Harnessing the Power of our Most Valuable Partners: Caregivers in Child Trauma Treatment

KELLY KINNISH, PHD & KELDRIC THOMAS, PHD
GEORGIA CENTER FOR CHILD ADVOCACY
ATLANTA GA

About Us/GCCA

- GCCA/CAC 1987
- Primary focus is Child Sexual Abuse and Commercial Sexual Exploitation (also other trauma, esp. Witness to Homicide)
- Approx. 800-1000 families served per year, 2 locations

GCCA Clinical Services

- TF-CBT
- PSB-CBT
- AF-CBT
- Let’s Connect

Our Orientation toward Caregivers

- Strength-based
- Holistic
- Culturally responsive
- Posture of curiosity
- Remoralization
- Goal of first session is a next session
Who is a Caregiver?

Although most often a custodial biological or adoptive parent, may be any adult who has a significant caregiving role in child’s life:

- Biological parents
- Adoptive parents
- Foster parents
- Relatives providing Kinship Care
- *Milieu staff
- *Case Workers, Mentors, teachers, other nontraditional partners in treatment (aid in treatment)

Key Points

- Caregivers are often critical determinants of child wellbeing following trauma - Caregiver functioning, emotional response, establishment of physical safety, social-emotional support, promotion of positive coping, etc. contribute to positive outcomes specifically including lower post-traumatic stress symptoms in children.

Caregiver Superheroes

Key Points

- Caregiver engagement is an ongoing, interactive, dyadic and systems-based process, beginning before a caregiver attends a session, continues throughout treatment and may be impacted by a number of individual, relational, contextual, and socio-cultural factors, including caregiver trauma history and symptoms; history of maltreatment or other safety threat to the child; cultural beliefs, community norms, and family values (healing, help-seeking, therapy, systems, sharing of personal, family, and community matters, etc.)

Key Points

- In treatment, caregivers are important agents of change, sources of support, partners in the transfer of skills from the therapy office to the “real world,” instruments in challenging maladaptive cognitions, and the foundation for sustaining improvements beyond treatment completion.

Key Points

- Caregivers often don’t know their power or how to use their “weapons” - Opportunities abound to strengthen caregiver contribution to child wellbeing in trauma treatment
Why is it important to engage and involve Caregivers?

Because kids can’t drive themselves to therapy...

Caregiving Factors, Child & Caregiver Outcomes - Research

- Trauma Treatment Participation
- Trauma Impacts
- General Child-Caregiver Impacts
Caregiver Trauma impacts

- Parent psychopathology, poor family functioning
- Parent trauma reactions, distress, PTS symptoms
- Parent support
- Parent coping, esp. modeling of avoidance coping
- Changes in parenting practices
- Parent trauma-related cognitions (esp. negative attributions)

...associated with child outcomes

Andrew and Katrina

Significant association between child hurricane exposure, parent distress, and negative child psychological outcomes
La Greca, Silverman, Vernberg, & Prinstein, 1996
Scheeringa and Zeenah, 2008
Kelley et al 2010

SCUD Missile Attack Laor, Wolmer & Cohen, 2011

6mo, 30mo, 5yrs (107 families, 81 at 5yrs)
- Child and mother reactions/functioning highly correlated, esp. younger children
- Family cohesion strongly associated child well-being, esp. displaced
- Mother’s capacity to “control mental images” related to own symptoms and child’s symptoms
- Caregiver avoidance assoc. with child PTS

Motor Vehicle Accidents Marsac et al 2014

243 children 8-17 years old with injuries (bike, pedestrian, car)
Child coping, child perceptions of parent coping assistance and parent report at 1 and 6 months
- 90% reported that their parents encouraged returning to routines, 74% that their parents used distraction, 66% that their parents offered emotional processing
- Children were more likely to use emotional regulation when parents helped with emotional processing
- More likely to use distraction when parents used distraction to help them cope

Maladaptive Cognitions, Negative Appraisals and Attributions
Parent appraisals of alienation and permanent change associated with later PTSS in children who experienced the death of a sibling (Morris et al, 2013)

Parental reports of disaster-related altered cognitions and behaviors associated with child PTSS after post natural disaster (Cobham and McDermott, 2014)

Negative post-traumatic cognitive appraisals in a children account for up to 60% of the variance in PTSS following MVA (Stollard and Smith, 2007)

Changes in caregiving practices...
What is communicated when parents do not maintain parenting structure?

Brisbane Storm Nov 2008 (Cobham and McDermott, 2014)

School-based screening - 874 elementary school children (ages 8-12 years) and their parents following a “severe storm of cyclonic proportions”

- Parents rated changes in parenting (more difficult to let their children do things on their own, more protective, emphasize to be more careful)
- Altered parenting related to child PTSS when parents reported altered disaster-related cognitions and behaviors. (“Avoid talking about or having anything to do with the storms”)

9/11

Children of mothers who endorsed anxious patterns of communication (“too upset to explain anything” “didn’t know what to say”) following 9/11 had higher PTSD (Wilson et al 2010)

Caregiver Impacts

- Caregiver shared trauma experiences (DV, MVA, Natural Disasters, Witness Homicide)
- Caregiver similar trauma history (e.g. CSA)
- Vicarious trauma and distress associated with child’s trauma, maladaptive cognitions, guilt, shame, blame, fear, anger
- Secondary Stressors
  - Investigation, systems—LE, Medical, MH
  - Economic impacts, Housing instability
  - Injuries
  - Loss of support, isolation, relational disruptions

Caregiver Experiences and Impacts
Caregiver Impacts

- Parent trauma, distress → Improve Coping
- Reactions to child’s trauma → Normalize/process reactions
- Secondary adversities → Resources and case mgt. support

So...
Provide information, support, safe containment
Instruct and support parent coping (and modeling to child)

Caregiving Factors, Child & Caregiver Outcomes - Research

- Trauma Treatment Participation
- Trauma Impacts
- General Child-Caregiver Impacts

Caregiver Treatment Participation Impacts

**Evidence that treating/including parent is important**

- Decreased behavioral and depressive symptoms in child
- Decreased depression and abuse-specific distress in caregivers

(Deblinger 1996; Cohen et al, 2004; Deblinger et al, 2011)

How do we engage and involve Caregivers?
Caregiver Engagement

What do we mean by engagement?

Engagement = Participation, getting started

Engagement = Buy-in; more than just showing up/dropping off, active participation themselves and active support of youth

Engagement = Supporting healing process outside of therapy

---

Clinician responses to working with caregivers*

- "I have to focus on the child/victim"
- "If this child had a different parent, they'd be okay"
- "Parents complicate things"

---

Caregiver Engagement

Significant engagement challenges

Caregiver cognitions related to:
Self-blame
Child blame
Own trauma experiences

---

Caregiver Engagement

Significant engagement challenges

Distrust of system and authority figures
Beliefs about mental health, therapy, healing
Prior unsuccessful treatment experiences—Do not believe intervention will help
May have not previously been included or welcomed in treatment

---

Caregiver Engagement

Significant engagement challenges

May have very limited resources
May have many other responsibilities (other children in care, aging/disabled relatives, work/business, etc.)
Am I bringing my child back here?

Yes

Lady at the front desk was nice
They asked about my challenges getting there and helped me figure some things out
They made the experience as comfortable and welcoming for my partner and I
They asked what my biggest concerns were and helped me with them right away

No

Am I bringing my child back here?

Yes

No

Am I bringing my child back here?

YES

Nobody looked like me
They assumed I had a car
He asked a bunch of questions that did not seem all that related to what's going on
I'm not sure this is going to be helpful

No

Engagement Pitfalls: When Engagement Goes Wrong

Confrontation: Challenging “dysfunctional” or “distorted beliefs” we don’t understand or without context

Negative Processes: Comments and behaviors that can be interpreted as judgmental, critical or blaming

Assumptions: Working from own perceptions of the relationship and treatment satisfaction and not inquiring about the youth’s and Caregiver’s perceptions

Therapist Centricity: Assessing treatment progress only through observation

Rigidity: Trying to make the youth and family fit the model rather than making the model fit the youth and family

4 Critical Elements of the Engagement Process (MAH, 2004)

1. Clarify helping process for youth AND Caregiver
2. Develop foundation for a collaborative working relationship
3. Focus on immediate practical concerns
4. Identify and problem-solve around barriers to help seeking

Engagement Strategies across Levels

Individual (Caregiver)
Relational (Therapist-client dyad)
Organizational (Agency, Practice, CAC)
Socio-cultural
Caregiver-Level Strategies

Invite Strengths (Search and name) into the room
- Past successes, in-the-moment reflections, journey up to this point

Invite Aspects of Self into the room
- Affect & Cognitions
- Engage cultural sense of self
- Social location—pathways of healing and supports
- Beliefs about healing resources (supports/practices/strategies)

Caregiver’s Relationship to:
- The presenting concern
- Formal systems (i.e. previous treatment) & informal systems of support

Caregiver-Level Interventions

Explore the Caregiver’s understanding of why this has happened?
- “Devil is just trying to attack her”
- “There are some bad people who mean her no good”
- “I don’t know. But I do know now we get to stop the curse.”

Ask about Caregiver’s journey
What are they already doing to support their sense of resilience?
- Rituals, traditions, supports, healing practices

Understand the behavior and its context
https://www.youtube.com/watch?v=O3TNCYo6-Bc

Caregiver-Level Interventions

Make the case for Caregiver participation in treatment
Connect therapy world to their day to day life.
Amp them up (Tell them they’re important)
- “You are a giant. How did you grow so tall?”
- “Talk to me about a really difficult time for you all. How did you make it”.

Relational

Therapist-Caregiver alliance is important!
- Agreement on Goals
- Agreement on Tasks
- Personal Bond of reciprocal positive feelings (Horvath & Luborsky, 1993)
*Can Develop in parallel with treatment
*Can Shift Throughout therapy

Relational Strategies

What would therapy success look like?
How does therapy fit with other supports in their life?
What could therapy accomplish that would be most meaningful to their life?
Provide some client and caregiver-related conceptualization and treatment rationale
Make therapy immediately useful (i.e. Early change research)
Solicit Caregiver feedback as early and often as possible (formal measures and/or informal check-ins)

Contextual

Concrete:
- Child Care, Appointment Hours, Transportation, Cost/Insurance, Location

Perceptual:
- Stigma of Seeking Help, Waste of Time, Past Negative Experiences

McKay et al. (2001)
Contextual Strategies

Organizational Policies
- Reducing Wait Times, Reminder phone calls/text messages/alerts, Partnering with agencies in different locales and/or of different types, Open Scheduling, Cancellation or Late fees, Flexible Hours, Education on therapy process
- Charging clients a small amount/deposit*

Diversifying the therapy space
Open exploration about barriers
Responding proactively to the Political Climate (GCCA 2016 Story)

Socio-cultural

Awareness of cultural constructs is important
- Faith, Race, Gender, Sexual Orientation, Language, Size, Class, Views on Death, etc., Stigma of reporting

However, culture is not static. It’s dynamic, it’s nuanced, it’s context-dependent

Decolonize the therapy process
- Acknowledge the role of oppression, marginalization, and intergenerational trauma in client’s lives

Exploring various social ills→ Stories of Resilience
Consider histories between identities and the therapy space

Socio-cultural Strategies

What do other people in their life/community think about/is causing the “trauma/problem”?
How would they describe the trauma/problem to other people in their life

What are some of the most important parts of their identity and how do they make the trauma better or worse?
Implicit Bias (Harvard Implicit Association Test)

Support clients to come up with their own labels and explanations
Integrate a client’s own practices into the therapy process

Intersectionality

All aspects of self (social and political identities) overlap
“Ongoing dialogues and conversations” between different parts of our identity, along dimensions of power and privilege
Most important is individual’s meaning
Common dialogues
- Race and faith
- Sexual Orientation and Faith
- Gender and Size

TF-CBT Parenting and Conjoint Work

TF-CBT

Psychoeducation
Relaxation
Affective Modulation
Cognitive Coping

Stabilization Phase

Trauma Narration and Processing

Trauma Narrative Phase

In vivo Mastery
Conjoint sessions
Enhancing Future Safety

Integration/Consolidation Phase
Parenting Skills and Conjoint Work

**Step one: Explain the rationale for parent inclusion in treatment**

- Not because parent is part of the problem but because parent can be the child’s strongest source of healing
- Child is with therapist only briefly, with caregiver the rest of the week, rest of their life
- Transfer of knowledge and skills from therapist’s office/treatment setting to real world where it matters most

**Step Two: Explain Rationale for addressing Parenting Skills and Behavior Management in TF-CBT**

- Children may have a range of problems following trauma that may impact parenting, especially managing emotions (dysregulation, aggression, inattention and impulse control) e.g. more fights with siblings, problems in school, sexual behavior problems
- Normalize that caregivers may have trouble with behavior management, maintaining typical behavioral expectations, family rules, parent practices (empathy/guilt, caregiver’s own fatigue, distress)
- But it is REALLY important to do so!
Psychoeducation

- Educate about trauma and its impact
- Normalize and destigmatize experiences and response
- Educate about treatment
- Instill hope

Children and their caregivers need this!

Psychoeducation

- Information About Specific Trauma(s)
- Common Client and Caregiver Reactions
- Explain Trauma Reminders
- Educate about TF-CBT

Children and their caregivers need this!

Psychoeducation

Address strategies for managing current symptoms in Psychoeducation:

- Provides symptom relief
- Communicates concerns are understood and respected
- There is hope and value in treatment

Psychoeducation

What are the KEY Goals of Psychoeducation?

You and your child are Normal/Not Crazy
- What you’re feeling/experiencing—normal reactions

You are Not Alone
- You are not the only one this has happened to

There’s Hope
- We know how to help you and your child feel better

Must address avoidance head on

Identify as a symptom of trauma
Predict the problem
Provide concrete strategies and action steps for caregiver
(strength and resilience-focused, “facing our fears,” using and reinforcing analogies)

Rationale for TF-CBT

- Analogies
  - Wound
  - Splinter
  - Glass in foot
  - Backpack, suitcase
  - “Facing your fears”

“We’re just gonna sweep it under the rug”
MI/Decisional Balance? How’s it working?
Tell Caregivers how they can help!

Caregivers often want to help but don’t know what to do. (and may be feeling especially anxious and uncertain)

Relaxation, Affect Expression & Modulation, Cognitive Coping

What does the caregiver already do to support coping? Teach skills to directly benefit caregiver, model for child

Parenting Skills and Behavior Management

What does your child do well? What are you proud of? How do you let your child know?

Parenting Skills and Behavior Mgt.

If you give them nothing else...
Is this a good idea?

Getting Caregiver Buy-in

Critical to get Buy In/Engagement...but NOT easy

Using adult examples to show why these components may be helpful for improving behavior (Boss, Spouse)

- Positive Time
- Praise
- Rewards

Praise and Positive Attention

Or... What do children MOST Want?

Focus on active, consistent praise

- Praise a specific behavior
- Provide praise ASAP after behavior occurs
- Do not qualify your praise
- Provide praise with same level of intensity as (or greater than!) criticism

Appropriate physical affection

Smile, thumbs up, acknowledgement

Encouragement, being fully present—pay attention

Parenting Priorities

- What is the Function of Behavior? (without saying “Function”)
- Giving Effective Commands
- Developmentally Appropriate Consequences
- Following through and Troubleshooting
- Addressing Problematic Sexual Behavior

My way of discipline, my form of discipline has always been really strict, and so she allowed me to see things from a different perspective as far as not changing my way of discipline, but just my way of looking at why I’m disciplining, so that I could have more options, in forms of discipline

And so that helped me a whole lot because I was just kind of a traditional, based upon what I was taught. Of how to discipline, and oh you take everything away, you tell them no, or you whoop ’em.

But it allowed me to listen to what JD would have to say and be able to respect her as a person, and not look at her just as my child but respect her as a person.

...so it helped me go a little deeper into why I was disciplining her and then why I chose those methods and what outcome I wanted to have.
Collateral and Conjoint Work

Collateral or Conjoint? Collateral TO Conjoint
Questionable/Impermissible caregiver
- Abuse history
- Unsupportive, blaming, shaming
- Exhausted caregiver (has given up, responsible for other children, etc.)
- Own untreated trauma, PTSD Symptoms

Red, Yellow, Green light caregivers

TN Conjoint Parent-Child Sessions

GOALS:
• Share trauma narrative
• Address and correct cognitive distortions (child and parent)
• Encourage optimal parent-child communication about the trauma(s)
• Prepare for future trauma reminders
• Praise for progress made

FORMAT OF SESSIONS:
• Meet individually with parent and child prior to joint part of session
• Meet together after child and parent prepared for session

WHEN NOT TO HAVE JOINT SESSIONS:
• Parent unable to provide appropriate support
• Parent continues to be overly emotional in response to child’s traumatic experience
• Child adamantly opposed (evaluate how realistic objections are)

TN Conjoint Parent-Child Sessions

Troubleshooting and Exploring Other Options:
Address hesitancies to share with parent. (Underlying cognitions may be very important)
Who else might be appropriate to include?
Have joint session with parent and child but do not include review of child’s TN - instead focus on general communication, conflict resolution, praising each for what they have done successfully and for persisting with therapy

Address unconventional situations

No Caregiver - Distant Caregiver - Unavailable Caregiver
• Involve (Additional/Alternate) Supportive Adults other than parents
• Other Relatives, Fictive Kin
• Older (Adult) Siblings
• CPS Case Workers, other Care Coordinators, etc.
• Milieu Staff

Be Creative, Flexible, Opportunistic
Work with youth to identify and determine appropriate involvement

Caregiver assistance in correcting/ balancing cognitions

“My family will never be the same.”
“I shouldn’t have told.”
“Everybody blames me.”
“Now my little sister won’t have a dad.”
“It’s all my fault my family isn’t together/everyone is fighting.”
“My dad will never be able to see me the same way again – I’m no this little girl anymore, I can tell everything is different now. He can’t even look at me.”
“Momma cries all the time now. It’s my fault.”
“If I just woulda kept my mouth shut, none of this would have happened.”
Caregiver assistance in correcting/balancing cognitions

Fact-checking –
"Not true – I blame HIM not you"

Balancing –
"It won’t be like it was before but...
...it’s better now because we are safe and not being hurt." (DV)

...But we are together and we will make a new start together." (Natural Disaster)

(Can you see differences in your relationship?)

That makes me want to cry... We had an okay relationship, but we were always butting heads because we’re so much alike. And I was always trying to protect her, not realizing that she was hearing me but she was seeing my actions versus listening to her. I’ve always tried to protect her but I learned through therapy through listening to her, listening to her readings and listening to Maggie, um she was hearing me but she was watching me more than anything.

And not knowing and understanding that I had been through a traumatic situation as well, well a couple of those traumatic situations. And so I didn’t have the healing opportunity that she had. And so mine has just kind of balled up and festered for so long, my actions were completely different than what I was trying to encourage her actions to be and so through this, her being able to tell me, “I heard you but [laughs]. I was watching you. And your actions didn’t line up with what you were telling me not to do or how to do things” [laughs].

And so it pretty much gave me an opportunity to be able to hear her and what she was saying but also be able to tell her, “I wasn’t telling you, I wasn’t being a hypocrite to you, I wasn’t telling you one thing and doing something else, but this is why I was encouraging you to be healed and go through the healing process so that you wouldn’t be my age and still making some of the same based upon the hurt and pain, and the traumatics of an experience.”

Banyard et al (2001)

“The broader literature on parenting interventions from a stress and coping perspective highlights the need to enhance coping and resilience through the adoption of a strengths perspective. We need to find ways to recognize that coping and adaptation are ongoing and to identify and honor what caregivers are already doing, including using resources they have available to them...Interventions with this population need to work against this by assuming that caregivers and their children will present with strengths and competencies, not just problems, and they need to use exercises, homework, and discussion formats that make room for acknowledging and sharing strengths. These components of competence, capacity, and mastery form the basis for interventions that are empowering and that convey a sense of hope for the possibilities of positive change.”

Questions?
Collateral and Conjoint Sessions and Phase-Based Treatment

Goals for Initial Phase
- Establish a working relationship
- Develop understanding of the impact of trauma
- Focus on enhancing positive interactions between caregiver and youth
- Troubleshoot concrete barriers to participation in the treatment process

Goals for Trauma Processing
- Processing and healing attachment disruptions
- Support youth during the trauma narrative and processing phase
- Develop skills for responding appropriately when youth initiates discussion of traumatic events
- Witness and understand the youth’s subjective experience of past traumatic events (if appropriate)

Goals for Integration/Consolidation Phase
- Prepare to support youth’s ongoing processing of trauma impact
- Promote positive, healthy communication between caregiver and youth
- Reinforce the use of structure and developmentally appropriate parenting strategies
- Increase ability to ensure ongoing safety

Caregiver Engagement Strategies
- Provide psychoeducation (as often as needed)
- Focus on enhancing caregiver’s positive coping skills
- Demonstrate empathy for challenging position
- Understanding of past and current parenting choices
- Validate desire to help and protect their child
- Praise to reinforce positive efforts

Major Barriers to Trauma Treatment
- Fear of retraumatizing the child
- Vicarious traumatization
- It won’t work—“Our clients are different”
- “We’re just gonna sweep it under the rug”

Cultural Awareness & Celebration
Previous surgeon general reports have indicated that ethnic minorities are less likely to receive these ‘best practices’
- Previous treatment outcome studies (Cohen & Mannarino; Deblinger et al.) - successful treatment for diverse ethnic and racial populations
- Essential to understand family’s values related to religion, ethnicity, and culture
- Modifications have been developed
  - Core Components are still present
  - Incorporation of culturally relevant, salient, and consistent
  - Culture and storytelling

Dorsey
Diverse Cultural Groups & EBPs: A GOOD FIT

New evidence that EBPs and Cultural Competence may be more complementary than disparate (Whaley & Davis, 2007; Huey & Polo, 2008).

CBT approaches, specifically, have the strongest evidence.

Ethnic minority youth respond best to txs that are highly structured, time-limited, pragmatic, & goal-oriented (Ho, 1992).

Adaptations: Risky if core components are substituted or compromised in favor of untested adaptations (Huey & Polo, 2008).

Maintain EBPs in original form, apply culturally-responsive elements already incorporated into protocol (Huey & Polo, 2008).

Engaging Families in Treatment

Establish common ground/form an alliance
Recognize concrete barriers to participating in treatment
Emphasize importance/primacy of parental role
Be flexible about scheduling
Focus on what parents need and want from therapy
Provide education about psychotherapy (what to expect: it occurs over time, not all at once, etc.)
Address such issues as stigma, cultural concerns, and previous experiences with therapists

Dorsey’s work on the effectiveness of engagement with foster families.

Common Parental Issues in Child Traumatization

Inappropriate self-blame and guilt
Inappropriate child blame
Overprotectiveness
Overpermissiveness
PTSD Symptoms