

Patient Preferences for Discussing Childhood Trauma in Primary Care

Ellen Goldstein, MFT, PhD; Ninad Athale, MD; Andrés F Sciolla, MD; Sheryl L Catz, PhD

Perm J 2017;21:16-055

E-pub: 03/15/2017

<https://doi.org/10.7812/TPP/16-055>

ABSTRACT

Context: Exposure to traumatic events is common in primary care patients, yet health care professionals may be hesitant to assess and address the impact of childhood trauma in their patients.

Objective: To assess patient preferences for discussing traumatic experiences and posttraumatic stress disorder (PTSD) with clinicians in underserved, predominantly Latino primary care patients.

Design: Cross-sectional study.

Main Outcome Measure: We evaluated patients with a questionnaire assessing comfort to discuss trauma exposure and symptoms using the Adverse Childhood Experiences (ACE) Study questionnaire and the Primary Care-PTSD screen. The questionnaire also assessed patients' confidence in their clinicians' ability to help with trauma-related issues. Surveys were collected at an integrated medical and behavioral health care clinic.

Results: Of 178 adult patients asked, 152 (83%) agreed to participate. Among participants, 37% screened positive for PTSD, 42% reported 4 or more ACEs, and 26% had elevated scores on both measures. Primary Care-PTSD and ACE scores were strongly positively correlated ($r = 0.57$, $p < 0.001$). Most patients agreed they were comfortable being asked about trauma directly or through screening questionnaires and did not oppose the inclusion of trauma-related information in their medical record. In addition, most patients perceived their clinician as comfortable asking questions about childhood trauma and able to address trauma-related problems.

Conclusion: Screening is acceptable to most primary care patients regardless of trauma exposure or positive PTSD screening. Findings may aid primary care clinicians to consider screening regularly for ACEs and PTSD to better serve the health care needs of trauma-exposed patients.

INTRODUCTION

Adverse childhood experiences (ACE) are an important contributor to stress and health problems across the lifespan and increase the risk of disease and psychosocial problems.¹ Exposure to ACEs encompasses abuse or neglect; witnessing domestic violence; exposure to mentally ill, substance-abusing, or criminal household members; and parental separation or divorce. The ACE count has been shown to display a strong, graded

relationship with health risk behaviors and some of the leading causes of early death in the US, such as cancer, diabetes, and heart disease. A fundamental correlate of this association is the presence of toxic stress, which is defined as prolonged activation of the stress response system in the absence of protective relationships.²

Current data suggest that posttraumatic stress disorder (PTSD) may affect up to 23% of individuals seen in primary care settings.³⁻⁵ Exposure to trauma and violence has been consistently shown to be more prevalent than national averages among low-income, urban neighborhoods.⁶ Individuals from socioeconomically disadvantaged backgrounds have higher levels of unmet needs for mental health services and are more likely to receive care for mental health exclusively in primary care settings.^{7,8} The most vulnerable populations experience social disadvantages and clinical vulnerabilities that can result in a disproportionate risk of not receiving the care that they need.⁹ In California, safety-net clinics provide health care services to individuals and their families regardless of a patient's ability to pay.¹⁰ Safety-net services are intended to ensure that individuals who are medically underserved and uninsured and living below poverty level receive adequate health care.¹¹

Trauma-related symptoms are often unrecognized and untreated in medical care.¹²⁻¹⁵ Medical clinicians are less likely to screen for trauma-related mental health issues because they overestimate the time it takes, and they have poor access to appropriate services and treatment.^{12,16} Early detection and intervention could decrease the likelihood of the assorted problems associated with childhood trauma exposure, such as mental health disorders, chronic medical conditions, and adult health risk behaviors.¹⁷ Early detection could also decrease the likelihood of revictimization,¹⁸ and improve overall health, which can positively influence quality of life.

There is considerable evidence that greater attention should be paid to the impact of trauma in primary care,^{15,19,20} and there is increasing sensitivity for clinician recognition of trauma impact, which can reduce PTSD symptoms.^{21,22} Although recognizing traumatic stress symptoms has been proposed as an important first step toward addressing the needs of higher-risk and complex patients,²³ patients who somatize are often unaware of links between past events and current symptoms²⁴ and may be

Ellen Goldstein, MFT, PhD, is a Doctoral Graduate from the Betty Irene Moore School of Nursing at the University of California, Davis. E-mail: ellengoldstein8@gmail.com. Ninad Athale, MD, is a Family Physician at OLE Health, an Associate Medical Director of County Campus, the Medical Director of Napa County Alcohol and Drug Services, and a Volunteer Clinical Instructor at the University of California, Davis School of Medicine. E-mail: nathale@olehealth.org. Andrés F Sciolla, MD, is an Associate Professor at the Department of Psychiatry and Behavioral Sciences at the University of California, Davis. E-mail: afsciolla@ucdavis.edu. Sheryl L Catz, PhD, is a Professor of Nursing Science from the Betty Irene Moore School of Nursing at the University of California, Davis. E-mail: scatz@ucdavis.edu.

reluctant to talk about traumatic experiences.²⁴ However, clinicians may be more apt to inquire about trauma exposure and symptoms if they know that screening for trauma is acceptable and appreciated by their patients.²⁵⁻²⁷

A growing body of research has been exploring patient preferences for making health care decisions.²⁸ Although studies performed in various settings have concluded that individuals with histories of physical and sexual abuse value being asked about their past trauma history,^{25,29} understanding patient preferences in relation to sharing sensitive information with clinicians in underserved populations is lesser known. This is an important gap given that vulnerable populations face a greater number of health disparities and are at a higher risk of having been exposed to trauma across the lifespan.

The primary goal of this study is to test the relationship of the ACE Study questionnaire¹ and Primary Care-PTSD (PC-PTSD)³⁰ scores with patient screening preferences. We tested the hypothesis that patients who report one or more ACEs or PTSD symptoms would endorse lower levels of comfort discussing their histories of trauma with clinicians than would patients who have no ACE exposure or PTSD symptoms. The second goal of this study is to evaluate patients' comfort with discussing stressful childhood experiences with clinicians, patients' perceptions of their clinicians' ability to help patients with trauma-related problems and comfort in completing ACE and PTSD screening tools, and patient preferences related to having such screening results shared with clinicians or documented in the medical chart.

METHODS

Setting and Patient Characteristics

OLE Health, a Federally Qualified Health Clinic, is an integrated clinic with co-located medical and behavioral health services that provides primary and preventive medical care to an estimated 24,651 patients, with 100,000 visits annually in suburban and rural Napa, CA. According to the OLE Health 2013 Uniform Data System, the clinic population is composed of patients who are mostly female (59%), below poverty level (62%), and uninsured (31%). More than one-half of patients are Latino (61%), and one-third are white (27%), with the remainder being black/African American (1%), Asian (2%), American Indian/Alaskan Native (0.8%), Hawaiian/Pacific Islander (0.2%), or more than 1 race (3%).³¹ Currently, there is not a comprehensive screening policy for ACEs or PTSD at OLE Health.

Sample

The study sample was composed of predominantly Latino primary care patients visiting OLE Health at its main medical clinic in Napa, CA. Participants were at least age 18 years, English-speaking, and cognitively able to provide informed consent. Of the 178 eligible patients approached, 152 (83%) agreed to participate. A refusal rate of 26 (17%) consisted of the following: general lack of interest (65%), not feeling well (15%), time constraints (12%), and discomfort with the topic (4%). No other information was collected about these patients other than reasons for not participating.

Procedure

From May 7, 2015, to May 26, 2015, the first author (EG) visited OLE Health 1 to 2 times a week and approached adult patients in the clinic waiting room who were attending their scheduled primary care visit with a clinician (physician, nurse practitioner, or physician assistant). Approximately 10 to 50 patients were enrolled on each of the 6 recruitment days. The principal investigator (EG) provided patients with an oral explanation as well as a consent form that further elaborated on the study. A 5-item patient questionnaire developed by the researchers was used in this study to assess comfort for discussing childhood trauma with medical clinicians. Participants were told that they could skip any question that they preferred not to answer and could end the session at any time because of the sensitive nature of the screening questions for trauma exposure. Those patients who agreed to participate and signed the consent form were asked to complete the questionnaire, which took approximately 10 minutes to complete. The questionnaire was administered orally to those patients who were unable to read and wanted to participate. The questionnaire included the ACE Study questionnaire, the PC-PTSD screen, and patient preference questions that assessed comfort with screening and disclosing a trauma history, and perception of clinician ability to help with associated problems.

Behavioral health counselors were onsite and available to meet with participating patients throughout the study period in the event that a study participant became acutely distressed. Each participant was informed before initiating the questionnaire that they would receive a \$10 Target gift card after returning the completed survey to the researcher. This study was approved by the University of California, Davis institutional review board.

Instruments

Adverse Childhood Experiences Study Questionnaire

The ACE Study questionnaire was used to assess the number of ACE exposures before age 18 years. The ACE Study questionnaire has been used in clinical and general population samples in the US³² and other countries³³ involving several thousand subjects. The ACE Study questionnaire is a 10-item survey with no or yes answers that are scored as 0 or 1 point for each category of exposure. Possible ACE scores range from 0 to 10. Each of the ACE questions was constructed from previously published surveys. Adversities include abuse (emotional, physical, sexual); neglect (emotional, physical); witnessing domestic violence; growing up with mentally ill, substance abusing, or criminal household members; and parental separation or divorce. Vincent Felitti, MD, and Robert Anda, MD, coprincipal investigators of the landmark ACE Study, found a dose-response relationship between the ACE score and the risk of numerous chronic diseases as well as social and behavioral problems.¹ For example, individuals with an ACE score of 4 or higher had a dramatically increased risk of adult health risk behaviors, poor health status, and disease.¹

Primary Care Posttraumatic Stress Disorder Screen

The PC-PTSD screen was selected on the basis of a review of several publications that tested screening performance to detect

PTSD prevalence in urban primary care.³⁴⁻³⁶ The PC-PTSD screen, developed by the National Center for PTSD in Washington, DC, is the most widely used PTSD screening tool that was designed to be used in primary care settings where time and resources are limited.³¹ The PC-PTSD screen assesses current PTSD symptoms (past month) and is consistent with the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* diagnostic criteria, including intrusive experiencing, avoidance behaviors, hypervigilance, and emotional numbing.³⁷ The PC-PTSD, a four-item self-report with no or yes answers, is scored as one point for each item with a yes response.

Questions included the following: “In your life, have you ever had any experience that was so frightening or upsetting that in the past month you: 1) Had nightmares about it or thought about it when you did not want to? 2) Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? 3) Were constantly on guard, watchful, or easily startled? 4) Felt numb or detached from others, activities, or your surroundings?” The recommended cutoff score is 3, which has been associated with a sensitivity of 78% and a specificity of 87%.^{35,38}

Patient Preference Questions

Patient preference questions developed by the researchers were based on a model of care aligned with trauma-informed and patient-centered principles that seek to improve communication and increase patient satisfaction. Each of the five patient preference questions was measured on a five-item Likert scale, which was coded for purposes of some analyses as a binary variable: yes = strongly agree and agree; no = neither agree nor disagree, disagree, and strongly disagree.

Patient preference questions were as follows for each screening tool: 1) I am comfortable being asked about [stressful childhood experiences or PTSD] by my clinician (physician, nurse practitioner, physician assistant); 2) I believe my clinician is comfortable asking me about my [stressful childhood experiences or PTSD]; 3) I am comfortable letting my clinician know the results of my [stressful childhood experiences or PTSD] questionnaire; 4) I am comfortable with my [stressful childhood experiences or PTSD] screen being included in my medical record; and 5) I believe my clinician is able to help with problems associated with [stressful childhood experiences or PTSD].

Table 1. Distribution of demographic characteristics by scores on Adverse Childhood Experiences (ACE) Study questionnaire and Primary Care-Posttraumatic Stress Disorder (PTSD) screen^a

Characteristic	Frequency, no. (%)	ACE score 0, no. (%)	ACE score 4 or more, no. (%)	PTSD score 0, no. (%)	PTSD score 3 or more, no. (%)
Age (years)					
18-34	44 (29.0)	9 (5.9)	21 (13.8)	24 (15.8)	17 (11.2)
35-64	98 (64.5)	20 (13.2)	42 (27.6)	47 (30.9)	37 (24.3)
≥ 65	10 (6.6)	7 (4.6)	1 (0.7)	8 (5.3)	2 (1.3)
Sex					
Men	52 (34.2)	11 (7.3)	17 (11.3)	29 (19.3)	16 (10.7)
Women	98 (64.5)	25 (16.7)	45 (30.0)	50 (33.3)	38 (25.3)
Race/ethnicity					
Latino	96 (63.2)	22 (17.6)	39 (31.2)	49 (39.2)	39 (31.2)
White non-Hispanic	11 (7.2)	5 (4.0)	4 (7.2)	9 (7.2)	1 (0.8)
Other	18 (11.8)	3 (2.4)	9 (7.2)	8 (6.4)	8 (6.4)
Education					
Less than high school	8 (5.3)	4 (2.7)	4 (2.7)	5 (3.3)	3 (2.0)
High school	56 (36.8)	13 (8.6)	21 (13.9)	32 (21.2)	16 (10.6)
More than high school	87 (57.2)	18 (11.9)	39 (25.8)	42 (27.8)	37 (24.5)
Insurance					
None	10 (6.6)	6 (4.0) ^b	3 (2.0) ^b	8 (2.6)	2 (1.3)
Public	132 (86.8)	27 (17.8) ^b	59 (38.8) ^{b,c}	64 (42.1)	53 (34.9)
Private	10 (6.6)	3 (2.0) ^b	2 (1.3) ^b	7 (4.6)	1 (0.7)
Annual income (US \$)					
< 10,000	50 (32.9)	10 (6.6)	23 (15.2)	25 (16.6)	19 (12.6)
10,000-30,000	73 (48.0)	16 (10.6)	32 (21.2)	36 (23.8)	31 (20.5)
> 30,000	28 (18.4)	10 (6.6)	9 (6.0)	17 (11.3)	6 (4.0)
Household members					
1-2	81 (53.3)	15 (9.9)	40 (26.3)	38 (25.0)	33 (21.7)
≥ 3	71 (46.7)	21 (15.8)	24 (15.8)	41 (27.0)	23 (15.1)

^a Some percentages do not total to 100% because of rounding or because some patients did not respond to that question.

^b Significant, p = 0.04.

^c More participants with public health insurance had 4 or more ACEs than would be expected by chance, χ^2 (4, N = 152) = 10.50.

Data Analysis

Analyses were conducted using Stata/IC Version 12 (Stata Corp, College Station, TX). The primary goal of this study was to test the relationship of the ACE Study questionnaire and PC-PTSD scores with patient preferences. The presumed hypothesis was that those patients who reported 1 or more ACEs or PTSD symptoms would endorse lower levels of comfort discussing their histories of trauma with clinicians than would patients who had no ACE exposure or PTSD symptoms.

A post hoc Cronbach α test was performed as an estimate of reliability for each measurement scale. Frequency and proportion described ACE and PTSD scores, and demographic characteristics and patient preferences were described by ACE and PTSD scores. Additionally, the χ^2 test examined the distribution of demographics and patient preferences by ACE and PTSD scores as categorical variables to test the likelihood of these distributions by chance. Fisher exact test was used to calculate more accurate p values for cells that contained frequencies less than 5. Pearson product-moment correlation coefficient analyzed the strength and direction of the relationship between patient preferences and ACE or PTSD scores. The Bonferroni adjustment was used to reduce the chances of obtaining false-positive results when performing multiple pairwise tests on a single set of data.

RESULTS

Demographic Characteristics and Trauma Histories

Of the 178 patients asked, 152 (83%) agreed to participate. More than one-third (34%) of patients reported 1 or more ACE item and 42% had 4 or more ACEs. Eleven percent of patients reported 1 or more PTSD symptoms, and 37% scored at or above the cutoff point for a positive PTSD screen. Approximately one-fourth (26%) of patients had elevated scores on both measures. As can be seen in Table 1, most patients were in the following categories: aged 35 to 64 years (65%), women (65%), Latino (63%), more than a high school education (57%), public health insurance (87%), annual income of \$10,000 to \$30,000 (48%), and 1 to 2 household members (53%).

Other than insurance status, none of the other demographic characteristics in the sample were associated with differences in ACE or PTSD scores. Alpha coefficients suggested a relatively high internal consistency among the items for each of the following: ACE Study Questionnaire ($\alpha = 0.80$), PC-PTSD screen ($\alpha = 0.88$), ACE patient preference questions ($\alpha = 0.84$), and PTSD patient preference questions ($\alpha = 0.87$).

Distribution of Patient Preferences

Tables 2 and 3 show the χ^2 distribution of patient preferences by ACE and PTSD scores. Most patients were comfortable being asked about ACEs (79%) and PTSD (82%) and being screened for ACEs (86%) and PTSD (89%) by their clinician. Most patients were comfortable with including their ACE study questionnaires (70%) and PC-PTSD (86%) screen results in their medical records. In addition, patients perceived that their clinician would be comfortable asking about ACEs (70%) and PTSD (76%) and addressing associated problems

for ACEs (73%) and PTSD (78%). The distribution of patient preference questions did not vary whether they reported none, low, or high ACE and PTSD scores.

Pearson Correlation Coefficient

Table 4 shows the results of the Pearson correlation coefficient test of patient preferences with ACE and PTSD scores. The ACE and PTSD scores were statistically significantly associated. As more ACEs were reported, PTSD symptoms increased and were strongly correlated in a positive direction ($r = 0.57$, $p < 0.001$). Patient preferences were not associated with either ACE or PTSD scores after adjustment for Type I error using a Bonferroni adjustment set at a significance level of 0.002.

DISCUSSION

Contrary to our hypothesis, most underserved patients from a sample at a safety-net clinic were comfortable being asked trauma-related questions directly by their clinicians or from screening questionnaires, and including this information in their medical records. Moreover, most patients expected that their clinician would be comfortable asking about ACEs and would be able to help them with the problems that arise from exposure to toxic stress in childhood. Our findings suggest that patients who do

Scores	Yes, no. (%)	No, no. (%)	p value (χ^2)
I am comfortable being asked about ACEs by my clinician			
0	30 (19.7)	6 (4.0)	0.36
1 or more	43 (28.3)	9 (5.9)	
4 or more	47 (30.9)	17 (11.2)	
Total	120 (79.0)	32 (21.1)	
I believe my clinician is comfortable asking me about ACEs			
0	28 (18.4)	8 (5.3)	0.52
1 or more	36 (23.7)	16 (10.6)	
4 or more	43 (28.3)	21 (13.9)	
Total	107 (70.4)	45 (29.6)	
I am comfortable letting my clinician know the results of my ACE survey			
0	32 (21.1)	4 (2.6)	0.44
1 or more	46 (30.3)	6 (4.0)	
4 or more	52 (34.2)	12 (7.9)	
Total	130 (85.5)	22 (14.5)	
I am comfortable with the results of an ACE survey being included in my medical record			
0	27 (17.8)	9 (5.9)	0.60
1 or more	37 (24.3)	15 (9.9)	
4 or more	42 (27.6)	22 (14.5)	
Total	106 (69.7)	46 (30.3)	
I believe my clinician is able to help with problems associated with ACEs			
0	27 (17.8)	9 (5.9)	0.94
1 or more	38 (25.0)	14 (9.2)	
4 or more	46 (30.3)	18 (11.8)	
Total	111 (73.0)	41 (27.0)	

not have an ACE history or PTSD symptoms, as well as those who *do* have an ACE history or who endorse PTSD symptoms are likely to find screening to be acceptable in this primary care setting. These findings also suggest that universal screening is acceptable to most patients regardless of trauma history, including those who screen positive for PTSD.

In this safety-net clinic, 1 in 4 participants (26%) had clinically significant elevations in ACE and PTSD scores. The PTSD screening rate in this study (37%) was comparable to that in a sample of underserved Latino patients being seen in a Federally Qualified Health Clinic, 30% of whom were at risk of PTSD³⁹ and, remarkably, is twice as high as the rate reported in inner-city primary care patients (18%).⁴⁰ In contrast to the 12% of patients with 4 or more childhood adversities in the ACE Study of 17,000 mostly middle-class, educated, and white patients in a health maintenance organization,¹ 42% of our sample reported 4 or more ACEs. Consistent with prior studies, our findings show that the chances of PTSD symptoms developing increase significantly as exposure to ACEs increases.^{41,42} ACEs and PTSD symptoms are associated with significantly greater general health symptoms, general medical conditions, and poorer health-related quality of life.⁴³ Moreover, the risk of adult health risk behaviors, morbidity, and mortality sharply increases with an ACE score of 4

Table 3. Chi-squared distribution of patient preferences by scores on Primary Care-Posttraumatic Stress Disorder (PTSD) screen

Scores	Yes, no. (%)	No, no. (%)	p value (χ^2)
I am comfortable being asked about PTSD by my practitioner			
0	65 (42.8)	14 (9.2)	0.10
1 or more	11 (7.2)	6 (4.0)	
4 or more	49 (32.2)	7 (4.6)	
Total	125 (82.2)	27 (17.8)	
I believe my practitioner is comfortable asking me about PTSD			
0	56 (36.9)	23 (15.1)	0.21
1 or more	13 (8.6)	4 (2.6)	
4 or more	47 (30.9)	9 (5.9)	
Total	116 (76.3)	36 (23.7)	
I am comfortable letting my practitioner know the results of the PTSD survey			
0	69 (45.4)	10 (6.6)	0.10
1 or more	13 (8.6)	4 (2.6)	
4 or more	53 (34.9)	3 (2.0)	
Total	135 (88.8)	17 (11.2)	
I am comfortable with the results of the PTSD survey being included in my medical record			
0	68 (44.7)	11 (7.2)	0.92
1 or more	14 (9.2)	3 (2.0)	
4 or more	48 (31.6)	8 (5.3)	
Total	130 (85.5)	22 (14.5)	
I believe my practitioner is able to help with problems associated with PTSD			
0	56 (36.9)	23 (15.1)	0.07
1 or more	13 (8.6)	4 (2.6)	
4 or more	49 (32.2)	7 (4.6)	
Total	118 (77.6)	34 (22.4)	

Table 4. Pearson correlation coefficient of patient preferences with scores on Adverse Childhood Experiences (ACE) Study questionnaire and Primary Care-Posttraumatic Stress Disorder (PTSD) screen^a

Patient preference ^b	ACE score	PTSD score
PTSD score	0.57 (0.001) ^c	1
ACE score	1	—
ACE patient comfort	0.18 (0.03)	(-0.06) (0.48)
ACE practitioner comfort	0.08 (0.30)	(-0.10) (0.22)
ACE results of screen	0.06 (0.49)	(-0.10) (0.23)
ACE medical records	0.10 (0.22)	(-0.05) (0.55)
ACE practitioner competence	0.03 (0.70)	(-0.13) (0.12)
PTSD patient comfort	0.03 (0.69)	(-0.06) (0.49)
PTSD practitioner comfort	0.03 (0.74)	(-0.10) (0.22)
PTSD results of screen	(-0.04) (0.60)	(-0.01) (0.23)
PTSD medical records	0.06 (0.48)	(-0.05) (0.55)
PTSD practitioner competence	(-0.11) (0.19)	(-0.13) (0.12)

^a Each cell contains *r* value followed by *p* value in parentheses.

^b See Table 2 for the full statement on each screen to which patients responded.

^c *p* value is significant at 0.002 using Bonferroni adjustment.

or more.⁴⁴ Therefore, addressing the impact of trauma on physical health should be a primary care concern.

Perhaps the most important finding of the study was the large proportion of patients who reported a high level of comfort with primary care clinicians asking about ACEs and PTSD and documenting screening results in medical records, regardless of how many ACE or PTSD symptoms they reported. This finding is counterintuitive given that avoidance of trauma reminders is a key diagnostic feature of the disorder.⁴⁵ Unique to this study was the evaluation of how patients prefer ACE and PTSD screening to be shared in a primary care setting (medical records) and the perception of clinician comfort to address problems that arise as a consequence of exposure to adverse events in childhood. These results confirm the findings by Friedman et al²⁵ in mostly white and educated patients in the US Northeast, in which most patients favored routine inquiry into a history of abuse and believed that their clinicians could help with associated problems, and extends those findings to underserved, mostly Latino patients in semirural Northern California.²⁵ These results strongly suggest that patients want to talk about what happened to them, and especially if this knowledge and understanding can help with the treatment of health problems.⁴⁶

These findings may be especially important in dispelling the perception among some clinicians that patients with a major history of trauma would not want to discuss their traumatic past.⁴⁷ Some clinicians argue that patients may object to the sensitive nature of the screening questions.⁴⁶ However, relevant studies have concluded that individuals who are exposed to trauma value being asked about their early-life history of trauma.²⁷ Supportive, nonjudgmental listening about ACEs not only builds trust but is also therapeutic, with a 35% reduction in clinic visits observed in 1 study (although this gain was not sustained beyond a 1-year follow-up).²⁶ Moreover, patients who know that their concerns are appropriately addressed by their clinician are more likely to be

satisfied with their care.⁴⁸ Future studies should compare patient satisfaction scores before and after implementing trauma screening to test whether asking these sensitive questions can translate into patient-centered health outcomes.

Although patients in this study believe that their clinicians are already trauma-competent, proper training and education are needed for health care professionals to inform patients about trauma impact on physical and mental health, to administer trauma-sensitive assessments, and to respond sensitively to patient disclosures.^{16,49,50} Study findings should encourage clinicians to obtain trauma-related training because most patients in this study already feel comfortable being asked about trauma exposure and believe their clinicians are able to help them with problems associated with such exposure.

Additionally, these findings underline the need to consider patient preferences to provide screening in a patient-centered way.^{51,52} Learning about patient preferences may help to effectively target and treat underserved individuals in need of treatment for the effects of ACEs and PTSD. Considering the trauma history of an individual might enhance the use of counseling techniques by highlighting how those experiences have affected health and life choices, and how a person might learn to integrate healthier choices into his/her life. Patients who know that their concerns are being addressed by their clinician may experience more satisfaction with their care and improved health outcomes.⁴⁸

Several limitations of this study should be noted. Individuals presenting with mental health needs in an integrated care clinic are often asked sensitive questions by a behavioral health clinician, which may skew patients' responses compared with when at a safety-net clinic without those resources. Therefore, findings should be replicated in primary care clinics that do not have co-located services. Furthermore, generalizability may be limited by surveying patients who were fluent only in English, and for some Latino patients English as a second language may compromise language comprehension. Additionally, patient perception of clinician competence may not be congruent with clinicians' own perceptions of their trauma-related competence. Nonetheless, it is encouraging that clinicians who receive training will encounter patients who are willing to be asked about trauma. Participation or refusal to participate may have been influenced by differing degrees of trauma exposure or could be biased by dissimilar characteristics between respondents and nonrespondents. Studies evaluating the accuracy of reporting childhood maltreatment show substantial underreporting and less overreporting.⁵³⁻⁵⁵ As a result, findings may underestimate self-reported ACE exposure and PTSD symptoms, and they could be subject to respondent bias.

CONCLUSION

Despite having high ACE scores and screening positive for PTSD, patients in this study were favorably disposed to being asked about trauma and perceived that their clinicians are able to help them. These findings warrant further exploration and should be replicated with larger samples and in other settings. Furthermore, universal screening may help clinicians to better

serve the health care needs and provide the necessary referrals to trauma-specific services for trauma-exposed patients. Although it is impossible to undo events of the past, knowing the events of a person's life may help clinicians to understand their patients who have more complex needs and to refer them to appropriate psychosocial resources, including evidence-based trauma-focused therapies. ❖

Disclosure Statement

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

Acknowledgments

Thanks to the OLE Health staff and the patients who generously donated their time and experiences to make this study possible.

Kathleen Loudon, ELS, of Loudon Health Communications provided editorial assistance.

How to Cite this Article

Goldstein E, Athale N, Sciolla AF, Catz SL. Patient preferences for discussing childhood trauma in primary care. *Perm J* 2017;21:16-055. DOI: <https://doi.org/10.7812/TPP/16-055>.

References

1. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 1998 May;14(4):245-58. DOI: [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8).
2. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 2012 Jan;129(1):e232-46. DOI: <https://doi.org/10.1542/peds.2011-2663>.
3. Gillock KL, Zayfert C, Hegel MT, Ferguson RJ. Posttraumatic stress disorder in primary care: Prevalence and relationships with physical symptoms and medical utilization. *Gen Hosp Psychiatry* 2005 Nov-Dec;27(6):2-9. DOI: <https://doi.org/10.1016/j.genhosppsych.2005.06.004>.
4. Liebschutz J, Saitz R, Brower V, et al. PTSD in urban primary care: High prevalence and low physician recognition. *J Gen Intern Med* 2007 Jun;22(6):719-26. DOI: <https://doi.org/10.1007/s11606-007-0161-0>.
5. Magruder KM, Frueh BC, Knapp RG, et al. PTSD symptoms, demographic characteristics, and functional status among veterans treated in VA primary care clinics. *J Trauma Stress* 2004 Aug;17(4):293-301. DOI: <https://doi.org/10.1023/b:jots.0000038477.47249.c8>.
6. Parto JA, Evans MK, Zonderman AB. Symptoms of posttraumatic stress disorder among urban residents. *J Nerv Ment Dis* 2011 Jul;199(7):436-9. DOI: <https://doi.org/10.1097/nmd.0b013e3182214154>.
7. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry* 1993 Feb;50(2):85-94. DOI: <https://doi.org/10.1001/archpsyc.1993.01820140007001>.
8. Howard KI, Cornille TA, Lyons JS, Vessey JT, Lueger RJ, Saunders SM. Patterns of mental health service utilization. *Arch Gen Psychiatry* 1996 Aug;53(8):696-703. DOI: <https://doi.org/10.1001/archpsyc.1996.01830080048009>.
9. Lewis VA, Larson BK, McClurg AB, Boswell RG, Fisher ES. The promise and peril of accountable care for vulnerable populations: A framework for overcoming obstacles. *Health Aff (Millwood)* 2012 Aug;31(8):1777-85. DOI: <https://doi.org/10.1377/hlthaff.2012.0490>.
10. Saviano EC. California's safety-net clinics: A primer [Internet]. Oakland, CA: California Health Care Foundation; 2009 Mar [cited 2016 May 15]. Available from: www.chcf.org/~media/MEDIA_LIBRARY/Files/PDF/PDF_S/PDF_SafetyNetClinicPrimer.pdf.
11. Redlener I, Grant R. America's safety net and health care reform—what lies ahead? *N Engl J Med* 2009 Dec 3;361(23):2201-4. DOI: <https://doi.org/10.1056/nejmp0910597>.
12. Meredith LS, Eisenman DP, Green BL, Basurto-Dávila R, Cassells A, Tobin J. System factors affect the recognition and management of posttraumatic stress disorder by primary care clinicians. *Med Care* 2009 Jun;47(6):686-94. DOI: <https://doi.org/10.1097/mlr.0b013e318190db5d>.

13. Green BL, Kaltman S, Frank L, et al. Primary care providers' experiences with trauma patients: A qualitative study. *Psychol Trauma* 2011 Mar;3(1):37-41. DOI: <https://doi.org/10.1037/a0020097>.
14. Samson AY, Bensen S, Beck A, Price D, Nimmer C. Posttraumatic stress disorder in primary care. *J Fam Pract* 1999 Mar;48(3):222-7.
15. Stein MB, McQuaid JR, Pedrelli P, Lenox R, McCahill ME. Posttraumatic stress disorder in the primary care medical setting. *Gen Hosp Psychiatry* 2000 Jul-Aug;22(4):261-9. DOI: [https://doi.org/10.1016/s0163-8343\(00\)00080-3](https://doi.org/10.1016/s0163-8343(00)00080-3).
16. Chung JY, Frank L, Subramanian A, Galen S, Leonhard S, Green BL. A qualitative evaluation of barriers to care for trauma-related mental health problems among low-income minorities in primary care. *J Nerv Ment Dis* 2012 May;200(5):438-43. DOI: <https://doi.org/10.1097/nmd.0b013e31825322b3>.
17. Litz BT, Gray MJ, Bryant RA, Adler AB. Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice* 2002 Jun;9(2):112-34. DOI: <https://doi.org/10.1093/clipsy.9.2.112>.
18. Kimerling R, Alvarez J, Pavao J, Kaminski A, Baumrind N. Epidemiology and consequences of women's revictimization. *Womens Health Issues* 2007 Mar-Apr;17(2):101-6. DOI: <https://doi.org/10.1016/j.whi.2006.12.002>.
19. Rosenberg HJ, Rosenberg SD, Wolford GL 2nd, Manganiello PD, Brunette MF, Boynton RA. The relationship between trauma, PTSD, and medical utilization in three high risk medical populations. *Int J Psychiatry Med* 2000;30(3):247-59. DOI: <https://doi.org/10.2190/j8m8-ydte-46cb-gydk>.
20. Katon W, Von Korff M, Lin E, et al. Distressed high utilizers of medical care. DSM-III-R diagnoses and treatment needs. *Gen Hosp Psychiatry* 1990 Nov;12(6):355-62. DOI: [https://doi.org/10.1016/0163-8343\(90\)90002-t](https://doi.org/10.1016/0163-8343(90)90002-t).
21. Walker EA, Katon W, Russo J, Ciechanowski P, Newman E, Wagner AW. Health care costs associated with posttraumatic stress disorder symptoms in women. *Arch Gen Psychiatry* 2003 Apr;60(4):369-74. DOI: <https://doi.org/10.1001/archpsyc.60.4.369>.
22. Taubman-Ben-Ari O, Rabinowitz J, Feldman D, Vaturi R. Post-traumatic stress disorder in primary-care settings: Prevalence and physicians' detection. *Psychol Med* 2001 Apr;31(3):555-60. DOI: <https://doi.org/10.1017/s0033291701003658>.
23. Marie-Mitchell A, O'Connor TG. Adverse childhood experiences: Translating knowledge into identification of children at risk for poor outcomes. *Acad Pediatr* 2013 Jan-Feb;13(1):14-9. DOI: <https://doi.org/10.1016/j.acap.2012.10.006>.
24. Del Piccolo L, Saltini A, Zimmermann C. Which patients talk about stressful life events and social problems to the general practitioner? *Psychol Med* 1998 Nov;28(6):1289-99. DOI: <https://doi.org/10.1017/s0033291798007478>.
25. Friedman LS, Samet JH, Roberts MS, Hudlin M, Hans P. Inquiry about victimization experiences. A survey of patient preferences and physician practices. *Arch Intern Med* 1992 Jun;152(6):1186-90. DOI: <https://doi.org/10.1001/archinte.152.6.1186>.
26. Felitti VJ, Anda RF. Chapter 8. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: Implications for health care. In: Lanius RA, Vermetten E, Pain C, editors. *The impact of early life trauma on health and disease: The hidden epidemic*. Cambridge, UK: Cambridge University Press; 2010. p 77-87.
27. Becker-Blease KA, Freyd JJ. Research participants telling the truth about their lives: The ethics of asking and not asking about abuse. *Am Psychol* 2006 Apr;61(3):218-26. DOI: <https://doi.org/10.1037/0003-066x.61.3.218>.
28. Acaster S, Cimms T, Lloyd A. The design and selection of patient-reported outcomes measures (PROMs) for use in patient centered outcomes research [Internet]. Washington, DC: Patient Centered Outcomes Research Institute; 2012 Mar 22 [cited 2016 Dec 7]. Available from: www.pcori.org/sites/default/files/The-Design-and-Selection-of-Patient-Reported-Outcomes-Measures-for-Use-in-Patient-Centered-Outcomes-Research1.pdf.
29. Havig K. The health care experiences of adult survivors of child sexual abuse: A systematic review of evidence on sensitive practice. *Trauma Violence Abuse* 2008 Jan;9(1):19-33. DOI: <https://doi.org/10.1177/1524838007309805>.
30. Prins A, Ouimette P, Kimerling R, et al. The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry* 2003;9(1):9-14. Erratum in: *Primary Care Psychiatry* 2004;9(4):151.
31. Uniform Data System. Health center profile. Napa, CA: Community Health Clinic Ole; 2013.
32. Gilbert LK, Breiding MJ, Merrick MT, et al. Childhood adversity and adult chronic disease: An update from ten states and the District of Columbia, 2010. *Am J Prev Med* 2015 Mar;48(3):345-49. DOI: <https://doi.org/10.1016/j.amepre.2014.09.006>.
33. Hughes K, Lowey H, Quigg Z, Bellis MA. Relationships between adverse childhood experiences and adult mental well-being: Results from an English national household survey. *BMC Public Health* 2016 Mar 3;16:222. DOI: <https://doi.org/10.1186/s12889-016-2906-3>.
34. Freedy JR, Brock CD. Spotting—and treating—PTSD in primary care. *J Fam Pract* 2010 Feb;59(2):75-80.
35. Ouimette P, Wade M, Prins A, Schohn M. Identifying PTSD in primary care: Comparison of the Primary Care-PTSD screen (PC-PTSD) and the General Health Questionnaire-12 (GHQ). *J Anxiety Disord* 2008;22(2):337-43. DOI: <https://doi.org/10.1016/j.janxdis.2007.02.010>.
36. Vera M, Juarbe D, Hernández N, Obén A, Pérez-Pedrogo C, Chaplin WF. Probable posttraumatic stress disorder and psychiatric co-morbidity among Latino primary care patients in Puerto Rico. *J Depress Anxiety* 2012 Dec;1(5):124.
37. American Psychiatric Association. DSM-IV: Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Publishing; 2000.
38. Freedy JR, Steenkamp MM, Magruder KM, et al. Post-traumatic stress disorder screening test performance in civilian primary care. *Fam Pract* 2010 Dec;27(6):615-24. DOI: <https://doi.org/10.1093/fampra/cmq049>.
39. Meredith LS, Eisenman DP, Green BL, et al. Design of the Violence and Stress Assessment (ViSA) study: A randomized controlled trial of care management for PTSD among predominantly Latino patients in safety net health centers. *Contemp Clin Trials* 2014 Jul;38(2):163-72. DOI: <https://doi.org/10.1016/j.cct.2014.04.005>.
40. Gillespie CF, Bradley B, Mercer K, et al. Trauma exposure and stress-related disorders in inner city primary care patients. *Gen Hosp Psychiatry* 2009 Nov-Dec;31(6):505-14. DOI: <https://doi.org/10.1016/j.genhosppsych.2009.05.003>.
41. Pratchett LC, Yehuda R. Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Dev Psychopathol* 2011 May;23(2):477-91. DOI: <https://doi.org/10.1017/s0954579411000186>.
42. Walling SM, Eriksson CB, Putman KM, Foy DW. Community violence exposure, adverse childhood experiences, and posttraumatic distress among urban development workers. *Psychol Trauma* 2011 Mar;3(1):42-9. DOI: <https://doi.org/10.1037/a0020566>.
43. Pacella ML, Hruska B, Delahanty DL. The physical health consequences of PTSD and PTSD symptoms: A meta-analytic review. *J Anxiety Disord* 2013 Jan;27(1):33-46. DOI: <https://doi.org/10.1016/j.janxdis.2012.08.004>.
44. Campbell JA, Walker RJ, Egged LE. Associations between adverse childhood experiences, high-risk behaviors, and morbidity in adulthood. *Am J Prev Med* 2016 Mar;50(3):344-52. DOI: <https://doi.org/10.1016/j.amepre.2015.07.022>.
45. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington DC: American Psychiatric Publishing; 2013.
46. Freedy JR, Magruder KM, Zoller JS, Hueston WJ, Carek PJ, Brock CD. Traumatic events and mental health in civilian primary care: Implications for training and practice. *Fam Med* 2010 Mar;42(3):185-92. DOI: <https://doi.org/10.1037/0003-066x.42.3.185>.
47. Becker-Blease KA, Freyd JJ. The ethics of asking about abuse and the harm of "don't ask, don't tell." *Am Psychol* 2007 May-Jun;62(4):330-2. DOI: <https://doi.org/10.1037/0003-066x.62.4.330>.
48. Jackson JL, Kroenke K. The effect of unmet expectations among adults presenting with physical symptoms. *Ann Intern Med* 2001 May 1;134(9 Pt 2):889-97. DOI: https://doi.org/10.7326/0003-4819-134-9_part_2-200105011-00013.
49. Green BL, Saunders PA, Power E, et al. Trauma-informed medical care: CME communication training for primary care providers. *Fam Med* 2015 Jan;47(1):7-14.
50. Heitzer DL, LaNoue M, Wilson B, de Hernandez BU, Warner T, Roter D. A randomized controlled trial of communication training with primary care providers to improve patient-centeredness and health risk communication. *Patient Educ Couns* 2011 Jan;82(1):21-9. DOI: <https://doi.org/10.1016/j.pec.2010.01.021>.
51. Robinson JH, Callister LC, Berry JA, Dearing KA. Patient-centered care and adherence: Definitions and applications to improve outcomes. *J Am Acad Nurse Pract* 2008 Dec;20(12):600-7. DOI: <https://doi.org/10.1111/j.1745-7599.2008.00360.x>.
52. Epstein RM, Franks P, Fiscella K, et al. Measuring patient-centered communication in patient-physician consultations: Theoretical and practical issues. *Soc Sci Med* 2005 Oct;61(7):1516-28. DOI: <https://doi.org/10.1016/j.socscimed.2005.02.001>.
53. Hardt J, Rutter M. Validity of adult retrospective reports of adverse childhood experiences: Review of the evidence. *J Child Psychol Psychiatry* 2004 Feb;45(2):260-73. DOI: <https://doi.org/10.1111/j.1469-7610.2004.00218.x>.
54. Della Femina D, Yeager CA, Lewis DO. Child abuse: Adolescent records vs adult recall. *Child Abuse Negl* 1990;14(2):227-31. DOI: [https://doi.org/10.1016/0145-2134\(90\)90033-p](https://doi.org/10.1016/0145-2134(90)90033-p).
55. MacDonald K, Thomas ML, Sciolla AF, et al. Minimization of childhood maltreatment is common and consequential: Results from a large, multinational sample using the Childhood Trauma Questionnaire. *PLoS One* 2016 Jan 27;11(1):e0146058. DOI: <https://doi.org/10.1371/journal.pone.0146058>.