2013

Overcoming Childhood Trauma: Strengthening Parent-Child Relationships after Something Bad Happens

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Document Type
Capstone Project

Degree Name
Bachelor of Social Work

Department
Sociology, Anthropology, Social Work and Public Health

Subject Categories
Social Work

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Overcoming Childhood Trauma:

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Cindy Simmons

Pacific University School of Social Work
Abstract
The United States Department of Health and Human Services estimates that only twenty nine percent of all children have not suffered some form of victimization. It is well documented that children who experience abuse-related trauma are less likely to grow up to become healthy, emotionally stable adults. However, surprisingly, almost twenty-five percent of children who have been sexually abused show no long-term adverse effects, and almost eighty-two percent show at least some degree of positive adaptation. By examining what works to overcome childhood trauma in the research literature, it was found that supportive relationships provide the best protection. This Senior Capstone will provide an overview of a brief parent-child group therapy program that can be used to teach therapeutic relationship building skills to non-offending parents and caregivers.
Introduction

The United States Department of Health and Human Services’ 2010 report on child abuse documented 5.9 million reports of child abuse that year. Of the substantiated cases, almost ten percent were determined to be child sexual assaults (CSA). According to a study conducted in 2004, as many as one in twelve children have been sexually assaulted. The report goes on to say that only twenty nine percent of all children have not suffered from some form of victimization (Finkelhor, Ormrod & Turner, 2005).

There is substantial evidence that survivors of CSA are less likely to grow up to become healthy, emotionally stable adults. Poor outcomes such as increased incidence of depression, alcohol and drug addiction and other serious mental illnesses are more prevalent among survivors of CSA than for other members of society (Lynskey & Fergusson, 1997; Swanston, Plunkett, O’Toole, Shrimpton, Parkinson, & Oates 2003). Additionally, there is some suggestion that children who have experienced the trauma of CSA may have more challenges forming strong relationships as adults (Bennett, Hughes, & Luke, 2000). They may also have less faith in their own parenting ability, including more anxiety, thus, may be passing on increased stress and anxiety to their children, which suggests generational impacts from CSA (Draucker, Martsolf, Roller, Knapik, Ross & Warner Stidham, 2011; Roberts, O’Connor, Dunn & Golding, 2004). CSA is a serious social problem, with indications that men who have been sexually abused as children are more likely to have a history of criminal activity (Forouzan & Van Gijseghem, 2005).

Not all children, however, who are sexually abused, have poor psychological outcomes (O’Dougherty Wright, Fopma-Loy & Fischer, 2005). For almost twenty five percent of children, no adverse affects of CSA are apparent (Lynskey & Fergusson, 1997). This is corroborated by a
study that assessed victims over a broad range of physical and mental health dimensions, which also found that approximately twenty percent of the participants showed a good level of resiliency. They also identified almost eighty two percent that showed some degree of positive adaptation in at least one area of positive functioning (O’Dougherty Wright et al., 2005).

Given the potential for dramatic negative outcomes that survivors of CSA could face and in light of the magnitude of the number of children subjected to childhood sexual assault each year, it is important to examine why some individuals recover, or have better outcomes than others. Examining which protective factors and which types of coping mechanisms or recovery strategies may be working for some, may give clues as to which approaches for treatment hold promise.

**Protective Factors**

A limited amount of research was found that explores several possible protective factors. There is some evidence that these factors, such as spirituality, family and peer support, attachment style, hardiness or resiliency, as well as some coping strategies may impact the degree of recovery from CSA (Feinauer, Mitchel, Harper & Dane, 1996; Gall, Basque, Damasceno-Scott & Vardy, 2007; Meyerson, Long, Miranda & Marx, 2002). There has also been exploration into the level of severity of the CSA, questioning if some types of abuse are more difficult to recover from than others, which could include the duration of the exposure and the victim’s age when the abuse occurred (Bennett, et al., 2000). Other factors, such as attachment style of the mother-child relationship, as well as the attachment style of adult survivors has also been examined for clues in determining why some victims have better outcomes than others (Forouzan & Van Gijsseghem, 2005; Kim, Trickett & Putnam, 2011).
Additionally, coping skills victims use to deal with the abuse, recovery techniques, and treatments all point to ways children and adults who have been exposed to CSA may be responding that helps them lead productive and meaningful lives (Draucker, et al., 2011; O’Dougherty Wright, et al., 2005). Examining each of these factors may be effective for unraveling which elements hold promise for CSA victims’ recovery from this all too prevalent form of childhood trauma.

**Severity of CSA**

Several researchers have explored the possibility that the severity of the CSA experienced may impact an individual’s ability to recover from the abuse (Bennett, et al., 2000; Fassler, Amodeo, Griffin, Clay & Ellis 2005; Feinauer, et al., 1996). It stands to reason that the more severe a trauma is, the more difficult it may be to overcome its impact. According to a study conducted in 2000, not all CSA is equal; furthermore, severity of CSA can greatly affect the outcome for survivors. Given the diversity of CSA experiences, accurately defining what constitutes severe abuse, and how to operationalize it for study, is somewhat complicated (Bennett, et al., 2000).

There is some indication however, that for many, the use of force was viewed as more traumatic than coercion. Women who experienced abuse as children that involved threat or force from a non family member reported the most anguish. Additionally, those who were molested by a peer also viewed the event as significantly traumatic. Also, more physically invasive forms of abuse are shown to reduce the ability of the victim to recover (Bennett, et al., 2000).

One surprising factor is the finding that some victims described their abuse as being an inappropriate relationship rather than an assault. These victims tended to be older with an adult perpetrator more than five years their senior, who often had a degree of authority over the victim.
These victims, however, still viewed the abuse as a negative, life altering experience (Bennett, et al., 2000). Men who had experienced CSA where the perpetrator was an older adult female also viewed the CSA in much the same way. They viewed the abuse as a relationship that negatively affected their lives, but not as a sexual assault. These men experienced far worse outcomes when the perpetrator was a coercive male stranger, indicating that they may have been helped by a strategy of reframing the abuse by the older woman but were not able to do so when the abuser was a male stranger (Forouzan & Van Gijseghem, 2005). Possibly, by minimizing the experience, they were able to retain some semblance of control that left them feeling more in charge of the abuse.

While the type and duration of CSA may hold some clues as to why some individuals achieve better outcomes than others, the results are mixed with many of the findings inconclusive. Other studies have shown CSA severity has no significant difference for the survivor’s outcomes (O’Dougherty Wright, et al., 2005). The severity of the abuse may also be less important than other factors, such as family support (Fassler, et al., 2005). Additionally, research points to the use of coping strategies. The victims who were able to reframe their experience to suggest that they had more control over their circumstances were reported to have less distress (Bennett, et al., 2000).

**Coping Strategies**

How victims cope with the aftermath of experiencing CSA provides additional information on what may help some individuals have better outcomes than others. Confronting the abuse, rather than minimizing or avoiding thinking about it, has been found to be therapeutic. A willingness to do so is shown to be determinant for the healing process. When evaluating
systems of recovery, those who are willing to fully examine their abuse are more likely to recover from the trauma (Murthi & Espelage, 2005).

When survivors were assessed for coping styles and emotional functioning, those who used avoidant coping strategies had far worse outcomes (O’Dougherty Wright, et al., 2005). Additionally, those victims who are reluctant to disclose their abuse are less likely to take the steps necessary to heal (Draucker, et al., 2011). When a survivor of trauma attempts to avoid thinking about the traumatic event, their life becomes constricted. Moreover, when the parent of the child who is traumatized cooperates or encourages avoidance, the behaviors are reinforced and the child becomes more entrenched in maladaptive behaviors that limit healthy emotional development (Carr, 2004).

Other forms of avoidance can result in involvement with drug and alcohol use (Carr, 2004). For example, male survivors of CSA who used avoidant coping strategies were more likely to also have difficulties with substance abuse and were more prone to have maladaptive avoidant attachment styles in current relationships. These adaptations were prevalent in victims who used minimizing and denial to explain their abuse experience (Forouzan & Van Gijseghem, 2005).

In contrast, an earlier study points out that “learned hardiness”, which is described as the ability to use healthy coping mechanisms, significantly improved the adjustment of CSA survivors (Feinauer, et al., 1996). Drawing on a sense of inner strength to confront an abusive experience was found to be instrumental in healing (Draucker, et al., 2011). Clearly, engaging actively in recovery, rather than ignoring, minimizing, or using avoidance, is more productive in promoting better outcomes for CSA victims.
Spirituality

Spirituality may also play a role in recovery. It is assumed that those with a relationship with a higher power, as well as the communal support from a church, can use these relationships both as a protective factor and as a path to recovery from the trauma (Gall, et al., 2007). There is an indication though, that a victim of CSA may turn away from religious affiliations, believing that God is cruel and uncaring in allowing the assault. Worse yet, they may blame themselves and feel that they are unworthy of God’s love (Draucker, et al., 2011).

It is important to note that those who have used spirituality as a help for recovery from CSA do so only after they have acknowledged the abuse and have engaged in an active healing process (Gall, et al., 2007). Although the use of spirituality may promote healing, the research suggests that the healthy communal relationships available to members of religious organizations may be beneficial as well. The relationship aspects of connecting with a higher power may also have significance. This evidence concurs with the mounting evidence that supportive relationships are instrumental for recovery from the trauma of CSA (Fassler, et al., 2005; Meyerson, et al., 2002; Robert, et al., 2004).

Family Support

The body of literature pointing to the benefits of strong family support seems to be the most promising. Children who have supportive families and peer relationships are more likely to achieve better outcomes (Linskey & Fergusson, 1997; Murthi & Espelage, 2005; Rosenthal, Feiring & Taska, 2002). Additionally, protective factors such as a secure attachment style of the parent-child relationship, less family conflict, and lower anxiety levels are shown to promote healing from CSA (Fassler et al., 2005; Kim, et al., 2011). Adult survivors of CSA, who
reported high levels of family dysfunction, also indicate high levels of adjustment difficulties (Bennett, et al., 2000).

Strong family relationships may also have implications for the likelihood of the child reporting the abuse. Children who think they will be believed may be more likely to disclose the abuse. This is significant when we consider that among children who report their abuse, being believed is a strong predictor of better outcomes (Alaggia & Kirshenbaum, 2005). Additionally, there is a strong relationship between being able to talk about the abuse and the ability of survivors to move through the healing process (Draucker, et al., 2011). Taking a closer look at what types of family relationships are most therapeutic for children recovering from trauma may be beneficial.

**Family Structure**

The complexity of family relationships can become very difficult to sort out, especially when the CSA perpetrator is a family member. Family structure has been examined by some in an attempt to determine the impact on CSA. Is there a difference between families comprised of biological parents, families with step parents or families with single parents (Leung, Curtis & Mapp, 2009)? There is some suggestion that lack of family cohesion may be a risk factor for developing depression in adolescents, as are physical and sexual abuse (Meyerson, et al., 2002). There is also some indication that children who live in non-intact families, and children who live with a stepfather, are more likely to be sexually abused (Leung, et al., 2009).

The research around family structure did not rise to the level of providing a causal relationship for CSA. The connection may be lack of supervision or supervision by a non parent. It is unclear why children in these families had higher levels of exposure to sexual abuse due to the perpetrator not being identified (Leung, et al., 2009). When the person who is responsible for
the abuse is a family member, family structure becomes more questionable. No study was identified that examined if the structure of the family had changed as a result of the abusive family member. Most, however, agree that the research indicating a relationship between family structure and CSA is inconclusive (Leung, et al., 2009; Meyerson, et al., 2002). In instances of CSA, however, family conflict, not family unity, was found to be more predictive of the development of depression among victims (Fassler, et al., 2005; Meyerson, et al., 2002).

**Cumulative Family Trauma**

The most recent research that takes a look at the impact of all types of child trauma concluded that cumulative effects of family-perpetrated violence increased risk factors for children. Of the types of trauma examined, emotional abuses, as well as inconsistent and hostile parenting, were found to be even more damaging than CSA. Interestingly, this hostile parenting style also served to undermine sibling relationships by increasing the level of fighting amongst siblings (Turner, Finkelhor, Hamby, Leeb, Mercy & Holt, 2012). These types of parenting styles also decrease the likelihood of a child disclosing their abuse, which in turn decreases their chances for recovery (Alaggia & Kirshenbaum, 2005).

Children who are diagnosed with Post Traumatic Stress Disorder (PTSD) are found to have lower rates of improvement when living in a home with high levels of conflict and where interpersonal violence is present (Carr, 2004). When PTSD in male victims of CSA is left untreated, they can develop serious emotional and behavioral problems, including more incidents of criminal activity (Forouzan & Van Gijseghem, 2005). Additionally, in a study using a control group, when the effects of CSA were factored out, all children in the study who lived in homes with high levels of conflict were found to have poorer levels of adjustment. This study
also found that family conflict was more destructive for personal development and happiness than was CSA (O’Dougherty Wright, et al., 2005).

Among children who have experienced CSA, more than seventy percent have also witnessed domestic violence (Hamby, Finkelhor, Turner & Ormrod, 2010). This number is significant when we recall that it is approximately seventy five to eighty percent of CSA survivors that have difficulty in adulthood. It may not be coincidental that high-conflict families where domestic violence is present, have similar characteristics to family dynamics of children who are less likely to disclose their abuse. These families tend to adhere strongly to patriarchal structure, where the opinions of women and children are both devalued (Alaggia & Kirshenbaum, 2005). The need for a safe, nurturing environment for children recovering from trauma is well documented (Carr, 2004). The relationship between a hostile or dismissive family environment and poor developmental outcomes for children is also clear (Alaggia & Kirshenbaum, 2005). Unfortunately, all too often children who are identified as living in a home where interpersonal violence is present receive almost no services (Hamby, et. al., 2010).

**Treatment Options**

It is also helpful to explore what is known about treatment options for those who have been traumatized by CSA. Understanding how a survivor transitions through recovery informs treatment providers about what may work. In their theoretical model, Draucker, et al., (2011) suggest that people in recovery transition through stages of healing. At each stage, a desire to engage in confronting, rather than denying or minimizing, was found to be useful. Additionally, although individuals transition through stages differently, reaching the ultimate level of healing often requires a life altering event, either positive or negative, and an understanding that they are
able to access a sense of inner strength. This inner strength is often the result of strong interpersonal relationships that have been formed with significant others (Draucker, et al., 2011).

Other indicators for treatment are found in recommendations for recovery from childhood PTSD. Again, strong relationships with emotionally healthy adults are the key (Carr, 2004). Recent literature from the leading researcher on child abuse, David Finkelhor, (2010, 2012) suggests that an interdisciplinary, community approach to treatment is desirable. Here, the efforts of those engaged in preventing, assessing and treating child abuse is combined with those advocating for women victims of domestic violence. Considering the data describing the overlap of all types of child abuse with domestic violence, this seems like a solid suggestion. Moreover, given that children exposed to family conflict have higher levels of poor outcomes than do children who have experienced CSA, also treating for the affects of living in a home with interpersonal violence and focusing on strengthening the relationship between non-offending parents and their children makes sense.

**Approved Interventions**

According to the Child Physical and Sexual Abuse Guidelines for Treatment issued by the National Crime Victims Research and Treatment Center, there are several therapies which have evidence to support their use for treatment of abused children. Two of these are Trauma Focused Cognitive Behavior Therapy (CBT), which is the most highly recommended, and Parent Child Interactive Therapy (PCIT), which was developed to address behavioral problems in children (Saunders, Berliner & Hanson, 2004). A leading researcher on CSA also recommends the use of PCIT with children who have been exposed to interpersonal violence in their homes (Hamby, et al., 2010). Additionally, Play Therapy, which is integral to PCIT, can also be used effectively with CBT. Play Therapy is shown to hold promise for working with children,
especially when used with primary caregivers engaging with the child as a lay therapist (Saunders, et al., 2004).

**Cognitive Behavior Therapy (CBT)**

The theory behind Cognitive Behavior Therapy (CBT) holds that our behaviors come from our own thoughts and by confronting maladaptive thinking strategies, behaviors can change. For this reason, CBT is widely supported as an appropriate approach for treating behavior problems resulting from a range of issues. It is a strongly supported, evidence based therapy which is also recommended as a therapy for treating those with Post Traumatic Stress Disorder (PTSD), often a result of systemic childhood trauma. CBT addresses the specific symptoms of PTSD such as hyper-vigilance, fearfulness, and aggressive behavior which can be associated with children who experience childhood sexual assault or witness family conflict (Runyon, Deblinger, Ryan & Thakkar-Kolar, 2004). CBT has also been used effectively in mother-child groups for treating children who have witnessed domestic violence (Sullivan, Egan & Gooch, 2004). Significantly, CBT has been shown to decrease anxiety disorders in children when used with a parent-child group approach (Toren, Volmer, Rosenthal, Elder, Koren, Lask, Weizman & Laor, 2000).

**Parent Child Interactive Therapy (PCIT)**

Parent Child Interactive Therapy (PCIT) was developed to specifically work with children, two to seven years in age, who display a range of conduct disorders. The goal of the therapy is to interrupt a negative progression of parent-child conflict (Bell & Eyburg, 2002; Urquiza, Zebell, Timmer, McGrath, & Whitten, 2011). Most of this therapy focuses on teaching the parent new models of communicating through the use of play with their child. The therapist sits on the other side of a two way mirror talking to the parent through an ear bug. The first
benchmark of learning is designed to strengthen the parent child relationship through the use of PRIDE (Praise, Reflection, Imitation, Description, and Enthusiasm) training. These skills are designed to change the focus of the parents’ attention to enthusiastically noticing positive behaviors in their child. This play therapy utilizes toys such as a farm set, paper and colored pens or markers, and modeling clay. Using toys without set rules permits the child to direct the play, which allows the parent to be supportive of the child’s autonomy. The parent’s role is to be an encourager rather than a director, reflecting the child’s statements back and praising the child enthusiastically (Urquiza, et al., 2011).

After the parent has mastered these skills, often many of the child’s behavior problems subside or disappear altogether. The second stage of the therapy works to change the remaining problem behaviors by switching the parents’ attention to reinforcing desired behaviors. The parent chooses two or three problem behaviors to work on by identifying positive replacement behaviors they would like to begin to encourage. The therapist instructs the parent on how to ignore the problem behaviors effectively while noticing and praising the desired behaviors (Urquiza, et al., 2011).

PCIT employs a specific protocol which begins with an extensive intake interview designed to rule out parents and children who may not be suitable for this therapeutic approach due to the severity of their problems, such as a drug or alcohol addicted parent, or a child with a developmental problem that would prevent them from participating. Two assessment tools, the Eyburg Child Behavior Inventory (ECBI), and the Parent Stress Scale (PSS) are used to evaluate progress throughout the therapy. These assessments allow the therapist to determine when the parent and child are ready to move on to the behavior modifying segment of the therapy (Urquiza, et al., 2011).
Research informs us of the importance of strengthening the parent child relationship for achieving better outcomes for survivors of CSA (Linskey & Fergusson, 1997; Murthi & Espelage, 2005; Rosenthal, Feiring & Taska, 2002). Utilizing a therapeutic approach for traumatized children that strengthens a child’s relationship with their primary care giver addresses this finding. The use of the benchmarks used in PCIT with traumatized children is also logical. After all, parental stress and behavioral problems in children, which are the targets of the ECBI and the PSS, are symptoms commonly associated with trauma. PCIT has also been used in a community setting (Self-Brown, Valente, Wild, Whitaker, Galanter, Dorsey & Stanley, 2012). Additionally, a curriculum presented as a parenting class, designed to prepare foster parents for the challenges of parenting traumatized children, uses a multi-theory approach employing both CBT and PCIT concepts (Monahan, 2009).

**Play Therapy**

Play therapy is not an independent theory model, but is often used in tandem with other treatment models. For example, both CBT and PCIT therapists use play therapy when working with young children. There is growing evidence that play therapy produces positive outcomes, particularly when employing a trained parent as a non-professional therapist (Bratton, Ray & Rhine, 2005). This is reinforced by evidence that play therapy is effective when used with a parent for developing strong parent-child relationships (Garza, Watts, & Kingsworthy, 2007). For this reason it is understandable that play therapy is a key component of PCIT, a therapy that focuses on building a strong bond between parent and child (Bell & Eyburg, 2002). Parent-child play therapy has also been used successfully with children who have experienced family violence (Kinsworth & Garza, 2010). Additionally, both PCIT and CBT, which use play
therapy, are two of the therapies recommended for use with victims of child abuse (Saunders, et al., 2004).

**Proposed Intervention**

There is strong support for involving non-offending parents in helping children overcome abuse (Bell & Eyburg, 2002; Bratton, et al., 2005; Garza et al., 2007). Parents, by engaging actively in recovery with their child, reinforce the therapy and negate the damaging effects of avoidance (Carr, 2004). Furthermore, research suggests that what can help children have better outcomes after experiencing childhood sexual assault are strong family relationships (Linskey & Fergusson, 1997; Murthi & Espelage, 2005; Rosenthal, et al., 2002). Additionally, confronting behavior problems associated with child abuse that may undermine the parent-child relationship and cause the child to be at greater risk for experiencing physical abuse at the hands of frustrated parents, is strongly supported (Runyon et al., 2004; Self-Brown et al., 2012).

For these reasons, an intervention teaching caregivers to act as the principal treatment provider, similar to the system used by Parent Child Interactive Therapy (PCIT), may achieve myriad benefits. It is reasonable to propose that some positive outcomes to this approach may be empowering parents by allowing them to take an active role in their child’s treatment, teaching parents skills that promote assertive (confident and self assured) rather than authoritarian (strict and inflexible) or permissive (lax and uninvolved) parenting styles, as well as strengthening the parent-child relationship. We should note that an authoritarian parenting style is closely related to family conflict, a serious indicator of poor outcomes for children. Growing up in an authoritarian household is closely associated with a victim of child sexual assault being less likely to disclose their abuse, which undermines their ability to overcome the trauma (Alaggia & Kirshenbaum, 2005; O’Dougherty Wright, et al., 2005). A therapy that instructs parents how to
teach healthy coping strategies to their children, increases the child’s hardiness, and promotes recovery, is likely to be helpful (Feinaner, et al., 1996).

A Group Therapy Approach

There is also evidence that group therapy is a beneficial intervention for victims of child sexual assault (Tavkar & Hansen, 2011). Group programs have been found to be effective at reducing self-blame and symptoms of trauma in children who have been exposed to domestic violence (Sullivan et al., 2004). Also, directed play therapy can successfully be conducted in a group setting (Kinsworthy & Garza, 2010). Moreover, group interventions promote overcoming stigma, increase socialization in a safe environment, provide an opportunity to learn from other group members, and promote interaction among parents (Tavkar & Hansen, 2011). Group therapy may also be a more cost effective approach, making it more accessible to some families. A study examining dropout rates of parents and children in joint therapy found that those parents
who were given added support and identified a friend they could discuss their progress with were less likely to drop out. The researchers suggest that using a group approach to therapy may be more successful at retaining participants than is the individual, parent-child dyad approach (Topham & Wampler, 2008).

There is an indication that the size and cohesiveness of the group is an important factor for the success of the intervention. Groups that are smaller, consisting of three to five families with children of similar ages and developmental levels may be more successful (Topham & Wampler, 2008). It is also important to consider the appropriateness of each individual for inclusion into a therapy group. Individuals who exhibit high levels of behavioral issues or high levels of stress and anxiety may not be suitable for a group intervention (Tavkar & Hansen, 2011). One of the benefits of group therapy is the interaction between individuals who have similar experiences using the group to normalize their experience. In other words, knowing that others have had a similar experience lessens an individual’s feelings of isolation and feelings of being singled out and oppressed by the abuse. A higher degree of beneficial experience from the group may be obtained by comprising the group for like experiences. For this reason, groups will either be conducted with caregivers and children who are either CSA survivors or children who have lived in homes with domestic violence, or children who have experienced both. Additionally, the ages and developmental stages of the children should be considered, as well as family structure. For example, a cohesive group may be constructed of three single mothers with two children each, ages five to nine, who have witnessed domestic violence. Another group may be four two parent families whose child, ages nine to twelve, were sexually assaulted by a relative. A group of foster parents and children might also be a viable option.
Brief Therapy

Some research suggests that brief therapy interventions can be beneficial and that an effective therapeutic response can be obtained in a ten week session (Garza, et al., 2007; Toren, et al., 2000). The rational for this approach suggests that some families cannot afford long treatment options (Garza, et. al., 2007). Additionally, dropout rates can be problematic for longer treatment groups, undermining group cohesion and the benefits of group camaraderie (Topham & Wampler, 2008). Therefore, the recommended treatment dosage for this intervention will be ten parent-child group sessions consisting of a twenty minute separate group check-in time for parents, with a simultaneous group cohesion-building exercise for children, followed by a thirty minute, therapist observed, parent-child interactive play session (Table 1). At first, the play sessions will focus on relationship building with parents implementing the PRIDE (Praise, Reflection, Imitation, Description, and Enthusiasm) skills taught in the PCIT protocol. These skills, and those implemented to encourage specific desirable behaviors will be taught in two sessions for parents conducted prior to the ten parent-child sessions (Table 1).

As parents begin to achieve mastery of these skills, they will move on to addressing specific behavior issues that have not yet been resolved in the prior relationship-building part of the intervention. These behaviors will be identified in an individual parent-evaluation session with the therapist. The parent will identify no more than three behavior problems along with the specific desired replacement behavior. By identifying the desired behavior, the parent can then begin to focus on noticing and encouraging what is wanted rather than focusing on what is not wanted. Making this “cognitive shift” will be facilitated by using CBT methods implemented as recommended in the PCIT protocol. Identifying what behaviors to encourage will facilitate the
desired behavior change process supported in both Solution Focused Therapy and the Strengths Based model of social work practice.

Table 1

<table>
<thead>
<tr>
<th>Structure of Group Sessions</th>
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<tr>
<td>Training session</td>
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<tr>
<td>Relationship building</td>
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<tr>
<td>Behavior enhancing</td>
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</table>

Implementation of this proposed brief parent-child group therapy must be carried out by a licensed clinical social worker (LCSW) experienced in working with children through play therapy. The therapist must be familiar with implementing CBT and have some formal training in the use of PCIT. The groups need to be conducted by a therapy team due to the separate child and parent sessions required to fully train parents in their role as their child’s instructor. The second team member, however, can be a well trained intern or a bachelor level social worker. The licensed therapist, however, will need to be the person who conducts the intake interview and administers the one-on-one parent assessment meetings which are necessary to evaluate the progress on the individual parent-child dyads in each group.

**Benchmarks**

The evaluation tools used by PCIT to conduct the intake interviews and to track the progress of the intervention are the Eyberg Child Behavior Inventory (ECBI) and the Parent Stress Index (PSI) (Urquiza, et. al., 2011). Both of these measures are widely used and have been validated to insure reliability (Berry & Jones, 1995; Boggs, Eyberg & Reynolds, 1990; Eyberg & Ross, 1978). PCIT utilizes these tools to track the targeted results of the therapy,
which is to decrease stress levels in parents resulting from an increase in desirable behaviors in their children, which occur due to building stronger, more secure, parent-child relationships (Bell & Eyburg, 2002; Runyon et al., 2004; Self-Brown et al., 2012). Having shown success in evaluating a similar intervention with nearly identical goals (strengthening the parent-child relationship), it makes sense to employ these two validated tools as well.

The PSI is an eighteen item questionnaire using a scale of choices ranging from one to five, with one being “strongly disagree”, and five being “strongly agree” (see Appendix A for the entire scale). The assessment is relatively short, taking only a few minutes to complete. The PSI has longevity, having been validated in the mid nineties. Adding to its legitimacy is the fact that this evaluation tool is widely used. The ECBI, with its thirty-six questions, is somewhat longer and uses nine choices ranging from “never” to “always” (see Appendix B for the entire scale). The ECBI is completed by the adult caregiver who documents their perception of the child’s behavior. Developed in 1978, validation of the ECBI is strongly documented. Additionally, the ECBI corresponds to the PCIT protocol for choosing targeted positive behavior goals which will be used in the last phase of this proposed intervention.

Administration of the scales will occur during the initial evaluation at an intake interview conducted by the senior group therapist (Table 2). The information obtained during this interview will be instrumental for forming the groups, scaling the scope of the disturbance, and identifying potential areas requiring further evaluation. The instruments will also provide a benchmark for evaluating the effectiveness of the treatment. Additionally, both scales will be administered again at the mid-point of the program to evaluate the readiness of the group members to move forward to the final stage of the treatment; the behavior identifying and modifying segment of the intervention (Table 2). A third administration of the assessments will
be conducted at individual termination sessions with the caregivers. This session will be used to provide closure for the participants individually and also to assess any ongoing issues that should be addressed by further treatment. To facilitate the evaluation of the program, it is recommended that a six month follow-up telephone interview be conducted to administer the assessments for a fourth time. This fourth data point will allow practitioners to evaluate the effects of the intervention over time.

### Table 2

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<tr>
<th>Intervals</th>
<th>Benchmark</th>
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<tr>
<td>1. Beginning Interview</td>
<td>Benchmark</td>
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<tr>
<td>2. Week 7</td>
<td>Assessment of Progress</td>
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<tr>
<td>3. Ending Interview</td>
<td>Outcome</td>
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<tr>
<td>4. 6 month follow-up</td>
<td>Rate of Expiration</td>
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</table>

### Additional Recommendations

Even though there is strong evidence to suggest that this type of group therapy, which is focused on building stronger parent-child relationships, will be effective helping children recover from the trauma of abuse, it is important that further research be conducted to validate this hypothesis. There is also an indication that this brief group intervention can be successful for use with a wide range of trauma and abuse types, and with a large age range of children and family type. For this reason, accurate demographic data should be collected and collated by researchers to determine if the intervention performs better with some populations than others. Collecting data on family structure may be valuable for determining if the intervention can be useful for foster parents or if the intervention is more helpful for single parents or married couples. Additionally, it would also be useful to know if the involvement of a step parent was helpful or not.
Although the proposal for a brief group intervention is intended to accommodate underserved populations who have found access to treatment costly and difficult, it is not know if this is true. As a component of implementing this proposal, it may be necessary to research possible barriers to this treatment. One barrier may be the willingness of private and public insurers to cover a group treatment implemented by an LCSW for treatment of their policy holders before the effectiveness has been documented. For this reason, it may be necessary to research and obtain funding for an initial pilot project to obtain and evaluate data.

Additionally, to reach the intended population for this intervention a community approach may need to be implemented. As Finklehor, (2005) and others suggest, agencies working with child abuse victims must collaborate with agencies working with victims of interpersonal violence, creating a community response to address childhood trauma. This is the best way a community can assure that children are receiving the services they need to help them grow up to be well adjusted, emotionally and physically healthy, adults. Implementing such collaboration may be the key to finding the funding necessary to carry out the initial groups. Doing so, however, may prove to be a vital component of helping children and their families overcome the long-term damaging effects of childhood trauma.
References


Appendix A
Parental Stress Scale

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of
the items in terms of how your relationship with your child or children typically is. Please indicate the degree to
which you agree or disagree with the following items by placing the appropriate number in the space provided.
1 = Strongly disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly agree

___ 1. I am happy in my role as a parent.

___ 2. There is little or nothing I wouldn't do for my child(ren) if it was necessary.

___ 3. Caring for my child(ren) sometimes takes more time and energy than I have to give.

___ 4. I sometimes worry whether I am doing enough for my child(ren).

___ 5. I feel close to my child(ren).

___ 6. I enjoy spending time with my child(ren).

___ 7. My child(ren) is an important source of affection for me.

___ 8. Having child(ren) gives me a more certain and optimistic view for the future.

___ 9. The major source of stress in my life is my child(ren).

___ 10. Having child(ren) leaves little time and flexibility in my life.

___ 11. Having child(ren) has been a financial burden.

___ 12. It is difficult to balance different responsibilities because of my child(ren).

___ 13. The behavior of my child(ren) is often embarrassing or stressful to me.

___ 14. If I had it to do over again, I might decide not to have child(ren).

___ 15. I feel overwhelmed by the responsibility of being a parent.

___ 16. Having child(ren) has meant having too few choices and too little control over my life.

___ 17. I am satisfied as a parent.

___ 18. I find my child(ren) enjoyable

**Scoring**

*To compute the parental stress score, items 1, 2, 5, 6, 7, 8, 17, and 18 should be reverse scored as follows: (1=5) (2=4) (3=3) (4=2) (5=1). The item scores are then summed.*

Appendix B

EYBERG CHILD BEHAVIOR INVENTORY

Rater’s Name: ______________________
Relationship to Child: ______________________
Date of rating: ______________________
Child’s Name: ______________________
Child’s Age: ______________________
Birthdate: ______________________

Directions: Below is a series of phrases that describes children’s behavior. Please (1) circle the number describing how often the behavior currently occurs with your child and (2) circle either “yes” or “no” to indicate whether the behavior is currently a problem.

Never Seldom Sometimes Often Always - Is this a Problem Now? 1 2 3 4 5 6 7 Yes No

1. Dawdles in getting dressed 1 2 3 4 5 6 7 Yes No
2. Dawdles or lingers at mealtime 1 2 3 4 5 6 7 Yes No
3. Has Poor table manners 1 2 3 4 5 6 7 Yes No
4. Refuses to eat food presented 1 2 3 4 5 6 7 Yes No
5. Refuses to do chores when asked 1 2 3 4 5 6 7 Yes No
6. Slow in getting ready for bed 1 2 3 4 5 6 7 Yes No
7. Refuses to go to bed on time 1 2 3 4 5 6 7 Yes No
8. Does not obey house rules on his own 1 2 3 4 5 6 7 Yes No
9. Refuses to obey until threatened w/ punishment 1 2 3 4 5 6 7 Yes No
10. Acts defiant when told to do something 1 2 3 4 5 6 7 Yes No
11. Argues with parents about rules 1 2 3 4 5 6 7 Yes No
12. Gets angry when doesn’t get own way 1 2 3 4 5 6 7 Yes No
13. Has temper tantrums 1 2 3 4 5 6 7 Yes No
14. Sasses adults 1 2 3 4 5 6 7 Yes No
15. Whines 1 2 3 4 5 6 7 Yes No
16. Cries easily 1 2 3 4 5 6 7 Yes No
17. Yells or screams 1 2 3 4 5 6 7 Yes No
18. Hits parents 1 2 3 4 5 6 7 Yes No
19. Destroys toys or other objects 1 2 3 4 5 6 7 Yes No
20. Is careless with toys and other objects 1 2 3 4 5 6 7 Yes No
21. Steals 1 2 3 4 5 6 7 Yes No
22. Lies 1 2 3 4 5 6 7 Yes No
23. Teases or provokes other children 1 2 3 4 5 6 7 Yes No
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.</td>
<td>Verbally fights with friends his own age</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>25.</td>
<td>Verbally fights with brothers and sisters</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>26.</td>
<td>Physically fights with friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>27.</td>
<td>Physically fights with brothers and sisters</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>28.</td>
<td>Constantly seeks attention</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>29.</td>
<td>Interrupts</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>30.</td>
<td>Is easily distracted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>31.</td>
<td>Has short attention span</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>32.</td>
<td>Fails to finish tasks or projects</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>33.</td>
<td>Has difficulty entertaining himself alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>34.</td>
<td>Has difficulty concentrating on one thing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>35.</td>
<td>Is overactive or restless</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>36.</td>
<td>Wets the bed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>