Should we be screening for trauma in schools?

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What is "screening" in schools?

- A process of **data collection** often used by education systems to identify students (and numbers, proportions of students) living with diagnosed disabilities.
- Helps with the **allocation of resources, funding, services, and supports** to education sites.
- Helps to guide **recommended adjustments** to the delivery of education services to individual learners.
- Depending on the education system, these screening processes may adopt differing definitions of disability and "types" of disability and some "types" of disability might be **included or excluded**.
- Some systems refer to **"emotional/behavioural disorders" or "mental health disorders"** under which trauma-impacted students may be "screened".
- Some don't have such categories and trauma-impacted students are not "screened" at all.

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Screening for complex trauma

Due to the growing recognition of the prevalence and impact of childhood trauma, there is increasing screening for trauma **in public health systems**, so that trauma-impacted children and young people are identified and have access to help.

There is growing international discussion and debate regarding whether there should be universal screening for trauma **in schools**, so that trauma-impacted children and young people have access to supports and resources needed to improve their access to and experience of their education.

Dr Nadine Burke Harris
See her "Ted Talks"!

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On the surface, screening sounds good! But should we, or shouldn't we?

- There are important reasons why screening might be helpful to education sites and to trauma-impacted learners.
- However, there are also serious cautions and perhaps these need to be considered before a systemic approach to screening, data collection, and resource distribution is adopted on a large scale.
- It is worth considering **pros and cons** as education systems consider whether to implement universal screening.

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We “screen” some students via medical or psychological diagnosis.

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But, with trauma, there are some issues regarding (mis)diagnosis

Symptoms of complex trauma include patterns of other conditions – which can lead to (what some believe to be) misdiagnosis.

- Some present with **“autistic–like” features** and can be diagnosed with **Autism Spectrum Disorder.**
- Some are constantly **aroused and hypervigilant** due to adverse events or conditions and many be diagnosed with **Attention Deficit/Hyperactivity Disorder.**
- Due to the impact on pre-frontal cortical development and functioning, some may be diagnosed with **Intellectual Impairment**
- Some who are **unresponsive, avoidant, withdrawn** may be diagnosed with **Depression**.
- Some who exhibit **acting out or non-provoked aggressive behaviours** may be diagnosed with **Oppositional Defiant Disorder**.
- Some might be rightly or wrongly diagnosed with **Post Traumatic Stress Disorder (PTSD).**

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Issues with (mis)diagnosis, con'd

The risk is both undertreatment and overtreatment of trauma-impacts.

- **Undertreatment** (e.g. trauma-impacted kids miss out on the important work involving provision of safety, relationships, emotional regulation)
- **Overtreatment** (e.g. overreliance on pharmaceutical treatments)

Concerning when we treating trauma-impacts as "hopeless" or "unfixable" and we don't provide opportunities for resolving the impacts.

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Diagnostic and Statistical Manual of Mental Disorders (DSM)

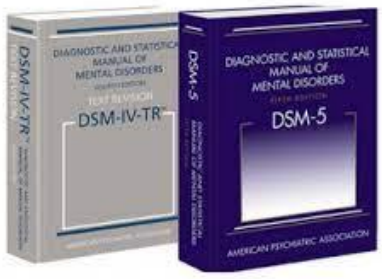
Handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.

Contains descriptions, symptoms, and other criteria for diagnosing mental disorders.

Originally published 1952

DSM-5

- 2000 - Work groups formed to create a research agenda, generated hundreds of white papers, monographs, and journal articles, providing the field with a summary of the state of the science relevant to psychiatric diagnosis.
- 2007 - Task Force began revising the manual as well as 13 work groups focusing on various disorder areas.
- 2013/4 – Published, released.



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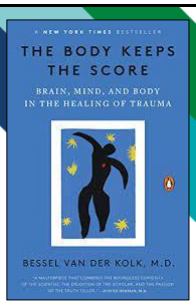
Bessel Van Der Kolk



When the revisions began for the new DSM V, van der Kolk and colleagues sought to include ***Developmental Trauma Disorder*** as a new diagnostic category.

Organised a task force to conduct and collect research that could help make their case.

Presented data from over 130 clinical research studies.

Wanted to encapsulate diagnoses such as bipolar disorder, ADHD, PTSD, conduct disorder, phobic anxiety, reactive attachment disorder and separation anxiety.

Dr. van der Kolk, who led this effort, estimated that as many as 8 million children in the U.S. had been diagnosed with Bipolar Disorder and/or ADHD and prescribed large doses of medication. **He believed, however, that the cause of these problems was often disrupted attachment and untreated emotional abuse and/or neglect.**

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Dr Bessel Van Der Kolk, M.D. (2015): Psychiatry must stop ignoring trauma! https://youtu.be/HR22lvBo1rQ

4 minutes

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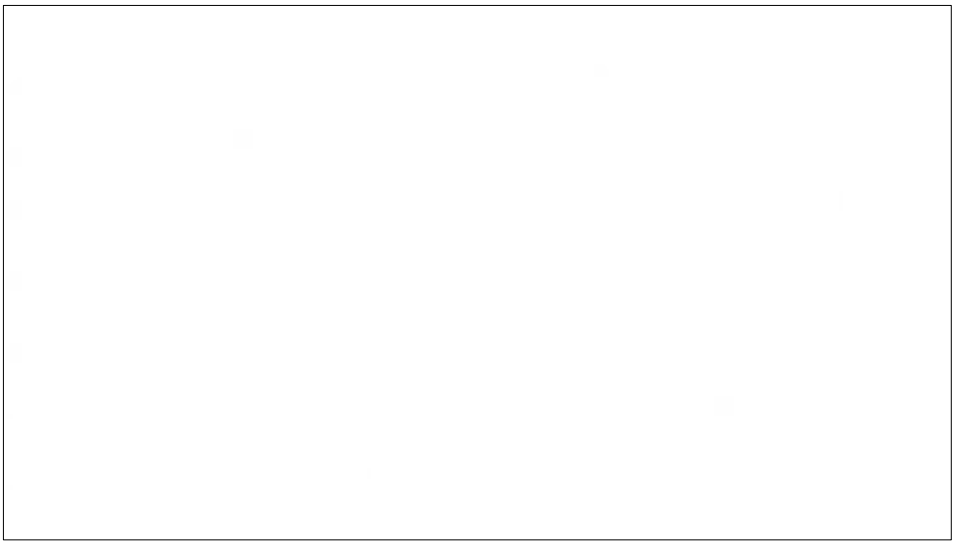
Dr Bessel Van Der Kolk, M.D. (2015): Psychiatry must stop ignoring trauma! https://youtu.be/HR22lvBo1rQ



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The "Politics"??

After much discussion and controversy, the DSM Committee rejected the proposal.

- Consensus was that DTD could not be included in the DSM V in its present form because of the **current lack of evidence in support of the diagnosis**. Saw it more as clinical intuition rather than a research-based fact.
- DSM subgroup stated that the range of symptoms covered in the proposed criteria was too broad and could supersede not only PTSD, it many internalizing and externalizing disorders that appeared following interpersonal trauma.
- This could require rethinking many diagnoses used in research and clinical practice and potentially even replacing many diagnoses.
- Would require huge changes in the way that mental health professionals are trained, paid, supervised and licensed. Textbooks would have to be re-written, insurance coverages would have to be updated, mental health practitioners already in the field would have to change the way that they practice, and require additional training.

Van der Kolk believes it will take a massive public crusade against child maltreatment to alter the political realities that are blocking change.

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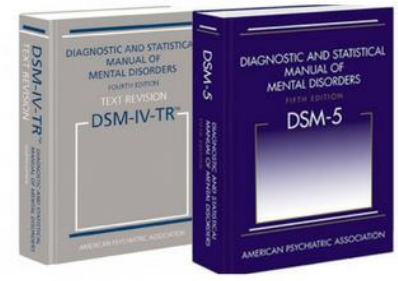
One change made: DSM-5 Criteria Reactive Attachment Disorder

Previous versions of this manual referred to two types of RAD

- One with externalising behaviours
- One with internalising behaviours.

The newest manual classifies **RAD** as a stressor-related disorder which can only be caused by social neglect during childhood (meaning a lack of adequate caregiving) with **internalising, withdrawn behaviours and depressive symptoms**.

Disinhibited Social Engagement Disorder presents with **externalising behaviour and a lack of inhibition**, and is also recognized as an emotional disorder that begins during childhood.



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Why it might be a good idea to screen!

- As more about the impacts of complex trauma are known and understood, it is timely to consider **systemic funding and support** to address this area of need that has **previously gone unnoticed, or under-noticed**.
- Could lead to **enhanced education and well-being outcomes** for trauma-impacted students – via **early identification and intervention**.

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However, this can present education sites and systems with ethical, logistical, and budgetary challenges.

It is worth considering pros and cons!

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How can we screen?

Which students are receiving child protection services?

- **Pros** - data are mostly easily available
- **Cons** - there are additional (and sometimes many more) students who are not associated with child protection services.

Use the Adverse Childhood Experience (ACE) list of 10 items of adversity

- **Pros** - quick and helpful to screen for trauma-impacted individuals (Felitti et al., 1998).
- **Cons** - concerns with reducing screening to just this measurement.
  - A summary of ACEs does not account for the positive events in a child's life that can counteract the impact of adversity.
  - Just measuring the number of ACEs does not adequately capture the chronicity and severity of each adverse experience, but rather just gives each an equal weighting, which can misrepresent just how much these experiences can impact on individuals.

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How can we screen?

Refer to doctors and psychologists for formal diagnostic procedures?

- What diagnosis, misdiagnosis, labelling, etc.

Use available trauma screening tools (checklists, rating scales, or individual interviews) that inquire into the adverse life experiences of students and/or or the impacts of these experiences on their current lives and functioning.

- **Pros** – there are a number available that are psychometrically valid in non-school contexts.
- **Cons**
  - Limited research on the efficacy of using trauma screening tools in schools or best practice for screening.
  - Without careful choice of tools & expertise in using tools - could lead to inadequate or inaccurate assessment.
  - Some education sites may opt to not ask the questions to which they are not prepared to know the answers. One example of this was identified in a study by Gonzalez et al. (2016) when school administrators omitted questions regarding child sexual abuse.

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Who do we screen?

Those who are "visible"?

- presenting with challenging behaviour?
- exhibiting more obvious mental health impacts?

What about those who are "invisible"?

- The quiet ones, who experience hypoarousal, may experience dissociation, but are not being noticed?

Who is screened?

Who is not screened?

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Real concerns with universal screening

- Participation in universal screening processes could prove to be:
  - confusing and disturbing to **non-traumatised learners**
  - potentially **re-traumatising and stigmatising** to those who have lived through adverse childhood experiences.
- This impact could be exacerbated if data collection measures are delivered by **untrained and trauma-unaware** adults.
- If not managed with great sensitivity and if not embedded in solid confidentiality processes, quite **private information** about the life experiences of learners could become known to other learners and adults in the education community.

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Also, what about consent?

Due to the sensitive nature of inquiring into trauma histories and experiences, initial caregiver consent for participation in screening is vital, but also presents with challenges.

- Dependant on policy and site procedures, can use either **active or passive consent** processes.
  - **Active consent** requires permission from the caregiver for their child to "opt in" to the screening process.
  - **Passive consent** suggests that consent is implied unless a caregiver actively "opts out" of the screening process.
- Passive consent is far less likely as it would contravene many commonly held assumptions about caregiver consent when working with minors.

In some studies examining universal screening for trauma in schools, less than half of caregivers gave active consent for their child to participate in screening.

- Caregivers can be less likely to (or may refuse to) issue consent if they are knowingly the source of harm to their child or children.
- Knowledge that universal screening will be occurring at their child's school, could place students from harmful homes at greater risk as caregiver anxieties are triggered in response.
- Or could lead to caregivers providing false information or their insisting that their children do the same.
- Or could remove their child or children from the school.

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Time and cost?

Well implemented, accurate, and successful universal screening is likely to **take much time**, to be **logistically challenging to implement and govern**, and to **be expensive (resources, training, staffing)**.

This process must consider not just the screening, but also the planning required for **how to address the results** of the screening.

Due to known **prevalence data** (and our growing understanding that this is a significant underestimate of actual cases), there is a strong argument that we already know trauma-impacted learners will be enrolled at most education sites.

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This begs the question:

Why implement a time and cost-heavy process of screening, when funds and human resources could be used (instead) to embed trauma-aware frameworks of practice in all education sites?

- This could benefit all learners and all educators and could reduce or remove altogether the potential for learners becoming retraumatised and stigmatised through screening processes.
- After all, screening just identifies, it does not remediate.
- It might just be more cost and time effective to use resources to support sites with quality staff training and support.

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Activity - Poll

https://www.menti.com/wczr4jeiq6

1. Chat in groups
   - **Should education sites and systems across Australia be embracing universal screening for trauma?**

2. Go to www.menti.com (on your phone or device).
   - Enter the code **85778235**
   - Vote **"Yes", "No"** or **"Still just not sure".**

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Results – 120 participants

Should education sites and systems across Australia be embracing universal screening for trauma?

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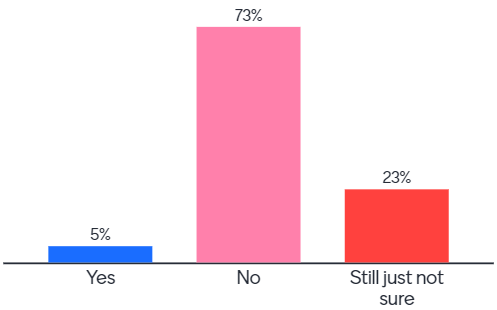

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References

Afifi., T.O. (2018). Continuing conversations: Debates about adverse childhood experiences (ACEs) screening. *Child Abuse & Neglect, 85*, 172–173. https://doi.org/10.1016/j.chiabu.2018.06.012

Blodgett, C. (2012). *Adopting ACEs screening and assessment in child serving systems.* Working Paper. WSU Area Health Education Center.

Bruhn, A. L., Woods-Groves, S., & Huddle, S. (2014). A preliminary investigation of emotional and behavioral screening practices in K-12 schools. *Education and Treatment of Children, 37*, 12 611-634.

Chafouleas, S. M., Kilgus, S. P., & Wallach, N. (2010). Ethical dilemmas in school-based behavioral screening. *Assessment for Effective Intervention, 35*, 245–252.

Dube. S. R. (2018). Continuing conversations about adverse childhood experiences (ACEs) screening: A public health perspective. *Child Abuse & Neglect, 85*, 180–184. https://doi.org/10.1016/j.chiabu.2018.03.007

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: *A product of the defending childhood state policy initiative.* The National Center for Mental Health and Juvenile Justice.

Eklund, K. R., Rossen, E., Koriakin, T., Chafouleas, S. M., & Resnick, C. (2018). A systematic review of trauma screening measures for children and adolescents. *School Psychology Quarterly*, *33*(1), 30-43. https://doi.org/10.1037/spq0000244

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 stress symptoms. *School Mental Health, 8*, 77-88.

McLennan, J. D., McTavish, J. R. & Harriet L. MacMillan, H. L. (2020) Routine screening of ACEs: Should we or shouldn't we?. In Asmundson, G. J. G., & Afifi, T. O. (Ed.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 145-159). Academic Press

Raja, Rabinowitz, E. P., & Gray, M. J. (2021). Universal screening and trauma informed care: Current concerns and future directions. Families Systems & Health, 39(3), 526–534. https://doi.org/10.1037/fsh0000585

Turner, H. A., Finkelhor, D., Mitchell, K. J., Jones, L. M., & Henly, M. (2020). Strengthening the predictive power of screening for adverse childhood experiences (ACEs) in younger and older children. *Child Abuse & Neglect, 107,* 104522–. https://doi.org/10.1016/j.chiabu.2020.104522

van den Heuvel, L. L. & Seedat, S. (2013). Screening and diagnostic considerations in childhood post-traumatic stress disorder. *Neuropsychiatry, 3*(5), 497–511. https://doi.org/10.2217/npy.13.61

Woodbridge, M. W., Sumi, W. C., Thornton, S. P., Fabrikant, N., Rouspil, K. M., Langley, A. K., & Kataoka, S. H. (2015). Screening for trauma in early adolescence: Findings from a diverse school district. *School Mental Health, 8*(1), 89–105. https://doi.org/10.1007/s12310-015-9169-5

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