

# Connecticut Trauma Screen

## Child Report (Age 7+)

Client ID #: \_\_\_\_\_

Case ID #: \_\_\_\_\_

Child's Gender:  M  F

Child's Age (years): \_\_\_\_\_

Administered By: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

Setting:  DCF Intake  DCF Ongoing  IE  BH Clinic  Pediatrician  Other: \_\_\_\_\_

**EVENTS: "Sometimes, scary or very upsetting things happen to people. These things can sometimes affect how we think, what we feel, and what we do. I am going to read off a list of things that may have happened to you in the past, and I'd like you to tell me if each happened to you."**

	Yes	No
1. Have you ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has someone ever really hurt you? Hit, punched, or kicked you really hard with hands, belts, or other objects, or tried to shoot or stab you?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has someone ever touched you on the parts of your body that a bathing suit covers, in a way that made you uncomfortable? Or had you touch them on the parts of their body that a bathing suit covers?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has anything else very upsetting or scary happened to you (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? <i>What was it?</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

**REACTIONS: "I would like to know how you have been feeling and thinking recently. I'm going to read some statements and I'd like you to tell me how often these things happened to you over the last 30 days."**

None = Never or rarely;    Little = 1-2 times per month;    Some = 1-2 times per week;    A lot = 3+ times per week

[Omit words in brackets if child has not reported any events]

	None	Little	Some	A lot
5. I have strong feelings in my body [when I remember what happened] (sweating, heart beats fast, feel sick).	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
6. I try to stay away from people, places, or things [that remind me about what happened].	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
7. I have trouble feeling happy.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
8. I have trouble sleeping.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
9. It's hard for me to concentrate or pay attention.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
10. I feel alone and not close to people around me.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>

### Staff Only

Reactions Score: \_\_\_\_\_ (Add items #5-10). *Score of 5+ indicates at-risk and trauma assessment is recommended.*

How valid do you consider this screen?  Not at all     Somewhat     Mostly

Observations & Recommendations:

Disposition:  No referral, indicate reason:  Score < 5     Other \_\_\_\_\_  
 Trauma assessment: Agency: \_\_\_\_\_  
 Other: Agency: \_\_\_\_\_ Reason: \_\_\_\_\_

## Connecticut Trauma Screen Caregiver Report (Age 6+)

Client ID #: \_\_\_\_\_

Case ID #: \_\_\_\_\_

Child's Gender:  M  F

Child's Age (years): \_\_\_\_\_

Administered By: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

Setting:  DCF Intake  DCF Ongoing  IE  BH Clinic  Pediatrician  Other: \_\_\_\_\_

**EVENTS: "Sometimes, scary or very upsetting things happen to people. These things can sometimes affect how we think, what we feel, and what we do. I am going to read off a list of things that may have happened to your child in the past, and I'd like you to tell me if each happened to him/her."**

	Yes	No
1. Has your child ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has someone ever really hurt him/her? Hit, punched, or kicked him/her really hard with hands, belts, or other objects, or tried to shoot or stab him/her?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has someone ever touched him/her on the parts of his/her body that a bathing suit covers, in a way that made you or your child uncomfortable? Or has someone had him/her touch them on his/her parts of their body that a bathing suit covers?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has anything else very upsetting or scary happened to your child (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? <i>What was it?</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

**REACTIONS: "I would like to know how your child has been feeling and thinking recently. I'm going to read some statements and I'd like you to tell me how often these things happened to him/her over the last 30 days."**

None = Never or rarely;    Little = 1-2 times per month;    Some = 1-2 times per week;    A lot = 3+ times per week

	None	Little	Some	A lot
<i>[Omit words in brackets if child has not reported any events]</i>				
5. He/she has strong feelings in his/her body [when he/she remembers what happened] (sweating, heart beats fast, feel sick).	0	1	2	3
6. He/she tries to stay away from people, places, or things [that remind him/her about what happened].	0	1	2	3
7. He/she has trouble feeling happy.	0	1	2	3
8. He/she has trouble sleeping.	0	1	2	3
9. It's hard for him/her to concentrate or pay attention.	0	1	2	3
10. He/she feels alone and not close to people around him/her.	0	1	2	3

**Staff Only**

Reactions Score: \_\_\_\_\_ (Add items #5-10). *Score of 5+ indicates at-risk and trauma assessment is recommended.*

How valid do you consider this screen?  Not at all  Somewhat  Mostly

*Observations & Recommendations:*

  
  

*Disposition:*  No referral, indicate reason:  Score < 5  Other \_\_\_\_\_

Trauma assessment: Agency: \_\_\_\_\_

Other: Agency: \_\_\_\_\_ Reason: \_\_\_\_\_

**Cuestionario de Evaluación Preliminar de Trauma  
Información dada por Niño-a (7+ años)**

Client ID #: \_\_\_\_\_

Case ID #: \_\_\_\_\_

Child's Gender:  M  F

Child's Age (years): \_\_\_\_\_

Administered By: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

Setting:  DCF Intake  DCF Ongoing  IE  BH Clinic  Pediatrician  Other: \_\_\_\_\_

**Eventos: "A veces pasan cosas que asustan o alteran a las personas. Estas cosas a veces afectan la forma cómo pensamos, lo que sentimos y lo que hacemos. Voy a leer una lista de cosas que te pudieron haber sucedido en el pasado y quisiera que me digas si algunas de estas cosas te han sucedido."**

	Yes	No
1. ¿Alguna vez has visto que personas se empujan, pegan, arrojan cosas entre si, o que alguien apuñala a otra persona, le dispara con un arma, o tratan de lastimarse?	<input type="checkbox"/>	<input type="checkbox"/>
2. ¿Alguna vez alguien te ha lastimado de verdad? ¿Te ha pegado, dado puñetazos o dado patadas muy duro, con manos, cinturones u otros objetos, o ha tratado de dispararte con un arma o apuñalarte?	<input type="checkbox"/>	<input type="checkbox"/>
3. ¿Alguna vez alguien te ha tocado en las partes de tu cuerpo que se tapan con un traje de baño, de una manera que te hizo sentir incómodo(a)? ¿O te hizo tocar las partes de su cuerpo que se tapan con un traje de baño, de una manera que te hizo sentir incómodo(a)?	<input type="checkbox"/>	<input type="checkbox"/>
4. ¿Te ha sucedido alguna otra cosa que te alteró o te asustó mucho? (p.ej. alguien que tú querías murió, fuiste separado de un ser querido, te dejaron solo por mucho tiempo, no tuviste suficiente comida, un accidente o enfermedad seria, incendio, mordida de perro, fuiste intimidado por alguien) ¿Qué fue? _____	<input type="checkbox"/>	<input type="checkbox"/>

**REACCIONES: "Quisiera saber cómo te has sentido y qué has estado pensando recientemente. Voy a leer unas frases y quiero que me digas qué tan frecuente estas cosas te han pasado en los últimos 30 días."**

Nada= Nunca o raramente; Poco = 1-2 veces al mes; Algo = 1-2 veces a la semana; Mucho= 3+ veces a la semana

	Nada	Poco	Algo	Mucho
<b>[Omita palabras en corchetes si el niño/a no ha reportado ningún evento traumático]</b>				
1. Tengo fuertes sensaciones en mi cuerpo [cuando recuerdo lo que sucedió] (por ejemplo, sudoración, latidos rápidos del corazón, sentirse enfermo)	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
2. Trato de evitar personas, lugares o cosas [que me hacen recordar lo que sucedió].	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
3. No me es fácil sentirme feliz.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
4. Me cuesta trabajo dormir.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
5. Es difícil para mí concentrarme o prestar atención.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
6. Me siento solo/a y alejado/a de las personas a mi alrededor.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>

**Staff Only**

Reactions Score: \_\_\_\_\_ (Add items #5-10). *Score of 5+ indicates at-risk and trauma assessment is recommended.*  
 How valid do you consider this screen?  Not at all  Somewhat  Mostly  
 Observations & Recommendations:

Disposition:  No referral, indicate reason:  Score<5  Other \_\_\_\_\_  
 Trauma assessment: Agency: \_\_\_\_\_  
 Other: Agency: \_\_\_\_\_ Reason: \_\_\_\_\_

**Cuestionario de Evaluación Preliminar de Trauma  
Informe del Padre/Madre o Guardián (6+ años)**

Client ID #: \_\_\_\_\_

Case ID #: \_\_\_\_\_

Child's Gender:  M  F

Child's Age (years): \_\_\_\_\_

Administered By: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

Setting:  DCF Intake  DCF Ongoing  IE  BH Clinic  Pediatrician  Other: \_\_\_\_\_

**Eventos: "A veces pasan cosas que asustan o alteran a las personas. Estas cosas a veces afectan la forma cómo pensamos, lo que sentimos y lo que hacemos. Voy a leer una lista de cosas que le podrían haber sucedido a tu niño/a en el pasado. Quiero que me digas si algunas de estas cosas le han sucedido a él/ella".**

	Yes	No
1. ¿Tu niño/a alguna vez ha visto que personas se empujan, pegan, arrojan cosas entre si, o que alguien apuñala a otra persona, le dispara con un arma, o tratan de lastimarse?	<input type="checkbox"/>	<input type="checkbox"/>
2. ¿Alguna vez alguien le ha lastimado de verdad? ¿Alguien le ha pegado, dado puñetazos o dado patadas muy duro, con manos, cinturones u otros objetos, o ha tratado de dispararle con un arma o apuñalarle?	<input type="checkbox"/>	<input type="checkbox"/>
3. ¿Alguna vez alguien le ha tocado en las partes de su cuerpo que se tapan con un traje de baño, de una manera que le hizo sentir incómodo(a)? ¿O le hizo tocar las partes de su cuerpo que se tapan con un traje de baño, de una manera que te hizo sentir incómodo(a)?	<input type="checkbox"/>	<input type="checkbox"/>
4. ¿Le ha sucedido alguna otra cosa que le alteró o le asustó mucho? (p.ej. alguien querido murió, fue separado/a de un ser querido, le dejaron solo/a por mucho tiempo, no tuvo suficiente comida para comer, un accidente o enfermedad seria, incendio, mordida de perro, fue intimidado por alguien) ¿Qué fue? _____	<input type="checkbox"/>	<input type="checkbox"/>

**REACCIONES: "Quisiera saber cómo se ha sentido tu niño/a y qué ha estado pensado recientemente. Voy a leer unas frases y quiero que me digas qué tan frecuente estas cosas le han pasado a tu niño/a en los últimos 30 días.**

Nada= Nunca o raramente; Poco = 1-2 veces al mes; Algo = 1-2 veces a la semana; Mucho= 3+ veces a la semana

	Nada	Poco	Algo	Mucho
<i>[Omita palabras en corchetes si el niño/a no ha reportado ningún evento traumático]</i>				
1. El/ella tiene fuertes sensaciones en su cuerpo [cuando recuerda lo que sucedió] (por ejemplo, sudoración, latidos rápidos del corazón, sentirse enfermo).	0	1	2	3
2. El/ella trata de evitar personas, lugares o cosas [que le hacen recordar lo que sucedió].	0	1	2	3
3. No le es fácil sentirse feliz.	0	1	2	3
4. El/ella tiene problemas para dormir.	0	1	2	3
5. Le es difícil concentrarse o prestar atención.	0	1	2	3
6. Se siente solo/a y alejado/a de las personas a su alrededor.	0	1	2	3

**Staff Only**

Reactions Score: \_\_\_\_\_ (Add items #5-10). *Score of 5+ indicates at-risk and trauma assessment is recommended.*  
 How valid do you consider this screen?  Not at all  Somewhat  Mostly  
 Observations & Recommendations:

Disposition:  No referral, indicate reason:  Score<5  Other \_\_\_\_\_  
 Trauma assessment: Agency: \_\_\_\_\_  
 Other: Agency: \_\_\_\_\_ Reason: \_\_\_\_\_

# Information about the Connecticut Trauma Screen

## Background

The Connecticut Trauma Screen (CTS) 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, medical providers, school personnel, and others.

The goals of the CTS are to

- 1) Identify children 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 as required for their professional role

The CTS is not a comprehensive screening tool or a clinical assessment, and does not screen for 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.

## Administration

Prior to beginning the questions, explain the purpose of trauma screening to child's caregiver(s). 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. It is recommended to administer both a caregiver and child report whenever 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

Preliminary analyses suggest that a Reactions Total score of 6 or greater, on either the child or caregiver report, indicates that the child may be suffering from clinically significant levels of PTSD symptoms. Until additional data are collected, a conservative cutoff of 5 or greater is recommended. In these cases, a clinical trauma assessment by a clinician trained in evidence-based trauma-focused treatment should be considered.

## 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

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 trauma symptom (reaction) items were empirically derived in the following manner to identify a subset of items that were most highly correlated with broad measures of PTSD assessments:
  - a. Data from two standardized measures of PTSD symptoms (the CPSS and UCLA PTSDI-RI) were used for item-level analysis. This data was drawn from caregiver and child (over age 7) ratings for youth referred to outpatient care clinics participating in TF-CBT Learning Collaboratives (UCLA PTSD-RI N = 596 Parent / 655 Child; CPSS N = 327 Parent / 329 Child).
  - b. Analysis consisted of item-level correlational analysis to identify items correlating with overall severity scores and identification of scores consistent with PTSD clinical range on each instrument, followed by ROC analyses to examine sensitivity and specificity of short-form scales. A split sample approach was used in which item-level correlations were examined with 40% of the total sample and ROC analyses were conducted with the remaining 60% of the total sample. Items were selected that had high correlation within specified symptom cluster domains for each instrument to ensure adequate coverage of PTSD domains.
  - c. The independent analyses of the UCLA PTSD-RI and CPSS yielded similar results, with slightly different underlying PTSD symptoms. PTSD symptoms were selected for the CTS based on a requirement to have items across the four symptom clusters of PTSD in DSM 5, and based upon the minimum number of symptoms required for PTSD diagnosis in each cluster:
    - i. Intrusion: 1 item
    - ii. Avoidance: 1 item
    - iii. Negative alterations in cognitions/mood: 2 items
    - iv. Alterations in arousal/reactivity: 2 items
  - d. Items were written for each identified underlying symptom in simple language, in order to capture the primary underlying symptom.
  - e. After items were finalized, ROC analyses were again conducted to identify initial cut-points to reduce false positives and false negatives while still ensuring adequate sensitivity and specificity for the purposes of a brief screen.

## Validation

We are developing plans to validate the CTS. Agencies interested in using the CTS and participating in validation should contact Jason Lang, Ph.D. ([jalang@uchc.edu](mailto:jalang@uchc.edu)) and Christian M. Connell, Ph.D. ([christian.connell@yale.edu](mailto:christian.connell@yale.edu))