Invited Commentary

Screening for Traumatic Childhood Experiences in Health Care Settings

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The heartfelt essay by Dr Austin[1] captures well the experience of many survivors of childhood sexual abuse and other traumatic and adverse experiences. Faced with medical history questionnaires, they may feel ambivalent about disclosing and disappointed with the follow-up when they do.

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As she points out, screening for the variety of adverse experiences has been rapidly increasing, in wake of the recognition of their prevalence and their contribution to poor health. But while screening is proliferating, it is not clear how beneficial it has been for patients and their health. Little is known about outcomes or whether those who disclose get an appropriate response.[2]

Trauma and adverse experiences are very common in both children and adults. For example, childhood sexual abuse/assault histories are prevalent in 6% of adult men and 16% of adult women in the US population.[3] Such histories are an established risk marker for higher rates of physical and behavioral health problems, with particularly high odds ratios for survivors of sexual abuse/assault, such as recent PTSD (4.1), suicide attempt (8.0), and mood disorder (3.4).[3]

Unfortunately, more than other traumas, sexual abuse/assault experiences tend to remain undisclosed to practitioners, to other authorities, or even to friends and family, due to fears of disbelief, stigma, or blame.[4] So, asking specifically and sensitively about these experiences can create the opportunity for health care professionals to counter such fears, identify health and health care implications, and offer help. But Dr Austin's account highlights a particularly common screening scenario: failure to appropriately acknowledge a trauma disclosure, reinforcing a sense that the survivor's pain or violation is too awful for even the clinician to bear.[1] In an ideal setting, the response would be a sympathetic acknowledgment of the patient's candor and their challenge, leading to further inquiry about the history in a nonjudgmental and sensitive fashion. A discussion would ensue about the implications of the experience for patient and their medical treatment, and whether more information or a referral might be helpful.

Here are some of the most important and helpful elements mentioned the literature.[5] Clinicians must be knowledgeable enough about the varieties of abuse and their effects to not respond with assumptions about potential effects or needs. It is less important to get details about the experience than to inquire about its possible implications for care and referral, for example, with an open-ended question such as, "What is it important for me as your health care professional to know about this?" Adequate discussion time may be needed after the disclosure or at a subsequent appointment for a patient to feel validated. Patients with such histories may also have discomfort around certain aspects of medical care such as undressing, touch, and positioning and need to be given advanced warnings and options.

In an ideal process, the infrastructure behind a fully comprehensive response would include training for health care professionals; having available informational resources such as pamphlets, videos, or websites; and the preplanning of a referral procedure. The exact options would depend on the resources within the settings. Some practices now employ social workers, care managers, and navigators who can contribute to effective responses. But in other cases, referrals will need to be vetted and clinicians trained in how to facilitate a successful hand off. Today, the comprehensive approach is likely more the exception than the rule. However, at the very least, when practices administer screening checklists for traumatic experiences, patients deserve an acknowledgment and an extension of empathy as someone who has shared a difficult experience at the clinician's request.

Other research highlights additional challenges. Although health care professionals generally support the idea of screening for such adversities, many of them feel unprepared for disclosures.[6] One of the biggest obstacles they underscore is that they do not have the time to deal adequately with the issue and see it as competing with other clinical priorities.[6]

Other unhelpful outcomes are also reported by survivors. Health care professionals may acknowledge the patient's trauma, but then ask questions or make comments that reveal ignorance or judgments. Confidentiality may be breached in the documentation or referral process. Patients may be referred for treatments that are inappropriate or unnecessary. Signs of poorly designed screening regimens appear in related domains where there has been more research. For example, among patients screening positive for depression in their annual health visit, three-quarters had no documentation in the records of any intervention, including for those who endorsed suicidal thoughts.[7]

A problem is that screening questions, especially on a preappointment form, are often the easily adopted gesture toward some problem the health system deems important. It is inexpensive and not time intensive. But the goal of treatment is benefit for patients, and that requires considerably more than just a screening question.

Unfortunately, there have been no studies that have comprehensively evaluated whether such screening has direct psychological or other benefits for patients. But research has found that most patients with histories of trauma support such screening and many clinicians see it as potentially useful. This suggests that practices with a strong interest, careful planning, and adequate training might implement such screening. But it is premature to recommend it as a universal practice, and adopters should closely monitor their patients' experiences and promote formal evaluation. To the burgeoning literature on childhood adver-

sities and the variety of screening approaches, the field needs to turn its attention much more systematically to how to respond well, ensure benefit, and avoid harm. Dr Austin[1] is properly cautioning the health care system that screening can be worse than doing nothing if it is not accompanied by a helpful response.

ARTICLE INFORMATION

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Published Online: May 3, 2021. doi:10.1001/jamainternmed.2021.1442

Conflict of Interest Disclosures: None reported.

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