Mental Health Treatment of Child Abuse and Neglect: The Promise of Evidence-Based Practice

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In 2006, 3.6 million children in the United States received a child protective services' investigation and 905,000 children (about one-quarter of those investigated) were found to have been abused and/or neglected.1 The majority of maltreated youth had substantiated neglect (64.1%), followed by physical abuse (16.0%), sexual abuse (8.8%), psychological maltreatment (6.6%) and other types (15.1%) (nonexclusive categories). There was fairly equal gender distribution among the child victims, with 51.5% of the victims being female. Younger children had higher rates of maltreatment than older children; African American and American Indian/Alaskan Native children were overrepresented among children substantiated for maltreatment.1 In 2006, 303,000 children entered out-of-home care (including foster care, kinship care, residential treatment, group homes) and 510,000 children were in care on September 30, 2006. African American children and multiracial children were overrepresented among children in care.2

Children who have been maltreated are at risk for experiencing a host of mental health problems including depression, post-traumatic stress, dissociation, reactive

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attachment, low self-esteem, social problems, suicidal behavior, aggression, conduct disorder, attention-deficit hyperactivity disorder (ADHD) and problem behaviors, including delinquency, risky sexual behavior and substance use. In a sample of 426 children receiving child welfare services, 42% met diagnostic criteria for a DSM-IV diagnosis based on youth- and parent-report. ADHD and Disruptive Disorders, such as Oppositional Defiant Disorder and Conduct Disorder, were among the diagnoses most frequently assigned to youth in the child welfare system. Not surprisingly, maltreated children who are placed in out-of-home care also manifest a host of emotional, behavioral, social and developmental problems, and they are in need of many specialized services. Based on their review of the epidemiologic literature describing the mental health needs of youth in out-of-home care, Landsverk and Garland reported that “between one-half and two-thirds of the children entering foster care exhibit behavior or social competency problems warranting mental health services.” Studies of Medicaid claims suggest that as many as 57% of youth in foster care meet Medicaid criteria for a mental disorder.

Given the high rate of mental health problems, it is not surprising that maltreated youth are in need of mental health services. Unfortunately, only a fraction of these children and adolescents receive services. For example, in one nationally representative study, between 37%–44% of youth with child welfare service involvement scored in the borderline or clinical ranges on parent-, teacher- and self-report measures of mental health and behavioral functioning; only 11% of these youth, however, were receiving outpatient mental health services. Rates of service use are higher among children placed in out-of-home care. One study found that children in foster care in California, who comprised less than 4% of Medi-Cal-eligible children, accounted for 41% of all users of Medi-Cal mental health services. Another study found that children in foster care used more mental health services (including hospitalizations), at greater expense than children in the Aid to Families with Dependent Children (AFDC) program or children receiving Supplemental Security Income (SSI). Despite reported high rates of service use of children in foster care, many youth in out-of-home care also do not receive needed services. For example, one study found that 80% of children ages 6–12 in foster care were given a psychiatric diagnosis, yet only 50% had received mental health or special education services and another study found that only 23% of children in foster care had received some type of mental health service.

Exacerbating the problem of effectively treating mental health problems in maltreated youth is the lack of evidence-based mental health treatment available, even for those children and adolescents who do receive treatment. The tide may be turning for our most vulnerable youth, however. Recently, several evidence-based practices have been rigorously tested and are demonstrating efficacy in reducing mental health problems associated with maltreatment.

**WHAT IS EVIDENCE-BASED PRACTICE?**

There has been a recent surge in interest in identifying, evaluating, and disseminating evidence-based practices for child abuse and neglect. Evidence-based practice (EBP) can be defined simply as using clinical interventions that have the best scientific support for their effectiveness. EBP typically have well-developed treatment manuals, established training protocols for clinicians, and ongoing assessment of clinician fidelity to the treatment model. EBP is unique from more traditional practice given that treatment effectiveness is demonstrated incrementally through well-designed, randomized clinical trials using outcomes that are tied to specific treatment goals.
Early clinical trials are typically conducted in controlled settings to determine treatment efficacy or the ability of the treatment to yield effects under ideal circumstances. After efficacy has been established, effectiveness trials are conducted to determine if the model will work when put into practice more widely within community-based settings. A scientific approach to determining treatment effectiveness avoids the many pitfalls that are encountered when relying on case studies or nonrandomized group comparisons, clinician judgement of progress, or outcomes that are not directly related to intervention goals (eg, client satisfaction) (See Chafin15 for a detailed discussion). It is important to note that EBP also shares many characteristics with traditional practice, including the recognition of the importance of core nonspecific factors (eg, client–therapist relationship), clinician interpersonal skills, and common codes of good practice and professional ethics.

IDENTIFYING EVIDENCE-BASED PRACTICES FOR MALTREATED CHILDREN

Two recent projects have focused on identifying EBP for treating abused children and their families. In 2003, a project funded by the U.S. Office for Victims of Crime (OVC) developed guidelines for treatment of child physical and sexual abuse.18 The primary goal of this project was to provide information to clinicians to encourage the use of theoretically-sound, empirically-based interventions for child abuse. To develop these guidelines, a national advisory group was convened to establish criteria to rate the extent of support available for 24 interventions that addressed concerns associated with child physical and sexual abuse. Criteria included the strength of empiric support, soundness of theoretical foundation, potential for harm, clinical utility, and acceptance among clinicians. Ratings ranged from the highest rating of “well-supported and efficacious” to the lowest rating of “concerning treatment.” Trauma-focused Cognitive Behavioral Therapy (TF-CBT)19 was the only intervention that received the highest rating. Fifteen of the remaining interventions, however, were rated as “supported and probably efficacious” or “supported and acceptable.”

The Kauffman Best Practices Project20 followed up on the OVG guideline project to systematically identify a small number of best practice interventions from the 24 already identified. The primary goal was to increase dissemination and use of these best practices among clinicians treating abused children and their families. The project convened a broad range of advisors including researchers, treatment providers, managers of clinical programs, and representatives from Authentic Voices International, an organization of adult, child abuse survivors dedicated to helping others recover from child abuse trauma. The advisory group identified three best practices based on criteria that emphasized research support, clinical acceptability, and the transportability to typical clinical settings. The three best practices identified were TF-CBT,19 Parent-Child Interaction Therapy (PCIT),21,22 and Abuse-Focused-Cognitive Behavioral Therapy (AF-CBT).23 (As the authors note, these are not the only interventions that could have been identified as best practices. These interventions, however, did have the greatest level of theoretical, empiric, and clinical support and consensus among committee members.)

The National Child Traumatic Stress Network (NCTSN) is also an excellent resource for identifying evidence-based practices in child abuse and neglect. NCTSN is a unique collaboration of academic and community-based service centers from all over the United States whose mission is to raise the standard of care and to increase access to evidence-based services for traumatized children and their families, including children exposed to child abuse. Through considerable interagency collaboration, NCTSN has identified evidence-based and promising practices for child
trauma and has developed strategies for effective dissemination of these interventions. The NCTSN Web site (www.nctsn.org) has considerable information about EBP as well as about other resources helpful to medical, mental health, and child welfare professionals. This Web site also has a list of grantees from all over the United States who can provide information regarding treatment referrals in their communities.

**EVIDENCE-BASED PRACTICES FOR CHILD MALTREATMENT**

The goal of this section is to highlight some of the most promising EBP in the treatment of child maltreatment. It is important to note that this is not an exhaustive list of well-supported interventions. Information about other evidence-based and promising practices for child abuse and neglect can be found in the resources discussed above (www.nctsn.org), as well as in recently published literature reviews on this topic.

**Parenting Interventions**

**Parent–child interaction therapy**

PCIT is a short-term, behavioral intervention for children and their parents that is focused on enhancing the quality of the parent–child relationship and teaching positive approaches to child behavior management. PCIT was originally developed to treat children 2 to 7 years of age with behavioral problems, but it has recently been adapted for physically abusive parents and their children up to age 12. PCIT has two primary treatment components. The first component focuses on teaching parents relationship-building skills (i.e., praise, reflection, imitation, description, enthusiasm) through a combination of didactic training and coaching of parent–child interaction. The second component uses didactic training and coaching of parent–child interaction to teach skills central to positive behavior management (e.g., effective use of commands, strategies for increasing compliance). Numerous clinical trials have demonstrated the efficacy of PCIT in reducing child behavior problems and parent–child interaction problems in a variety of populations. Treatment effects have been demonstrated to maintain over time and to generalize to untreated siblings and to school settings. A recent randomized clinical trial with physically maltreating families indicates that PCIT substantially reduced the re-report rate for physical abuse as compared with a standard community-based parenting group (19% re-report rate for PCIT group; 49% for standard care group at a median follow-up of 850 days post-treatment). The superiority of PCIT was mediated by a greater reduction in negative parenting behaviors in the PCIT group. PCIT has been used clinically with diverse populations, with cultural adaptations available for Mexican Americans and Native American families. Preliminary research, based on uncontrolled, pre/post-test designs, suggests that PCIT shows promise for treating children in foster care and for training foster parents.

**Abuse-focused cognitive behavioral therapy**

Abuse-focused cognitive behavioral therapy (AF-CBT) is a short-term intervention for physically abusive parents and their school-age children based on behavioral, cognitive-behavioral, and family systems theories. Treatment delivery is organized into three phases, which include: psychoeducation and engagement; individual and family skills training; and family applications. Core components include development of: (a) child-directed skills (e.g., psychoeducation about abuse; cognitive processing of abuse-related experiences; emotion regulation and coping skills; social support planning); (b) parent-directed skills (e.g., understanding coercive behavior; processing/challenging views on hostility, child-related developmental expectations, and maladaptive attributions; emotion regulation; positive approaches to discipline); and (c) parent–child
or family system components (eg, safety planning; no violence agreement; clarification to establish responsibility for abuse and focus on needs of victim/family; family problem-solving and communication skills). In a small, randomized clinical trial, the individual (parent and child components) and family approaches in AF-CBT were compared, respectively, to routine community services. Findings demonstrated that both the individual and the family components resulted in greater reduction in children’s externalizing problems, child-to-parent violence, parental distress and abuse risk, and family conflict and cohesion. AF-CBT has been used clinically with urban African American families and has been reviewed by African American stakeholders for relevance and clinical utility.

Interventions for Child Trauma

Trauma-focused cognitive behavioral therapy
TF-CBT\(^{19,35,36}\) is a short-term, cognitive-behavioral intervention used to treat traumatized children ages 3 to 17. Although TF-CBT was originally developed for child sexual abuse, this model has been used to treat children exposed to multiple types of trauma.\(^{37}\) Core treatment components include: psycho-education about trauma; strategies for managing distressing feelings, thoughts and behavior; exposure to and processing of trauma-related memories through development of a trauma narrative; and enhancing parenting skills and child safety. Children and non-offending parents are initially seen individually but, when ready, come together so that the child may share the trauma narrative with his or her parent. A number of randomized clinical trials have demonstrated the superiority of TF-CBT over nondirective play therapy and child-centered therapies in traumatized children with regard to several areas of child functioning (eg, posttraumatic stress symptoms, anxiety, depression, externalizing behaviors, sexualized behaviors, shame)\(^{19}\) (see Cohen et al for a review). Additionally, parents who participate in treatment show improvements with regard to parenting practices and the ability to support their child as well as reductions in their own levels of depression and distress about their child’s abuse. Treatment gains are maintained at one-and two-year follow-up.\(^{38–40}\) TF-CBT has been used with diverse populations (eg, African American, Latino) and with children in foster care.

Child–parent psychotherapy
Child–parent psychotherapy (CPP)\(^{41}\) is an attachment-based intervention used to treat traumatized children from birth to six years of age. CPP emphasizes the importance of treating mental health problems from within the context of the parent-child relationship by working with the parent-child dyad. Treatment targets several areas including safety, affect regulation, and the quality of the child-parent relationship as well as joint processing of child’s trauma experiences. Typical treatment duration is 50 sessions. Randomized, clinical trials with maltreated children have indicated the superiority of CPP over standard community services with regard to enhancing the quality of the parent-child attachment relationship\(^{42}\) and the child’s representations of self and caregivers.\(^{43}\) A third randomized trial demonstrated that CPP, as compared with a case management/individual psychotherapy group, resulted in greater reductions in behavioral problems and traumatic stress symptoms in children who had witnessed domestic violence and greater reductions in parent’s avoidance PTSD symptoms.\(^{44}\) Additionally, gains in child and maternal functioning were maintained at 6 month follow-up.\(^{45}\) Related clinical trial research has demonstrated the efficacy of CPP with regard to improvements in the quality of the parent–child relationship as indicated by attachment security and both parent (ie, increased empathy and interactiveness with children) and child behaviors (eg, decreased anger, avoidance,
resistance, increased partnership with mother) in different clinical groups (ie, anxiously attached children of recent immigrants; maternal depression).\textsuperscript{46,47} Clinical trials were conducted with predominantly ethnic minority samples and CPP has been used clinically with many diverse groups (ie, Mexican, Central and South American, African American, and Chinese).

**Interventions for Children in Out-of-Home Care**

Although children placed in foster care are at substantial risk for a host of mental health problems and a number of adverse life outcomes, these findings do not necessarily suggest that foster care, per se, causes or contributes to these outcomes. In fact, we have found that maltreated children who were placed and remained in foster care demonstrated better functioning than maltreated children who reunified with their biologic families or maltreated children who were never removed from their homes.\textsuperscript{48,49} The sequelae of maltreatment, described above, likely contribute to the identified problems for foster youth. Studies that have interviewed youth currently and formerly placed in foster care report that youth generally have positive feelings about foster care. Most thought placement was necessary and in their best interests, and they reported that things would have gotten worse at home without child welfare intervention.\textsuperscript{50–53}

Although foster care placement is, in most cases, a necessary intervention, children in foster care are still at significant risk for adverse mental health outcomes, as they suffer the consequences of child maltreatment and experience additional trauma when they are removed and often isolated from their homes, schools, friends and families. Furthermore, these stressors may be exacerbated by placement changes. In addition to their already increased risk of emotional and behavioral problems, many of these youth lack appropriate coping resources to handle the multiplicity of stressors associated with multiple life transitions.\textsuperscript{12,54}

There are significant challenges in developing and implementing evidence-based mental health treatments for youth in foster care. Conducting randomized controlled trials with a population in which custody and placements change frequently can lead to low recruitment rates and high attrition. Not surprisingly, then, there have been only a few studies of evidence-based practices that have been rigorously tested in foster care populations.

**Multidimensional treatment foster care**

One of the most well-regarded treatments for the reduction of significant behavior problems among adolescents is Multidimensional Treatment Foster Care (MTFC). Until recently, however, MTFC had not been tested with maltreated populations who had been placed into out-of-home care, because it was focused on adjudicated delinquent populations. A recent, randomized controlled trial was conducted in San Diego, CA. Keeping Foster Parents Trained and Supported (KEEP) was an effectiveness trial of a modification of MTFC conducted with 700 foster and kinship families who were caring for children, ages 5–12 years old, placed in out-of-home care through social services. The modified MTFC intervention consisted of 16 weeks of a 90-minute parent management group (traditional MTFC services include several additional components that were not implemented in this trial), consisting of 3–10 foster parents. Groups employed didactic presentations, group discussions, role playing, and videos to help foster parents increase their use of positive reinforcement and reduce their use of discipline. It also focused on teaching foster parents to use non-harsh discipline. Similar to findings with delinquent populations, the effectiveness trial reduced behavior problems for children in the treatment condition. These effects were
concentrated among children with high levels of initial behavior problems and the effect was mediated by parenting practices.\textsuperscript{55}

\textit{Early intervention foster care}

Early Intervention Foster Care (EIFC) is a modification of MTFC for preschool-age (ages 3–6) maltreated children who have been placed in out-of-home care. Specialized foster parents receive training before children being placed in their homes. After children are placed, they receive ongoing support from program staff. Biologic parents also receive training if the permanency plan is for children to reunify. In addition to parent training, the intervention also includes a therapeutic playgroup and services provided by a behavioral specialist who works with families in their homes. Similar to MTFC, parents are encouraged to provide more reinforcement than discipline and to provide a predictable routine that enhances the development of children in their care. In a small, quasi-experimental study with 30 parent–child dyads, parenting practices improved, children evidenced better behavioral functioning, and there was a reduction in salivary cortisol over time in the intervention group, which the authors attributed to reduced stress.\textsuperscript{56} A randomized controlled trial of the EIFC program was subsequently conducted with 90 children and families. This study demonstrated fewer failed permanent placements for children in the intervention arm.\textsuperscript{57}

\textit{Attachment and biobehavioral catch-up}

Attachment and Biobehavioral Catch-up (ABC) is a 10-week parent–child intervention aimed at enhancing regulatory capabilities in infants and young children. The intervention focuses on training foster parents to nurture the children in their care by: (1) following their child’s lead; (2) engaging in positive physical touching (eg, hugging); and (3) allowing children to express emotions. In this study, 60 foster parent–child dyads (ages 3 to 39 months) were randomized to receive either an educational intervention or the ABC intervention. One month after completion of the intervention, children in the treatment group evidenced better regulatory capability, as measured by a more typical pattern of cortisol production. There was no significant difference in parent-reported behavior problems in the two experimental groups.\textsuperscript{58}

\textit{Incredible years adaptation}

The Incredible Years (IY) is an evidence-based parenting program for children ages 3–10 years who are at risk of developing conduct disorder. The intervention was adapted for use with a foster care sample, in which foster and biologic parent pairs received the IY intervention together, along with a coparenting component, aimed at increasing positive parenting practices and ultimately reducing child behavior problems. The study randomly assigned 64 foster and biologic parent pairs to the intervention condition or treatment as usual. The intervention group received 12 weeks of manualized groups, which included 4 components (ie, play, praise and rewards, effective limit setting, and handling misbehavior) that were taught through videos, role playing, and homework. The coparenting component was delivered to the parent dyads in separate sessions and included opportunities to practice effective communication and resolve conflict. The intervention group demonstrated gains in positive parenting, and improvements in coparenting (only immediately following the intervention), and there was a trend for fewer externalizing behaviors among children in the intervention.\textsuperscript{59}

\textit{Wraparound services}

In an innovative study, 132 children in foster care (ages 7–15 years) with behavioral and/or emotional disturbances were randomized to either a services-as-usual
condition or a “wraparound” services condition. The wraparound services consisted of “individualized, case-managed, collaborative” services that were implemented by family specialists. The four components of the services provided by the family specialists included strength-based assessment, life-domain planning, clinical case management, and follow-along supports and services. Children who received these enhanced services demonstrated greater improvement in emotional and behavioral adjustment over time according to their caregivers (there was no difference based on youth self-reports).\textsuperscript{50}

**Fostering healthy futures**
Fostering Healthy Futures (FHF) is an ongoing randomized, controlled trial of a novel intervention for preadolescent youth in out-of-home care. The intervention consists of three components. First, all youth receive a no-cost evaluation of their mental health, cognitive functioning, and academic achievement. The findings are summarized in a screening report that is given to their caseworkers. After the baseline assessment has been completed, approximately one half of the youth are randomized to the prevention program, FHF. Children in the prevention arm of the trial receive a 30-week therapeutic skills group and one-on-one mentoring from graduate students in social work.\textsuperscript{61} Thus far, FHF has enrolled 261 children into this innovative program and it has high rates of recruitment and retention (over 90% at each time point). Outcomes are expected to be published in the upcoming year.

**FUTURE DIRECTIONS**
Recent research in EBP for child maltreatment is exciting and has already had a significant impact on enhancing the quality of mental health services for maltreated children and their families. This work, however, is still in its infancy. Additional efficacy research is needed to expand the understanding of existing evidence-based practices and to evaluate other promising intervention programs. Specific goals for ongoing efficacy research would include: addressing methodological challenges common in this research (eg, small sample size, low retention rates); evaluating intervention appropriateness for diverse populations; and developing effective strategies to enhance already promising and efficacious interventions. Research should also focus on adapting and evaluating current EBP for use with additional types of trauma, different developmental levels, and comorbid conditions.\textsuperscript{19} Children who are neglected constitute one population that needs particular attention given the paucity of research on treatment efficacy. The SafeCare Program\textsuperscript{62} is a promising intervention that directly addresses problems associated with child neglect as well as child maltreatment more generally. Preliminary support based on nonrandomized research trials suggests that the SafeCare Program, as compared with standard community services, significantly reduces recurrence of child maltreatment (including neglect) and enhances positive parenting behaviors. Finally, there is a need to develop and evaluate strategies for effective dissemination and implementation of EBP in the community context. Work in this area must address challenges to the adoption of EBP at community, organizational, and clinician levels, which will require considerable collaboration among researchers, community mental health agencies, and child welfare.

**REFERENCES**
Mental Health Treatment of Child Abuse and Neglect


