a comprehensive look at a prevalent child welfare issue

Safety

Permanency

Well-Being

Trauma-Informed Child Welfare Practice
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The Heart of the Matter: Complex Trauma in Child Welfare

Joseph Spinazzola, Ph.D., Mandy Habib, Psy.D., Angel Knoverek, Ph.D., LCPC, Joshua Arvidson, MSS, LCSW, Jan Nisenbaum, MSW, Robert Wentworth, MSW, Hilary Hodgdon, Ph.D., Andrew Pond, LICSW, and Cassandra Kisiel, Ph.D.

Complex trauma involves chronic or repeated, typically early-onset exposure to two or more of the following forms of trauma exposure: sexual, physical or emotional abuse, domestic violence, or neglect, as well as severe caregiver impairment and school/community violence (Kisiel et al., 2009). A national sample of over 2,200 children in child welfare found that over 70% met exposure criteria for complex trauma (Greenson et al., 2011). A substantial subset of children—typically those with the fewest social and economic resources, and those living amidst poverty, crime or cultural minority status (Cohen, 2007)—have experienced all of these forms of exposure.

Complex trauma impacts multiple core domains of functioning: children's physiology and brain development; their ability to identify, tolerate, control and appropriately express emotions, impulses and bodily sensations; to concentrate, learn and engage in goal-directed behavior; to form a positive and cohesive sense of self, meaningful values and hopeful future outlook; to cultivate secure and healthy attachment bonds, sustain intimate relationships, safely negotiate conflict and communicate their needs; and to interpret social cues accurately, set healthy personal boundaries and differentiate safe from threatening situations and interactions with peers and adults (Cook et al., 2005; Kisiel et al., 2009; Spinazzola et al., 2005). By the time they reach adolescence, many complexly traumatized youth are already caught in a vortex of intense somatic, behavioral and emotional dysregulation in which daily life is fraught with an ever-expanding host of traumatic reminders and subtle false alarms that activate extremes of hyper- and hypo-arousal. Like “live wires,” complexly traumatized youth can become charged with heightened vigilance and physiological reactivity at levels that are emotionally overwhelming and debilitating to the immune system. Like “walking dead,” they can retreat or slip into extended periods of severe withdrawal, emotional constriction, avoidance and numbing of consciousness induced via coping strategies that include dissociation, binge eating or substance dependence.

The legacy of unresolved complex trauma is staggering, and has been causally linked with increasingly dire outcomes across the lifespan that collectively place an enormous economic burden on society, conservatively estimated at over $200,000 per impacted child and over 100 billion per year.

Psychological maltreatment: The sleeping giant of complex trauma

Psychological maltreatment has been recognized by the American Pediatric Association as the most prevalent form of child maltreatment and thus far the most overlooked despite substantial evidence of its deleterious impact at levels comparable to more readily recognizable forms of maltreatment such as physical and sexual abuse (Hibbard et al., 2012). Psychological maltreatment is comprised of various overt and subtle forms of chronic emotional abuse and neglect, including prolonged verbal abuse, terrorizing, shunning, and social isolation. A recent study on a large sample of over 5,000 children and adolescents from the Core Dataset of the NCTSN revealed psychological maltreatment to have equal or significantly greater association than physical or sexual maltreatment to 27 out of 30 frequency and severity symptom, diagnostic and risk indicators assessed (Spinazzola et al., 2011). Psychologically maltreated youth were the most likely to exhibit significant internalizing, attachment and substance abuse problems and the most likely to develop anxiety and depressive disorders. Also notable was that exposure to psychological maltreatment resulted in equal levels of PTSD symptom severity compared to physical or sexual abuse. The child welfare system can serve as a critical gatekeeper of suspected disability and premature mortality (Edwards et al, 2004; Felitti et al, 1998, Ford et al, 2010).
What lies beneath: The need for comprehensive assessment

Children impacted by complex trauma are not only at high risk for revictimization but are more vulnerable than other youth to exposure to other forms of acute, non-interpersonal trauma. For example, chronically neglected children are at significantly increased risk of exposure to accidents and burns in the home. The aberrant socialization that frequently accompanies familial incest or emotional abuse can increase children’s susceptibility to school bullying and lead to juvenile delinquency, substance abuse and high-risk sexual behaviors. In turn, chronic physical abuse often underlies and fuels conduct problems and social aggression. Comprehensive evaluation that includes a thorough caregiving and trauma history and integrates developmental, psychiatric, behavioral, scholastic and interpersonal strengths and difficulties is essential. The child welfare system can play a pivotal role not only through early screening and assessment, triage, and trauma-informed referral but in working with providers to connect all the dots. “Unpacking” these exposure, risk and protective trajectories for youth in the child welfare system is the critical first step toward rerouting pathways to healthy outcomes, fostering resilience, and disrupting intergenerational cycles of complex trauma (Layne et al., 2008).

Placement instability: The sine qua non of complex trauma?

Children in child welfare with complex trauma have been found to have significantly higher rates of placement disruption (Kisiel et al., 2009). A child’s risk for poor outcomes can increase exponentially in child welfare as a result of cycles of impaired caregiving followed by periods of separation from primary caregivers, potential incidents of placement instability, revictimization in the new home, failed reunification attempts, or ultimate loss of primary caregivers. For children whose sense of self, intimate attachments, material possessions, access to friends and siblings—in effect, their entire world—hangs in the balance of the success or failure of these placements, each juncture can be experienced as another complex trauma exposure irrespective of the efforts and intentions of child welfare personnel and foster, kinship, or biological parents. The child welfare system can play a pivotal role in mitigating this risk by: a) recognizing the critical importance of placement stability in altering risk trajectories for complexly traumatized children, b) prioritizing careful deliberation around the timing and nature of placement decisions, c) establishing structures to support emotional regulation of children facing unavoidable placement transitions, and d) delineating proactive strategies to prevent or rapidly respond to child decompensation associated with abrupt placement disruption.

Helping the most vulnerable: Complex trauma and residential care

Placement in a residential treatment facility can be a common outcome for those children most severely and chronically impacted by complex trauma. In turn, complex trauma is heavily over-represented in youth in residential care. Analysis of the NCTSN Core Dataset revealed that when compared with traumatized youth receiving outpatient or community-based services, those receiving residential services had the highest rates of trauma exposure and associated impairment (Briggs et al., 2012). While the majority of outpatient youth no longer exhibited symptoms by the end of treatment, a substantial percentage of complexly traumatized youth in residential care continued to manifest impairment indicating the need for more extensive services. The highly structured, predictable and consistent environment and caregiving offered within trauma-informed residential settings may provide these children with a sufficient sense of safety and emotional containment to begin to shift from a survival-based preoccupation with threat detection and avoidance to a more present and future-oriented focus on skill acquisition and identity development. A residential placement can afford child service providers a unique window of opportunity to guide complexly traumatized children in the development of internal capacities for self-control and affect management, in the rehearsal of effective problem-solving and communication skills, and in the delineation of interpersonal boundaries and cultivation of safe and healthy relationships. The child welfare system can provide leadership on initiatives that ensure maximal treatment gains for complexly traumatized children by making purposeful, collaborative, treatment-goal driven decisions about the timing, duration and type of residential placements to which complexly traumatized children are assigned, extended, transitioned and discharged.

Complex trauma requires complex solutions

Traditional treatment of PTSD in children has focused on processing and resolving vivid and painful memories, beliefs, and emotions associated with one or more specific traumatic experiences. Intervention models designed to treat complex trauma of necessity attend to the broader array of deficits and domains of maladaptive functioning. Of the over two dozen evidence-based and empirically supported interventions created or advanced by members of the NCTSN over the past decade (NCTSN, 2012), several have been specifically developed to treat complex trauma by addressing six core components identified in complex trauma intervention: safety; self-regulation; attachment; identity development; trauma experience integration; and strength-based cultivation of self-worth, positive affect, personal competencies and mastery experiences (Cook et al., 2005). Treatment models are predicated upon a shared recognition that training is insufficient to achieve successful intervention with complexly traumatized children; responsible treatment of complex trauma entails ongoing training, supervision, fidelity assessment and careful adaptation responsive to unique cultural, setting and developmental needs of
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those being served.

Two complex trauma intervention models bear special mention given their widespread dissemination with ethnoculturally diverse child welfare populations served in outpatient, residential, specialized foster care and scholastic settings. The Attachment, Self-Regulation and Competency (ARC) model provides a comprehensive, system-based approach to treating complexly traumatized children aged 3-21 (Blaustein and Kinniburgh, 2010; Kinniburgh et al., 2005). Particularly notable among published outcome evaluations on the ARC model is the finding that children involved in the Alaskan child welfare system who successfully completed ARC treatment exhibited placement stability rates over twice that of the state average only one year after starting treatment. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) is a well-supported, 16-session, manualized, group-based intervention for complex trauma that has been used extensively with high-risk youth populations (DeRosa and Pelcovitz, 2008). A project with youth served by the Illinois child welfare system found that adolescents in foster care who received SPARCS were half as likely to run away and one-fourth less likely to experience placement interruptions (e.g. arrests, hospitalizations) compared to a standard of care group (Mental Health Services & Policy Program, 2008).

The child welfare system can advance effective intervention for complexly traumatized children by facilitating appropriate referrals to empirically supported interventions designed to treat the whole child. This begins with education of child welfare personnel on the overarching treatment needs of complexly traumatized children and the specific evidence-based treatment models designed to target these clinical objectives and is followed by support of initiatives to establish and sustain local and regional service hubs trained to provide complex trauma treatment for child welfare-referred clients.

Conclusion

Consideration of childhood trauma from a complex trauma framework invites a subtle but pivotal paradigm shift: from the traditional premise that “traumatic stress” derives from exposure to one or more events that lead to specific manifestations of distress which in turn compromise certain aspects of a child’s otherwise normative functioning, to the recognition that under certain circumstances the fundamental elements of a child’s daily life can be characterized by violations so egregious or deficits so severe that these become primary determining factors shaping a child’s foundational capacities and overall development. Cumulative exposure to trauma exponentially increases the likelihood of revictimization. In turn, maladaptive coping strategies developed in effort to survive experiences overwhelming to the child—including running away, self-harm, aggression or substance abuse—can evolve into direct or vicarious traumatic experiences in and of themselves for the child, their caregiving system, and secondary victims. These patterns of trauma exposure, coping deficits, illness, and retraumatization form the building blocks of intergenerational trauma. As prevention, detection and response to precisely these deleterious childhood adversities is, for better or worse, its unique purview, the child welfare system seeking to become truly trauma-informed cannot afford to overlook complex trauma. After all, it has always been the heart of the matter.

Joseph Spinazzola, PhD is Executive Director of The Trauma Center at Justice Resource Institute. He can be reached at jspinazzola@jri.org.

Mandy Habib, PsyD, is Assistant Professor of Psychology, Hofstra North Shore-LIJ School of Medicine.

Angel Knoverek, PhD, LCPC is Director, Chaddock Trauma Initiative of West Central Illinois.

Joshua Arvidson, MSS, LCSW, is Director of the Alaska Child Trauma Center, Anchorage Community Mental Health Services and Director of the Pacific Northwest Regional Training Center, CTTN.

Jan Nisenbaum, MSW, is Deputy Commissioner Massachusetts Department of Children and Families.

Robert Wentworth, MSW, is Assistant Commissioner Massachusetts Department of Children and Families.

Hilary Hodgdon, PhD, is Trauma Programming Director at The van der Kolk Center, Glenhaven Academy and Assistant Director of The Trauma Center at Justice Resource Institute.

Andrew Pond, LICSW, is President, Justice Resource Institute.

Cassandra Kisiel, PhD is Research Assistant Professor at Northwestern University Feinberg School of Medicine.

surveyed expert trainers on the CWTTT. The majority of trainers responded that all training modules were clear, easy to use, contained all relevant content for the child welfare workforce, and had the correct time allotment necessary to cover the material. Trainer feedback was both positive and constructive with recommendations for revision and improvement.

CTISP is leading a sub-committee of the NCTSN to revise the CWTTT incorporating feedback from trainers and other professionals in the field of child welfare. The revisions will incorporate recent research about trauma and its treatment as well as principles of adult learning and implementation science. These revisions include: streamlining and reorganizing the Essential Elements and structure of the CWTTT to facilitate training and integration; enhancing content related to topic areas including trauma among young children, the impact of trauma on brain development, trauma and culture, birth parent trauma, and secondary traumatic stress in the child welfare workforce; and providing guidance and support on training delivery and implementation. It is hoped that the revisions, which will be complete in the fall of 2012, will improve the quality of the CWTTT and its usefulness as a resource for educating child welfare professionals about trauma and for teaching them how to intervene to more effectively help children and families heal from traumatic experiences.

Alison Hendricks, LCSW is Operations Manager for the Chadwick Trauma-Informed Systems Project at Chadwick Center for Children and Families, Rady Children’s Hospital, San Diego. She can be reached at ahendricks@rchsd.org.