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Post-traumatic Stress in Children and Adolescents Exposed to Family Violence: II. Treatment

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Abstract

Interventions for youth exposed to family violence recently have incorporated a trauma focus with the objective of reducing Posttraumatic Stress Disorder (PTSD) symptoms along with alleviating other wide-ranging childhood disorders. This paper describes generally agreed-upon treatment components for youth exposed to violence in the home, including re-exposure interventions, education about violence and cognitive restructuring, processing of emotional cues, social problem-solving skills, and parenting interventions. Empirically evaluated treatment programs for different developmental stages (preschool, school-age, and adolescence) are summarized and remaining questions about how to best focus treatment efforts for youth traumatized by family violence are presented.

Keywords

Child and adolescent intervention; Posttraumatic stress disorder (PTSD); child physical abuse; domestic violence; trauma based therapy; cognitive behavioral interventions

Family violence exposure as a potential precipitant of Post-traumatic Stress Disorder in children and adolescents involves unique features (see Margolin & Vickerman, this issue) that raise important considerations for treatment. For instance, can therapeutic re-exposure procedures be used as part of treatment if there is a high likelihood of re-exposure in real life? What is the role of parents in treatment if one or both parents have perpetrated the violence? To what extent does treatment for traumatic stress generalize to other co-morbid symptoms associated with family violence exposure? Cognitive behavioral treatments are increasingly recognized as the preferred treatment for childhood PTSD related to natural disasters, medical procedures, and sexual abuse (Feeny, Foa, Treadwell, & March, 2004). It is only in the past several years, however, that post-traumatic stress has emerged as a unifying direction for conceptualizing and treating problems associated with child physical abuse and domestic violence exposure (Graham-Bermann, 2001; Wekerle, Miller, Wolfe, & Spindel, 2006).

This paper details selected treatment components for children traumatized by family violence, specifically child physical abuse and exposure to interparental aggression. Our focus here is on these forms of family violence, which are distinct from and less common than child sexual abuse, but have received less attention as trauma stressors. First, we discuss important

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considerations and targets in treatment. In the second half of this paper, we review the existing empirically supported treatment programs that have specifically examined efficacy in trauma reduction for youth who have been physically abused or exposed to domestic violence. Due to the limited number of such programs, we also highlight several interventions for traumatized youth that have led to treatment gains in areas other than PTSD, and several trauma-focused treatments that appear promising but have yet to be tested with this population.

Treatment Considerations and Targets

The treatment modalities specifically developed for children exposed to family violence are varied (individual, group, family, and school). One-on-one treatment permits attention to individualized traumatic cues, distorted thoughts, and behavioral interactions. Group treatments, which typically are administered in schools, community settings, and domestic violence shelters, target general beliefs and attitudes about violence, reactions to violence, and social problem solving skills. Although many children benefit from the positive, fun atmosphere where they feel validated and appreciated (Suderman, Marshall, and Loosely, 2000), group treatment may be counter-indicated for children with particularly poor social skills who risk further rejection (Friedrich, 2002). A number of treatments are designed for violence-exposed youth at specific developmental stages, typically preschool children, school age children, or adolescents. Interventions with younger children frequently incorporate play, whereas interventions with adolescents draw on adult oriented treatments, but attend to the unique challenges of adolescents regarding risk taking and social pressures. Some treatments focus on specific adjustment problems related to the violence exposure (e.g., aggression or conduct disorders related to child abuse), whereas others provide preventive strategies to address the wide-ranging risks of living in violent families. Some treatments are designed to assist children and families at specific transitions, e.g., as the mother and children leave battered women's shelters.

Nonetheless, despite variability in treatment modalities, targeted clients, and symptom presentation, there is considerable consensus across the clinical literature and empirically tested treatments on important intervention objectives and strategies for children traumatized by family violence. Trauma-focused treatments are predominantly based on cognitive behavioral models, which aim to optimize adaptive functioning in youth. These interventions typically use a combination of the following treatment components: trauma re-exposure, violence education and cognitive restructuring, emotion expression and regulation, social problem solving, safety planning, and parent training. As noted (Margolin & Vickerman, this issue), before beginning treatment, clinicians should do a comprehensive assessment of all salient domains, including the child's symptoms, strengths, family context, and broader environment.

Re-Exposure Interventions

The overall goals for exposure interventions in response to trauma are to help the child: (a) separate the thoughts, cues, and other reminders surrounding the trauma event from overwhelming and incapacitating negative emotions; (b) make sense of reactions during and subsequent to the traumatic event, and (c) discuss and rehearse alternative responses (Cohen, Mannarino, & Deblinger, 2006; Kerig, Fedorowicz, Brown, & Warren, 2000). Theoretically, re-exposure is thought to work as an informal desensitization process. By discussing the event and the conditioned aversive stimuli surrounding the event without re-traumatization, conditioned responses between the aversive stimuli and the painful emotional reactions are extinguished. If there is a reduction in the physiological and psychological reactions to trauma cues and intrusive thoughts, then the child no longer will need to avoid those cues or suppress the thoughts, and will be able to engage in normal activities.

For re-exposure interventions to be therapeutic and not re-traumatizing, the clinician needs to carefully guide the intervention so that the child maintains control and ultimately obtains mastery over the experience (Cohen et al., 2006; Kerig et al. 2000). As contrasted with one-time trauma exposures, which may be accompanied by unrealistic fears, the repeating and ongoing nature of violence in the home makes it important to use re-exposure techniques to prepare youth for coping with future episodes. The objective is to assist youth in developing a personal story with new strategies of coping with the violence, or responding even to less dangerous but still threatening anger and conflict related cues.

One commonly used form of re-exposure is the trauma interview, which allows the child to disclose and review details of the traumatic event in a safe, accepting environment where the danger cannot reoccur. Pynoos and Eth (1986) developed a widely used interview protocol to engage children ages 3 to 16 in a discussion of the traumatic event. Within the safe confines of the therapeutic relationship, the child can review and integrate the fragmented impressions of the trauma into a coherent story, increase his or her tolerance for negative emotions associated with the event, learn what to expect in terms of future traumatic reactions, and address the personal meanings of the event. The Silvern, Karyl, & Landis (1995) "straight talk" model of the trauma interview emphasizes the need for direct rather than polite questions in eliciting salient details about the child's response to a traumatic event. Silvern and colleagues recommend reframing, normalizing or offering comfort when the child reveals behaviors that she or he finds embarrassing or shameful, e.g., "if a child laments his or her failure to take action, the therapist might assert that staying out of the batterer's way was smart." (p. 56). This example also illustrates the importance of reinforcing strategies that are effective toward the goal of safety.

In the Cohen et al. (2006) trauma narratives, children write a trauma story, dictate the story to the therapist, or enact the story through play activities. In developing the narrative of the traumatic event, the child first writes an account of the details and facts, then elaborates that story with thoughts and feelings, and eventually adds the worst part that previously was too difficult to discuss. When young children enact the narrative through dolls or puppets, or by drawing, the therapist needs to actively direct the play and interrupt repetitive enactments of the trauma. Play also can provide behavioral rehearsal of adaptive ways of coping with violence exposure, for example, telephoning someone for help.

Education about Violence and Cognitive Restructuring

Education about violence and cognitive restructuring typically focus on changing cognitions about aggression, and gaining control over intrusive re-experiencing symptoms. Cognitive interventions have several goals in common with re-exposure—namely thinking about the violence from a new perspective, and developing different coping strategies to respond to violence—but often are conducted in group settings to allow children to learn from one another.

Cognitive interventions are used to help children understand connections between violence exposure and violence reactions, and also to highlight the non-normative nature of aggression and violence in relationships (Graham-Bermann, 2001; Peled & Edleson, 1995). Children typically experience considerable relief as they learn that their seemingly out-of-control symptoms actually are quite normal given the circumstances of violence exposure. Group leaders also help children develop vocabularies to describe violent events. As children tell their stories of abuse, they receive support and validation from others, and come to realize that they are not alone in living with violence.

A related goal is to undo the lessons learned from growing up in a violent home, specifically messages that aggression is an acceptable way to deal with conflict. These interventions convey three unambiguous messages: that violence and abuse are unacceptable, that violent behavior

is a choice, and that children are not responsible for parents' aggression and violence. With respect to child abuse, Kolko and Swenson (2002) recommend helping the child distinguish between discipline and harm, and explaining that there are laws to protect children from harm. Interventions with children exposed to domestic violence often address gender role beliefs that foster aggression (Graham & Bermann, 2001) and, with adolescents, help youth develop strategies to combat societal messages about power and control in relationships, sex role stereotypes, and gender-based attitudes (Wolfe et al., 1996).

Thought-stopping, self-talk, and positive imagery are strategies to help children interrupt intrusive, distressing thoughts (Kerig et al., 2000; Wekerle et al., 2006). The important component is that children learn they have control over their thoughts. When a child's new perspectives on violent episodes translate into self-statements such as "I am not responsible for my parents' frightening behaviors" or "I did the best I could under the circumstances", that child may have less need for mentally replaying the violent episodes.

Emotion recognition and expression

Interventions that address the processing of emotional cues have several important objectives. Attending to and expressing one's own emotions can lead to improved emotional regulation. Recognizing emotions in others can facilitate the development of empathy. Learning to interrupt anxiety gives youth a sense of control over unpleasant emotions. Identifying connections between emotions, automatic thoughts, and behaviors enables youth to respond in a more intentional manner to ambiguous or stressful situations.

An important step toward these objectives is developing an emotional vocabulary. By learning the full range of emotions, both positive and negative, youth can better distinguish between anger and other negative emotions such as sadness, disappointment, and fear, and then express more nuanced emotions (Suderman et al., 2000). Identifying connections between bodily sensations and emotions can help youth identify specific emotions, such as anxiety. Deep breathing, relaxation, guided imagery, and visualization often are taught so that youth have strategies to interrupt anxiety, and short circuit the common occurrence of fear escalating into anger (Kolko & Swenson, 2002; Wekerle et al., 2006).

Social Problem Solving and Social Interaction Skills

Social problem solving teaches children new ways of interacting and working out conflicts, once they have developed non-violent cognitions and emotion recognition skills. Behavioral rehearsal is the primary strategy for learning new interaction skills. Interventions with school-age children emphasize how to open conversations, take turns, listen to one another, be polite to others, and use assertive rather than aggressive or passive behaviors for conflict resolution (Graham-Bermann, 2001; Kolko & Swenson, 2002). The Wolfe et al. (1996) adolescent intervention addresses assertiveness versus aggressiveness in dating relationships with role-play exercises to help youth learn how to handle conflict, respond to abuse in their own relationships, and develop positive social skills such as giving compliments.

Safety Planning and Coping with Violence

Safety must be a primary and continuing concern when working with children exposed to domestic violence or who have been the victim of child abuse. Child abuse reporting may be necessary depending on how the child is brought to the attention of a therapist (e.g., child protective services referral, individual therapy, etc.), or if additional abusive incidents are discussed in therapy. As part of ongoing safety assessments, the therapist must be alert for changes in the family situation that could elevate chronic states of tension and stress to a crisis level with the potential of serious injury to the youth or another family member.

Children who remain in family environments with the potential for violence need to learn to recognize and plan for future instances of family aggression. Distinctions are needed between not being responsible for the violence, but being responsible for actions to protect one's own safety. Protecting one's own safety includes anticipating the cues of dangerous situations at home or elsewhere, and identifying people who can be helpful (Kolko & Swenson, 2002). The consistent message is that children should 'break the silence' and disclose situations that pose a danger to themselves or others (Peled & Edleson, 1995). Although it is important to praise children for their previous responses to the violence so that they do not feel as though they failed to act responsibly, children understand the message they can always expand their options for responding to family violence (Cohen et al., 2006).

Parenting Interventions

Even when one or both parents are the source of the child's exposure to violence in the home, parents are important in the child's recovery from PTSD (AACAP, 1998). Involving the non-offending parent in some portion of treatment is quite standard. It is less clear to what extent and under what circumstances to include the offending parent, although some investigators recommend involving offending parents who continue to interact with the child on a day-to-day basis (Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004). When engaging parents in the therapeutic process, it is important not to underestimate the parents' fundamental desire to do what is best for the child, despite evidence that they have, at least on certain occasions, created or contributed to a dangerous, threatening home environment. One reason to include parents is to convey the essential message that familial risk to the child must be reduced. Another reason is to inform parents about the therapeutic interventions with the youth and have them prompt and reinforce the child's efforts toward mastery. Formalized parenting interventions typically focus on stopping aggressive parenting, improving constructive and positive parenting skills, and lessening parents' own distress and isolation.

One important parent intervention is communicating the message that physical aggression in parenting is not an effective discipline strategy and actually promotes negative child behavior and adverse child outcomes (Kolko & Swenson, 2002; Runyon et al., 2004). Straus (1994) argues that corporal punishment itself is "deeply traumatic for young children" (p. 9), leading to high levels of aggression and low empathy for others' distress. With a child already traumatized by family violence, the further use of physical punishment, even commonly used corporal punishment, can re-traumatize that child. It often is difficult to overcome parents' resistance to relinquish physical punishment, due to its accepted legitimacy in parents' viewpoints. However, parents tend to be more likely to consider other strategies if the therapist recognizes and commends the parents' well-meaning intentions. Prioritizing problem behaviors based on discussion of age-appropriate expectations is an important step. Parents also need alternatives to physical punishment, such as effective ways of doing 'time out', contingency management, withdrawal of reinforcement, and communication skills (Patterson & Forgatch, 2005; Wekerle et al., 2006). Parents often benefit from rehearsing the new skills and from assistance as they incorporate new behaviors into their lives, for example, through home visits so that the therapist can help resolve specific obstacles to carrying out non-aggressive discipline strategies. Parents also benefit from knowing in advance that their initial attempts at non-aggressive discipline strategies may result in immediate, albeit short-term, spikes in undesirable child behaviors.

Treatments also aim to lessen coercive interactions by emphasizing more positive and supportive parenting techniques, sometimes through direct coaching during observed parent-child interactions (Urquiza & McNeil, 1996). Kolko (1996) worked with the entire family to promote identification and reduction of coercive behaviors and to replace them with constructive problem solving and positive communication skills.

Violence prone families are affected by many contextual stressors, including poverty, single parenthood, racism, as well as parents' own trauma symptoms, substance abuse, and psychopathology. In light of the ample evidence that parents' own distress is a risk factor for youth's PTSD symptoms, treatments aimed at reducing parents' distress through stress management and anger modulation can have added benefits for youth (Kolko & Swenson, 2002; Wekerle et al., 2006). Parenting interventions include knowledge about child development, in-home visits to identify the ways that parents express anger toward the child, and opportunities to discuss their parenting concerns and worries (Graham-Bermann, 2001). These parenting interventions are bolstered by other types of instrumental assistance (e.g. helping the mother to interact with the school, and obtain transportation, employment, housing) and emotional support through a system of one-on-one advocacy or a supportive group environment.

Empirically Evaluated Treatments

Of the empirical studies that have examined treatments for child physical abuse or exposure to domestic violence, some focus on posttraumatic stress whereas others focus on other types of youth outcomes. In the following section, we first discuss four interventions that have examined the impact of treatment on PTSD symptoms or diagnoses in youth who have been physically abused or exposed to domestic violence. Our focus is on published outcome research; we did not include case studies in this review. Next, due to the dearth of interventions evaluating PTSD as an outcome, we review several select treatments for physically abused children and children exposed to partner aggression that show treatment gains in other problem areas but have not evaluated PTSD as an outcome. Finally, we refer to several treatments that deserve mention because they effectively address PTSD in children exposed to other forms of interpersonal violence, or because they have some preliminary data on youth exposed to family violence.

Table 1 summarizes treatment details, targets, and outcomes for empirically supported treatments that either specifically target PTSD or that target other important outcomes for youth exposed to family violence. Each child intervention is based on a treatment manual (see asterisked references for treatment manuals or component descriptions), except The Learning Club, which has a manual for the mother advocacy intervention, but not the child intervention. Several expert panels have rated the level of empirical support of treatments for youth PTSD or for victims of child abuse. The final column in Table 1 includes ratings, when available, from the National Child Traumatic Stress Network (NCTSN) treatments for PTSD (2005; www.nctsn.org), the National Crime Victims Research and Treatment Center and Center for Sexual Assault and Traumatic Stress (treatments for child physical and sexual abuse; Saunders, Berliner, & Hanson, 2004), and the Kauffman Best Practices Project (treatments for child abuse; Chadwick Center for Children and Families, 2004).

Violence Exposure Treatments Targeting Youth PTSD

Child-Parent Psychotherapy for Preschoolers Exposed to Marital Violence (CPP)—Lieberman and colleagues have developed an intervention for preschoolers exposed to partner violence toward their mother (Lieberman & Van Horn, 2005). CPP builds on attachment, social cognitive, psychodynamic, and cognitive behavioral theories and targets the mother-child relationship during joint mother-child and mother only sessions. The goals of CPP include creating a joint trauma narrative for the mother and child, increasing maternal responsiveness, addressing developmentally appropriate interactions and non-aggressive parenting, and decreasing maladaptive behaviors. A randomized clinical trial (RCT) evaluating CPP versus case management and community treatment referral found significant reductions in children's traumatic stress (Lieberman, Van Horn, & Ippen, 2005). It is notable that these children often had multiple traumas and exposure to other types of violence including child

physical abuse, child sexual abuse, and community violence. Improvements in children's behavior problems and mother's distress were maintained at a 6-month follow-up assessment, although no information is provided about PTSD in the follow-up study (Lieberman, Ippen, & Van Horn, 2006.)

The Kids' Club and The Preschool Kids' Club for Children Exposed to Partner Violence—Graham-Bermann and colleagues designed group interventions for school-aged (The Kids' Club) and preschool children (The Preschool Kids' Club) that have been used in shelter and community settings (Graham-Bermann, 1992; Graham-Bermann & Follett, 2002). These psycho-educational groups help children recover from traumatic exposure to intimate partner aggression and aim to prevent future problems through learning about and discussing feelings and concerns related to violence, increasing coping skills and resilience, and addressing assumptions and cognitions about violence in intimate relationships. Treated mothers participated in a group that provided empowerment, parenting support, and discussion about the impact of violence exposure on children. An efficacy study comparing families sequentially assigned to child only, mother and child, or wait list control groups showed that children in both treatment conditions (child only, and mother and child) received fewer PTSD diagnoses after treatment than did control children (Graham-Bermann & Hughes, 2003). Only the mother and child treatment showed significant improvement in other outcomes (externalizing behaviors and violence attitudes) compared to the wait list control (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007).

The Youth Relationships Project Promoting Teenagers' Nonviolent Relationships—Wolfe and colleagues created a group 'competency enhancement approach' for at risk adolescents intended to prevent intimate violence victimization and to promote healthy relationships (Wolfe et al., 1996). This approach originally was created for teens with histories of violence exposure and risk factors for abuse, but also has been used in general school populations. The group involves psycho-education, skills training, and community involvement in anti-violence efforts. Youth are encouraged to recognize that being aggressive is a choice, to examine social attitudes and power dynamics that foster relationship violence, to increase assertiveness, respect, and safety in romantic relationships, and to develop coping skill sets for dealing with relationship aggression. Although this program is preventive in nature, it can be seen as potentially derailing a trajectory of prior intimate violence exposure leading to an increased risk of re-victimization. A RCT involving 14-16 year olds with child maltreatment histories (including abuse, neglect, and domestic violence exposure) found that youth receiving the intervention showed a greater decline in aspects of posttraumatic stress compared to control condition youth (Wolfe et al., 2003). These groups were not meant to address problems related to past abuse and the authors note that it is unclear whether posttraumatic stress improvement is directly related to treatment or indirectly related to treatment through decreased involvement in aggressive relationships.

Trauma-Focused-Cognitive-Behavioral Therapy for Child Abuse Victims (TF-CBT)—Cohen and colleagues have done extensive research on treatment for child sexual abuse victims with PTSD using TF-CBT (Cohen et al., 2006). The acronym PRACTICE is used to identify the key treatment components in order of use: "psychoeducation, parenting skills, relaxation, affective modulation, cognitive coping and processing, trauma narrative, in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing future safety and development" (Cohen et al., 2006, p. 57). The developers promote phase-oriented treatment with the belief that knowledge of one component facilitates work on the next component. Sessions initially are conducted with the parent and child individually and, later, as joint parent-child meetings. RCTs with TF-CBT have repeatedly shown improvements in PTSD and other outcomes for youth who have been sexually abused. Notably, TF-CBT was effective with child

victims of sexual abuse exposed to multiple types of trauma, specifically 26% were also physically abused and 58% had witnessed domestic violence (Cohen, Deblinger, Mannarino, & Steer, 2004). Additional research is examining PTSD outcomes in TF-CBT, compared to child-centered therapy, for children exposed to domestic violence (Cohen, Mannarino, Murray, & Igelman, 2006).

Violence Exposure Treatments Evaluating Other Child Outcomes

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) for physically abused children incorporates behavior therapy and cognitive behavior therapy principles (Kolko & Swenson, 2002). A RCT with abused and maltreated children found AF-CBT, compared to community parent training groups, had greater efficacy in multiple child domains, including fewer externalizing symptoms, and in family outcomes, most notably lower parent-to-child violence risk. PTSD is addressed in the AF-CBT treatment components through anxiety management techniques. However, PTSD was not directly evaluated in clinical trials, perhaps because very few children met full criteria for PTSD at pre-treatment. The investigators indicated that their study participants typically experienced minor types of abuse, and noted the need for further evaluation of AF-CBT with children who experience severe physical abuse (Kolko, 1996).

Parent-Child Interaction Therapy Parent-Child (PCIT) therapy was originally developed for children with externalizing behavior problems (Eyberg, 1988), but has now been suggested for physically abusive parents and their children (Urquiza & McNeil, 1996). PCIT is based on behavioral parenting principles and involves step-by-step live coaching of parent-child interactions. It aims to stop coercive interactions that may escalate children's behavior problems, and to teach parents appropriate child management techniques. One RCT found that PCIT, compared to community treatment, decreased the risk of physically abusive parents re-abusing their child; moreover, children in both conditions had significant decreases in internalizing and externalizing symptoms (Chaffin et al., 2004). Posttraumatic stress outcomes have not been evaluated for physically abused children treated with PCIT, and PCIT still needs evaluation for parents who have engaged in severe physical abuse of their children.

Two interventions show treatment gains for children and mothers leaving domestic violence shelters: The Learning Club (Sullivan, Bybee, & Allen, 2002; Sullivan, Campbell, Angelique, Eby, & Davidson, 1994) and Project SUPPORT (Jouriles et al., 2001; McDonald, Jouriles, & Skopp, 2006). Both involve an advocacy and a mentoring component for the mother that includes modeling of appropriate child management strategies, empowerment and support, and assistance in acquiring resources. The Learning Club pairs the community advocacy intervention with a psycho-educational group to educate children about feelings, safety, and respect for themselves and others (Sullivan, et al., 2002). In Project SUPPORT, children with clinical levels of aggressive or oppositional behavior work with a supportive mentor, while mothers work with a therapist on child management skills and nurturing behaviors (Jouriles et al., 2001). Neither of these treatments mentions posttraumatic stress as an outcome.

Other Promising Interventions For PTSD in Youth Exposed to Interpersonal Violence

Several other treatments targeting PTSD in youth deserve mention. The Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2004) is a group-based school intervention and has successfully reduced PTSD symptoms in violence-exposed youth (Stein et al., 2003). This treatment uses education about trauma, relaxation and imaginal exposure, thought stopping, positive imagery and distraction, and social problem solving. This project primarily focuses on community violence exposure, but the NCTSN (2006) suggests that CBITS can also target PTSD resulting from physical abuse. Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPCCBA) incorporates principles from TF-CBT and AF-CBT and preliminary findings evidence

decreases in PTSD (Runyon et al., 2004; NCTSN, 2005). Similarly, preliminary findings on the Community Outreach Program (COPE; de Arrellano, et al., 2005), which incorporates components from TF-CBT, PCIT, and intensive case management, show trauma symptom improvement for physically abused children. With little research on PTSD in physical abused children, data from CPCCBA and COPE are promising and have been rated as “supported and acceptable” by the NCTSN. Finally, for adolescents with significant affect regulation and risk taking problems, the use of Dialectical Behavior Therapy (DBT; Linehan, 1993) has been suggested prior to TF-CBT or other CBT treatment (Chadwick Center on Children and Families, 2004; Wekerle et al., 2006). Skills Training in Affective and Interpersonal Regulation/Narrative Story Telling (Cloitre, Koenen, Cohen, & Han, 2002) employs this approach by coupling group affect regulation and social skills training with individual sessions focused on emotional reprocessing of trauma and is rated “supported and acceptable” by the NCTSN.

Treatment Summary

Several promising empirically supported treatments that directly target PTSD symptoms are available for traumatized child victims of physical abuse or witnesses to domestic violence. Treatments for preschoolers (CPP) and school-aged children (The Kids' Club) show decreases in posttraumatic stress. The Youth Relationship Project prevention program also evidenced reductions in PTSD symptoms for adolescents. Considerable data support TF-CBT for reducing PTSD symptoms and other problems in children and adolescents traumatized by interpersonal aggression although, as yet, limited outcome data are available for child physical abuse victims and children exposed to intimate partner violence. CBITS also shows reductions in PTSD symptoms for young adolescents exposed to community violence but its generalizability to violence in the home as the primary trauma exposure is untested. Other treatments for youth exposed to family violence, most notably AF-CBT and PCIT, have successfully targeted problem areas for youth who have been physically abused or exposed to domestic violence, but have not evaluated PTSD as an outcome.

Conclusion and Future Directions

Current thinking about the assessment and treatment of children exposed to child abuse and domestic violence reflects two important advances—developmentally informed perspectives on PTSD and recognition that violence in the home can be a traumatic experience. Treatment manuals provide excellent guidelines for integrating a trauma focus into clinical work with these youth. Recently published and ongoing investigations suggest empirical support for these newly developed interventions; however, more research is needed specifically with youth exposed to family violence. There are many still-to-be explored issues as we work to improve the lives of youth who experience child abuse and witness domestic violence, including the following:

- The need for dismantling studies increases as treatments become more integrative and inclusive (Cohen, 2005). Are some components more essential than others if children and their families can be in treatment only for a limited number of sessions? Do some components lead to specific outcomes, thus becoming more or less necessary depending upon the specific needs of the youth?
- With the potential for delayed effects of exposure to family violence, particularly as youth deal with challenges of adolescence, it is unclear where treatment efforts should be directed. Should prevention programs be offered to all youth who have experienced family violence, whether or not they exhibit problems? Does the assumption that all children exposed to family violence are at-risk result in a misdirection of services from the youth who really need clinical interventions? Does treatment provide greater

benefit if provided before symptoms develop, at the early stage of symptom development, or when PTSD is clearly present?

- Little is known about where to intervene when there are multiple and diverse manifestations of symptoms in violence exposed youth, particularly given that intervention studies sometimes show reductions in PTSD symptoms without reductions in depression, or other problems (Yule, 2003). To what extent do we rely on trauma-focused versus standard treatments for these other problems?
- It has been suggested that treatments targeted at one type of violence exposure, e.g., child sexual abuse or community violence, are likely effective for other types of exposure, e.g., family violence (Cohen, et al., 2006). However, empirical evaluations are needed to test this hypothesis and determine if adjustments are necessary.
- Children also can be multiply traumatized when they have a history of family violence and then experience a non-familial adverse event, such as a natural disaster. Interventions related to the new traumatic event should consider how pre-existing family context may impact children's reactions to an external trauma, and parents' abilities to be supportive following the new stressor (Proctor, et al., 2007).
- In light of the potentially disabling nature of PTSD symptoms and the strong psychobiological impact, information is needed on the benefits and risks of psychopharmacological interventions specifically for children and adolescents with PTSD (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002). Results from adult clinical trials cannot be generalized to youth but are likely to prompt future studies on the use of psychopharmacological agents with youth as an adjuvant treatment.

Future work should address these questions with continued attention to the salience of developmental stage and the potential for impact across multiple domains in youth traumatized by family violence.

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Table 1
Selected Treatments for Youth Exposed to Child Physical Abuse (CPA) and Domestic Violence between Intimate Partners (DV)

Treatment	Age Range	CPA / DV	PTSD targeted?	Length of Treatment	PTSD Outcome	Other Youth Outcomes	Parent/ Mother Outcome	Empirical Ratings ^a
Child-Parent Psychotherapy (Lieberman et al., 2005)	3-5	DV	Yes	1 year, weekly	• ↓ symptoms • ↓ diagnoses	• ↓ behavior problems	• ↓ distress • ↓ PTSD avoidance, reexperiencing ^e , hyperarousal ^e symptoms	1 ^b , 3 ^c
The Kids' Club (Graham – Bernmann, 2000; Graham-Bernmann et al., 2007)	5-13	DV	Yes	10 weeks	• ↓ diagnoses	• ↓ externalizing symptoms • improved violence attitudes	none reported	--
Trauma-Focused Cognitive-Behavioral Therapy (Cohen et al., 2004)	8-14 ^f	CPA, DV	Yes	12-16 weeks	• ↓ symptoms • ↓ diagnoses	• ↓ depression • ↓ behavior problems • ↓ shame • improved abuse-related attributions	• ↓ depression • ↓ distress about abuse • ↓ support to child • ↓ parenting effectiveness	1 ^b , 1c, BPd
The Youth Relationships Project (Wolfe et al., 2003)	14-16	DV	No	18 weeks	• ↓ symptoms	• ↓ dating abuse-physical & emotional	not applicable	--
Abuse-Focused Cognitive-Behavioral Therapy (Kolko, 1996; Kolko & Swenson, 2002)	6-13	CPA	Yes	12-16 weeks	--	• ↓ externalizing symptoms • ↓ child to parent violence	• ↓ parent to child violence • ↓ distress • ↑ family cohesion • ↓ family conflict • ↓ belief in need for punishment	2 ^b , 3c, BPd
Parent-Child Interaction Therapy (Chaffin et al., 2004)	4-12	CPA	No	Motivation Enhancement + 12-14 sessions + 4 week group (6 months)	--	• ↓ internalizing symptoms ^e • ↓ externalizing symptoms ^e	• ↓ CPA re-report risk • ↓ negative parent behavior (coded)	2 ^b , 3c, BPd
The Learning Club (Sullivan et al., 2002)	7-11	DV	No	10 weeks	--	• ↑ feelings of competency	• ↓ depression • ↓ self-esteem • quicker ↓ in child witnessing DV	--
Project SUPPORT (Jouriles et al., 2001; McDonald et al., 2006)	4-9	DV	No	M= 23 sessions over 8 months	--	• ↓ externalizing symptoms & diagnoses • ↓ internalizing diagnoses • ↑ happiness and social relationship functioning	• ↑ child management skills • ↓ aggression toward child • ↑ return to abusive partner	--

Notes.

^a 1="well-supported and efficacious", 2="supported and probably efficacious", 3="supported and acceptable", BP= Best Practice designation

- ^b National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices (2005) for treatment of youth PTSD
- ^c Child Physical and Sexual Abuse: Guidelines for treatment from the National Crime Victims Research and Treatment Center and the Center for Sexual Assault and Traumatic Stress (Saunders, et al., 2004)
- ^d Best Practice designation for treatment of child abuse by Kaufman Best Practices Project in collaboration with field leaders (Chadwick Center for Children and Families, 2004)
- ^e Treatment compared to an active treatment (not no treatment control) and symptoms decreased in both groups
- ^f 4-18 for child sexual abuse.