

Evidence-Based Treatment for Children in Child Welfare

Many children in the child welfare system exhibit behaviors or social competency problems warranting mental health care. Studies of children in foster care suggest at least 50% meet criteria for a mental health diagnosis. Often, these difficulties are related to trauma they have experienced. This paper presents a review of the research evidence for trauma-focused interventions for children and adolescents. The goal is to provide guidance about effective strategies for addressing emotional and behavioral problems associated with trauma.

Children with posttraumatic stress disorder (PTSD) or symptoms related to trauma often exhibit other mental health disorders as well. Although interventions for these other disorders are not addressed in this review, trauma-affected children and adolescents may also need diagnosis-specific treatment for co-occurring conditions such as attention deficit hyperactivity disorder (ADHD) and depression. They may also require intensive home- and community-based services (e.g., wraparound, therapeutic foster care, Multisystemic Therapy) for persisting difficulties.

Evidence-Based Treatments for Child Trauma

In the last decade, a number of organizations have created lists of "evidence-based" practices for treating children and youth who experience emotional and behavioral difficulties.



However, the standards required for a treatment to be "evidence-based" vary from list to list. This proliferation of standards and lists of evidence-based practices may have created confusion around how to determine what is effective for children and youth with emotional and behavioral problems. For this review, our goal was to highlight treatments that have been evaluated according to the criteria proposed by the Division of Clinical Psychology of the American Psychological Association.^{12,4}

Four reviews of treatment for child abuse and neglect, completed in the last three years, provide the basis for this paper.^{13,10,2,3} These reviews rated the extent to which interventions meet criteria that have been deemed essential for a treatment to be labelled as an "evidence based practice." Essential criteria include use of a treatment manual, positive findings from at least two rigorous studies, evidence of long-term outcomes beyond treatment termination, and use of standardized therapist training and adherence monitoring.

Two of the four reviews aimed

to identify the leading treatment candidates with the most controlled research, while the other two aimed to review the evidence for some of the most commonly provided treatments for child trauma. Our goal was to determine where these reviews converged to identify some exemplary candidates for treatment dissemination. Seven treatment models

emerged as the most-supported interventions for children with histories of trauma. All are evidence-based, meeting criteria for either "well-established" or "probably efficacious" (see Table 1). Each treatment model is described briefly below.

Trauma Focused Cognitive Behavior Therapy (TF-CBT)

TF-CBT⁵ addresses behavioral and emotional symptoms as well as the negative thought patterns associated with childhood trauma. Treatment is targeted at both the parent and the child. For example, the therapist teaches the child how to regulate his or her emotions stemming from the trauma, and how to cope when experiencing reminders of the trauma. Parents are taught how to encourage these skills in the child. In joint sessions, parents and their children practice these skills with live feedback from the therapist. A PTSD diagnosis is not necessary; TF-CBT treatment is appropriate for any child who exhibits behavioral or emotional problems related to past trauma, such as nightmares, clinging

to caregivers, or an increased startle response to loud or unusual noises. The model is clinic-based and short-term (12-16 weeks). In randomized trials TF-CBT has been linked to improvements in PTSD symptoms, depression, anxiety, behavioral problems, and feelings of shame and mistrust. Moreover, these improvements have been maintained for a year following treatment completion. When parents are also involved in TF-CBT, the positive effects for children increase. This occurs through improvement of parental depression, increased support of the child, decreased emotional distress about the child's abuse, and more effective parenting practices.

TF-CBT for Childhood Traumatic Grief

TF-CBT for Childhood Traumatic Grief,¹ a revised form of TF-CBT, is designed specifically to help children suffering from traumatic grief after experiencing the loss of a loved one in traumatic circumstances. These children often have PTSD symptoms that prevent them from successfully grieving their loss. The therapy model is calibrated for two age groups: children up to six years old, and children and adolescents over age six. Treatment is provided to both child and caregiver (together and alone) over 12-16 sessions, focused at first on trauma and then on grief. The treatment pays special attention to cognitive, behavioral, and physiological reactions to the combination of trauma and bereavement, most notably sadness and fear. The components of the model are similar to those for TF-CBT, but with added focus on fear and sadness resulting from bereavement. The evidence base for TF-CBT for Childhood Traumatic Grief is emerging because the treatment is relatively new. Two studies have linked specific components of treatment to targeted changes in symptoms over time.

Abuse-Focused Cognitive Behavior Therapy (AF-CBT)

AF-CBT¹⁰ is delivered in an outpatient

setting to physically abusive parents and their school-age children. Treatment is brief (12-18 hours) and can be applied in the clinic or the home. The model incorporates aspects of learning/behavioral theory, family systems, and cognitive therapy. Individual child and parent characteristics, as well as the larger family context, are targeted. AF-CBT addressed both the risks for abuse in the parent and the consequences of abuse in the child. For example, the therapist may work with the parent on relaxation training and anger management, while discouraging aggressive behavior in the child and teaching positive social



Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

CBITS⁹ is a group intervention intended to build coping skills for children suffering from symptoms of PTSD, depression, and anxiety related to trauma. CBITS is commonly used for children ages 10 to 15 that have experienced or directly witnessed a traumatic event, including violence. Briefly, during group sessions, children express their

interaction skills. Experimental studies suggest that AF-CBT can decrease parental anger and use of physical discipline and force.

Parent Child Interaction Therapy (PCIT)

PCIT⁸ is a highly structured treatment model involving both parent and child. Originally developed by Eyberg in the 1970s for children with behavioral problems, PCIT has been adapted for physically abusive parents with children ages 4 to 12. The overarching goal of PCIT is to change negative parent-child interaction patterns. Treatment is brief (12-20 sessions) and involves live-coached sessions where the parent/caregiver learns skills while engaging in specific play with the child. The time in each session is usually divided among enhancing the relationship between the parent and child, teaching the parent how to use positive discipline tech-

niques, and working with the child to improve his or her compliance with parent directions. Specific parent and child behaviors are tracked and charted on a graph during each session, and the therapist provides feedback to the parent on his/her mastery of skills. Parents and children are given daily homework assignments to reinforce the skills learned in therapy. Experimental and quasi-experimental findings have shown that abusive parents and their children participating in PCIT reported declines in physical abuse, child behavior problems, and parental stress, as well as increased positive parent-child interactions.

feelings through drawings and group discussion. This serves as the context for building skills with guidance from the therapist. Some of the skills taught include relaxation, social problem solving, challenging upsetting thoughts, and processing traumatic memories and grief. Children are then given homework assignments to practice the skills learned in each session. Research shows that CBITS is effective, particularly in cases where trauma was more recent. Emerging findings also suggest that CBITS is effective for Latino immigrant children.

Child-Parent Psychotherapy for Family Violence (CPP-FV)

CPP-FV¹¹ is an individual psychotherapy model for infants, toddlers, and preschoolers who have witnessed domestic violence or display symptoms of violence-related trauma such as PTSD, defiance, aggression, mul-

TABLE 1. WELL-ESTABLISHED* AND PROBABLY EFFICACIOUS** INTERVENTIONS FOR CHILD TRAUMA

Intervention	Age Group	Research Design	Main Findings
<i>Adapted CBT models for physical and sexual abuse (TF-CBT, AF-CBT, CBT for child traumatic grief)*</i>	4-18 years	10 randomized trials 4 quasi-experimental	<ul style="list-style-type: none"> Improvement in child PTSD, depression, anxiety, behavior problems, sexualized behaviors, and feelings of shame & mistrust Decreased parental PTSD, depression and emotional distress about the child's abuse Decreased parent use of physical discipline and parent anger problems Decreased family conflict
<i>Parent-Child Interaction Therapy (PCIT)*</i>	4-12 years	1 randomized trial 4 quasi-experimental	<ul style="list-style-type: none"> Decreased parent physical abuse Reduced negative parent-child interactions Maintained effects at long term follow-up (3-6 years after treatment)
<i>Child-Parent Psychotherapy for Family Violence*</i>	Up to 5 years	4 randomized trials	<ul style="list-style-type: none"> Decreased PTSD symptoms and behavior problems Decreased maternal avoidance
<i>Cognitive Behavioral Intervention for Trauma in Schools**</i>	10-15 years	1 randomized trial 1 quasi-experimental	<ul style="list-style-type: none"> Improvement in PTSD and depressive symptoms Maintained improvements at 6-month follow up
<i>Project 12-Ways/Safe Care for Child Neglect**</i>	Young children	4 quasi-experimental	<ul style="list-style-type: none"> Improved skills in assertiveness and home management Improved job skills

*Meets criteria for "well-established" as defined by Lonigan, Elbert & Johnson, 1998. Efficacy results from at least two group-design studies in which the intervention was either superior to another intervention or equivalent to another evidence-based treatment; Treatment manuals preferred; Sample characteristics clearly specified.

**Meets criteria for "probably efficacious" as defined by Lonigan, Elbert & Johnson, 1998. Two studies showing superior results when compared to no-treatment control, or two group-design studies conducted by the same investigator; Treatment manuals preferred; Sample characteristics clearly specified.

multiple fears, and/or difficulty sleeping. The treatment incorporates aspects of psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories. The parent and child attend therapy sessions together. The therapist targets the child-parent relationship and the individual child's functioning, helping the child to gain a sense of security and self-esteem. Typically, treatment is delivered for one hour per week for approximately 12 months. Randomized trials have shown better outcomes in areas including behavior problems, symptoms of traumatic stress, and maternal avoidance of the child for children who received CPP-FV compared to children receiving other control or comparison treatments.

Project 12-Ways/Safe Care for Child Neglect

Project 12-Ways/Safe Care⁶ is focused on child neglect and is included in this review because neglect is a form of maltreatment that places children at risk for mental health problems. The intervention targets the various

contexts in which the child and family live, and is based on behavioral principles. Parents are taught skills in safety, bonding, and health care. The intervention often incorporates video modeling, and is used for both prevention and treatment. The evidence consists of as many as 60 program evaluations and quasi-experimental studies, showing improvement in both interpersonal (social interactions, assertion skills) and functional (job training, home management skills) domains for parents.

Disseminating Evidence-Based Practice

Many efforts are underway to spread evidence-based practice across the country. Some of these initiatives are being undertaken directly within child welfare/foster care service settings and therefore provide a direct application to a foster care population.

The State of Oklahoma has partnered with Mark Chaffin and his colleagues at the University of Oklahoma School of Medicine to test and

disseminate evidence-based interventions in child welfare populations and foster care settings. Their work to date has included initiatives with a strong federally-funded research component that seek to implement PCIT and Project Safe Care across the state.

The State of California recently funded the development of a clearinghouse for evidence-based practice in child welfare that is being implemented under contract by the Chadwick Center for Children and Families at Children's Hospital, San Diego. This initiative will post reviews of the evidence for interventions in numerous areas, including mental health treatment for children and adolescents involved with child welfare.

The Oregon Social Learning Center in Eugene, Oregon has recently partnered with the County of San Diego child welfare system and the Child and Adolescent Services Research Center at Children's Hospital to test a parent management training intervention for foster parents that is modeled on the principles of Multidimensional Treatment Foster Care. With funding from

the National Institutes of Mental Health, the partnership has recently completed a two-phase study of the model's effectiveness with promising results for children in foster care.

The National Child Traumatic Stress Network, supported by the Substance Abuse and Mental Health Services Administration, is currently disseminating TF-CBT to several sites around the country. The network provides training, subsequent consultation/supervision, and manual development. As the intervention developers train local clinicians who will then become trainers, a cascading effect should be seen through greater availability of expert treatment. Use of the internet for training in areas of the country where face-to-face training is not available (or in concert with in-person training where trainers are available) will further increase access to TF-CBT.

Finally, resources are available to provide conceptual and empirical guidance about factors that require attention prior to and during dissemination initiatives. An example of one guide is *Implementation research: A synthesis of the literature*.⁷

Conclusions

This article has described exemplary trauma-focused treatments, focusing on how these treatments are useful for treating the mental health difficulties typically experienced by children who are involved in child welfare systems. Research on these interventions has revealed some common characteristics of effective treatments for children who have experienced trauma. Specifically, treatment is more effective when it is brief and when parents are involved. Overall, the findings presented here are promising and give hope that children who receive evidence-based treatment for trauma can have significantly improved lives.

References

1 Brown, E. J., Pearlman, M. Y., & Goodman, R. F. (2004). Facing fears

and sadness: Cognitive-Behavioral Therapy for Childhood Traumatic Grief. *Harvard Review of Psychiatry*, 12, 187-197.

2 Chadwick Center for Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA: Author. www.chadwick-center.org/kauffman.htm.



3 Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review*, 26, 1097-1113.

4 Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.

5 Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.

6 Dubowitz, H. (1999). *Neglected children: Research, practice, and policy*. Thousand Oaks, CA: Sage.

7 Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: The University of South Florida, National Implementation Research Network. <http://nirn.fmhi.usf.edu/resources/publications/Monograph/>.

8 Herschell, A., Calzada, E., Eyberg, S. M., & McNeil, C. B. (2002). Parent-Child Interaction Therapy:

New directions in research. *Cognitive and Behavioral Practice*, 9, 9-16. <http://pcit.org>.

9 Jaycox, L. (2003). *Cognitive Behavioral Intervention for Trauma in Schools*. Sopris West Education Services, www.sopriswest.com.

10 Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive behavioral approach*. Thousand Oaks, CA: Sage.

11 Lieberman, A. F. & Van Horn, P. (2004). *Don't hit my mommy! A manual for child-parent psychotherapy for young witnesses of family violence*. Washington, DC: Zero to Three Press.

12 Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology*, 27, 138-145.

13 Saunders, B. E., Berliner, L., & Hanson, R. F. (2002). *Child physical and sexual abuse: Guidelines for treatment*. Charleston, SC: Office for Victims of Crime.

Authors

Leyla Stambaugh is a Postdoctoral Fellow at the Services Effectiveness Research Program in the Department of Psychiatry at Duke University Medical Center.

Barbara J. Burns is Professor and Director of the Services Effectiveness Research Program in the Department of Psychiatry at Duke University Medical Center.

John Landsverk is Director of the Child and Adolescent Services Research Center at San Diego State University.

Jennifer Rolls Reutz is a Research Coordinator at the Child and Adolescent Services Research Center at San Diego State University.