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Treating Trauma in Children Across Multiple Service Agencies: A Systematic Review

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Treating Trauma in Children Across Multiple Service Agencies: A Systematic
Review

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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This Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Children and adolescents in the U.S. and worldwide are commonly exposed to traumatic events. There are several questions regarding childhood trauma that this study aimed to explore. The focus of this systematic review was to explore the prevalence and impact trauma has on children, necessary qualities of trauma informed care, and what treatment methods are commonly used in various service agencies working with children exposed to trauma. Additionally, this systematic review aimed to explore barriers to implementing trauma informed care. Results identified several intervention strategies including; Trauma Focused-Cognitive Behavior Therapy (TF-CBT), Cognitive Behavior Therapy (CBT), Cognitive Behavioral Intervention for Traumatized Students (CBITS), Seeking Safety (SS), Eye Movement Desensitization and Reprocessing (EMDR), Attachment Self-Regulation Competency (ARC), Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET), Child Parent Psychotherapy (CPP), and Calm Attuned Present Predictable Don't (CAPPD). The findings of this study have several implications for future research for clinical social work practices with children exposed to trauma. There appears to be a lack of research evaluating the other treatment interventions and their effectiveness when working with children exposed to trauma. Due to the millions of youth in the U.S. estimated to have experienced at least one traumatic event, more research in the area of effective treatment interventions used to treat childhood trauma is a need.

Keywords: Trauma Informed Care, Treating Trauma, Child Welfare System, Education System, Juvenile Justice System, Trauma Interventions

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Treating Trauma in Children Across Multiple Service Agencies: A Systematic Review

"With four million youth in the U.S. estimated to have experienced at least one traumatic event, childhood trauma has become a pressing public health concern," (Adams, 2010, pg.1). Children and adolescents who have a history of experiencing trauma are served by many child serving agencies such as the child welfare system, education system, and criminal justice system (Ko, et al., 2008). In recent years, these agencies have begun to understand the prevalence of trauma and its pervasive impact on children, families, and society as a whole (Brown, Baker, & Wilcox, 2012). Children exposed to trauma may experience both immediate and long-term challenges. These challenges can include depression, anxiety, anger, behavior problems, learning disabilities, dissociation, Post Traumatic Stress Disorder, and developmental delays (Klain & White, 2011). For example, researchers suggest children whose behavioral and emotional development are impacted by trauma often are more susceptible to negative outcomes such as dropping out of school, substance abuse issues, crime, and decreased job fulfillment as adults (Klain & White, 2011).

The U.S. Department of Health and Human Services reports, "in 2011, 676,569 children in the U.S. were victims of substantiated maltreatment by child protective services" (U.S. Department of Health and Human Services, 2011, p. ix). Most likely, no other child-serving agency serves a greater percentage of children exposed to trauma than the child welfare system. Research suggests a large majority of children served by child welfare have experienced at least one major traumatic event in their life. Many have a long and complex history of trauma (Ko. et al., 2008). In one study, findings indicated more than 60% of children from the age of 0-17 have experienced or witnessed some form of trauma within the past year (Holmes, Levy, Smith, Pinne, & Neese, 2015). Trauma focused interventions in a school system can support school

aged children in their natural settings (Holmes, et al., 2015). Many trauma victims go untreated.

School based services are particularity important to the underserved ethnic minority youth who

are less likely to access mental health services (Langley, Santiago, Rodriguez, & Zelaye, 2013).

Another leading child service agency working with traumatized children and youth is our

nation's juvenile justice system. There is over 93,000 children and youth who are currently in a

juvenile correctional facility of some sort around the country (Adams, 2010). Research shows

between 75 and 93 percent of these children and youth are estimated to have experience some

sort of trauma (Adams, 2010).

For purposes of this paper, there are two types of trauma. The first type of trauma

explored is acute trauma. This type of trauma occurs when a child experiences a serious injury

to him/herself or witnesses a serious injury to someone else. Acute trauma also includes if a

child were to witness the death of another or is facing imminent threats of serious injury or death

to oneself or another. Acute trauma may also include if a child experiences a personal physical

violation of integrity. The second form of trauma explored is trauma that occurs repeatedly over

a prolonged period and can affect the development of a child.   This is complex trauma (Henry,

et al., 2001). Some examples of complex trauma might include; domestic violence, sexual

abuse, and physical abuse. Both forms of trauma cause a range of responses including but not

limited to intense feelings of fear, loss of trust in others, decreased sense of safety, guilt, shame,

and emotional dysregulation (The National Child Traumatic Stress Network, n.d.).

Given that trauma is so prevalent, it is important for child serving agencies to be trauma

informed. The National Child Traumatic Stress Network defines a Trauma Informed System

(TIS) as:

One in which all parties involved recognize and respond to the impact of traumatic stress

on those who have contact with the system including children, caregivers, and service

providers. Programs and agencies within such a system infuse and sustain trauma

awareness, knowledge, and skills into their organizational cultures, practices, and

policies. They act in collaboration with all those who are involved with the child, using

the best available science, to facilitate and support the recovery and resiliency of the child

and family (The National Child Traumatic Stress Network, n.d.).

There are several benefits to implementing a TIS. Systems focus on maximizing a child's sense

of physical and psychological safety, help them develop coping strategies, and increase resilience

(Klain & White, 2011). Treating trauma in children can allow children to achieve a sense of

balance and stability, allow children to make progress in meeting necessary developmental

milestones, and heal deep emotional scars (Klain & White, 2011). Research is indicating that

some of the outcomes of implementing a trauma informed system includes the following: a)

fewer children requiring crisis services, such as emergency department visits or residential

treatment, b) decreased use of psychotropic medications, c) fewer foster home placements, d)

improved child functioning, and e) increased well-being (U.S. Department of Health and Human

Services, 2013). It is important that trauma informed systems closely analyze and evaluate

outcomes before and after being trained in trauma informed care to provide the statistical

evidence to affirm the value of a TIS.

Each child-serving agency approaches treating trauma differently. They each have a

different level of awareness, knowledge, and skill when treating trauma. However, the goal for

all systems is to improve outcomes for children who have a history of trauma (Ko, et al., 2008).

The purpose of this qualitative project is to gain a better understanding of how child service

agencies are addressing the treatment of trauma that children are exposed to. In this study, the following research question will be examined: How are child serving agencies treating the trauma that children have been exposed to? A systematic review, an intentional method of systematically reviewing articles with specific selection criteria will be conducted.

Literature Review

Trauma Informed Care

Literature is showing that trauma is under-recognized, under-diagnosed, and under-treated (Hanson, Hesselbrick, Tworkowski, & Swan, 2002). In an effort to improve services for children and families who are involved in child serving agencies, Trauma Informed Care (TIC), is a relatively new phenomenon in which researchers have begun to understand the prevalence of trauma and its pervasive impact on children, families, and society as a whole (Brown, et al., 2012). An agency that adopts trauma informed care as a treatment, realizes the impact of trauma, understands pathways for recovery, recognizes the signs and symptoms of trauma, and fully integrates knowledge of trauma into policies, procedures, and practices. (Substance Abuse and Mental Health Services Administration, Trauma and Justice Strategic Initiative, 2014).

TIC describes services provided in a manner that recognizes and focuses on the persistent biological, psychological, and social impact of trauma (Brown, et al., 2012).   The Substance Abuse and Mental Health Services Administration (SAMHSA) National Child Traumatic Stress Network (NCTSN), has been a key organization in promoting trauma informed services by educating professionals and the public about trauma, fostering development, testing, and disseminating evidence based practices that serve traumatized children across multiple service agencies (NCTSN, 2015).

Essential Elements of Trauma Informed Care

Research suggests there are seven essential elements which make a system trauma informed. These elements include:

1) Maximize physical and psychological safety for children and families.

2) Identify trauma-related needs of children and families.

3) Enhance child well-being and resilience.

4) Enhance family well-being and resilience.

5) Enhance the well-being and resilience of those working in the system.

6) Partner with youth and families.

7) Partner with agencies and systems that interact with children and families.

(Chadwick Center for Children and Families, 2014)

It is critical in TIC that the children receive the appropriate trauma screening, trauma-focused assessment, and referral to the appropriate trauma focused mental health providers (Conradi, Wherry, & Kisiel, 2011). Learning about a child's trauma history is necessary to identify current symptoms or developmental delays, which drive the treatment plan. It is important to keep the initial screening brief. The screen identifies possible exposure to traumatic experiences and the presence of traumatic stress symptoms (Conradi, et al., 2011).   A trauma screening tool is designed to be universal. After the initial screening, a more comprehensive assessment should take place (Pence, 2011).

An assessment is more in depth than a screen.   An assessment typically involves speaking with several individuals that interact with the child including but not limited to; teachers, parents, grandparents, siblings, other caregivers, and therapists. Speaking with these

individuals allows the mental health provider to obtain more specific information about a child's

symptoms, functioning, family environment, and strengths (Conradi, et al., 2011). The

assessment gives the clinician a base in which to create an appropriate treatment plan and

provide resources to the child/family. There are several tools used to assess trauma in children

such as; the UCLA PTSD Reaction Index for DSM-IV, the Child PTSD Symptom Scale, the

Trauma Symptom Checklist for Children, and many more (Conradi, et al., 2011).

The National Child Traumatic Stress Network (NCTSN) has done research in the

importance of addressing and treating trauma in parents, caregivers and staff. Many parents have

their own history of trauma that has gone untreated (Walker, 2007). One researcher discusses

how trauma can compromise a parents' ability to make appropriate judgments about safety

and/or make it challenging for them to form and maintain secure and trusting relationships with

their children (Walker, 2007). In another study, new mothers described ambivalence about

seeking help but also a sincere desire for healing (Muzik et al., 2013).

Secondary Traumatic Stress is another key component of TIC. Individuals who work

with traumatized children and families can often experience Secondary Traumatic Stress. The

NCTSN defines Secondary Traumatic Stress as the emotional pressure that results when an

individual hears about the firsthand trauma experiences of another (NCTSN, 2015). Individuals

affected by secondary stress may find themselves re-experiencing their own personal trauma

(NCTSN, 2015). Secondary stress can often lead to burnout. It is important for service agencies

to build in systems that support professionals who may experience secondary stress (Chadwick

Trauma-Informed Systems Project, 2014).

Barriers

TIC does not come without its challenges. Some of these challenges include: a) funding constraints, b) training barriers, and c) collaboration difficulties, to name a few. Because of lack of funding, agencies need to carefully allocate monies to meet the growing need to serve the nations vulnerable children and families (Fraser, et al., 2011). Cost is likely the largest barrier to creating TIC. At a community level, dissemination of evidence-based trauma focused mental health treatment is resource intensive, with recent research estimating costs as high as $500,000 to implement (Fraser, et al., 2011). Rural communities face even more challenges to implementing TIC due to higher poverty rates than urban and suburban areas as well as increased substance abuse and mental health issues while having significantly less resources (Sudol, 2009).

Another barrier is training. As with any system-wide training initiative, building a capacity for trauma sensitive care involves a substantial long-term commitment of resources, planning, and oversight (Fraser, et al., 2011). Chadwick Trauma Informed Systems Project found there is inconsistent access to trauma-focused mental health treatment and lack of trauma training among many clinicians who serve children and families (Hendricks, Conradi, & Wilson, 2011). Intense training and commitment is essential for TIC. At an organizational level, administrative and frontline workers need sufficient knowledge, skills, and tools to support implementing trauma-informed practices (Fraser, et al., 2011). One worker remarked, when you are drowning, it is hard to see new training as important (Hendricks et. al., 2011).
Studies also are showing collaboration and system barriers to TIC. System barriers such as challenges related to collaboration with mental health providers and the courts were cited across the research. As discussed previously, secondary traumatic stress was prevalent among clinicians in all jurisdictions and was identified as a barrier to providing trauma informed care

(Hendricks, et al., 2011). Given the high rates of traumatic stress symptoms clinicians' work with, compassion fatigue can often lead to job burnout and job withdrawal (Fraser, et al., 2014). Although barriers exist, many child-serving systems are taking on the challenge to become trauma informed.

Trauma Informed Child Welfare

A Trauma Informed Child Welfare System (TICWS) is designed to provide a structure for teaching the workforce to better understand the impact trauma has on children and families as well as provide the workforce with strategies to manage a child's challenging behaviors and overwhelming emotions that stem from the trauma (Fraser, et al., 2014). By doing this, it ensures the child receives services that are the most needed, effective, and decreases the risk of re-traumatization (Klain & White, 2013). As Richardson, Coryn, Henry, Black-Pond, and Unrau (2012) argue, child welfare workers who are not trained in TIC could misunderstand the child's traumatic experience, which can be detrimental to understanding the symptoms of the child, especially any disruptive behavior problems and the need for appropriate mental health treatment interventions (Conners-Burrow, et al. 2013).

TIC changes the direction of treatment from treating the symptoms of trauma to treating the underlying causes and context of the trauma itself (Conners-Burrow, et al., 2013). TIC is designed to increase the child's sense of physical and psychological safety, assist in developing coping strategies, heal deep emotional scars, meet developmental goals, and to achieve stability for children and families (Conners-Burrow, et al. 2013). The U.S. Department of Health and Human Services reports:

Trauma informed care produces the following outcomes: Fewer children requiring crisis services, such as emergency department visits or residential treatment, decreases the use

of psychotropic medications, fewer foster home placements, placement disruptions, and

reentries, reduces length of stay in foster care, and improves child functioning and

increased well-being (US Department of Health and Human Services, 2013).

Another benefit to a TICWS is that it not only focuses on the child's trauma but also the

caregivers and the workforce who experience secondary trauma (Fraser, et al., 2011). Being a

TICWS requires you to be aware of the effects trauma has on all participants in the system

(Hendricks, et al., 2011). It is essential to keep in mind that family members may also have

experienced their own trauma (Walker, 2007). Untreated traumatic stress for parents can cause

an inability to regulate emotions, maintain physical or mental health, engage in relationships,

parent effectively, or maintain stability (Muzik, M., et al. 2013). All of these have a large impact

on a family's ability to function well. In a TICWS, it is crucial the caseworkers assess and

understand the impact trauma has on the parents and their ability to function (SAMSHA, 2015).

A TICWS needs to pay close attention to secondary trauma in order to be successful. Secondary

Trauma is the trauma professionals and caregivers experience by working with children who

have traumatic histories (Pynoos, Fairbank, Brown, 2011). This is important because if

secondary trauma is left untreated, it can decrease the effectiveness, lead to burnout, and

eventually turnover. As a staff in a TICWS you must find ways to take care of yourself (Child

Welfare Information Getaway, 2015). Some ideas include taking a walk, taking your breaks, and

using supervision to process secondary trauma.

Trauma Informed Education

Another major child serving system is our nation's schools. Becoming a trauma

informed school goes beyond identifying and referring students with traumatic stress histories to

outside services (Oehlberg, B., 2008). Taking a passive stance like this does not ensure every

student can meet their full potential (Oehlberg, B., 2008). Trauma can negatively affect the parts

of the brain that regulate learning and self-control (Klain, & White, 2013). Research clearly

illustrates that brain structure and brain chemistry is altered for children who have experienced

trauma (Oehlberg, B., 2008). If trauma is not addressed, these children have a decreased

likelihood of being successful in school (NCTSN, 2015). This is why it is essential that our

nation's schools are trauma informed.

Schools have the ability to capture those children whose trauma has gone untreated due to

financial barriers or cultural barriers to accessing mental health treatment in a traditional setting

(Langley et al., 2013). Minority children are particularly vulnerable to experiencing trauma due

to high community rates of poverty, drug use, and crime (Holmes, et al., 2015). These and all

students can benefit greatly from relationships with supportive adults at school. Educators can

provide stability, consistency, and empathy offering a traumatized child a safe environment

where to work through traumatic experiences (NCTSN, 2015). It is important educators have

the ability to recognize what trauma looks like and respond through compassion, not discipline

(Oehlberg, B., 2008). Changing disciplinary practices from punitive to restorative can help

educators understand 'problematic behaviors' serve as a function for children who have

experienced trauma (NCTSN, 2015). Instead, educators can help children identify the triggers

that result in the "problematic behaviors" and teach new coping skills (NCTSN, 2015).

In the Huffington post, one article states children who are experiencing the toxic stress of

severe and chronic trauma cannot learn, it is physiologically impossible (Stevens, 2012).

Trauma Informed Schools have proven to increase academic achievement and test scores

(Oehlberg, B., 2008). Research suggests there is a reduction in dropouts, a reduction for the

need for special education services, and a reduction in absenteeism (NTCSN, 2015). One study

found treating trauma in a school system can significantly improve a child's ability to pay attention and decrease externalizing behavior and oppositional defiance (Holmes, et. al, 2015). When addressing children's negative behaviors the criminal justice system is another service system working with our nations traumatized children and youth.

Trauma Informed Juvenile Justice

Researchers, Finkelhow, Shattuck, Turner, Ormrod, & Hambly, (2011), report that over 80% of youth in the juvenile justice system have experienced some sort of trauma. Childhood abuse or neglect increases the likelihood of involvement in the juvenile justice system by 53% (Hodas, 2006). Juvenile justice systems historically have had three primary goals; increasing safety in the facility and community, bringing justice for crimes committed, and rehabilitation or prevention of recidivism (Ford & Blaustein, 2013). Recently a new goal has emerged. Juvenile Justice Systems have found it increasingly important to address juveniles mental health concerns if they want to meet the goals of safety, justice and recidivism (Ford & Blaustein, 2013). Ford, Elhai, Connor, & Frueh, (2010), report that longitudinal research demonstrates trauma in childhood is predictive of adolescent delinquency as well as the severity of offenses and the likelihood of recidivism (Kerig, Ford, & Olafson, 2014). Addressing a child's trauma is critical to promoting the well-being of the child, his/her family, and the community (Adams, 2010).

Tracy Velazquez, executive director of the Justice Policy Institute states:

We simply cannot afford to ignore the evidence and prevalence of the long-term effects of untreated childhood trauma. If we are to have strong healthy communities, then we must start with these children whose unseen and untreated wounds hinder their ability to become healthy production adults (Adams, 2010).

 If trauma informed principles are introduced in juvenile justice systems, staff can play a major

role in minimizing triggers, stabilizing offenders, and avoid seclusion or other measures that may

repeat aspects of past abuse (Miller & Najavits, 2012). Correctional facilities are challenging

settings for trauma-informed care. They are designed to house perpetrators, not victims (Miller

& Najavitis, 2012).   Although research suggests that correctional facilities that have introduced

the use of cognitive-behavioral treatments with strong educational competents have helped

stabilize inmates who have experience trauma (Miller & Najavits, 2012).

        Trauma-Focused Cognitive Behavioral Therapy (TFCBT) has several components

including: parenting skills, psychoeducation, relaxation skills, affective modulation skills,

cognitive processing, trauma narration, and an overall goal to enhance safety (Igelman, Ryan,

Gilbert, Bashant, & North, (2008). TFCBT can help children, youth, and their parents overcome

the negative effects of traumatic life events by restoring and enhancing interpersonal trust,

empowerment, and resilience (Jennings, 2008). Integrating this treatment throughout child

serving systems would dramatically decrease the number of children who go untreated.

Conceptual Framework

        The growing number of children who have been exposed to trauma and the impact it has

on their ability to function has motivated service agencies to become more trauma informed.

While working as a social worker in child welfare, the awareness of the importance of using a

'trauma lens' became clear quickly. As stated previously, "with four million youth in the U.S.

estimated to have experienced at least one traumatic event, childhood trauma has become a

pressing public health concern," (Adams, 2010, pg.1). The realization of the enormous impact

trauma has on children, families, and communities motivated a desire to learn and understand

more about treating trauma. During the beginning stages of research on what it means to be a

Trauma Informed Child Welfare Agency, it became clear children who experience trauma are not only served by Child Welfare Agencies. Children and adolescents who have a history of experiencing trauma are served by many child serving agencies such as the child welfare system, education system, and juvenile justice system (Ko, et al., 2008).

As social workers, there are certain theories that guide practice. The primary framework through which this clinical research study is conducted is 'Systems Theory.' Systems Theory describes the family as a unit of interconnected individuals who develop patterns of communication that can facilitate the growth and functioning of this unit, or retard it (Boss, Doherty, Larossa, Schumm, & Steinmetz, (1993). When children experience trauma it can often interfere with the interconnectedness of a family and get in the way of growth and functioning. Traumatized youth often develop symptoms of anxiety, aggression, depression, or developmental delays (Pinna & Gewirtz, 2003). Traumatized parents often experience similar symptoms making it difficult to provide their children with support, safety, and well-being (Tullberg, Avinadav, & Chemtob, 2013). Both are variables that make it difficult for a family unit to develop and facilitate growth and functioning.

Methods

According to Petticrew & Roberts (2006), a systematic review is defined as a "method of making sense of large bodies of information and a means of contributing to the answers to questions about what works and what does not" (p. 4). This systematic review like all others consists of specific inclusion criteria, a distinct search strategy, and objective criteria for synthesizing and reporting the findings (Petticrew & Roberts, 2006). This systematic review searched a variety of databases in order to identify articles related to how the treatment of trauma

in children is being implemented across 3 service sectors including; child welfare, education, and

juvenile justice systems.

Selection of Articles and Specific Criteria

      The researcher began with a general search of peer reviewed articles using the databases;

socINDEX, psychInfo, National Criminal Justice Reference Service (NCJRS) Abstracts

Database, Child Development & Adolescent Studies, Education full text, and Google Scholar.

Table 1 shows the search phrases that were used under the criteria "trauma informed…"

Table 1. Search Categories

Search Categories
Education System
Child Welfare System
Juvenile Justice System

81 articles were gathered in the initial search. These included qualitative, systematic reviews,

and exploratory studies. Of these articles, any published prior to the year 2000, were removed.

Articles were also removed if they were not peer-reviewed. Of the 49 remaining, the author

reviewed the title and abstract to assess if the articles met the selection criteria determined by the

author. This meant that   the title and the abstract, included terms related specifically to the

implementation of trauma informed care, treating trauma in the education system, treating

trauma in the child welfare system, and treating trauma in the juvenile justice system. Thirty-

seven articles were then remaining. A table was created to organize the articles by service

system , title, author, and a short review of the abstract (See Table 2).

Method to Analyze Articles

The researcher read the methods, discussion, and findings sections of these 37 articles to identify common themes of treatment methods and interventions that the child welfare, education, and juvenile justice system used to treat children exposed to trauma. Twelve articles were removed, as they did not provide enough information specific to an intervention or model of treatment used to treat children exposed to trauma in trauma informed care or one of the three service agencies. The remaining fifteen articles were then systematically reviewed to address the question, how is trauma being treated across multiple child serving agencies? (See Table 3). Treatment and intervention themes were highlighted using several different colors of highlighters to organize the themes and notes were taken to analyze the data. The researcher also analyzed each service systems barriers to treat childhood trauma, and implications for the future.

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Results

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Of the fifteen articles, three articles focused on general Trauma Informed Care interventions, three focused on interventions used in the Child Welfare System, five focused on the Education System, and four on the Juvenile Justice System. Fourteen of the total articles addressed Trauma Focused-Cognitive Behavior Therapy (TF-CBT), five addressed Cognitive Behavioral Interventions for Traumatized Students (CBITS), five addressed Seeking Safety (SS), four addressed Eye Movement Desensitization and Reprocessing (EMDR), four addressed Attachment Self-Regulation Competency (ARC), three addressed Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET), three addressed Child Parent Psychotherapy (CPP), and two addressed Calm Attuned Present Predictable Don't (CAPPD; See Table 4). While the majority of the findings fell within these treatment methods, there were additional treatment methods worthy to refer to.

Trauma Informed Care

Three articles were systematically reviewed to better understand common treatment interventions used in articles that focused on Trauma Informed Care in general. Of the overall treatment interventions used in Trauma Informed Care, TF-CBT was the most common. Other treatment interventions that were used in Trauma Informed Care worth making note of include CBITS, SS, EMDR, ARC, TARGET, and CPP. These treatments are further described as we move into the three service agencies working with children exposed to trauma.

Child Welfare System

Three articles were systematically reviewed to better understand common treatment interventions used in the Child Welfare System. Of the most common treatment interventions across the three service agencies (see Table 4), TF-CBT, CBITS, SS, EMDR, ARC, TARGET, and CPP were used in the Child Welfare System. In addition, a common theme was the need for Trauma Informed Screening and Assessment in the Child Welfare System.

Trauma Informed Screening and Assessment

It is important to conduct a thorough assessment of a child's trauma history, current psychological, and behavior problems (Igelman et al., 2007). The Child Welfare Trauma Referral Tool (CWT) can be used to guide child welfare workers in making appropriate referrals for treatment (Igelman et al., 2007). The Chadwick Center and the National Child Traumatic Stress Network developed the CWT. Using the CWT, the caseworker obtains information on a child by reviewing the child's records, collateral interviews, and if appropriate an interview with the child (Igelman et al., 2007). Relevant information would be the type of trauma the child has experienced and at what age, current level of distress and functioning, developmental concerns, traumatic stress reactions, and emotion and behavior regulation (Igelman et al., 2007).

Igelman et al., (2007) also discuss the Trauma Assessment Pathway Model (TAP). TAP assists clinicians to better understand their clients and ensure they are triaged into the correct form of trauma treatment given the clients' current level of functioning (Igelman et al., 2007). TAP includes "three primary components: assessment of the child with the goal of creating a 'Unique Client Picture' triaging the child to the correct treatment strategy; and helping clinicians identify which evidence-supported therapeutic strategies to use with children who may not fit into a specific evidence-based treatment model" (Igelman et al., 2007, p. 24). Within this model, children and their caregivers complete a core set of assessment measures. These measures gain information on the child's social, cultural, familial, and community context that surround the child (Igelman et al., 2007). The measures help the clinician to understand the child's attachment style and functional and chronological developmental levels (Igelman et al., 2007). The 'Unique Clint Picture' as previously mentioned, is created by collecting the data from the assessment measures. The Unique Client Picture guides the clinician in understanding the underlying cause of the child's symptoms and provides direction for the focus of treatment (Igelman et al., 2007).

Education System

Five articles were systematically reviewed to better understand common treatment interventions used in the Education System. Of the most common treatment interventions across the three service sectors (see Table 4), TF-CBT, CBITS, ARC, and CAPPD were commonly used interventions in the Education System. Another treatment intervention that was used in the Education System worth making note of was the Rap Club. Similar to the Child Welfare System, a common theme was the need for Trauma Informed Screening and Assessment tools in the Education System.

Rap Club

The Rap Club targets success in schools by providing students with evidence-based skills for regulating their emotions and making effective decisions (Mendelson, Tandon, O'Brennan, Leaf, & Ialongo, 2015). The Rap Club comes from a structured psychotherapy called Adolescents Responding to Chronic Stress (Mendelson et al., 2015). The Rap Club is a twelve-session group intervention that incorporates psychoeducation, cognitive behavioral therapy, and mindfulness (Mendelson et al., 2015). The psychoeducation targets the nature and effects of the stress. CBT teaches problem solving and communication skills. Lastly, the mindfulness targets emotion regulation skills. All which help the participants make positive decisions and be able to regulate their emotions.

Trauma Informed Screening and Assessment

Early prevention and intervention are essential to treating trauma-affected children in the education system. Walkey and Cox (2013), report assessment at any age must include a thorough exploration of the child's experiences to guide interventions that respond to the developmental impact that has likely occurred as a result of the trauma. Several instruments were mentioned throughout the literature to assist in assessing childhood trauma in the education system such as the Childhood Trust Events Survey (CTES) and the Achenbach System of Empirically Based Assessment.

The Childhood Trust Events Survey (CTES) is a questionnaire intended to be used as a trauma-screening instrument. It contains twenty-six items about traumatic events across a range of topics including accidents, abuse, domestic violence, medical situations, and loss of caregivers. (Holmes, Levy, Smith, Pinne, & Nesse, 2015). This screening tool is completed by

parents and the purpose is to help determine the need for services to tailor treatment to address the child's trauma (Holmes et al., 2015).

The Achenbach System of Empirically Based Assessment is a diagnostic tool that assesses a child and adolescent behavior (Holmes et al., 2015). This tool is completed during the assessment phase and again either when treatment ends or every six months (Holmes et al., 2015). A set of questionnaires is completed by parents/caregivers, teachers, and the students themselves. By doing this, it provides a comprehensive approach to assessing adaptive and maladaptive functioning (Holmes et al., 2015).

Juvenile Justice System

Four articles were systematically reviewed to better understand common treatment interventions used in the Juvenile Justice System. Of the most common treatment interventions across the three service sectors, TF-CBT, CBITS, SS, EMDR, ARC, TARGET, and CPP were commonly used interventions in the Juvenile Justice System. Similar to the Child Welfare and Education Systems, a common theme was the need for Trauma Informed Screening and Assessment tools in the Juvenile Justice System.

Trauma Informed Screening and Assessment

Juvenile Justice Systems work with thousands of youth every day. Screening and assessing for trauma among youth are the first two steps of identifying children exposed to trauma. The screening process identifies potential problem areas (Huskey & Tomczak, 2013). The assessment process defines the type and degree of trauma the child has experienced (Huskey & Tomczak, 2013). Both are necessary to develop a plan of treatment. Several instruments were identified throughout the review of the literature to assist in screening and assessing for Trauma. A few of them include The Massachusetts Youth Screening Instrument–version 2

(MAYSI-2) and the Youth Justice Board Screening Questionnaire Interview for Adolescents (SQIfA).

Massachusetts Youth Screening Instrument–version 2 (MAYSI-2)

The Massachusetts Youth Screening Instrument-version 2 (MAYSI-2) is the most widely used mental health screening tool in juvenile justice systems (Kerig, Moeddel, & Becker, 2010). The MAYSI-2 is used to detect trauma and symptoms of posttraumatic stress disorder (PTSD) among youth in juvenile justice systems (Keerig, Moeddel, & Becker, 2010). It also measures, substance use, anger/irritability, depression/anxiety, and suicidal ideation. (Keerig, Moeddel, & Becker, 2010). The screening is administered by detention center staff, and is ideally completed within the first 24-48 hours of the juvenile's admission to the facility (Keerig, Moeddel, & Becker, 2010). The MAYSI-2 is a 52-item questionnaire and is used in both boys and girls (Keerig, Moeddel, & Becker, 2010).

Screening Questionnaire Interview for Adolescents (SQIfA)

Another common tool used to assess trauma in youth in the Juvenile Justice System is the Screening Questionnaire Interview for Adolescents (SQIfA). The SQIfA is broken up into three sections (Bailey, Doreleijers, & Tarbuck, 2006). Section A asks direct questions regarding depressive symptoms, anxiety, reaction to severe trauma/stress, self-harm, and alcohol and drug misuse (Bailey, Doreleijers, & Tarbuck, 2006). Section B asks about a history of contact with child and adolescent mental health services as well as about past illness and interventions (Bailey, Doreleijers, & Tarbuck, 2006). Lastly, section C is more observational with questions to be answered by the interviewer concerning hyperactivity and any possible psychotic symptoms (Bailey, Doreleijers, & Tarbuck, 2006). The SQIfa is designed to be able to be re-administered over time if health needs have changed (Bailey, Doreleijers, & Tarbuck, 2006).

Any positive scores in problem areas indicate a need of more extensive assessment (Bailey,

Doreleijers, & Tarbuck, 2006).

Trauma Focused-Cognitive Behavior Therapy (TF-CBT)

Trauma Focused-Cognitive Behavior Therapy (TF-CBT) is said to be the most widely

evaluated treatment for trauma in children (Fraser et al., 2014). Amaya-Jackson and DeRosa

suggest that TF-CBT is the only treatment identified as "well-established" to significantly

improve trauma related symptoms in children and youth (as cited in Holmes et al., 2015). TF-

CBT is a treatment model that includes cognitive behavioral, interpersonal, and family therapy

principles (Ingelman et al., 2008). Cohen & Mannarino report that TF-CBT originally was

designed as a treatment intervention for sexually abused children and adolescents (as cited in

Ingelman et al., 2008, p.38). More recently, research suggests it is an intervention useful for

children exposed to any type of trauma (Ingelman et al., 2008). Examples of types of trauma

would be: sexual abuse, physical abuse, domestic violence, natural disasters, community

violence, or life threatening illness (Wethington, et al., (2008). TF-CBT is used in both single

trauma exposer incidents and/or multiple trauma exposures as well as for children who have

experienced or are experiencing complex trauma (Fraser et al., 2014). For children experiencing

complicated or complex trauma, the intervention is modified to include safety planning, and the

length of treatment tends to be longer (Fraser et al., 2014).

TF-CBT is a components based trauma treatment designed to treat PTSD as well as

related emotional and behavioral problems in youth (Fraser et al., 2014). The major components

are designed to be conducted in 12-18 treatment sessions (Fraser et al., 2014). These major

components include psychoeducation, parenting skills, relaxation, affective expression and

modulation, cognitive coping, development of a trauma narrative, in vivo exposure, conjoint

parent-child sessions, and enhancing future safety and development (Fraser et al., 2014). The

components are meant to be implemented sequentially, each building off the previous (Fraser et

al., 2014).

The psychoeducation component provides parents and children with information about

the type of trauma the child experienced, validates both the child's and parents reaction to the

trauma, and helps to normalize their feelings (Igelman et al., 2008). The parenting skills

component focuses on enhancing the parents' use of praise, time-out, and educates on positive

reinforcement techniques (Igelman et al., 2008). The relaxation component of TF-CBT includes

instruction on deep breathing, muscle relaxation, and stress reduction techniques to assist parents

and children in managing the physical indicators of anxiety that is related to the trauma (Igelman

et al., 2008). Affective expression and modulation includes identifying and expressing feelings,

instruction on how to interrupt negative thoughts, increase the use of positive self-talk, and

enhancing problem solving and social skills (Igelman et al., 2008). Cognitive coping helps both

the child and parent recognize the connection between thoughts, emotions, and actions (Igelman

et al., 2008). The use of a trauma narrative in TF-CBT requires the child to create or write a

description of their traumatic experience/experiences (Igelman et al., 2008). The child and

therapist process the narrative to identify the child's thoughts and beliefs about the traumatic

experience (Igelman et al., 2008). Along with the trauma narrative, in vivo exposure assists the

child in gaining skills to cope with trauma reminders (Igelman et al., 2008). After these

components are completed sessions are held with the parent and child together to again process

the trauma narrative and other activities will enhance the parent-child relationship (Igelman et

al., 2008). Lastly, enhancing safety addresses current and future safety issues for both parent and

child using role-plays, a written safety plan, and other activities (Igelman et al., 2008).

Cognitive Behavioral Intervention for Traumatized Students (CBITS)

Cognitive Behavioral Intervention for Traumatized Students (CBITS) was found to be most commonly used in the education system, but was also mentioned as an intervention used in the Child Welfare System and Juvenile Justice System. CBITS was originally designed for trauma-impacted, recently immigrated students (Dorsey, Briggs, & Woods, 2011). Research now reports CBITS has been effective for youth with a wide range of trauma experiences (Dorsey et al., 2011). CBITS is a Cognitive Behavioral Therapy designed to reduce symptoms and behavior problems in trauma exposed youth between 10 and 15 years old (Dorsey et al., 2011; Ai, Foster, Pecora, Delaney, & Rodriguez, (2013). Research suggests CBITS improves functioning, coping skills, and offers peer and parent support (Ai et al., 2013). According to Crosby (2015), trauma-informed educational practices can immediately affect students by decreasing trauma symptoms in the school setting.

CBITS incorporates many of the same components TF-CBT uses including; psychoeducation, relaxation training, cognitive coping skills, gradual exposure to trauma memories through the trauma narrative, in vivo exposure, affective modulation skills, cognitive restructuring, and social problem solving (Dorsey et al., 2011). CBITS is delivered in a group setting of 6-8 children per group (Dorsey et al., 2011). The group meets for 10 weeks for about one hour (Dorsey et al., 2011). In addition to the group sessions, one to three individual sessions take place to focus on exposure to the traumatic event (Dorsey et al., 2011). CBITS also includes two parent sessions that are used to educate parents on the effects of trauma on children and what the children are learning in treatment to cope with the trauma (Dorsey et al., 2011). CBITS also includes a teacher session in which teachers also learn about the effects of trauma on

children and how trauma related symptoms might present themselves in a classroom (Dorsey et al., 2011).

Seeking Safety (SS)

From the literature reviewed, Seeking Safety (SS) was used in both the Child Welfare Setting and Juvenile Justice Setting. Seeking Safety is designed to treat trauma, PTSD, and substance abuse (Miller & Najavits, 2012). This intervention teaches coping skills both in group and individual settings, with safety being the primary goal (Ai, et al., 2015). Seeking Safety addresses trauma in terms of the current impact, symptoms, other related problems, offers psychoeducation, and increases safe coping skills (Miller & Najavits, 2012). SS aims to provide psychoeducation about the effects of trauma and links between trauma and substance abuse (Miller & Najavits, 2012). Seeking Safety interventions are said to be flexible, 25 topics are provided, but clinicians can choose to do as many as time allows, in any order, with any number of sessions per week (Miller & Najavits, 2012). Cognitive, behavioral, and interpersonal topics are addressed and specific coping skills are taught (Miller & Najavits, 2012). Participants in this intervention are discouraged from describing their traumatic experiences in detail, which Miller and Najavits (2012) report as a benefit for offenders in a juvenile justice setting.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR), is delivered as an individual therapy and much like TF-CBT it involves recalling traumatic memories (Ford, Chapman, Connor, & Cruise 2012). EMDR differs from TF-CBT in that it does not use a story-like narrative as a tool for the child to retell the traumatic experience (Ford, et al., 2012). EMDR uses the clinician to assist the child in recalling personal strengths or social resources that can help the child feel confident in his/her own ability to cope with any unwanted memories of past

trauma (Ford, et al., 2012).   EMDR is based on Adaptive Information Processing, a theory that

involves 8 components of psychotherapy that integrate cognitive behavioral, interpersonal,

experiential, and body-centered therapies (Ai et al., 2013). Studies have shown EMDR has

significantly reduced symptoms of memory-related distress, problem behaviors, and a decrease

in PTSD symptoms (Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2012).

Attachment Self-Regulation Competency (ARC)

Attachment Self-Regulation Competency (ARC) is a comprehensive but flexible

framework of interventions to use with children who have experienced complex trauma (Fraser

et al., 2014; Ford et. al., 2012). Its flexibility allows it to be applied across many service systems

working with traumatized youth and families. ARC uses ten treatment targets that fall within

three core domains of attachment, self-regulation, and competency which are areas typically

affected when exposed to trauma (Fraser et al., 2014). These treatment targets focus on the

impact of traumatic stress, normative and impacted attachments, normative development, and

factors associated with resilience among traumatized youth (Fraser et al., 2014). ARC based

treatment services have shown consistent significant reductions in behavioral problems and

symptoms of PTSD in children exposed to trauma (Fraser et al., 2014). ARC offers principles

and strategies to help to create an environment of respect and compassion for traumatized youth

(Smithgall, Cusick, & Griffin, 2013).

Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET)

TARGET is an educational and therapeutic approach for the treatment of complex

Trauma and PTSD (Ford & Hawk, 2012). TARGET is an intervention most often used in

juvenile justice systems. TARGET is implemented through either individual or group therapy.

TARGET teaches a seven-step sequence of skills to assist in processing and managing trauma-

related symptoms such as grief, guilt, shame, anger, hostility, and rejection (Ford & Hawk, 2012). These skills are summarized by the acronym FREEDOM which includes; focus, recognize triggers, emotion self-check, evaluate thoughts, define goals, options, and make a contribution (Ford & Hawk, 2012). This skill set provides children exposed to trauma a way to de-escalate and regulate extreme emotions, an ability to manage trauma triggers/memories, and shift the way a child processes information to maximize awareness of the present situation (Ford & Hawk, 2012)

The first and second steps of the seven steps of FREEDOM is focus and recognize triggers. These steps teach children to pay attention to body signals and the current environment and to recognize triggers which provides a foundation for shifting from hypervigilance to metalizing (Ford & Blaustein, 2013). The next four steps; emotion self-check, evaluate thoughts, define goals, and options assists in differentiating stress-related and core grounded emotions, thoughts, goals and behavior options (Ford & Blaustein, 2013). The final skill, make a contribution, teaches ways to enhance self-esteem (Ford & Blaustein, 2013). These steps have proven to decrease behavior incidences in juvenile justice settings and dramatically decrease symptoms of PTSD in trauma exposed youth in the juvenile justice system (Ford et al., 2012).

Child Parent Psychotherapy (CPP)

Child Parent Psychotherapy (CPP) is a trauma-focused, attachment-informed model developed for very young children who have been exposed to family violence, physical abuse, and physical neglect and includes their caregivers (Fraser et al., 2014; Leenarts et al., 2013). CPP is one of few empirically validated interventions that can be used with such young children (Fraser, et al., 2014).   CPP addresses the fundamental role of the parent-child relationship through healing the effects of trauma and promoting healthy development (Fraser et al., 2014).

The goal of CPP is to decrease traumatic responses, decrease learning difficulties, decrease relationship problems, and improve the overall parent-child attachment (Leenarts et al., 2013). CPP uses the parent-child relationship to repair the inability to self-regulate emotions that are often a result of trauma, increase the attachment bond between the parent and child, and decrease the child's aggressiveness and the parent's use of negative punishments (Leenarts et al., 2013). Many times therapists must work long and hard with a child who has suffered from trauma to rebuild these parent-child attachments (Terr, 2013).

Similar to other treatment interventions previously discussed, CPP also includes a trauma narrative. What makes CPP unique is that a trauma narrative is created jointly by both the child and the parent and then processed in session in order to recognize and address any blame, cognitive distortions, and/or maladaptive thoughts occurring (Igelman et al., 2008). CPP is held in 60-90 minutes sessions for approximately 50 weeks (Igelman et.al., 2008). Lieberman, Briscoe-Smith, Ippen, and Van Horn (2006), suggests there is evidence children who received CPP showed statistically significant increases in IQ scores the year following their treatment.

Calm Attuned Present Predictable Don't (CAPPD)

Calm Attuned Present Predictable Don't (CAPPD), is used to guide schools to be trauma responsive (Walkley & Cox, 2013). It is composed of five guidelines to guide school staff in creating a welcoming and supportive environment for traumatized students (Crosby, 2015). Calm, the first of the five guidelines, aims to keep both the school staff and the students calm, relaxed, and in a focused state (Walkley & Cox, 2013). Attuned the second of the five guidelines, helps school staff learn to connect with the children who have been exposed to trauma on an emotional level before moving to a cognitive level (Walkley & Cox, 2013). It helps teachers be more aware of children's body language, tone, and emotional state (Walkley &

Cox, 2013). Present is the next of the five guidelines. This is a reminder for school staff to be present and focus their attention on the child they are with and to be in the moment (Walkley & Cox, 2013). Children exposed to trauma carry a mistrust of others; these children with support can learn to form secure relationships with adults (Walkley & Cox, 2013). Predictable requires school staff to provide children with a structured routine, which can assist in helping traumatized children feel safe (Walkley & Cox, 2013). Lastly, do not let children's emotions escalate your own. This final guideline requires school staff to be in control of their own emotions and how they choose to express them (Walkley & Cox, 2013). By maintaining this control when a child is angry or frustrated, school officials can be sure to not escalate the situation and/or trigger trauma symptoms (Walkley & Cox, 2013).

In summary, the objective of this systematic review was to explore the prevalence and impact trauma has on children, necessary qualities of trauma informed care, and what treatment methods are commonly used in various service agencies working with children exposed to trauma. Overall, the review indicates there is an elevated awareness throughout the three service agencies of the prevalence of children exposed to trauma. Despite this awareness, this review suggests there is little evidence outside of TF-CBT to treat children exposed to trauma. Increasing service system collaboration will allow agencies to collectively create a universal trauma screening, assessment, and effective interventions. This would also allow trauma survivors adequate access to treatment interventions that would cover the broad range of trauma exposures.

Strengths and Limitations

Several limitations can be identified in the completion of this systematic review. First, this review is that only fifteen articles met this study's inclusion criteria. The inclusion criteria

only allowed for treating trauma in children in the child welfare, education, and juvenile justice

systems. Another limitation of this systematic review is that a variety of interventions were

reviewed, making it difficult to get a clear sense of effectiveness. This could also be considered a

strength, as it provided a comprehensive review of many types of treatment interventions and

models used to treat trauma in three of the most common child serving systems. Because

treating trauma is a relatively new phenomenon, systematically reviewing the literature for

different treatment interventions is valuable and helpful for social workers to use in the future.

The last limitation was the inability to cross check with another to assess and cross check the

findings.

Implications for Social Work Practice

In a nationally representative sample of children and adolescents in the U.S., 60.4%

reported some kind of exposure to trauma (Dorsey, et al., 2011). Social workers have only

begun to understand the widespread prevalence of children exposed to trauma as well as its

impact on those children, their families, and society as a whole. Social workers have an

obligation to address the root causes of trauma in support of child well-being. This can be done

through collaboration and partnerships between systems committed to the safety and well-being

of the child. Each child serving system must recognize the pervasiveness of trauma, its impact

on families and the need for these systems to implement trauma informed interventions.

The Department of Health and Human Services Administration for Children and

Families, Centers for Medicare & Medicaid Services, and Substance Abuse and Mental Health

Services Administration (SAMHSA), are diligently working to address trauma and improve

social-emotional health for children exposed to trauma. These agencies are working to create a

comprehensive approach for funding services to traumatized youth through reimbursement by

three federal sources: Child Welfare, Mental Health, and Medicaid. Through system

collaboration costs can be reduced while improving care for traumatized youth.

Implications for Future Research

Throughout this systematic review, strong evidence supported Trauma Focused-

Cognitive Behavior Therapy (TF-CBT) as an effective form of treatment for children exposed to

trauma. The education system has modified TF-CBT and created Cognitive Behavioral

Interventions for Traumatized Students (CBITS). Unfortunately, several of the other

interventions noted in this review, (Seeking Safety, Eye Movement Desensitization and

Reprocessing, Attachment Self-Regulation Competency, Trauma Affect Regulation: Guidelines

for Education and Therapy, Child Parent Psychotherapy, and Calm Attuned Present Predictable

Don't), do not currently have definitive and sufficient evidence to determine their effectiveness

specific to working with traumatized children. It is important for clinicians to continue to

develop knowledge and make use of different treatment modalities to provide the long-term

evidence based proof for effectiveness. Because this evidence does not yet exist, it is important

for social workers to be flexible enough to use the evidence that does exist to help the many

children exposed to trauma.

Due to the millions of youth in the U.S. estimated to have experienced at least one

traumatic event, more research in the area of effective treatment interventions used to treat

childhood trauma is needed. We can all help by at the very least understanding trauma and

working with children exposed to trauma through a trauma lens. Social workers as well as other

professionals are at the forefront of helping children exposed to trauma and have a duty to serve

our nations traumatized youth.

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Table 2. Initial Data Abstraction Form

Trauma Informed Care/Treatment/Interventions

Journal Articles	Author	Abstract
SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)	SAMHSA's Trauma and Justice Strategic Initiative	SAMHSA organized a group of national experts who had done extensive work in treating trauma. This group conducted an environmental scan of trauma definitions and models of trauma informed care.
Risking Connection Trauma Training: A Pathway Toward Trauma-Informed Care in Child Congregate Care Settings (2012)	Steven M. Brown Courtney N. Baker Patricia Wilcox	Research study of the effectiveness of Risking Connection (RC) Trauma Training.
The Prevalence and Management of Trauma in the Public Domain: An Agency and Clinician Perspective (2002)	Theresa C. Hanson Mischie Hesselbrock Sophie H. Tworkowski Susanne Swan	Research study surveying the ways in which the needs of trauma survivors have been addressed within the public mental health system.
The National Child Traumatic Stress Network: Collaborating to Improve the Standard of Care (2008)	Robert S. Pynoos John A. Fairbank Alan M Steinberg Lisa Amaya-Jackson Ellen Gerrity Mary L. Mount Jenifer Maze	A research study of the formation of The National Child Traumatic Stress Network.
Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice (2008)	Susan J. Ko Nancy Kassam-Adams Charles Wilson Julian D. Ford Steven J. Berkowitz Marleen Wong Melissa J. Brymer Christopher M. Layne	A review of how traumatic stress affects children and adolescents' daily functioning and how various service systems approach trauma services differently.

Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care (2006)	Gordon R. Hodas	A review on the challenge of childhood trauma and meeting the challenge of implementing trauma informed care.
Perspectives on Trauma-Informed Care from Mothers with a History of Childhood Maltreatment: A Qualitative Study (2013)	Maria Muzik Menatalla Ads Caroline Bonham Katherine L. Rosenblum Amanda Broderick Rosalind Kirk	A qualitative study that aimed to obtain data from trauma-exposed new mothers in regards to their healthcare preferences with the ultimate goal to design personalized, supportive interventions.
Treating Childhood Trauma (2013)	Lenore C. Terr	A research study on treating childhood trauma.
The Effectiveness of Interventions to Reduce Psychological Harm for Traumatic Events Among Children and Adolescents (2008)	Holly R. Wethington Robert A. Hahn Dawna S. Fuqua-Whitley Theresa Ann Sipe Alex E. Crosby Robert L. Johnson Akiva M. Liberman Eve Moscicki LeShawndra N. Price Farris K. Tuma Geetika Karla Sajal K. Chattopadhyay Task Force on Community Preventative Services	A systematic review that evaluated interventions commonly used to reduce psychological harm among children and adolescents exposed to traumatic events.
Evidence-Based Treatments for Children with Trauma-Related Psychopathology as a Result of Childhood Maltreatment: A Systematic Review (2013)	Laura E. W. Leenarts Julia Diehle Theo A.H. Doreleijers Elise P. Jansma Ramon J.L. Lindauer	A systematic review of evidence-based treatments for children whom have been exposed to childhood maltreatment.

Child Welfare System

Journal Articles	Author	Abstract
Linking Child Welfare and Mental Health Using Trauma-Informed Screening and Assessment Practices (2011)	Lisa Conradi Jeffrey Wherry Cassandra Kisiel	A research study that highlights existing trauma-focused screening and assessment tools that are used within child welfare systems and the challenges related to integrating trauma-focused screening practices in child welfare systems.
Implementation of a Workforce Initiative to Build Trauma Informed Child Welfare Practices and Services: Findings from the Massachusetts Child Trauma Project (2014)	Jenifer G. Fraser Jessica L. Griffin Beth L. Barto Charmain Lo Melodie Wenz-Gross Joseph Spinazzola Ruth A. Bodian Jan M. Nisenbaum Jessica D. Bartlett	A research study of an initiative that was launched to enhance the capacity of child welfare workers and child mental health providers to identify, respond, and intervene early and effectively with children who have experienced trauma.
A Grassroots Prototype for Trauma-Informed Child Welfare System Change (2011)	James Henry Margaret Richardson Connie Black-Pond Mark Sloane Ben Atchinson Yvette Hyter	A research study that describes the core elements that emerged from 9 Michigan communities that field-tested a model for a trauma informed child welfare system.
Trauma-Informed Care Training in Child Welfare System: Moving it to the Front Line (2013)	Nicola A. Conners-Burrow Teresa L. Kramer Benjamin A. Sigel Kathy Helpenstill Chad Sievers Lorraine McKelvey	A research study that evaluates an initiative in Arkansas to train child welfare front-line staff members in trauma-informed practices.
Creating Trauma-Informed Child Welfare Systems Using a Community Assessment Process (2011)	Alison Hendricks Lisa Conradi Charles Wilson	A research study that describes strengths and barriers related to creating a trauma child welfare system in three child welfare systems in the United States.

Promising Practices and Strategies for Using Trauma-Informed Child Welfare Practice to Improve Foster Care Placement Stability: A Breakthrough Serious Collaborative (2011)	Lisa Conradi Jen Agosti Erika Tullberg Lisa Richardson Heather Langen Susan Ko	A research study on a "Breakthrough Series Collaborative" that was conducted to improve foster care placement stability by using trauma informed child welfare practices.
Creating More Trauma-Informed Services for Children Using Assessment Focused Tools (2007)	Robyn Igelman Nicole Taylor Alicia Gilbert Barbara Ryan Alan Steinberg Charles Wilson	A research study that promotes integrating assessment and evidence-based practice in the treatment of traumatized children through two newly developed trauma assessment tools.
Constellations of Interpersonal Trauma and Symptoms in Child Welfare: Implications for a Developmental Trauma Framework (2014)	Cassandra L. Kisiel Tracy Fehrenbach Elizabeth Torgersen Brad Stolbach Gary McClelland Gene Griffin	A research study where the trauma exposure and symptoms were examined in a sample of 16,212 children in Illinois child welfare and the support to develop a trauma framework.
Helping Children in the Child Welfare Systems Heal from Trauma: A Systems Integration Approach (2008)	Nicole Taylor Kletzka Christine Siegfried	The NCTSN conducted a survey of 53 child-serving organizations in 10 states to assess the ways the organizations gather and share trauma-related information and the basic training about treating childhood trauma that their staffs receive.
Reshaping Child Welfare's Response to Trauma: Assessment, Evidence-Based Intervention, and New Research Perspectives (2013)	Amy L. Ai Lovie J. Jackson Foster Peter J. Pecora Nancy Delaney Wenceslao Rodriguez	A critical review that aims to use the evidence to reshape the child welfares response to treating trauma in children and adolescents.

Education System

Journal Articles	Author	Abstract
Building Trauma-Informed Schools and Communities (2013)	Meg Walkley Tory L. Cox	A research study that focuses on the impact of trauma on a child's development and the implementation of trauma-informed schools.
Toward a Trauma-Informed Practice: What Educators Need to Know (2015)	Tricia R. Shalka	A research study that provides guidelines for supporting post trauma student growth and learning.
An Ecological Perspective on Emerging Trauma-Informed Teaching Practices (2015)	Shantel D. Crosby	A research study that describes emerging trauma-informed treatments for students, examined through the lens of the ecological perspective.
Brief report: Moving Prevention Into Schools: The Impact of a Trauma-Informed School-Based Intervention (2015)	Tamar Mendelson S. Darius Tandon Lindsey O'Brennan Phillip J. Leaf Nicholas S. Ialongo	A pilot study that evaluated RAP Club, a 12-session school-based trauma-informed group intervention co-facilitated by a mental health counselor and a young adult community member that utilizes evidence-based cognitive behavioral and mindfulness strategies.
A Model for Creating a Supportive Trauma-Informed Culture for Children in Preschool Settings (2015)	Cheryl Holmes Michelle Levy Avis Smith Susan Pinne Paula Nesse	A research study that describes Head Start Trauma Smart, an early education/mental health cross-systems partnership designed to work within the child's natural setting.
Improving Implementation of Mental Health Services for Trauma in Multicultural Elementary Schools: Stakeholder Perspectives on Parent and Educator Engagement (2013)	Audra Langley Catherine DeCarlo Santiago Adriana Rodriguez Jennifer Zelaya	A research study to explore issues related to community engagement and the feasibility of mental health intervention for elementary school students exposed to trauma.
Responding to Students Affected by Trauma: Collaboration Across Public Systems (2013)	Cheryl Smithgall Gretchen Cusick Gene Griffin	A research study that reviews data from three initiatives in which public systems attempt to assess trauma and meet both the behavioral health and academic needs of students.

Building Resilience to Trauma: Creating a Safe and Supportive Early Childhood Classroom (2009)	Ilene R Berson Jennifer Baggerly	A research study that discusses the impact of trauma on children, challenges that teacher's face, and provides strategies to foster resiliency in children.

Juvenile Justice System

Journal Articles	Author	Methods-Purpose
Systemic Self-Regulation: A Framework for Trauma-Informed Services in Residential Juvenile Justice Programs (2013)	Julian D. Ford Margaret E. Blaustein	A research study of the barriers to successful provision of mental health services for youths in juveniles justice facilities, including those involving youth, parents, and juvenile justice residential facility staff and administrators.
Unraveling Probation Officers' Practices with Youths with Histories of Trauma and Stressful Life Events (2012)	Tina Maschi Craig S. Schwalbe	A research study that examines how probation officer's knowledge of juveniles' trauma influences probation practices.
Best Practices for Serving Traumatized Children and Families (2008)	Robyn S. Ingelman Barbara E. Ryan Alicia M. Gilbert Cynthia Bashant Katherine North	A research study that highlights the impact of trauma on children and adolescents who are commonly seen in the court system.
Healing Invisible Wounds (2010)	Erica J. Adams	A summarization of recommendations on investing in trauma-informed care from a new study released by the Washington, DC-based Justice Policy Institute.
Creating Trauma-Informed Correctional Care: A Balance of Goals and Environment (2012)	Niki A. Miller Lisa M. Najavits	A review of literature including a comparison of gendered responses, implications for men's facilities, and the compatibility of trauma recovery goals.
Trauma, Psychiatric, Substance Use, and Thought Disorders among Youth in the Juvenile Justice System and How to Deal with Them (2013)	Bobbie L Huskey Paula Tomzak	A research study intended to create a greater awareness of the trauma, psychiatric, and substance abuse disorders experienced by so many youth within the juvenile justice system.
Trauma Exposure and PTSD in Justice-Involved Youth (2011)	Keith R. Cruise Julian D. Ford	A systematic review of four original research reports that build on the field's knowledge of trauma stress exposure and PTSD in justice-involved youth.

| Complex Trauma and Aggression in Secure Juvenile Justice Settings (2012) | Julian D. Ford
John Chapman
Daniel F. Connor
Keith R. Cruise | A research study on the treatment of youth who have complex trauma histories and problems with aggression in secure juvenile justice settings with directions for future research and program development. |

Table 3. Final Data Abstraction Form

Trauma Informed Care/Treatment/Interventions

Journal Articles	Author	Identified Interventions/Treatments
Treating Childhood Trauma (2013)	Lenore C. Terr	1. Abreaction 2. Context 3. Correction 4. Talk Therapy 5. Play Therapy 6. Parental (or Caretaker) Counseling 7. Interventions with Schools, Hospitals, Churches, and Coaches 8. Cognitive-Behavioral Treatment (CBT)
The Effectiveness of Interventions to Reduce Psychological Harm for Traumatic Events Among Children and Adolescents (2008)	Holly R. Wethington Robert A. Hahn Dawna S. Fuqua-Whitley Theresa Ann Sipe Alex E. Crosby Robert L. Johnson Akiva M. Liberman Eve Moscicki LeShawndra N. Price Farris K. Tuma Geetika Karla Sajal K. Chattopadhyay	1. Individual TF-CBT 2. Group TF-CBT 3. Play Therapy 4. Art Therapy 5. Psychodynamic Therapy 6. Pharmacologic Therapy 7. Psychological Debriefing

Evidence-Based Treatments for Children with Trauma-Related Psychopathology as a Result of Childhood Maltreatment: A Systematic Review (2013)	Laura E. W. Leenarts Julia Diehle Theo A.H. Doreleijers Elise P. Jansma Ramon J.L. Lindauer	1. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 2. Eye Movement Desensitization and Reprocessing (EMDR) 3. Cognitive Processing Therapy (CPT) 4. Child Parent Psychotherapy (CPP) 5. Cognitive Behavioral Therapy (CBT) (child & family) 6. Child and Family Traumatic Stress Intervention (CFTSI) 7. Child-Centered Therapy (CCT) 8. Non-Directive Supportive Therapy (NST) 9. Risk Reduction through Family Therapy (RRFT) 10. Trauma Affect Regulation Guide for Education and Therapy (TARGET) 11. Enhanced Treatment as Usual (ETAU) 12. Prolonged Exposure Therapy for Adolescents (PE-A) 13. Time Limited Dynamic Psychotherapy for Adolescents (TLDP-A) 14. Life Story Intervention (LSI) 15. Seeking Safety (SS) 16. Trauma Intervention Program for Adjudicated and At-Risk Youth (SITCAP-ART) 17. Structured Psychotherapy Adolescents Responding to Chronic Stress (SPARCS) 18. Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) 19. Enhanced Outpatient Treatment (EOT) 20. Systematic Training for Effective Parenting of Teens (STEP-TEEN) 21. Youth Relationships Project (YRP) 22. Mental Health for Immigrants Program (MHIP) 23. Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) 24. Sanctuary Model

		25. Cognitive Behavior Intervention for Trauma in Schools (CBITS) 26. Fostering Health Futures (FHF) 27. Open Group Therapy 28. Closed Group Therapy

Child Welfare System

Journal Articles	Author	Identified Interventions/Treatments
Implementation of a Workforce Initiative to Build Trauma Informed Child Welfare Practices and Services: Findings from the Massachusetts Child Trauma Project (2014)	Jenifer G. Fraser Jessica L. Griffin Beth L. Barto Charmain Lo Melodie Wenz-Gross Joseph Spinazzola Ruth A. Bodian Jan M. Nisenbaum Jessica D. Bartlett	1. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 2. Child Parent Psychotherapy (CPP) 3. Attachment Self-Regulation Competency (ARC)
Creating More Trauma-Informed Services for Children Using Assessment Focused Tools (2007)	Robyn Igelman Nicole Taylor Alicia Gilbert Barbara Ryan Alan Steinberg Charles Wilson	1. Trauma Assessment Pathway Model (TAP) 2. Parent Child Interaction Therapy (PCIT) 3. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 4. Child Welfare Trauma Referral Tool (CWT)
Reshaping Child Welfare's Response to Trauma: Assessment, Evidence-Based Intervention, and New Research Perspectives (2013)	Amy L. Ai Lovie J. Jackson Foster Peter J. Pecora Nancy Delaney Wenceslao Rodrigues	1. Individual TF-CBT 2. Group TF-CBT 3. Eye Movement Desensitization and Reprocessing (EMDR) 4. Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) 5. Child and Family Traumatic Stress Intervention (CFTSI) 6. Combined Parent Child-Cognitive Behavior Therapy (CPC-CBT)

		7. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
		8. I Feel Better Now!
		9. Sanctuary Model
		10. Seeking Safety (SS)
		11. Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART)
		12. Trauma-Focused Coping (TFC)
		13. Mindfulness
		14. Sweat Lodge Ceremonies
		15. Yoga

Education System

Journal Articles	Author	Identified Interventions/Treatments
Building Trauma-Informed Schools and Communities (2013)	Meg Walkley Tory L. Cox	1. Calm Attuned Present Predictable Don't (CAPPD)
An Ecological Perspective on Emerging Trauma-Informed Teaching Practices (2015)	Shantel D. Crosby	1. Calm Attuned Present Predictable Don't (CAPPD) 2. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Brief report: Moving Prevention Into Schools: The Impact of a Trauma-Informed School-Based Intervention (2015)	Tamar Mendelson S. Darius Tandon Lindsey O'Brennan Phillip J. Leaf Nicholas S. Ialongo	1. "RAP Club" 2. Psychoeducation 3. Mindfulness 4. Cognitive Behavioral Therapy (CBT)
A Model for Creating a Supportive Trauma-Informed Culture for Children in Preschool Settings (2015)	Cheryl Holmes Michelle Levy Avis Smith Susan Pinne Paula Nesse	1. Attachment Self-Regulation Competency (ARC) 2. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
Responding to Students Affected by Trauma: Collaboration Across Public Systems (2013)	Cheryl Smithgall Gretchen Cusick	1. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

	Gene Griffin	2. Second Step 3. Anger Coping 4. Attachment Self-Regulation Competency (ARC)

Juvenile Justice System

Journal Articles	Author	Identified Interventions/Treatments
Best Practices for Serving Traumatized Children and Families (2008)	Robyn S. Ingelman Barbara E. Ryan Alicia M. Gilbert Cynthia Bashant Katherine North	1. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 2. Parent Child Interaction Therapy (PCIT) 3. Abuse Focused-Cognitive Behavior Therapy (AF-CBT) 4. Child Parent Psychotherapy (CPP)
Creating Trauma-Informed Correctional Care: A Balance of Goals and Environment (2012)	Niki A. Miller Lisa M. Najavits	1. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 2. Seeking Safety (SS) 3. Trauma Informed Correctional Care (TICC)
Trauma, Psychiatric, Substance Use, and Thought Disorders among Youth in the Juvenile Justice System and How to Deal with Them (2013)	Bobbie L Huskey Paula Tomzak	1. Trauma Survivors Group 2. Seeking Safety (SS) 3. Trauma Affect Regulation: A Guide for Education and Therapy (TARGET) 4. Trauma Recovery and Empowerment Model (TREM) 5. Eye Movement Desensitization and Reprocessing (EMDR) 6. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 7. MOVING-ON 8. Cognitive Behavioral Therapy (CBT) 9. Skills Training in Affective and Interpersonal Regulation (STAIR) 10. Integrated Treatment for Co-Occurring Disorders 11. Dialectical Behavioral Therapy (DBT) 12. Brief Eclectic Therapy

		13. Functional Family Therapy
		14. Multi-systemic Family Therapy
Complex Trauma and Aggression in Secure Juvenile Justice Settings (2012)	Julian D. Ford John Chapman Daniel F. Connor Keith R. Cruise	1. Trauma Affect Regulation Guide for Education and Therapy (TARGET) 2. Attachment Self-Regulation Competency (ARC) 3. Trauma Systems Therapy (TST) 4. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) 5. Cognitive Behavioral Intervention for Traumatized Students (CBITS) 6. Cognitive Behavioral Therapy with Prolonged Exposure (CBT-PE) 7. Eye Movement Desensitization and Reprocessing (EMDR) 8. Multidimensional Family Therapy (MDFT) 9. Multidimensional Treatment Foster Care (MTFC) 10. Anger Coping Program (ACP) 11. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) 12. Multisystem Therapy (MST) 13. Life Skills/Life Story 14. Seeking Safety (SS)

Table 4. Results Table

Most Common Treatment Interventions	Trauma Informed Care (3)	Child Welfare System (3)	Education System (5)	Juvenile Justice System (4)	Total (15)
Trauma Focused-Cognitive Behavior Therapy (TF-CBT) **Including: Cognitive Behavior Therapy (CBT)	3	3	4	4	14
Cognitive Behavioral Intervention for Traumatized Students (CBITS)	1	1	2	1	5
Seeking Safety (SS)	1	1	0	3	5
Eye Movement Desensitization and Reprocessing (EMDR)	1	1	0	2	4
Attachment Self-Regulation Competency (ARC)	0	1	2	1	4
Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET)	1	0	0	2	3
Child Parent Psychotherapy (CPP)	1	1	0	1	3
Calm Attuned Present Predictable Don't (CAPPD)	0	0	2	0	2