

Trauma-focused models for caregivers: a systematic review of empirical research

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TRAUMA-FOCUSED MODELS FOR CAREGIVERS:
A SYSTEMATIC REVIEW OF EMPIRICAL RESEARCH

by

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A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Social Work
in the College of Health and Public Affairs
and in The Burnett Honors College
at the University of Central Florida
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ABSTRACT

Child and Adolescent caregivers are rarely the focus of research and/or trauma-focused or informed models when working with traumatized children (Baynard, Englund, & Rozelle, 2001; Chapman, Dube, & Anda, 2007). It has been shown that use of caregivers in the treatment of children who have suffered trauma can have a significant impact on not only the child, but also reduce the trauma symptoms of the caregivers themselves (Cohen, Mannarino, & Staron, 2006). The purpose of this study is to critically review the empirical research of trauma-focused and trauma-informed trainings and treatment models for children who have suffered some form of trauma and whose caregiver is included in the treatment. The outcomes of trauma-focused models will be examined in terms of its purpose, intervention, facilitation, adaptability and modification. Implications for further research and application are drawn.

DEDICATION

For my loving wife Kimberlee, who supported me unconditionally with love and understanding, this could not have happened without you.

For my entire family who believed in me.

For all the teachers who led me to this point and would not let me settle for just good enough.

For my LifeStream family for giving me the opportunity to explore the world of Trauma-Informed Care that led to this project.

And for my friends, who I never see enough, thanks for understanding.

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INTRODUCTION

Research has indicated that childhood traumatic stress increases the use of health and mental health services including child welfare and the juvenile justice (Chapman, Dube, & Anda 2007). Further research has found a link between childhood trauma and an increase in substance abuse and psychological distress as they age (Min, Farkas, Minnes, & Singer, 2007). Schechter, Zygmont, Coates, Davies, Trabka, McCaw, Kolodji, & Robinson (2007) found that when a mother's experience of violence and trauma are untreated, her child responds to self and others through dysregulated fluctuating aggressive mood swings, avoidance, and withdrawal which in turn may impede positive development of further generations. Ko, Ford, Kassam-Adams, Berkowitz, Wilson, & Wong (2008) described how childhood abuse increases risk for maternal battery as an adult. All too often the caregivers, whether biological or direct care providers at residential facilities, are an afterthought due to limited research in the field and a paucity of resources available to those working with the children (Chapman, Dube, & Anda, 2007 & Ko, Ford, Kassam-Adams, Berkowitz, Wilson, & Wong, 2008).

A Trauma Focus

A key component to trauma is how the incident affects the individual's current and future relationships (Murphy & Dillon, 2011). Throughout the past few years of research the term trauma has been expanded to include experiences, exposure, or witnessing life events of sexual assault, domestic violence, child abuse and neglect, interpersonal violence, natural disasters, serious accidents, life-endangering medical issues and procedures, traumatic loss, and the disruption of attachment to a caregiver (Baynard et al., 2001; Brown, Baker, & Wilcox, 2011; &

Rosenberg, 2011). To provide a full continuum of trauma-focused services mental health practitioners need to be aware of the trauma caregivers suffer while working with the children and adolescents (Rosenberg, 2011). Murphy and Dillon (2011) define this suffering as secondary trauma. The caregivers who were not the perpetrators or causes of the child's trauma may be suffering from trauma; responding to the traumatic response of another. Furthermore, without a trauma-informed understanding of what the caregivers are going through and/or their inability to understand the cause of the child's trauma, the risk increases that they will fall further into a state of severe trauma (Murphy & Dillon, 2011).

Overview of Caregivers

The term caregiver is used to describe any individual who is currently or may provide direct care for a child or youth in a home, residential, in-patient, or foster setting. Direct care providers in residential programs need trauma-focused intervention training to develop trauma-informed programs and communities to provide true holistic services where the entire living surroundings of the children and caregivers can be built (DePrince & Newman, 2011; Gewirtz, DeGarmo, & Medhanie, 2011; Igelman, Taylor, Gilbert, Ryan, Steinberg, Wilson, & Mann, 2007; Ko, ford, Kassam-Adams, Berkowitz, Wilson, Wong, 2008; Mercer, 2011; Osofsky, 2009; & Rosenberg, 2011). Caregivers represent a wide range of duties and professions from biological parents raising their children at home to direct care workers providing care for children and youth in residential settings when biological caregivers are absent (Brown, Baker, & Wilcox, 2012; Cohen, Mannarino, & Staron, 2006; Greenwald, Siradas, Schmitt, Reslan, Fierle, & Sande, 2012; Pearl, Thieken, Olafson, Boat, Connelly, Barnes, & Putnam, 2012; &

Schechter, Zygmunt, Coates, Davies, Trabka, McCaw, Kolodji, & Robinson, 2007).

Educational Programs

Min, Farkas, Minnes, and Singer (2007) state that there is a need for more educational programs regarding interventions to teach coping skills to children who have experienced trauma in effort to prevent both substance abuse and psychological distress. Beyond the basic training, there is a need to make sure that training is developed through methods of individualized, family, and group treatment. In addition, there is a need for Trauma Informed Care (TIC) training for caregivers of children that is flexible enough to be used by various programs depending on the needs of the organization and that of the population being served (Elliott, Bjelajac, Fallot, Markoff, & Reed (2005) & Igelman, Taylor, Gilbert, Ryan, Steinberg, Wilson, and Mann (2007).

METHOD

An initial search of literature on trauma-focused and TIC training programs for caregivers was performed in the PsyARTICLES, PsycINFO, and Medline databases. Keywords used in the search included *trauma informed, trauma, mental illness, caregiver, family, parent, child, youth, facility, residential, training, modules, curriculum, and education*. Despite the hundreds of articles from the initial search of the above terms, there were few articles focusing on working with caregivers and even fewer empirical studies. The literature typically interchanges the terms parents and caregivers the term caregiver will be used for the purpose of this analysis.

Seven recent (2006-2012) empirical studies specifically on trauma-focused or TIC caregiver training models, fitting the requirements of serving both the child and the caregiver from a trauma-focused or informed perspective were found. Articles selected for review were published in *Psychological Trauma: Theory, Research, Practice, and Policy* (n=2), *American Academy of Child and Adolescent Psychiatry* (n=1), *Residential Treatment for Children & Youth* (n=1), *Child Abuse & Neglect* (n=1), *Attachment & Human Development* (n=1), and *International Journal of Play Therapy* (n=1).

The following criteria are used in the delineation of the seven models used in the study: (a) type of model, (b) length of model, (c) sample size, (d) design, (e) measures, (f) participant eligibility, (g) facilitator requirements, (h) caregiver involvement, (i) findings, and (j) limitations. The criteria used in the delineation of the seven models used in the study were developed through review of a highly cited empirical research study (Abel, 2000). Table 1 in the Appendix provides the summary of the framework of the studies to be reviewed per criteria.

ANALYSIS OF EMPIRICAL LITERATURE

The following section provides studies of trainings and intervention programs based on increasing the Trauma-Focused and TIC aptitudes of caregivers. Articles in this review focus on models of modified cognitive-behavioral therapy for childhood traumatic grief (CBT-CTG), MacArthur Story Stem Battery (MSSB), Risking Connection (RC) trauma training, child-parent psychotherapy (CPP) for children experiencing traumatic and stressful events, child-centered play therapy and trauma-focused cognitive-behavioral therapy, Fairy Tale model, and Parent-Child Interaction Therapy (PCIT).

Modified Cognitive-Behavioral Therapy for Childhood Traumatic Grief

Cohen et al. (2006) studied whether a modified 12-session Cognitive-Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG) model, which met the session limit of many community child bereavement programs over that of the standard 16-session model, would receive the same response from children with CTG. While this is the earliest of included articles, it is important to consider as this is a pilot study for modifying a trauma-focused model to be used in the community behavioral health arena (Cohen, et al., 2006). Children participating in the module lost either parents or siblings through traumatic causes. Caregivers in the original full CBT-CTG model showed depression, anxiety, behavior, and PTSD symptom improvement and as such were also included in the modified version (Cohen et al., 2006).

The researchers sought to determine if the modified CBT-CTG would (a) “reduce distress associated with CTG and in decreasing psychiatric symptoms,” (b) “significant improvement in PTSD symptoms would occur only during the trauma-focused module, whereas significant

improvement in CTG reactions would occur during both the trauma- and grief-focused modules,” and (c) “whether the effect size of CTG improvement within the grief-focused module would be less than the effect size of improvement of CTG during the trauma-focused module” (Cohen et al., 2006, p. 1468).

Children participating in the module were referred to an outpatient child psychiatric program with a specialization in treating childhood trauma and grief. Of the seventy-two original participants, thirty-nine and their caregivers’ completed the 12 session module. The children were aged from six to seventeen and lost significant others through sudden medical condition, accident, homicide, suicide, sudden infant death syndrome, and drug overdose.

Measurements were made through child self-reporting and the caregivers reporting on the children. This was a limitation as there was a concern that the child self-reports were read to them which is not standard procedure for the module. The key components of the CBT-CTG model were maintained throughout the treatment with only the grief module changing from 8 to 4 sessions (Cohen et al. 2006). The treatment proceeded through separate child and caregiver sessions which discussed similar topics. The only difference was the addition of a behavior management component for the caregivers.

Cohen et al. (2006) hypotheses are partially supported. The children made significant positive changes in their CTG, PTSD, depression, and anxiety, whereas, the caregivers show no significant improvement in their depressive symptoms. One reasoning for this is the lack of clinical pretreatment scores. Another possibility for this lack of positive growth is the lack of measurements regarding the caregivers’ PTSD symptoms and personal grief issues (Cohen, et

al., 2006). The major limitation of this research is not having a randomly assigned control group. Other limitations are the sample size, low minority demographics other than African American/biracial, the amount of dropouts, and that there is no follow up. The research shows again that including caregivers in treatment of traumatized children through CBT-CTG can provide positive and that there is a possibility for other programs to be modified to fit within the constraints of community behavioral health if the basic components are held.

MacArthur Story Stem Battery

While Cohen et al. (2006) research focused on the intervention of a trauma-focused treatment model with children and the parents and caregivers improving without current solid measurements, Schechter et al. (2007) researched and measured the caregiver's traumatic symptoms in relation to that of the child's. In this study the caregiver represents the child's mother. The researchers used the MSSB to study the impact of the trauma experienced by the mothers and how the children view themselves and their caregivers two years after a baseline assessment had been made (Schechter et al., 2007). In the original assessment, 41 inner-city mothers with eight to fifty month old children participated while 24 mothers and 25 children agreed to participate in the current study. Caregivers were voluntarily seeking either parenting help and/or assistance with their own emotional difficulties (Schechter et al., 2007).

The researchers were seeking to determine whether the level of the PTSD caused by violence of the caregiver would relate to increased child aggression, hypervigilance, avoidance/withdrawal from conflict, and other negative effects. They also desired to determine whether "narrative incoherence in children's narratives about family relationships

and conflicts assessed with the MSSB two years after the baseline assessments” (Schechter et al., 2007, p. 189). At the time of the MSSB study, caregivers were 32 years old on average and children were between four to seven years old and the majority of caregivers were of Caribbean Hispanic descent. Measurements were taken by caregivers self-reporting, caregivers reporting on the children, and clinician-rated PTSD severity.

The study was conducted through the caregivers meeting with a research assist updating their demographic and treatment history and filling out the self- and child-reporting measurements while the child was brought into a playroom with the clinical psychologist. The MSSB was facilitated blind to any child or family information. The psychologist administered eight story stems reflecting topics of attachment/authority (n=2), family conflict, moral dilemma, attachment (n=2), and moral dilemma. The visit was videotaped and lasted between one to two hours. In response to the hypothesis the following themes expressed by the children were recorded: verbal, physical, and unprovoked aggression; assaulting an adult; injuring self; and escalating conflict (Schechter et al., 2007).

A serious limitation to this study was the absence of a control group. All caregivers, through the original assessment, showed signs of interpersonal violence and PTSD. The use of caregiver reporting of the child’s exposure to violence and the inability to directly measure child maltreatment were other limitations. The researchers were able to find that a caregiver’s traumatic experiences significantly impact a child’s representation of themselves and of others. Schechter et al. (2007) stated that if the caregiver was not a part of the treatment plan, the children will continue to be re-traumatized. This speaks to the necessity of focusing on the

trauma experienced by caregivers when working with their children and how the severity of that trauma may regulate the severity of the child's self-belief and how they interact and respond to others.

Risking Connection

Brown et al. (2011) researched the importance of TIC for both the individual being treated and those providing the treatment as caregivers for children in child congregate care settings. The Risking Connections (RC) model differs from others through the foundation of a constructivist self-development theory (CSDT) which can be adopted throughout agencies as a whole instead of an approach which may focus on specific populations or diagnosis (Brown et al., 2011). The authors researched the process of training employed caregivers regarding their knowledge, beliefs, and behaviors in relation to the trauma suffered by children. The training was facilitated by both RC staff and through a train-the-trainer (TTT) model where the agency's own staff would train.

Researchers hypothesized that participants: (a) "will increase their knowledge of RC concepts from pre- to post-test;" (b) "will improve their beliefs favorable to TIC from pre-Basic training to post-Basic training" (Brown et al., 2011, p. 509); (c) in three Agencies B, C, and D were compared and varied with the agency having the highest clinical level of the agency, TIC awareness and pre-study adoption, and agency facilitating change "that outcomes in Agency B would exceed those in Agency C, while Agency D would have the least favorable outcomes of the three agencies;" and (d) will report more consistent staff behavior in the milieu indicative of TIC from the RC Basic training to the TTT" (Brown et al., 2011, p. 509). Five agencies were

represented and 261 participants completed the program in 12 groups. The majority of the participants were direct caregivers of children and youth with emotional and psychiatric diagnosis in child congregate care settings (Brown et al., 2011, p. 509).

The data collection varied between agencies due to the agency adoption of TIC principles as the program progressed, levels of service and financial backing differences, and how the methods of researching the data itself changed over time (Brown et al., 2011). Another characteristic which was different between the agencies were the training intervention procedures as some agencies used RC Faculty Trainers and others used the TTT method (p. 510). Of the trainees; 68% were women, 44% were listed as direct caregivers with an average age of 38.7 (Brown et al., 2011,). No other demographic information was given. Knowledge, Beliefs, and Behaviors were the main components measured in this study. There were multiple limitations in the measurement process due to a lack of existing measurements before the research, not all agencies performed all measurements, and that the measurements were only collected through self-reporting (Brown et al., 2011,).

While the research was not able to determine the long-term retention of TIC principles, there were positive increases in knowledge, beliefs, and behaviors. The hypotheses were supported by Agency B scoring higher overall than both Agency C and D. Finally, the data suggests that caregivers trained by TTT will increase in the RC components as would those trained by RC faculty (Brown et al., 2011). All staff trained increased their knowledge, beliefs, and behaviors building the TIC principles throughout their agencies. The researchers provided a starting point for agencies employing caregivers to develop TIC principles through TTT sessions.

This has broad implications for diverse behavioral health organizations that employ varying degrees of caregivers while also providing TIC training to supportive and other specific professions.

Child-Parent Psychotherapy

Expanding on previous CPP research, Ippen, Harris, Horn, & Lieberman (2011) sought to explore if the model could be successful with preschoolers who have been exposed to both more and less than four traumatic and stressful life events (TSEs) and their primary caregivers (mothers) compared to a control group including a posttest (one year after randomization) and six month follow up proceeding the posttest. In CPP, both child and parent participate in the treatment. It has been shown to enable children to be more resilient, have a greater cognitive test performance, lessen the symptoms of traumatic stress, behavioral problems, and reduce PTSD. In the parents, it has been shown to increase their ability to provide safe and developmentally appropriate caregiving and reduce PTSD avoidance and improve global symptoms (Ippen et al., 2011).

Ippen et al. (2011) hypothesized compared to a control group that (a) “greater symptom reduction for children who experience four or more TSEs,” (b) “to be efficacious for those with fewer than four TSEs,” (c) “whether the level of child risk influences treatment effects on maternal symptoms” (Ippen et al., p. 505). Inclusion criteria was subject to the child being of age three to five, domestic violence exposure as dictated by the Conflict Tactics Scale two as reported by the mother, and that the father figure no longer lived with the dyad if he was the violent component. Of these, 39 girls and 36 boys with their mothers participated (Ippen et al.,

2011). The dyads were randomly assigned to CPP or the comparison group which received case management monthly and individual treatment referrals for the mother and/or child. The CPP progressed through one hour weekly sessions for 50 weeks (on average the dyads completed 32 sessions). At one year following the randomization the dyads were assessed and then six months later received a follow up when the mothers completed the Child Behavior Checklist and Symptom Checklist-90 (Ippen et al., 2011).

The hypotheses were well supported. In both the <4 and 4+ TSEs, the CPP showed greater improvement than the comparison group for both the children and the mother. The 4+ TSEs children showed greater reduction in PTSD, depression, and behavior problems. The <4 TSEs children showed significant PTSD symptom improvement while the comparison group showed no improvement. The <4 TSEs CPP and comparison mother groups both had significant PTSD improvements, but depression was reduced after treatment only through the CPP group. In the 4+ TSEs CPP mother group, there was a significant reduction in PTSD and depression, whereas the comparison group received no reduction (Ippen et al., 2011). At the six month follow-up, the 4+ TSEs CPP group continued to reduce depression in both the child and caregiver.

While indicating positive results, the Ippen et al., (2011) study is not without limitations. The small sample size and maternal report appear to be a common theme in many of the articles reviewed. More importantly, the use of strictly <4 and 4+ TSEs over that of severity, frequency, and type is an issue which should be researched further to obtain whether or not the CPP efficacy holds true. Despite these limitations, there are significant implications for multiple programs regarding the use of CPP for both the children and their primary caregiver.

This study provides further research opportunities for agencies to expand their treatment to include the caregivers building from the wealth of results of this and previous CPP studies (Ippen et al., 2011).

Child-Centered Play Therapy compared to Trauma-Focused Cognitive-Behavioral Therapy

Schottelkorb, Dumas, & Garcia (2012) expands on the trauma-focused research of children and their caregivers to include the refugee population. The authors researched the types of trauma suffered by refugee children and why they may not seek help. The immediate needs of the families to find shelter, food, and settling into the new country as well as cultural stigma keeps many from seeking help (Schottelkorb et al., 2012). The stigma especially brings up the importance of including the caregiver as a partner in the treatment process of refugee children.

The researchers hypothesized that children and their parents would report a significant decrease in PTSD symptoms of the children in both CCPT and TF-CBT (Schottelkorb et al., 2012). Trauma-Focused Cognitive-Behavioral Therapy has been established as an evidence-based practice in working with traumatized children and contains parenting skills instructions and parent-child sessions (Grasso, Marquez, Joselow, & Webb, 2011). Child-Centered Play Therapy has been considered developmentally and culturally appropriate and used to allow children to use play to communicate their emotions and thoughts. There has been concern over the use of TF-CBT and refugee population regarding their ability to understand the components and adjustments needed to be made to accommodate (Schottelkorb et al., 2012).

Thirty-one children ages six to 13 participated and were randomly assigned to the two studies. Those participating were rated as full or partial PTSD as designated by the UCLA PTSD

Index for DSM-IV and/or a score in the clinical range from the Parent Report of Posttraumatic Symptoms (Schottelkorb et al., 2012). The majority of children were from the Africa region which later developed into a limitation as the study has a possibility of only being generalized to refugees from Africa (Schottelkorb et al., 2012).

Many modifications had to be made due to the intervention occurring at three elementary schools due to their high number of students classified as English Language Learners (ELLs). Both CCPT and TF-CBT were facilitated through 30 minute sessions. Child-Centered Play Therapy was used twice a week for 12 weeks and TF-CBT was used once a week for nine weeks. Parents in the CCPT model were to receive six 15 minute sessions and in TF-CBT they were to receive again nine weeks of 30 minute sessions (only two to four sessions took place) and three 90 minute parent-child sessions (of which none took place) (Schottelkorb et al., 2012). The difficulty with the parenting session completion was due to scheduling of the therapist, parent, and the interpreter. Of the 31 who participated in the comparison study, 26 completed the follow-up (Schottelkorb et al., 2012).

The authors hypothesized that both models would significantly reduce the severity rating from baseline to follow up and that there would not be a significant difference between the two. In both instances for the child reporting and the parent reporting of the children, met the criteria (Schottelkorb et al. 2012). Not only did this study show that CCPT could be effective in working with traumatized children, but that TF-CBT could be effective in working with refugee children.

A significant limitation and implication for further research was the inability to meet any of

the prescribed parental involvement parameters. Even without the parental involvement in the treatment, both models showed positive child growth (Schottelkorb et al., 2012). This brought up questions of further research regarding both CCPT and TF-CBT in treating children with and without the parent involvement. The researchers failed to address the role the parent plays in stigma reduction and in prioritizing mental health services as noted earlier in the article to the point of making them “feel alone with their grief and distress (Schottelkorb et al., 2012, p. 58).”

The encouragement of school counselors and other faculty and community practitioners working with refugees to use CCPT due to both the possible lack of parental involvement and the symptoms of refugee trauma is a valid implication for further practice based on the research findings (Schottelkorb et al., 2012). This indicates the need for further research on the use of CCPT by caregiver faculty in residential or foster settings where the parents are not available.

Fairy Tale Model

Similar to Brown et al. (2011) in working with children and youth in a congregate care residential setting, Greenwald et al. (2012) primary focus is the trauma-informed training of caregiver staff in a residential treatment facility. The researchers trained clinical and direct caregiver staff in the Fairy Tale model as an addition to an already functioning Positive Peer Culture (PPC) milieu approach in order to add TIC. This study represents the one year evaluation of the Fairy Tale implementation. Greenwald et al. (2012) hypothesized: (a) “post-traumatic stress symptoms will be reduced,” (b) “primary presenting problems will be reduced,” (c) “total time in residential treatment will be reduced,” & (d) “rate of positive

discharges (i.e., to a lower level of care) will be increased” (p. 145).

There were 53 youth participants between the ages of 10-21 as residents of the facility. Of those 53, five were excluded due to limited data (Greenwald et al. 2012). Baseline data was pulled using the Problem Rating Scale (PRS). Of those trained, 18 were social workers who received a total of 13-14 days training over nine months in the Fairy Tale model and received eye movement desensitization and reprocessing (EMDR) training as well. The addition of EMDR does drastically increase the time it takes staff to be trained and the cost. Seventeen direct caregivers were trained in just the Fairy Tale model. The social workers varied greatly on their use of the model due to a sense of competing responsibilities and tended to instead use former therapeutic habits as they continued to become out of practice with the Fairy Tale model. As in the CCPT and TF-CBT model comparison, competing needs keeps many individuals from seeking mental health services (Schottelkorb et al., 2012). The caregivers, on the other hand, used the model frequently and continued supported practice through booster sessions (Greenwald et al. 2012).

The Fairy Tale model is facilitated through the process of training staff by telling a fairy tale and corresponding parts of the story to the eight phases of treatment. The phases of treatment are evaluation; identification, enhancement, and motivation of goals; trauma-informed formulation and treatment; stabilization; identifying and enhancing coping skills; resolving trauma and memories of loss; consolidation of gains; & defining further challenges (Greenwald et al. 2012). The key component to the Fairy Tale model and the reason it is included in this review is the adaptability of the program through how each phase is worked through and

reached due to what will work the best with the individuals served opposed to the need for multiple models depending on the type of trauma experienced by the individual.

A significant limitation to the study was the lack of continuity in the delivery of the phases by the social workers. Another point of limitation is the absence of a control group which may have provided useful data regarding prevention strategies or court judges and the duration of their placements (Greenwald et al. 2012). The findings supported the hypotheses by increasing problem reduction by 34%, reducing the time in treatment by 39%, and doubling the positive discharge rate. The ability of this model to function successfully without needing any exclusion criteria is very positive regarding applications in community behavioral health programs. By focusing on increasing the direct caregivers' TIC knowledge and application, there was a positive and continual use of a Trauma-Informed treatment model.

Parent-Child Interaction Therapy

The latest of the research reviewed is not one which directly seeks to ameliorate symptoms of childhood or caregiver trauma, but has the ability to assist in working with those who have experienced trauma. The research performed by Pearl et al. (2012) differs greatly as compared to the other studies listed above. The Trauma Treatment Training Center (TTTC) at Cincinnati children's Hospital as part of a grant from the Abuse Mental Health Services Administration (SAMHSA) through the National Child Traumatic Stress Network (NCTSN) chose PCIT based on (a) "agency need," (b) "clinical effectiveness," (c) "agency costs and resources," (d) "reimbursement potential," (e) "client population" (Pearl et al. 2012, p. 205). Their purpose was to "develop expertise in implementing evidence-based treatments for traumatized children

in community settings (Pearl et al. 2012, p. 205).” It is also important to note that the NCTSN seeks to increase the services to children who have been traumatized and their caregivers.

Of the 59 clinicians trained throughout eight states, 23 turned in post-treatment data. Of the 154 families who began the session, 53 completed the post-treatment caregiver and child demographic and trauma history measurements (Pearl et al. 2012). The caregivers were given self-report measurement tools for the baseline, mid-, and post-treatment sessions. The majority of children in the program had experienced at least two forms of trauma (Pearl et al. 2012). A significant difference between this type of treatment and others reviewed is the lack of session limits of PCIT. Parent-Child Interaction Therapy is performance-based following the progress of the parent through live coaching sessions.

During the sessions, the parent begins with relationship building skills. When this is mastered they move to command-giving and discipline skills. This is where many facilities had to modify the treatment as some facilities and states had seclusion free policies and could not use time-out or seclusion skills and instead used a loss of privileges system for the children (Pearl et al. 2012). While the modification was in the end useful, this brings up the point that when implementing a new treatment there needs to be oversight as to whether all of the modules are going to be able to be facilitated appropriately without applying undue liability to the facilities. There was also an ethical concern of when the seclusion would be allowed for a facility, should it be used due to the trauma experienced by the children (Pearl et al. 2012).

Fifty of the families completed the pre-and post-treatment Trauma Symptom Checklist for Young Children (TSCYC). The Anger and Post Traumatic Stress-Arousal scales showed large

effect sizes while the Anxiety, Post Traumatic Stress-Intrusion, Post-Traumatic Stress, and Dissociation scales showed medium effect sizes (Pearl et al. 2012). While PCIT was not created to directly address trauma symptoms, it was able to significantly improve the Sexual Concerns subscale and all of the other scales showed improvement as well as defined in the TSCYC.

As with many of the studies, there were no comparison or control groups. There was also a data missing from a number of measurements. There were many dropouts and the researchers were not able to pull sufficient data as to the causes of such limitations. Even with the amount of dropouts, improvement was still shown through the first treatment phase (Pearl et al. 2012). High turnover and an inability to track whether clinicians continued to perform PCIT at other facilities was unable to be tracked and limited the study as well as the high caseload of the remaining clinicians which in turn impeded the caregivers from learning the skills as the PCIT training dictated through not receiving the weekly sessions. Finally, the last limitation was the inability to always use one-way mirrors that may have affected the results.

Despite the limitations and modifications, PCIT was still able to show positive significant results in helping children and caregivers who have suffered trauma. This brought up a question of whether it is necessary to have a therapeutic model which directly seeks to treat trauma symptoms such as Trauma-Focused Cognitive Behavioral Therapy, or if using a model as PCIT with the addition of coping skills could work for some children (Pearl et al. 2012).

DISCUSSION

The purpose of this review was to evaluate various types of trauma-focused models for caregivers of children who have experienced trauma. The journal articles reviewed have focused on the importance of including the caregiver as part of the treatment of the child. Through this systematic review of empirical research of trauma-focused models for caregivers who function as the parent or a direct care staff member at a residential or congregate care facility, five of the seven published articles have shown a need to include the caregiver directly in the services provided to further increase the healing of the trauma-suffering child. Schechter et al. (2007) and Schottelkorb et al. (2012) did not show a direct significant need for caregivers to participate in the services. Even with minimal caregiver participation there was still a belief in the research for continued caregiver involvement. This opens further research opportunities for other caregiver-based models as to whether or not the participation itself causes the significant improvements or if there are other unknown variables in the trauma-focused treatment. Moreover, the review found the following: (a) The majority of studies reviewed used self-measurements and listed this as a limitation; (b) the sample sizes were small for all but one of the studies; (c) caregivers directly involved in the trauma-focused aspects have a significant impact on those served; (d) All but one of the studies utilized a comparison group; and (e) whether the caregiver is a parent or direct care faculty, significant positive impact on children who have experience trauma will result.

Limitations and Challenges

A significant limitation of the research was the inclusion of multiple definitions of a

caregiver. The purpose of this review was to compare several trauma-focused models which focused on the caregiver. A second limitation was the lack of research on trauma-focused models for caregiver faculty which made the review more difficult to directly compare and contrast with models for biological caregivers. To this limitation it should be noted that even with the various caregiver definitions used, when the faculty were the direct caregivers of the traumatized children, there was a greater positive result as in the case of parental caregivers (Greenwald, Siradas, Schmitt, Reslan, Fierle, & Sande, 2012).

Finally, the lack of information regarding the training of social workers and others in non-direct caregiver capacity led to an underutilization of the trauma-focused models (Greenwald et al., 2012). The lack of information provided by this research as to what other specific treatment the social workers used and if that was trauma-focused or if they had prior TIC training which was utilized in their treatment of choice was not discussed as a limitation of the research. The research also left out if the caregivers had another form of treatment to fall back on as the social workers did or if the Fairy Tale model was all that they were taught.

Future Research Opportunities

As noted by researchers, there is a need for not only a trauma-focused model which can be used for multiple forms of caregivers, but one that can be modified appropriately and ethically to provide similar treatment (Cohen, Mannarín, & Staron, 2006; Brown, Baker, & Wilcox, 2011; & Pearl, Thieken, Olafson, Boat, Connelly, Barnes, & Putnam, 2012). The adaptability of the Fairy Tale method to various presenting problems opens up the possibility of further research of its use in other residential populations (Greenwald, Siradas, Schmitt, Reslan, Fierle, & Sande,

2012). This adaptability of trauma-focused models has major applications as in the study utilizing the CBT-CTG model and the RC training for expanding the use of trauma-focused and TIC models for a variety of behavioral programs and residential entities previously thought unable to participate due to session limit and/or training constraints (Cohen, Mannarin, & Staron, 2006 & Brown, Baker, & Wilcox, 2011).

The need for caregivers in trauma-focused models set up to include caregivers in the treatment has been questioned in two of the articles researched (Schechter et al., 2007 & Schottelkorb et al., 2012). This opens up opportunities for future research in the use of trauma-focused caregiver models in situations where biological caregivers may not be present due to incarceration or placement in a residential setting or in a school setting. This may also be an important research opportunity to examine models for use in scenarios when the children were excluded from previous research due to lack of involvement from parents. Other research opportunities may be present in the use of the reviewed trauma-focused models for direct caregivers in other residential settings for developmentally delayed adults or geriatric populations.

Further research on specific trauma experiences over generalized trauma experiences may better define which trauma-focused model will provide the most significant improvement for various populations. Specific environmental factors were not addressed in the reviewed research and would provide a person-in-environment perspective as to the extent an individual's environment or economic status effects their trauma and treatment. A limitation to the majority of articles reviewed was the lack of comparison studies. Researching

comparisons of the trauma-focused models using the Ippen et al. (2011) system of case management and individual treatment may show what the addition of trauma-focused elements specifically treats over that of other models.

Implications for Social Work

Greenwald et al.'s (2012) depiction of the lack of Fairy Tale model usage provided by social workers lacks supporting documentation of whether or not they were using other trauma-focused techniques. This limitation does not remove the use of trauma-focused caregiver models by social workers, but brings up an implication for social workers to further expand their repertoire through the use these services. The research does bring up a significant point of needing to determine if the trauma-focused model will need to be modified to work within the client-focused self determination realm of social workers before applying the techniques to clients. Schottelkorb et al. (2012) further backs this point through their work with the refugee population who tend to be more concerned with meeting their basic needs than seeking behavioral health treatment. Further attention to this may lend a better understanding of how social worker applied trauma-focused treatment to specific traumatic life events can function alongside working with clients where they are in their treatment instead of abandoning the trauma-focused treatment altogether.

APPENDIX

Table 1: Overview of Empirical Literature

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Feature	Citation			
	<i>Cohen, Mannarin and, Staron (2006)</i>	<i>Schechter, Zygmunt, Coates, Davies, Trabka, McCaw, Kolodji, and Robinson (2007)</i>	<i>Brown, Baker and Wilcox (2011)</i>	<i>Ippen, Harris, Van Horn and Lieberman (2011)</i>
Type of Model	Modified CBT-CTG	MacArthur Story Stem Battery	Risking Connection	Child-Parent Psychotherapy
Length of Model	12 Sessions	8 sessions at 25-30 minutes each	3-Day Basic Training and 16-18 Hour Train the Trainer	60 minutes for 50 weeks
Sample Size	39 Children and 39 Caregiving Adults	24 Mothers and 25 Children	261 Residential, Foster, & Outpatient Staff	75 Children & their Mothers
Design	Quasi-Experimental with no comparison group	Quasi-Experimental with no comparison group	Quasi-Experimental with no comparison group	Experimental with random assignment
Measures	Child self-report measures: (a) UCLA/BYU EGI (b) Children's PTSD Symptom Scale (c) Moods and Feelings Questionnaire (d) Screen for Child's Anxiety Related Emotional Disorders Parent measures: (a) UCLA PTSD Index for DSM-IV Parent Report Version (b) Child Behavior Checklist (c)	Demographic and Treatment History Questionnaire Maternal Trauma Measures: (a) Demographic and Treatment History Questionnaire (b) Life-Events Checklist (c) Brief Physical and Sexual Abuse Questionnaire Maternal symptoms of PTSD: Structured Clinical Interview	Knowledge was measured through the RC Curriculum Assessment Beliefs were measured through the Trauma-Informed Belief Measure Behavior was measured by the Staff Behavior in the Milieu	Traumatic and stressful events, semi-structured interview for diagnostic classification DC: 0-3 for clinicians, Child Behavior Checklist, Clinician-administered PTSD Scale, Symptoms Checklist-90 Revised

Participant Eligibility	PTSD Diagnostic Scale (d) Beck Depression Inventory-II (e) Client Satisfaction Questionnaire-Parent and Child Versions Children ages 6 to 17 with CTG and parents or caretakers	Child adverse life events and dissociative symptoms: Life-Events Checklist Voluntary participation from baseline study	Administrators, Clinicians, Direct Care, Nurses, Teachers, Other) Initially RC Professional Trainers and others skilled in trauma professionally	Children Age 3-5 and Mothers
Facilitator Requirements	At least master's level therapist trained in CBT-CTG	Psychologist	Initially RC Professional Trainers and others skilled in trauma professionally	CPP: At least Master's in Clinical Psychology. Individual Psychotherapy: PHD Clinician
Caregiver Involvement Findings	Parents involved in all sessions Positive: child & parent-reporting showed improvement for CTG population	Mothers involved in all sessions Mothers with PTSD can affect their children to point of heightened anxiety and dissociation	44% caregivers Trainees knowledge, beliefs and behaviors were positively impacted	Mothers must remain in program May retain positive aspects seen during treatment if focusing on both caregiver and child
Limitations	No comparison or random control condition and only self and parent measurements	No control group of mothers. Use of maternal reporting. Unable to study child maltreatment.	No tracking of knowledge retention. Use of self-reporting only.	Small sample size

Table 1

<i>Feature</i>	<i>Citation</i>		
	<i>Schottelkorb, Doumas and Garcia (2012)</i>	<i>Greenwald, Siradas, Schmitt, Reslan, Fierle and Sande (2012)</i>	<i>Pearl, Thieken, Olafson, Boat, Connelly, Barnes and Putnam (2012)</i>
Type of Model	Child-Centered Play Therapy compared to Trauma-Focused Cognitive-Behavioral Therapy	Fairy Tale	Parent-Child Interaction Therapy
Length of Model	CCPT: Two 30 Min sessions weekly for 12 weeks TF-CBT: Nine 30 min sessions	Social Workers: 13-14 days in 9 months plus 10 day EMDR Caregiver: 3 monthly full-day & 3 bimonthly half-day trainings.	Performance-based therapy instead of session limits Clinician training limited to a five-day workshop
Sample Size	38 Children	53 Children and 70 Direct Care Workers	23 Clinicians and 53 Families completed post data
Design	Experimental with random assignment	AB	ABA, Single-Subject Design
Measures	UCLA PTSD Index for DSM-IV and Parent Report of Posttraumatic Symptoms	Problem Rating Scale, A multi-variant mixed model ANOVA to determine effects, independent sample test to determine duration of treatment, and a 2 x 2 contingency table was used to compare discharge types.	Childhood Trust Events Survey-Caregiver Version, UCLA PTSD Index, Dyadic parent-Child Interaction Coding System-III, Eyberg Child Behavior Inventory, Child Behavior Checklist, Parenting Stress Index-Short Form, and Trauma Symptom Checklist for Young Children
Participant Eligibility	Full or partial PTSD or score on Parent Report of Posttraumatic Symptoms	In residential facility during certain time frame	Family: 1-5 English-speaking, non-psychotic, and sexual abuser families from Clinician caseload Clinicians: Master's degree or higher

Facilitator Requirements	<p>All therapists: 2nd or 3rd year master counseling students with training in working with refugees, interpreters, and trauma suffered.</p> <p>CCPT: 1-credit play therapy course or 10 hr training.</p> <p>TF-CBT: online training & TF-CBT Certified Therapist supervision</p>	Social Workers and direct care workers in residential facility	PCIT Trainers
Caregiver Involvement	<p>CCPT: six 15 min parent sessions</p> <p>TF-CBT: Parent participates in nine 30 min weekly sessions</p>	Direct caregiver full involvement in training	Family participation throughout
Findings	Both reduced PTSD symptoms even when parents were minimally involved.	Findings support model with target population.	Child behavior, trauma symptom, dissociation, and caregiver stress were all improved
Limitations	Small sample size, results not generalized, higher TF-CBT attrition, no control group, lack of parent participation, limited resources, and use of students.	No control group, individual therapy delivery was not constant, and lack of PTSD symptom impact data.	No randomization, missing data, high attrition rates, lack of trainer supervision, limited drop-out explanations, clinician turnover, appropriate space, and time constraints

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