

Clinical Guide for Administering the Child and Adolescent Trauma Screen (CATS)

The “Child and Adolescent Trauma Screen (CATS)” is a DSM-5 based checklist that includes 15 potentially traumatic events or series of events, the 20 posttraumatic stress symptoms (PTSS) and 5 impairment items. It has established good psychometric properties (Sachser, et al, 2017). There is a self-report measure for 7-17 year old children/youth, and two caregiver versions; one for 3-6 year old children and one for 7-17 year old children/youth. The younger child version conforms to the DSM-5 3-6 year old PTSD symptom criteria. The CATS can be administered as a self-report or as an interview. Interview may be preferable with younger children or youth with reading comprehension challenges.

Administration of the CATS should be conducted as a clinical encounter. The CATS may be part of routine assessment procedures and/or occur at a later point with the assigned clinician. It may be used as a stand-alone screening or be part of a larger assessment and clinical interview. Administering both the children/youth and caregiver versions (7-17 years) provides a more complete picture. Review and feedback of the results with patients and their caregivers is essential. Collaborative review of the results creates the opportunity to validate the children/youth’s experiences, learn about key factors that are relevant to therapy and recovery such as identifying trauma memory hotspots, trauma reminders, and children/youth cognitions about the trauma and its aftermath. The screening is an opportunity to assess immediate safety and do important clinical activities to help support the recovery process for children/youth affected by trauma. The measure can further be implemented as routine symptom monitoring during treatment.

In addition to identifying the potentially traumatic events and the presence of PTSD symptoms, it is important to explore how the children/youth perceive the trauma and its context. Cognitions are important in the development and maintenance of PTSD. These perceptions may be at the individual level or societal level. A child abuse victim is aware that family members, teachers or government child protection knew but failed to act protectively. Assaults may be perceived as the result of racial targeting and racism. Being bullied might be ascribed to discrimination based on group membership (e.g., being gay). A child whose parents are undocumented may have been reluctant to report abuse due to worries that the parents might be deported. Youth victims of community violence may believe that social inequality and lack of government action is the reason for high levels of neighborhood violence. A disaster can be experienced as being caused by government or corporate failure to take the proper action.

Not reviewing the measure in a clinical way carries a risk of creating further harm. For example, if children/youth endorse a trauma that is associated with in-home risk (child abuse, domestic

violence) and there is no immediate follow up, they might conclude that health care professionals do not care about their safety.

Administering the CATS and inquiring directly about trauma experiences does not cause undue distress, even when administered as part of a routine screening before a therapeutic relationship is established (Skar, Ormhaug, & Jensen, 2019). Children/youth without a trauma history and those with a trauma history but no PTSD have minimal or no distress. Those with PTSD may have distress but this is the evidence that they have clinical needs. However, what children/youth reveal about their trauma history and PTSS on a checklist such as the CATS, will only be one part of the full clinical picture. It is expected that over time a more complete picture of the trauma and its impact will emerge (Berliner, Meiser-Stedman, & Danese, 2020).

A clinical diagnosis of PTSD should not be based on completion of the CATS alone. A clinical interview with children/youth and whenever possible, a caregiver is necessary. There are standard structured clinical interviews available such as the CAPS-CA or CAPS-CA-5. However, children with elevated PTSS, but without PTSD diagnosis, should also be offered trauma-focused treatment.

Clinically Based CATS Feedback and Review

1. **Trauma Screen**

Endorsement of at least one threat-related event is sufficient to proceed with the PTSS inquiry.

Purpose:

Learn about trauma exposure history. All children/youth benefit by validation and normalization. Feedback may contain the following clinical components: validation, psychoeducation on trauma, identification of trauma-related cognitions, child and family strengths and resources, assessment of immediate safety and promote family confidence in trauma-focused treatment.

Clinical Feedback:

Engagement [Validate experience]:

“I am so sorry that you went through that”; “Thank you for telling me about your experiences”.

Psychoeducation [Normalizing]:

“You are not alone; lots of kids have had experiences like these.”; “I work with a lot of teens who have been through some similar things.”

Exposure [Model “facing up to fears” by talking about the traumas endorsed]:

“I see you said you were in a serious accident, what happened?”; “You marked that you saw someone in your family get slapped, punched or beat up, how often did that happen?”; “You checked that being touched on the private parts was the worst, what made it the worst for you?”

Exploring trauma context:

“Tell me the reasons you think it happened?”; “Could anyone have done anything to prevent or stop what happened?”; “Why do you think you were the person he chose to assault?”; “Is there anything about you or your identity that you think might be related to what happened?”; “Do you think you were targeted?”; “What do others think about what happened to you?”

2. PTSD symptoms

PTSS intensity and frequency is determined by adding up the total score for each symptom. PTSD diagnostic criteria require a specified number of symptoms from each cluster.

Purpose:

To determine the intensity of PTSS and whether probable PTSD is present. To learn more about which symptom clusters are most distressing, identify trauma reminders, and identify unhelpful thoughts.

Explaining Results: Total PTSS intensity score not clinically elevated:

Normalization:

“It’s normal to have some reactions after a scary experience.”; “many people have reactions and then they get better over time”; “If you ever feel that the problems are getting worse, feel free to come back; we can help”

Reinforcing Strengths:

“Impressive job. Even though you had those traumas, you have been able to cope effectively. What strengths do you have that you used?”

Explaining Results: Total PTSS intensity score clinically elevated:

Engagement [Validate distress]:

“Your score is pretty high. This means you are dealing with thoughts and feelings about what happened that are stressful and upsetting. No wonder you are having a rough time.”

Psychoeducation [Info about PTS and PTSD - Normalizing]:

- Young children: “Kids often have feelings and worries like yours after going through [NAME SOME OF CHILD’S TRAUMATIC EVENTS]. These feelings and worries can be hard. I see a lot of kids and parents who have feelings like these.”
- Older children and parents: “These questions find out about feelings, thoughts, worries and behaviors that can go with having been through traumas like [NAME SOME OF CHILD’S TRAUMATIC EVENTS]. Together these are called posttraumatic stress symptoms. Have you heard of that? I can tell you a little bit about it”.

Specific symptom cluster review:

- *Intrusions*: “I see that you almost always have upsetting thoughts or pictures about what happened pop into your head. Tell me what the picture is when that happens”; “You marked that you almost always feel very upset when you are reminded of what happened. Tell me what reminds you of what happened.”
- *Avoidance*: “You marked that you almost always stay away from people, places, things or situations that remind you of the [NAME EVENT]. Can you give me an example of something you avoid?”
- *Mood and cognitions*: “You marked that you blame yourself or blame someone else when it isn’t their fault. Tell me more about those thoughts.”; “You marked that you have bad feelings almost all of the time. Tell me which feelings you have.”; “You said that half the time you have negative thoughts about yourself or others. Tell me what some of those thoughts are.”
- *Hyperarousal*: “You marked that you are overly careful and on guard. Tell me more about the situations when that happens.”; “You answered that you have trouble falling asleep almost every day, tell me more about that?”; “You said that you have trouble concentrating. Give me an example of a situation in which concentrating is especially difficult?”

Instilling hope: “We have a treatment that really works for children and youth who have posttraumatic stress”; “People can get over posttraumatic stress and have good lives”.

3. Functional impairment

Purpose: In order to derive a probable PTSD diagnosis, the symptoms must come with functional impairment in at least one of the five categories at the end of the CATS measure.

CATS Scoring and Interpretation

CATS 7-17 Years Score <15	CATS 7-17 Years Score 15-20	CATS Score 7-17 Score 21+
Normal. Not clinically elevated.	Moderate trauma-related distress.	Probable PTSD.
<p>Clinical Tip: Brief review of results with clients. Validate, normalize and reassure. Anticipatory guidance.</p>	<p>Clinical Tip: Carefully review results with clients. Validate, normalize and reassure. Provide psychoeducation and coping tips. Convey hope that many children recover naturally and that there are effective treatment available if desired. Offer trauma-specific treatment if interested.</p>	<p>Clinical Tip: Carefully review results with clients and conduct PTSD diagnostic interview using results. Validate and normalize. Convey hope regarding recovery with effective treatment. Offer TF-CBT or other evidence-based trauma-specific treatment.</p>
CATS Caregiver 3-6 Years Score < 12	CATS Caregiver 3-6 Years Score 12-14	CATS Caregiver 3-6 Years Score 15+
Normal. Not clinically elevated.	Moderate trauma-related distress.	Probable PTSD.
<p>Clinical Tip: Brief review of results with caregiver. Validate, normalize and reassure regarding trauma and impact. Anticipatory guidance.</p>	<p>Clinical Tip: Carefully review results with caregiver. Validate, normalize and reassure regarding trauma and impact. Provide psychoeducation and coping tips. Convey hope that many children recover naturally and that there are effective treatment available if desired. Offer trauma-specific treatment if interested.</p>	<p>Clinical Tip: Carefully review results with caregiver. Conduct PTSD diagnostic interview using results. Validate and normalize regarding trauma impact. Convey hope regarding recovery with effective treatment. Offer TF-CBT or other evidence-based trauma-specific treatment.</p>

Literature

- Berliner, L., Meiser-Stedman, R., & Danese, A. (2020). Screening, Assessment, and Diagnosis in Children and Adolescents. *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*, 69.
- Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., ... & Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of Affective Disorders*, 210, 189-195.
- Skar, A. M. S., Ormhaug, S. M., & Jensen, T. K. (2019). Reported levels of upset in youth after routine trauma screening at mental health clinics. *JAMA Network Open*, 2(5), e194003-e194003.worr