



School Mental Health Practice Brief

Screening Students for Trauma

PUBLISHED AUGUST 2024
<https://doi.org/10.17077/rep.006673>



Author:

Katie Eklund, PhD

Associate Professor in the School Psychology Program, University of Wisconsin-Madison

Schools and primary healthcare settings are beginning to incorporate screening for trauma exposure and symptoms into routine practice (Nadeem et al., 2020; Schapiro et al., 2018). Approximately two-thirds of all students report one or more adverse experiences during their school-aged years, and trauma can have a negative impact on student’s academic, cognitive, social, emotional, and behavioral functioning (Finkelhor et al., 2015; McLaughlin et al., 2013). Given schools are the primary location where youth receive mental health services, they are well-positioned to screen for a variety of health and wellness indicators, including trauma (Biliass-Lolis et al., 2017; Perfect et al., 2016). Research has pointed to the implementation of multi-tiered systems of support that integrate trauma-informed practices for children who have experienced trauma. Within this framework, many school districts have considered the use of universal screening to help identify students who have experienced trauma and to guide the delivery of tiered interventions and supports at school. Brief screening measures often include students self-reporting their own exposure to traumatic events and/or mental health symptoms (Eklund & Dowdy, 2014). However, screening for trauma exposure among children is relatively new, with very few studies demonstrating the utility of these practices within schools (Eklund et al., 2018). As a result, schools are encouraged to consider universal screening practices that can identify all students in need of mental health support, including students with trauma exposure.

Prevention and Identification Strategies

Schools play an important role in providing a safe and inclusive environment, whereby children who have experienced trauma can form positive relationships with school staff and their peers. Trauma-informed practices have emerged within schools to help educators not only understand the impact of trauma on children's development and learning, but also to increase support for school staff, improve responses to children who have experienced trauma, and to reduce student academic and behavioral concerns (e.g., Alisic et al., 2012; Mendelson et al., 2015). Multi-tiered, trauma-informed programs in schools have been found to reduce secondary trauma for teachers and to improve students' emotion regulation, social competence, and academic behavior (e.g., Berger et al., 2016; Jaycox et al., 2009; Mendelson et al., 2015). Within this framework, screening for trauma and related symptoms would serve as a universal practice to assess potential barriers to learning for all students.

Universal screening for various physical, academic, and mental health concerns has become increasingly popular in U.S. public schools since the 1960s. Screening for vision, hearing, and academic concerns is now customary in early childhood and elementary school settings. In recent years, this practice has expanded to include screening students for various behavioral and mental health concerns given their correlation with academic performance (Eklund & Dowdy, 2014; Koslouski et al., 2024). Research highlights the importance of early detection and intervention for mental health concerns, as about half of all mental health disorders emerge before the age of 15 (Kessler et al., 2005). Additionally, there is an increased risk of mental health concerns for children exposed to traumatic events.



Exposure to traumatic events can lead to the development of depression, anxiety, and other disruptive behavior concerns (Kennedy et al., 2009; Turner et al., 2010; Zinzow et al., 2009). Additionally, children who have been exposed to trauma have lower grades, academic achievement, and school attendance (Perfect et al., 2016). Taken together, childhood trauma and adversity have emerged as one of the most critical public health concerns for youth (Blaustein, 2013), making this both relevant and necessary for schools to address.

Implementing early screening and identification for childhood trauma is seemingly intuitive as elevated trauma symptoms are predictive of negative short- and long-term academic and health outcomes (Alisic et al., 2011). Schools can develop systematic processes and utilize screening measures to identify the extent and severity of student concerns as well as individuals' resilience and ability to cope after traumatic experiences. These results can help mental health professionals and school professionals adequately respond by considering how to connect students with schoolwide, targeted, and individualized services. However, screening for student exposure to traumatic events and trauma symptomatology can raise several challenges.

Increasing the Feasibility and Utility of Screening

A variety of methods have been used to improve the feasibility and utility of screening within schools. This includes considering (a) the use of developmentally appropriate methods for assessing youth (e.g., rating scales, interviews), (b) appropriate consent procedures, and (c) who might serve as the best informant of assessing traumatic exposure and symptoms among youth (e.g., self-report, caregivers).

Developmentally Appropriate Screening Methods

Most universal screening measures that assess trauma risk use brief rating scales or individual student interviews (Eklund et al., 2018; Gonzalez et al., 2016). As students are often most aware of their own mental health functioning, they can be key informants in providing helpful information about their trauma experiences or symptoms. Given that student reading levels can vary, it is important to ensure students adequately comprehend survey items and/or interview questions. Adults can also read questions aloud to students, when needed. It is important that students understand what is being asked of them to gather accurate information on the nature and severity of student's traumatic risk.



Consent Procedures

Consent procedures for screening can impact who is identified and ultimately receives mental health services at school. In previous studies of universal screening for trauma or adverse experiences, less than half of students' caregivers gave consent to participate when using active parental consent procedures that ask parents to sign permission to have their child participate in universal screening (Gonzalez et al., 2016; Woodbridge et al., 2016). Requiring active parental consent for students to participate in universal screening can result in sample selection biases, including disproportionate identification and referral of students impacted by economic factors and racial-ethnic minority status (Esbensen et al., 2008; Huang et al., 2007). A passive consent procedure where families are informed of universal screening procedures and can opt out when desired could assist in identifying more youth with mental health needs. This would include a process where caregivers are fully informed about the rationale for screening, the types of questions that will be asked, and how results will be used to connect students with supports at school. School mental health professionals are encouraged to refer to state and local policies regarding consent procedures prior to engaging in screening.

Teacher, Parent, and Student Self-Report Data

Educators often refer students for services, such as individual and small group supports that are provided by school mental health professionals. However, sole reliance on staff referral for trauma intervention groups or mental health supports can be problematic for several reasons. First, students who could benefit from services are often not referred by educators. School staff tend to report lower rates of child anxiety-related problems than do the youth themselves (Jaycox et al., 2010). Second, many teachers report a lack of knowledge of trauma-related symptoms and reactions among students and may be unaware of students' adverse experiences outside of school (Baweja et al., 2016). Student self-report data through interviews or rating scales can help address some of these limitations.



When administering trauma screening measures, caregivers and schools may object to screeners that ask questions about potential exposure to abuse or violence in the home and the mandatory reporting procedures that could ensue (Jaycox et al., 2010; Reinbergs & Fefer, 2018). Second, there are limited tools that have been validated for use within schools (Eklund et al., 2018) and there are multiple unanswered questions about the efficacy and ethics of universal screening for adverse childhood experiences (Finkelhor, 2017). As a result, schools may wish to administer measures that move away from solely focusing on student's exposure to traumatic events and instead consider the broad experience of students' current social, emotional, and behavioral functioning.



Universal screening using measures that assesses student's social, emotional, and behavioral functioning may be helpful for identifying all students in need of behavioral support, including those experiencing challenges due to trauma. Using broad universal screening measures that assess social, emotional, and behavioral risk may offer (a) information about a wide range of behavioral concerns that could be considered for all students and (b) increased acceptability and usability in schools among parents and teachers. In this manner, broad universal screening measures offer an opportunity for schools to detect concerns among all students, including students who may have experienced trauma.

Trauma Screening Measures

Several brief trauma risk screening measures have been developed and initial research has explored their utility in school settings. Initial data are available that support their psychometric properties; however, additional information is needed to examine their utility in schools (Eklund & Rosen, 2016; Finkelhor, 2017). Given these limitations, school mental health professionals are encouraged to also consider the use of universal screening measures that broadly assess student's social emotional and behavioral (SEB) functioning. Table 1 provides an overview of a few trauma screening measures, as well as SEB measures. This includes the name of the instrument, the construct(s) assessed, length, informant, age range of the individual being assessed, and evidence available to support their reliability and validity. Additional trauma measures can be found by visiting the National Child Traumatic Stress Network and universal screening guidance is available at <https://smhcollaborative.org/wp-content/uploads/2019/11/universalscreening.pdf>.

Key Implications for Practice



There is a need for more well-validated and normed measures that screen for trauma exposure and symptomatology, especially for use in schools.



When screening in a trauma-informed school, it is important to have processes that identify students who have externalizing (e.g., aggression, disruptions) and internalizing (e.g., withdrawal, sadness, anxiety) behavior problems, given that both are associated with trauma.



Universal screening can be helpful for identifying all students in need of mental health support, including students who experience challenges due to trauma.



Universal screening can promote inclusivity and reduce false negatives, or miss the identification of students who would benefit from trauma intervention groups.



Within any type of screening process, ensure that youth, caregivers, and educators are aware of the purpose of screening and how results will be used.



Training and support should be provided to school mental health professionals and educators on how to discuss universal screening processes and results with youth and caregivers. Training and ongoing consultation should address adaptations that could be made to the process for students from diverse linguistic and cultural backgrounds.



Implementation of trauma-focused screening, assessment, and interventions should take into consideration the reality of staff turnover and challenges with implementing schoolwide screening. Training should be provided regularly to keep new staff up to speed and to allow seasoned providers to share their practice-based insights (Nadeem et al., 2020).



Related Resources

- Eklund, K., & Rossen, E. (2016). *Guidance for trauma screening in schools*. National Center for Mental Health and Juvenile Justice. <https://www.prainc.com/wp-content/uploads/2022/03/Guidance-for-Trauma-Screening-in-Schools-109408.pdf>
- National Child Traumatic Stress Network. *Trauma screening*. <https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening>
- National Child Traumatic Stress Network. *Children's Experiences of Trauma Measure Review*. <https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews/all-measure-reviews>
- Substance Abuse and Mental Health Services Administration. *Understanding child trauma*. <https://www.samhsa.gov/child-trauma/understanding-child-trauma>

References

- Alisic, E., Bus, M., Dulack, W., Pennings, L., & Splinter, J. (2012). Teachers' experiences supporting children after traumatic exposure. *Journal of Traumatic Stress*, 25, 98- 101.
- Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *British Journal of Psychiatry*, 204, 335-340.
- Anda, R. F., Butchart, A., Felitti, V. J., & Brown, D. W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine*, 39(1), 93-98.
- Berger, R., Abu-Raiya, H., & Benatov, J. (2016). Reducing primary and secondary traumatic stress symptoms among educators by training them to deliver a resiliency program (ERASE-Stress) following the Christchurch earthquake in New Zealand. *The American Journal of Orthopsychiatry*, 86(2), 236-251.
- Berger, E. (2019). Multi-tiered approaches to trauma-informed care in schools: A systematic review. *School Mental Health*, 11(4), 650-664.
- Biliass-Lolis, E., Gelber, N. W., Rispoli, K. M., Bray, M. A., & Maykel, C. (2017). On promoting understanding and equity through compassionate educational practice: Toward a new inclusion. *Psychology in the Schools*, 54(10), 1229-1237.
- Blaustein, M. E. (2013). Childhood trauma and a framework for intervention. In E. Rossen and R. Hull (Eds.), *Supporting and educating traumatized students: A guide for school-based professionals* (pp. 1-21). Oxford University Press.
- Dever, B. V., & Gaier, K. (2021). Psychometric properties of the behavior assessment system for children-3 behavioral and emotional screening system student-report form among a predominantly Latinx elementary school sample. *Journal of Psychoeducational Assessment*, 39(1), 128-133.
- Eklund K., & Dowdy, E. (2014). Screening for behavioral and emotional risk versus traditional school identification methods. *School Mental Health*, 6, 40-49.
- Eklund, K., & Rossen, E. (2016). *Guidance for trauma screening in schools*. National Center for Mental Health and Juvenile Justice. <https://www.praire.com/wp-content/uploads/2022/03/Guidance-for-Trauma-Screening-in-Schools-109408.pdf>
- Eklund, K., Rossen, E., Koriakin, T., Chafouleas, S., & Resnick, C. (2018). A systematic review of trauma screening measures for children and adolescents. *School Psychology Quarterly, Special Issue on Trauma*, 33, 30-43. <https://doi.org/10.1037/spp0000244>
- Esbensen, F. A., Melde, C., Taylor, T. J., & Peterson, D. (2008). Active parental consent in school-based research: How much is enough and how do we get it? *Evaluation Review*, 32, 335-362.
- Finkelhor, D. (2017). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect*, 85, 174-179.
- Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse. *JAMA Pediatrics*, 168, 540-546.
- Furlong, M. J., Dowdy, E., Nylund-Gibson, K., Wagle, R., Carter, D., & Hinton, T. (2021). Enhancement and standardization of a universal social-emotional health measure for student's psychological strengths. *Journal of Well-being Assessment*, 4(3), 245-267.
- Furlong, M. J., Nylund-Gibson, K., Dowdy, E., Wagle, R., Hinton, T., & Carter, D. (2020). *Modification and standardization of Social Emotional Health Survey-Secondary— 2020 edition*. University of California Santa Barbara, International Center for School Based Youth Development.
- Gonzalez, A., Monzon, N., Solis, D., Jaycox, L., & Langley, A. K. (2016). Trauma exposure in elementary school children: Description of screening procedures, level of exposure, and posttraumatic stress symptoms. *School Mental Health*, 8, 77-88.
- Grassetti, S. N., Williamson, A. A., Herres, J., Kobak, R., Layne, C. M., Kaplow, J. B., & Pynoos, R. S. (2018). Evaluating referral, screening, and assessment procedures for middle school trauma/grief-focused treatment groups. *School Psychology Quarterly*, 33(1), 10-20.
- Huang, N., Shih, S. F., Chang, H. Y., & Chou, Y. J. (2007). Record linkage research and informed consent: Who consents? *BMC Health Services Research*, 7, 18.
- Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., Scott, M., & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*, 23(2), 223-231.
- Kamphaus R. W., Reynolds C. R. (2015). *Behavior assessment system for children—Third Edition (BASC-3): Behavioral and emotional screening system (BESS)*. Pearson.
- Kennedy, A. C., Bybee, D., Sullivan, C. M., & Greeson, M. (2009). The effects of community and family violence exposure on anxiety trajectories during middle childhood: the role of family social support as a moderator. *Journal of Clinical Child and Adolescent Psychology*, 38(3), 365-379.
- Kessler, R., Chiu, W., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, 62(6), 617-627.
- Kilgus, S. P., Eklund, K., von der Embse, N. P., Taylor, C. N., & Sims, W. A. (2016a). Psychometric defensibility of the Social, Academic, and Emotional Behavior Risk Screener (SAEBRS) teacher rating scale and multiple gating procedure within elementary and middle school samples. *Journal of School Psychology*, 58, 21-39.
- Kilgus, S. P., Sims, W., von der Embse, N. P., 7 Taylor, C. (2016b). Technical adequacy of the Social, Academic, and Emotional Behavior Risk Screener in an elementary sample. *Assessment for Effective Intervention*, 42(1), 46-59.
- Kilgus, S. P., & von der Embse, N. P. (2014). *Social, Academic, and Emotional Behavior Risk Screener (SAEBRS)*. FastBridge.
- Koslouski, J. B., Chafouleas, S. M., Briesch, A. M., Caemmerer, J. M., Perry, H. Y., Oas, J., Siong, S. S., & Charamut, N. R. (2024). School-based screening of social determinants of health: A scoping review. *School Mental Health*, 16(1), 1-14.
- McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Traumatic event exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 780-783.
- Mendelson, T., Tandon, S. D., O'Brennan, L., Leaf, P. J., & Jalongo, N. S. (2015). Brief report: moving prevention into schools: The impact of a trauma-informed school-based intervention. *Journal of Adolescence*, 43, 142-147.
- Nadeem, E., Floyd-Rodríguez, V., De La Torre, G., & Greswold, W. (2021). Trauma in schools: An examination of trauma screening and linkage to behavioral health care in school-based health centers. *Journal of School Health*, 91(5), 428-436.
- Perfect, M. M., Turley, M. R., Carlson, J. S., Yohanna, J., & Pfenninger Saint, G. M. (2016). School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. *School Mental Health*, 8(1), 7-43.
- Reinbergs, E. J., & Fefer, S. A. (2018). Addressing trauma in schools: Multitiered service delivery options for practitioners. *Psychology in the Schools*, 55(3), 250-263.
- Schapiro, N. A., Soleimanpour, S., & Brindis, C. D. (2018). Reaching out to youth about trauma: Adolescent rapid screening validation pilot. *Journal of Adolescent Health*, 62(2), S14-S11-S19.
- Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). The effects of adolescent victimization on self-concept and depressive symptoms. *Child Maltreatment*, 15(1), 76-90.
- Zinzow, H. M., Ruggiero, K. J., Resnick, H., Hanson, R., Smith, D., Saunders, B., & Kilpatrick, D. (2009). Prevalence and mental health correlates of witnessed parental and community violence in a national sample of adolescents. *Journal of Child Psychology and Psychiatry*, 50(4), 441-450.

Photo credits: Canva

Table 1.

Sample of Trauma Screening Measures and Universal Screening SEB Measures for Use with Children and Youth

Trauma Screening Instrument	Construct(s) addressed	Length, informants, age range	Reliability and validity
Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)	Assesses childhood emotional, physical, & sexual abuse; and emotional & physical neglect	28 items, Child self-report, Ages 12 and up	IC = .81-.95; TRT = .79-.86; VC = .50-.75 (Bernstein & Fink, 1998; Bernstein et al., 2003; Bernstein et al., 1997)
Traumatic Events Screening Inventory for Children – Brief Form (TESI-C-Brief; Davis et al., 2000; Ford et al., 2002)	Assesses exposure to direct or witnessed trauma	21 items, Structured child interview, Ages 6-18	IC = .80; IR =.73-1.00 (Ford et al., 2008; Ribbe, 1996)
Trauma Symptom Checklist-Child Version-Posttraumatic Stress Subscale (TSCC-PTS; Briere, 1996)	Assesses general traumatic stress symptoms	10 item subscale of larger 54-item measure, Child self-report, Ages 8-16	IC = .81-.93 (Briere, 1996; Breire et al., 2001)
UCLA Post-traumatic Stress Disorder Reaction index (RI; Pynoos, Rodriguez, Steinberg, Struber, & Fredrick, 1998)	Assesses child report of post-traumatic stress symptoms during the previous month & frequency of DMV-IV PTSD symptoms	48 items, Child self-report or structured interview, Ages 7-18	IC =.90; TRT = .84; VC = .70-.93 (Roussos et al., 2005; Steinberg, Brymer, Decker, & Pynoos, 2004)
Universal Screening Instruments for SEB concerns	Construct(s) addressed	Length, informants, age range	Reliability and validity
BASC-3 Behavioral and Emotional Screening System (BESS; Kamphaus & Reynolds, 2015)	Behavioral and emotional risk, Internalizing risk, Externalizing risk, Adaptive skills	25-30 items; Teacher, parent, and student self-report; Ages 3 – 18	IC = .76-90; TRT = .55-.89; VC = .43-.95 (Kamphaus & Reynolds, 2015; Dever & Gaier, 2021)
Social, Academic, and Emotional Behavior Risk Screener (SAEBRS; Kilgus & von der Embse, 2014)	Total behavior, Social behavior (externalizing, peer relations); Academic behavior (enablers, instruction); Emotional behavior (internalizing, emotional competencies)	19 items, Teacher and self-report, Grades K-12	IC = .79-.94; VC = .72-.94 (Kilgus et al., 2016a; Kilgus et al., 2016b)
Social, Emotional Health Survey-Secondary (SEHS-S; Furlong et al., 2020)	Covitality (positive mental health); Belief in self; Belief in others; Emotional competence; Engaged living	36 items, Student self-report, Grades 7-12	IC = .87-.94; TRT = .59-.68 (Furlong et al., 2021)

Note. IC = Internal Consistency Reliability, SEB = Social Emotional and Behavioral, TRT = Test-Retest Reliability, VC = Validity Coefficient.