VIEWPOINT

Trauma-Informed Care as a Universal Precaution
Beyond the Adverse Childhood Experiences Questionnaire

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Experiences of childhood adversity are common, with more than 50% of adults reporting having experienced at least 1 adversity as children and more than 6% exposed to 4 or more adverse childhood experiences (ACEs).[1] There is currently a controversial debate in the medical field as to whether the ACEs questionnaire, which asks about abuse, neglect, and household dysfunction before age 18 years, should be administered as routine practice by pediatricians. While some argue that identifying and addressing ACEs can lead to support that may promote resilience and help decrease the well-established health burden of ACEs,[2] others caution against its limited evidence and effectiveness as a universal "screening tool" as well as its potential harms in terms of revictimization and increased patient stigma.[3,4] Although research on the potential benefits and consequences of universal screening for ACEs is in its infancy, the ACEs questionnaire has been rapidly adopted into pediatric care settings across North America. For example, $45 million has recently been allocated to state funding in California to increase ACEs screening and trauma-related training in pediatric care settings. Moreover, there are now 27 states that have statutes and resolutions associated with ACEs and trauma-informed approaches to care.

Given this widespread adoption, which likely cannot be halted altogether, we encourage practitioners to adopt a trauma-informed approach to patient care, which extends well beyond the use of a single ACEs questionnaire. Trauma-informed care (TIC) realizes the universal effect of trauma; recognizes how trauma presents in children, families, and staff; and responds in a way that resists retraumatization.[5] Trauma-informed care is rooted in the assumption that any child or adult could have a trauma history, and this approach should be used across medical settings with all patients whether an ACEs questionnaire is administered or not. Given the high rates of adversity in the lives of children and families, TIC should be a universal precaution.

Two decades ago, a fundamental paradigm shift on the understanding of the development of health and mental health difficulties across the lifespan was spurred by the original ACEs study.[1] This study found an association between experiences of adversity in childhood and the pathogenesis of health, disease, and mortality.[1] Understanding the consequences of exposure to "toxic stress" as a result of childhood adversity has galvanized initiatives to identify exposure to ACEs within the medical community. In a policy statement, the American Academy of Pediatrics called on pediatricians to "screen for precipitants of toxic stress"[6] because of physicians' unique position to identify adversity in the lives of children and youth. Accordingly, clinical assessment tools on how to implement the ACEs questionnaire into routine practice have been developed. However, this early adoption has been deemed premature.[4]

What evidence exists to support adopting the ACEs questionnaire into routine practice? Unfortunately, very little. First, the psychometric properties of the ACEs questionnaire have been questioned.[4] Specifically, unlike several other screening measures used in the pediatric setting (eg, the Strengths and Difficulties Questionnaire and Pediatric Symptom Checklist-17), the ACEs questionnaire was not developed through a rigorous psychometric evaluation.[4] Furthermore, excluded from the questionnaire is the identification of residual trauma symptoms (eg, anxiety, panic, and intrusive thoughts) as well as other adversities associated with poor health outcomes, such as poverty, peer victimization, and community violence.[4] Another concern with the ACEs questionnaire is the exclusive focus on adversities in childhood. Although childhood has been identified as a sensitive period for the exposure to toxic stress, the recency and severity of adversity beyond childhood may also have significant implications for an individual's health or parenting. Asking about ACEs should not preclude a comprehensive assessment of current psychosocial risk factors (eg, poverty), environmental influences such as parenting, and protective or resilience factors that may mitigate risk. Lastly, despite the intention for the ACEs questionnaire to reduce the effect of adversity, there is limited evidence from other initiatives, such as domestic violence, that screening alone leads to reduced incidents.[4] Taken together, in the absence of targeted interventions, the use of the ACEs questionnaire as a universal screener may be insufficient for providing tangible clinical benefit.

What are the potential harms of universal ACEs screening? First, retraumatization can occur. Retraumatization refers to the process of re-experiencing distress associated with a past trauma as a result of events or reminders. Although some studies have shown that most children and youth feel comfortable reporting on ACEs, children who have had more traumatic experiences are more likely to be upset by being asked about them.[7] This finding points to the need to consider the emotional and physical toll of administering the ACEs questionnaire on those with substantial trauma histories. Furthermore, it highlights the need for trauma-informed training (eg, how to adequately debrief after adversity has been reported) for pediatricians and health professionals to reduce the likelihood of distress following the completion of the ACEs questionnaire. Health care clinicians' comfort and knowledge of using the ACEs questionnaire likely increases with experience and training in trauma-informed approaches. In addition to in-

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creased distress, universal ACEs screening is deficit-focused rather than strength-focused and has the potential to induce patient stigma among those with high ACE scores.

Having a child or their caregiver fill out the ACEs questionnaire without an organizational and systemic approach to trauma may not only be ineffective but also potentially harm-inducing. This is because asking about, and responding to, adversity experienced by patients requires adherence and commitment to a TIC approach, which extends beyond an ACEs questionnaire. Trauma-informed care involves integrating knowledge about trauma into all aspects of patient care, including policies, procedures, and practices. This includes staff training, budgeting, and support from leadership for trauma-informed initiatives. Within a trauma-informed organization, policies and procedures demonstrate a commitment to respecting and promoting recovery for individuals who have experienced trauma. From a practical perspective, practitioners can use trauma-informed communication skills (ie, listening, empathy, validation, and compassion) to increase patient comfort and reduce distress. Given that experiences of trauma and adversity are near universal, trauma-informed practice should be incorporated into medical school and health practitioner curriculums to encourage its widespread use. Moving forward, research evaluation regarding TIC is also needed to demonstrate its effectiveness. Essentially, similar to handwashing before a patient interaction, being trauma-informed is a universal precaution that should be used with all patients whether the ACEs questionnaire is administered or not.

The universal implementation of the ACEs questionnaire without prior consideration and implementation of a broader trauma-informed approach is not recommended. For some health care clinicians, asking about ACEs in the context of a trusted, compassionate relationship may be informative and helpful. The goal of asking about a child or youth's trauma history should be part of a larger trauma-informed approach that also incorporates a strengths-based component so that resiliency factors are identified. Screening for ACEs is only appropriate if a trauma-informed approach to patient care is implemented, targeted follow-up resources are available, and referrals can be made for children and families who require additional support. Using the ACEs questionnaire in clinical practice requires careful consideration about whether the benefits outweigh the potential harms and costs.

ARTICLE INFORMATION

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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;14(4):245-258. doi:10.1016/S0749-3797(98)00017-8

2. Watson P. Moving upstream: the case for ACEs screening. *Paediatr Child Health*. 2019;24(4):274-275. doi:10.1093/pch/pxz043

3. McLennan JD, MacMillan HL, Afifi TO, McTavish J, Gonzalez A, Waddell C. Routine ACEs screening is not recommended. *Paediatr Child Health*. 2019;24(4):272-273. doi:10.1093/pch/pxz042

4. Finkelhor D. Screening for adverse childhood experiences (ACEs): cautions and suggestions. *Child Abuse Negl*. 2018;85:174-179. doi:10.1016/j.chiabu.2017.07.016

5. SAMHSA. SAMHSA's concept of trauma and guidance for a trauma-informed approach. https://store.samhsa.gov/system/files/sma14-4884.pdf. Accessed May 13, 2019.

6. Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1):e224-e231. doi:10.1542/peds.2011-2662

7. Skar AS, Ormhaug SM, Jensen TK. Reported levels of upset in youth after routine trauma screening at mental health clinics. *JAMA Netw Open*. 2019;2(5):e194003. doi:10.1001/jamanetworkopen.2019.4003

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