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Advances in Psychotherapy –
Evidence-Based Practice

Childhood Maltreatment

2nd edition

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Dedication

First and foremost, this book is dedicated to all victims who have lost their lives to causes related to child maltreatment – your imprints on this world are not lost. To all those who have survived abuse and neglect – your daily efforts to engineer your own resilience journey is acknowledged and admired. We appreciate the participation of all child maltreatment research participants in building the evidence base upon which this book is based. We recognize the tremendous efforts of trainees, research assistants, and other support persons who make the research enterprise happen on a daily basis. A special note of research thanks goes to Mr. Ronald Chung, who married his sweetheart Cindy during the creation of this book.

Second, this book is dedicated to professionals who, in their own ways, form a river of resilience to keep victims buoyant and moving forward. This book is dedicated to the memory of professionals who have shown a persistent devotion to violence prevention. We acknowledge the sizeable contributions of Dr. Mark Chaffin and Dr. Murray Strauss. We wish to remember further two individuals: Dr. Anne-Marie Wall, 1964–2005, an alcohol researcher who came to embrace work in the family violence field, coediting *The Violence and Addiction Equation* with Dr. Wekerle; and Dr. Angus MacMillan, 1930–2015, a pediatrician who advocated for the need to establish a children's hospital, in part, to reflect the sensitivity in approach that children need in health care. His lifelong work in child health and violence prevention at McMaster University, inspired his daughter, Dr. Harriet MacMillan, a pediatrician and child psychiatrist, to initiate the Child Advocacy and Assessment Program (CAAP) at McMaster's Children's Hospital. She now leads the Violence, Evidence, Action Group (VEGA; http://projectvega.ca/).

Acknowledgments

This second edition represents an update covering the vast volume of new research in child maltreatment. We thank our publishers, acknowledging especially Robert Dimbleby and series editor Dr. Danny Wedding, and are grateful for their ongoing interest in child maltreatment knowledge exchange. The current authorship provides expertise in assessment and treatment issues, consistent with the current gold standard of trauma-focused cognitive behavior therapy with pediatric clients. Ongoing research that reflects the contributions of international teams and practitioners across diverse disciplines and systems, as well as those with lived experience, remains essential to upholding the foundational principles of doing no harm and acting in the best interests of the child. As professionals, we recognize the primacy of the child's and adolescent's right to safety and freedom from violence. Without physical and psychological safety, it is very challenging to optimize development and galvanize resilience. We are very pleased to join with you as part of the global collective to put children first, end violence, and to work toward peace and justice for all of the world's children.

Contents

1

Description

My father began screaming.… It snowballed from there. I do remember his face being distorted by rage, barking at us like a drill sergeant. I remember veins bulging…. He hit my brother upside the face. I was next.… He knocked me down again, incensed, and then dragged me to the bed…. I thought I was going to die.… My dad and I bumbled our way through my youth…. I began to show troubling behavior. I began to steal … trying to fill something inside, trying to find power in my powerless life…. If I was so lovable, then why did those closest to me seem to see fit to treat me so badly?… I have so much compassion for my dad. He endured so much as a child, and then he was shipped off to war. He had suffered from PTSD.… While he and I did not speak for most of my early career, we have a healthy and loving relationship now. Through a combination of therapy and self-examination, he has fought hard for the happiness he has, and [now] *... allows me to feel a lot of safety….*

Jewel, American singer–songwriter–writer
(Jewel, 2015)

1.1 Terminology

Worldwide, over 1 billion children were exposed to violence in 2014 (Hillis, Mercy, Amobi, & Kress, 2016). The Global Partnership to End Violence Against Children estimates that 120 million females and tens of millions of males are sexual abuse victims (UNICEF, 2014). Child maltreatment can be understood only by examining the nature of close relationships. Only through the context of relationships can such illogical, illegal, and illicit actions be repeated, over hours, over days, over years. "It is a private family matter" is a phrase that illustrates how child maltreatment was once treated; however, after decades of rigorous research and robust results, we are now realizing that child maltreatment is a serious public health issue with humanitarian and human rights import. As musician Jewel's quote above reminds us, caregiver vulnerabilities deserve our compassion. Because of the drive to attachment, and later affiliation, children tilt toward tenderness. In a meta-analytic review of the adverse childhood events (ACEs) literature by Hughes and colleagues (2017), there was a strong urgency felt by all involved parties to prevent maltreatment, minimize its negative impact by targeting reoccurrence, and build resilience. With four or more ACEs, there was a 5–10 times increase in the likelihood of

problematic alcohol and drug use, 3–5 times increase in the likelihood of sexual health risk behaviors, and over 30 times increase in the likelihood of a suicide attempt. While cumulative stress in childhood is the key concern, five of the ACEs involve child maltreatment (physical, sexual, emotional abuse, neglect, exposure to intimate partner violence), while three are caregiver vulnerability factors (household substance abuse, mental health problems, criminality). The annual costs of maltreatment are estimated at between US $124 billion and US $585 billion in the US (Fang, Brown, Florence, & Mercy, 2012).

Parental stress and impairments impact parenting in many ways

The adults' issues do deserve therapeutic attention. Parental socioeconomic stress, personality vulnerabilities, addiction, partnership problems, social isolation, cognitive impairment, and psychopathology certainly impact parenting. The adults' stress narrows their attentional capacities, leading to an overfocus on child problem behavior and an underattention to child discovery and positive behaviors. There is robust evidence for the harm of spanking and verbal abuse toward children, and yet, in developing countries in particular, most children experience adversive, coercive parenting. Overwhelmed adults also disengage from child care. However, the fact remains that adults take care of children; children do not parent and protect adults. The child's stress systems are overwhelmed due to their dependent and in-development nature. Behaviorally, the child will freeze, faint, flee, or fight. Increasingly, youths are becoming more active, reporting their maltreatment directly to national and international child helplines (Bentley, O'Hagan, Raff, & Bhatti, 2016). Data from 2003–2013 from Child Helpline International – a global network of helplines – documents the fact that over 4 million children have reported violence, primarily at the ages of 10–18 years old; 60% of reportees were girls, and 58% of physical abuse perpetrators were family members (Child Helpline International, 2013). There is a changing landscape of dangers to youth: In 2015, the Internet Watch Foundation and partners removed over 68,000 URLs with child sexual abuse images worldwide (International Watch Foundation, 2016). The details alone should shock us into our advocacy roles as professionals: 3% of victims were assessed as 2 years old or under, with most victims assessed to be 10 years old and under; 85% of images were of girls, with 39% of images showing extreme violence. The drivers for this content are persons in developed nations: Most of these sites were hosted in North America and Europe.

These statistics highlight the need to support two of the UN's Sustainable Development Goals (SDGs): SDG 5.2, to "eliminate all forms of violence against all women and girls in public and private spheres" (United Nations, 2017); and SDG 16.2, to "end abuse, exploitation, trafficking, and all forms of violence and torture against children" (United Nations, 2017). For clinicians engaged in cases of family violence, it is important to be aware of the full range of violence and risks, as well as the resilience resources. We need to be prepared to consider cross-cutting issues, such as the environment and poverty, alongside human rights and public health initiatives in violence prevention, as expressed in the principles underlying the SDGs.

Violence and poverty are important contributors to maltreatment

While we may think of child maltreatment as relevant to a child or family, its ripples extend much further. Violence is a social determinant of health, and there are disparities in the ways in which violence affects relationships, parenting, and communities. In a 27-year birth population cohort, economic and social instability were found to be predictors of child maltreatment (Doidge,

Higgins, Delfabbro, & Segal, 2017). Higher rates of maltreatment are linked to economic and financial crises in countries, as well as poor adult financial health in terms of employment and property ownership (Currie & Widom, 2010). The implications of poverty include spill-over effects that further impact physical health.

An ongoing concern is the disproportionate numbers of socioeconomically disadvantaged children in out-of-home care. For example, according to Statistics Canada, in 2011 (Turner, 2016), Aboriginal children aged 14 and under accounted for 7% of Canadian children but 48% of foster care children (*Aboriginal* is the term used in the study for this report and reflects predominantly First Nations children, but also Métis and Inuit children. For the report on the 2011 National Household Survey data [Turner, 2016]). Of these, 44% lived with at least one Aboriginal parent. Indigenous cultural practices promote well-being, as they target a balance in mental, physical, emotional, and spiritual well-being, as well as the maintaining of a tangible connection to community resources. Children and youths living in indigenous communities are also exposed to land-based trauma, where the ongoing requirement to defend and protect land and water resources is heightened with environmental concerns over corporate and government challenges to treaty rights. Recently, a connection was made between government and public health concerns such as clean water, degradation of land, and available green space, on the one hand, and location and (re)location of children and families on the other. In the United Nations Declaration on the Rights of Indigenous Peoples (United Nations General Assembly, 2007);, rights to intellectual property, traditional knowledge, language, and ancestral domains, as well as treaty and land rights, are detailed. Article 22 specifically addresses children, stating that they have a right to "full protection and guarantees against all forms of violence and discrimination" (p. 9). People in governmental positions and professionals in care and contact positions are duty bearers, upholding our duty to support well-being and to address violence. As such, we have a responsibility to respect, promote, and realize human rights, and to abstain from human rights violations.

The portrait painted herein of child maltreatment is one of adult disadvantage and poor decision making, often in the context of historical and current violence and deprivation. The body of research is clear that maltreatment is an environmental and relationship toxin, a modifiable health risk factor, and a driver of health care costs. Yet, in day-to-day experience, violence is one adult's choice among a myriad of other options for that one child. A parent's capacity to buffer a child from the parent's own stress, as well as to scaffold a child's response, is critical to developing the adaptive *serve-and-return* mutual attention interactions, which include the capacity for interactive repairs – the *how to* of reconciling conflictual interactions. A serve-and-return interaction occurs when a child is given feedback on their actions or verbalizations from the parent, thereby engaging the child in a reciprocal manner. Interactive repairs involve exchange between the parent and child working together to remedy conflict, allowing for the parent to take responsibility for correcting a potentially harmful interaction. An example of this would be the parent explaining the use of punishment that is reasonable or apologizing for a harsh discipline approach, letting the child know what they should expect in the

2

Theories and Models of Child Maltreatment

Theories of maltreatment consider the transaction of biological, individual, familial, and community risk and protective factors

Child maltreatment can be likened to a "natural experiment" in which development accommodation and adaptation proceed based on the meaning the victims ascribe to their experiences. Current thinking about childhood maltreatment attempts to integrate biological, child, caregiver, familial, and community risk and protective factors in a transactional model in which environments, within and across time and key developmental junctures, may be sustained or altered substantially. More scientific effort has gone into understanding victimization than perpetration, with the exception of sexual offending. Detailed analyses of ethnic, cultural, and religious values and identification, as well as immigrant and refugee health service experiences, are yet to be fully explored.

Despite the centrality of trauma in the theory of maltreatment-related impairment, the majority of affected children do not have PTSD. A compounding of traumatic events may be most relevant in understanding the harmful outcomes, as seen in polyvictimization, clinical and care subpopulations, and what is labeled complex trauma. Foster care youth populations are exposed to a wide array of traumatic events, and many will experience PTSD. Recent work has focused on resilience of maltreated and foster care youths, stressing self-maintaining and self-righting systems.

A key theoretical concept is to view child maltreatment as an indicator of relationship dysfunction. The learning ground for the child is largely an interactional one. Thus, maltreatment can be expected to impair successful resolution of developmental goals across the lifespan (e.g., attachment, communication, autonomy, intimacy, generativity, altruism, and enlightenment). In keeping with "living what you learn," maltreated children are vulnerable to reenacting learned schemas or scripts for victim–victimizer–rescuer roles and withdrawal and avoidance patterns in relationships, driven by fear reactions and love needs. Given the disruption to the typical caregiver role in social referencing, maltreatment can be expected to disrupt the way a child would typically learn from others and see their role in relation to others. This disruption has implications for prosocial development, self-care, and self-righting mechanisms, and the balance between basic survival and self-actualization. Thus, the complex range of outcomes associated with maltreatment may reflect several interconnected processes, including alterations in neurobiological processes, learning-based mechanisms, and biased information processing.

Child maltreatment is an indicator of relationship dysfunction

Those with a trauma spectrum disorder frequently have an altered regulation of the hypothalamic-pituitary-adrenal (HPA) axis, our central stress response system. In brief, the hypothalamus releases corticotrophin-releasing factor, which stimulates the pituitary gland to release adrenocorticotrophic

hormone into the bloodstream. This leads to the adrenal gland releasing the stress hormones (cortisol). The value of stress is that it enables quick action to increase safety under threat, and it increases the availability of the body's food supply (carbohydrate, fat, and glucose). Threat gets averted, and the person can return to their readiness state. But following maltreatment, the person could detect a threat, question if the threat is a false alarm or real, and their system would go from 0 to 100 in its attempt to avert threat. This process creates a special kind of conditioning to environmental sounds, relationship cues, bad news – minor and major stressors sometimes alike. This process primes a person to be on alert. Outside the maltreating home, it often results in overreactivity and oversensitivity. If cortisol levels remain too high for too long, there is muscle breakdown, decreased inflammatory response, and suppression of the immune (defense) system. For a review of how the brain deals with cumulative stress, see Frodl and O'Keane (2013).

Toxic stress and trauma explain connections between an abusive environment and brain vulnerabilities

The theory of toxic stress and developmental traumatology has driven greater understanding in the brain-based vulnerabilities ensuing from chronically, relationally unhealthy environments. This eco-bio-developmental framework recognizes the impact of health disparities within populations, and represents a paradigm shift in understanding the convergence in findings from molecular biology, neuroscience, clinical and experimental psychology, epidemiology, social work practice, and public health interventions. Child maltreatment (5 of the 10 ACEs) affects personal economics and well-being, and is a high priority for prevention. Normatively, the *flight or fight* (threat response) system works in a coordinated fashion with the *tend and befriend* (relational) system – for example, attachment processes help the child begin to quantify threat levels and gain confidence in survival self-efficacy. In short, the child learns to recognize that not everything in this early environment is trying to cause their death, or is harmfully intrusive and aversive. The transient increase in stress hormones protects the child from harm by dangerous persons, places, and things. However, excessively high levels of stress hormones and prolonged exposure to stress dysregulate the body's systems yielding wear-and-tear effects on organs, including the brain.

This accumulated life-course science points back to the preventable problem of child maltreatment, and prenatal care as a starting point, for prevention of chronic stress and the ensuing disruptions in mental, physical, financial, and community health across the lifespan. Traumatic events sensitize the brain, particularly during periods of critical brain growth and development, leading to atypical growth and connections (e.g., the corpus callosum becomes smaller in maltreated children). The fundamental emotional backdrop to the high intensity, unpredictability, and threat of injury is fear, and posttraumatic stress symptomatology or disorder develops from dysregulated fear circuitry. For an individual, the interaction between genetics and the child's environment sets neurodevelopmental changes in motion, such as neuronal growth, migration, myelination, and synaptic changes, and the general "use it or lose it" rule can lead to individual vulnerabilities or competencies. When certain pathways are heavily used, these brain connections become stronger and quicker to initiate, which may support overuse of processes such as hypervigilance and dissociation. When neuronal synaptic connections in the brain are less well used, they may be eliminated (i.e., selective pruning or neuronal death) and denote areas

3

Diagnosis and Treatment Indications

Maltreatment overlaps with bullying and sexual harassment at school, adolescent dating violence, and CSA

A history of child maltreatment poses a risk for re-experiencing violence and victimization, increased proximal distress, and challenges in coping that can spiral a youth downward. Our current understanding is one of polyvictimization across childhood, with potential overlaps among types of maltreatment, bullying and sexual harassment at school, and adolescent dating violence and sexual assaults (Wolfe, Scott, Wekerle, & Pittman, 2001). According to the 2015 US Youth Risk Behavior Survey, overall these are salient issues for all adolescents (Centers for Disease Control and Prevention, 2016). The survey showed that 6.7% of youths reported "ever experiencing forced sexual intercourse" (significantly down from 7.7% in 2013). About one fifth were bullied on school property, with fewer reporting electronic bullying. Dating violence reporting, historically equivalent between males and females, show recent trends indicating higher female victimization (i.e., with an overall 9.6% reporting physical dating violence and an overall 10.6% sexual dating violence) and high rates of sad mood (nearly every day for past 2 weeks; 29.9%). While potentially risky coping is not tied to health risk behaviors in the items surveyed, it is noted that the first drink of alcohol (before age 13) was reported by nearly one fifth of males, and past-month drinking by about one third of youths, with 6.1% of males reporting a recent binge episode of 10 or more drinks in a row. Many youths (30%) are currently sexually active, with just over half reporting condom use. The variability in trauma events, co-occurring health risks, and protective factors lead to a range of victim responses, from being asymptomatic, to being severely impaired and chronically suicidal. Additional factors that may present clinically include turbulence in the living environment (e.g., entry into formal service systems); whether or not there is at least one stable, safe, nurturing relationship that provides a sense of mattering to the child; and community resilience resources. A detailed description of the diagnostic assessment and appropriate diagnostic instruments is available elsewhere (Kisiel, Conradi, Fehernbach, Torgersen, & Briggs, 2014).

The following section reviews common maltreatment-related disorders and research with maltreated or CPS populations. While CPS populations receive more mental health attention, an overall mental health service rate of 33% has been observed among investigated youths (e.g., Horwitz, Hurlburt, Goldhaber-Fiebert, Heneghan, Zhang, Rolls-Reutz, 2012), confirming that CPS-involved youths are a priority subgroup for mental health care.

Child maltreatment is causally linked to numerous mental health disorders

Child maltreatment-related impairment is robustly linked to mental health problems and is believed to be a causal factor (Norman et al., 2012). As such, maltreatment is deemed an important modifiable factor, and directly addressing traumatic events with symptomatic children and youths is part of

crafting a story that helps a child make sense of the remembered events and experiences. Clinicians are often left with concerns about child and youth odd behaviors and the problem solving that belies acting-out behaviors that may be labeled "attention getting." The trauma-informed approach, with its emphasis on child centeredness, prioritizes feelings of internal and external safety, respecting autonomy and agency, and understanding that trauma-related reactivity may be connected to acting-out behaviors (e.g., sexual or aggressive acting out). Providing a rationale (and explicit permission) for discussion of uncomfortable, confusing, or threatening events when it is your job to take care of health and safety helps to convey the principles of respect, concern, and honesty that should be affirmed consistently with every child.

There are few consistent linkages between maltreatment and *specific* problem behavior profiles, with two exceptions: (1) CSA and sexual acting out, and (2) physical abuse and aggressive acting out. Children who are sexually abused engage in sexualized behaviors beyond what is developmentally appropriate. Such behaviors may include sexualized play with dolls, inserting objects into genitalia, excessive masturbation, seductive behavior, and age-inappropriate sexual knowledge. Early CSA may be especially damaging due to the qualitatively different experience of body invasion, body restraint, and accompanying emotional abuse (shaming, unwanted "special" attention or comments about a child's body).

Due to the pernicious impact of violence on females, with higher rates of CSA and incest, childhood maltreatment is a critical risk factor for many of the problems women face, including partner violence, ill health (e.g., gynecological health, chronic pain, arthritis, irritable bowel syndrome), depression, self-harming (cutting) and suicidal behaviors, anxiety, substance abuse, disordered eating, and PTSD. In terms of risky sexual practices, childhood maltreatment is associated with a greater number of partners, earlier onset of *wanted* sex, and larger age differentials between partners. In a study of child welfare–involved youths, CSA was predictive of gender-specific motives for sex, with males and females reporting having sex for coping with negative affect, but boys reporting higher levels of having sex for peer and partner approval. The coping motive for sex functioned as a mediator between the maltreatment and adolescent sexual health risk behaviors (Wekerle, Goldstein, Tanaka, & Tonmyr, 2017).

Child sexual abuse is not empirically linked to becoming a sexual offender as an adult

A relationship between experiencing sexual abuse in childhood and sexual offending has not been supported by research. A prospective longitudinal birth cohort study found little evidence that CSA of males was a major factor among sexual offenders (i.e., only 4% of sexually offending males experienced CSA; Leach, Stewart, & Smallbone, 2016). In a meta-analysis of juvenile offenders, sex offenders differed from non–sex offenders primarily in atypical sexual interests, as well as CSA history, criminal history, antisocial associations, and substance abuse (Seto & Lalumière, 2010). This study suggests that a connection between child maltreatment and adult sexual offending relates to more different forms of victimization, as well as nonsexual, nonviolent offending.

While studies show a link between maltreatment and behavioral problems, maltreated children may show both aggressive and withdrawal behaviors, resulting in less social effectiveness and greater risk for delinquency. Physical abuse teaches a lack of empathy (e.g., nonresponsivity to the crying of others)

4

Treatment

Even within different categories, trauma experiences vary widely. Some traumatic events are more restricted, while others have much more impact. Social ecology can exacerbate existing maltreatment, such as with natural disasters and migration, potentially adding in further loss and death. Other traumatic experiences, by their very nature (e.g., incest), require compartmentalized living, and different response repertories at nighttime or at the breakfast table in the morning. When trauma is part of the everyday home environment, there is the dual problem of ongoing exposure and adaptation to changing circumstances. Traumatic stress can impact all ages; however, there is no consensus on posttraumatic symptoms in the very young child, although behaviors like gaze aversion are responses to parental intrusiveness.

As noted, mental health practitioners do not treat child maltreatment itself, but rather the negative behavioral, emotional, and other problems that children develop in response to trauma. Mental health services are indicated for children who develop trauma responses following child maltreatment. However, several interventions with inadequate empirical support are too commonly used in clinical practice, such as nondirective play therapy, art therapy, and sand tray therapy. Instilling a more directive therapeutic approach in students during the course of their training (in contrast to teaching nondirective approaches) may be important in fostering ongoing use of evidence-based interventions. In a meta-analysis of treatment impacts on common outcomes of CSA, cognitive-behavioral treatment was effective at addressing PTSD symptoms as well as externalizing and internalizing problems, at medium effect sizes (Trask, Walsh, & DiLillo, 2011).

Treatment should focus on behavioral, emotional, and other problems children develop from trauma

Thus, providing practicing clinicians and students with experience in the effective use of evidence-based interventions tends to shift their clinical process beliefs. Based on an assortment of factors, efforts should be focused on educating trainees about the benefits of using evidence-based interventions (in contrast to treatment-as-usual or nondirective strategies), and on ensuring that students have multiple experiences of successfully implementing such treatments throughout the course of their training.

The US Substance Abuse and Mental Health Services Administration (SAMHSA) has a trauma and justice strategic initiative to advance the use of trauma-informed practices (Substance Abuse and Mental Health Services Administration, 2014). This initiative hopes to prevent retraumatization, by changing how institutions and service systems manage problem behavior of youths coercively (e.g., restraints, isolation, and physical punishment), and address those that fail to recognize vulnerabilities due to polyvictimization. This initiative is based on a foundation of (1) realizing that trauma is wide-

spread, (2) recognizing the signs and symptoms, (3) responding with trauma-based knowledge, and (4) protecting against retraumatization. Efforts by service systems may range from a mission statement indicating dedication to trauma recovery, to a trauma-based intervention such as TF-CBT, the current gold standard for intervention with traumatized youth (described in detail in the paragraphs that follow) (Box 4).

Box 4
Six Principles of Trauma-Informed Practice

1. Prioritizing felt sense of safety and safety protocols: supporting physical and emotional security, calming, and de-escalation protocols;
2. Trustworthiness and transparency, and clear role expectations;
3. Peer support, and working to preserve and enhance social network;
4. Collaboration and mutuality: partnership orientation;
5. Empowerment, voice, and choice: cultivating self-advocacy skills, valuing of lived experience, bolstering resilience;
6. Sensitivity to gender, cultural, and historical issues: access to cultural and gender supports.

To determine the appropriate mental health services for each child, the mental health practitioner must begin by conducting a thorough diagnostic assessment. Diagnostic assessments must address potential difficulties or disruptions in multiple domains of mental health functioning, and collect information from the child, current primary caregiver, and others, as indicated (e.g., child protection caseworker, juvenile justice parole officer, school and medical records, forensic evaluations, etc.).

As described earlier, many children develop PTSD symptoms at some point following maltreatment. These symptoms can include nightmares or upsetting thoughts about their maltreatment experiences; not wanting to talk or think about their maltreatment experiences; negative beliefs about themselves, including self-blame for the maltreatment; negative emotional states (e.g., anger, sadness); irritability, temper outbursts, and trouble sleeping, paying attention, or concentrating; or reckless or self-destructive behavior.

Successive versions of the DSM have attempted to make the PTSD diagnosis more appropriate for young children, with DSM-5 providing separate diagnostic criteria for children under the age of 7 years. Evaluators must be able to identify potential environmental trauma reminders and understand how these reminders impact the child's symptoms. However, a PTSD diagnosis is not required to receive trauma-informed intervention. Child maltreatment impacts multiple domains of functioning, including affect, biology, behavior, cognition, school, and/or social and attachment relationships. Some youths develop complex trauma responses, consisting of severe dysregulation in multiple domains of functioning.

Alternatively, children may develop depressive, anxious, or behavioral responses to child maltreatment, with or without PTSD symptoms. Any of these trauma responses are appropriate indicators for trauma-informed treatment, such as TF-CBT. As with other diagnostic assessments, the goals of the assessment are to develop comprehensive case formulation, diagnosis, and treatment planning. During the assessment, the mental health practitioner pri-

oritizes the child's mental health needs and makes a plan for treating the most highly prioritized problem(s). During case formulation, the practitioner puts together a biopsychosocial approach to understanding the child's presenting problems. The diagnosis presents the same data from a DSM perspective. The treatment plan proposes a response to these problems.

Practitioner's role is to explain connections between child's symptoms and their maltreatment experiences

Treatment planning is an important part of engaging families. If the child has significant trauma responses (e.g., PTSD, depressive, anxiety, behavioral, cognitive, relationship, or other significant symptoms related to the maltreatment experiences), the practitioner should refer the child for trauma-focused treatment. However, it is critically important that not only the practitioner, but also the *parent and child* understand these as trauma responses, and agree to trauma-focused treatment as the best plan for addressing these responses. Specifically, the practitioner must clearly explain the *connections between the child's presenting problems (symptoms) and their maltreatment experiences*. Additionally, the practitioner must explain that treatment will focus on addressing *the maltreatment experiences, during every treatment session,* in order to address the presenting symptoms. The more the buy-in from the family, the less likely the treatment will be disrupted by a series of behavioral crises (often referred to as *crises of the week,* or COWs), especially if the child has presented with externalizing behavior problems.

TF-CBT is the most evidence-supported treatment protocol for survivors of maltreatment

TF-CBT, described at length in the following section, is the most evidence-supported treatment protocol for children, youths, and adult survivors of maltreatment, including child abuse, neglect, domestic violence, and/or traumatic grief (and complex trauma responses to these experiences). TF-CBT has an excellent training and support model, including a free online course – TF-CBT*Web* (https://tfcbt2.musc.edu/). The Web-based training provides free continuing education credits upon completion, provides streaming video examples of how to provide the treatment, and has downloadable scripts and other resources for how to implement the TF-CBT model. The online training is required before the 2-day, face-to-face training with a TF-CBT expert trainer, followed by at least 6 months of twice-monthly consultation calls during which practitioners receive guidance in how to implement their own TF-CBT treatment cases with fidelity. Licensed practitioners with a master's or doctoral degree may choose to become nationally certified as a TF-CBT therapist. More information about how to access training and consultation and the TF-CBT National Therapist Certification Program is available from their website. More detailed information about providing the traumatic grief module of TF-CBT is given in Cohen, Mannarino, and Deblinger (2006) and in the free online course, TF-CBT*Web* (available at http://www.musc.edu/ctg/).

Treatment indications for receiving TF-CBT include (1) the child is between the ages of 3 and 19 years (TF-CBT can be used for younger and older individuals, but the evidence base for TF-CBT is for this age range); (2) the child has experienced at least one remembered traumatic experience (remembering the experience is required for many TF-CBT components); (3) the child has significant trauma-related symptoms (e.g., PTSD or depressive, anxiety, cognitive, behavioral, interpersonal, and/or other trauma-related symptoms); (4) the child and parent (or legal guardian) agree to TF-CBT (in some jurisdictions youths $\geq$ 14 may agree to treatment without parental consent); and (5) although not required, the nonoffending parent or primary

caregiver is strongly encouraged to participate in the TF-CBT treatment (Box 5).

Box 5
Treatment Indications for TF-CBT

- Aged 3–19 years
- Experienced traumatic event
- Significant trauma-related symptom(s)
- Child/youth and parent (or legal guardian) agree to TF-CBT
- Nonoffending caregivers are encouraged to participate

4.1 Methods of Treatment

Many treatments are available to address the impact of trauma. An overview of empirically supported treatments and fact sheets on different methods are provided by National Child Traumatic Stress Network (http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices/). Of these, TF-CBT has the strongest evidence for improving a variety of outcomes following child maltreatment. As described in Section 4.3., TF-CBT has been studied in 15 randomized controlled treatment studies for children, ages 3–18 years, who had experienced diverse types of child maltreatment, including CSA, domestic violence, traumatic grief, and/or complex and multiple traumas, and has also been tested in diverse settings and formats (e.g., outpatient, foster care, residential treatment facilities, postwar settings; individual and group formats) as well as in diverse domestic and international settings. Positive outcomes that have been consistent across populations, settings, and formats have further contributed to the widespread dissemination of this treatment model for traumatized maltreated children.

TF-CBT involves three treatment phases

TF-CBT is a phase- and components-based treatment model. The model is divided into three treatment phases: an initial stabilization skills phase, a middle trauma narrative phase, and a final integration and consolidation phase. These phases are provided in equal proportions for typical traumas. However, children with complex trauma typically have more severe behavioral and emotional dysregulation, which requires proportionally greater time being spent on the initial stabilization skills phase. For these children, the proportionality of the phases is adjusted so that about half of the total treatment sessions are dedicated to this initial phase; about one quarter of the remaining sessions are spent on each of the remaining phases. There are other possibilities of length of phases depending on the case presentation, assessment, and treatment plan.

The nine TF-CBT components spanning the three phases are summarized in the acronym PRACTICE. The order of these components is provided in the PRACTICE order for typical treatment (see Table 1). For youths with complex trauma, this order may be modified such that the safety component is provided initially and then again at the end of treatment as illustrated in Table 1. As indicated, an additional TF-CBT traumatic grief module may also be provided for these youths after completing the standard PRACTICE components, because so many of these youths have also experienced traumatic

5

Case Vignette

Overview

A 9-year-old boy and his 10-year-old sister both experienced years of maltreatment from their biological parents, including being left alone, with limited food in the house, constant presence of strangers in the house for drug parties, witnessing domestic violence, and suffering physical abuse by both parents. The biological parents separated; the father went to jail, and the mother continued to use drugs. The children went into the foster care system where they both were demonstrating significant behavioral problems. These problems let to several different placements within a short amount of time. At the time they came in for TF-CBT, some of their presenting problems included lying, tantrums with hitting and throwing objects, poor attention in school (they missed years of schooling), defiant behavior, and frequent yelling at foster caregivers and other children. The sessions proceeded as follows:

First Session

Psychoeducation included engagement of the foster family and a discussion about their ability to commit to 12 weeks of the TF-CBT program. The foster caregivers expressed that they were concerned about their own children, and they said that 12 weeks felt like a long time to commit. The therapist explained how TF-CBT was like an antibiotic, in that it was really important to have a commitment for the 12 weeks, and also that there are often positive changes seen after the first few weeks. The foster family agreed to "contract" that they would keep the siblings (bearing no serious offenses) for at least 6 weeks, and bring them consistently. The plan was to discuss another "contract" to keep the siblings and bring them in after 5 weeks. The TF-CBT program was explained to the children, along with the time frame of 12 weeks. The therapist decided to meet with the children separately.

Second Session

For relaxation, the therapist taught two activities to the children: progressive muscle relaxation via the *cooked and uncooked noodle game*, as well as deep breathing. After understanding more about how their bodies felt, the therapist

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A compact, how-to reference on assessing, diagnosing, and treating childhood maltreatment

The new edition of this popular, evidence-based guide compiles and reviews all the latest knowledge on assessment, diagnosis, and treatment of childhood maltreatment – including neglect and physical, sexual, psychological, or emotional abuse. Readers are led through this complex problem with clear descriptions of legal requirements for recognizing, reporting, and disclosing maltreatment as well as the best assessment and treatment methods. The focus is on the current gold standard approach – trauma-focused CBT. An appendix provides a sample workflow of a child protection case and a list of extensive resources, including webinars. This book is invaluable for those training or working as expert witnesses in childhood maltreatment and is also essential reading for child psychologists, child psychiatrists, forensic psychologists, pediatricians, family practitioners, social workers, public health nurses, and students.

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