

RESEARCH ARTICLE

“They may be confronting but they are good questions to be asking” young people's experiences of completing a trauma and PTSD screening tool in an early psychosis program

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Abstract

Background: There is a history of inadequate enquiry about, and assessment of, trauma in young people within Early Psychosis services and even when screening does occur there is little known about how young people experience this process.

Aims: This study aimed to explore young people's experiences of completing a trauma and PTSD screening tool when receiving a service in an Early Psychosis Program.

Method: Semi-structured interviews were conducted with 10 young people, aged 18–24 years, to explore their subjective experience of this process. Transcripts were analysed via interpretative phenomenological analysis.

Results: Four super-ordinate themes were identified: (i) an emotional experience, (ii) the importance of the relationship with the clinician, (iii) an opportunity to reflect on past experiences, and (iv) the ability to be able to provide honest responses. Results from this study indicated that young people expected to be asked about their trauma experiences, acknowledged that this was challenging for them but found that this was made easier due to the relationship they had built with the clinician, the timing of the screening and also, possibly, by the written style format of the questionnaires.

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Conclusions: Young people in this study accepted the need for screening for traumatic histories, and expected to be asked about their traumatic experiences, despite the possibility of a short-term increase in distress. The support offered by a trusted clinician, whom the young person had built a relationship with, appeared to be an important component to the willingness and the ability of the young person to complete the questionnaires. This reinforces the fact that screening for trauma in an early psychosis service can be conducted in a way that is safe and acceptable to young people.

KEYWORDS

childhood, early psychosis, PTSD, questionnaires, screening tools, trauma, young people

Practitioner Points

- Young people expect to be asked about their trauma experiences.
- The process of screening for trauma using a questionnaire only appears to be less intrusive than having to discuss trauma in detail.
- The support offered by the clinician appeared to be integral to the young person's agreement and commitment to attempting the completion of the questionnaires.
- Screening for trauma in an early psychosis service can be conducted in a way that is safe and acceptable to young people.

INTRODUCTION

It is well established that many people with psychosis have experienced traumatic events in childhood (Bendall et al., 2008; Varese et al., 2012; Loewy et al., 2018). Findings from studies suggest that childhood trauma is not only a risk factor for psychosis (Brew et al., 2018; Matheson et al., 2013; Murray, 2017) but that this exposure to traumatic experiences is associated with psychosis in a dose–response fashion (Alsawy et al., 2015; Trauelsen et al., 2015; Varese et al., 2012) with increased reports of trauma increasing the risk or severity of psychosis (Bailey et al., 2018; Duhig et al., 2015). Estimates of prevalence of childhood trauma in those with first-episode psychosis range from 53% to 82% (Bendall et al., 2012; Peach et al., 2018; Trauelsen et al., 2015). The combination of exposure to childhood trauma, post-traumatic stress disorder (PTSD) and first-episode psychosis (FEP) is common (Bendall et al., 2012; Hardy, 2017) with one study showing 27% of young people with FEP meeting diagnostic criteria for PTSD (Peach et al., 2018).

Best practice national guidelines have recommended that trauma and PTSD should be routinely assessed in those experiencing psychosis and, where deemed appropriate, treatments for these to be offered (Galletly et al., 2016; NICE, 2014). While there is growing consensus about the need to enquire about childhood trauma, the reality is that many services do not routinely conduct such assessments (Mersky et al., 2019; Tink et al., 2017). Mental health service users who have experienced trauma

have indicated that they have not always been asked about trauma during a period of mental health care (Kirst et al., 2017), and have also reported that they have experienced ineffective care due to this missed opportunity to recognise the possible presence of traumatic experiences (Agency for Clinical Innovation, 2019).

The main reason cited for not completing trauma screening in early psychosis services is that clinicians are concerned about the potentially distressing and destabilising effect screening and assessment for trauma may have on the young person. In particular, clinicians are concerned about the possibility of suicidal ideation, acts of suicide and/or self-harming (Gairns et al., 2015; Mersky et al., 2019). Clinicians within broader mental health services also cite barriers to assessing trauma such as time constraints and costs associated with screening (Bruce et al., 2018; Mersky et al., 2019). There is also concern that clinicians perceive they have a lack of skills and training to address any trauma that is reported and this has been found to affect their overall confidence in screening (Gairns et al., 2015; Galletly et al., 2016; Skar et al., 2019; Walters et al., 2016). Whilst there is an assumption by clinicians that young people may experience some level of distress when completing trauma and PTSD assessments there are no published research findings, to the best of our knowledge, on how young people experience this specific process. Research has been conducted however, exploring young people's experiences when they were asked about trauma more broadly (Jansen et al., 2016). Young people either felt in control of their mental health issues due to gaining a better understanding of the causal relationship trauma had in the development of their psychotic disorder or were dismissive of the trauma experiences and instead focused on the diagnosis of schizophrenia and the recovery goals.

There are now recurring recommendations that clinicians should receive more training in conducting trauma and PTSD assessments in order to offer the appropriate care (Gairns et al., 2015; Galletly et al., 2016; NICE, 2016; Tong et al., 2017). However, even before this can occur, there is the need to provide training and education in the principles of trauma informed care as a basis on which clinicians can foster recovery for people who access these services whilst also protecting them from ongoing trauma (Isobel, Wilson, Gill, Schelling, & Howe, 2021; Mitchell et al., 2021). Trauma-informed care is an approach to service delivery that realises the widespread impact of trauma, recognises the signs and symptoms of trauma among clients and staff, responds by integrating knowledge about trauma into practice and proactively resists retraumatisation (SAMHSA, 2014). Bendall et al. (2021) highlight the broad consensus that universal screening is one of the essential components of trauma informed care in youth mental health settings.

Taking this information into account, trauma informed care principles were introduced within an Early Psychosis program in 2019 in headspace Adelaide, followed by implementation of routine trauma and PTSD screening. The purpose of this study was to explore how young people experienced this screening process.

METHOD

Context and setting

The study was conducted as part of a trauma screening implementation project that occurred at headspace, within a publicly funded youth mental health service for young people aged between 12 and 25 years, in a metropolitan catchment area, Adelaide. Headspace Adelaide provides support for young people who have a first-episode psychosis or are at ultra-high risk for psychosis, and uses a service model that includes providing case management, via occupational therapists, mental health nurses, psychologists and/or social workers, as well as medical management from psychiatrists and GP's. The young person accessing the service is allocated a clinical case manager, with comprehensive support including assertive outreach, cognitive based therapeutic interventions and psychosocial recovery components of care (Staveley et al., 2013 -EPPIC model).

TABLE 1 Demographic data of participants

	Age	Gender	Sexual orientation	Birth country	First nations	Relationship	Accommodation	Weeks in service
1	20	Female	Bisexual	Australia	No	Partnered	Family	4 weeks
2	20	Female	Bisexual	Asia	No	Single	Friend	8 weeks
3	18	Male	Heterosexual	Australia	No	Single	Family	2 weeks
4	18	Female	Bisexual	Australia	No	Partnered	Family	4 weeks
5	18	Female	Undecided	New Zealand	Does not know	Single	Family	12 weeks
6	21	Female	Bisexual	Australia	No	Partnered	Family	12 weeks
7	20	Male	Bisexual	Australia	No	Single	Family	2 weeks
8	24	Non-binary	Bisexual	Australia	No	Single	Friend	4 weeks
9	21	Male	Heterosexual	Australia	Yes	Single	Family	8 weeks
10	24	Male	Heterosexual	Africa	No	Single	Family	6 weeks

Implementation of trauma screening

The team leader (author TDM), supported by the operational management team, introduced the principles of trauma informed care across the service. This service improvement strategy included a plan to implement routine trauma screening. Relevant screening tools were reviewed by the leadership team taking into account a number of considerations. They reached the consensus that the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994) and the Post-Traumatic Stress Disorder Checklist (PCL-5; Weathers et al., 2013) provided appropriate measures to screen for childhood trauma experiences and PTSD symptoms. A childhood trauma question was considered appropriate due to the early adult age range of the service.

To support this change process, information sessions were provided to all staff (managers, clinical, administration, peer workers), followed by training to clinical staff. Information sessions and training was led by author (TDM), who was a clinician and team leader of the service, and overseen by author (SB). This training included introducing current research, evidence base for screening tools, scenario role playing as well as the provision of a script to provide guidance for staff when introducing the screening tools to young people. Broadly, the trauma-informed screening process involved introduction of trauma screening questionnaire to young people who were then given support and choices as to when, or if, to complete questionnaires. Clinicians were given information as to how to present the information but then used their clinical judgement about when this should be introduced to their individual clients. The team leader was available on site for continued support, coaching and consultation. Once the questionnaires were in use, clinicians were offered ongoing individual tuition, debrief opportunities and clinical supervision.

Participant sample

All young people referred to headspace Adelaide between September 2019 and July 2020, who had taken part in the screening process, were considered for inclusion in the study (with a pause in recruitment between March–June 2020 due to the COVID-19 restrictions that were in place). The screening had been conducted by the young person's clinician, otherwise known as their key worker or case manager, who was responsible for providing coordination of care and were the young persons and families key contact whilst they were in the service.

Study inclusion criteria were: (i) completion of the CTQ and PCL-5 in the first 3 months of entering the service, (ii) young people aged between of 18–25 (inclusive), (iii) adequate understanding

of the English language, (iv) able to access the centre for the interview, (v) in at least the early recovery phase of psychosis and (vi) had been deemed by their psychiatrist of having adequate capacity to consent to research. All participants were able to complete the interview process (Table 1).

Measures

As well as being used for the trauma screening process the CTQ and the PCL-5 were used to characterise the sample in the study. The PCL-5 is a 20-item self-report measure that assesses the core symptoms of PTSD (American Psychiatric Association, 2013). The PCL-5 has questions that correspond to the symptoms in order to screen for the potential diagnosis of PTSD. Each of these questions are rated on a four-point scale from “a little bit” (1 point) through to “extremely” (4 points) with the inclusion of “not at all” that does not equate to any points (Weathers et al., 2013). A PCL-5 score (cut-point) of 33 or more is a reasonable value to consider in the diagnosis of PTSD. In studies PCL-5 scores exhibited strong internal consistency ($\alpha = .94$), test–retest reliability ($r = .82$), and convergent ($r_s = .74$ to $.85$) and discriminant ($r_s = .31$ to $.60$) validity. Overall, results indicate that the PCL-5 is a psychometrically sound measure of PTSD symptoms (Blevins et al., 2015). The CTQ is a 28-item self-report questionnaire that assesses the retrospective frequency and severity of childhood trauma across five domains, including physical, sexual, emotional abuse and physical and emotional neglect (Bernstein et al., 1994). Each of these 28 questions are rated on a five-point scale from “never true” (1 point) through to “very often true” (5 points). These scores are then quantified to provide the severity of the maltreatment in each area (Bernstein & Fink, 1998). These are classified as: none or minimal, low to moderate, moderate to severe and severe to extreme. During psychometric studies analysis indicated high test–retest reliability (Spearman $\rho = .75$) and internal consistency (Cronbach $\alpha = .89$) with the CTQ being positively related to post-traumatic stress symptoms and pathological dissociation, demonstrating the convergent validity of the scale (Kim et al., 2013).

Procedure

Once the young person had been identified (via clinical review meetings) as a potential participant, information was provided by the researcher, verbal consent obtained, and the interview appointment booked in. All eligible participants received a full explanation of the aims of the study and the possible discomfort, risks and benefits in taking part. Each participant provided their written informed consent for participation in the study.

Data collection – Interview

Prior to being interviewed, participants read through the participant information sheet and once all questions had been answered to the satisfaction of the participants, they signed the consent form. The interview schedule was developed by the authors (TDM and SB) in consultation with young people with lived experience of psychosis via the services youth reference group. Participants were asked a number of primary questions and depending on their answers the researcher then explored the responses with follow up prompting questions (see Table 2). The interview was guided by the participant's individual experiences and the questions were developed to reflect this.

All interviews were undertaken by author (TDM), who is a mental health nurse with over 20 years of clinical experience. It was recognised that this prior clinical experience in the areas of trauma and psychosis may have influenced data collection and analysis, in particular the participants' willingness

to talk openly about their experiences. The authors acknowledged that the profession of being a mental health nurse may lead to bias when collecting and interpreting data, that explored the experiences of completing a trauma and PTSD screening tool. In order to minimise any pre-existing ideas from influencing data analysis, the author aimed to ensure that the analysis of the participants' perspectives, on what their experience was like, remained as close as possible to the participants descriptions of their lived experience.

Data analysis—Interpretive phenomenological analysis (IPA) approach

In order to “try and understand the participant's world” (Larkin et al., 2006) concerning their experience of completing the trauma and PTSD screening tools the researcher listened to each recorded interview whilst transcribing it. The researcher became immersed listening to the data provided through the recorded interview and transcribed the information by listening and re-listening to this information typing the information provided verbatim into a transcript document.

The subsequent analysis followed the IPA guidelines as described in Table 3 by Smith et al. (2009). The approach that IPA uses was well suited to this study as it aimed to capture the rich experience of the participants. This was then interpreted by the researchers from the material gathered into what would then become the emerging themes.

Transcripts were then coded by annotating the information line by line. These notes included paying attention to the descriptions of what was experienced (Starks & Trinidad, 2007), commenting on where possible themes began to emerge, questioning meaning behind the information in order to note similarities, differences, elaborations and contraindications within the participant's interview (Smith et al., 2009). In order to “consider the initial description in relation to a wider social and cultural context” (Larkin et al., 2006) the researcher took time to move back and forth in the interview recordings to recall associated facial expressions and body language. A relook at the individual transcripts turned to focusing on using the researcher's knowledge and experience to interpret what the individual participant's words may have meant. When the initial data analysis was completed for each participant the emerging themes were then visualised both as a whole whilst also retaining the individuality of the experience. The important things to consider were not only the similarities in participants' experiences but the differences, the contradictions and the elaborations to really get a feel for what the individual had truly experienced and whether this had had a long-lasting effect on them (Smith et al., 2009). Similar themes were coded and grouped into clusters. Super-ordinate themes were established that connected a number of related themes together by looking at patterns across the entire data. Within the super-ordinate themes there were a number of subthemes that were identified as being connected and these were then illustrated using a table which can be seen in the results section. This work was primarily conducted by author (TDM) with review by and exploration with author (SB).

TABLE 2 Interview questions

<p>What was your experience of filling in these questionnaires? <i>Prompt: Can you tell me more about that?</i> How did you feel before the questionnaires? <i>Prompt: Can you explain more about what (descriptive word used by participant) that means to you?</i> How did you feel whilst you were completing the questionnaires, in the moment? How did you feel after you completed them? <i>Prompt: What about a week later, one month later and today?</i> How did you feel about the information you were given before you completed the questionnaires? Do you feel you were provided with support before, during and/or after you completed them? When do you think is the best time to give these questionnaires to young people? What has been your experience of support around your responses since then? <i>Prompt: Is there anything else you would like to tell me about your experiences around completion of these questionnaires?</i></p>
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RESULTS

Participants have been de-identified using identification numbers in order to protect their anonymity. The 10 participants had a mean age of 20 ($SD = 2.2$), with the ages spanning between 18–24 and consisting of 5 females, 4 males and 1 identifying as non-binary. All had completed the CTQ and PCL questionnaires within the first 3 months of their time in the service.

The participants reported high levels of traumatic childhood experiences with 90% reporting experiences in 2 or more domains. There was only one participant who did not identify any childhood trauma in this screening tool. [Table 4](#) provides data on how this was reported across each domain.

PCL-5 scores ranged between 7 and 61 with a mean of 38, with 60% of participants scoring above the screening cut off of 33 for consideration of the presence of PTSD (Weathers et al., 2013).

Qualitative analysis results

Through the process of the analysis there were 4 main super-ordinate themes that emerged. Themes 1–3 were then further divided into subthemes to capture the phenomena explored, whereas theme 4 has been highlighted through a standalone theme. These details are outlined in [Table 5](#).

Super-ordinate theme 1: An emotional experience

During the interview, participants were encouraged to reflect on their experiences of the whole screening process. They described a number of emotions attached to the experiences from when they were introduced to the screening process, during the process itself and right through to its completion. These emotional experiences have been divided into 3 subthemes.

1a. Nervousness and anxiety

Before the questionnaires were given out to participants (often in an earlier session) the clinician provided an explanation as to what they were and a choice as to whether they felt able to complete them. It was common for the young people to feel nervous both before (P2, 3, 4, 7, 9) and during the completion of the questionnaires but this did not stop them from doing so. There was a feeling of being “a little bit nervous, but not too bad and just a little bit uncomfortable” (P2). The rationale for this being that “I didn't know how I would react to these forms or what the content of them was” (P3) so just felt “unsure” (P4) whilst also accepting that “it was just a thing that I needed to fill in for them to kind of make sense of I guess how I saw my childhood” (P7).

Participants acknowledged that they did not really know what to expect until they were actually given the questionnaires. There was a short time delay between being first told about the questionnaires and then having to wait without really knowing what to expect, thereby creating this anticipatory anxiety. Completion of trauma questionnaires was something that they had not experienced in their life before

TABLE 3 IPA methodology

1. A detailed coding and analysis of the interview data verbatim
2. Discovery of emergent themes from each participant
3. Gaining an understanding of the personal meanings for each participant
4. Developing an interpretative account
5. Abstraction of themes into super-ordinate themes
6. Numeration of all of these to consider the importance of these responses to each participant
7. Developing a framework to illustrate the relationships between the themes
8. Developing the research process so that this can be understood by all
9. Reflection on the findings and their implications for further research

and so had no comparison to draw upon when they were provided with the information in the beginning, “as wasn't sure what the content in the forms would be” (P1).

The process of completing the questionnaires brought about feelings of anxiety and nervousness beforehand but this reduced after completion of the questionnaires.

Sort of like a bell curve. I felt a bit like, OK. Oh yeah, I can do that. And then as I was doing it, it was a bit more anxiety involved. And after I finished, the anxiety sort of went away.

(P9)

1b. Challenging but important

Whilst the participants experienced the whole process of being given the questionnaires challenging, as:

Despite not feeling comfortable about some of the questions I was able to complete the questionnaires, somehow.

(P10)

they recognised how important it was to share this information with the service.

There was a level of acceptance that completing the questionnaires was necessary in order to receive appropriate treatment and support in the service.

They are good questions to be asking and if they may not be enjoyable to have the answers to all of it, it is very important information that sort of gives you an idea what that person has experienced in the past.

(P1)

Whilst there was acceptance of the need to complete the questionnaires and a general willingness to do so, there was acknowledgement that these questionnaires were “direct” (P1) and “confronting” (P1, 2, 4, 5) and “a lot of the questions were quite upfront” (P8).

For some it was particularly challenging as “remembering my past made me really anxious” (P8) and “the questions make you show your emotions and feels really raw” (P2).

One of the participants appreciated the use of the questionnaires as opposed to being asked questions directly about their trauma experiences. It was considered that “numbers are better than complicated words” (P4) because “words can be difficult to put into perspective as what might upset one person might not upset another” (P4).

There was a level of pride and accomplishment displayed in the participant's confirmation that had been able to complete the questionnaires as if it was somehow a test of how they were doing generally. This may represent their experiences in life up until this time being heavily age related, focused on schooling accomplishments and completing tests or exams, as a way to measure themselves against peers and be praised from parents or significant adult figures in their life.

TABLE 4 Reported levels of abuse across the domains of the CTQ

	None	Low	Moderate	Severe/extreme
Emotional Abuse	2	3	3	2
Physical Abuse	4	3	2	1
Sexual Abuse	7	0	0	3
Emotional Neglect	1	3	2	4
Physical Neglect	2	4	3	1

TABLE 5 Themes

Super-ordinate themes	Subthemes
1. An emotional experience	(1a) Nervousness and anxiety (1b) Challenging but important (1c) Relief after completion
2. The importance of the relationship with the clinician.	(2a) Support received from clinician. (2b) Building a relationship with clinician in order to be able to trust them.
3. An opportunity to reflect on past experiences.	(3a) Exploration of traumatic experiences. (3b) Reflections on past experiences.
4. The ability to be able to provide honest responses.	

As they “felt pretty comfortable completing them, actually” (P3), “didn't find it hard” (P7), “completed them quite easily” (P6), “was able to answer them pretty succinctly, pretty quickly” (P3) and described the experience as being “pretty smooth” (P9).

The researcher considered that the extent of the participants' assertions was also akin to competitiveness that appears to exist within the adolescent/young adult population and even when a particular sensitive issue was being introduced this competitive edge appeared to be present.

1c. Relief after completion

After completing the questionnaires, participants reporting feeling “good” (P6,7,10), there was a sense of “relief” (P3,4,8,9,10) and “satisfaction” (P5) that they had been able to finish them. Alongside a sense of hope that this will allow clinicians to provide the support they were seeking in managing the emotional aftermath of not only the trauma experiences but also the ongoing effects of them as (P4) “there are different strategies to deal with them” (the feelings) and “there are people that can help” (P4).

The completion of the questionnaires came with a type of catharsis for some, being described as “quite freeing” (P2) and “like a weight off my chest” (P3). A sense that the completion of these questionnaires was part of the treatment and was being used to assist with supporting the participants allowed them to push through any uncomfortable feelings regardless of individual mental health issues in order to obtain understanding, acceptance and resolution.

Super-ordinate theme 2: The importance of the relationship with the clinician

Participants described the importance of the clinician as somebody with whom they could build a safe and supportive relationship with, which assisted them to feel able to complete the questionnaires.

2a. Support received from clinician

There was a nice supportive environment.

(P4)

The participants discussed the level of support that they perceived they had from their clinician as a significant decider of whether they were able to complete the questionnaires, whether they became distressed whilst completing them and/or whether they were able to seek support during this time. “They were there for me, which was nice” (P4).

The description provided by most of the participants acknowledged the presence of the clinician in the room with them whilst they were completing the questionnaires was welcome and supportive. Participant 2 explained that having somebody in the room with her was “more helpful than expected”

as “they were just there”, indicating that filling in these questionnaires would have been more challenging to do on their own whilst reinforcing that “just having someone there was really, really good” (P2).

It was also acknowledged that the clinician was able to prepare the participant with their explanations of what the questionnaires entailed and thus assisting the participant then feeling able to complete these questionnaires.

The way it was described to me to just answer what you can...which I thought was a pretty good way to go about it

(P1)

The permission given by the clinician allowed the participant to feel safe to begin the questionnaire knowing that any time they could stop. Participant 3 felt particularly supported all the way through the process detailing their experience in the stepped way that the clinician would have presented them with their options:

So, when completing them.... they gave me opportunities to, like, stop or wait between completing them just in case they ... triggered anything. They gave us plenty of opportunity to stop doing the questions like filled out halfway or like do one and then wait a period of time before doing the next. They asked how I was feeling, whether I needed to take a break all that kind of stuff.

(P3)

There was a sense of relief from participants that the clinicians provided containment and allowed them to feel comfortable in the setting whilst tackling potentially challenging experiences that they may have had.

I think the questionnaires are best given whilst at headspace with a person in the room to provide emotional support in case you get triggered and have a response, it is helpful having someone in the room with you.

As well as a genuine feeling of appreciation for the service and the clinicians.

All the workers I've worked with so far have been brilliant.

(P8)

2b. Building a relationship with clinician in order to be able to trust them

Participants were quite vocal about the importance of feeling comfortable enough to be vulnerable and being able to trust the clinician with their sensitive information. In order for this to occur there was a recurring conversation about the optimal time to provide these questionnaires.

I feel like maybe establishing a relationship first or having at least that first consultation dialogue about what they're experiencing just to sort of make the person more comfortable when coming in and make them trust the person they are working with a bit more because can see if they have had difficult experiences in the past.

(P1)

It appeared that the general feeling was that taking some time to build this relationship was more important than gaining the information about past trauma experiences in the first few weeks of service usage with participants 2, 4, and 8 being quite specific about the timing being “around a month after they start” (P2) so that it is “near the beginning” (P4) of their time in the service but they have “been here a few times now” (P8).

The emphasis was on the “need to feel that you can trust them” (P2) by “forming the connection first” (P8). No participant thought that these questionnaires should be given on the first visit. There was often a visual recoiling for the participant in the interview when this was suggested as if this was abhorrent to even contemplate. This reinforces the notion that relationship building is key to their experience of care and the ability to provide this sensitive information “as my whole life is on a piece of paper” (P1) so I need to “trust them to take care of it and work with me to find a solution” (P1).

I've formed connections and I trust and I know our plan of where we're going and what we're trying to tackle and stuff like that.

(P5)

The experience of being held by the clinician was like an unspoken essence within the space where they were present, consistent and predictable in their support to the young person so that trust was established in order to make the young person feel comfortable.

Super-ordinate theme 3: Reflection for the individual

The completion of the questionnaires allowed the participants to reflect on their past, whether or not it entailed trauma experiences, and it provided them with an opportunity to consider how the therapeutic interventions through the headspace service could support them to review things from a different perspective.

3a. Exploration of trauma experiences

A number of participants acknowledged that their trauma experiences were inextricably tied up with the need for mental health support and subsequent referral to this service and therefore there was a level of expectation that these experiences would be explored.

Consensus on this rationale for focusing on trauma experiences came with an acknowledgement that “it can give you a better understanding” (P1) and “it's a way for you to revise your childhood and everything” (P7). The participants, as young people, showed a level of maturity and acceptance that experiences that had occurred in childhood could be impacting on them now and that, in order to process this and move on, completing these questionnaires was something “I've got to do it. So, let's just go do it. It's just something I've got to do” (P8).

Despite the reality that the questionnaires “did remind me of some negative things that happened” (P3) and that “I relate to the experience... in those questions” (P10) there was a clear commitment to the process as “this is just part of dealing with it I guess. Like still an after effect” (P4) and the philosophical acceptance of what had happened to them in the explanation that “like I get that it's technically it's a negative of nature, but I don't have like any angry thoughts or anything” (P5).

3b. Reflections on past experiences

I had to think back to all these different things that had happened in the past.

(P4)

Whilst some of these reflections obviously centred on trauma experiences other reflections were about their upbringing, both positive and negative, but also an acceptance through the use of the questionnaires that this did happen to them.

I was reminded of a new perspective for my experience.

(P2)

Where participants did not report traumatic experiences in childhood they still valued the completion of the questionnaires as “I sort of reflected a lot on my positive childhood and the upbringing that my parents had given me which you know happy thoughts and good memories” (P1). This allowed their perspective to shift around the current difficulties that had brought them into the service providing a deeper level of understanding and connection with themselves.

In relation to completing the screening, young people described their awareness and acceptance of what had occurred without any apparent blame, towards themselves or others, attached to it. This did not mean that they are not adversely affected by the trauma, but that they are able to be aware that it occurred, acknowledge it, and consider the support that is required and can be utilised to assist in processing these things.

I don't think about it in a bad way. I just think it happened.

(P5)

Super-ordinate theme 4: The ability to be able to provide honest responses

I want to be as honest as possible.

(P4)

Honesty was an important theme for participants in the study, with some reflecting surprise at their ability to be honest. Some of the young people were surprised that the way the information was provided, through questionnaire format, and the relationship they had built up with the clinician and the service allowed them to provide quite honest responses when there had been times in the past, when previous services had asked about traumatic experiences, when they were not able to do this.

There was some reflection that this may have been related to the fact that they had already built a relationship with the clinician so felt safe enough to be honest. Others were not able to articulate why they were able to be honest, only that they had not been in the past when asked, by mental health service providers, directly about their trauma experiences.

I felt it was ok to answer truthfully...because sometimes I don't.

(P5)

It is possible that this is related to the way the information was gathered, less direct, more specific questioning with tick box answers only. Whilst they were about the young person there was a level of anonymity being slightly removed from having to answer face to face verbal questioning and try to explain their experiences in depth.

I could be honest and not have to worry about the consequences.

(P8)

DISCUSSION

To the best of our knowledge, this is the first study to qualitatively explore young people's experiences of completing routine screening for trauma experiences and PTSD symptoms.

Results from this study indicated that young people expected to be asked about their trauma experiences, acknowledged that this was challenging for them but found that this was made easier due to the relationship they had built with the clinician, the timing of the screening and also, possibly, by the written style format of the questionnaires.

Whilst other studies have reported varied responses from trauma affected young people with a first-episode psychosis when they have been asked to talk in-depth about trauma, these studies have been in relation to therapeutic trauma interventions, rather than just screening. Experiences have included both reticence, (Tong et al., 2017) not wanting to talk about trauma at all (Tong et al., 2018) but also finding it beneficial, even if it was distressing (Tong et al., 2017). The process of screening for trauma using a questionnaire only did not elicit such responses, appearing to be less intrusive than having to discuss trauma in detail. In a further study to detect PTSD in patients with psychotic disorders, (de Bont et al., 2015) as part of a larger randomised clinical trial of treatments for PTSD and psychosis (de Bont et al., 2013) it was noted in the discussion that adverse experiences did not occur during screening, but this was antidotally reported by caregivers rather than being systematically assessed for by participants.

The young people interviewed in this study accepted the possibility that the trauma assessment process could cause them to become distressed but thought that ultimately it would assist them, through subsequent interventions, to improve their mental wellbeing. Therefore, it was deemed worthwhile going through the process. This finding adds nuance to quantitative findings that trauma screening is not found to be upsetting by most participants (Skar et al., 2019). The finding further supports qualitative studies of trauma affected young people accessing mental health services for PTSD and depression, and for PTSD and FEP, which found a clinical paradox in that the process of talking about trauma can be distressing but ultimately experienced as beneficial (Eastwood et al., 2021; Tong et al., 2017). Whilst this study was only concerned about the experiences in initial trauma screening, and in theory was not a therapeutic intervention, the participants described it as important and described benefitting from the process.

The support offered by the clinician appeared to be integral to the young person's agreement and commitment to attempting the completion of the questionnaires. These findings suggest that the clinician being alongside the young person as they completed the questionnaires provided containment, connection and an unspoken sense of non-judgemental understanding as to what the young person may have experienced in their lifetime. This experience of authentic care has been highlighted in other recent studies (Eastwood et al., 2021; Tong et al., 2018) as being integral to aiding the development of the therapeutic relationship, allowing the young person to feel ready to talk about trauma and to realise their own autonomy in recovery. This information further highlights the need for therapists to be attuned to the interpersonal needs of trauma-exposed young people (Eastwood et al., 2021) and supports consensus that the clinician to build a trusting relationship with the service user is central to trauma informed care in early psychosis services (Mitchell et al., 2021). The importance of engagement has been highlighted as a key component of early psychosis service delivery (Bendall et al., 2014). It creates a collaborative therapeutic alliance that allows young people to trust clinicians, a central component for therapy with trauma symptoms.

Consensus around the need to conduct routine clinical assessment of trauma experiences in mental health services continues to be strong (Maunder et al., 2019; Bendall et al., 2021; Duhig et al., 2015) with national and international guidelines emphasising the need to sensitively enquire about trauma in those with psychosis (Galletly et al., 2016; NHS, 2008; NICE, 2013). The use of a screening tool could be considered to be the first step which introduces the possibility of assessing and discussing trauma more in depth with young people when, or if, they are interested and feel safe to do so (Bendall et al., 2021). Little direction has been given as to when screening should occur with one suggestion that services should consider screening during the process of admitting a client to the service to ensure that the screening is completed (Sampson & Read, 2017). Our findings do suggest otherwise as young people valued the time taken to build the trusting relationship with their clinician. However, there is not enough currently information to state whether our results directly contrast to the Sampson and Read (2017) recommendation. The participants in the current study, having been screened approximately 4 weeks after engagement to the service, then expressed a preference for screening to occur at about that time. It is unclear how they would have experienced screening earlier in their engagement with service.

Our data does suggest that it is possible that, if young people are asked these questions before they feel comfortable enough to be vulnerable in the therapeutic relationship, they may not answer honestly, as there is a need for them to be able to trust the clinician with their sensitive information. Recent studies have corroborated the importance of the young person building a relationship and the service fostering a level of trust and engagement for them to feel comfortable in sharing this information (Hiratsuka et al., 2017; Kirst et al., 2017; van den Berk-Clark et al., 2021; Wang et al., 2018). Our findings further support the importance of the therapeutic relationship (Wilson et al., 2017; Tong et al., 2018) where the genuine collaboration to build the relationship between the young person and the clinician requires an active building of trust (Isobel, Wilson, Gill, & Howe, 2021; Toner et al., 2013).

There remains a need for a reliable, validated and safe screening tool that can be used for young people accessing early psychosis programs. As Finkelhor (2017) stated, much more sensitive and specific trauma screening tools could be developed through a more exhaustive and systematic review. He further noted that there are cautions that screening and assessment could be harmful if there are not appropriate resources and treatments available once the screening process has been completed (Finkelhor, 2017). Resources could include post screening support as routine practice to address elevated distress, alongside appropriate training to clinicians to be attuned to possibility of assessment related distress (Greene et al., 2020). From a wider perspective Raja et al. (2021) states that following any development, adaptation or refining of screening tools, there is a need to consider service users preferences and privacy concerns, assessing the resource limitations, as well as integrating public health advocacy into screening programs. Further, treatment approaches should be trauma-informed, which could include assessment, psychoeducation, and managing safety in early psychosis (Bendall et al., 2017). More research and training in how to assess and treat the effects of trauma sensitively and effectively is essential to the delivery of trauma informed services for psychosis (Bailey et al., 2018).

Guidelines promote screening and assessment for trauma exposure and subsequent symptomatic effects (NICE, 2013) However, for clinicians to feel comfortable, skilled and able to sensitively screen for trauma experiences the mental health organisations that they work within must invest in providing both supervision and training to clinicians. Whilst it would be beneficial for these organisations to develop and invest in trauma informed care principles to ensure that this framework of operating sensitively is embedded throughout the service, there is a need for more research around how this implementation process can best be achieved with a consistent and sustainable approach (Hanson & Lang, 2016; Sweeney et al., 2018; Mihelicova et al., 2017; Palfrey et al., 2018).

Strengths and limitations

The strength of the study is the heterogeneity of the participant group with regard to ethnicity and cultural makeup of the group, which are not always able to be captured in research settings. It provided valuable insight into vulnerable population groups who presented with diverse childhood trauma experiences.

It is acknowledged that this study presents a number of limitations. There was potential bias in the data collection as the young people who had agreed to be part of the study and were subsequently interviewed may have been those who were more likely to have had more positive experiences of completing the questionnaires. There is no record of the number of young people who were specifically asked to participate and who chose to decline and the researcher did not collect data pertaining to the total number of young people screened for trauma and PTSD during the study period, or how many young people were initially approached to take part in the qualitative study. During the interview, the participants were asked directly about the support they received in completing the questionnaires, which may have led them to talk about support that they would have thought of or revealed spontaneously. Furthermore, the researcher did not engage the participants to analyse any of the emerging themes and interpretation of their interview transcripts.

CONCLUSION

Young people in this study accepted the need for screening for traumatic histories, and expected to be asked about their traumatic experiences, despite the possibility of a short-term increase in distress. The support offered by a trusted clinician, whom the young person had built a relationship with, appeared to be an important component to the willingness and the ability of the young person to complete the questionnaires. This reinforces the fact that screening for trauma in an early psychosis service can be conducted in a way that is safe and acceptable to young people.

AUTHOR CONTRIBUTIONS

Tracey Dryden-Mead: Conceptualization; data curation; formal analysis; investigation; methodology; project administration; writing – original draft; writing – review and editing. **Barnaby Nelson:** Conceptualization; methodology; supervision; writing – review and editing. **Sarah Bendall:** Conceptualization; formal analysis; methodology; project administration; supervision; writing – review and editing.

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CONFLICTS OF INTEREST


There are no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

Raw data were generated at headspace Adelaide. The data that support the findings of this study are available on request from the corresponding author.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Appendix S1.

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