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Identifying the trauma recovery needs of maltreated children: An examination of child welfare workers' effectiveness in screening for traumatic stress

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ABSTRACT

Children in the child welfare system comprise a group characterized by exposure to trauma via experiences of maltreatment, under circumstances presenting multiple risk factors for traumatic stress. High rates of posttraumatic stress have been observed in this population. However, there is currently no standard for the universal screening of children in child welfare for trauma exposure and traumatic stress. This study examined the trauma experiences of a sample of maltreated children and whether their child welfare workers were effective screeners of traumatic stress symptoms. Descriptive and correlational analyses were conducted regarding a sample of children (N = 131) with trauma screenings completed by their child welfare workers and clinical measures of traumatic stress symptoms. Four hierarchical regression models were also examined to determine whether workers' screening information regarding child age, trauma exposure history and symptoms of traumatic stress were predictive of outcomes on clinical measures. The analyses revealed complex trauma exposure histories and high rates of traumatic stress symptoms among this generally younger sample of maltreated children. Additionally, the models supported workers' efficacy in screening for symptoms of total posttraumatic stress and specific trauma symptoms of intrusion and avoidance. Workers were less effective in screening for the symptoms of arousal. These findings support the importance of identifying the trauma recovery needs of maltreated children and the utility of child protection workers in assisting with the trauma screening process. Implications are provided for related practice, policy and training efforts in child welfare.

1. Introduction

Children in the child welfare system represent a group characterized by exposure to maltreatment-related trauma with multiple risk factors for traumatic stress and other associated mental health concerns. In 2012, approximately 679,000 children in the United States were found to be victims of maltreatment, with a child maltreatment victim rate of 9.2 per 1000 children in the general population (U.S. Department of Health & Human Services, 2014). Studies have found rates of maltreatment-related trauma in children in foster care that range from 80 to 93% (Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999; Stein et al., 2001; U.S. Department of Health & Human Services, 2013). The vast number of children maltreated and subsequently involved in child welfare systems present a significant public health problem in the United States, especially given the associated negative effects of these

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experiences (Jamora et al., 2009).

The impact of child maltreatment is evident in the growing body of related research including the Adverse Childhood Experiences study and others that demonstrate the deleterious, long-term consequences of early trauma such as mental health disorders, substance abuse and serious physical health problems such as heart disease, obesity and even shortened life expectancy (Anda et al., 2006; Felitti et al., 1998). One study indicates that childhood maltreatment presents a ten-fold increase in the lifetime risk for Posttraumatic Stress Disorder and other anxiety, mood and substance abuse disorders (Scott, Smith, & Ellis, 2010). The short-term impact of child maltreatment can also be severe. Studies demonstrate significantly higher rates of Posttraumatic Stress Disorder and various other mental health diagnoses in samples of maltreated children versus the general population (Jamora et al., 2009; Keller, Salazar, & Courtney, 2010; Pecora, White, Jackson, & Wiggins, 2009; White, Havalchak, Jackson, O'Brien, & Pecora, 2007). Therefore, general mental health screening with children in child welfare systems is indicated, and the nearly universal trauma exposure rates for children in this system combined with the significant risks for adverse reactions and long-term consequences of childhood trauma support the need for specific trauma screening and assessment to be a part of this process. Screening and assessment are the gateway to identifying a child's needs in terms of recovery from the trauma of abuse and neglect. Fortunately, if necessary, there are many evidence-based trauma interventions that can interrupt the cascade of potential problems cited in the literature. Some of the trauma treatment programs rated as effective based on their evidentiary support include *Child-Parent Psychotherapy* (CPP), *Trauma Affect Regulation: Guide for Education and Therapy* (TARGET), *Trauma-Focused Cognitive Behavior Therapy* (TF-CBT) and *Cognitive Behavioral Intervention for Trauma in Schools* (CBITS) (Pilnik & Kendall, 2012). These interventions meet the needs of a variety of children across settings, and there are several other evidence based trauma treatments and promising practices available as well. In spite of these facts and best practice recommendations for child welfare, there is currently no standard for universal trauma screening in most child welfare systems though some states are making progress toward this goal (Griffin et al., 2012).

Child welfare workers represent an important resource for addressing problems associated with the under-identification of maltreated children's trauma recovery needs. Not only are child welfare workers mandated by policy to assess the mental health and other basic needs of children as part of the case planning and family intervention process, they also have access to a unique database that should prove useful in screening for traumatic stress and related concerns. McCrae and Barth (2008) found that the information typically collected during a maltreatment investigation including the age, frequency and intensity of exposures to maltreatment; parental history of mental illness and substance misuse; and other environmental risks are critical elements of assessing mental health and trauma recovery needs in children.

This study was designed to address the research questions of whether child welfare workers are able to effectively screen children from their caseloads for traumatic stress, and whether there are notable differences in their abilities to screen for specific manifestations of trauma symptoms such as intrusion, avoidance and arousal. There are no known studies that examine child welfare workers' trauma screening abilities and compare their identification of child traumatic stress symptoms to those of caregivers or child self-reports. Additionally, this study aimed to describe the trauma experiences of the sample in order to further examine the nature of traumatic stress observed in children from the child welfare population. The specific symptoms reported by the child welfare workers were compared to the clinical measures administered with children and caregivers as informants to further analyze what aspects of trauma screening may be more or less challenging. Implications for training and the implementation of trauma screening protocols in child welfare are provided based on the results of the analysis.

The empirical literature and theoretical models reviewed supported the consideration of child age and history of trauma exposure as pertinent information when assessing traumatic stress reactions in children. Age and developmental stage not only exert significant influences on the manifestation of a child's trauma response, but knowledge of a child's age may also affect the way others observe and contextualize a child's behavior and expressions of distress (Cicchetti & Toth, 1997; Margolin, 2005). Numerous studies additionally confirm the significance of trauma exposure history and number of traumas experienced as risk factors for traumatic stress reactions (Breslau, Chilcoat, Kessler, & Davis, 2014; Green et al., 2000). Knowledge of what traumatic events children have been exposed to should provide necessary context for their emotional and behavioral responses are interpreted. Child welfare workers attain knowledge of these two critical categories of information as part of their routine case work with children; first learning basic information such as the age of a child, then acquiring historical information including a child's history of trauma exposure. Workers then accumulate observational and collateral data regarding a child's functioning during the course of service provision. Therefore, for the primary research question regarding whether child welfare workers can effectively screen for traumatic stress in children, the following hypothesis statement was tested:

H_1: Utilizing knowledge of a child's age, trauma exposure history and a child's emotions and behaviors, child welfare workers are able to effectively predict posttraumatic stress scores indicated on clinical measures.

A secondary question was also examined regarding whether there are differences in child welfare workers' abilities to screen for certain types of traumatic stress symptoms. Information regarding the nature of these symptoms, how they manifest in children, and challenges regarding the assessment of child traumatic stress was used to guide the development of the second hypothesis. For example, intrusive or re-experiencing symptoms are directly connected to traumatic experiences, and may be more clearly reported by children or observed to be effects of their trauma history. Avoidance is less visible or difficult to observe, and the nature of successful avoidance prevents children from talking about it (Cohen & Scheeringa, 2009). Screening or assessing for arousal in children is complicated by these symptoms being more easily confused with other emotional and behavioral conditions. As a result, children with traumatic stress are often misdiagnosed with or experience co-morbid conditions such as Separation Anxiety Disorder, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder, and the overlap of symptoms associated with these disorders and trauma-related arousal specifically is considerable (Cohen & Scheeringa, 2009; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Consequently, for the secondary research question regarding whether there are differences in child welfare workers'