PERSPECTIVE

Screening for Traumatic Experiences in Health Care Settings
A Personal Perspective From a Trauma Survivor

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"Do you have a history of emotional, physical, and/or sexual abuse? If so, please describe." I was recently asked this question when completing new patient paperwork prior to being seen by a health care professional. For most of my life, when asked questions about experiences of trauma, I checked "no" despite having been repeatedly sexually abused as a child. My primary concern was not sharing what had happened to me, but how others would react to this information. How would others respond when I told my story? Would they believe me? Would they take my trauma seriously? I felt deep shame about what had happened to me, and the fear of negative, or even neutral, responses made disclosure seem unfathomable.

In my early 20s, I started checking "yes." Checking this box was the first time I disclosed to anyone that I had been sexually abused as a child. While I was full of anxiety, unsure of what disclosing this information would mean, I was also hopeful that disclosing my abuse to a health care professional would mean I would get some needed support. In the subsequent appointment, the health care professional did not acknowledge that I had disclosed early experiences of sexual abuse. She did not assess my current mental health or safety or ask if I needed additional services or referrals. Disclosing this information was a significant moment in my life, and the lack of follow-up reinforced my fears. Was my physician not asking me about my abuse because she did not believe me? Was my sexual abuse, in fact, something I should feel ashamed of? Should I continue to be silent about my trauma?

For more than a decade, I have consistently indicated on screeners that I was sexually abused as a child. Not once have I received any form of follow-up. I have independently sought the care I needed and am both mentally and physically well. However, there was a time when I desperately needed some form of support or intervention, and checking "yes" on those screeners was the only way I felt comfortable asking for help.

We are in an era of increased focus on traumatic experiences, and more specifically traumatic experiences in early childhood (commonly referred to as adverse childhood experiences, or ACEs), and the potential implications of these experiences for health and development. This has resulted in a groundswell of innovative and necessary research and practice. It has also resulted in calls for widespread screening of children, adolescents, and adults for past or current trauma exposure. My personal experiences echo the serious concerns voiced by some professionals regarding this screening.[1,2] What is the purpose of screening for traumatic experiences? Are well-developed screening tools available? What types of traumatic experiences should we screen for? Have health care professionals received sufficient training on how respond in the event of a disclosure? Do they know how to determine what services and referrals are needed for each trauma survivor, given individual differences in trauma responses? Are the needed services available and accessible? In one case, I was asked about past or current experiences of sexual abuse or assault in a single question. When I received no follow-up after my disclosure, I wondered how many patients currently experiencing sexual violence left their appointments to return to unsafe environments, with no resources, supports, or referrals in hand.

Questions about traumatic experiences are deeply personal. And while perhaps well intentioned, asking patients to disclose potentially painful and distressing experiences with no follow-up can cause more harm. A key tenet of public health and medical ethics is that screening without readily available and accessible evidence-based interventions, let alone a compassionate conversation, is unethical.[3,4] There is a critical need for the public health and medical communities to respond to childhood trauma specifically and lifetime trauma more broadly, but it is imperative this is not done in a way that causes more harm. Rushing to implement screening without a strong evidence base and careful planning, training, and resource allocation is not justified. A recent review of the scientific literature[5] revealed that we know little about how health care professionals respond to patient disclosures of traumatic experiences on screening questions and whether such screening results in additional services or referrals offered to patients. Moreover, this review[5] highlighted that no studies have examined whether screening for traumatic childhood experiences improves patient health and well-being. Other reviews[6] indicate that health or safety benefits of screening for intimate partner violence have not yet been demonstrated. This gap in our understanding of the implications and value of screening for traumatic experiences underscores the need for more evidence prior to widespread implementation. As an alternative to screening, some have called for universal adoption of a trauma-informed approach to care for all patients.[7] While this is promising, evidence regarding the effectiveness of this approach is still needed.[7]

Although I am both mentally and physically well, to this day, there is still a small part of me that wonders if my health care professionals do not believe me when they fail to follow-up after I disclose my experiences of childhood sexual abuse on screening questions. Screening can provide a window of opportunity to offer help and improve outcomes. But without appropriate follow-up, it can retraumatize survivors and create hesitancy to seek help in the future.

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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.

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]

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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]