# In Pursuit of a More Trauma-Informed Child Welfare System

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Children's lives can be affected by trauma in a variety of ways, from natural disasters and accidents to violence in the community and home. The traumatic experience of child abuse and neglect, especially when combined with a history of other, sometimes unrelated, traumatic events can lead to a variety of emotional and behavioral problems for children. As a result of trauma, abused and neglected children are more likely to experience social, emotional, behavioral, cognitive, and physiological problems as they mature into adolescence and adulthood. This article explores the traumatic impact of child abuse and neglect on children and addresses the need for social services systems to work with children in a manner that is sensitive and responsive to their traumatic experiences in order to help them cope with trauma and prevent long-term negative outcomes.

Child welfare caseworkers serve some of the most severely traumatized children, and it is therefore crucial that they be trained to recognize traumatic stress in maltreated children and know how to respond once it is identified. A large subset of the child welfare population includes children who have been removed from their homes due to abuse and neglect and placed in substitute care. These children often lack many of the supports that facilitate resiliency and are at an extremely high risk for mental health problems, particularly traumatic stress. For this reason, we emphasize the child welfare system.

## What Is Trauma?

Traumatic experiences are typically unexpected and uncontrollable (Pynoos, Steinberg, & Wraith, 1995; Terr, 1990). According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, American Psychiatric Association, 2000), a traumatic experience includes two elements: "The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and the person's response involved intense fear, helplessness, or horror" (pp. 427-428). Such traumatic events may overwhelm children, disrupt their sense of safety and security, and leave them feeling highly vulnerable.

### Types of Trauma

Some traumatic experiences may be abrupt, lasting only a few moments or hours. Rapes, auto accidents, exposure to a natural disaster, or kidnapping are instances of this type of traumatic experience. Other traumatic experiences are more chronic, such as ongoing sexual abuse, physical abuse, or exposure to domestic violence. Children with multiple or chronic traumatic experiences are more likely to be adversely affected by trauma, even if the experiences are unrelated, than are children who have experienced a single traumatic event (Terr, 1991).

### Subjective Experience of Trauma

A traumatic experience can affect children differently depending upon the type of traumatic experience, the level of exposure, the child's temperament and history, the child's environment, and the nature of the support systems available to the child. Children's reaction to trauma depends partially on their appraisal of the situation. Because each traumatic experience comprises numerous traumatic moments, the most traumatic part of an experience may differ for different children (Pynoos, Steinberg, & Piacentini, 1999). During a traumatic experience, children undertake an ongoing appraisal of both external and internal threats and make ongoing efforts to manage their reactions. They may attend to visual, auditory, kinesthetic, or somatic sensations as they process this information. During the event, there are often changes in their focus of attention from their personal safety to the safety of loved ones. They may inhibit their own wishes to intervene, retaliate, or try to protect others due to fears of self-harm. If a child is physically injured during a traumatic experience, the child may dissociate or may initiate other self-protective mechanisms to handle the pain. For many children, the most traumatic moment is not during the actual experience, but afterward, as they seek outside help or attempt to help others. They may be separated from their loved ones and support systems, and worry about the safety of others whose well-being is unknown. After the traumatic event, they may experience feelings of guilt for not thinking of or protecting others or for the family disruption that often results from the trauma or their reporting of it.

### Intrinsic Factors Influencing the Experience of Trauma

Factors intrinsic to a child can either mitigate or increase the impact of the trauma (Pynoos, Steinberg, & Wraith, 1995). Some children have more biologically sensitive natures and are more easily influenced by negative experiences. These children may startle more easily or be more sensitive to anxiety-provoking situations. Children's prior experiences, typical behavioral responses in stressful situations, and developmental capacities or deficiencies can either provide children with additional resources or create additional challenges for them during trying times. Some children have preexisting psychopathology or may have experienced prior trauma or loss experiences before a traumatic event. Some children have attachment disorders resulting from early instability in their family of origin (Cook et al., 2003). The impact of a current trauma may be affected by these prior experiences.

Another intrinsic factor influencing how children may react is their stage of development at the time of the trauma (Pynoos & Nader, 1998).

1. The primary developmental tasks of infants and toddlers are attachment to primary caregivers and getting their basic needs met. Common problems following trauma for very young children may include eating disturbances, developmental regression, such as bedwetting or soiling, language delay, failure to thrive, or attachment problems (Cahill et al., 1999; National Child Welfare Resource Center for Family-Centered Practice, 2002; Pynoos & Nader, 1998).
2. Preschoolers, who are not yet able to make logical sense of the trauma, may attribute magical qualities to traumatic events and reminders of these events. They may experience cognitive confusion or generalized fear and may have trouble identifying what is distressing them (Pynoos & Nader, 1998). Preschool children may also experience attention problems or become aggressive with others.
3. School-aged children are more likely to take responsibility for a traumatic experience (Pynoos & Nader, 1998). They are more likely to internalize problems, resulting in psychosomatic symptoms and feelings of guilt. Children in this age group may be frequently absent from school and may experience inattention or depression. They may experience en-

uresis or may exhibit violent or aggressive behaviors toward others.

4. Symptoms of trauma in adolescents, who are seeking greater independence from their family of origin, may include dating violence, relationship problems, loss of trust, or runaway behaviors (Pynoos & Nader, 1998). Adolescents may also exhibit antisocial behaviors, substance abuse, or eating or sleeping disorders. They are also at a higher risk for suicide attempts.

### Extrinsic Factors Influencing the Experience of Trauma

Children's environments also influence how they appraise and respond to traumatic events (Finkelhor & Kendall-Tackett, 1997). The developmental cycle of the family, including the relationship between the parents and changes in the composition of the household, can influence both stressors and the supports available to the child in the family system. Families disrupted by divorce or by medical or psychiatric illness of parents may create added stressors for a child, as can additional environmental stressors such as living in a violent neighborhood, exposure to drugs, separation from caregivers, multiple school and family placements, and other situational stressors, all of which are commonly experienced by children in the child welfare system. A disruptive family environment may also serve as a continuing reminder of the child's traumatic experience. These factors and others can influence how children respond to traumatic experiences (Cook et al., 2003) and can elevate the risk of subsequent behavioral, emotional, social, and psychiatric problems.

### Coping With Trauma

Handling stress associated with trauma is difficult for even the most resourceful and well-adjusted adult with dependable social supports and easily available community resources. Many children have not yet developed either the cognitive or the emotional resources to cope adequately with trauma. When faced with traumatic situations, these children may adopt behavioral strategies to help them cope with a trauma that eventually create additional problems for them. This can be especially true for children who expect trauma to reoccur. They may develop strategies in an attempt to manage the ongoing trauma, which later become maladaptive and prevent them from functioning to their potential. For instance, some children may "check out" mentally or dissociate in response to traumatic experiences (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). While this may be psychologically protective during a traumatic event, if a child is not mentally alert at school, or an adolescent is inattentive while driving, "checking out" behaviors can be disruptive and even dangerous and are associated with a range of risk-taking behaviors (Kisiel & Lyons, 2001).

### Incidence and Prevalence of Psychological Problems Among Youth Within Systems of Care

There are wide variances in the reported incidence and prevalence of symptoms among children who have experienced trauma (Cicchetti & Toth, 1995). One report, the "Congressional Briefing on Mental Health Services and Former Foster Care Youth" (2005), identified that within a one-year period, more than half of the youth in the study reported clinical levels on at least one of the following mental health problems: major depression, posttraumatic stress disorder (PTSD), social phobia, panic syndrome, or drug dependence. Consistent with this, researchers in San Diego, California, found that out of 1,618 parents and youths interviewed, 54% of children in five public sectors of care, including child welfare, met criteria for at least one disorder, with the most commonly occurring disorders being ADHD/disruptive disorders and anxiety disorders. About 9% of the children from the child welfare system reported anxiety disorders, with separation anxiety being the most common (4.6%), followed by social phobia (2.5%) and posttraumatic stress disorder (1.7%) (Garland, Hough, McCabe, Yeh, Wood, & Aarons, 2001).

## Short-Term Impact of Trauma

Children who have experienced traumas such as child abuse, neglect, or exposure to family violence are at risk for a variety of emotional and behavioral problems (Cahill, Kaminer, & Johnson, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993). As suggested before, common sequelae of traumatic experiences include depression and anxiety (Fergusson, Horwood, & Lynskey, 1996; Lanktree, Briere, & Zaidi, 1991), anger (Flannery, Singer, & Wester, 2001), conduct problems and oppositional behaviors (Ford, 2002; Guterman, Cameron, & Hahm, 2003), dissociation (Kendall-Tackett et al., 1993; McLeer et al., 1988), problems with attention or memory, and learning impairment (Cahill, Kaminer, & Johnson, 1999). One of the most commonly seen problems is PTSD (McLeer et al., 1988). The common symptoms include persistent reexperiencing of the trauma, persistent avoidance of stimuli associated with the trauma, or persistent symptoms of increased arousal (American Psychiatric Association, 2000). Children often manifest these symptoms differently than adults. They may show some symptoms of PTSD but not meet the full criteria, or they might exhibit agitated or disorganized behaviors or other symptoms (Cahill et al., 1999). Exposure to trauma in young children can also alter the neurobiological development of the brain to reflect a repeated state of hyperarousal that can influence their responses to stress for years to come (DeBellis et al., 2002; Perry & Pollard, 1998).

## Long-Term Impact of Trauma

Research shows that trauma also has a long-term impact on children's functioning, behavior, and physical health. With support from the Centers for Disease Control and Prevention (CDCP), Felitti and colleagues' Adverse Childhood Experiences (ACE) Study linked exposure during childhood to emotional, physical or sexual abuse, mental illness of a family member, or incarceration of parents to adult behaviors that increase risks to their health (Felitti et al., 1998). These behaviors included smoking, severe obesity, promiscuity, physical inactivity, depressed mood, suicide attempts, and history of sexually transmitted diseases, alcoholism, and drug use. These risky behaviors, in turn, lead to increased risk for serious health conditions, such as stroke, heart attack, cancer, and diabetes (Felitti et al., 1998). By establishing the link between early childhood stress and trauma and later health problems, Felitti and colleagues underscore the importance of treating trauma and its many sequelae in children not only to minimize the potential impact of these traumas on quality of life for these children but also to address the ever-rising healthcare costs of treating serious health problems.

## Creating a Trauma-Sensitive Response System

To mitigate both the short-term and long-term impacts of trauma on children, all of the service providers who interact with children in the aftermath of a traumatic experience must be fully educated and informed about their role in treatment and in effective treatment strategies. An initial goal is to create a *trauma-sensitive response system*, in which professionals are trained to recognize children who have experienced trauma, understand the impact of such trauma, and are knowledgeable about trauma-specific service resources available in the community. Within such a system, policies and procedures must emphasize and promote easy access to trauma-specific services for children. Assessment of every child's traumatic experi-

Cont'd on page 6

ences and their impact is a central component of a trauma-sensitive system. Multiple disciplines and service systems should be well educated and prepared so that each child has access to trauma-sensitive services from all involved providers, including mental health professionals, pediatricians, law enforcement officials, judges, school personnel, and child welfare professionals.

## Trauma-Sensitive Services in the Child Welfare System

Creating a trauma-informed system may have different implications for different services systems. Within the public child welfare system, the creation of a trauma-informed system has far-reaching implications.

Public child welfare agencies across the country are focusing increasingly on three federally mandated goals: safety, permanency, and child well-being (Harden, 2004). Building a "trauma-informed child welfare system" is vital to achieving all three of these goals. In such a system, professionals understand the impact of trauma on children's behavior, development, relationships, and their coping and survival strategies, and can integrate that understanding into planning for the children and their families. Professionals in a trauma-informed system recognize the need for specialized trauma treatment services and know how to find providers who are qualified to provide the types of services children need. In a trauma-informed system, policies reflect this awareness, professional education supports acquisition of the necessary knowledge and skills, and contract resources and community-based services are knowledgeable about empirically sound programs and practices to treat childhood trauma.

How trauma-informed is the child welfare system currently? There has been minimal research exploring this question for child welfare organizations and for other service systems interacting with children in the aftermath of child abuse and neglect. The National Child Traumatic Stress Network (NCTSN) is a consortium of 54 organizations funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Its mission is to raise the standard of care and to improve access to trauma-sensitive services for traumatized children, their families, and communities throughout the United States (www.NCTSN.org). The NCTSN's Systems Integration Working Group has begun looking at the different agencies that touch the lives of children and their families following incidents of child maltreatment to determine how these agencies help protect children from the negative impact of trauma or, conversely, how they may actually exacerbate traumatic symptoms through their responses (Taylor & Siegfried, 2005). A small survey of 53 agencies in 11 different communities was initiated to explore how service systems gather, assess, and share trauma-related information and how they train their staff concerning child trauma. The survey included representatives from child welfare agencies, dependency courts, foster parent and foster care agencies, schools, and mental health agencies. These agencies were selected because the literature about the integration of trauma-related information and expertise into the responses of these agencies has been scant or nonexistent to date.

The survey revealed mixed results (Taylor & Siegfried, 2005). Most of the organizations surveyed indicated they gathered some information on child trauma; however, the organizations were inconsistent in screening for previous traumas. Only 70% of the sampled agencies routinely assessed for PTSD-related symptoms, and only 59% of the agencies gathered information about trauma reminders and triggers. Although 80% of the agencies trained personnel on the impact of trauma, only 45% reportedly trained their employees on the evidence-based practices available for treating child trauma.

Several recommendations for the child welfare system emerged from this small-scale study, including the following:

1. Provide education and training for front-line staff and supervisors on assessing trauma in children, evidence-based treatment practices, and the importance of recognizing and helping children deal with traumatic reminders.
2. Increase the use of standardized assessment measures.
3. Integrate the completion of a child's trauma profile instrument into child assessment and interview protocols so workers will understand a child's traumatic history and can make appropriate referrals.

### Making the Child Welfare System More Trauma-Sensitive

To help the current child welfare system become more trauma-sensitive, it is recommended that education related to trauma and its effects be integrated into the system at multiple levels. At the community/state level, it is important to facilitate the expanded availability of empirically sound treatment programs for children who have experienced trauma. This objective can be achieved by training staff on how to recognize the need for specialized trauma services and how to find or develop service providers qualified to offer it. Other strategies include linking funding to best or promising practices and increasing advocacy for, and contracts with, agencies that are committed to evidence-based practices. Financial support should also be provided for essential training and associated "retooling" costs related to fully implementing a newly learned treatment program.

Governmental agencies and other funding sources can help promote this movement through the programs they fund and the ways in which they hold providers accountable. At the organizational level, policies can be developed that are more trauma-sensitive and further encourage employees to adopt trauma-sensitive practices. Training of front-line workers and substitute care providers can help them gain a greater understanding of child trauma and its impacts on a day to day basis. Training can also increase their sensitivity to the need for specialized treatments for children's problems related to child trauma.

Some specific strategies to increase trauma-sensitive casework are consistent with well-established best practices in the child welfare field. First and foremost is the need to establish the child's actual and perceived physical safety. Good active listening skills, taught at all levels of clinical practice, serve to help children feel heard and less anxious. Children have a need for structure and predictability. As long recognized in child welfare, workers should respect the continuity of the familiar for children and try, whenever possible, to help children remain in a stable environment.

Over the past few years, experts at the NCTSN and National Center for PTSD have been adapting existing adult emergency response models for use with children. While these models were developed to provide disaster-related mental health services in the aftermath of mass traumatic events (such as a natural disaster or a school shooting), many of the principles of this Psychological First Aid (NCTSN and National Center for PTSD, 2005) model can apply to the activities of child welfare workers as well.

In Psychological First Aid, the first goal is always to establish a child's safety and meet immediate, concrete needs for support or help (NCTSN and National Center for PTSD, 2005). Workers should, whenever possible, specify how the child will be kept safe. Predictability and normalcy are important for children, and workers should strive to help reestablish familiar routines to maintain continuity for children. Often when a crisis occurs, children may lose trust in the adults and in the systems that are expected to support them. One of the first goals of intervention is to help reestablish dependable adult protection so the child can regain a sense of trust. This will increase their sense of safety and also help create an environment in which they can begin to heal.

### Eight Essential Elements of Trauma-Informed Child Welfare Practice

The NCTSN has identified eight practical but essential elements of trauma-informed child welfare practice to guide caseworkers (NCTSN, 2006):

1. *Maximize the child's sense of safety*: The more anxiety children have about their future, the harder it will be for them to control their fears and emotions and the deeper their problems are likely to become. Caseworkers can build a sense of physical safety by protecting children from further abuse, and they can build a sense of emotional safety by reinforcing the continuity of stable, supportive caregivers, which might include placement with supportive and protective relatives or well-trained foster parents. Maximizing predictability in children's environments through activities such as maintaining current school placements also enhances their sense of safety.

2. *Connect children with professionals who can assist them in reducing overwhelming emotions*: Caseworkers should seek out trauma-informed mental health providers who are trained to deliver well-established and empirically sound trauma treatment protocols, such as Trauma Focused-Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2005). These interventions teach children practical ways to identify and control the emotions associated with traumatic memories, including relaxation techniques, such as focused breathing and progressive muscle relaxation. Other techniques include teaching children to control their thoughts (thought stopping) and encouraging them to engage in positive, self-soothing activities.

3. *Connect children with professionals who can help them develop a coherent understanding of their traumatic experience*: A key component of recovering from trauma appears to be the ability to understand and accept what happened (Cook et al., 2003; Taylor, Gilbert, Mann, & Ryan, 2005). Effective trauma treatment includes exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the traumatic experience(s). Through this component of intervention, children learn to think in new and healthier ways about the trauma and their role in it.

4. *Connect children with professionals who can help them integrate traumatic experiences and achieve mastery over their experiences*: Beyond simply understanding their traumatic experience, children must be able to integrate these experiences within their view of themselves and the world around them (Cohen et al., 2005; Cook et al., 2003; Taylor et al., 2005). Effective trauma treatment exposes children gradually, through clinical exercises, so they are able to learn to discuss the events in ways that do not produce overwhelming emotions.

5. *Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma*: Children sometimes adopt techniques and strategies to help them cope with traumatic experiences that are adaptive in a traumatic situation, but maladaptive if applied in different settings or contexts (Cook, et al., 2003). These behaviors or strategies become problematic if a child continues to use them once the traumatic situation has ceased. However, since these may have served a child well during the trauma, a child may resort to using them when faced with other challenges or stress. Caseworkers may be able to assist children directly or through referrals to address these issues.

6. *Provide support and guidance to the child's family*: When faced with stressors related to the involvement of child welfare agencies, children and their families often feel overwhelmed and do not know how to proceed. Caseworkers are in a unique position to assist family members in taking steps toward understanding their situation, helping them regain their equilibrium, and working toward stability for their children and themselves. Toward this end, caseworkers should have a strong commitment to guiding families, which in some cases may include providing direction to help strengthen the family system, while in others, intervention may be directed to move toward a permanent out-of-home placement for a child with the least possible stress for all involved.

7. *Coordinate services with other agencies*: Numerous organizations, including courts, mental health agencies, schools, foster care agencies, child welfare agencies, and others, become involved in the lives of children and families following incidents of child maltreatment (Taylor & Siegfried, 2005). Managing the complexity of interacting with multiple agencies can be overwhelming for children. In addition, children may be retraumatized by having to retell their story multiple times as they interact with different service sectors. Caseworkers have the potential to reduce the negative impact of working with multiple service systems by taking an active role in coordinating services among agencies.

8. *Caseworkers must manage their own professional and personal stress*: Dealing with traumatic events and children's reactions to them on an ongoing basis can be overwhelming for caseworkers. Added to this are frequently high caseloads and stressors associated with logistical and organizational demands. This can create burnout and personal stress. It is vitally important for caseworkers to find ways to manage their own personal and professional stress so they can function effectively on the job and help children and families recover from traumatic experiences.

### NCTSN Child Welfare Products

The NCTSN is developing several products for use by the child welfare community to help accomplish the goals described above. These include a policy guide for child welfare administrators, a training toolkit for child welfare agencies, foster parent training materials, and a trauma profile and referral algorithm to help child welfare agencies make appropriate mental health referrals. The goals of these

Cont'd on page 8

products are to help child welfare professionals appreciate the contribution of a lifetime traumatic history to a child's current behaviors; understand the range of acute and long-term responses children may display from prior trauma; recognize how child traumatic stress is exacerbated by ongoing stressors in a child's environment (including separation/loss of caregivers and foster placement stress); be able to sensitively assess children for symptoms related to child traumatic stress in the context of individual development and culture; understand how the impact of child traumatic stress can be mitigated and prevented by the responses of child welfare workers; and be able to make trauma-sensitive plans, communications, and referrals for case management and therapeutic services.

The Training Toolkit is being developed with the involvement of several state agencies and national organizations and will serve as the foundation for training of child welfare professionals in trauma-specific knowledge and skills. One component of the NCTSN initiative to support child welfare is the development of a tool to help caseworkers more fully understand the child's trauma history and its relationship to current behavior. The Child Welfare Trauma Referral Tool is an instrument designed to help child welfare workers make more trauma-informed decisions about the need for referrals to trauma-specific and general mental health services. It is completed by child welfare workers through record reviews and gathering information from key informants. The tool allows caseworkers to document all known forms of trauma in a child's history and the ages at which these traumas were experienced. Questions help to identify a variety of common problems following a traumatic experienceand help determine whether or not the presence of such problems are associated with a child's traumatic experiences. Depending on the answers to these questions, a caseworker may make no referral, make a general mental health referral, or make a referral for trauma-specific services. Additional training products will eventually be developed for foster parents and residential treatment providers as well.

## Making an Informed Trauma-Specific Referral

There are a variety of trauma-treatment centers across the country, with varying levels of expertise in treating trauma. Some of these centers use techniques that are evidence-based; others use techniques with little or no research support. Some use techniques that may actually be harmful for children in treatment (Saunders, Berliner, & Hanson, 2004). To make a beneficial trauma-specific referral, caseworkers should be familiar with the core elements of effective trauma treatment and the efficacy of the practices that are being used by the potential trauma treatment providers or centers in their communities.

Common elements of trauma-specific mental health services include a strong therapeutic relationship, psychoeducation about normal responses to trauma, parent support and training, affect expression and regulation skills, stress management and relaxation skills, exposure to traumatic memories/trauma processing, the creation of a coherent narrative story to describe the traumatic experience, building strategies to cope with unpleasant feelings and physiological sensations related to the trauma, and techniques to help correct distortions in thinking or factual misunderstandings about the trauma.

Some of the treatment modalities with evidence to support their efficacy include Cohen, Mannarino, and Deblinger's (2005) Trauma-Focused Cognitive Behavioral Therapy to treat sexually abused children; Kolko and Swenson's (2002) Abuse-Focused Cognitive Behavioral Therapy to treat physical abuse; and Lieberman and Horn's (2002) Child-Parent Psychotherapy for Family Violence.

Many resources exist to help caseworkers identify practices with evidence concerning their efficacy. Some of these resources include the following: *Child Physical and Sexual Abuse Guidelines for Treatment* (Saunders et al., 2004) (www.musc.edu/cvc/guide1.htm); the Substance Abuse and Mental Health Services Administration's National Registry of Effective Programs and Practices (NREPP)(http://modelprograms.samhsa.gov/template.cfm?page= nreppover); the California Evidence-Based Clearinghouse for Child Welfare (www.cachildwelfareclearinghouse.org); the University of Colorado —Boulder's Blueprints project (www.colorado.edu/cspv/blueprints); and Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices (www.chadwick center.org/kaufman.htm). Additional resources are also available through the NCTSN Web site (www.nctsnet.org).

## Conclusion

Creating a trauma-informed child welfare system can significantly enhance safety, permanency, and child well-being for the nation's abused and neglected children. This involves accurately recognizing and assessing trauma and then knowing when and to whom to refer children in order to help them manage the aftereffects of traumatic experiences. Accurate assessment and effective intervention may also reduce stress on an already overburdened system. As children's symptoms become less intense, the demands on their caregivers, including foster parents and birth families, will often ease. With reduced stress in families and greater sense of self-control on the part of the child, placements are likely to be more stable and children likely to be at reduced risk of repeated abuse.

A major challenge facing child welfare professionals who hope to enhance the trauma-sensitive nature of their system is the current lack of community professionals who are fully prepared to provide empirically sound, or at least empirically informed, trauma treatment services. While this deficit is quite significant in many communities, child welfare professionals and foster parents should not underestimate their power to help change the system. Active, informed professionals and lay consumers who ask the right questions and expect providers to be trauma-informed and trained in the most effective interventions create a social demand for change in the provider community. Consistent consumer expectations can and will lead to changes in the behavior of community agencies and providers. Merely asking about a provider's training in evidence-based, trauma-specific protocols creates a powerful incentive for providers who are ignorant of the latest research and training to seek it out and to develop new competencies. Therefore, the power to transform the system, over time, may well be in the hands of front-line child welfare professionals and foster parents.

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