Family Services of Peel – Peel Institute on Violence Prevention

The Need for an Effective Trauma Screening Tool and Training Program in the Region of Peel

- A Literature Review

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Acronyms

CTD - Cumulative Trauma Disorder

DV - Domestic Violence

IPV - Interpersonal Violence

PIVP - Peel Institute on Violence Prevention

PTSD - Post-Traumatic Stress Disorder

VAW - Violence against Women

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1. The Need for an Effective Trauma Screening Tool and Training Program in the Region of Peel - A Literature Review

1.1 What is Trauma?

The word "trauma" is used to describe experiences or situations that are emotionally painful and distressing, and that overwhelm people's ability to cope, leaving them powerless. Trauma has sometimes been defined in reference to circumstances that are outside the realm of typical human experience. Unfortunately, this definition does not always hold true. For some groups of people, trauma can occur frequently and become part of the collective human experience. In addition to terrifying events such as violence and assault, we suggest that relatively more subtle and insidious forms of trauma—such as discrimination, racism, oppression, and poverty—are pervasive and, when experienced chronically, have a cumulative impact that can be fundamentally life altering. 1 http://www.nonviolenceandsocialjustice.org/FAQs/What-is-Trauma/41/ Retrieved March 2016

1.2 Introduction

In October 2012, following a presentation facilitated by Saundra-Lynn Coulter from the Ontario Woman Abuse Screening Project, managers and stakeholders from numerous sectors joined forces to begin an effort to coordinate and improve mental health, addictions and trauma services within the Region of Peel. It was identified that there was a strong need within the Region of Peel to improve services for women who had experienced trauma. Seamless Services for Mental Health, Addiction, Trauma (SSMHAT) was established to coordinate the sectors of trauma, mental health and addictions and to create a seamless continuum of service for individuals in need, while still being sensitive towards the needs of the diverse population of Peel. Initial work focused on gathering information on screening tools in general

An initial literature review was done including academic medical journals as well as literature from mental health, substance abuse, and trauma associations were utilized to find information about what tools are the most recommended. In trying to locate the best screening tools, several similarities

[1] http://www.nonviolenceandsocialjustice.org/FAQs/What-is-Trauma/41/ accessed March 2016

amongst the top-rated options became apparent. The best screening tools are ones that cover as wide a range as possible and have high assessment reliability, but at the same time are still easy to understand and do not require a vast amount of time to administer.

In the year 2014, the committee looked at screening/assessment tools that were already used by several of the Committee member agencies. The focus was shifted from women to be more gender-inclusive. Interviews with practitioners were conducted, and the 'Jean Tweed trauma questionnaire' was suggested as an alternative to the training given the complexity of previously suggested questionnaires. The Jean Tweed tool was considered more conversational, something that is already working, trauma-focused, and versatile across sectors. The Committee found this tool easier to fill out by intake workers during screening and assessment with the client. The questions are to be asked conversationally, not as formal clinical questions.

During the year 2015, the committee established a sub-committee to focus on developing training using an adaptation of the Jean Tweed Trauma Questionnaire. A training was developed including the following areas: Social determinants of health and well-being and introduction of an equity framework, what is trauma, trauma screening vs trauma assessment, introducing the trauma screening tool, practicing using the tools with a case scenario, strategies for dealing with disclosure, responding to trauma exposure for the workers and referrals, resources and bibliography.

The literature review presented here is an attempted of the committee to continue expanding its knowledge of trauma screening tools.

1.3 Prévalences

According to an online self-report survey conducted on a panel of adults in the USA, 89.7% of respondents reported exposure to at least one traumatic event listed in the DSM-5 criterion (Kilpatrick et al., 2013). Studies have also shown that trauma exposure is a risk factor for depression, substance

abuse, panic disorders, obsessive-compulsive disorder, borderline personality disorders, eating disorders and sexual problems (Kubany et al., 2000; Carlson et al., 2011). Thus, one traumatic event could lead to a plethora of mental and health problems that could have a lasting negative impact on a person. In addition, exposure to traumatic events is quite common in North America, particularly among those who currently have mental health and addiction problems. For example, a Canadian study found that 80% of women who reported depression or alcohol use had experienced a traumatic event (Brown, Petite, Haanstra & Stewart, 2009). Similarly, a separate study involved interviews with women participating in programs for mental health, and substance abuse found that out of 1500 women interviewed, 95.7% of women using both programs reported a traumatic experience (Newmann & Sallmann, 2004 as cited in Jean Tweed, 2013). There is a well-supported association between traumatic experiences and later development of mental disorders and substance abuse (The Jean Tweed Centre, 2013).

The current literature tends to focus on more vulnerable populations who may experience traumatic events more frequently or more intense types of trauma. For example, women offenders have significantly higher rates of trauma exposure than other women (Tam & Derkzen, 2014) do and thus many studies focus on trauma screening and treatment in correctional facilities. Another study showed that American Indian and Alaskan natives show higher rates of “acute, chronic, and intergenerational trauma” than other aboriginal populations (Hiratsuka et al., 2016). Finally, many studies focus on identifying trauma in children, to prevent the worsening of trauma-related symptoms in the future. A study conducted by Copeland, Keeler, Angold and Costello (2007) found that 68% of all children experience serious potentially traumatic events. The differences between the prevalence and intensity of trauma between populations can make it difficult to accurately screen for trauma without being equipped with multiple screening tools and participating in various training programs.

In essence, there is a need for a simple and straightforward screening tool that can be used on all clientele with a high degree of accuracy. A trauma-screening tool is a brief measure or tool that is administered universally to clients in order to identify potentially traumatic experiences (Conradi, Wherry & Kisiel, 2011). Its purpose is not to diagnose any mental disorders or health problems nor is it meant to treat clients directly either. Screening provides essential information to professionals in social services that can then be used to narrow down techniques for treatment. Unfortunately, Conradi et al. (2011) surveyed child welfare workers and found that while 85% of the respondents use trauma questions in their general mental health screenings, only 45% administer trauma-specific screenings. Respondents also stated that although they understand the use of trauma screenings, there are barriers that prevent the use of these tools such as a lack of training and time to administer screening tools (Conradi et al., 2011).

Professionals who work in social services may frequently hear about traumatic experiences from their clients. Unfortunately, this repeated exposure can increase a counsellor`s susceptibility to developing vicarious trauma which is defined as secondary exposure to trauma from listening to stories about traumatic experiences, thereby resulting in the development of some degree of trauma symptoms (Kanno & Giddings, 2017). Vicarious trauma (also known as secondary trauma or compassion fatigue) has been shown to share symptoms with post-traumatic stress disorder and depression (Aparicio, Michalopoulos & Unick, 2013) which can include sleep disruption, nightmares, irritability, fatigue, negative affect and numbing. Other identified impacts include emotional burnout, which can hinder a counsellor’s ability to complete their work to the best of their ability (Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D., 2015). In a study conducted by Bride (2007), 70.2% of social workers were found to have experienced one symptom of vicarious trauma in the previous week while 15.2% met the

criteria for a diagnosis of post-traumatic stress disorder. Therefore, it is essential for social services organizations to educate their employees on how to prevent the development of vicarious trauma.

Thus, the experience of traumatic events is widespread and consequently, so is the development of various mental disorders and addictions. There is a need for a simple and straightforward trauma screening tool that social services professionals are trained to use. Additionally, due to the frequent exposure to secondary trauma that is experienced by social services professionals, there is a need for a training program that educates counsellors on self-care and preventing the development of vicarious trauma.

1.4 Purpose of the Report

The purpose of this report is to discuss the currently available trauma screening tools and outline the need for a more comprehensive trauma screening training program. The report will attempt to answer the following questions:

1. How do we identify trauma?
2. What questions do we ask when screening for trauma?
3. How do we prepare counsellors for the stress associated with assisting survivors of trauma?

1.5 Methodology

This review will scan existing literature, including academic publications, government reports and other grey literature to review pre-existing trauma training programs geared towards screening clients for exposure to traumatic events. Articles will be identified using Boolean search terms and the final papers will be selected based on relevance to the research questions and keywords. The following keywords, inclusion and exclusion criteria will be applied to the literature search:

1.5.1 Keywords

Trauma, screening, informed, training, evidence-based, exposure, impaired health, emotionally painful, distressing or shocking experiences, trauma treatment, trauma identification, impact evaluation of trauma training, psychosocial risk factors, traumatic stress

1.5.2 Inclusion Criteria

- Peer-reviewed articles and grey literature that identify review and evaluate pre-existing trauma training programs or trauma screening tools
- Mental trauma resulting from life experiences
- Literature is written in English
- Studies that focus on local, provincial and national trauma training programs in North America
- Literature published between 2007-2017 in addition to original papers relating to the formation of trauma screening tools

1.5.3 Exclusion Criteria

- Literature not published in English
- Training programs that do not focus on screening for trauma
- Screening tools that do not screen for trauma
- Studies conducted outside of North America

Databases	Search Terms Used
PubMed	Canada AND Trauma Screening education AND Mental, Canada AND Trauma Screening Training AND Mental, Impact AND Evaluation AND Trauma Training AND Mental AND Canada
Psych INFO	Canada AND trauma training AND exposure AND life experiences, Canada AND trauma identification AND training AND mental, Impact AND Evaluation AND Trauma Training AND Mental AND Canada, Mental AND Training AND Canada AND Screening
UTM library	Mental trauma AND Canada AND Screening AND Training, Canada AND trauma screening training AND psychosocial, Canada AND trauma screening training AND emotionally painful, Canada AND trauma identification AND training AND mental, Canada AND trauma training AND exposure AND life experiences, Emotional Trauma AND Screening AND Training AND Canada, RAI-MH, Screening AND assessment of traumatic stress, Traumatic Stress AND Training AND Screening AND Canada, Trauma Exposure AND (Identify OR Screen OR Assess) AND (Canada OR US OR United States), Traumatic Events Screening,

1.6 How do we Identify Trauma?

The first step to treating clients with trauma is first to identify whether the client has gone through a traumatic experience. The complexity and variety of events that cause trauma make it difficult to identify whether or not a patient has had a traumatic event without using a multitude of screening tools. Often professionals identify trauma by screening for Post-Traumatic Stress Disorder (PTSD) (Twigg, E. Humphris, G., Jones, C., Bramwell, R. & Griffiths R. D., 2008; Sachser, C. et al., 2017). However, patients may not always develop PTSD because of their traumatic event or exhibit the symptoms in a way, which meets the diagnostic criteria for PTSD. (Forkey, Morgan, Schwartz, & Sagor, 2016 ;(Sachser, C. et al., 2008). Thus, unfortunately, many clients may fall through the cracks when screening for trauma.

Various studies have been conducted to create reliable techniques to screen for all forms of trauma. Current screening tools will include questions related to trauma-related symptoms, the presence of mental disorders, as well as health screenings (Centre for Substance Abuse Treatment, 2014). Additionally, screening tools have been developed to address preventative factors that may pick up on predictors of the development of the trauma-related disorder. Thus far, it has been determined that pre- and post-traumatic factors, as well as those associated with one's resiliency,
have shown to be strong predictors of the development of the trauma-related disorder. (Walters, J. T. R., Bisson, J.I., & Shepherd, J. P., 2006). The Trauma Screening Questionnaire is an example of a tool that has been proven to hold high validity and reliability in predicting the psychological manifestation of traumatic events (Walters, J. T. R., Bisson, J.I., & Shepherd, J. P., 2006).

As stated by the Peel Institute on Violence Prevention (2017), it is the meaning a person moulds from the experience, rather than the experience itself, that makes an event a traumatic one. For this reason, the literature has also shown the effectiveness of screening tools that are brief and focus on the subjectivity of traumatic experiences. Along with the 10-item TSQ, screening tools such as the Stressful

Life Experience screener, the University of California, Los Angeles (UCLA) Life Adversities Screener (LADS), and the Subjective Traumatic Outlook (STO) have shown high sensitivity and specificity within the literature (Centre for Substance Abuse Treatment, 2014, Honghu et al., 2015, Palgi, Y., Shrira, A., & Ben-Ezra, M., 2017). The 21-item UCLA LADS allows more preventative action to occur as it focuses more on the event(s) rather than the presentation of symptoms, which may not manifest in the same way or time in every person (Honghu et al., 2015). Similarly, the brief 5-item STO questionnaire serves as a client-centered screener, providing autonomy and agency to the client with the assumption that the client has strong insight into the impact of their experience (Palgi, Y., Shrira, A., & Ben-Ezra, M., 2017).

A study conducted by Carlson et al. (2011) discussed the creation of another easy to read tool that could screen for trauma quickly without requiring clients to make complex judgements. With these characteristics, they asserted that the tool could be used in research, clinical and non-clinical settings (Carlson et al., 2011). Trauma screening tools that have the above characteristics are ideal for application in social services. However, many of the currently used and studied tools may not be reasonable for everyday use, as they do not have any of the above characteristics.

Screening tools with fewer questions can be just as useful when identifying multiple traumatic experiences. Kira et al. (2012) identified that many screening tools do not provide a comprehensive trauma assessment and will often only focus on traumatic experiences that occurred in the past. Thus, they set out to create the Cumulative Trauma Disorder Scale (CTD) that will serve as a general but comprehensive screening tool while still using the least number of questions possible. After using the tool on two samples, they found that the measure had high reliability.

Another important characteristic of the CTD is that the items were asked using an interview format instead of the commonly used self-report/survey format (Kira et al., 2012). With proper training, this format allows counsellors to omit certain items based on the client's responses. Oral administration

of screening tools is also useful when screening in populations who do not know how to read (e.g. children) (Gonzalez, Monzon, Solis, & Jaycox, 2016). Many of the commonly used trauma screening tools are conducted as written surveys. However, social workers can greatly benefit from learning how to verbally administer these tools as it allows the freedom to modify the tool on the fly and build a greater rapport with the client.

Trauma screening with children becomes a little bit more complicated. There are three different types of screening tools for children: child-completed tool, caregiver-completed tool, and information integrated tool. As outlined by Conradi et al. (2011), child-completed tools have been shown to provide more accurate results than caregiver-completed tools. However, proper training must be given to counsellors on how to ask these questions sensitively (Conradi et al., 2011). Unfortunately, social services professionals are often not given training before utilizing these tools. For example, Forde et al. (2012) tested the reliability of the Childhood Trauma Questionnaire short form (CTQ-SF) on male and female street youth in Vancouver, British Columbia. The tool was an interview that was administered by one of the researchers who has spent quite a bit of time in the field. However, the paper does not outline how the questions were administered with great care and sensitivity for the respondents.

Another issue that has been noted with commonly used trauma screening tools is that there have not been proper assessments with regard to the reliability of these tools. For example, Tam & Derkzen (2014) described how various screening tools had been used to measure trauma exposure in women offenders. However, during their search of the literature, they found that studies have been referencing previously obtained reliability rates instead of measure reliability again (Tam & Derkzen, 2014). Consequently, social workers may be utilizing tools that at one time may have been useful but may be less reliable than newly developed tools.

Thus, the ideal trauma screening tool contains few but easy to understand questions and is generalizable to all populations and traumatic event types. In addition, professionals working in social services should be trained to administer these tools verbally with great care and sensitivity. Finally, the screening tool should undergo extensive testing to provide support for the reliability of the tool. Since many of the currently available tools do not fit the above criteria, a new tool may need to be synthesized while drawing inspiration from tools that were useful in the past.

1.7 What questions do we ask when screening for trauma?

When developing a trauma-screening tool, it is important to put careful thought into the questions that will be used. Each question must be sensitive not to harm the respondent in any way. However, the questions must also be informative and be able to identify the presence of traumatic experiences in the most concise way possible. A study conducted by Watson & Haynes (2007) looked at evaluating a screening tool by looking at the clinical significance of the traumatic life event, acceptability and validity of the screening tool, the time required for the assessment, and discriminative validity of the tool. All trauma-screening tools should be evaluated according to those criteria to identify which tools would be the most useful.

The common misconception is that screening tools need to be lengthy in order to cover all types of trauma and thus increase the accuracy of the tool. However, other studies have shown that brief screening tools can be just as effective in identifying people who have had traumatic experiences. Brief screening tools are more useful to use in any clinical and non-clinical settings, as they are less time-consuming but still provide professionals with the information necessary to begin assisting their clients (Watson & Haynes, 2007).

Moreover, the study outlined that the wording of questions can affect how well the tool identifies traumatic experiences. As referenced by Watson & Haynes (2007), studies have found that trauma is less

likely to be reported when loaded or legal terms are used. Two different versions of a question were used to screen for trauma where the modified version was behaviorally worded, as based on the Partner Violence Screen, as follows:

Sometimes, extremely disturbing things happen to people such as being in life-threatening situations. A major disaster, serious accident or fire; being hit, kicked, punched, or otherwise physically hurt by someone; being forced or verbally coerced into any kind of sexual activity that you did not want; seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. Have any of these kinds of things ever happened to you?

Another study that compared the single question Partner Violence Screen to a three-question screen found that the single question screen identified just as many cases as the three-question screen and demonstrated more specificity (Feldhaus et al., 1997, as cited in Watson & Haynes, 2007). Besides, other studies found that the Partner Violence Screen question demonstrated high sensitivity and thus preferred by clinicians and respondents (McIntyre et al., 1999; Resnick et al., 1996). Therefore, when developing an effective trauma screening tool, other screening tools and evaluation studies can be used to determine the appropriate wording for the questions.

Similar strategies can be used when screening for trauma in children. Pediatricians suggest that single questions can be used to screen for trauma. An example of a question that can be used is “Since the last time I saw you, has anything really scary or upsetting happened to you or your family?” (Cohen, Kelleher, & Mannarino, 2008).

It is important to note that the question is concise which will appeal to children who tend to get distracted easily. In addition, the question utilizes language that is simple and sensitive enough to be understood by children without triggering negative emotions. Not only pediatricians but also professionals working in social services can utilize this question. It is also easy to modify these tools for

use on parents when identifying trauma in children younger than eight years old. For example, the question can become “Since the last time I saw your child, has anything terrifying or upsetting happened to your child or anyone in your family?” (Cohen, Kelleher, & Mannarino, 2008).

Furthermore, to maintain sensitivity in the screening process, it is imperative to maintain a safe environment using the language. This involves consideration of the detail in which the practitioner asks for their questioning and maintaining a client-centred approach by continually informing the client of the screening process and being sensitive to their responses (Missouri Trauma Roundtable, 2015). Jean Tweed developed a screening tool that meets the criteria listed above, providing open-ended questions that utilize sensitive and straightforward language to maintain a safe environment (The Peel Institute on Violence Prevention, 2017). The trauma-screening tool that was developed was qualitative and open-ended. The questions focus on the current impact of trauma comprised of one opening question and seven micro questions. While the first question allows the client to be micro questions referred to the present moment are strength based that identify where the client is in the recovery process, what is working for them, and emphasize safety.

Therefore, a brief trauma-screening tool can be effective in identifying trauma and is quite easy to apply in all settings. Inspiration can be drawn from previously developed screening questions to provide guidelines on what terms are appropriate to use for trauma screening. Finally, many of the well-developed screening tools can be modified by changing the vocabulary for use on children, parents or adults and should modify the language to maintain a sensitive and safe environment for disclosure.

1.8 How do we prepare ourselves for the stress associated with assisting survivors of trauma?

Although it is crucial to identify trauma in patients, it is also essential that social services professionals take care of themselves. With more experience, professionals who listen to stories about the traumatic experience can learn to disconnect themselves from their client and thus prevent any

emotional impact. However, these professionals are consistently exposed to stories about traumatic experiences, and thus they can experience vicarious traumatization. Vicarious trauma has been shown to share symptoms with post-traumatic stress disorder and thus can have negative impacts on employees (Aparicio, Michalopoulos & Unick, 2013).

Currently, various available tools are utilized to screen for indirect trauma social services professionals. The Compassion Fatigue Self-Test (CFST), Professional Quality of Life Scale (ProQOL), Impact of Event Scale (IES), The Psychologist's Burnout Inventory, and the Trauma and Attachment Belief Scale are examples of such measures that have been proven valid and reliable. As determined above, tools that are short in length and simple to use while being sensitive to the effects trauma may have on the individual are characteristics of successful screening measures. Those currently and most frequently used possess these qualities, being on average, revised 20-30 item long left report tools (Bride, B. E., Radey, M., & Fidley, C. R., 2007; McKim, L. L., & Smith-Adock, 2013; Sinclair, S., Raffin-Bouchal, S., Venturato, L, Mijovic-Kondejewski, J., & Smith-MacDonald, L., 2017). However, there could be room for improvement. While specific measures are too long to become a regularly used tool, others are based on DSM-III-R or DSM-IV criteria for PTSD, preventing certain service providers from accessing support (Sachser, C. et al., 2008). A study conducted by Aparicio et al. (2013) developed a new vicarious trauma screening tool and studied the accuracy and reliability of the tool. Sufficient evidence was found to support the use of the tool to screen for vicarious trauma.

Although few studies found in the literature regarding useful screening tools for vicarious trauma, there are studies that provide insight into preventative factors of indirect stress symptoms as well as identify prevention and intervention methods. Phelps, A., Lloyd, D., Creamer, M., & Forbes D. (2009) identify the personal and organizational means of prevention for mental health practitioners. It is recognized that a hardy and resilient personality have the ability to establish emotional boundaries with

clients, strong belief systems, and social supports in the workplace, as well as accessibility to resources for conflict resolution and self-care strategies in the workplace, allow for a decreased susceptibility to burn out and an improved ability to recover (Phelps, A., Lloyd, D., Creamer, M., & Forbes D., 2009, Adams, R.E., Figley, C. R., & Boscarino, J. A., 2008).

Many studies have also been conducted regarding the effectiveness of various self-care techniques. For instance, (McKim & Smith-Adcock, 2013) determined that a higher sense of control and support, as well as the ability to create appropriate boundaries between professional and private spheres in the workplace, allows service providers to maintain resiliency. A study conducted by Killian (2008) also found that higher emotional awareness as developed through self-care practices led to decreased stress and lower rates of burnout. Self-care prevents instances of poor clinical judgement, ethical breaches, boundary violations and inappropriate emotional involvement (Killian, Hernandez-Wolfe, Engstrom & Gangsei, 2017). Developing a self-care plan has been a key tool mentioned in the literature in addressing trauma exposure response (Phelps, A., Lloyd, D., Creamer, M., & Forbes D., 2009, McKim, and Smith-Adcock, 2013, Peel Institute on Violence Prevention, 2017, BC TIP Project Team, 2013). By applying this method, service providers become accountable for maintaining awareness, balance, and connection in the workplace (BC TIP Project Team, 2013).

Furthermore, Compassion Fatigue Workbook (Mathieu, 2012) outlines personal and organizational strategies that can be used to increase self-care and promote the development of vicarious resilience. In this book, Mathieu details the process by which professionals working in social services can utilize mindfulness and meditation as a self-care strategy. In another study conducted with oncology nurses, the nurses expressed concern with how time-consuming meditation can be. Hevezi (2016) developed a condensed meditation schedule, to resolve the time issue that was shown to increase self-reported feelings of well-being. Thus, the creation of one training session outlining meditation and

mindfulness techniques can equip participants with the skills to take care of themselves and prevent the development of vicarious trauma (Hevezi, 2016). Other commonly suggested self-care strategies include body-centred therapies, neurofeedback, theatre, and Tai Chi (Killian, Hernandez-Wolfe, Engstrom & Gangsei, 2017). Wang et al. (2014) found that Tai Chi improves various psychological well-being measures including those that look at depression, anxiety, general Tai Chi stress management and exercise.

It is vital for organizations to educate their employees on the effects of vicarious trauma and strategies to prevent it and alleviate the symptoms. Trauma training conducted in social services organizations can ensure that all professionals who may be vulnerable to vicarious trauma are equipped with the tools needed to develop vicarious resilience. A study conducted by Sprang et al. (2007) found that specialized trauma training for therapists increased compassion satisfaction and subsequently decreased compassion fatigue and burnout. Craig and Sprang (2010) also suggests that trauma training is associated with a sense of personal accomplishment, time away from daily routines and peer support and may contribute to the decrease in compassion fatigue and burnout. Therefore, organizations and social services professionals will greatly benefit from incorporating a self-care component into the trauma-training program.

Furthermore, it would benefit from maintaining such practices within the workplace. This could take the form of engaging in retreats, educational intervention programs, mentor programs, and providing staff with opportunities to engage with support groups or debriefings (McKim, and Smith-Adcock, 2013). Debriefing, for instance, has been shown to create a significantly significant improvement in indirect traumatic stress as it is thought to assist in the organization and processing of memory (Davidson, A. C., & Moss, S. A, 2008; Pender & Prichard, 2009; Gerhart, J. ET. al., 2016). One study noticed a decrease in symptoms of PTSD such as anxiety, insomnia, avoidance, re-experiencing

compared to those who refused to disclose emotionally triggering events (Davidson, A. C., & Moss, S. A, 2008). Similarly, 20 minutes of the intervention, ACCEPTS, a brief group mindful meditation practice that incorporates debriefing have shown to reduce PTSD symptoms in palliative care providers (Gerhart, J. et al., 2016). By improving the resiliency of the service provider on an individual level as well as improving workplace environments so that they are pertinent in providing necessary resources and supports to staff, organizations can be better prepared to manage stress related to assisting survivors of trauma.

1.9 Conclusion

Majority of the population experience some forms of trauma, and it has been shown to have adverse effects on the emotional and physical well-being of clients. Thus, an effective trauma-screening tool is necessary to identify the presence of trauma in clients in order to inform professionals in social services about how to effectively help their client. A review of the literature has shown that there are various tools available to screen for trauma. However, many of these tools have not been extensively evaluated and are too long to be used regularly in social services settings.

The ideal trauma-screening tool is easy to read and contain a few questions (Carlson et al., 2011). The tool should also be general and able to identify a wide variety of traumatic experiences as well as the presence of multiple traumatic experiences (Kira et al., 2012). Similar strategies are useful when screening for trauma in children. Although it is common for counsellors to screen for trauma in children by asking the parents, a study conducted by Conradi et al. (2011) found that a screening tool completed by children has a higher rate of identifying traumatic experiences. It is also essential that these tools be consistently evaluated to ensure that the most effective screening tools are used. However, as identified by Tam & Derkzen (2014), many studies that reference evaluation of the tools recycle old numbers and do not conduct brand new evaluations. Finally, the utilization of these tools rarely involves training professionals on how to use these tools effectively (Forde et al., 2012; Kira et al., 2012). Thus,

professionals may not be administering the tools with high sensitivity or modifying the tools to suit the audience, which thus decreases the rate of identifying traumatic experiences.

Unfortunately, the currently available tools do not meet many of the above criteria. Thus, the creation of a brand new trauma-screening tool that meets the suggested criteria may be required. One of the challenges associated with creating a new trauma-screening tool is determining what questions to ask. A study conducted by Watson & Haynes (2007) showed that a brief screening tool is just as effective in identifying traumatic experiences in clients. The wording of questions also has an impact on whether clients will disclose their traumatic experience. For example, Watson & Haynes (2007) found that using “legal” and “loaded” resulted in lower rates of identifying traumatic experiences. However, a modified version of a trauma-screening tool that utilized behavioural terms instead was found to be more effective in identifying trauma. Besides, questions containing terms that have been chosen with sensitivity can be used on children as well. Finally, once an effective question or series of questions has been created, it can be easily modified to be used on different populations, thus increasing effectiveness (Cohen, Kelleher & Mannarino, 2008).

Although it is crucial to create a proper trauma-screening tool, it is also essential to prepare social services professionals for repeated exposure to secondary trauma. Studies have shown that counsellors and social services professionals are susceptible to the development of vicarious trauma. This condition shares symptoms with PTSD and can negatively affect a social worker’s emotional well-being (Aparicio, Michalopoulos & Unick, 2013; Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D., 2015). Various self-care techniques have been shown to increase emotional well-being such as mindfulness, meditation and Tai Chi (Mathieu, 2012; Hevezi, 2016; Wang et al., 2014). Thus, training counsellors on effective self-care techniques should be incorporated into a trauma-training program in order to develop vicarious resilience.

In conclusion, an effective trauma-screening tool must be created to identify trauma in all populations with a high decrease of accuracy. Moreover, social services organizations should conduct training programs to train their counsellors on how to effectively use the newly developed trauma-screening tool as well as inform them on self-care techniques to prevent the development of vicarious trauma. If these suggestions are followed, organizations will be taking a significant step towards reducing the prevalence and impact of traumatic experiences in the general population.

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