Information about the Child Trauma Screen (CTS)

Background
The Child Trauma Screen (CTS), originally called the Connecticut Trauma Screen, was developed as a very brief, empirically-derived screen for child traumatic stress that can be administered by trained clinical and non-clinical staff, including intake staff, child welfare workers, juvenile probation officers, clinicians, medical providers, and school personnel. It can be administered as an interview in person or on the phone, or completed as a self-report form.

The goals of the CTS are to

1) Identify children who are likely to be suffering from trauma exposure, and who would benefit from more comprehensive trauma-focused assessment by a trained clinician
2) Function as an engagement tool to allow professionals working with children to briefly discuss the child's exposure to trauma and trauma-related reactions and to support the child/caregiver

The CTS is not a comprehensive screening tool or a clinical assessment, and does not screen for all types of trauma exposure or all symptoms of Post Traumatic Stress Disorder (PTSD) or other traumatic stress reactions. It is not intended to promote lengthy discussions or detail about a child's trauma exposure or reactions.

Training
Those administering a trauma screen should have basic training in child traumatic stress, how to use a trauma screen to engage children/caregivers, and how to manage responses and disclosures of trauma.

Age
The CTS is intended for children age 6-17 years old. A young child version for age 3-6 is under development.

Administration
The CTS can be administered as a self-report form or as an in-person interview. Generally, in-person interview is recommended as it provides an opportunity to engage the child/caregiver directly, to observe non-verbal responses, to provide a supportive response to disclosures, and to provide some information about trauma. When an in-person administration is not possible, it is important that the results of the CTS are reviewed with the child/caregiver immediately after being completed.

Prior to asking the questions or asking a child/caregiver to complete the CTS, explain the purpose of trauma screening to the child and caregiver(s) as appropriate. You may use some version of this, modifying as you see fit:

"Unfortunately, children may experience upsetting events that can make it difficult for them to be happy and healthy. We know that children who experience very upsetting or scary things sometimes have strong physical and/or emotional reactions to them, and these reactions may cause changes to how children think, act, and feel at home and school. I'd like to ask you and your child some questions about things that he/she has experienced and about some common reactions that children can have. I'd like to speak to you first about your child, and then would like to speak with him/her for a few minutes alone. Is that okay? Do you have any questions?"

The caregiver report is administered with caregivers of children age 6 and older. The child report version is also administered directly with children age 7 and older. A young child version administered to caregivers of children age 3-6 is under development. It is recommended to administer both a caregiver and child report for children age 7 and older when possible, as there is relatively poor concordance between child and caregiver reports of a child's trauma exposure and reactions. It is also acceptable to complete the CTS with multiple caregivers of the same child separately in order to provide additional information.

Scoring
The Event items (#1-4) may be summed to indicate the number of different types of potentially traumatic events a child has experienced (Event Total). The Reaction items (#5-10) are summed to provide a Reactions Total score ranging from 0 to 18.

Interpretation/Cutoff Scores
Initial analysis of validation data for the CTS in a published study was completed with a sample of 74 children seen at an outpatient behavioral health clinic. This analysis suggests that the optimal cut scores for Reactions Total on the CTS are 6 or greater on the child report or 8 or greater on the caregiver report, which indicate a high likelihood that the child may be suffering from clinically significant levels of PTSD symptoms. In these cases, a clinical trauma assessment by a clinician trained in evidence-based trauma-focused treatment should be considered, including using more comprehensive standardized assessments of PTSD and traumatic stress symptoms.

These optimal cut scores are developed based on optimizing and equally balancing the sensitivity (accurately predicting children who DO have high PTSD symptoms) and specificity (accurately weeding out children who DO NOT have high PTSD symptoms). Ultimately, selection of a cut point depends on the setting and purpose of the tool, as well as determinations about how to best balance sensitivity and sensitivity in the setting where it is used.

Structure
The CTS has 4 traumatic event (exposure) items, and 6 trauma symptom (reaction) items. Even when no exposures are endorsed, the reaction items may be asked, as sometimes an event that occurred may not be reported.

Development
The development of the CTS is described in detail in the published paper cited below. The following is a brief summary:

1. The traumatic event (exposure) items were developed to assess the most common and distressing trauma exposure types (victim of violence, witnessing violence, sexual abuse), with one question about other forms of trauma exposure.
2. The PTSD symptom (reaction) items were empirically derived from longer, validated PTSD symptom measures (total N=1065) to identify a subset of items that were most predictive of PTSD severity while capturing symptoms from each of the PTSD symptom clusters. Items were developed to reflect both the DSM-IV and the DSM-5 definitions of PTSD.

Validation
Initial validation in a clinical sample and a description of CTS development is presented in the publication below. The CTS is reliable (alpha .78 child report; .82 caregiver report), has strong convergent validity with longer PTSD symptom measures, and divergent validity with other measures of behavioral health problems. Additional study of the CTS with other populations is underway, and a young child version for children age 3-6 is being developed.

Contact
More information about the CTS is available on www.chdi.org. Agencies interested in using the CTS and/or participating in validation should contact Jason Lang, Ph.D. (jalang@uchc.edu) and Christian M. Connell, Ph.D. (christian.connell@yale.edu)

Reference
Lang, J. M., & Connell, C. M. (in press). Development and Validation of a Brief Trauma Screening Measure for Children: The Child Trauma Screen. *Psychological Trauma: Theory, Research, Practice, and Policy.*

CTS Frequently Asked Questions

1. If a child/caregiver reports no trauma exposure or events, do I ask the reaction questions?

Yes. We have found that some children/caregivers are less comfortable reporting events than symptoms (and vice versa). There are other reasons people may not endorse an event (there are only a few specific events on the CTS, they may not think something was traumatic or fits with the items listed, were told not to disclose, etc.). If there are high levels of trauma-related reactions, even in the absence of a disclosed event, further trauma assessment would typically be recommended.

2. When there are no traumas indicated on the "Events" section, do I change any of the trauma reaction questions? Questions 5 and 6 don't make sense if there were no traumas reported.

Questions 5 & 6 refer to upsetting events. If no events were identified, children could still have been exposed to other upsetting events. If the child/caregiver asks, it is permitted to clarify that the questions refer to any upsetting events, even if nothing was endorsed on the CTS. If the child/caregiver says that the child never experienced any upsetting events, questions #5 and #6 would be answered 'never/rarely.'

3. What if I have information that a child was exposed to a trauma (or has a trauma reaction), but it is denied on the CTS?

The CTS is intended to supplement other information when it is available. Prior to introducing the screen, you can decide if it is appropriate to introduce the CTS in the context of other known information, such as trauma exposure. The child's responses, even if you believe them to be inaccurate, should be recorded on the form, as the CTS simply reflects the child or caregiver's responses. The "validity" item at the bottom can be used to indicate to what extent the responses appear to be accurate. If the child denies something you know happened, that is helpful information and should inform your recommendations and conceptualization. Other information can and should be used to determine your recommendations, not just the CTS scores alone. The results and cutoff score are intended as a guide.

4. Are you considering false positives or false negatives based on the screening cutoff recommendation? Some of the reaction items sound general, and not specific to traumatic stress.

A false positive is when a child who does not truly have trauma concerns is identified by the screen cutoff as having concerns (and further services are recommended). A false negative is when a child who truly has trauma concerns is NOT identified by the screen cutoff (and thus further services are NOT recommended). The recommended cutoff on the screen is based on available data to balance sensitivity (minimizing false positives) and specificity (minimizing false negatives). Because it is a screen, we prefer to minimize false negatives, as it is preferable that a child receives further assessment to rule out concerns rather than a child who has trauma concerns <u>not</u> getting referred. This results in an increased likelihood of false positives (a child who scores above the cutoff, but does not have true trauma concerns). A brief screen is intended to minimize both false positives and false negatives, but no measure will eliminate them completely. As more data is collected, the cutoff will be revised if needed. All recommendations for referrals should also be based on the full clinical evaluation, including information from sources other than the CTS.

5. Do I always refer a child who scores above the cutoff?

The cutoff recommendation is a guide only. It should be integrated with any other information you have to make recommendations for future services. For example, if a child reports very few symptoms but you believe he is showing signs of trauma avoidance, you might refer for further assessment. On the

other hand, a child who shows high levels of symptoms on the CTS but whom it is determined is currently receiving an evidence-based trauma treatment may not need an additional referral.