Appendix 3-A
Louisiana Child Welfare Trauma Project
Frequently Asked Questions

Trauma and PTSD definitions

What is trauma?

In terms of mental health, trauma is defined as an experience that is perceived as life-threatening or a severe threat to a person's body. This includes sexual abuse, physical abuse, witnessing domestic violence, motor vehicle collisions, burns, dog bites, disasters, and medical procedures. Trauma does not include chronic neglect, divorce, or watching violence on TV.

How common is trauma?

In one of the largest studies ever conducted in the United States, researchers from Duke University found that more than two-thirds of all children had experienced at least one life-threatening traumatic event by the age of sixteen years. Of those who had experienced at least one trauma, 38% had experienced more than one trauma.

Why focus on PTSD?

Nearly 100% of children in care have experienced maltreatment or some other type of trauma and PTSD is the core psychological issue for traumatized children. You cannot tell if someone has PTSD just by looking at them, so it's important to ask specific trauma-related questions.

How is PTSD different from other problems?

Many of the symptoms of PTSD are internal to a person and cannot be seen easily on the outside. For example, avoidance of thoughts or feelings associated with the traumatic event is something that goes on inside a person's head. Children may feel distant from loved ones and not know how to verbalize that to their parents.

Sometimes symptoms are only present when children are confronted by reminders of the event, and if they are successful at staying away from reminders, the symptom may not appear very often. Unlike any other psychological problem, avoidance is part of the disorder of PTSD. People who have experienced trauma don't want to remember what happened to them, and children will avoid talking about their symptoms as a result.

What are the symptoms of PTSD?

PTSD symptoms are divided into three clusters.

I. Re-experiencing symptoms:

Intrusive and distressing recollections of the event;
Flashbacks and freezing;
Nightmares; and,
Psychological or physiological distress at reminders

II. Numbing and avoidance symptoms:

Loss of interest in usual activities, sense of a foreshortened future, detachment or estrangement from others, avoidance of thoughts, feelings, conversations, people, places, or things associated with the event.

III. Increased arousal symptoms:

Difficulty concentrating, difficulty sleeping, irritability or outbursts of anger, exaggerated startle response, and hypervigilance.

Trauma and Behavioral Health Screen (TBH)

What is the TBH?

The TBH is a 56-item survey that covers traumatic events, PTSD symptoms, and other co-occurring (or comorbid) psychiatric diagnoses like depression, anxiety, ADHD, and oppositional defiant disorder. The TBH is designed to be self-administered and has two versions—one for caregivers, and one for 7 to 18 year olds to fill out themselves.

Why is the TBH replacing the BH-1 assessment?

The TBH is replacing the BH-1 as a more effective tool in identifying symptoms of PTSD and trauma in children and adolescents. Some questions from the BH-1 have been retained for use in the TBH as well. Unlike the BH-1, the TBH gives you scores to determine if there is a need for referral.

Is this screen a tool that a caseworker can use to use to make a diagnosis?

A diagnosis of PTSD can only be made by a licensed clinician. The TBH screen is designed to help caseworkers determine if a client needs a referral for mental health treatment.

Administering the TBH

Who should receive the TBH screen?

The TBH should be administered to every child in a caseworker's caseload. Administer the screen within the first 30 days of opening a new case, and re-administer approximately every six months as part of the Family Team Conference or Family Team Meeting activities to track the child's change in symptoms over time. Screens are not required for closing a case, and should not be completed after a case has closed.

Why does a screen need to be completed for infants?

Until a new tracking system is in place, the TBH is completed to track children of all ages in DCFS to monitor completion. Only the first page (traumatic events page) of the caregiver version needs to be filled out for children under the age of 12 months.

Why are there two versions of the TBH?

Two versions of the TBH are collected because caregivers and children tend to endorse different symptoms. Caregivers are more aware of the child's externalizing symptoms like disruptive behaviors, whereas the child is better at reporting internalizing symptoms, such as nightmares and intrusive recollections of the traumatic event. At times it may be possible that the caregivers and children have reported different answers and have significantly different scores. This is why the TBH utilizes a joint score when determining the need for a referral.

How do you administer the TBH?

The TBH will always be administered to the child and the caregiver in paper form. The child's caregiver will fill out the caregiver version, and if the child is aged 7 to 18, they will fill out the child version as well. The screen is designed to be self-administered, so you can allow the client to read and respond to the questions on their own while you do other work.

If you need to administer the screen verbally, be sure to speak as calmly and matter-of-factly as possible. If a person is feeling distressed, offer to assist them in reading the question, or give them the option of skipping to the last page.

Any distress the child experiences should be temporary. If distress continues, remove the questionnaire and do things you would normally do to comfort the child. Remind the child or their caregivers that they have your office number to call if they need assistance after you leave.

What should you do if a caregiver or child seems unable to complete the assessment on their own?

It may be possible that a caregiver or child may not be able to read or understand the questions. If this is the case, you may need to walk them through the TBH yourself. It's important to be familiar with the assessment in advance so you can anticipate any potential questions.

What if someone does not want to finish completing the assessment?

Completing the TBH is always a voluntary activity. If the screen is only partially completed, you may enter any information that you have collected into the online database. If the participant refuses to complete the screen, you must indicate this in the database so that there is a record of your attempt. There are check-box options for you to select from if you are unable to collect the TBH.

If you are unable to collect a caregiver version you will select from the following options:

- The caregiver refused to complete the screen
- No caregiver is available for this child
- I have not collected it yet

If you are unable to collect a child version you will select from the following options:

- The child is under the age of seven
- The child is not cognitively or developmentally able to complete the screen
- The child refused to complete the screen
- The child is currently a runaway or in another region
- I have not completed it yet
- Parent did not consent for child to participate

What should you do if a child is aged 7 to 18, but is not cognitively or developmentally able to complete the TBH on their own?

At times, there will be cases in which it may not be possible to have the child report on their own symptoms. In instances like this, you should rely on the caregiver's version of the TBH.

What if children or adolescents deny that anything happened to them and withhold information when filling out the TBH?

Sometimes, it is likely to happen that children will deny that maltreatment happened to them (e.g. they feel that they need to protect their parents or other reasons). How should you, as the caseworker, handle this when administering the TBH screen? Your approach will depend on a case-by-case basis. Use your skills and experience to decide what approach will work best. Here are some techniques you can try:

I. The Skip-the-Details approach

This straightforward and honest approach usually works best with a child or teen whom you think is willing to voluntarily let you or others help them, but is not sure of the right thing to say or do. You can say something like:

> *"I see that you did not mark this event for physical abuse (or sexual abuse, or witnessed another person being beaten, etc.). We already know from other reports that you got some bruises from getting whipped (use your own language to fit each case). That's what this means by 'physical abuse.' I don't really need to know the details for this form. I just want to know if anything like this happened to you and how we can help you."*

II. The Skip-the-First-Page approach

This compromise approach usually works best if you are sure that the child is not going to disclose any maltreatment. You can say something like:

> *"I see that you did not mark this event for physical abuse (or sexual abuse, or witnessed another person being beaten, etc.). That's fine. You don't have to tell me about those if you don't want to. This form is just to let us know if it would be helpful for you to talk with a counselor. You don't have to fill in the first page, but can you think about these things that happened to you in your head and fill in the other pages?"*

III. The Try-Again-Another-Day approach

If you feel that the child or adolescent is just not ready to disclose any of these events or problems on the TBH, you can say something like:

> *"I see that you did not mark any of these trauma events or symptoms. I'm a little worried that this doesn't match with some other concerns that I have. This is probably not the best time for you to fill this out. When I come back to visit in a month or so, I might ask you to try again."*

Should you remind children of a traumatic event in order to help them accurately report?

If children or adolescents deny that maltreatment happened to them, or deny that they witnessed domestic violence, it could be for several reasons.

- Protecting their parents
- Avoiding the topic because they have PTSD

- Not understanding the question

You have to remind them of the event to figure out which one of these reasons it is.

Are you re-traumatizing the child by asking them about these events?

Asking these questions can be difficult, but it is very important. Administration of the TBH can occur in three different contexts, each of which raises different concerns:

1. **Children experienced traumas and remembers them.** The concern is that being reminded of the traumas will upset the children. If being reminded of their traumas by these questions is upsetting, remember that they already are having upsetting reminders anyway

   In a 2014 study 2,312 children and adolescents were given a survey about traumatic events. Later, they were polled to measure the level of upset that they experienced while being asked those questions. Nearly 95% reported that they were not upset at all. Only 4.6% reported being upset at all, and less than 1% described being "a lot" upset (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014).

2. **Children experienced traumas and truly do not remember them.** The concern is that being reminded of the traumas will cause children to remember events that are better left forgotten. Most trauma experts believe that persons can truly block trauma memories, but it is rare. It is more common that persons are able to not think about traumatic events but can recall the events voluntarily when they want to. Because of the absence of data that asking about traumas in this situation is harmful in the long term, there appear to be many more benefits to asking about traumas than not asking about them.

3. **Children did not experience traumas**. The concern is that children are suggestive, and asking about traumas may plant memories in their heads that things happened to them that never really happened. A single question about each type of event will not plant false memories of events. Most children understand that you are trying to help them. The cases in the literature in which false memories may have been planted were reported in long-term psychotherapy cases with severely troubled adults where the possibility of abuse had been entertained over a long period of time.

How do you explain sexual assault or rape to a child?

If clients need help from you to read or understand the TBH items on traumatic events or posttraumatic stress disorder symptoms, they may feel uncomfortable when the traumas involve sexual abuse or sexual assault. These victims often feel shame and embarrassment. Younger children may not understand the terms "sexual abuse" or "sexual assault" and will require further explanation.

When asking about item #6 "Sexual abuse, sexual assault, or rape," you can refer to these examples of how to rephrase the question:

> *"This next question can be difficult to talk about. You don't have to talk about it if you don't want to but I need to ask. Has someone touched you somewhere on your body where you didn't want them to?" Who? Where on your body? When?"*
>
> *"Did someone make you touch them on their body where you didn't want to?" Who? Where on their body? When?*

If they answer yes, and they seem reluctant to talk about it, here are some examples of follow-up questions:

> *"I don't have to know the details, but are you able to tell me a little bit about what happened?"*
>
> *"You don't have to tell me the details, but can you tell me who did it? . . . How old were you the first time it happened? . . . About how many times did it happen?"*

It can be easier for the clients to simply name who did it and where it happened rather than going into the details of what happened. Remember that the TBH is just a screen. If the client needs clinical help, the clinicians can work with the child to gradually talk about more details of the sexual trauma.

Talking about sexual abuse or assault traumas may be more difficult when caseworkers are males and the perpetrators on the children were males. A male figure may serve as a reminder and an extra trigger for traumatic memories. As the caseworker, you should almost always still be able to ask the questions as long as you reassure the children that they don't have to talk about it and/or they only have to give as much detail as they are comfortable with.

What if the children say there are too many questions and they don't want to continue?

The children are right. The TBH covers a lot of questions and it is a voluntary activity. There will be a proportion of children who will refuse to complete the TBH. Ask them to do the best they can and accept whatever they can complete.

Also keep in mind how important you are as the caseworker for setting the tone. If you set the tone that you think this is important and you would like the answers to do your job the best possible way, your attitude might encourage some reluctant children to complete the questions.

What if you have access to more than one caregiver, and want to administer the TBH to a relative or biological parent in addition to the foster parent?

If you have access to additional caregivers who may know more accurate information about your clients, then we encourage you to administer the TBH to them. This additional screen may provide very helpful data for your case planning or may be passed on to the child's clinician.

The online database can accept entries for multiple caregiver TBHs, but they cannot be entered in the same data entry session. To enter TBH scores from a second caregiver, you must return to the online database start page and begin a new data entry session. You must re-enter the child version for each Caregiver TBH you enter into the database. DO NOT try to take a shortcut and enter a caregiver version in place of the child's version in the same data entry session. If you do this, there will be no way to differentiate the information and you will get an inaccurate score.

Is there any circumstance under which the caseworker should fill out the caregiver version of the TBH?

In very rare instances, in which a child is placed in a residential treatment facility and has no person at the facility who is informed enough to report as a caregiver, and the caseworker feels that they have enough information about the child to accurately fill out the screen, the caseworker may act as the caregiver for that child.

Some children say they have no problems, but caregivers disagree. Should you point out behaviors to the children?

It is a well-documented phenomenon from research that caregivers and children do not agree about children's symptoms. For disruptive behaviors (or externalizing symptoms) in particular, caregivers often endorse these while children deny them. That is why we want both the caregivers and children to fill out TBH screens whenever possible. It is probably not productive for you to point out the behaviors to the children. That is something that can occur during counseling with a therapist.

Using the TBH results page

What is the joint score?

A unique aspect of the TBH scoring is that it anticipates that caregivers and children will answer the questions differently at times. The joint score utilizes the highest score that has been endorsed by either the parent OR the child. For example, if a child reports a 3 on experiencing nightmares, but a parent reports a 2 on the same question, the joint score will utilize the child's higher score when calculating the results.

Where will the results of the TBH be recorded and scored?

Once you have collected the paper forms from the caregiver and the child, you will be entering the information into an online database. The database will prompt you to enter the score from every question and will automatically calculate the results for you. It's important to remember that you should print the results page for your records.

How will you know if a client should receive a referral based on the results of the screen?

After a caseworker enters the responses to the TBH into the online database, the database will generate scores automatically and provide a box of text next to each score that states whether the child should receive a referral.

Is there anything that should indicate an immediate cause for referral?

Yes. The last page of the TBH covers dangerous behaviors, psychosis, substance abuse, autism, and preschool conditions. If any of those last eleven questions have been answered "yes", that is cause for follow-up questions and a referral if the child is not already in treatment. If follow-up questions indicate that a child is unsafe, the caseworker should consult with their supervisors regarding the agency's protocol for crisis intervention.

If the TBH scores do not indicate a need for a referral, but you still feel that a referral is necessary, what should you do?

The TBH is just one tool for you to use when making the decision about the best course of action for a client. Even if the score itself does not suggest that a referral is necessary; you should always consider all the other information you have when deciding to make a referral.

With whom should you share the results of the TBH?

The results of the TBH should be shared with key players in the child's life, such as caregivers, pediatricians, and mental health providers. In some cases, it can also be a helpful tool when shared with schools or child-care facilities to aid in understanding the cause of the child's behavior.

What types of treatment have been proven effective for treating PTSD?

Cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing therapy (EMDR), and sometimes psychodynamic therapy have been shown to be effective in the treatment of PTSD symptoms. The most commonly recommended treatment is CBT.

Whom do you refer your clients to if the screen indicates that they need treatment?

Consult with your supervisors about your agency's list of clinicians in the region who provide evidence-based treatment. You can also search for providers with online provider directories that are specific to each insurance carrier.

How will you know if a child that you have referred is receiving appropriate treatment?

If the children's score for the TBH indicates that they need referrals for treatment, it would be ideal to refer them to providers who specialize in an evidence-based treatment that has been proven effective for those suffering with PTSD. Research supports the use of cognitive behavioral therapy (CBT) as a good method to help children recover from trauma, and as part of this project.

What is CBT for PTSD?

CBT for PTSD is a 12 session, manualized course of treatment that has three essential elements. With this treatment, children will learn how to emotionally engage with their trauma memory, organize and articulate their own story of the traumatic event that happened to them. They also learn how to modify their beliefs about the world and themselves to reflect a healthier, more stable outlook. The children's caregivers should be present for every session, and will help them do homework every week based on the goals that the therapist helps them set.