

Original Paper

Childhood Trauma and Effective Empirically Based Interventions

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Abstract

Trauma affects many children in various ways globally. According to SAMHSA (2017), the “occurrence of child trauma is very prevalent, and 75% of children reported experiencing at least one traumatic event by age 16”. Traumatic events consist of “psychological, physical, or sexual abuse; community or school violence; witnessing or experiencing domestic violence; national disasters or terrorism; commercial sexual exploitation; sudden or violent loss of a loved one; refugee or war experiences; military family-related stressors; physical or sexual assault; neglect; and serious accidents or life-threatening illness” (SAMHSA, 2017). This literature review evaluates three different attachment-based, trauma-informed interventions for young children 0-7 years of age which are: Attachment and Bio-Behavioral Catchup (ABC), Child-Parent Psychotherapy (CPP), and Parent-Child Interaction Therapy (PCIT). Throughout this review, childhood trauma will be defined, and the current occurrence rates will be discussed. Furthermore, the descriptions of the above therapies, clinical trials, and research findings will be examined, and a discussion of the literature review findings will follow.

Keywords

Attachment and Bio-Behavioral Catchup (ABC), Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT)

1. Introduction

According to Larkin and Record (2007), early childhood trauma is related to traumatic experiences endured by children during the age of 0-6 (2007). Research indicated that 60% of adults from a study reported having had experienced a traumatic event during childhood. Moreover, 26% of all children in the continental United States will endure some type of trauma during their lifetime (Larkin & Record,

2007). The treatments for children who are enduring or have endured childhood trauma that will be discussed in detail throughout this review are Attachment and Bio-behavioral Catch-Up (ABC), Child-Parent Psychotherapy (CPP), and Parent-Child Interaction Therapy (PCIT). In addition, the research methods used will be discussed in addition to the methodology and summary of the literature. This literature review will examine childhood trauma and the results from being exposed to intimate partner violence. In addition, the review will focus on three particular therapeutic treatments (ABC, CPP, and PCIT) that are utilized with young children ages 0-7 years old who are currently experiencing trauma or who have experienced trauma.

2. Method

The primary objective of this review of the literature is to explore and analyze the current studies relating to these evidence-based therapeutic treatments for children exposed to trauma. The research highlighted in the current paper was gathered by ProQuest and Academic Search Complete databases primarily limited to peer-reviewed articles from the past ten years. Journal articles and dissertations were used to aid the researcher in their efforts to obtain data. Moreover, the articles required to have been published in a peer-reviewed journal in order to be used as a reference. Any material found to lack empirical studies were excluded from being used and, articles that were found on multiple databases were also excluded. In totality, 49 articles met inclusion criteria, and were referenced for this study.

2.1 Empirical and Theoretical Etiology

Children experience trauma when exposed to maltreatment, violence, natural disasters, war, and loss of a parent through death, parental abandonment and parental incarceration. The top five subtypes of child maltreatment include physical abuse, sexual abuse, psychological abuse, neglect, and exposure to intimate partner violence (MacMillan et al., 2009). When children experience trauma, outcomes can include the development of social, emotional, and behavioral challenges, and if not treated can have devastating consequences on their futures and social lives (Samuels, 2011). In a study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente named Adverse Childhood Experiences, adverse childhood experiences were defined as the following: emotional, physical, and sexual abuse; violence, mental illness or substance abuse in the home, and physical and emotional neglect (2016). Adverse childhood experiences that meet the definition of trauma were found to cause disrupted neural development, emotional, social, and cognitive impairment, in addition to the adoption of health risk behaviors, disease, disability, social problems, and early death (Bethell, Newacheck, Hawes, & Halfon, 2014). Practitioners need to have a clear understanding of the specific trauma the child has experienced. Many different variables influence the effect trauma has on a child such as: age, sex, socioeconomic status, familial relationships, intensity and duration of the trauma, existing support systems, and the specific type of trauma all contribute to the child's impairment and recovery (Eslinger, Sprang, & Otis, 2015; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013). According to clinical

trials, children who have been exposed to trauma benefit the most when they treated with a strategy that includes practices supported by empirical evidence of efficacy. The same clinical trials found that customized treatment plans that focus on the exact nature of a child's trauma and incorporate factors such as the child's age or chronological development levels, personality, the severity of symptoms, and familial structure are also essential (Igelman et al., 2007). Early intervention is of utmost importance, and if left untreated, trauma-exposed children can develop co-occurring psychiatric problems such as mood disorders, anxiety disorders, eating disorders, self-injury and substance abuse (Racco & Vis, 2015).

2.2 Attachment Theory

The attachment theory coined by John Bowlby was developed in the mid-nineteenth century after working with children who experienced prolonged separation from their mothers before five years of age. The outset of this research was during World War II and continued until he was over. Bowlby concluded from his research with these children that prolonged separation, which is defined as six months or more away from a parent had a negative effect on a child's healthy development, and as a result, these children became affectionless and delinquent (Bowlby, 1946). The predominant assertion of attachment theory is that a child's emotional, social, and cognitive developments are directly related to the early bonding between the child and their primary caregiver (Bowlby, 1995, 1950). Children are dependent on their primary caregiver to provide them with basic survival, safety, and emotional needs during their first five years of life. Moreover, Infants and children have an evolutionary need to be near their primary caregiver to feel safe and secure (Bowlby, 1995, 1950).

According to Prather and Golden, children do experience intense distress and can feel threatened when they are separated from their primary caregiver. The learning behavioral theory of attachment suggests that an infant will form an attachment to the person who provides them with food. Bowlby suggests that the attachment between an infant and caregiver or mother comes from the mother's care and responsiveness toward her child. A secure attachment between a child and his or her parent is reflected in the child's interpersonal relationships throughout his or her lifespan (2009).

Prather and Golden further posited that childhood trauma such as abuse and neglect can interfere with secure attachment, and disrupt the healthy development in children. Abused and neglected children become untrusting and self-reliant and often seek to control their environment. These children do not view their new caregivers as a source of security and display avoidant, aggressive and hyperactive behaviors (2009). Children that lack a secure attachment exhibit no observable indicators of experiencing shame, guilt, anxiety or fear, and can grow up to be distrustful and lack moral development (Prather & Golden, 2009). There are three types of insecure attachment: ambivalent attachment, avoidant attachment, and disorganized attachment. Ambivalent attachment develops when primary caregiver responsiveness is inconsistent. These children develop tactics to receive attention from their caregivers that are not always positive. Avoidant attachment develops when the primary

caregiver is consistently unresponsive. These children do not seek comfort from their caregiver because they do not believe they will get their needs met. Disorganized attachment develops when the primary caregiver is both unresponsive and frightening or unsafe. These children see no value in relationships (Mirick & Steenrod, 2016).

3. Results

3.1 Attachment and Bio-Behavioral Catchup (ABC)

Children that experience trauma due to attachment disruption or abuse from their primary caregiver have trouble forming secure and trusting relationships with their new caregivers. ABC is an intervention developed by Dr. Mary Dozier for young children which focuses on training the caregiver in providing the child with a nurturing, responsive, and predictable environment (Dozier et al., 2009). Children who have been removed from their home of origin due to maltreatment, or children who have experienced extended separation from their caregivers tend to turn away from or alienate their new caregivers when they are hurt or frustrated. Children in these situations can experience immense and chronic stress which can lead to emotion-focused coping behaviors (avoidant or distracting), rather than problem-focused strategies (Schneider & Phares, 2005). The ABC therapist provides weekly 60-90-minute sessions for ten weeks where the parent or caregiver receives immediate feedback regarding the interactions with their child. These sessions are videotaped and then the therapist and parent view the videotape together. Many of these children are dysregulated biologically and behaviorally. ABC assists caregivers with re-interpreting their child's behavioral signals so that they provide nurturance even when it is not elicited (Dozier et al., 2009). A randomized controlled trial was conducted by Dozier and her colleagues where 46 children in foster care were randomly assigned to receive either ABC or educational intervention.

The educational intervention, Developmental Education for Families (DEF) focused on cognitive development, and specifically the development of language for the young child. The race/ethnicity of the children was 63% African American; 26% White; 3% Hispanic or Latino, and 7% biracial. The age range of the children was 3.6 months to 39.4 months and 50% of the children were female. The outcome of the study showed that children whose parents received ABC rather than DEF exhibited less avoidance when distressed and developed better behavioral and biological regulation (Dozier et al., 2009). Another similar study conducted by Dozier and her colleagues found that children receiving the ABC intervention had lower post-intervention cortisol levels when compared to the children receiving DEF (Dozier et al., 2006). One of the limitations of these two studies includes the small sample size.

3.2 Child-Parent Psychotherapy (CPP)

CPP is a therapeutic intervention designed for children 0-5 years old that is based on attachment, psychodynamic, and trauma theories, and combines cognitive-behavioral and social learning strategies (Lieberman & Van Horne, 2009; Fusco & Cahalane, 2014; Lieberman et al., 2011). The focus of CPP is

to improve the parent-child attachment relationship, decrease traumatic symptoms and responses, learning difficulties, and maladaptive behavior. When trauma occurs in a child's life, the child's perception of the parent as a reliable protector is fragmented. The CPP therapist seeks to rebuild the trust in the child's relationship with her parent by engaging the parent and child with play, words and other interactions designed to express and respond to the child's emotional needs. By co-creating a life narrative that includes the traumatic events, the aim is to break the cycle of intergenerational transmission of trauma and psychopathology in families with young children (Lieberman et al., 2011). There have been several randomized controlled trials demonstrating the efficacy of CPP. One study that included mothers who had been victims of intimate partner violence and their exposed preschool-aged children showed significant improvement over time compared to a control group (MacMillan et al. 2009). Moreover, there are other additional studies that included low-income Latina mothers and their anxiously-attached toddlers, maltreated infants and preschoolers in the child welfare system, and toddlers of middle-class depressed mothers (Lieberman, Weston, & Pawl, 1991; Lavi, Gard, Hagen, Van Horn, & Lieberman, 2015; Lieberman et al., 2011; Cicchetti, Rogosch, & Toth, 2006; Lieberman et al., 2011; Lavi et al., 2015; Toth, Rogosch, Manly, & Cicchetti, 2006). The outcomes in these studies include improvement in the child-mother relationship, improvements in the child cognitive functioning, and a reduction in child and mother psychiatric symptoms (Lieberman et al., 2011). Approximately 75% of the participants from the studies conducted to evaluate CPP were ethnic minorities. One challenge to be noted with CPP is the length of treatment which is 50 weeks. This length of time has the propensity to become a detriment for the client and be difficult to complete for certain families.

3.3 Parent-Child Interaction Therapy (PCIT)

PCIT is an evidence-based treatment used for children 2-7 years old who have emotional or behavioral disorders such as Oppositional Defiant Disorder (ODD). PCIT is also considered to be a trauma-based therapy as many of the children that receive this type of treatment have experienced trauma. PCIT is based on Baumrind's developmental theory of parenting and draws on attachment and social learning theory, which combines nurturance, good communication, and firm control in parenting (Pincus, Santucci, Ehrenreich, & Eyberg, 2008). It combines play therapy with parent behavior training rather than direct child engagement. The clinician coaches the parent in real time by monitoring the parent through an ear receiver and an observation room. The coaching focuses on training the parent to use consistency and problem-solving. Positive reinforcement and improved communication are stressed to the parent. Consistent with operant conditioning, the parent is instructed to identify an effective enforcer, apply that enforcement consistently by praising positive behavior and actively ignoring negative behavior with the goal of maladaptive behavior extinction (Pincus et al., 2008).

There are two components to PCIT: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). During CDI, the parent lets the child lead the play and the parent must communicate at least ten labeled praises, ten reflections, and ten behavior descriptions to their child during the therapeutic play

sessions to move on to the next phase which is Parent-Directed Interaction (PDI). The parent is to avoid using commands, questions, or criticism. Negative behavior by the child is to be actively ignored. During PDI, the parent is instructed on how to direct the child's behavior when it is important that the child obey their instruction (Barnett, Niec, & Acevedo-polakovich, 2014). The Eyberg Child Behavior Inventory (ECBI) is a measure used in PCIT in which parents evaluate their child's behavioral problems. The instrument has 36 items and utilizes the Likert scale (Eyberg & Funderburk, 2011).

While PCIT was originally designed to address externalizing problems, it has been adapted recently to target internalizing problems such as mood and anxiety issues in children. One internalizing behavior problem that is being targeted for PCIT is Separation Anxiety Disorder (SAD). This disorder is characterized when a child experiences severe and persistent fear of separation from a parent or caregiver. These symptoms must be present for four weeks or more to warrant a diagnosis of SAD. Pincus et al. (2008) were the first to introduce and evaluate a modified version of PCIT to treat SAD. Another PCIT program called the coaching approach behavior and leading by modeling or CALM was developed to address other anxiety disorders in addition to SAD in young children. These twelve live coaching sessions provide immediate feedback to the parent with a larger emphasis on parent directed interaction (Carpenter, Puliafico, Kurtz, Pincus, & Comer, 2014). Other adaptations of PCIT for internalizing problem behavior include Group PCIT for behavioral inhibition (Chronis-Tuscano et al., 2009) and a module incorporating emotional development (PCIT-ED) for depression in preschool-aged children (Luby, Lenze, & Tillman, 2012).

A study was done on 81 Norwegian families with children (52% boys and 48% of girls) ages two to seven years old. The families were randomly assigned to either receive PCIT or TAU (treatment as usual). The families were assessed after six months of treatment and again after 18 months of treatment. Children's behavior problems were measured using the ECBI scale, and the parenting skills were measured by the Dyadic Parent-Child Interaction Coding System (DPICS). Results from these measurements showed that children who received PCIT exhibited fewer behavior problems as compared with the children receiving TAU, and that parent's skills improved (Bjorseth & Wickstrom, 2016).

4. Discussion

Parents or caregivers are a child's most important and effective teacher's due to the fact that they are with their children most of the child's waking hours. These three therapies require a parent or caregiver to participate actively and play an integral role in a successful intervention. Ultimately, the parent has the most influence over a child and the greatest impact on a child's recovery from trauma (Wolfolk & Unger, 2009). There has been a vast amount of research conducted on CPP, PCIT, and ABC alone, but there has not been researched specifically on comparing the criteria in choosing one of these interventions over the other. Current trends include utilizing ABC in adoptive or foster care situations;

CPP in domestic violence situations and PCIT when externalizing behavior problems are the target. This review of CPP, PCIT, and ABC serves as a foundation for conceptualizing various treatment modalities in traumatized children. With an understanding of the various treatments available, the opportunity to assess the efficacy is prompted. It would be important for future researchers to make an attempt to include more African-Americans in their studies to better assess the population. In addition, more research needs to be conducted on the impact of psychotropic medicines and how they affect youth that is enduring childhood trauma.

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