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Community Outreach Program for Child Victims of Traumatic Events

A Community-Based Project for Underserved Populations

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Behavioral and cognitive behavioral treatment interventions have been shown to be effective for the treatment of trauma-related problems in children. However, many children and families in need of treatment do not have adequate access to services and do not have access to effective, evidence-based treatment services. The present article describes a community-based program that provides in-home and in-school treatment services, based on behavioral and cognitive behavioral approaches to addressing trauma-related emotional and behavioral problems in children.

Keywords: underserved populations; community based; ethnic minority; child maltreatment; trauma

Meta-analyses of interventions for children and adolescents have indicated that behavioral interventions have better outcomes than...
other types of psychological interventions for a variety of childhood disorders and behavior problems (Weiss & Weisz, 1995; Weisz, Weiss, Han, Granger, & Morton, 1995). Kazdin and Weisz (1998) outlined treatments for child and adolescent anxiety, depression, delinquency, and oppositional and aggressive behaviors. They gave special emphasis to particularly promising treatments, focusing on the most thoroughly investigated interventions. Behaviorally based interventions were heavily represented in their review, reflecting the consistently positive outcomes achieved with behavioral programs.

A common aspect of behavioral and cognitive behavioral therapy for children is parent training (Cohen, Mannarino, Berliner, & Deblinger, 2000). Because parents have a responsibility for shaping their children’s environments and determining consequences for their behavior, parents can learn to make the interventions used in therapy a regular part of the child’s life. By including parents in the treatment process, therapists help to ensure that children are getting responses at home that are consistent with those that they receive in therapy. In fact, the findings of a randomized controlled trial, examining the efficacy of cognitive behavioral interventions, suggest that the direct involvement of nonoffending parents in the therapeutic process may be particularly critical in helping children who have suffered sexual abuse and overcome depression and acting out behavior problems (Deblinger, Steer, & Lippmann, 1999). In addition to targeting children’s symptoms, cognitive behavioral interventions (e.g., exposure, cognitive processing, stress management techniques) are used to address parents’ own distress related to their children’s traumatic experiences (Cohen et al., 2000).

Some treatments go beyond office-based family sessions with parents to include sessions conducted at the child’s home or school. Kazdin and Weisz (1998) highlight some of these community-based treatments in their review. Community-based interventions may enhance the generalizability and durability of treatment benefits by making changes in the client’s natural environment (Henggeler & Borduin, 1990; Henggeler, Schoenwald, & Pickrel, 1995; Kashani, Jones, Bumby, & Thomas, 1999; Rosqvist et al., 2001). When children are taught new skills while in familiar settings, they may learn and apply them more readily than if those skills had been taught in an
office setting. In addition, community-based interventions often draw parents and teachers into the therapy process, making them active agents of change by training them in therapeutic skills. Community-based work also may have the added benefit of increasing accessibility to children who would otherwise be unable to receive services.

Maltreated children from ethnic minority groups are an example of a population that are underserved and may benefit from community-based services. Although the topic of racial or ethnic differences, with regard to treatment, has been anecdotally discussed in the literature, racial and ethnic differences in treatment outcomes for trauma-related sequelae in children of ethnic minorities have not been supported by research to date (Cohen, Deblinger, Mannarino, & de Arellano, 2001). Unfortunately, research evaluating the efficacy of treatment interventions for trauma-related sequelae, specifically in children from ethnic minority backgrounds, is scarce. In fact, treatment-outcome research for psychological disorders, in general, among ethnic minority populations is quite limited (U.S. Department of Health and Human Services, 2001). More research is needed to evaluate treatment efficacy in different ethnic groups and determine whether differential treatment effects exist. Despite the fact that research is currently limited, all efforts should be made to provide ethnic minority populations with the best available treatment interventions possible. The surgeon general’s report on ethnicity and mental health (U.S. Department of Health and Human Services, 2001) emphasizes this point with its repeated recommendation that, in the absence of interventions normed on or validated with ethnic minority samples, strong efforts should be made to use existing evidence-based treatment interventions. These should be implemented with an awareness of potential cultural issues, and their effectiveness should be carefully evaluated.

In addition, recent research has suggested that offering home- and school-based services to such underserved populations is one method of improving treatment outcomes in this group. For example, Coatsworth, Pantin, and Szapocznik (2002) reported on the efficacy of a community-based treatment program (Familias Unidas), that employs modifications in the environment (e.g., helping parents build a strong support network) as a method of reducing the risk of problem behaviors in Hispanic adolescents. Also, multisystemic therapy,
another community-based treatment program, has been shown to be efficacious in reducing delinquent behaviors in both rural African American and urban White adolescent populations (Huey, Henggeler, Brondino, & Pickrel, 2000).

The article provides a description of a community-based treatment program that provides trauma-focused treatment for underserved child populations. The program has a strong emphasis on empirically supported treatments for children, including a variety of behavioral and cognitive behavioral therapeutic interventions that have received the most empirical support for the treatment of the negative sequelae of childhood maltreatment (Cohen et al., 2000). The typical components of these treatments are exposure, cognitive reframing, coping skills training, and parent-focused interventions (Cohen et al., 2000). For example, interventions that emphasize exposure techniques have been found to reduce posttraumatic stress disorder (PTSD) symptoms in victimized children (Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger et al., 1999). In addition, cognitive interventions have successfully reduced depression and PTSD symptoms in sexually abused children ranging in age from 3 to 14 years old (Cohen & Mannarino, 1996, 1998). Given the heterogeneity of presenting symptomatology and the wide range of problems with which families present, the treatment approach is not standardized, but, rather, is tailored to the specific needs and environments of children and their families. Nonetheless, several treatment techniques that have demonstrated efficacy in other populations are commonly used with most families, including psychoeducation, relaxation training, exposure, and cognitive coping skills. In addition to these treatment techniques, significant case management has been necessary to more adequately address the needs of participants in our program.

**PROGRAM OVERVIEW AND PATIENT POPULATION**

With the assistance of a Victims of Crime Act Grant, the Community Outreach Program–Esperanza (COPE) was established to provide services to children victimized by crime and who are from traditionally underserved populations (i.e., ethnic minority and rural). The
The majority of children are African American or Hispanic (mostly Mexican). The COPE clinic receives referrals from a variety of sources, including child protective services, children’s advocacy centers, law enforcement, family and criminal courts, schools, and medical and mental health agencies throughout the community. Most families are from economically disadvantaged backgrounds, live in rural communities, and receive public assistance. Children’s ages range from 2 to 17 years old, with the majority of children receiving treatment falling between the ages of 6 and 12 years old. For very young children and those with serious cognitive delays, parents have greater involvement in treatment. Conversely, older adolescents in treatment tend to be more the focus of treatment, with less involvement from parents. Children are most often referred for emotional and behavioral difficulties secondary to physical abuse, sexual abuse, exposure to violence (i.e., community or domestic), and other types of violent crime. Children who have recently immigrated have also reported military- and guerilla-warfare-related events (e.g., encountering the corpse of an individual who had been executed) and other traumatic events that occurred while crossing the Mexico-United States border.

**CHALLENGES TO COMMUNITY-BASED WORK**

As discussed in the introduction, the benefits of community-based treatment as provided by COPE have been numerous and include enhancing generalizability of treatment gains, facilitating the learning process of new skills in a more applicable environment, encouraging participation of caregivers and teachers, and increasing accessibility of services to underserved populations (Henggeler & Borduin, 1990; Henggeler et al., 1995; Kashani et al., 1999; Rosqvist et al., 2001). These factors highlight the advantages to providing treatment to children and their families in their communities; however, this approach has not been without its challenges. A primary concern when traveling into the community is the safety of the therapist. Some of the crime victims with whom we work live in historically high-crime areas. In addition to community violence, domestic violence or otherwise high conflict homes can increase potential risk to the safety of the therapist.
A number of safeguards are taken in the program to reduce such risks, including logging travel plans and carrying a mobile phone; traveling in pairs; conducting visits during daylight hours; and, in the event that the home environment is not considered safe, meeting in alternate locations (e.g., schools, churches, community centers).

Once these safeguards are in place, observing such high-crime neighborhoods or problematic home circumstances can be pivotal in understanding the context in which the client’s difficulties have developed and in identifying realistic and optimal intervention strategies to implement. For example, behavioral activation techniques (i.e., having the youth engage in pleasant activities, such as playing a game of basketball or riding a bike with a friend) are implemented for maltreated children who are exhibiting depressive symptoms. On observing the level of potential danger in the child’s neighborhood, the therapist may instead help the child become involved with supervised activities, such as sport camps at the local YMCA or Boys and Girls Club.

An additional challenge to providing services outside of the office is making the environment amenable to teaching and implementing therapeutic interventions. Every effort is made to work with children and families in an area that is free from distractions and as private as possible. This can be an especially important issue when discussing sensitive information, such as when practicing exposure techniques. Similarly, ensuring confidentiality can also be a cause for concern when coming to a child’s home or school. Neighbors or schoolmates often ask questions about the reason for regular visits from a therapist or doctor. The therapist can role play these situations with the child or family, so as to assist in developing a response with which the children and family are comfortable and confidentiality is better protected.

Last, there are several other environmental factors with which therapists are not usually confronted in traditional office-based therapies. Although most homes are safe and clean, our therapists occasionally have dealt with aggressive dogs, roach and flea infested houses, children with lice, intoxicated visitors, vehicle problems (e.g., getting stuck on a muddy road), and a number of other unexpected factors that are not usually covered in most training for mental health professionals. Creativity, flexibility, and finely honed problem-solving skills are
assets to engaging in community-based provision of services. Again, however, exposure to these environmental factors illustrate the importance of such community-based services. For example, observing an insect infestation problem in the bedroom of a client helped one therapist understand a factor that may have been contributing to her sleep difficulties. Thus, engaging in problem-solving on how to improve living conditions in such cases can impact certain areas of treatment outcome. Group supervision may be one way to help therapists learn how to assess and proceed with unexpected and perhaps threatening situations by increasing awareness of such situations and providing opportunities to brainstorm on solutions. This team approach, in which ample supervision, consultation, and support are available, can be critical to maintaining morale of service providers and evaluating various trouble-shooting suggestions. Despite these occasional challenges, reaching children who likely would not otherwise receive services to cope with the consequences of victimization is worth the additional efforts.

ASSESSMENT

The assessment battery used at COPE is comprehensive but flexible. The intake assessment includes structured clinical interviews and self-report measures. The child and primary caregiver are initially interviewed together but are also interviewed individually. Detailed, behaviorally descriptive questions are used to collect information about the child’s victimization experiences, reactions of significant others, and protective actions taken so far. A set of screening questions are then used to assess for other potentially traumatic experiences, including sexual abuse, physical abuse, witnessing domestic violence, car accidents, and natural disasters. Caregiver interviews also include questions about the family environment and the child’s school performance and symptoms. Depression and PTSD modules from structured (e.g., Diagnostic Interview for Children and Adolescents; Reich, 2000) and semistructured interviews (e.g., Schedule for Affective Disorders and Schizophrenia in School-Aged Children; Kaufman et al., 1997) are also helpful for clarifying and quantifying diagnoses.
In addition to the clinical interview, caregivers are asked to complete a number of self-report measures. The child behavior checklist (CBCL; Achenbach, 1991) may be completed by caregivers and teachers to provide information about internalizing and externalizing behaviors. Children ages 8 and older complete the trauma symptom checklist for children (TSCC; Briere, 1996) to provide information about symptoms often associated with traumatic experiences. Both the CBCL and the TSCC are well normed, reliable behavioral checklists that have been validated on a variety of samples. The CBCL has been examined across at least 12 different cultures (Crijnen, Achenbach, & Verhulst, 1997, 1999) and the normative samples were representative of the contiguous United States on variables including ethnicity and socioeconomic status (Achenbach & Rescorla, 2000, 2001). In the TSCC normative sample, African American and Hispanic respondents were overrepresented at 27% and 22% of the sample, respectively (Briere, 1996). The measure has also been used in a number of studies with ethnically diverse samples (Lanktree & Briere, 1995; Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2001). Caregivers also complete the Interpersonal Support Evaluation List (Cohen, Mermelstein, Kamarck, & Hoberman, 1985) to provide the clinician with a brief indicator of the caregiver’s general social functioning and system of support. This is an important construct to consider because the participation of caregivers is quite important to the success of behavioral treatments for children.

Although the intake assessment described above is relatively structured, other measures (e.g., Child Depression Inventory; Kovacs, 1980) and additional interview questions may be added, depending on the child’s presenting problems. Regular assessment continues throughout treatment and may include measures of depression, school performance, or other problem areas. Conducting behavioral observations in the home whenever possible is invaluable to providing a realistic, ecologically valid behavioral intervention. A therapist can gain information about the structure of the home (e.g., availability of space for placing a child in time out), the composition of the home (e.g., number of children in the home, extended family members or friends that spend significant amounts of time in the home), how the home
functions (e.g., schedules, discipline practices, level of family conflict), and other valuable information to be considered when working with the family. In addition, classroom and daycare observations are also conducted as needed to gather information on level of functioning across domains. A clinician other than the child’s therapist may conduct the observations, taking appropriate notes, to enhance the validity of the observations obtained. These observations are often more informative than caregiver or teacher reports for understanding the antecedents and consequences to behaviors, patterns of behavior, and other useful data.

Assessment in the home can be useful when working with ethnic minorities because it makes it easier to include family members, who are often involved in the care and, thus, behavioral management of children, as additional reporters. For example, family, including immediate and extended family members, often play an important role in Latino culture (i.e., *familismo*). By going into a home of a Puerto Rican child for assessment of disruptive behaviors, a therapist was able to gather information from the child’s grandmother and two aunts, whom were all very involved in the caretaking of this client. Furthermore, through this format, the therapist was able to gather information on both the child’s behavior and the mother’s follow-through on intervention strategies as treatment progressed.

**TREATMENT PLANNING**

Based on assessment results, an individualized treatment plan is developed. At this time, treatment rationale is discussed with the family, which we have found to be critical for compliance in treatment, both for the child and the parents.

Rather than following a protocol-driven approach, all treatment plans are individualized and sensitive to potential developmental, gender, ethnic, and other individual issues. The interventions selected are based on the identified problems and consist of an integration of evidence-based approaches specific to the identified problems. For example, some form of exposure-based intervention (Cohen & Mannarino, 1993; Deblinger & Heflin, 1996; Foa, Rothbaum, Riggs,
& Murdock, 1991) would likely be included for a child who is experiencing significant levels of distress and avoidance as a result of trauma-related cues. Similarly, a young child who is evidencing significant noncompliant and oppositional behavioral problems may receive components of Parent-Child Interaction Therapy (Hembree-Kigin & McNeil, 1995; Urquiza & McNeil, 1996). For an overview of treatment-outcome research for child abuse, physical and sexual, the reader is referred to Saunders, Berliner, and Hanson (2001).

**PSYCHOEDUCATION FOR PARENTS AND CHILDREN**

All children and families receive information regarding the prevalence of victimization, common consequences to victimization, and potential treatment options. Providing prevalence information can help individuals become aware of others who have experienced victimization and makes children and their family members feel less alone. Frequently, children and families are surprised to learn how high the prevalence rates are for various types of victimization. Discussing common consequences of victimization can help to address worries and fears regarding the reactions that children and other family members may be having in response to the child’s victimization. For example, physiological hyperarousal and reexperiencing can potentially be very distressing and may cause fears of going crazy. For example, an 8-year-old African American boy who witnessed a shooting had significant sleep disturbance and would wake up startled almost nightly to the sound of a gunshot (i.e., nightmare ending in a gunshot), but he did not report it for several weeks because he thought he was “losing his mind” and was “going to need surgery to get the sound out of his head.”

This initial stage of treatment is also the ideal time to lay the groundwork for treatment rationales by discussing in lay terms a behavioral conceptualization of how clients’ symptoms are likely to have developed and the mechanism through which treatment can help. For example, Mowrer’s (1960) two-factor theory (see Keane, Zimering, & Caddell, 1985; Kilpatrick, Veronen, & Resick, 1979) can be presented in layman’s terms as an explanation of avoidance of
trauma-related cues and how therapy can help. Children and parents can be taught that children can experience a fear response to anything that reminds them of a traumatic event, even when the reminder is harmless (e.g., fear of the dark developing in a child who was sexually assaulted in the dark), and that they, as a result, may avoid reminders of the traumatic event to avoid becoming distressed. They can also be taught that avoidance of reminders of a traumatic event will not make them go away permanently and will, in fact, enhance the fear response (e.g., keeping the bedroom light on at night may increase child’s fear of dark). Parents and children are then advised that, through therapy, the child can better learn skills to help them cope with the distress associated with the reminders (e.g., through coping skills-building) and to reduce the level of distress that is caused by the reminders (e.g., through exposure-based treatment). For a more detailed example, please refer to Deblinger and Hefflin (1996). It is of course important to gear explanations to individuals’ developmental and educational levels. Helping the child and parents to achieve this understanding can improve compliance, especially with interventions that can be distressing, such as exposure.

When presenting rationales for treatment with ethnic minority families, it is important to consider whether particular strategies are consistent with their cultural belief systems. Treatment interventions may conflict with traditional coping strategies or beliefs. For example, exposure strategies targeting trauma-related memories may be particularly difficult for patients whose belief system supports avoidance coping rather than disclosing traumatic memories in graphic detail. In cases such as this, acknowledgement of and particular sensitivity to this discrepancy, although providing a strong rationale for the treatment intervention, are necessary to increase the likelihood that patients will engage in treatment.

PARENT TRAINING

Alterations in children’s emotional or behavioral functioning can be very distressing to parents and have the potential to alter the ways in which parents respond to their children. Parents may feel that their
children have been through a lot and may not want to be too strict with them. For example, a parent may give in to a child’s tantrum more easily when, prior to the victimization, the parent would have ignored or not conceded to such behavior. Again, with regard to ethnic minorities, depending on the cultural views on parenting, explanations of parent-training strategies and treatment goals may be framed in terms of concepts and phrases with which the family is familiar. For example, because the concept of *respeto* (respect) was an important value for one Latino mother, the therapist framed the goal of parent training as increasing respect rather than decreasing noncompliance.

Similarly, parents may inadvertently reinforce trauma-related behavior problems with negative attention. Presenting a thorough explanation of behavioral principles of learning, as applied to how behaviors (both trauma and nontrauma related) are learned and maintained, is often helpful in teaching parents more appropriate parenting skills. Breaking down behavioral patterns into this level of analysis can sometimes help reduce the negative valence of children’s trauma-related emotional or behavioral difficulties (e.g., sexualized behaviors) and may allow parents to approach behavioral problems more objectively.

A number of parent-training programs exist based on operant and social-learning theories, which teach parents to reinforce desirable behaviors and punish undesirable behaviors (Barkley, 1997; Clark, 1985; Deblinger & Heftlin, 1996; Forehand & McMahon, 1981; Hembree-Kigin & McNeil, 1995; Kazdin, 1997; Kazdin, Siegel, & Bass, 1992; Patterson & Guillion, 1968). Interventions are drawn from these approaches to help address noncompliant, oppositional and other undesirable behaviors secondary to child victimization. Parents are taught to attend to and reinforce appropriate behaviors, through techniques such as positive social reinforcement (e.g., attention) and token economies. This can often be difficult because parents sometimes more easily attend to undesirable behaviors. Strategies to reduce undesirable behaviors include selective ignoring (especially for apparent attention-seeking behaviors), time out, behavioral substitution, and response costs-rewards plans. Parents are also taught to direct and redirect children using clear instructions and consistent follow-through.
In-home parent training can offer a number of potential advantages over office-based treatment. Assessing behavior problems and parental responses in vivo, rather than simply relying on parent or child report, allows the therapists to develop interventions and provide instruction that is more specific to the needs of each family. As with parent-child interaction therapy (Hembree-Kigin & McNeil, 1995), therapists can help parents to implement parenting strategies in their homes and help problem solve as challenges develop. Therapists can teach strategies by didactic instruction, informal discussion, modeling, and coaching. Conducting parent-training in the home is particularly helpful when working with families from different cultures. It permits a more thorough assessment of environmental factors and potential cultural considerations. For example, while conducting parent training with a Hispanic father, it became clear that his parenting interactions with his daughter were significantly affected by his mother, who lived in the home with them and frequently interrupted and corrected him. Based on these observations, both father and grandmother became involved in the parent-training exercises, which served to improve the efficacy of the intervention. Going to the home and observing directly may lend credibility to the therapist’s assessment of the situation, perhaps decreasing concerns that the therapist, who may be of a different ethnicity than the family, cannot understand the family’s perspective.

Providing treatment in a family’s home is invaluable to implementing more comprehensive interventions when there is significant disruption in the home and when the caretakers’ resources are limited. For example, a grandmother who was feeling overwhelmed caring for her 6- and 8-year-old grandsons was helped over several sessions in the home to implement a behavior plan (sticker chart), which she had trouble implementing during office visits. Several problems were identified and successfully addressed during the home visits, including poor visibility of the chart (folded in a wall cabinet), sporadic use of the chart (placed 2 to 3 days worth of stickers at a time), and inconsistent giving of rewards for achieved goals. Although she continued to have difficulties consistently using the chart, troubleshooting the above problems increased her grandsons’ attention to the chart, and several target behaviors improved.
Similarly, addressing behavior management strategies in a school environment can be very useful in addressing disruptive behaviors that are demonstrated in the classroom as well as home. Advantages to the therapist for school-based treatment include (a) the ability to communicate with outside reporters, including teachers, principals, and guidance counselors; (b) the opportunity to conduct behavioral observations that involve authority figures other than the parent as well as peers; and (c) the occasion to meet with the child in an environment in which the parent is not present. In a case of two brothers, ages 6 and 8 years old, who were seen at school, teachers who had become quite frustrated and resigned to the children’s disruptive behavior seemed to become reinvested in applying behavioral principles as the therapist’s visibility at the school increased. The teachers seemed encouraged by the therapist’s willingness to collaborate with them on setting treatment goals and designing ways to implement interventions.

**RELAXATION TRAINING**

In many trauma-focused therapies, clients are asked to repeatedly talk about the traumatic events that they experienced. This process can produce quite intense emotional responses, including fear and anger. Relaxation techniques may be used in and out of therapy sessions to modulate conditioned responses of anger or fear to trauma-related triggers (Deblinger & Heflin, 1996). When angry or fearful responses are appropriate to the situation, children can use relaxation skills to manage their emotions, thus allowing them to choose helpful behaviors to deal with the situation.

One basic relaxation skill often used with adults is diaphragmatic breathing. Engaging in diaphragmatic breathing allows one to reduce sympathetic arousal in the nervous system, lowering heart rate, breathing rate, and other physiological reactions associated with anger and anxiety. The same skill can be easily taught even to younger children. A balloon may be used to explain how the lungs expand and fill with air during inhalation and then deflate with exhalation. To begin, have the child select a small toy to use in the exercise. Have the child recline in a chair or lie on his or her back, placing the small toy on
his or her belly. Then, instruct the child to inhale and exhale slowly, trying to make the toy rise on the belly with the inhalation and fall with the exhalation. Children should be encouraged to practice this skill regularly when they are feeling more calm so that they are prepared to use it in situations when they are feeling nervous, scared, or very angry.

Children can also learn progressive muscle relaxation (PMR) as a way of dealing with tension. With younger children, the intervention may be embedded in a story. For example, a story of a turtle encountering several other animals can focus on a different muscle group with each aspect of the story. At different points in the story, the turtle is startled by an encounter with another animal and quickly pulls his head and legs inside his shell, a signal for children to tense their muscles and pull themselves into a ball. Then, after the turtle realizes that the other animal is friendly, he stretches out each leg individually. The story continues, including opportunities for children to tense and release the muscles in their hands, neck, and so forth. Other, more simple images to teach PMR include having the child first act like a robot (i.e., walking stiffly with tense muscles), then changing into a rag doll (i.e., collapsing loosely to the floor). Because the goal is to teach the child how to become relaxed and calm, it is important that the environment in which the PMR is taught is a quiet and nondisruptive one. By providing treatment in the home, the therapist is able to help the parent identify specific rooms and times of day that are ideal (or not ideal) for implementation. For example, in one COPE case, a therapist had assigned a mother of three young children to practice the turtle relaxation with the oldest son every night. It was only when the therapist went to the family’s home that we realized the mother was attempting to implement the relaxation protocol in the area of the house used by the younger children to play with their toys. Thus, the mother often was interrupted in her administration of the relaxation protocol because she was reprimanding the siblings for interrupting. With this knowledge gained, the therapist was able to help the mother identify a better time to do the relaxation protocol with the client (e.g., after the siblings went to bed).
COPING SKILLS

Coping skills allow children who have been victimized to regain some sense of control over their reactions to their victimization experiences. The majority of the coping skills we use are cognitive and behavioral in nature and have been influenced by many authors (Beck, 1995; Deblinger & Heflin, 1996). The cognitive model (Beck, 1995) can assist children and their parents in addressing the dysfunctional thoughts they have about the traumatic event. For example, a parent may need to address the thought, “My child is permanently damaged”, and replace it with a more rational thought, such as “My child will probably always remember what happened, but she can still recover and have a happy life” (Deblinger & Heflin, 1996). In addition, while assessing and addressing dysfunctional thoughts, it is important to consider the family’s cultural belief system. For example, a Hispanic family, seen through the COPE clinic for problems secondary to sexual abuse, presented particular challenges when addressing beliefs about the victims’ loss of virginity as a result of the abuse. The child’s father was so distressed about this that he began avoiding interactions with his daughter for fear that she would notice his level of distress and become more upset herself. To address the family’s concerns, their religious beliefs about the importance of virginity prior to marriage had to be assessed and integrated into the intervention. Clearly, the intense emotions that are often associated with victimization experiences may feel overwhelming to children and their parents. As a result, children can typically benefit from some psychoeducation to learn to label and express emotions appropriately. Parents may need assistance in managing their own feelings about their child’s experiences and in responding appropriately to the child’s expressed emotion. Another aspect of coping skills that can help to enhance a child’s social functioning is problem-solving skills. Even young children can be taught to think through and consider alternative ways to address potentially troublesome situations. Many of the children in the COPE program live in rural areas or small towns where news of child-abuse cases spreads quickly, particularly when perpetrators are being criminally prosecuted. It may be important to help children develop
responses to questions from their peers and siblings about what happened to them.

One of the first steps in implementing cognitive therapy is to help the client distinguish between thoughts, feelings, and behaviors (Beck, 1995). With children, this can be accomplished through the use of the three-channel model (Saunders & Berliner, 1996). Children are presented with drawings of three television screens, each with a drawing representing a different channel: thinking, feeling, and doing. For example, the thinking channel may have a drawing of a child with a bubble above her head that contains the thought, “The other kids don’t like me.” The feeling channel could have a drawing of a child crying, and the doing channel might show the child sitting apart from the other children. As with other cognitive therapies, clients are encouraged to focus on changing their thinking as an effective way of modifying their reactions in the other two domains. Once the child has selected which channel to change, he or she can draw a picture illustrating the new approach or new way of thinking about the problem situation.

Children need to learn to appropriately identify and label feelings so that they can learn appropriate ways to cope with these feelings. An early focus of treatment should be to help children accurately label the four basic emotions: happy, sad, angry, and scared. Children may be asked to give examples of situations in which they would feel each of these emotions. They may also be asked to practice facial expressions that demonstrate each of these emotional states. Using a mirror can make the exercise more fun for the child. The therapist may play along and act out the facial expressions and other emotionally expressive nonverbal behaviors with the child. Fear and anger are common responses to victimization, and this exercise provides a good opportunity for the therapist to validate and normalize the child and parents’ responses to the child’s victimization.

In working with ethnic minority clients on the identification and labeling of feelings in therapy, it is important to be aware of and sensitive to cultural norms. For example, although we may we emphasize the importance of maintaining eye contact when being assertive with others about feelings (e.g., “I feel” statements), in some cultures, direct eye contact is observed as a sign of disrespect. This delineates
yet another valuable benefit to home-based services where the therapist is provided with an opportunity to directly observe to what extent the family is acculturated, including cultural norms with regard to feeling expression.

**EXPOSURE**

Exposure-based treatment has been used successfully for trauma-related symptoms secondary to combat exposure (Keane, Fairbank, Caddell, & Zimering, 1989) and adult sexual assault (Foa et al., 1991). As noted previously, the rationale behind exposure-based approaches is based on classical and operant conditioning theories of learning. Mowrer’s (1960) two-factor theory of classical and operant conditioning of fear response has been applied to responses to trauma (Keane, Zimering, & Caddell, 1985; Kilpatrick, Veronen, & Resick, 1979). The first factor addresses the process through which a neutral stimulus becomes associated with a fear-producing unconditioned stimulus and, consequently, also becomes a fear-producing conditioned stimulus. For example, a child who was sexually assaulted in the dark can exhibit a conditioned fear response to being in the dark. Although being in the dark in and of itself is not dangerous, it elicits a fear response, as did the sexual assault.

Although there are several different exposure methods, prolonged (flooding) and gradual exposure have received the most attention with trauma victims. Prolonged imaginal exposure involves having the child imagine they are experiencing the traumatic event as realistically as possible, across several treatment sessions, until there is a reduction in distress associated with the traumatic memories. In addition to exposure sessions that the therapist conducts with the child during therapy visits, the child can be taught to practice exposure techniques in between sessions, such as listening to an audiotape of the previous in-session exposure exercise (Foa et al., 1991). A useful rationale for children is comparing the process to repeatedly watching a movie that is scary initially, but becomes less scary after many viewings (Falsetti & Resnick, 1995). A child’s ability to visualize scenes in detail should be assessed prior to using prolonged or any
other imaginal exposure technique. Prolonged exposure may be difficult to use with victimization histories that do not easily lend themselves to imagining a discrete event (e.g., chronic abuse). In addition, it can be difficult to get some children, especially young children, to visualize a distressing event in great detail for a prolonged period of time. Another challenge to using this type of exposure is the limited control the therapists can sometimes have when providing treatment in a community setting, which has to be free from distractions, comfortable, and private for a prolonged period of time to properly conduct prolonged exposure.

A less intense alternative to prolonged exposure that has been used for the treatment of anxiety disorders, including specific phobias, is systematic desensitization (for a review, see King, Hamilton, & Ollendick, 1988; Silverman & Rabian, 1994). Although children may be more willing to engage in a more graduated exposure hierarchy, it may be difficult to effectively construct and follow a graduated fear hierarchy to some traumatic events and with more complicated trauma histories. For example, children may have difficulty remembering the correct sequencing of discrete parts of a traumatic event to achieve a graduated hierarchy, or they may not be able to focus on one discrete part of a larger traumatic event. These conditions are necessary to allow the child to experience a limited amount of distress at each step of the hierarchy and to allow for habituation to the hierarchy item.

In addition, children are generally not motivated by long term therapeutic benefits. Thus, knowing that the top of the hierarchy may include talking about the most upsetting traumatic experiences, they may inadvertently create greater avoidance of the entire therapy process. Therefore, it is generally not advisable or necessary to outline the entire hierarchy in collaboration with young clients. Rather the therapist may formulate the hierarchy as therapy proceeds, sharing the proposed next level of the hierarchy with the child and parent as they prepare to take that step.

Gradual exposure has been used to address some of the concerns and potential limitations of prolonged exposure and systematic desensitization (Cohen & Mannarino, 1993; Deblinger & Helfin, 1996). It combines elements of both techniques by providing graduated exposure to trauma-related cues (e.g., memories of abuse experiences).
The therapist encourages the child to deal with less anxiety-producing stimuli initially, gradually working up to more distressing stimuli, as determined by an initial assessment and on-going observations and reports from the child and his or her caretakers. In general, it should be noted that most children find it least anxiety provoking to think and talk about a traumatic event in the abstract. Thus, for many children, a comfortable first step in the gradual-exposure hierarchy would be describing or defining the identified trauma in general terms. Deblinger & Heflin (1996), for example, recommend starting with a question and answer game in which children are asked simple questions, such as “What is child sexual abuse? Why don’t children tell about sexual abuse? Why does sexual abuse happen?” These questions do not require children to talk about their own personal experiences, but they allow them to habituate to the anxiety provoked by the general subject. In addition, these types of questions provide therapists with opportunities to praise children’s accurate knowledge and effort and may also reveal children’s cognitive distortions and developing dysfunctional beliefs. To help children talk about increasingly anxiety-provoking aspects of their personal traumatic experiences, the therapist will need to continue to structure the sessions and specifically plan at least two potential gradual exposure exercises. Given a choice, children will likely choose the exercise they view as less anxiety provoking. Encouraging children to choose between two potential exposure exercises seems to not only increase their likelihood to cooperate but may also encourage a sense of control and collaboration in the therapeutic process.

Interventions that include gradual exposure as a central component have been found to reduce PTSD symptoms in sexually abused children (Cohen & Mannarino, 1996; Deblinger et al., 1999). Gradual exposure has been effectively used in our community-based program as well. Its structure lends itself to the flexibility needed to deliver treatment interventions in home and school settings. Given that a prolonged state of arousal is not necessary to achieve habituation as in prolonged exposure, treatment sessions can be shorter if necessary and interruptions can be worked around when present. Gradual exposure’s flexibility also allows it to be administered to a broader range of children. For children who have difficulty talking about the traumatic
event, because of developmental delays, shyness, and so forth, gradual exposure sessions can be facilitated in a number of ways, including use of drawing, puppets, and dolls (Deblinger & Heflin, 1996). Children can be asked to draw the location or the perpetrator of the abuse, and then they can be encouraged to talk about the drawing. This is especially useful for younger children whose verbal skills may be less developed. Although the majority of exposure-based techniques used for trauma-related fears are imaginal, opportunities to conduct in vivo exposure are also possible and can greatly facilitate reductions in conditioned fear responses. For example, a 10-year-old Hispanic boy, who had been sexually assaulted by an extended family member in his bedroom, was refusing to sleep in his room and reported a high level of anxiety when entering his room, especially near his bed where the assault took place. After practicing relaxation training and imaginal prolonged exposure at his school, the therapist also conducted in vivo exposure in his home and soon helped him to sleep in his own bed again.

**SUMMARY AND CONCLUSIONS**

Although challenging to implement at times in community settings, evidence-based interventions (e.g., behavior and cognitive behavioral therapy) have been used effectively to address emotional and behavioral sequelae to victimization in children. It is further noteworthy that these interventions have resulted in treatment gains for children of Hispanic or African American ethnicity, supporting the surgeon general’s recommendations to use evidence-based treatment interventions with individuals from ethnic minority groups (U.S. Department of Health and Human Services, 2001). Although no formal outcome data is available at present on COPE, it is noteworthy that as clients have improved and been discharged, there has been an increase in the number of referrals to the program. The program has resulted in an increased number of referrals for children in the community since it was first developed. As with any client, individual factors, such as cultural issues, can be included in the treatment to possibly improve rapport with and compliance from the family. Creativity and flexibility
are key factors in being able to provide effective treatment across various settings (e.g., school, home, office) and to individuals from various cultures (e.g., as determined by ethnicity, poverty, geography).

The treatment interventions described above are not intended to be an exhaustive list for the treatment of trauma-related problems in children, nor are they presented in sufficient detail to implement easily. For this reason, the reader is referred to Saunders et al. (2001) for a more comprehensive review of evidence-based treatment interventions for child maltreatment. In addition, because many of the active components of the interventions described in this article were modeled after the approach described by Deblinger & Heflin (1996), the reader is referred to their book for a more detailed description of these interventions.

Until more research is available evaluating treatment effectiveness within ethnic minority groups and comparing differential treatment effects across ethnic groups, existing evidence-based treatment approaches should be used to provide ethnic minorities with the same opportunity to receive the most current, state-of-the-art treatment available. Thus far, behavioral and cognitive behavioral interventions have enjoyed the most research support and logically lend themselves to application across various cultural groups, assuming universal behavioral principles of learning. However, in the absence of validation studies, special care must be taken when applying these interventions to individuals from various backgrounds to be certain to address their special needs, as determined by contextual variables, such as ethnic background, nationality, geographic region, religion, family background, and so forth. Only with a thorough consideration of these environmental influences can any treatment intervention be implemented effectively.

REFERENCES


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