

Trauma and Behavioral Health Screen (TBH)

Frequently Asked Questions

General

How did the TBH get started?

In 2012, Tulane University, in partnership with DCFS, received federal funding from the Administration of Children Youth and Families and the Children's Bureau to improve access to needs-driven, evidence-based mental and behavioral health services in child welfare. In a close collaboration, Tulane helped DCFS to implement this new trauma-focused screening instrument to identify children who are suffering from trauma and PTSD in child welfare. According to the DCFS policy, the screen is to be administered by DCFS caseworkers to all children in foster care and family services in the state of Louisiana, and will result in caseworkers more accurately identifying those clients who need mental health referrals.

Why was Tulane involved?

While this was a DCFS project that is in DCFS policy, Tulane assisted in executing the grant for the state of Louisiana until September of 2017.

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 is this project focused 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 four clusters.

I. Re-experiencing symptoms:

Intrusive and distressing recollections of the event, flashbacks and freezing, nightmares, and psychological or physiological distress at reminders.

II. Avoidance symptoms:

Avoidance of thoughts, feelings, conversations, people, places, or things associated with the event.

III. Negative alterations in cognitions and moods symptoms:

Loss of interest in usual activities, negative beliefs about oneself or the world, detachment or estrangement from others, and restricted range of affect.

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.

Please note that DCFS policy now **requires** the administration of the TBH screen for all open FC, FS, and adoptions cases. DCFS caseworkers can refer to Chapter 3 of DCFS Child Welfare Policy (Policy 3-220 - Behavioral Health Screening and Assessment of Children) for more information regarding this requirement.

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.

Does the traumatic events page refer to events that have happened throughout the entirety of the child's life, or only events that have occurred while they have been in care?

The traumatic events page refers to events that have happened throughout the child's lifetime.

My child is already in mental health therapy. Should I still administer the TBH?

Yes, a child must still be administered the TBH regardless of whether or not they are receiving mental health therapy. However, the child's mental health clinician may find the screen useful as many clinicians do not have a standardized behavioral health screen that assesses trauma. Therefore, we recommend sharing the TBH results with the child's therapist.

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.

A foster mother has just recently accepted a child into her home. Should I wait until the foster parent knows the child more before they complete the TBH screen?

DCFS policy requires the administration of the TBH within the first 30 days for all new cases. Ideally, the screen should be completed towards the end of the 30 days, but can be completed anytime during that first 30-day assessment period that is practicable. Though the foster parent may not know the child well, filling out the TBH may be extremely beneficial for her because it educates her on what to watch for in her child. The foster parent can learn more about the symptoms of PTSD, and compare them with the child's behavior while under her care. During the six-month rescreen, the foster parent can more accurately complete the TBH screen. If the foster parent is concerned about the child's mental health, they can complete another TBH screen before the six-month rescreen.

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, 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 our 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?"*

* Note that questions on the traumatic events page (the first page) will not affect the child's score on the TBH.

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 of 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.

I have a foster parent with several children, and I feel overwhelmed. How do you suggest I administer the TBH to all of the children?

We suggest collecting screens for all of the children gradually, with priority given to children who may benefit the most from being administered the TBH promptly. For example, if a foster parent has six children (all newly opened cases), we recommend that the TBH be administered to two children per week. In this way, you will successfully be able to complete all TBHs for the children within 30 days of opening the case.

We also recommend circling portions of the TBH that are applicable to the age of your child. For younger children, there are less questions to answer, and it may seem less overwhelming for you and the caretaker.

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, the worker may complete the screen.

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.

Can I rescreen a child more often than every six months?

Yes, there are no restrictions to how many times you may administer the TBH to a child.

After a traumatic event, should we rescreen the child?

If a traumatic event has occurred and the child's PTSD symptoms persist after 30 days, we recommend that you administer a TBH to the child, regardless of the last time the child has been screened.

Does the LCTP provide Spanish resources?

Yes. The [caregiver and child version of the TBH in Spanish](#) is available through our website. In addition, we have also posted a list of [Spanish-speaking providers](#) who have not been trained by Tulane University in trauma-focused therapy, and may or may not have that qualification. Please ask the provider if they conduct trauma-focused therapy if the child is being referred for PTSD treatment.

Is there an equivalent of the TBH for adults?

Unfortunately, this project does not offer a trauma screen for adults. However, if you would like resources, please feel free refer to the following:

- A self-administered screen for PTSD is available at the National Center for PTSD website.
- Screens for other disorders can be found by Googling "self-administered screen for x."

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.

What is INT and EXT?

INT and EXT refer to internalizing behavior and externalizing behavior. Internalizing behavior refers to depression, anxiety, nightmares, intrusive recollections of the traumatic event, etc. Externalizing behavior refers to disruptive behaviors, such as "acting out" or conduct disorder.

Are the answers of the TBH kept confidential?

Yes. The data that you will be collecting with the TBH is entered into a SNAP software system that is viewed only by the partners in this project. All of the staff are trained in strict confidentiality for client information. Furthermore, the only personally identifying data that we collect is the TIPS number of each client.

Can I go back and retrieve the TBH results?

Unfortunately, DCFS caseworkers are unable to go back and retrieve the TBH results at this time. Therefore, we highly recommend printing the TBH results page once you are finished entering the TBH into the online database. Should you have lost or forgotten to print the results, you can either re-enter the TBH into the online database, or e-mail Thao Anh Mai at amai1@tulane.edu to retrieve the results.

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.

Are there going to be services available to the children who endorse problems on the TBH?

It is no secret that easily-accessible, high-quality services often can be difficult to find. So, another component of this project is that Tulane University has trained therapists in your region in evidence-based cognitive behavior therapy (CBT) to treat PTSD and trauma-related problems. For a list of these trained providers, please visit the [Resources for Caseworkers](#) and/or [Training](#) pages of our website.

You can also get in touch with Tulane staff and we might be able to help you find services.

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.

To whom do you refer your clients if the screen indicates that they need treatment?

Tulane University has trained therapists in your region in evidence-based cognitive behavior therapy (CBT) to treat PTSD and trauma-related problems. For a list of these trained providers, please visit the [Resources for Caseworkers](#) and/or [Training](#) pages of our website. Additionally, you may want to 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?

The child's scores on the TBH should be improving (decreasing) when the TBH is repeated. If the scores are not improving, this might be an indication that they are not receiving appropriate treatment. The TBH scores can help direct children to the right type of treatment. For example, if the children's PTSD score on 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, Tulane University has offered free training to clinicians across the state in CBT for PTSD.

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, as well as 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.

Does the LCTP still offer training of CBT for PTSD for clinicians?

Unfortunately, our project is no longer offering any more trainings. However, if you would like more information and resources concerning the training we offered, please feel free to contact Tulane staff or visit our [Resources for Clinicians](#) and/or [Training](#) pages of our website.

Troubleshooting

Who can you contact if you have questions or feedback about the screen?

We welcome your questions and input. If you have questions about the TBH, please contact a member of the Tulane staff:

Thao Anh Mai
504-988-2165
amai1@tulane.edu

Who can you contact if you have technical difficulties with the SNAP survey site?

For questions about SNAP, please contact the Policy and Research Group:

Alethia Gregory
504-865-1545
alethia@policyandresearch.com

Finkelhor, D., Vanderminden, J., Turner, H., Hamby, S., & Shattuck, A. (2014). Upset among youth in response to questions about exposure to violence, sexual assault and family maltreatment. *Child Abuse & Neglect*, 38(2), 217-223. doi: 10.1016/j.chiabu.2013.07.021