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Research article

Child–Adult Relationship Enhancement (CARE): An evidence-informed program for children with a history of trauma and other behavioral challenges☆

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ABSTRACT

Child maltreatment impacts approximately two million children each year, with physical abuse and neglect the most common form of maltreatment. These children are at risk for mental and physical health concerns and the ability to form positive social relationships is also adversely affected. Child Adult Relationship Enhancement (CARE) is a set of skills designed to improve interactions of any adult and child or adolescent. Based on parent training programs, including the strong evidence-based treatment, Parent–Child Interaction Therapy (PCIT), CARE was initially developed to fill an important gap in mental health services for children of any age who are considered at-risk for maltreatment or other problems. CARE subsequently has been extended for use by adults who interact with children and youth outside of existing mental health therapeutic services as well as to compliment other services the child or adolescent may be receiving. Developed through discussions with Parent–Child Interaction Therapy (PCIT) therapists and requests for a training similar to PCIT for the non-mental health professional, CARE is not therapy, but is comprised of a set of skills that can support other services provided to families. Since 2006, over 2000 caregivers, mental health, child welfare, educators, and other professionals have received CARE training with a focus on children who are exposed to trauma and maltreatment. This article presents implementation successes and challenges of a trauma-informed training designed to help adults connect and enhance their relationships with children considered at-risk.

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Introduction

In 2012, the U.S. Department of Health and Human Services, Administration for Children and Families, reported that over two million children were documented as founded reports of child maltreatment; approximately 680,000 were unique victims. Physical abuse and neglect is the most common type of abuse (U.S. Department of Health and Human Services, 2013). Annually, reports indicated approximately 400,000 children are in the foster care system (Child Welfare Information Gateway, 2013), which presents additional challenges. When children experience maltreatment, psychosocial development is negatively impacted, especially regulation of emotions, control of impulses and behaviors, and the ability to have healthy and happy relationships (Putnam, 2006). Each year, several million children are referred for services to address these consequences of child maltreatment (U.S. Department of Health and Human Services, 2013). The referrals for services are generally for one of two reasons: (1) prevention of future child maltreatment referrals or (2) improvement in the conditions that brought the child to the attention of the child welfare system.

In recent years there has been a rapid proliferation of both evidence-based and promising treatments for children with maltreatment and trauma exposures. The Kaufman Best Practices Project (2004) identified three practices which meet standards for a strong evidence-based intervention: Trauma-Focused Cognitive Behavioral Therapy for Child Sexual Abuse (now extended to include all forms of abuse), Abuse-Focused Cognitive Behavioral Therapy for Physical Abuse (renamed: Alternatives for Families: A Cognitive Behavioral Therapy) and Parent–Child Interaction Therapy (PCIT). As Chaffin and colleagues note (Chaffin et al., 2004), parent (caregiver) involvement and parent training are included in most all referred services. The three best practices all include parents/caregivers.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), with multiple randomized trials documenting effectiveness for children aged 3–18 and their caregivers (Cohen, Mannarino, & Deblinger, 2006, 2012; de Arellano et al., 2014), includes both parallel and joint sessions. Parental participation is seen as central to recovery. Parenting skills are addressed early in treatment and throughout, and psycho-education for both parent and child address posttraumatic symptoms and behaviors. Other standard trauma components for both parent and child include cognitive processing, affect regulation, exposure therapy, sharing of the trauma narrative, and safety planning. Research shows that TFCBT reduces posttraumatic stress and improves caregiver support for their traumatized children (de Arellano et al., 2014).

AF-CBT, Alternatives for Families—A Cognitive Behavioral Therapy (Kolko & Swenson, 2002), targets children aged 5–17 and their caregivers/parents with histories of child physical abuse and concurrent emotional abuse such as verbal aggression. Children and parents are seen both individually and together, and components for each include psycho-education about the impact of abuse and conflict, cognitive processing, and affect regulation training. Children are taught social and interpersonal skills and supported through exposure work about traumatic events, and parents are trained in non-violent child behavior management strategies. In joint sessions, caregivers clarify their responsibility for the abuse and families develop safety plans. Families practice improved communication skills and non-coercive family problem-solving skills in sessions and with home practice assignments. Research comparing AF-CBT with routine community services showed lower rates of parent child physical abuse recidivism and improvements in child externalizing behaviors (Kolko & Swenson, 2002).

Parent–Child Interaction Therapy (PCIT) is an evidence-based treatment developed to decrease externalizing behavior problems in young children (2–7 years of age) and to improve the parent–child relationship (Brinkmeyer & Eyberg, 2003). An assessment-driven intervention, PCIT is unique in parent management training and therapy programs as it involves direct coaching of the parent and child. Studies have consistently found improvements in child behaviors reported by caregivers on standardized measures (Chase & Eyberg, 2008), reductions in parenting stress (Harwood & Eyberg, 2006) and depression (Ho, 2004), and generalization to school settings (Funderburk et al., 1998) as well as to improvements in behaviors of untreated siblings (Brestan, Eyberg, Boggs, & Algina, 1997). Recent data suggests PCIT can be effective in reducing some forms of childhood anxiety (e.g., separation anxiety disorder; Choate, Pincus, Eyberg, & Barlow, 2005). Although not specifically developed as a treatment for children with a child abuse and neglect history, a randomized controlled trial of PCIT with children ages 4–12 years and their parents/caregivers with history of physical abuse/neglect, examined recidivism rates of child physical abuse at two years post-treatment. For the PCIT-only condition, the study found recidivism rates at less than twenty percent, which is significantly less than the norm (Chaffin et al., 2004). Furthermore, Pearl and her colleagues have found a reduction in trauma symptoms in children who received PCIT (Pearl et al., 2012). These findings have increased the demand for PCIT in agencies, which serve children with a history of child abuse and neglect.

Although these three programs are being widely disseminated across the United States, many children who are at risk for maltreatment or at risk for mental health problems do not present or qualify for mental health services. Behavior problems also place children at risk for stress in any child–adult relationships, including problems which result in failed foster care placements (Rubin, O'Reilly, Luan, & Localio, 2007). A void existed for services to enhance the child–adult relationships for these children, and potentially reduce risk for maltreatment or other behavioral and relationship concerns; CARE (Child–Adult Relationship Enhancement) was the created to fill this void.

Parent Training Programs, PCIT, and CARE

Evidence-based parent training programs such as Helping the Noncompliant Child (Forehand & McMahon, 1981), Incredible Years (Webster-Stratton & Reid, 2003), Parent Management Training—Oregon Model (Forgatch, Bullock, & Patterson, 2004) and Parent–Child Interaction Therapy (Eyberg & Robinson, 1982) have many attributes in common. Each works to