

# Managing traumatized children: a trauma systems perspective

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**Current Opinion in Pediatrics** 2010, 22:621–625

## Purpose of review

To review the current research on trauma-informed child-serving systems. Research on this topic, although sparse, is critically important because most children who come into contact with systems, including the child welfare and juvenile justice systems, have experienced at least one traumatic event.

## Recent findings

Very little research has actually been done on this topic area. Although it makes intuitive sense to integrate a trauma-informed approach into child-serving systems, much more research needs to be conducted in order to determine the efficacy of trauma-informed thinking in child-serving systems.

## Summary

A number of research studies have been conducted that focus on adults with co-occurring disorders who have received trauma-informed treatment. These results suggest that a 'trauma-informed' approach is a helpful and effective way to implement services. These same principles may be applied to work with children in order to create a 'trauma-informed child-serving system'. Twelve literature-supported and research-supported components of such a system are introduced in this review, ranging from the importance of specialized knowledge about trauma to trauma assessment and the value of trauma-informed policy.

## Keywords

adult trauma, child trauma, systems, trauma-informed

Curr Opin Pediatr 22:621–625  
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1040-8703

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## Introduction

The purpose of the current review is to introduce the concept of a 'trauma-informed approach' when working within child-serving systems. According to the Substance Abuse and Mental Health Service Administration's (SAMHSA) National Center for Trauma-Informed Care, 'Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization' [1]. Although this concept makes sense intuitively, there has been very little research that focuses on creating trauma-informed systems, specifically related to working with children.

As the field of 'trauma-informed systems' is a relatively new phenomenon that has emerged in the literature [2,3\*] over the past 5 years, there has been little research on this concept in the last 18 months. For this reason, the review period covers articles published from 2007 to the present and includes work focusing both on adult and child trauma. On the basis of this review, the authors will

introduce 12 components of a trauma-informed child-serving system.

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## Prevalence of trauma

Studies have reported high rates of trauma among children in the United States since the 1950s [4]. For example, in one study, the authors found that 25% of their sample of 9–16-year-olds had recently experienced some potentially traumatic event [5]. Child abuse and neglect represent a substantial subset of these children. Each year, almost 3 million children are reported as abused or neglected [6]. Another study found that approximately 15.5 million children were estimated to live in homes where they were exposed to at least one incidence of domestic violence in the previous year [7]. Taken together, these studies suggest that a substantial number of children have experienced abuse or exposure to other traumatic events prior to their 18th birthday. Clearly child abuse and exposure to domestic violence are among the most common forms of major childhood trauma in the nation.

Not only are these forms of trauma common, they are among the most emotionally devastating and have been

linked to a host of negative outcomes in childhood, from emotional and behavioral problems to impaired school performance [8]. Without effective intervention, there is compelling evidence of long-term adverse consequences of untreated trauma lasting into adulthood that include substance abuse, suicidality, serious mental illness, and long-term physical health factors associated with early death [9,10\*\*].

Children who have experienced a traumatic event are likely to come into contact with multiple systems, including the child welfare and juvenile justice systems. Child welfare alone comes into contact with over 3 million children a year [6] and there are as many as 500 000 children placed in the protective custody of state or local governments at any one time [11]. Children involved in the juvenile justice system also present with high rates of trauma. In one study, 92.5% of participants had experienced one or more traumatic events in their lifetime and 11.2% of the sample met criteria for posttraumatic stress disorder (PTSD) in the past year [12]. More than half of the participants with PTSD reported witnessing violence as the precipitating trauma. By virtue of the events that led the children into contact with these systems and the additional traumas the system may impose (removal from the home, changes in placement, instability of relationships, risk of re-abuse, inconsistent caregivers and caseworkers, separation of siblings, etc.), virtually all have suffered major childhood trauma.

### **Current state of the field on trauma-informed systems**

The conceptualization of trauma-informed systems grew out of the developing body of empirical research on the efficacy of specialized trauma-focused interventions for the treatment of trauma-related symptoms in children and adults [13–16]. Although it is critical to provide individuals with treatment focused specifically on treating trauma symptoms (i.e., PTSD, depression, anxiety, etc.), that is only one component of a trauma-informed system. A trauma-informed system is a wider system impacting children and families, with multiple components designed to meet the varying needs of traumatized individuals who are receiving services. These include collaboration across service agencies (i.e., child welfare, mental health, domestic violence, substance abuse, etc.), partnership with youth and families receiving services, knowledge and understanding of trauma and its symptoms, and supporting the workforce in trauma work. Each of these components is discussed in more detail later in this article.

### **Adult trauma**

In adults, the early research focused on those suffering from co-occurring disorders, such as severe depression

and alcohol abuse [2]. Beginning in 2007, research on the efficacy of trauma-informed models for the treatment of co-occurring disorders among adult women began to emerge, largely due to the ‘Women, Co-Occurring Disorders and Violence Study’ sponsored by the SAMHSA. In an examination of a subset of these data, one study focused specifically on associations between trauma and physical health, as well as changes in physical health over time, in women with co-occurring disorders and histories of violence who received either integrated trauma-informed services or usual care. Results revealed that women who had experienced more severe trauma also suffered worse physical health and were more likely to engage in poor health behaviors. Receiving behavioral healthcare services was associated with improved physical health and health behaviors. Predictors of physical health improvements included reduced interpersonal abuse, reduced severity of posttraumatic symptoms, improved health behaviors, and adequate access to medical care [17\*]. In another quasi-experimental, non-randomized group design study that explored whether trauma-enhanced substance abuse treatment results in stronger engagement and better residential treatment retention and improved outcomes compared with treatment-as-usual, the authors found that the intervention group was 31% less likely to discontinue treatment within 4 months. Substance abuse and mental health symptoms improved with increased duration of treatment, particularly for women with more severe baseline symptoms [18\*].

Specific interventions for treating adult women with co-occurring disorders who have experienced trauma have recently been developed. These interventions have been shown to be effective in research studies. For example, one study [19\*] evaluated the effectiveness of ‘Seeking Safety’ [15], an integrated trauma-informed approach to treating women with co-occurring disorders and histories of trauma. Baseline and 12-month assessments were completed by 136 intervention and 177 comparison-group women. The intervention group received ‘Seeking Safety’, whereas the comparison group received similar services but not trauma-specific group treatment. Intervention women showed significantly better treatment retention over 3 months and greater improvement in posttraumatic stress symptoms and coping skills [19\*]. In 2009, another study explored how ‘Seeking Safety’ changed the content of services reported by clients. The researchers found that the intervention led to an increased provision of integrated services as well as services addressing each content area: trauma, mental health, and substance abuse [20\*].

Other models developed to treat women with co-occurring disorders who have experienced traumatic events include the ‘Women’s Integrated Treatment’ (WIT)

model [16]. This model is based on three foundational theories: relational–cultural theory, addiction theory, and trauma theory. Research on the model has shown it to be effective when working with women who have experienced trauma. In one study examining this treatment’s efficacy, researchers examined women who successfully completed the treatment program. They were assessed at several points in time on several scales, including trauma symptomology, depression, and substance use before and after the program. The findings indicated less substance use, less depression, and fewer trauma symptoms ( $P < 0.05$ ) after participation in the WIT curricula [21•].

### Child trauma

Although the initial formulation of ‘trauma-informed systems’ began in work focused on adults, researchers have recently started to identify the need to apply a ‘trauma-informed’ approach across child-serving systems, such as child welfare, juvenile justice, education, and others. The forerunners of this movement have been members of the National Child Traumatic Stress Network (NCTSN). In 2008, NCTSN colleagues introduced the concept of addressing the needs of traumatized children across multiple systems in an article that reviewed how various service systems approach trauma services differently. It also provided recommendations for how to make each of these service systems more trauma-informed [3•]. The NCTSN Child Welfare Committee was also instrumental in defining the ‘Essential Elements of a Trauma-Informed Child Welfare System’ [22]. These include concepts such as maximizing the child’s sense of safety, assisting children in reducing overwhelming emotion, and managing personal and professional stress. Many of these ‘Essential Elements’ are consistent with the research and are similar to the 12 components of a trauma-informed child-serving system that are described later in this article.

The literature has begun to focus on specific interventions that can be applied across child-serving systems in order to make them more trauma-informed. For example, one article promotes the integration of assessment and evidence-based practice in the treatment of traumatized children through a review of two trauma assessment tools: The Child Welfare Trauma Referral Tool (CWT) and Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP) [23]. These tools use pathways and algorithms to increase understanding of individual child trauma victims and assist professionals working with children to make appropriate referral and treatment decisions within both child welfare and mental health contexts [24•]. In a more recent qualitative study focusing on the utility of the TAP model as a framework to help mental health agencies become more trauma-informed, the TAP model shows promise in helping clinicians, supervisors, and

mental health agencies organize information, direct treatment, and meet the individual needs of each client in a trauma-informed manner [25•].

In terms of treatment, there are various treatment models that aim to create a more integrated trauma-informed system. Due to the complexity of these models that address multiple dimensions, the research has been primarily qualitative in nature and there is a lack of randomized controlled trial (RCT) studies on these interventions. The Sanctuary Model [26] was first used with adult inpatients traumatized as children. This model is applied within the context of a well tolerated, supportive, stable, and socially responsible therapeutic community, and a trauma recovery treatment framework is used to teach clients effective adaptation and coping skills to replace nonadaptive cognitive, social, and behavioral strategies that may have emerged earlier as means of coping with traumatic life experiences. A number of qualitative research studies on the Sanctuary model have shown it to be an effective trauma-informed approach for working with youth in residential treatment settings [27] and with women in domestic violence shelters [28]. Another model is the Attachment, Regulation, and Self-Competency (ARC) framework [29]. The ARC framework provides a component-based framework that incorporates knowledge about the effects of trauma, including the core effects of trauma exposure on an individual’s attachment to others, ability to self-regulate, and developmental competencies. This model emphasizes the importance of understanding and intervening with the child-in-context, with a philosophy that systemic change leads to effective and sustainable outcomes. Research on the ARC framework is currently underway and pending publication.

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### Components of a trauma-informed child-serving system

On the basis of the review of the research focused on creating trauma-informed child-serving systems, a number of key components have emerged. Many of these align with well-established priorities of child-serving systems. Each of these components is highlighted below:

- (1) Individual and organizational knowledge that trauma is pervasive and includes numerous short-term and long-term effects: these effects include long-term impact on attachment, neurobiological processes, behavior, substance abuse, health problems, and mental illness [9,10••,30].
- (2) Trauma-specific screening and assessment: incorporating trauma-specific assessment processes that include taking into account the child’s culture and developmental stage. This ensures that these

children are identified, diagnosed appropriately, and triaged into the most effective intervention [23,24\*,25\*].

- (3) Integrating the use of evidence-based and evidence-supported trauma-focused treatment and 'core components' of trauma treatment: these include psychoeducation, addressing maladaptive cognitions, trauma integration, and other components that exist across trauma-focused treatments [13,30].
- (4) Safe, nurturing and predictable social environment, including psychological safety: it is critical to provide an environment that includes calmness and reflection, good boundaries. Many child-serving systems, particularly child welfare, have long focused on physical safety, but the research reveals the vital importance of the systems attending to the child's psychological sense of safety that may have little to do with real physical dangers [22,26].
- (5) Helping children build attachment and relationships: these include helping children develop or improve relationships with caregivers, therapists, treatment staff, and other key individuals in their lives. This also includes the importance of caregiver involvement in trauma-focused treatment whenever possible [13,29,30].
- (6) Partnership with youth and families receiving services: this includes child welfare practices such as Family Group Decision Making [31] or family involvement and partnership within the context of mental health services [32].
- (7) Training and self-care for practitioners/front-line workers to prevent secondary trauma and burnout: the literature supports the notion that high levels of compassion fatigue and burnout can lead to turnover and may interfere with effective decision-making [33\*].
- (8) Treating the entire person: treatment includes multiple components designed to access the needs of the child at multiple entry points (i.e., body movement, spirituality, sports and hobbies, gardening, etc.). In this way, multiple methods are utilized to help the child develop relationships with others, gain mastery, and overcome anxiety and depression through in-vivo learning [22,25\*].
- (9) Interventions are tailored to meet the individual needs of the child and family: understanding a child also involves understanding the child's familial, social, and community contexts [34].
- (10) Strengths-based: they include opportunities to help build mastery and improve the child's self-concept [29].
- (11) Cross-system collaboration: it is critical for systems to collaborate with one another, such as mental health, juvenile justice, residential treatment, and others [3\*].

- (12) Acknowledgment and incorporation of trauma-specific knowledge and thinking into local, state, and federal policy: this includes resources such as the federally-funded National Child Traumatic Stress Network and the state of Ohio's integration of trauma-informed thinking into their strategic plan [35].

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## Conclusion

Given the high prevalence of trauma within the United States, there is a high likelihood that service systems such as child welfare, education, and juvenile justice are going to encounter children who are suffering from the aftereffects of trauma. The notion of a trauma-informed system is a relatively new one that has only been recently applied to fit the needs of children who have experienced traumatic events. Although it makes intuitive sense, very little research has been done on the concept of a trauma-informed child-serving system. The current article identified 12 components that are prevalent throughout the literature on trauma-informed systems. It is highly recommended that these components be studied in future research much more comprehensively – both individually and combined. Further, as there is a lack of RCTs on interventions focused on creating trauma-informed child-serving systems, future research should focus on conducting RCTs on these interventions.

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## References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- of special interest
- of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 681–682).

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