

Evidence-Based

Mental Health Treatments

for Child Abuse Victims

Quick Reference Guide for Multidisciplinary Teams & Brokers



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Introduction

Brokers and their multidisciplinary teams are professionals who identify needed services and make referral and case management decisions for the children and families they serve. As professionals responsible for connecting children with mental health treatment, it is important for teams and brokers to understand:

The potential impact of maltreatment on a child

- The role of assessment

- The problems particular treatments are designed to improve

Available treatments

- The level of research in support of treatment options

- How to identify if a proposed treatment intervention is evidence-based.

One might expect that all therapists provide evidence-based treatments, but there is a great deal of inconsistency in the use of treatments among community practitioners. Therefore, brokers need to be informed consumers of the mental health services available in their community and connect each client with treatment that is proven to help his or her specific symptoms. This requires that brokers ask mental health professionals questions regarding their knowledge, training, and use of evidence-based, trauma-focused treatment.

A broker is a person who refers clients to treatment or is authorized to purchase treatment services for clients. Brokers may be CPS workers, CAC staff, or other child abuse professionals.



Determining If A Clinician Is Providing Evidence Based Treatment

Asking these questions of therapists helps to ensure that evidence-based treatment is delivered and that children receive appropriate, effective treatment in response to trauma.

How familiar are you with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?

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Do you have specific training in an evidence-based trauma treatment model? If so, what model(s)?

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When were you trained, where were you trained, by whom were you trained, and how much training did you receive?

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What specific standardized measures are given?

Do you conduct a comprehensive trauma-focused mental health assessment?

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How do you approach therapy with children and families who have been impacted by trauma (regardless of whether they indicate or request trauma-informed treatment)?

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What does a typical course of therapy entail? Can you describe the core components of your treatment approach?

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How are parent support, conjoint therapy, parent training, and/or psycho-education offered?

How are cultural competency and special needs issues addressed?

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Do you receive ongoing clinical supervision and consultation on any of the models in which you have been trained?

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Are you willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

**The Chadwick Trauma Informed Systems Project (2012). Creating trauma-informed child welfare systems: A guide for administrators (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Why Assess Symptoms?

Child maltreatment victims are at risk for a host of emotional and behavioral problems, though some child victims do not develop these symptoms. Of the children who do develop problems, symptoms fall into two categories:

Internalizing Symptoms

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Usually difficult for other people to see

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Examples include: depression, anxiety, PTSD, nervousness, intrusive thoughts about the abuse, and fears.

Externalizing Symptoms

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Usually more easily seen by others

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Examples include: nightmares, defiance, aggression, attention problems, and opposition.

If these symptoms begin or are worsened in response to the child's trauma experience, they are considered to be "trauma-related symptoms."

Once it is known that a child has experienced some form of maltreatment, the next step is to determine if the child has developed these problems/symptoms. This information is gathered through a comprehensive assessment of the child that includes a trauma-specific assessment. This includes the use of standardized measures. The assessment measures are used prior to the start of evidence-based treatments to help determine if the child needs treatment, and if symptoms are identified, to determine what treatment is most appropriate. The assessment is then administered again at the end of treatment to help evaluate whether therapy was successful. Brokers and/or professionals at Children's Advocacy Centers can receive training on the use of these measures, and administer these to help guide MDT recommendations regarding the need for and/or the most appropriate treatment for each child.

Commonly used standardized assessment screening tools

Mood and Feelings Questionnaire
(Angold & Costello, 1987)

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Strengths and Difficulties
Questionnaire (Goodman, 1997)

Child PTSD Symptom Scale
(Foa et al., 2001)

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UCLA PTSD Reaction Index
(Pynoos, et al., 2002)



Evidence-Based Treatments

Currently, there are three treatments with extensive evidence to support their effectiveness in addressing trauma related symptoms.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino & Deblinger, 2006), has the highest evidence base in reducing children's internalizing symptoms and has been shown to have moderate effectiveness in reducing children's externalizing symptoms. In randomized trials, TF-CBT has been directly compared and found to be more effective than routine community care, nondirective supportive therapy and child-centered therapy. TF-CBT is appropriate for children ages 3-18 and their non-offending caregivers. It was first developed for children with histories of sexual abuse or of witnessing domestic violence, and has been extended for use with children with related trauma symptoms.

Parent-Child Interaction Therapy (PCIT; Eyberg 2005) was developed for caregivers and children ages 2-7 who have disruptive behavior disorders. PCIT is an excellent treatment option for young children with predominantly externalizing symptoms. Over 50 randomized controlled trials support the effectiveness of PCIT in reducing parent stress levels and children's behavioral problems in children with or without histories of maltreatment. PCIT has been used for children and caregivers with a history of physical abuse and has shown to be effective in lowering both caregiver abuse and risk for further abuse to occur.

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT; Kolko et al. 2011) was developed for caregivers and children ages 6-adolescence who have a history of caregiver physical abuse or coercive parenting practices. Two randomized trials have shown it to be superior to routine community care for reducing children's conduct and oppositional behaviors, as well as in reducing internalizing symptoms. Further, parents who receive AF-CBT demonstrate significantly greater decreases in the use of physical discipline and in anger at post-treatment as compared to those in routine community care. AF-CBT differs from TF-CBT in that it was developed specifically for families with histories of physical abuse and that it frequently includes the caregiver who engaged in physical abuse.

Common Components of EBTs

These evidence-based treatments have several elements in common. It can be helpful for brokers to know these elements, and to know the training required for therapists to be proficient in them.

This knowledge helps brokers ask questions to better understand a given therapist's use and adherence to an evidence-based treatment.

All of the described treatments include both children and caregivers in the treatment process. For TF-CBT and AF-CBT, children and caregivers have individual sessions, and some sessions are held jointly. For PCIT, most sessions involve both child and caregiver together.

Each of the three treatments involves skill building, or teaching the child and caregiver ways to manage symptoms. This can involve teaching skills for managing physical symptoms, distressing thoughts, or disruptive behaviors.

The treatments are structured and follow clear protocols. They typically include weekly sessions and last between 12 and 20 weeks. Therapists who are trained and proficient in these treatment models typically follow three steps:

1. Reading introductory material (for TF-CBT, there is an introductory web course);
2. Attending a multi-day, in-person training with a certified trainer;
3. Receiving ongoing case consultation, typically for 6 to 12 months. Some treatments, such as TF-CBT, have additional requirements to become certified in the model.

Most evidence-based treatments are designed to be delivered during weekly sessions. It is important for brokers of treatment to ensure that therapists to whom they refer clients are able to deliver the treatment in the manner intended to support the effectiveness of the treatment.

For a list of certified therapists nationwide, find the roster at: www.tfcbt.org/members/

Promising Treatments

The child trauma field is continually improving and developing new treatments to address gaps in service needs for children and families. Several of these are relevant to children served by CACs, and many are being evaluated within CAC settings.

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Child and Family Traumatic Stress Intervention (CFTSI; Berkowitz, Stover, & Marans, 2010) was developed specifically for children in the acute (45 days or less) time frame after a traumatic event occurred. It has shown to be helpful in preventing the development of PTSD.

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Child Parent Psychotherapy (Lieberman & Van Horn, 2004) is a treatment for young children (ages 0-5) and their caregivers. It has been shown to reduce externalizing symptoms and PTSD in children who have witnessed domestic violence.

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The Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program (Silovsky, Niec, Bard & Hecht, 2007) is a group treatment approach for reducing children's sexual behavior problems. It has been shown to reduce sexual behavior problems among children ages 6-12.

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Prolonged Exposure for Adolescents (Foa et al., 2013) is a well-established treatment for adult PTSD, which recently has been applied to adolescents (ages 13-18) with histories of sexual abuse or assault, and shown to be more effective in reducing PTSD than supportive counseling. Prolonged exposure differs from TF-CBT in that it includes less of a focus on developing coping skills, and has an increased focus on processing trauma memories.

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Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001) was originally developed for adults, and has now been used with children. To date, research has shown that for children who have experienced disasters or accidents (such as car accidents); EMDR is equally as effective as cognitive behavioral therapy. In one sample group, EMDR has also been shown to reduce PTSD symptoms in children ages 6-16 with histories of maltreatment.

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Risk Reduction through Family Therapy (RRFT; Danielson, 2010) takes a systems-based approach to reducing negative outcomes among sexually abused adolescents. RRFT has been shown to reduce adolescent girls' internalizing symptoms (including PTSD), while reducing the potential for risky behaviors. RRFT is unique from other treatments for child maltreatment victims in that it includes, and specifically targets, high risk behaviors such as substance abuse. Children with these types of problems are typically excluded from studies on other treatments.

Commonly Used Treatments That Are Ineffective In Reducing Trauma Symptoms

Research to identify mental health treatments that are effective in reducing the symptoms of trauma has grown exponentially over the past 10 years.

Although there are now several evidence-based treatments, many community therapists continue to use treatment modalities with child maltreatment victims that do not have evidence supporting their effectiveness. Such treatments are typically non-directive, such as supportive counseling, play therapy, or art therapy. These treatments are not recommended because they have not demonstrated effectiveness, through research described above, in reducing trauma symptoms.

Conclusion

Child victims and their families who are experiencing trauma symptoms deserve to be treated by mental health professionals with special training in treatments that have been shown, through research, to be effective in reducing their specific symptoms. For more information, the NCA Mental Health Accreditation Standards provide clear guidance regarding the role of CACs to ensure that the children and families have access to the most appropriate and effective treatment to heal from any identified traumatic event.

It may be found at www.nationalchildrensalliance.org/ncamembership-types. More information regarding evidence-based treatment can be found at the National Child Traumatic Stress Network www.nctsn.org or the California Evidence Based Clearinghouse for Child Welfare at www.cebc4cw.org.