was surprised by how readily I identified with the physician participants. When they described their experiences and expressed feelings of helplessness or frustration, I empathized with them and I too felt helpless or frustrated in the moment. A resident described a situation when her patient showed physical signs of aggression and she reported feeling unsafe. I immediately thought of how I could have been a clinician in a similar situation. A practicing physician provided a detailed account of a patient who
presented with anxiety and hypochondriasis, and who she labelled as a “difficult” patient. After working with the patient for 20 years, the physician discovered the patient’s traumatic past and how it had affected the patient every day since. She expressed profound guilt for not investigating her patient’s traumatic history sooner, and she felt that if she had, she could have provided better care for her patient. I was deeply moved by her story. I could imagine being the clinician in each of the situations the providers described.

The two most challenging aspects of my interview experience with the providers were time and appearing respectful. I had advertised that the interviews would take 30 minutes with the option of extending it for longer; but in practice, they took 40 to 50 minutes. The majority of my participants were able to complete the interview in its entirety, although I sensed a few were annoyed. As for appearing respectful, many of the questions came across as patronizing to the physicians since the interview guide was originally designed for trauma survivors. For example, one of the questions was, “Do you ever wonder how these traumatic experiences affect your patients’ physical health?” At first glance, the questions appeared suitable. However, after a few practicing physicians scoffed at the question, I quickly realized some of the questions had to be modified, and rephrased to take into consideration their level of education and experience. The difficulty was imagining how a physician might interpret the questions and asking them in a manner that allowed them to understand the questions the way I understood them.

Sometimes after hearing healthcare experiences from the trauma survivors, it was easy to vilify the physicians. When some physicians were described as someone who
only wants to prescribe medication, they may be understood as someone who only wanted a quick fix for their patients. When trauma survivors expressed the desire to disclose their traumatic experiences to their physicians but had not because they felt their physicians did not care, physicians may be seen as uncaring and impersonal.

Interviewing physicians helped me appreciate the broader context of healthcare. One of the physician participants said, “I am human first.” They are affected not only by their patients but also by any policies regulated by the healthcare system. The ones I interviewed do care about their patients and about their patients’ wellbeing. While many listed challenges they encountered when treating trauma survivors, they had taken action to provide the best possible care within the time constraints and resources they had available. I interviewed them because I wanted to know their side of their story, and I am grateful I had the opportunity to do so.

5.3.3 Qualitative Research Process. My research approach had been solely quantitative in the past. I felt unsure at the beginning of this project as this thesis was my first time using a qualitative approach. At first I did not know how coding was done. I had initially selected data extracts and placed them in the respective categories I created. After I coded five interviews, the uneasiness was still unsettling. It was after Dr. Symthe’s advice to read Saldaña’s (2009) *The coding manual for qualitative researchers* that I learnt how to code data properly. I also did not realize how long the analysis process would take. I read about the iterative process of qualitative research, but I did not fully comprehend it until I started analyzing. As I was organizing the codes for emerging themes, I spent a significant amount of time reorganizing the codes and renaming the themes several times. However, I had to be practical and gave myself a deadline at which
point I stopped until I met with the second analyst, Ms. Reid. I will address my experience working with a second analyst in a later paragraph.

As mentioned previously, I collected my data first as participants were contacting me before I had a chance to analyze the preceding interviews. Once I started writing the results and discussion, I realized there were a few points I would have liked to explore more with participants. For example, one participant said it was easier to advocate for her family members than for herself. It would have been beneficial to explore why that is. In my discussion, I speculated it was IU. Since I did not analyze the interviews soon after they were conducted, I did not have the foresight to explore this further when another participant made a similar remark at a later time. Although it may be hard to closely follow the guidelines of theoretical sampling, I realized I could have been more diligent in making an effort to try to achieve it.

Coming from a quantitative perspective, I thought having a second analyst would increase the reliability of the results. Ms. Reid had previous experience in qualitative research, she knew my project well, and I provided her with instructions on style of coding I would like to apply to my study. I was surprised by the difference in the data extracts we each coded and the code labels as well. We developed similar themes, but we had different labels and categorized the codes differently. We spent numerous hours discussing the themes to resolve all the disagreements. I had not anticipated the amount of time required for these discussions. Similarly, I had not previously taken into consideration Ms. Reid’s personal schedule when I set deadlines for when each phase of the analysis should be completed. Working with a second analyst taught me to be more flexible in my timelines and in the way data may be analyzed. In the end, I found Ms.
Reid’s input to be invaluable as her insight combined with mine allowed for a more well-rounded analysis.

Overall this entire qualitative research experience has been fulfilling. As I mentioned earlier, I learnt in depth the experiences of trauma survivors and providers. Some of these concepts are not easily captured using quantitative methods. I had the option of exploring topics in greater detail during each interview as they applied to my research questions; however, I could have made better use of this opportunity. My interview skills improved over the course of this project and this will be helpful for future clinical training. Any apprehensions and uneasiness I experienced early have dissipated and I would not hesitate to use qualitative methods in future.


Betancourt, J. R. & Green, A. R. (2010). Linking cultural competence training to improved health outcomes: Perspectives from the field. *Academic Medicine, 85*, 583-585. doi: 10.1097/ACM.0b013e3181d2b2f3


DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA


DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA


DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA


DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA


Appendix A. Ethics Approval

Research Ethics Board
Certificate of Approval

Principal Investigator: Seint Kokoky
Department: Psychology
REB#: 2015-088 (U of R)
REH 15-177 (U of S)
REB 15-80 (RQHR)

Supervisor: Dr. Bridget Kest - Psychology

Funder(s): Saskatchewan Health Research Foundation Establishment Grant

Title: Exploring experiences of doctor-patient relationships for trauma survivors and primary healthcare providers

Approval of:
Application for Behavioural Research Ethics Review
Appendix A - Poster for Trauma Survivors
Appendix B - Online Screening Questionnaire Consent Form
Appendix C - Telephone Invitation to participate in telephone interview for trauma survivors
Appendix D - Email for verbal consent in writing and mental health resources
Appendix E - Verbal Consent for Telephone Interview for Trauma Survivors
Appendix F - Poster for Physicians, Residents or Medical Students
Appendix G - Initial Contact/Invitation to Primary Healthcare Providers
Appendix H - Email for verbal consent in writing for providers
Appendix I - Verbal Consent Form for Healthcare Providers
Appendix J - Demographic and Contract Information for Trauma Survivors
Appendix K - Brief Betrayal Trauma Survey, Expanded Version
Appendix L - Life Events Checklist for DSM-5 LEC-5
Appendix M - PTSD Checklist for SMD-5 PCL-5
Appendix N - Healthcare utilization questionnaire
Appendix O - Health Experiences Interview - Trauma Survivors
Appendix P - Demographic Information for Primary Healthcare Providers
Appendix Q - Health Experiences Interview - Providers

Full Board Meeting ☑ Delegated Review ☑

Certification:
The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process, or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

Ongoing Review Requirements:
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.uregina.ca/research/REB/main.shtml

University of Regina Research Ethics Board

Please send all correspondence to:
Office for Research, Innovation and Partnership
University of Regina
Research and Innovation Centre 100
Regina, SK S4S 0A2
Telephone: (306) 585-4776 Fax: (306) 585-4892 research.ethics@uregina.ca
August 27, 2015

Dr. Bridget Klest
University of Regina
Regina, SK S4S 0A2

Dear Dr. Klest,

RE: REB-15-80, U of R 2015-088, U of S Beh 15-177
Title: Exploring Experiences of Doctor-Patient Relationships for Trauma Survivors and Primary Healthcare Providers

Your application for research ethics review has undergone a harmonized review by the Regina Qu’Appelle Health Region (RQHR) and University of Regina (U of R) Research Ethics Boards (REBs). In accordance with the Research Ethics Review Reciprocity Agreement signed by the University of Saskatchewan, University of Regina, and Regina Qu’Appelle Health Region, the RQHR REB accepts the Certificate of Approval issued by U of R REB. This letter is issued to you in lieu of a Certificate of Approval by the RQHR REB. This letter permits you to conduct research activities as approved by the U of R REB, provided that you maintain a valid and up-to-date Certificate of Approval.

All continuing ethics review will be conducted by the U of R REB. The U of R is authorized to share all communications pertaining to this file with the RQHR REB at their discretion. The RQHR REB may provide input into continuing ethical review activities, as agreed upon by both REBs.

The RQHR REB reserves the right to revoke the privileges described in this letter at any time in order to conduct their own independent research ethics review of your project. Such a decision would be communicated to you and the U of R REB in writing.

This letter also serves to acknowledge that you have obtained all necessary departmental approvals within the RQHR and are permitted to proceed with this research on operational grounds. Approval for this study has been received from the following:
- Dr. Lourens Bilgnaat (Family Medicine)

If at any time you will require resources, participants, or data from any additional departments, you must provide the RQHR REB with the required signatures before proceeding.

Best wishes for your continuing research endeavours.

Sincerely,

[Signature]

Dr. Michelle McCarron, Chair
Research Ethics Board
Regina Qu’Appelle Health Region

cc. University of Regina Research Ethics Board
September 1, 2015

Dr. Bridget Klest
Department of Psychology
University of Regina
Regina, SK S4S 0A2

RE: Exploring Experiences of Doctor-patient Relationships for Trauma Survivors and Primary Healthcare Providers

U of R File#: 2015-088; RQHR File#: REB-15-80; U of S File#: BEH 15-177

Your application for research ethics review has undergone a harmonized review by the University of Saskatchewan and University of Regina. In accordance with the Research Ethics Review Reciprocity Agreement signed by the University of Saskatchewan, University of Regina, and Regina Qu’Appelle Health Region, the University of Saskatchewan REB accepts the Certificate of Approval issued by the University of Regina REB. This letter permits you to conduct research activities as approved by the University of Regina, provided that you maintain a valid and up-to-date Certificate of Approval.

All continuing ethics review will be conducted by the University of Regina REB. The University of Regina is authorized to share all communications pertaining to this file with the University of Saskatchewan REB at their discretion. The University of Saskatchewan REB may provide input into continuing ethical review activities, as agreed upon by both REBs.

The University of Saskatchewan REB reserves the right to revoke the privileges described in this letter at any time in order to conduct their own independent research ethics review of your project. Such a decision would be communicated to you and the University of Regina REB in writing.

Best wishes for your continuing research endeavours.

Sincerely,

Vivian Ramsden, Chair
University of Saskatchewan
Behavioural Research Ethics Board

CC: University of Regina Research Ethics Board
RQHR Research Ethics Board

/nb
PARTICIPANTS NEEDED FOR RESEARCH ON HEALTHCARE EXPERIENCES

We are looking for volunteers who have experienced trauma in the past to take part in a study of experiences with doctors and the healthcare system.

Participants must be at least 18 years old, and have experienced one or more traumatic events. You do not need to have regular contact with a healthcare provider to participate.

Your participation would involve completing an online screening survey, which takes approximately 10-15 minutes. There is no compensation for completing this survey. Some of the people who complete the screening survey will be invited to participate in a telephone interview, which takes 60-90 minutes. Participants who complete the telephone interview will receive $40 in appreciation of their time.

As a participant in this study, you would be asked to answer a series of open-ended questions about your experiences with healthcare providers and system.

For more information about this study please contact:
Seint Kokokyi
Department of Psychology
at
306-585-4300 or
Email: schtlab@uregina.ca

To volunteer for this study, go to:
https://uregina.qualtrics.com/SE/?SID=SV_d6BYrxae7ad7E6F

This study has been reviewed and received approval through the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Review Ethics Boards.
Online Screening Questionnaire Consent Form

Project Title: Exploring experiences of doctor-patient relationships for trauma survivors and primary healthcare providers

Researcher: Seint Kokokyi, M.A., University of Regina Department of Psychology, 306-585-4300, kokokyis@uregina.ca, and Bridget Klest, Ph.D., University of Regina Department of Psychology, 306-585-4214, Bridget.Klest@uregina.ca. The research team includes Seint Kokokyi, Dr. Klest, and other undergraduate and graduate student researchers in the Social Context, Health, and Trauma Lab at University of Regina.

Purpose and Objectives of the Research: This is a study of adults who have experienced a traumatic event. The primary goals of this research are:
To understand healthcare experiences of trauma survivors
To understand primary healthcare providers’ professional experience with trauma survivors
Information gathered as part of this study will be presented in journal articles and conference presentations.

What you will be asked to do if you decide to participate:
Answer a short screening questionnaire to determine whether you are eligible to participate in a longer telephone interview. You will:
   Complete a survey online, which will take about 10-15 minutes.
You will be asked to provide demographic and contact information, and will be asked questions about your past traumatic experiences, and how often you utilize services from healthcare professionals.
If eligible, you will be contacted to participate in a 60-90 minute telephone interview, in which you will be asked questions about your experience with healthcare professionals and the healthcare system. The interview will be digitally audio recorded.
Eligible participants would be at least 18 years old and would have experienced a traumatic event. We will be using the definition provided in the Diagnostic Statistical Manual of Mental Disorders, fifth edition, which states trauma is “any event or events that may cause or threaten death, serious injury, or sexual violence to an individual, or his or her close family member or close friend” (American Psychiatric Association, 2013, p. 830).
If we receive more responses to the survey than are needed for interviews, we will use information from the questionnaires to choose a diverse set of participants for the interviews.

Potential risks to you if you decide to participate:
Some research participants who are asked about personal experiences and life events (including questions about past physical or sexual abuse) will experience a strong emotional response. This may be especially true of people who find they get upset when
they think about negative things that have happened in the past, or are ongoing challenges. Usually this emotional response goes away quickly. Should you require further assistance, an emergency telephone number in your region can be found at the end of the survey. At the end of the survey there will be additional links to online sources of support and referral sources. You may want to make sure that a friend, family member, or other support person will be around as you complete the survey, in case you find that it is upsetting.

**Potential Benefits:**
There are no known benefits directly to you related to participating in this study. This research may be helpful in the future to trauma survivors’ healthcare experiences and in future research examining doctor-patient relationships for trauma survivors. It may also contribute to understanding things that contribute to the well-being of individuals living with past trauma more generally and how experiences with the medical system may have a direct impact on well-being.

**Compensation:**
You will not receive any compensation for completing this online survey. Eligible individuals will be contacted to participate in a telephone interview. Each individual who participates in the telephone interview will be compensated $40 for their time.

**Confidentiality:**
This survey is completely confidential. All information collected in this survey will be kept confidential – only the researchers will have access to the raw data, and any of your responses presented in journal articles or presentations will be combined with the responses of other participants. Security options in Qualtrics have been set to include data encryption, in order to increase data security and confidentiality. When data collection is complete, data will be downloaded from Qualtrics, and deleted from the Qualtrics website. Data will be stored indefinitely in a password locked file on computers located at the University of Regina, that only the research team members (researchers named above and students under their supervision) have access to.

**Right to Withdraw:**
Your participation is voluntary and you can answer only those questions that you are comfortable with. You can skip any questions you do not feel comfortable answering. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you wish to withdraw, you may leave the survey at any time by closing your browser window. The data collected will be stored in password-protected documents for at least 5 years but it will be used towards any analyses.
Should you wish to withdraw your completed survey prior to or during the interview, you may notify Seint Kokoky (seint.kokoky@uregina.ca) at anytime.

**Follow up:**
A summary of results from the study will be posted to the website http://schtlab.ca/completed-research-projects.php.

**Questions or Concerns:**
You may contact the researcher with any questions, comments, or concerns, using the information at the top this page. This project has been approved on ethical grounds by the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Research Ethics Boards on August 27, 2015. Any questions regarding your rights as a participant may be addressed to the committee at 306.585.4775 or research.ethics@uregina.ca. Out of town participants may call collect.

**Consent:** By clicking on “I Agree” below, YOUR FREE AND INFORMED CONSENT IS IMPLIED and indicates that you understand the above conditions of participation in this study. Please print or save a copy of this consent form for your records before proceeding to the survey.
Appendix D. Demographic information for trauma survivors.

Name:
How old are you?
What is your gender?
    Male
    Female
    Other
What is your telephone number?
    May we leave a message:
What is your email address?

What Saskatchewan healthcare region do you live in? (Please check one that applies)
    Athabasca
    Cypress
    Five Hills
    Heartland
    Keewatin Yatthe
    Kelsey Trail
    Mamawetan Churchill River
    Prairie North
    Price Albert Parkland
    Regina Qu’Appelle
    Saskatoon
    Sun Country
    Sunrise

What is your ethnicity? (Please check all that apply)
    White/Caucasian
    Aboriginal or First Nations
    Black/African American
    Asian/Pacific Islander
    Latin American/Hispanic

What is your highest level of completed education? (Please select one)
    Less than high school graduate
    High school diploma or GED
    Some college/post-secondary credit, no degree
    Associate or technical degree, or professional program graduate
    Bachelor’s degree
    Graduate or professional degree

Are you currently employed?
    If yes, what is your occupation?
    If no, what was your last job?

Should we select you to participate in the telephone interview, what time of day is best to reach you? (Please check all that apply)
    Weekday
    Weekend
    Morning
    Afternoon
    Evening
For each item below, please mark either “Yes” or “No” in the columns labeled “Before Age 18” AND one response in the columns labeled “Age 18 or Older.”

<table>
<thead>
<tr>
<th>Have each of the following events happened to you?</th>
<th>Before Age 18 (Yes/No)</th>
<th>Age 18 or Older (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been in a major earthquake, fire, flood, hurricane, or tornado that resulted in significant loss of personal property, serious injury to yourself or a significant other, the death of a significant other, or the fear of your own death.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Been in a major automobile, boat, motorcycle, plane, train, or industrial accident that resulted in similar consequences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Witnessed someone with whom you were very close (such as a parent, brother or sister, caretaker, or intimate partner) committing suicide, being killed, or being injured by another person so severely as to result in marks, bruises, blood, broken bones, or broken teeth. This might include a close friend in combat.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Witnessed someone with whom you were not so close undergoing a similar kind of traumatic event.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Witnessed someone with whom you were very close deliberately attack another family member so severely as to result in marks, bruises, blood, broken bones, or broken teeth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Witnessed someone with whom you were not so close deliberately attack a family member that severely.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. You were deliberately attacked that severely by someone with whom you were very close.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. You were deliberately attacked that severely by someone with whom you were not close.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. You were made to have some form of sexual contact, such as touching or penetration, by someone with whom you were very close (such as a parent or lover).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. You were made to have such sexual contact by someone with whom you were not close.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. You were emotionally or psychologically mistreated over a significant period of time by someone with whom you were very close (such as a parent or lover).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. You were emotionally or psychologically mistreated over a significant period of time by someone with whom you were not close.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Experienced the death of one of your own children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Experienced a seriously traumatic event not already covered in any of these questions.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F. Life Events Checklist for DSM-5.

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you’re not sure if it fits; or (f) it doesn’t apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

<table>
<thead>
<tr>
<th>Event</th>
<th>Happened to me</th>
<th>Witnessed it</th>
<th>Learned about it</th>
<th>Part of my job</th>
<th>Not Sure</th>
<th>Doesn’t Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Natural disaster (for example, flood, hurricane, tornado, earthquake)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2. Fire or explosion</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)</td>
<td></td>
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<tr>
<td>4. Serious accident at work, home, or during recreational activity</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5. Exposure to toxic substance (for example, dangerous chemicals, radiation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. Other unwanted or uncomfortable sexual experience</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Combat or exposure to a war-zone (in the military or as a civilian)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Life-threatening illness or injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Severe human suffering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Sudden violent death (for example, homicide, suicide)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Sudden accidental death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Serious injury, harm, or death you caused to someone else</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Any other very stressful event or experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LEC-5 (10/27/2013) Wouters, Blake, Schnurr, Kaloupek, Marx, & Keane – National Center for PTSD
Appendix G. PTSD Checklist for DSM-5.

## PCL-5

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

<table>
<thead>
<tr>
<th>In the past month, how much were you bothered by:</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing, and unwanted memories of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Avoiding memories, thoughts, or feelings related to the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Trouble remembering important parts of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Blaming yourself or someone else for the stressful experience or what happened after it?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Loss of interest in activities that you used to enjoy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Feeling distant or cut off from other people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Irritable behavior, angry outbursts, or acting aggressively?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Taking too many risks or doing things that could cause you harm?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Being “superalert” or watchful or on guard?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Feeling jumpy or easily startled?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Having difficulty concentrating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Trouble falling or staying asleep?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix H. Healthcare utilization questionnaire.

What medical treatments have you accessed within the past year?

<table>
<thead>
<tr>
<th>tếnt</th>
<th>Once</th>
<th>2-3 times</th>
<th>4-5 times</th>
<th>5-10 times</th>
<th>More than 10 times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse or Nurse Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician assistant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsellor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk-in clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized doctor (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I. Telephone invitation to participate in telephone interview for trauma survivors

**Telephone Invitation to participate in telephone interview for trauma survivors**

Hi _______ [participant’s name],

I’m Seint Kokoky from the University of Regina. I am calling to follow-up on the online survey you completed as part of a research study examining healthcare experiences in trauma survivors. Firstly, thank you for completing the survey. At this time, I would like to invite you participate in the next part of the study, a telephone interview.

The interview would be a 60-90 minute telephone interview, in which you would be asked questions about your experience with healthcare professionals and the healthcare system. The interview would be digitally audio recorded, and you would receive $40 in compensation for your time. Is this something you are still interested in doing?

You indicated on the online survey that ________ [weekday/weekend and morning/afternoon/evening] works best for you. I would like to schedule you for the telephone interview on ________ [date and time]. Is this a convenient time for you? [If no, schedule a mutually convenient time.]

If anything comes up and you would like to change your interview time, please feel free to call and leave a message at (306) 585-4300. I will be emailing you a copy of the consent form for the telephone interview but I will also review the consent form with you verbally when I call you for the \
Email for verbal consent in writing and mental health resources

Subject Line: Research Study Consent Information and Resources

Dear [participant’s name],

Thank you for your continued interest in our research study on healthcare experiences of trauma survivors.

As per our previous conversation, I am sending you an email to provide the consent form in writing. At the end of this email, there is a list of crisis hotlines and mental health resources for every health region in Saskatchewan. These resources are there for you should you feel the need anytime, particularly after our scheduled telephone interview.

Your telephone interview is scheduled for [date and time]. Please feel free to contact me at (306) 585-4300 or schtlab@uregina.ca if you have any questions, comments, or concerns.

Thank you,

Seint Kokokyi, M.A.
Department of Psychology
University of Regina
(306) 585-4300
schtlab@uregina.ca

What will happen during the study?
I’m inviting you to do a one-on-one telephone interview that will take about 60-90 minutes. I will ask you questions about your healthcare experiences such as any recent health problems you have had, any positive and negative interactions you may have had with healthcare professionals, and any difficulties with your medical visits. I will take handwritten notes to record your answers as well as use an audio recorder to make sure I don’t miss what you say.

Are there any risks to doing this study?
It is not likely that there will be any serious harms or discomforts associated with the interview. However, you may feel a little tired. You may feel uncomfortable with discussing your experiences with healthcare professionals and any sensitive information related to that. You may find it stressful to recall uncomfortable situations and any negative interactions you may have had with healthcare professionals. You may worry about how others will react to what you say.
You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You can withdraw (or stop taking part) at any time. Should you feel you need to talk to somebody due to any distress participating in the interview may have caused, there are a list of mental health resources at the end of this email. The research team will not be directly providing any kind of counselling. I will describe next the steps I am taking to protect your privacy.

What is discussed during the telephone interview will be kept confidential between you and the research team; however, there are limits to this confidentiality. If you provide information telling me that you may be at risk of harming yourself or another individual, that a child is in need of protection, or that there is potential abuse of a vulnerable adult, I have a duty to inform the appropriate officials.

The audio recordings from this interview will be sent via the Internet to Transcription Divas Canada through their secured site. Although the method of transporting the recordings is in compliance with the Health Information Protection Act, there is always a slight risk of interception when sending information via the Internet. Transcription Divas Canada has also agreed to sign a confidentiality agreement form with the research team. The transcribed script will be sent to the research team in an encrypted document via email.

Benefits:
It is unlikely that there will be direct benefits to you, however, by better understanding healthcare experiences of trauma survivors, researchers and others may be able to develop research tools to investigate this topic for society at large. A summary of results from the study will be posted on the website: http://schtlab.ca/completed-research-projects.php.

I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared beyond the research team and Transcription Divas Canada unless we have your permission. Any data from this research which will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons.

Compensation
By participating in this 60-90 minute telephone interview, you will be compensated $40 for your time. If you withdraw before verbal consent is obtained, then you will not receive compensation. However, if you withdraw after verbal consent and withdraw anytime during the interview, you will still receive compensation.

Voluntary participation:
Your participation in this study is voluntary. You can decide to stop at any time, even part-way through the interview for whatever reason, and withdraw your data from the study up until approximately April, 2016. If you decide to stop participating, there will be no consequences to you.
If you do not want to answer some of the questions you do not have to, but you can still be in the study.
If you have any questions about this study or would like more information you can call or email Seint Kokokyi at (306) 585-4300 or schtlab@uregina.ca.

This project has been approved on ethical grounds by the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Research Ethics Boards on August 27, 2015. Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or research.ethics@uregina.ca). Out of town participants may call collect.

**Mental Health Resources**
The following resources are available in Saskatchewan:

**Crisis Centers:**
Saskatchewan Crisis Services/Hotline: dial 8-1-1 for professional health advice.
Mobile Crisis Service (Saskatoon): (306) 933-6200
Southwest Crisis Services: (306) 779-3386
FHHR Mental Health & Addiction Intake Worker: 1 (877) 564-0543 or (306) 691-6464
West Central Crisis & Family Support Centre: (306) 463-6655
North East Crisis Intervention Centre: 1 (800) 611-6349 or (306) 752-9455
Hudson Bay & District Crisis Centre: 1 (866) 865-7273 or (306) 865-3064
Prince Albert Mobile Crisis Unit: (306) 764-1011
Regina Mobile Crisis Services: (306) 525-5333 (24 hours) or (306) 569-2724 (after hours)

*Athabasca*
Athabasca Health Authority, (306) 439-2200

*Cypress*
Mental Health Services, (306) 778-5280

*Five Hills*
Mental Health and Addiction Services, 455 Fairford Street East, Moose Jaw, (306) 694-0379

*Heartland*
Heartland Health Region Centralized Intake: 1(866) 268-9139

*Keewatin Yatthe*
St. Joseph’s Hospital and Health Centre, Ile a la Cross, (306) 833-2016
La Loche Health Centre and Hospital, La Loche (306) 688-7087

*Kelsey Trail*
Melfort Hospital, 510 Broadway Ave N, Melfort, (306) 752-8767
DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA

Nipawin Hospital, 800 6th Street E, Nipawin, (306) 862-9822
Cumberland House, Box 218, Cumberland House, (306) 888-2155
Tisdale Hospital, 2010 110th Ave, Tisdale, (306) 873-3760
Hudson Bay Hospital, 614 Prince Street, Hudson Bay, (306) 865-5646

Mamawetan Churchill River
Creighton Community Health Services, (306) 688-8291
La Ronge Health Centre, 227 Backlund Street, La Ronge, (306) 425-2422
Pinehouse Health Centre, (306) 884-5670

Prairie North
Battlefords Mental Health Centre, 1092-107th Street, North Battleford, (306) 446-6500
Mental Health and Addictions Services-Meadow Lake, #8-711 Center Street, Meadow Lake, (306) 236-1580
Mental Health and Addictions Services-Lyodminster, 38030-43 Avenue, Lyodminster, (306) 820-6250

Price Albert Parkland
Victoria Square 2345 10th Ave W, Prince Albert, (306) 765-6055
Shellbrook Hospital, 211 2nd Ave W, Prince Albert, (306) 747-4278
Spiritwood & District Health Complex, 400-1st St E, Prince Albert (306) 883-4262

Regina Qu’Appelle
Mental Health Clinic, 3rd Floor, 2110 Hamilton Street, Regina, (306) 766-7811
Rural Mental Health Clinics, 721 Stella Street, Grenfell, 1(866) 367-8743
Fort Qu’Appelle, 178 Boundary Ave, Fort Qu’Appelle, 1(866) 367-8743
Moosomin, 1(866) 367-8743

Saskatoon
Mental Health and Addictions Services, Suite 156, 122 3rd Ave North, Saskatoon, (306) 655-7777
Adult Outreach Services, (306) 655-4195
Community Adult Mental Health, (306) 655-4100

Sun Country
Arcola Mental Health Centre, P.O. Box 419, Arcola, (306) 455-2159
St. Joseph’s Hospital, 1174 Nicholson Road, Estevan, (306) 637-3610
Kipling Mental Health, Old Willowdale Lodge Building, Kipling, (306) 736-2638
Weyburn Mental Health, Community Health Services Building, 900 Saskatchewan Drive, Weyburn, (306) 842-8665
Emergency Psychiatry Services, (306) 842-8665

Sunrise
Mental Health Community Services, (306) 786-0558 or 1(888) 989-8444
Verbal Consent for Telephone Interview for Trauma Survivors

Introduction:

Hello _______ [participant’s name]. I’m Seint Kokokyi from the University of Regina. I have you scheduled for a telephone interview as part of a research study. Is now still a good time?

[If no, schedule a new appointment time.]
[If yes, continue with consent.]

I am conducting interviews about healthcare experiences of trauma survivors. I’m conducting this as part of my master’s research at University of Regina’s psychology department. I’m working under the direction of Dr. Bridget Klest also at University of Regina’s psychology department. Just before we begin the interview, I would like to tell you a little bit more about what is to be expected.

What will happen during the study?

I’m inviting you to do a one-on-one telephone interview that will take about 60-90 minutes. I will ask you questions about your healthcare experiences such as any recent health problems you have had, any positive and negative interactions you may have had with healthcare professionals, and any difficulties with your medical visits. I will take handwritten notes to record your answers as well as use an audio recorder to make sure I don’t miss what you say.

Are there any risks to doing this study?

It is not likely that there will be any serious harms or discomforts associated with the interview. However, you may feel a little tired. You may feel uncomfortable with discussing your experiences with healthcare professionals and any sensitive information related to that. You may find it stressful to recall uncomfortable situations and any negative interactions you may have had with healthcare professionals. You may worry about how others will react to what you say.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You can withdraw (or stop taking part) at any time. Should you feel you need to talk to somebody due to any distress participating in the interview may have caused, there was a list of mental health resources in the email previously sent to you. The research team will not be directly providing any kind of counselling. I will describe next the steps I am taking to protect your privacy.

What is discussed during the telephone interview will be kept confidential between you and the research team; however, there are limits to this confidentiality. If you provide information telling me that you may be at risk of harming yourself or another individual, that a child is in need of protection, or that there is potential abuse of a vulnerable adult, I have a duty to inform the appropriate officials.
The audio recordings from this interview will be sent via the Internet to Transcription Divas Canada through their secured site. Although the method of transporting the recordings is in compliance with the Health Information Protection Act, there is always a slight risk of interception when sending information via the Internet. Transcription Divas Canada has also agreed to sign a confidentiality agreement form with the research team. The transcribed script will be sent to the research team in an encrypted document via email.

**Benefits:**

It is unlikely that there will be direct benefits to you, however, by better understanding healthcare experiences of trauma survivors, researchers and others may be able to develop research tools to investigate this topic for society at large. A summary of results from the study will be posted on the website: [http://schtlab.ca/completed-research-projects.php](http://schtlab.ca/completed-research-projects.php).

I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared beyond the research team and Transcription Divas Canada unless we have your permission. Any data from this research which will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons.

**Compensation**

By participating in this 60-90 minute telephone interview, you will be compensated $40 for your time. If you withdraw before verbal consent is obtained, then you will not receive compensation. However, if you withdraw after verbal consent and withdraw anytime during the interview, you will still receive compensation.

**Voluntary participation:**

Your participation in this study is voluntary. You can decide to stop at any time, even part-way through the interview for whatever reason, and withdraw your data from the study up until approximately April, 2016. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still be in the study. If you have any questions about this study or would like more information you can call or email Seint Kokoky at (306) 585-4300 or schtlab@uregina.ca.

This project has been approved on ethical grounds by the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Research Ethics Boards on August 27, 2015. Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or [research.ethics@uregina.ca](mailto:research.ethics@uregina.ca)). Out of town participants may call collect.

**Consent questions:**
Do you have any questions or would like any additional details? [Answer questions.]
Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you?
[If yes, begin the interview.]
[If no, thank the participant for his/her time.]

Consent (for research team only):

I read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it. In addition, consent will be audio taped.

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Researcher’s Signature</th>
<th>Date</th>
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HEALTHCARE EXPERIENCES INTERVIEW (trauma survivors)

Thank you for completing the online screening survey. Now I would like to learn more about your experiences in the health care system, with your doctors, nurse practitioners, nurses, and other staff people, and what it has been like seeking and getting help for your physical problems. Ultimately, we would like to be able to help survivors get the care that is most appropriate and comfortable care for them. To better understand how to make this possible, I will be talking with a number of trauma survivors about their health care experiences. As one of these survivors, you would be helping me in this task by describing some of your thoughts, feelings, and experiences with medical care settings.

Why don’t we start off with a very brief description of any recent health problems you have had. (If going on too long: Which is the most problematic?)

I would like for you to think about some of your experiences with doctors, nurse practitioners, nurses, or other health providers in the past year or so. Can you tell me about a good discussion or experience you have had in the past year or so, one that you felt positive about? (Describe)

(Get occupation/role, gender, ethnicity of provider, if applicable)

Now I would like to ask you to choose 3 or 4 words that best describe the discussion, how you felt about it, or how you were thinking about it. (List words first, then ask for a short elaboration of each word)

What made it feel/seem like a positive experience for you?

Now I would like for you to tell me about a bad discussion or experience you have had in the past year or so, one that you felt upset or distressed about? (Describe)

(Get occupation/role, gender, ethnicity of provider, if applicable)

Now I would like to ask you to choose 3 or 4 words that best describe the interaction, how you felt about it, or how you were thinking about it. (List words first, then ask for a short elaboration of each word)

What made it feel or seem like a particularly negative experience for you?

Did any of your own reactions to the doctor, nurse practitioner, nurse, or clinic in either of these situations surprise you, or did you react differently than you usually do?
What about others in the office, like receptionists, etc. What are your interactions with them usually like? (Any examples?)

What are the difficult parts of telling your doctor or nurse practitioner what is bothering you?
Why is it difficult?
(Probes: Hard to put into words? Not sure if it is important? Embarrassing? Hard to choose only one problem to discuss?
Ask for a story or example if the above do not work).

Have you ever talked to your doctor or other health provider about the (traumatic) experiences we were discussing earlier? (Name)

If not: Have you wanted to?

Why didn’t you bring it up? (Is having enough privacy an issue?)

Did you want your doctor to ask about it?

If yes: How did it come up?

How did the conversation go?

What was the doctor’s reaction? Was this what you expected or hoped for?

Was the conversation helpful? How?

If not, what didn’t work about it?

Do you ever wonder how these traumatic experiences are related to your physical health?

Say more/ How so?

Your mental or emotional health?

Say more/How so?

(If not already answered well) What is the most difficult part of going for a medical visit?

What is the most difficult part of interacting with doctors?
Would it be more or less difficult to discuss sensitive or very personal concerns with a nurse in the office, compared to a doctor?

Would it matter if the doctor or nurse were a man or woman?

Is there anyone else you could tell?

What would you find helpful in dealing with doctors or nurse practitioners? In being sure they understood you and were able to help?

What would you find helpful in dealing with your health problems?

We are trying to develop ways of helping trauma survivors feel more comfortable and confident in their interactions with health care providers, and to feel that they are getting what they need medically. I would like to tell you about some of the things we have been talking about, and have you tell me if you think these things would be helpful, and whether you would participate in something like this if it were available:

Information/pamphlets on symptoms and health concerns that trauma survivors might have and what to do about them

Educational groups covering how stressful and traumatic experiences affect the body, physical health, and relationships with others

Tips about how to prepare for a doctor visit or exam, including how to talk to the doctor

Being able to talk with a nurse in the doctor’s office before or after you meet with the doctor, to help you explain your concerns or answer any questions

Are there any other things that might be helpful that you would like to suggest?

Finally, is there anything related to your health care that you would like to tell me about that I haven’t already asked?

Is there anything you would like to ask me?

What has it been like for you talking about these experiences?
PARTICIPANTS NEEDED FOR RESEARCH ON HEALTHCARE EXPERIENCES

We are looking for volunteers who are either practicing general physicians, medical residents, or medical students (in their 3rd or 4th year), to take part in a study of doctors’ experiences with trauma survivors.

As a participant in this study, you would be asked to answer a series of open-ended questions about any experience with trauma survivors in your professional career.

Your participation would involve a telephone interview which takes 30 minutes.

In appreciation for your time, you will receive a $100 honorarium upon completion of the telephone interview.

For more information about this study, or to volunteer for this study, please contact:
Seint Kokoky
Department of Psychology
at
306-585-4300 or
Email: schtlab@uregina.ca

This study has been reviewed and received approval through the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Review Ethics Boards.
Initial Contact/Invitation to Primary Healthcare Providers

Subject Line: Research on Healthcare Professional’s Experience with Trauma Survivors

My name is Seint Kokokyi and I am a graduate student in the Department of Psychology at the University of Regina. I am seeking participants for my thesis research, a part of which involves investigating professional experiences of primary health care providers with trauma survivors.

Participants in this study will either be practicing general physicians, medical residents, or medical students in their third or fourth year of their studies. Participants in this study will be asked to take part in a one-on-one interview lasting approximately 30 minutes. Interviews will be conducted over the phone. Interviews will be audio recorded so that they may be transcribed verbatim for use in analyses. In appreciation for their time, participants will receive $100 honorarium after completing the interview.

If you are interested in participating, please contact me at schtlab@uregina.ca or please leave a message at (306) 585-4300. Also, please feel free to forward this email to other general physicians, medical residents, and medical students whom you think may be interested in participating.

Thank you,

Seint Kokokyi, M.A.
Department of Psychology
University of Regina
(306) 585-4300
schtlab@uregina.ca

This project has been approved on ethical grounds by the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Research Ethics Boards on August 27, 2015. If research participants have any questions or concerns about their rights or treatment as participants, they may contact the Chair of the Research Ethics Board at (306) 585-4775 or by email: research.ethics@uregina.ca
Email for verbal consent in writing for providers

Dear Dr. ________ [provider participant’s name]

Thank you for your interest in participating in our research study investigating healthcare providers’ experience with trauma survivors. Please find below a copy of the consent form. I will also be reviewing this with you and asking for your verbal consent over the telephone before the start of the interview. I have you scheduled for _______ [date and time].

Please feel free to contact me at (306) 585-4300 or schtlab@uregina.ca if you have any questions or comments. Thank you again for your time and consideration.

Seint Kokokyi, M.A.
Department of Psychology
University of Regina
(306) 585-4300
schtlab@uregina.ca

What will happen during the study?

I’m inviting you to do a one-on-one telephone interview that will take about 30 minutes; however, there is an option of extending the duration if you wish to discuss more. I will ask you questions about your professional experiences such as any recent patients you have seen who have a history of trauma, any positive and negative interactions you may have had with trauma survivors, and any difficulties with your medical consultations. I will take handwritten notes to record your answers as well as use an audio recorder to make sure I don’t miss what you say.

Are there any risks to doing this study?

It is not likely that there will be any serious harms or discomforts associated with the interview. However, you may feel a little tired. You may feel uncomfortable with discussing your professional experiences with trauma survivors and any sensitive information related to that. You may find it stressful to recall uncomfortable situations and any negative interactions you may have had with trauma survivors. You may worry about how others will react to what you say.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You can withdraw (or stop taking part) at any time. Should you feel you need to talk to somebody due to any distress participating in the interview may have caused, there are a list of mental health resources at the end of this email. The research team will not be directly providing any kind of counselling. I will describe next the steps I am taking to protect your privacy.
What is discussed during the telephone interview will be kept confidential between you and the research team; however, there are limits to this confidentiality. If you provide information telling me that you may be at risk of harming yourself or another individual, that a child is in need of protection, or that there is potential abuse of a vulnerable adult, I have a duty to inform the appropriate officials.

The audio recordings from this interview will be sent via the Internet to Transcription Divas Canada through their secured site. Although the method of transporting the recordings is in compliance with the Health Information Protection Act, there is always a slight risk of interception when sending information via the Internet. Transcription Divas Canada has also agreed to sign a confidentiality agreement form with the research team. The transcribed script will be sent to the research team in an encrypted document via email.

**Benefits:**

It is unlikely that there will be direct benefits to you, however, by better understanding experiences of healthcare professionals in their work with trauma survivors, researchers and others may be able to develop research tools to investigate this topic for the society at large. A summary of results from the study will be posted on the website: http://schtlab.ca/completed-research-projects.php.

I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared beyond the research team and Transcription Divas Canada unless we have your permission. Any data from this research which will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons.

**Compensation**

You will receive $100 honorarium for your participation in the interview. If you withdraw before verbal consent is obtained, then you will not receive compensation. However, if you withdraw after verbal consent and withdraw anytime during the interview, you will still receive compensation.

**Voluntary participation:**

Your participation in this study is voluntary. You can decide to stop at any time, even part-way through the interview for whatever reason, and withdraw your data from the study up until approximately April, 2016. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still be in the study. If you have any questions about this study or would like more information you can call or email Seint Kokokyi at (306) 585-4300 or schtlab@uregina.ca.
This project has been approved on ethical grounds by the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Research Ethics Boards on August 27, 2015. Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or research.ethics@uregina.ca). Out of town participants may call collect.

**Mental Health Resources**
The following resources are available in Saskatchewan:

**Crisis Centers:**
- Saskatchewan Crisis Services/Hotline: dial 8-1-1 for professional health advice.
- Mobile Crisis Service (Saskatoon): (306) 933-6200
- Southwest Crisis Services: (306) 779-3386
- FHHR Mental Health & Addiction Intake Worker: 1 (877) 564-0543 or (306) 691-6464
- West Central Crisis & Family Support Centre: (306) 463-6655
- North East Crisis Intervention Centre: 1 (800) 611-6349 or (306) 752-9455
- Hudson Bay & District Crisis Centre: 1 (866) 865-7273 or (306) 865-3064
- Prince Albert Mobile Crisis Unit: (306) 764-1011
- Regina Mobile Crisis Services: (306) 525-5333 (24 hours) or (306) 569-2724 (after hours)

**Athabasca**
- Athabasca Health Authority, (306) 439-2200

**Cypress**
- Mental Health Services, (306) 778-5280

**Five Hills**
- Mental Health and Addiction Services, 455 Fairford Street East, Moose Jaw, (306) 694-0379

**Heartland**
- Heartland Health Region Centralized Intake: 1(866) 268-9139

**Keewatin Yattche**
- St. Joseph’s Hospital and Health Centre, Ile a la Cross, (306) 833-2016
- La Loche Health Centre and Hospital, La Loche (306) 688-7087

**Kelsey Trail**
- Melfort Hospital, 510 Broadway Ave N, Melfort, (306) 752-8767
- Nipawin Hospital, 800 6th Street E, Nipawin, (306) 862-9822
- Cumberland House, Box 218, Cumberland House, (306) 888-2155
- Tisdale Hospital, 2010 110th Ave, Tisdale, (306) 873-3760
- Hudson Bay Hospital, 614 Prince Street, Hudson Bay, (306) 865-5646

**Mamawetan Churchill River**
DOCTOR-PATIENT RELATIONSHIP EXPERIENCES AND TRAUMA

Creighton Community Health Services, (306) 688-8291
La Ronge Health Centre, 227 Backlund Street, La Ronge, (306) 425-2422
Pinehouse Health Centre, (306) 884-5670

Prairie North
Battlefords Mental Health Centre, 1092-107th Street, North Battelford, (306) 446-6500
Mental Health and Addictions Services-Meadow Lake, #8-711 Center Street, Meadow Lake, (306) 236-1580
Mental Health and Addictions Services-Lyodminister, 38030-43 Avenue, Lyodminister, (306) 820-6250

Price Albert Parkland
Victoria Square 2345 10th Ave W, Prince Albert, (306) 765-6055
Shellbrook Hospital, 211 2nd Ave W, Prince Albert, (306) 747-4278
Spiritwood & District Health Complex, 400-1st St E, Prince Albert (306) 883-4262

Mental Health Clinic, 3rd Floor, 2110 Hamilton Street, Regina, (306) 766-7811
Rural Mental Health Clinics, 721 Stella Street, Grenfell, 1(866) 367-8743
Fort Qu’Appelle, 178 Boundary Ave, Fort Qu’Appelle, 1(866) 367-8743
Moosomin, 1(866) 367-8743

Saskatoon
Mental Health and Addictions Services, Suite 156, 122 3rd Ave North, Saskatoon, (306) 655-7777
Adult Outreach Services, (306) 655-4195
Community Adult Mental Health, (306) 655-4100

Sun Country
Arcola Mental Health Centre, P.O. Box 419, Arcola, (306) 455-2159
St. Joseph’s Hospital, 1174 Nicholson Road, Estevan, (306) 637-3610
Kipling Mental Health, Old Willowdale Lodge Building, Kipling, (306) 736-2638
Weyburn Mental Health, Community Health Services Building, 900 Saskatchewan Drive, Weyburn, (306) 842-8665
Emergency Psychiatry Services, (306) 842-8665

Sunrise
Mental Health Community Services, (306) 786-0558 or 1(888) 989-8444
Appendix P. Interview consent form for primary healthcare providers

**Verbal Consent Form for Healthcare Providers**

**Introduction:**

Hello. I’m Andreea Tamaian from the University of Regina. I have you scheduled for a telephone interview as part of a research study on healthcare providers’ experience with trauma survivors. Is now still a good time?

- [If no, schedule a new appointment time.]
- [If yes, continue with consent.]

I am conducting interviews about doctors’ [or medical residents or medical students] professional experience with trauma survivors. I’m conducting this to assist my colleague, Seint Kokokyi’s research at University of Regina’s psychology department. She and I are working under the direction of Dr. Bridget Klest also at University of Regina’s psychology department. Just before we begin the interview, I would like to tell you a little bit more about what is to be expected.

**What will happen during the study?**

I’m inviting you to do a one-on-one telephone interview that will take about 30 minutes; however, there is an option of extending the duration if you wish to discuss more. I will ask you questions about your professional experiences such as any recent patients you have seen who have a history of trauma, any positive and negative interactions you may have had with trauma survivors, and any difficulties with your medical consultations. I will take handwritten notes to record your answers as well as use an audio recorder to make sure I don’t miss what you say.

**Are there any risks to doing this study?**

It is not likely that there will be any serious harms or discomforts associated with the interview. However you may feel a little tired. You may feel uncomfortable with discussing your professional experiences with trauma survivors and any sensitive information related to that. You may find it stressful to recall uncomfortable situations and any negative interactions you may have had with trauma survivors. You may worry about how others will react to what you say.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You can withdraw (or stop taking part) at any time. Should you feel you need to talk to somebody due to any distress participating in the interview may have caused, there was a list of mental health resources in the email previously sent to you. The research team will not be directly providing any kind of counselling. I will describe next the steps I am taking to protect your privacy.

What is discussed during the telephone interview will be kept confidential between you and the research team; however, there are limits to this confidentiality. If you provide information telling me that you may be at risk of harming yourself or another individual, that a child is in need of protection, or that there is potential abuse of a vulnerable adult, I have a duty to inform the appropriate officials.
The audio recordings from this interview will be sent via the Internet to Transcription Divas Canada through their secured site. Although the method of transporting the recordings is in compliance with the Health Information Protection Act, there is always a slight risk of interception when sending information via the Internet. Transcription Divas Canada has also agreed to sign a confidentiality agreement form with the research team. The transcribed script will be sent to the research team in an encrypted document via email.

**Benefits:**

It is unlikely that there will be direct benefits to you, however, by better understanding experiences of healthcare professionals in their work with trauma survivors, researchers and others may be able to develop research tools to investigate this topic for the society at large. A summary of results from the study will be posted on the website: http://schtlab.ca/completed-research-projects.php.

I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared beyond the research team and Transcription Divas Canada unless we have your permission. Any data from this research which will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons.

**Compensation**

You will receive $100 honorarium for your participation in the interview. If you withdraw before verbal consent is obtained, then you will not receive compensation. However, if you withdraw after verbal consent and withdraw anytime during the interview, you will still receive compensation.

**Voluntary participation:**

Your participation in this study is voluntary. You can decide to stop at any time, even part-way through the interview for whatever reason, and withdraw your data from the study up until approximately April, 2016. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still be in the study. If you have any questions about this study or would like more information you can call or email Seint Kokoky at (306) 585-4300 or schtlab@uregina.ca.

This project has been approved on ethical grounds by the University of Regina, Regina Qu’Appelle Health Region, and University of Saskatchewan Research Ethics Boards on August 27, 2015. Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or research.ethics@uregina.ca). Out of town participants may call collect.

**Consent questions:**
Do you have any questions or would like any additional details? [Answer questions.]
Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you?
[If yes, begin the interview.]
[If no, thank the participant for his/her time.]

Consent (for research team only):

I read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it. In addition, consent will be audio taped.

<table>
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<tr>
<th>Name of Participant</th>
<th>Researcher’s Signature</th>
<th>Date</th>
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Appendix Q. Demographic questions for primary healthcare providers.

**Demographic Information for Primary Healthcare Providers**

Date of interview (dd/mm/yyyy): ___ / ___ / ______

Gender:

Age:

Are you currently a practicing physician?
   [If yes, ask number of years practicing.]
   [If no, ask whether medical resident or medical student.]

What Saskatchewan healthcare region are you currently practicing in?
   [If resident or medical student, ask which healthcare region they have most experience in.]

If practicing physician:
What kind of practice (e.g. private, community clinic, walk-in clinics) do you have?

How much time on average do you spend with each patient in your practice?

If resident:
What kind of practice (e.g. private, community clinic, hospital, walk-in clinics) have you received your residency training in?

How much time on average do you spend with each patient in your practice?

What is your ethnicity?
   White/Caucasian
   First Nations or Aboriginal
   Black/African American
   Asian/Pacific Islander
   Latin American/Hispanic
HEALTHCARE EXPERIENCES INTERVIEW (Providers)

I would like to learn more about your experiences in the health care system, with your patients with a history of trauma, and what it has been interacting with those patients. Ultimately, we would like to be able to help trauma survivors get the care that is most appropriate and comfortable care for them. To better understand how to make this possible, I will be talking with a number of physicians about their professional experiences with trauma survivors. As one of these physicians, you would be helping me in this task by describing some of your thoughts, feelings, and experiences with trauma survivors.

Why don’t we start off with a very brief description of any recent patients you have had who have a history of trauma. (If going on too long: Who is the most problematic?)

I would like for you to think about some of your experiences as a physician with trauma survivors in the past year or so. Can you tell me about a good discussion or experience you have had in the past year or so, one that you felt positive about? (Describe)

(Get gender, ethnicity of provider, if applicable)

Now I would like to ask you to choose 3 or 4 words that best describe the discussion, how you felt about it, or how you were thinking about it. (List words first, then ask for a short elaboration of each word)

What made it feel/seem like a positive experience for you?

Now I would like for you to tell me about a bad discussion or experience you have had in the past year or so, one that you felt upset or distressed about? (Describe)

(Get occupation/role, gender, ethnicity of provider, if applicable)

Now I would like to ask you to choose 3 or 4 words that best describe the interaction, how you felt about it, or how you were thinking about it. (List words first, then ask for a short elaboration of each word)

What made it feel or seem like a particularly negative experience for you?

Did any of your own reactions to your patient in either of these situations surprise you, or did you react differently than you usually do?

What are the difficult parts of telling your patients about what is bothering them? Why is it difficult?
(Probes: Hard to put into words? Not sure if it is important? Embarrassing? Hard to choose only one problem to discuss? Ask for a story or example if the above do not work).

Have you ever talked to your patients about their traumatic experiences? (Name)

If not: Have you wanted to?

Why didn’t you bring it up? (Is having enough privacy an issue?)

Did you want your patient to talk about it?

If yes: How did it come up?

How did the conversation go?

What was the patient’s reaction? Was this what you expected or hoped for?

Was the conversation helpful? How?

If not, what didn’t work about it?

Do you ever wonder how these traumatic experiences are related to your patients’ physical health?

Say more/How so?

Their mental or emotional health?

Say more/How so?

(If not already answered well) What do you think is the most difficult part of going to a medical visit for a patient with a history of trauma?

What is the most difficult part of interacting with these patients?

Would it be more or less difficult for patients to discuss sensitive or very personal concerns with a nurse in the office, compared to a doctor?

Would you think it would matter if the doctor or nurse were the same sex as the patient?

Is there anyone else you could tell?
What would you find helpful in dealing with trauma survivors? In being sure they understood you and that you understood them?

What would you find helpful in dealing with your patients?

We are trying to develop ways of helping trauma survivors feel more comfortable and confident in their interactions with health care providers, and to feel that they are getting what they need medically. I would like to tell you about some of the things we have been talking about, and have you tell me if you think these things would be helpful, and whether you would participate in something like this if it were available:

Information/pamphlets on symptoms and health concerns that trauma survivors might have and what to do about them

Educational groups covering how stressful and traumatic experiences affect the body, physical health, and relationships with others

Tips about how to prepare for a doctor visit or exam, including how to talk to the doctor

Being able to talk with a nurse in the doctor’s office before or after patients meet with the doctor, to help them explain their concerns or answer any questions

Are there any other things that might be helpful that you would like to suggest?

Finally, is there anything related to your professional experience that you would like to tell me about that I haven’t already asked?

Is there anything you would like to ask me?

What has it been like for you talking about these experiences?
Appendix S. Ethics Amendment

Research Ethics Board
Certificate of Amendment Approval

PRINCIPAL INVESTIGATOR
Seint Kokokyi

DEPARTMENT
Psychology

REB#
2015-088 (U of R)
REB 15-17 (U of S)
REB 15-80 (RC-1HR)

SUPERVISOR
Dr. Bridget Kleski-Psychology

TITLE
Exploring experiences of doctor-patient relationships for trauma survivors and primary healthcare providers

AMENDMENT APPROVAL OF

- Appendix G-Initial contact/ invitation to primary health providers
- Recruitment flyer, on line and word of mouth

ORIGINAL DATE of APPROVAL
August 27, 2015

NEXT RENEWAL DATE
August 27, 2016

Date of Amendment Approval
September 17, 2015

Full Board Meeting

Delegated Review [x]

AMENDMENT CERTIFICATION
The University of Regina Research Ethics Board has reviewed the changes to the above-named research project as outlined in your memo dated September 17, 2015, and they are approved.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions:
http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms2/ethics-forms.html

Dr. Lorena Hoeber, Chair
University of Regina
Research Ethics Board

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