Journal of Child & Adolescent Trauma (2019) 12:515–528
https://doi.org/10.1007/s40653-018-0244-6

EVIDENCE BASED INTERVENTION

Treatments for Early Childhood Trauma: Decision Considerations for Clinicians

Karin L. Vanderzee[1] · Benjamin A. Sigel[2] · Joy R. Pemberton[1] · Sufna G. John[1]

Published online: 15 December 2018

Abstract

The period from birth to age six represents a time of significant risk for exposure to trauma. Following trauma exposure, children may experience significant negative and lasting psychological, cognitive, and physical effects. Over the last two decades, the demand for and availability of evidence-based treatments (EBTs) for children under the age of six who have experienced trauma has dramatically increased. Three of the most well-supported and widely disseminated EBTs for early childhood trauma are Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Child-Parent Psychotherapy. Increasingly, clinicians are receiving training in more than one EBT. This paper provides an overview of each intervention; presents clinicians with various child, caregiver, and environmental factors to consider when deciding amongst these three EBTs; and applies these considerations to three composite cases.

Keywords Early childhood trauma · Intervention · Toddlers · Preschoolers

Introduction

Early childhood presents an especially risky period of development with respect to exposure to trauma. Annual data from the National Child Abuse and Neglect Data System consistently indicates that children birth to age six are at the greatest risk for experiencing child abuse and neglect (U.S. Department of Health and Human Services 2018) with this age group accounting for 78.5% of all substantiated cases in 2016, the most recent year for which statistics are available. Furthermore, children birth to age six account for approximately 60% of children with direct exposure to domestic violence (Fantuzzo and Fusco 2007). Children birth to age five also are disproportionately more likely than children of other age groups to be hospitalized and die from injuries related to submersion and drowning, burns, falls, poisoning, suffocation and choking (Grossman 2000).

There are significant and lasting psychological, cognitive, and physical outcomes for young children following trauma exposure. Cross-sectional studies of infants, toddlers, and/or preschoolers suggest that traumatized children under age six are at increased risk for developmental delays, lower cognitive functioning, mental health difficulties, and trauma symptoms such as high levels of fussiness, increased crying, sleep disturbance, difficulty regulating emotions and behavior, clinginess and separation anxiety, posttraumatic play, restrictive play or environmental exploration, temper tantrums, and regression from previously acquired developmental skills (Mongillo et al. 2009; Pears and Fisher 2005; Scheeringa et al. 2003). These findings are consistent with prospective studies which find that infants, toddlers, and/or preschool age children exposed to trauma are at risk for deficits in social and daily living skills, internalizing and externalizing problems, cognitive deficits, and symptoms of posttraumatic stress disorder (PTSD; Enlow et al. 2013; Keiley et al. 2001; Scarborough and McCrae 2010).

Fortunately, over the last 20 years, the availability of evidence-based treatments (EBTs) for children under the age of six who have experienced trauma has surged. Along with increasing availability, demand has also increased as some states have recognized the specialized care that is required to

✉ Karin L. Vanderzee
KLVanderzee@uams.edu

[1] Department of Psychiatry, Psychiatric Research Institute, University of Arkansas for Medical Sciences, Child Study Center, 1210 Wolfe Street, Slot 654, Little Rock, AR 72202, USA

[2] Department of Psychiatry, Psychiatric Research Institute, University of Arkansas for Medical Sciences, 4301 W. Markham Street, Slot 554, Little Rock, AR 72205, USA

work with very young children and their families. Increasingly, states are beginning to consider or implement infant mental health endorsements, certifications, and/or higher reimbursement rates for providers who use EBTs to treat children in this age group (Cohen et al. 2013; Zero To Three 2016). Three of the most well-supported EBTs for trauma in early childhood are Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al. 2017), Child-Parent Psychotherapy (CPP; Lieberman et al. 2015), and Parent-Child Interaction Therapy (PCIT; Funderburk and Eyberg 2011). Large-scale dissemination projects have been undertaken to disseminate TF-CBT (Sigel et al. 2013), PCIT (Scudder et al. 2017), and CPP (Joy Osofsky, personal communication, April 16, 2018).

Within our small, mostly rural state, we disseminate all three of these interventions statewide through the Arkansas Building Effective Services for Trauma (ARBEST), a program sponsored by the state legislature to improve outcomes of traumatized children throughout the state through collaboration among the University of Arkansas for Medical Sciences Psychiatric Research Institute; Commission on Child Abuse, Rape and Domestic Violence; and Children's Advocacy Centers of Arkansas. ARBEST, initiated in 2009, trains mental health professionals, child advocacy center advocates, child welfare staff and other stakeholders in evidence-based, trauma-informed practices including TF-CBT, PCIT, and CPP; helps coordinate and support mental health services provided in CACs and in the community for traumatized children; and monitors outcomes for traumatized children and their families. The authors of this manuscript are trainers in at least one of the EBTs disseminated by ARBEST and participate in training therapists throughout our state in TF-CBT, PCIT and/or CPP through in-person trainings and ongoing phone consultation throughout the duration of the training period.

Since 2013, when ARBEST began disseminating more than one EBT, 79 clinicians within our state have been trained in two or more EBTs for early childhood trauma, with many more having been placed on waiting lists to receive training in an additional EBT. Naturally, clinicians routinely inquire as to how to decide which trauma treatment to use. Osofsky and colleagues (Osofsky et al. 2017) have provided guidance for how clinicians may decide amongst CPP, PCIT and a home-based intervention called Attachment and Biobehavioral Catch-up (Dozier et al. 2014), but no such guidance exists for providers who may find themselves choosing amongst TF-CBT, CPP, and PCIT. Given that TF-CBT is the most widely disseminated EBT for childhood trauma with 20 randomized controlled trials completed to date (Cohen et al. 2017), this guidance is necessary. This paper first provides an overview of the three interventions, then offers considerations for clinicians when selecting amongst them, and then applies these case considerations to three composite cases. As such, client names and demographic information have been altered. We close by offering implications for training.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (Cohen et al. 2017) is an evidence-based and manualized treatment for children ages three to 18 who present with posttraumatic stress symptoms related to any type of traumatic event they may have experienced or witnessed. However, it is not necessary for a child to have a full diagnosis of PTSD to participate in TF-CBT. TF-CBT is typically delivered in 12 to 16 weekly sessions. In reviews of research on treatment for children with posttraumatic stress symptoms (i.e., Chadwick Center for Children and Families 2004; Chadwick Center for Children and Families and Child and Adolescent Services Research Center 2018; Saunders et al. 2004; Silverman et al. 2008), TF-CBT was the only treatment given the highest rating (i.e., evidence-based practice) in all of the reviews. Due to TF-CBT's positive outcomes in children with a history of trauma and posttraumatic symptoms, large-scale dissemination is under way across the country through a variety of projects with differing funding sources (Sigel et al. 2013).

For children ages three through five, TF-CBT has demonstrated efficacy in reducing child PTSD symptoms, depression, anxiety, and behavior problems (Cohen and Mannarino 1996; Cohen and Mannarino 1997; Deblinger et al. 2011; Mannarino et al. 2012; Scheeringa et al. 2011). For this age range, TF-CBT has also been shown to improve parenting skills and parental support of the child, as well as reduce parental distress (Deblinger et al. 2011; Mannarino et al. 2012). The therapeutic components of TF-CBT include psychoeducation about trauma; parenting skills; development of relaxation and other coping skills; feelings identification; understanding the links among thoughts, feelings and behaviors; narration of the traumatic event(s) which have been witnessed or experienced by the child and verbally processing associated thoughts, feelings and behaviors; gradual exposure to reminders of the traumatic event(s) in an effort to teach the youth how to manage being exposed to such reminder(s); conjoint caregiver-child work; and enhancing safety/prevention skills. Most sessions are divided equally between the child and the caregiver with the therapist conducting a session with each person alone. However, some sessions are conducted as conjoint sessions in which the child, caregiver, and therapist are all present. TF-CBT is structured and directly focuses on the impact of traumatic stress. It is consistent with the principles of cognitive-behavioral, exposure, and parenting therapies that are widely accepted by mental health professionals.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (Eyberg and Funderburk 2011) is an evidence-based, manualized treatment for children ages two to seven with disruptive behavior problems, including those with trauma histories and/or posttraumatic stress symptoms, and their caregiver(s). The Chadwick Center for Children and Families and Child and Adolescent Services Research Center's California Evidence-Based Clearinghouse for Child Welfare (2018) rates PCIT as "well supported by research evidence," its highest rating.

PCIT has consistently been shown to reduce disruptive behavior problems in children (Herschell et al. 2002; Ward et al. 2016). It has also been shown to improve parenting skills, increase the warmth of the caregiver-child relationship, and decrease parenting stress (Bjorseth and Wichstrom 2016; Danko et al. 2016; Timmer et al. 2005). Timmer et al. (2010) have shown that PCIT decreases both internalizing and externalizing symptoms in children exposed to trauma, indicating that PCIT can help reduce trauma reactions beyond disruptive behavior. Finally, Pearl and colleagues (Pearl et al. 2012) found that PCIT can reduce trauma-related symptoms without making any adaptations to the treatment model.

PCIT is conducted in two phases, both of which use directive therapist coaching to guide the caregiver toward skill mastery in real-time, play-based situations with the child. The first phase, Child-Directed Interaction (CDI), focuses on increasing the caregiver's positive attention skills and strengthening the warmth of the caregiver-child relationship. The second, Parent-Directed Interaction (PDI), focuses on increasing the caregiver's consistent, appropriate use of discipline, using a specialized form of time-out as the contingency for child noncompliance. Each phase is mastery-based rather than time-limited, resulting in varying lengths for PCIT across families, although a typical estimate is 12 to 16 weekly sessions (McNeil and Hembree-Kigin 2010). Each phase begins with a caregiver-only didactic session; all other sessions require both the child and the caregiver(s) to be present, as PCIT is based entirely on dyadic interactions. In addition, the dyad is assigned "homework" in the form of a daily, five minute play time in which the caregiver intensively practices the PCIT positive attention skills.

Child Parent Psychotherapy

Child Parent Psychotherapy (Lieberman et al. 2015) is a relationship-based, dyadic intervention that targets emotional and behavioral concerns in children birth through five years of age who have experienced trauma. It is listed as an evidence-based treatment on the Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices (2010) and designated as "Level 2, supported by research evidence" on the California Evidence-Based Clearinghouse for Child Welfare (Chadwick Center for Children and Families and Child and Adolescent Services Research Center 2018). CPP has demonstrated efficacy in improving attachment quality (Lieberman 1991; Toth et al. 2006); child cognitive development (Cicchetti et al. 2000); child posttraumatic stress symptoms, depressive symptoms, and behavior problems (Ghosh Ippen et al. 2011; Cicchetti et al. 2011); child physiological regulation (Lieberman et al. 2005); and caregiver depressive and posttraumatic stress symptoms (Ghosh Ippen et al. 2011).

CPP is typically delivered in 20–25 weekly sessions, can be practiced in a variety of settings (e.g., in home, in outpatient clinics, in school environments), and is divided into three phases: Foundational Phase – Assessment and Engagement; Core Intervention Phase; and Recapitulation and Termination (Lieberman et al. 2015). In the Foundational Phase, the clinician aims to build a collaborative working relationship with caregivers while simultaneously gathering information about the reason for treatment referral, demographic information, specific child and parent symptoms, and risk and protective factors that exist within the family system (Lieberman et al. 2015). In addition to gathering information, the therapist collaborates with the parent to incorporate a trauma-informed perspective regarding the child's presenting problems and treatment plan. The therapist and caregiver introduce CPP to the child in the first Core Intervention session in order to set the trauma frame for understanding behavior. They discuss how the trauma experience(s) and the child's behavioral and emotional reactions are connected, and give the child permission to tell or show how he or she feels (Lieberman et al. 2015). During the remainder of the Core Intervention Phase, the clinician uses "ports of entry" (Stern 1995) which are naturally occurring moments in session during which it is appropriate to use strategies to intervene in the parent-child system to promote therapeutic progress towards treatment goals. The primary goals of CPP include returning children's development to a typical trajectory, increasing the capacity of the dyad to realistically respond to threat, re-establishing trust in bodily sensations, restoring reciprocity within relationships, normalizing the traumatic response, increasing differentiation between reliving trauma and remembering it, and placing traumatic experiences in perspective (Lieberman et al. 2015). CPP clinicians rely on several strategies to realize these goals, including promoting developmental progress through play, physical contact, and language; offering unstructured reflective developmental guidance; modeling appropriate protective behavior; interpreting feelings and actions; providing emotional support and empathic communication; and providing crisis intervention, case management, and concrete assistance (Lieberman et al. 2015). The Termination and Recapitulation Phase involves shifting the focus from areas of problem to areas that have positively changed since treatment began, acknowledging that treatment is ending,

and processing feelings associated with the end of treatment (Lieberman et al. 2015).

Considerations when Selecting an EBT

Considerations for EBT selection may be grouped into three main categories: child factors, caregiver factors, and environmental factors. Child factors include the child's age, developmental level (particularly with regard to speech and language), size, type of symptoms (trauma, behavioral, emotional, relational, etc.), timeline of symptoms, stability of symptoms, and the ability to verbalize aspects of the traumatic event. Caregiver factors include the availability of a supportive caregiver to participate in services, the offending status of the caregiver (i.e., whether the caregiver perpetrated abuse against the child), primary concern of the caregiver, and parent's level of impairment related to traumatic and/or other psychiatric symptoms. Environmental factors include the stability of the child's placement, case plan goal and visitation frequency (for children engaged in the child welfare system), and the use of other trauma treatment modalities within the same family. See Table 1 for a list of sample questions clinicians may ask themselves when selecting amongst TF-CBT, PCIT, and CPP. Clinicians should consider all factors (child, caregiver, and environmental) simultaneously as they relate to a particular case prior to selecting a treatment. For some cases, different factors may become more salient and weighted more heavily in the decision-making process, as will be illustrated using the composite case descriptions below. Although a simple guidance system such as a flow diagram to help clinicians to select a treatment may initially appear most helpful, our work with these families has demonstrated that the multiple factors which must be considered simultaneously are too complex to be represented in this way.

Table 1 Sample clinical questions that inform treatment selection

Consideration	Question
Child	What is the age of the child?
	What is the developmental level of the child's speech and language functioning?
	What is the physical size of the child?
	What types of symptoms (e.g., posttraumatic stress, emotional, behavioral, relationship) are present? Which are most impairing?
	Did the symptoms start before or after the trauma?
	Has the symptom presentation changed over time? How?
	Can the child verbalize memories of the trauma?
Caregiver	Is there a supportive caregiver available to participate in treatment with the child? Who?
	Will an offending caregiver participate in treatment?
	What is the primary concern of the caregiver(s)?
	What is the level of impairment of the caregiver's symptoms? Is the caregiver able to hear the child's trauma?
Environmental	How stable is the child's placement?
	What is the case plan goal?
	How often does the child have visits with his or her biological parent(s)? What are these visits like? Does the child show symptoms before, during, and/or after these visits?
	What other trauma treatments are being used in the family?

Considerations for Selecting TF-CBT

Child Factors As mentioned previously, TF-CBT is an evidenced-based treatment for children ages three to 18 who have experienced any type of potentially traumatic event(s) and who are currently showing symptoms of posttraumatic stress, though a full diagnosis of PTSD is not necessary to proceed with TF-CBT. In order to implement TF-CBT, a child must have the verbal level of a two-and-a-half year-old child (Deblinger et al. 2017). TF-CBT may proceed with children of any size. Additionally, the child must have a memory of their traumatic experience(s) and, to some degree, be able to verbally express this memory and its impact (Deblinger et al. 2017).

A child may present with other emotional, behavioral, and/or social relatedness symptoms in addition to posttraumatic stress symptoms, as comorbidity is common for children with posttraumatic stress symptoms. For some children, comorbid symptoms of anxiety, depression, behavior problems, and/or social relatedness may have occurred *after* the traumatic events, and may be explained by a diagnosis of PTSD or the failure of the child's environment or support system following the traumatic event (i.e., a caregiver becomes so overwhelmed with his or her child having been sexually abused that he or she has significant difficulty setting limits so as to not cause the child further upset which has resulted in behavior problems). In order to proceed with TF-CBT, posttraumatic stress symptoms should be causing the greatest impairment and thus, are the primary treatment need (Cohen et al. 2017). Comorbid symptoms that occur in response to the trauma may be reduced when posttraumatic stress symptoms are effectively addressed with TF-CBT (Cohen and Mannarino 1996; Cohen and Mannarino 1997; Deblinger et al. 2011; Mannarino et al. 2012; Scheeringa et al. 2011).

Alternatively, if comorbid symptoms preceded the traumatic event(s), a child may continue to experience the comorbid symptoms after completing TF-CBT, although some improvement is possible. If the child has frequent or impairing comorbid symptoms which require immediate focus and prioritization, an alternative intervention may be appropriate prior to

initiating TF-CBT (Cohen et al. 2017). For instance, a child who is showing significant disruptive behavior (e.g., frequent aggressive behavior, defiance, oppositionality) across settings, who experiences frequent daycare/school suspensions, and who is in danger of expulsion may need a treatment that primarily targets disruptive behaviors, such as PCIT, to increase daycare/school placement stability, and prosocial behaviors. Although, the parenting component of TF-CBT effectively reduces disruptive behavior, some children with high levels of disruptive behaviors may require a specialized treatment to reduce these symptoms (Cohen et al. 2017). After the disruptive behaviors decrease, the child may benefit from TF-CBT if impairing symptoms of posttraumatic stress remain.

Caregiver Factors TF-CBT is appropriate for children with posttraumatic stress symptoms and their non-offending caregiver(s; Deblinger et al. 2017). A "caregiver" is broadly defined and can include any primary caregiver active in the child's life (e.g., biological parent, foster/adoptive parent, extended family member, etc.). In order to participate, the caregiver must be generally stable, safe, supportive and available to help the child apply the skills learned in sessions to other environments (Deblinger et al. 2017). TF-CBT may be implemented without a caregiver if an appropriate caregiver cannot be identified (Cohen et al. 2017). However, outcome data suggest that although children's posttraumatic stress symptoms may reduce, children's behavior problems may be unaffected if a caregiver is not included in TF-CBT (Deblinger et al. 1996; Deblinger et al. 1999).

Caregivers who share the child's trauma history (e.g., domestic violence, traumatic loss, motor vehicle accidents) or who have unique trauma histories may experience reductions in their own posttraumatic stress symptoms, emotional distress, and depression by participating in TF-CBT with their children (Cohen et al. 2004a, b, 2006; Deblinger et al. 2006). However, some caregivers may be so impaired by their own symptoms and/or distress that they find it difficult to focus on the child's experience and symptoms. Such caregivers may require their own individual therapy services to make significant reductions in posttraumatic stress symptoms or other emotional or behavioral difficulties, or make improvements in safety and stability prior to participating in TF-CBT (Cohen et al. 2017). In these situations, an alternate caregiver may participate in TF-CBT until the other caregiver can make necessary treatment gains in his or her individual services.

Some caregivers may be most concerned about the child's posttraumatic stress symptoms, whereas others may be most concerned about the child's emotional or behavioral symptoms and his or her ability to manage them. Certain components within TF-CBT may need to be emphasized to meet the needs of the family, based on the clinician's judgment (Cohen et al. 2017). For instance, parenting work may become a large focus early and frequently throughout TF-CBT for families most concerned about problem behaviors. However, when children present with extremely high levels of emotional or behavioral symptoms and the caregiver reports high levels of distress in managing these symptoms, an alternative effective treatment may be needed prior to initiating TF-CBT (e.g., PCIT; Cohen et al. 2017).

TF-CBT is not designed to be used with offending caregivers except in very rare cases (see Deblinger et al. 2017 for a detailed review). Therefore, offending caregivers are not typically included in TF-CBT treatment and never in instances where the caregiver physically abused, sexually abused, or neglected the child (Deblinger et al. 2017). In TF-CBT cases in which the child is in the custody of child welfare, treatment developers recommend that the child complete TF-CBT with a non-offending caregiver such as a foster parent (Deblinger et al. 2017). According to Deblinger and colleagues (Deblinger et al. 2017), if, after TF-CBT is complete and reunification with the offending caregiver is proceeding, the child and offending caregiver should be referred to an effective treatment designed to meet the needs of both the child and caregiver such as Alternatives For Families Cognitive Behavioral Therapy (AF-CBT; Kolko 1996), Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT; Runyon and Deblinger 2014), PCIT (Eyberg and Funderburk 2011), or SafeCare (Gershater-Molko et al. 2002). Additional implementation guidance for using TF-CBT with children in the custody of child welfare, such as how to proceed with TF-CBT when a child has visitation with an offending parent or under what circumstances a biological parent may participate in TF-CBT, is extensively described elsewhere (e.g., Deblinger et al. 2017).

Environmental Factors In order to proceed with TF-CBT, the child's environment should also be fairly safe and stable (Deblinger et al. 2017). For instance, if a placement change is imminent, TF-CBT may be delayed until the child is in the new placement (Deblinger et al. 2017). However, in situations where a move may be possible but is not imminent, treatment developers recommend proceeding with TF-CBT because it may serve to stabilize the placement by giving the child concrete skills to manage his or her difficulties, and provide foster parents with skills for understanding what the child has experienced and how to manage the child's problem behavior (Deblinger et al. 2017).

If the child's current home, school, or community environment is unsafe prior to the initiation of TF-CBT, therapists should consider if and how to proceed with TF-CBT. For example, if the child is actively experiencing ongoing physical or sexual abuse prior to the start of TF-CBT, TF-CBT would be inappropriate to initiate. Clinicians should follow all mandated reporting laws and work with the family to increase safety. If posttraumatic stress symptoms are present after the traumatic event ends, then TF-CBT may be appropriate.

There may be occasions when implementing TF-CBT may be appropriate when there is a risk of further trauma, but abuse is not actively ongoing. For example, it is possible to implement TF-CBT in some instances of community or domestic violence when the *threat* of violence is present but violence is not ongoing (e.g., a parent and child have moved away from the abuser but the abuser has threatened to find them), because there may never be a time when the threat of violence ends entirely (Cohen et al. 2011; Murray et al. 2013). In situations such as this, TF-CBT may help the child and caregiver enhance safety, more accurately perceive danger, distinguish between true danger and generalized trauma reminders, acknowledge traumatic events, and process traumatic events (Cohen et al. 2011; Murray et al. 2013).

For children in the custody of child welfare, TF-CBT may proceed with a non-offending caregiver, often a foster parent, regardless of the case plan goal or visitation frequency (Deblinger et al. 2017). However, the manner in which TF-CBT is implemented may change depending on whether visitation is ongoing, the child's biological caregiver is meeting requirements of the case plan, and/or reunification is likely. For instance, the TF-CBT therapist should monitor the impact of the child's visits with biological parents on the child's functioning, help the child apply skills learned in TF-CBT during visits (as needed), discuss the impact of the visits with the child in session, and support the caregiver's ability to help the child use coping skills prior to, during, and after visits (Deblinger et al. 2017). As mentioned previously, there are special considerations for involving a biological parent in treatment when courts decide that reunification will occur during the course of TF-CBT (see Deblinger et al. 2017, for a review).

In situations in which multiple children from the same family are seeking treatment, it is important that clinicians consider other treatment models that may currently be used, or are proposed to be used in the family prior to selecting TF-CBT. For instance, TF-CBT takes a structured approach which directly addresses the impact of traumatic stress. This is similar to the structured approach used in PCIT which directly addresses disruptive behavior. However, this structured and directed approach differs from the non-directive and reflective approach used in CPP. Switching between these two approaches may be challenging for caregivers.

Considerations for Selecting PCIT

Child Factors As described by McNeil and Hembree-Kigin (2010), PCIT was originally developed for children ages three to five, and is typically appropriate for children ages two to seven. However, the developmental level of the child, particularly with regard to speech and language, is a more important consideration than the child's chronological age. The skills taught in CDI, the first phase of PCIT, are appropriate for use with children beginning in infancy, and variations of PCIT for infants and toddlers have been developed (e.g., Kohlhoff and Morgan 2014). However, to implement PCIT as described in the manual (Eyberg and Funderburk 2011), children need the developmental capacity to understand "if-then" commands, which typically develops around 24–30 months of age (McNeil and Hembree-Kigin 2010). Therefore, children whose language development is similar to that of typically-developing two-year-olds are usually considered appropriate for PCIT. With older children, an additional consideration in PCIT is the size of the child. Because many children initially refuse to comply with the time-out procedure in PDI, it is frequently necessary for the parent to carry the child to the time-out chair or backup area. Therefore, the child should be small enough for the parent to lift and carry. Although rarely the case in the five-and-younger age range, some children may be too large to be transported in this way, particularly if parents have mobility difficulties. In these cases, PCIT may be more challenging, and the therapist's level of experience may be an important consideration. For example, it may be helpful for the therapist to be sufficiently experienced to implement PCIT with modifications as described by McNeil and Hembree-Kigin (e.g., a "hands-off time-out procedure").

In terms of symptoms, PCIT is appropriate when a child has clinically significant externalizing behavior problems, as noted above. These behavioral difficulties may have developed prior to or after the child's trauma. Also as noted above, other symptoms, such as anxiety, mood difficulties, or posttraumatic stress, may also be present. However, PCIT does not include direct processing of traumatic experiences, so it is not necessary for the child to remember the trauma or be able to discuss it verbally. Among children who receive PCIT, the child's behavioral difficulties may make other types of treatment excessively difficult until the child's behavioral symptoms reduce. For example, an oppositional child with a trauma history may refuse to engage in relaxation or other skill practice in TF-CBT or refuse to play in CPP. In some cases, a child whose initial behavioral difficulties preclude another form of treatment may be able to participate in this treatment if it is still needed after PCIT is complete (Cohen et al. 2017; Gurwitch et al. 2017). For instance, a child whose disruptive behaviors required PCIT initially may then benefit from TF-CBT for continued posttraumatic stress symptoms such as re-experiencing. Finally, PCIT may be recommended in some cases in which behavioral problems are milder, but significant challenges exist within the caregiver-child relationship (McNeil and Hembree-Kigin 2010). This can include physically abusive parenting, as described in Chaffin and colleagues (Chaffin et al. 2004). It may also include other situations in which the caregiver is in need of direct, "hands-on" positive attention and/or child management skills, such as when forming relationships with newly adopted children or

when continuing relationships that have previously been disrupted (e.g., following custody changes, military deployments, or other caregiver absences; McNeil and Hembree-Kigin 2010).

Caregiver Factors As noted above, PCIT requires a caregiver to participate in every session, typically scheduled once per week. "Caregiver" is defined broadly; in general, any adult who has a regular, long-term caregiving role in the child's life may participate in PCIT, including biological parents, foster and adoptive parents, and extended family members who provide day-to-day care for the child (e.g., grandparents). PCIT is most commonly conducted with a caregiver with whom the child lives full time. However, several other living situations are appropriate for PCIT as well. Examples include an extended family member who has care of the child while the parent is working or a non-custodial biological parent with regular visitation (see below for more details regarding visitation schedules).

PCIT is not recommended for use with sexually offending caregivers, but can be used with caregivers referred following physical abuse or neglect. Multiple studies (Chaffin et al. 2004; Kennedy et al. 2016) have found significant reductions in physical abuse risk factors or recidivism following PCIT. In addition, intergenerational trauma is not uncommon in families seeking treatment, including those receiving PCIT. Parental experience of trauma certainly does not preclude PCIT, and parents may derive secondary benefit from the increased stability and self-efficacy promoted by PCIT. However, because PCIT's primary focus is on child behavior management, as opposed to parental symptoms, highly salient caregiver posttraumatic stress reactions may impede PCIT progress and/or completion (Ware and Herschell 2010). Clinicians should consider whether an EBT with greater emphasis on caregiver trauma or shared caregiver-child trauma, such as CPP, may be more appropriate in these cases.

Finally, in situations in which multiple symptoms are present, such as both disruptive behavior and anxiety, the caregiver's greatest concern should be strongly considered when choosing a treatment. For example, a therapist may consider a child's separation anxiety to be more clinically significant than behavior problems, but if the caregiver views the behavioral difficulties as the greater problem, treatment is likely to be more effective if those difficulties are addressed first (e.g., Weisz et al. 2012). Adaptations of PCIT for comorbid conditions have been developed and are in various stages of dissemination (see Carpenter et al. 2014 for a review). Furthermore, because PCIT focuses on strengthening the parent-child relationship first, comorbid symptoms may be partially or fully addressed during the course of PCIT (Chase and Eyberg 2008).

Environmental Factors Finally, several factors in the child's environment are relevant when choosing among PCIT and other EBTs. The stability of the child's placement is a very important factor. Because PCIT focuses on strengthening the caregiver-child relationship, it should not be conducted in situations in which the relationship is likely to end (e.g., a foster placement that is known to be short-term; Gurwitch et al. 2017). Similarly, in situations in which a parent has lost custody of the child, it would not be appropriate for that parent to participate in PCIT as it is only appropriate if there is a case plan goal of reunification (Gurwitch et al. 2017). However, a different caregiver (e.g., foster parent) may participate with the child. Even when the goal is reunification with the parent, the parent must have sufficient contact with the child to conduct and practice PCIT. At a minimum, the parent must be permitted sufficient unsupervised contact with the child so that weekly therapy appointments are possible (McNeil and Hembree-Kigin 2010). However, because outside-session practice is also a vital part of PCIT, Campbell et al. (2014) recommend that the parent have at least three visits per week in addition to the therapy session. Ideally, these visits should take place in the home environment so that the PCIT skills can be practiced in that context.

An additional environmental factor is the presence of siblings in the home who may also have experienced trauma or may be experiencing their own behavioral and emotional symptoms. Several factors should be considered when treatment is recommended for multiple siblings in a family. As delineated by McNeil and Hembree-Kigin (2010), PCIT is typically conducted with one child in a family at a time, but parents are directed to use the skills with other children within or near the two to seven age range who live in the home as reductions in behavior problems have been shown in siblings of children treated with PCIT (Brestan et al. 1997). PCIT is sometimes pursued for these children following completion of PCIT with the first identified child. In some situations, different children within the same family could participate in separate treatment models, such as conducting PCIT with one child while conducting TF-CBT with another, because the parenting component in TF-CBT uses similar strategies to those used in PCIT, and takes a structured approach. However, in most cases the same caregiver should not participate in both CPP and PCIT, because the differing styles of parent-child interaction and therapist stance (i.e., directive versus reflective) could cause confusion.

Considerations for Selecting CPP

Child Factors CPP is evidence-based for children under the age of six. Due to its ability to treat children starting at birth, there are no minimum developmental requirements for participation. However, developmental considerations are made in the delivery of the intervention such that different techniques may be used depending upon the age of the child. CPP is designed to treat emotional and behavioral symptoms within

children who have been exposed to trauma, with an additional treatment goal of returning children's development to a more typical trajectory if delays are noted (Lieberman et al. 2015). A timeline of symptom presentation and associated trauma exposure is often challenging to establish in young children, with many children experiencing potential trauma in-utero (e.g., maternal substance use while pregnant). Therefore, it is not necessary to establish that current mental health symptoms emerged subsequent to trauma exposure to pursue CPP. A fundamental tenet of CPP is that memory starts at birth and that pre-verbal memories have an impact on child functioning; therefore, a child does not need to have the ability to verbalize trauma memories in order to participate in CPP. Instead, caregivers and children learn to identify and respond to body-based dysregulation or other impacts of pre-verbal trauma (Lieberman et al. 2015).

Caregiver Factors CPP is a dyadic intervention which necessitates the involvement of a caregiver within treatment. CPP is practiced within a relationship-based framework, and as such, the primary vehicle for change is the parent-child relationship (Lieberman et al. 2015). Therefore, parents and children typically participate in treatment sessions together. During the initial phase of CPP (Foundational Phase: Assessment and Engagement), the clinician assesses the needs of each caregiver-child relationship, understanding that child symptoms and attachment are relationship-specific. Indeed, a child often presents with different needs within different caregiver-child dyads. CPP can be conducted with one caregiver or multiple caregivers. If multiple caregivers are identified, initially they each typically participate with the child in separate dyadic sessions. Triadic work (e.g., sessions involving both caregivers and the child) may be considered at a later point in the intervention (Iwaoka-Scott and Lieberman 2015).

The nature of the caregiver who participates in treatment with the child varies based on the presenting needs and stability of placement, and can include biological parents, foster/adoptive parents, kinship parents, or other adults that provide a significant caregiving role for the child. The presenting concerns of the caregiver are obtained in the first phase and, when appropriate, are framed to be understood in the context of the traumatic event. As previously noted, the clinician establishes whether a child is able to participate with a specified caregiver in CPP during the first phase of the intervention, considering various factors about the child and caregiver (e.g., stability of caregiver symptoms and associated impairment, ability of the caregiver to acknowledge the child's trauma history; Lieberman et al. 2015). CPP takes care to explicitly query caregiver trauma history and mental health symptoms, acknowledging the impact of intergenerational trauma on the current parent-child dyad and associated child functioning. It is common for caregivers participating in CPP to endorse significant posttraumatic stress or depressive symptoms in addition to other high-risk behaviors such as substance abuse (Ghosh Ippen et al. 2011; Lieberman et al. 2005). Caregivers who have perpetrated abuse or neglect against their children (e.g., physical abuse, environmental neglect) may still participate in CPP, with the exception of sexual abuse (Lieberman et al. 2015). Considerations for "offending" caregivers may differ from those of other caregivers, including the degree to which they acknowledge their role in the child's trauma exposure and associated symptoms, or the current safety within the dyad (Lieberman et al. 2015).

CPP may be contraindicated if a caregiver is not agreeable to the treatment model (e.g., dyadic sessions, the need to address the child's trauma history) or is experiencing unstable mental health difficulties that pose significant risk to the safety of the child (e.g., untreated psychosis, inability to present to sessions sober; Lieberman et al. 2015). If CPP is not deemed appropriate, alternative treatments or modifications may be pursued (e.g., starting with caregiver-only sessions to enhance safety and provide necessary case management, or focusing CPP on enhancing safety and building the caregiver-child relationship without trauma processing; Lieberman et al. 2015).

Environmental Factors In addition to child and caregiver factors, aspects of the environment are also considered when making treatment decisions (including whether to proceed with CPP). One such environmental factor relates to physical safety of the child. CPP may be contraindicated if the child is currently in an unsafe home environment (e.g., the child has ongoing contact with a violent caregiver who denies that the child has experienced trauma; Lieberman et al. 2015). The stability of placement is also a consideration when choosing a caregiver to participate in the intervention, particularly for children involved in the child welfare system or custody disputes between caregivers. CPP has successfully been used as part of the case plan for child welfare-involved families, with results demonstrating higher rates of parental reunification and lower rates of placement disruption (Chinitz et al. 2017). One indicator of placement stability is the case plan for children involved in the child welfare system. For example, if the goal is parental reunification, the CPP clinician may choose to begin CPP with the biological parent and the child (Chinitz et al. 2017). If the goal is termination of parental rights, the CPP clinician may instead choose to begin CPP with the most stable caregiver (e.g., a foster parent or pre-adoptive parent). There is no minimum visitation requirement related to a caregiver's ability to participate in CPP, though a CPP clinician recognizes that attachment is built over multiple interactions between a child and caregiver, and thus may choose to advocate for increased contact between children and caregivers when safety is not a concern (Chinitz et al. 2017). CPP additionally recognizes that building secure attachment within a caregiver-child dyad, even if the relationship is temporary, enhances a child's ability to build healthy relationships in

the future, and thus a permanent caregiver is not required (Lieberman et al. 2015).

Finally, it is important to consider treatment needs for the entire family when making intervention decisions. There are significant differences among all three models discussed in this paper related to theoretical orientation regarding processes of change, therapist stance, requirements of treatment, and choice of strategies to address mental health symptoms that would likely make it challenging for a caregiver to participate in multiple interventions at the same time. For example, all three treatments address child disruptive behavior, but the therapist takes a structured, directive stance in PCIT and TF-CBT whereas a therapist takes a primarily non-directive, reflective stance in CPP. This may be confusing for a parent, whose experience of therapeutic intervention would vary vastly between the interventions. With regard to requirements, TF-CBT requires the presence of trauma memories that a child can verbalize and CPP does not, and therefore again could be confusing for a caregiver when providing the trauma framework needed for trauma processing. Finally, specific, in-the-moment approaches to address mental health symptoms can vary, in sometimes contradictory ways, between interventions. For instance, in response to minor, misbehavior, a PCIT therapist may coach a parent to remove his or her attention in order to avoid reinforcing the misbehavior, thereby reducing the frequency of the misbehavior. However, a CPP therapist may approach the same behavior by helping the parent and child to engage in a discussion about the meaning of the behavior and ways to use body-based regulation strategies to reduce the frequency of the behavior. In this example, the PCIT approach removes parental attention to the behavior, whereas the CPP approach would increase parental attention to the behavior with the purpose of improving regulation. If caregivers participate in multiple treatment interventions with their children, it may be difficult for them to discern when to use these differing in-the-moment approaches to misbehavior. Inconsistent responses to misbehavior may unintentionally serve to maintain the occurrence of the misbehavior.

Case Examples

Case 1 Thomas, age four-and-a-half years, was referred for treatment after he and his eight year-old sister were removed from their biological parents' care eight months ago. Removal occurred after a neighbor called the police when Thomas' sister asked her for food and disclosed that she had not eaten in two days. Both children are noticeably small for their age. The subsequent child welfare investigation found methamphetamine and drug paraphernalia in the home, very little available food, and squalid living conditions including animal and human feces on the floor. Both children later tested positive for methamphetamine in a hair follicle test. Upon removal, Thomas and his sister spent the first two weeks together in a shelter until a foster family could be identified. They have remained with the same foster family ever since.

Thomas' foster parents report that Thomas has intense bedtime crying episodes in which he calls for his biological mother and sister and is very difficult to soothe, wakes frequently in the night due to nightmares and has difficulty falling back to sleep, steals food, is irritable and easily upset, has frequent toileting accidents, has difficulty separating, and tantrums during the day. At daycare drop-off, he regularly clings to his foster mother and says "Don't leave me." His foster parents indicated they are most concerned about his nighttime crying episodes and nightmares due to the toll the sleep disruption is having on everyone in the household, although they note some improvement since he arrived in their home. Following supervised visits with his biological parents, his foster parents report an increase in bedtime tearfulness, nightmares, and poor sleep. His foster parents are eager to support Thomas and his older sister and are willing to participate in treatment with both children. With his foster parents' support, Thomas has already begun weekly speech and occupational therapy to address developmental delays. His language age equivalents are three years, four months for receptive language and three years, two months for expressive language. Although the child welfare case plan has been designated as reunification, Thomas' biological parents have not consistently attended once weekly supervised visits and have repeatedly tested positive for alcohol and methamphetamine despite both having completed inpatient substance abuse treatment. They have also failed to attend court-ordered family therapy. In the latest staffing, the team began discussing the possibility of recommending a change of the case plan goal to termination of parental rights at the next court hearing.

Case 1: Treatment Selection When considering which treatment to select, we will first consider child factors. At four years old, Thomas is within the appropriate age range for CPP, PCIT, and TF-CBT. Although he has speech and language delays, both his receptive and expressive language are greater than that of a two-and-a-half year-old child which would suggests all three treatments may be possible to select. Thomas is a small child, so his size would not be an influencing factor for participating in any treatment. Thomas appears to be showing posttraumatic stress symptoms and related emotional and behavioral difficulties which may be directly treated with CPP or TF-CBT; the greater salience of emotional as compared to behavioral symptoms indicate that PCIT may be less appropriate. The mild improvement in his behavioral symptoms over the course of his current placement also indicates that an intensive focus on behavioral difficulties is not currently necessary, again suggesting that a treatment focusing specifically on trauma reactions may be most appropriate (i.e., CPP or TF-CBT rather than PCIT). Thomas's clingy behaviors and crying for his mother and sister suggest he is aware of

the parental separation and is impacted by it, which further suggests that either TF-CBT or CPP may be appropriate treatment selections. Thomas' clingy behavior and difficulty soothing within the caregiving relationship suggest that a dyadic treatment such as CPP, that emphasizes strengthening co-regulatory capacities of the caregiver and child together, in addition to promoting sensitive and responsive caregiving, may be a good fit.

With regard to caregiver factors, Thomas has two caregivers who appear supportive and eager to participate in his treatment. Furthermore, his biological parents have been unwilling to participate in his treatment at this time. All three treatments are appropriate for use with non-offending and supportive caregivers, which his foster parents are. Thomas' foster parents identify his posttraumatic stress symptoms, particularly his nightly crying, difficulty soothing, nightmares and problems falling back to sleep as most concerning at this time, which points toward use of a trauma-specific treatment such as TF-CBT or CPP.

When considering environmental factors, Thomas is currently in a stable placement, one that he has had for the last eight months. His foster parents are engaged and have expressed no desire for the children's placement to change, so any of the treatment models would be appropriate to pursue with their participation in treatment. Although the case plan goal currently is for reunification with Thomas' biological parents, the care team is considering recommending a case plan goal change to termination of parental rights based on Thomas' biological parents' inconsistent visitation, refusal to participate in family treatment, and repeated failed drug screens. Should the case plan goal change to termination of parental rights, it will be important for the therapist to determine if the current placement is likely to remain stable or whether the children may move to a different pre-adoptive family. If the children will move to another placement in the near future, it may be best to provide support to the family and children during the transition, but wait to formally start treatment with his pre-adoptive caregiver(s). Once the children move to a stable placement with a supportive caregiver, any of the models may be appropriate depending on the assessment of treatment needs at that time. In this particular case, Thomas' foster parents also wish for his older sister to receive treatment, and her therapist has selected TF-CBT as the best treatment choice for her. Given the significantly different approaches to trauma treatment between TF-CBT and CPP, it may be most helpful to use a single treatment model within the same family. Therefore, TF-CBT may be the most appropriate treatment to select for Thomas.

Case 2 Martinique, age three, was referred for treatment by her pediatrician after she was expelled from daycare for aggression including punching her teacher in the face, biting peers, and attempting to choke a peer. When she was 18 months old, Martinique's mother and father were in a physical altercation in which her father pushed her mother who was holding Martinique. Martinique and her mother both fell to the ground and her father continued to kick her mother while Martinique lay crying. Martinique's mother was bruised but did not sustain serious or lasting physical injuries. Martinique sustained bruises but was otherwise unharmed. After this incident, Martinique and her mother moved in with Martinique's grandmother in another state, and neither she nor her mother have had further contact with her father. Martinique's mother reported that initially, Martinique became clingy following the abusive episode, had difficulty separating, had nightly nightmares, and would say things such as "Mama boo boo, Daddy hurt" when she noticed her mother's bruises. However, her mother reported that these symptoms subsided a few weeks after she and Martinique began living with Martinique's grandmother. She noted that she would acknowledge the abusive incident and reassure Martinique that they were safe. A current thorough assessment of posttraumatic stress symptoms yielded no clinically significant symptoms of posttraumatic stress at this time other than occasional nightmares. Martinique's mother reported that she experienced posttraumatic stress symptoms initially as well, but that she had participated in individual therapy which effectively reduced them. Her mother reported that Martinique is currently aggressive towards her at home, is non-compliant, and has daily tantrums that last 30–60 min. These behavioral symptoms first started after the traumatic event occurred, when Martinique was two years old. Her mother and pediatrician believed that she would "outgrow" these symptoms as she grew older and matured, but they have intensified instead. She is of average size and has no known developmental delays. Her mother is concerned that she may lose her job because she has had to repeatedly leave work to care for Martinique when she has been suspended from daycare. She has had difficulty identifying another daycare that will accept Martinique due to her aggression. In addition, she reported feeling frustrated with herself because she was "always getting on to her" about her behavior.

Case 2: Treatment Selection At age three, Martinique is the appropriate age for all three treatments. She has no known speech or language delays and is of average size, so again, she would be an appropriate candidate for all three treatments. Although Martinique originally evidenced symptoms associated with her trauma exposure, those normalized within one month following the traumatic event other than occasional nightmares. Her behavioral symptoms first emerged at two years old and have worsened since that time. Together, this suggests that PCIT may be most appropriate. Given that the trauma occurred when Martinique was 18 months-old and she is not currently showing clinically significant symptoms that precipitated directly from the traumatic event other than occasional nightmares, TF-CBT or CPP may be less appropriate.

Martinique's mother expressed concern that she was "always getting on to her" which suggests that she has concerns about her responses to her child's behavior which could be effectively addressed with PCIT.

In regard to caregiver factors, Martinique's mother, a non-offending caregiver, is willing and able to participate in Martinique's treatment. Her biggest concern relates to Martinique's disruptive behavior which is impairing in both child care and home environments and is threatening to her mother's current employment. Her mother has successfully participated in individual therapy and is not experiencing impairing posttraumatic stress symptoms at this time. This information again points to PCIT as the most appropriate treatment selection.

Environmental factors are less applicable in this scenario, as Martinique is currently living in a stable placement with her biological mother and grandmother with no plans to alter this living situation. She is not involved in child welfare and has no siblings. In this instance, child and caregiver factors are the most salient to her treatment selection, and collectively they suggest PCIT is the most appropriate treatment to address Martinique's behavioral symptoms.

Case 3 Bryson, age five, was referred for therapy by his caseworker following his removal from his biological mother's care due to substantiated physical abuse (i.e., slapping him on the face and striking him on his bottom with a belt leaving bruises) that she inflicted after he soiled himself. His one year-old sister was also removed and was placed in a different foster home where she has remained. Bryson had previously been removed from his home briefly at age two after his mother was arrested and jailed for several days for assaulting a coworker during a verbal altercation, and his father could not be located. Upon his mother's release from jail, Bryson was reunited with her.

Since entering into child welfare custody four months ago, Bryson has been placed in three separate foster homes. His first placement lasted six days, and was a temporary emergency placement until a more permanent placement could be found. He was removed from his second placement after two months, due to his foster sister alleging that their foster father had sexually abused her during the night. Bryson has not disclosed any sexual abuse to date. He has lived in his current foster placement for approximately two months, and the caseworker reports that she does not anticipate any further placement changes. The case plan goal is reunification with his mother and younger sister. The caseworker also reported that his mother has been attending twice weekly supervised visits consistently, has attended anger management classes, is currently attending parenting classes, is participating in individual therapy, and has held a job for the last two months. At the most recent court hearing, his mother expressed responsibility and remorse at her actions and was court ordered to participate in Bryson's treatment, which she agreed to do. The caseworker reported that Bryson's mother, age 23, "grew up in the system" due to her own mother's substance abuse, physical abuse, and failure to protect her children from sexual predators. Bryson's mother has a history of substance abuse and she received substance abuse treatment as an adolescent.

Bryson's foster mother reports that since he has lived in her home, he is easily upset and frequently tearful, often asks when his next visit with his mother is, refuses to talk about the abuse, has nightmares and difficulty falling asleep, has frequent toileting accidents, does not show happy feelings, is irritable, has lost his appetite, and shows aggressive and abandonment play themes. His preschool teacher reports that since his removal from the home, he looks sad frequently, seems withdrawn, refuses to talk about his foster placement, and is less interested in learning. She noted that this is a significant change from his previous presentation. She reported that previously, he was a bright child who, despite some social skills deficits, had several friends in the classroom, liked school and was eager to participate in learning activities.

Case 3: Treatment Selection All of the treatments are appropriate for a child who is five years old. No significant developmental concerns have been raised, and Bryson's teacher describes him as a bright child, which suggests he would be able to participate in all treatments. Bryson is showing posttraumatic stress symptoms such as intrusion (i.e., nightmares), avoidance (i.e., refusing to talk about his foster placement or the abuse), negative alterations in cognition or mood (i.e., diminished interest in school activities, social withdrawal, reduction in the expression of positive feelings), and hyperarousal (i.e., irritability and sleep disturbance) which manifested after the physical abuse and separation from his mother. He is also showing symptoms of depression and relational problems with both his mother and foster parent, but no significant behavioral symptoms. Bryson's symptoms reportedly began after the traumatic events which suggests that a trauma treatment such as CPP or TF-CBT may be most appropriate.

With regard to caregiver factors, Bryson's foster parent has also expressed a willingness to participate in his treatment, so it would be possible to choose to complete TF-CBT with the foster parent. Bryson's mother has consistently been making progress towards reunification by meeting the requirements of her case plan and has expressed responsibility and remorse for her actions. However, since Bryson's mother is an offending caregiver who physically abused Bryson, her participation in TF-CBT is not appropriate. If TF-CBT were to be implemented, his foster parent would participate while Bryson's mother continued her own individual treatment which would continue to focus on acknowledging the impact of her physically abusive behavior on Bryson and her own mental health needs including her own posttraumatic stress symptoms. Her services could also focus on processing events that contributed to her physically abusive behavior as well as learning

strategies to manage her emotions, increase household safety, and manage child emotional and behavioral difficulties. By contrast, CPP may be used in instances when a physically abusive caregiver is deemed "safe enough" to participate in treatment sessions with the intention of improving safety and strengthening the parent-child relationship. Bryson's mother's similar trauma history (e.g., physical abuse, parental separation, foster care, etc.) suggests that a treatment that underscores the importance of breaking the intergenerational cycle of trauma, such as CPP, may be most appropriate.

When considering environmental factors, Bryson is currently residing in a stable placement. The goal of the case plan is reunification, and his mother has been making adequate progress towards this. Her willingness to participate suggests that beginning the CPP Foundational Phase with her may be the best choice for treatment at this time. Given that Bryson is having difficulty in his foster home and at school as well, it would be appropriate for his foster parent also to complete the Foundational Phase of CPP. Such a plan would support the parent-child relationship while also supporting Bryson's current placement. Determining whether to proceed with the Core Intervention Phase of CPP and with whom, would be made following the conclusion of the Foundational Phase.

Training Implications

In their 2011 call to improve the system of care for maltreated infants, toddlers, and preschoolers, Osofsky and Lieberman advocate for improved undergraduate and graduate training curricula in early childhood development and trauma for mental health practitioners. Graduate clinicians-in-training also need to be able to access trainings for EBTs for early childhood trauma so that upon graduation they may be appropriately equipped to work with families to address the effects of trauma in early childhood. Given their empirical support and widespread dissemination, clinicians-in-training may have the greatest access to trainings in TF-CBT, PCIT, and CPP. Therefore, the child, caregiver, and environmental considerations and applications of the framework offered above may be used as teaching tools within graduate programs and continuing education trainings to provoke discussion and enable clinicians to make informed decisions regarding which treatment to use. It is our hope that these considerations may also be helpful to use in trainings by TF-CBT, PCIT, and/or CPP trainers in states that disseminate more than one EBT to help clinicians make thoughtful, treatment-informed decisions about EBT selection. Such careful consideration of treatment selection may enable clinicians to select the treatment that may provide the best care for the child and family when multiple treatments are available.

Summary

Very young children under the age of six are disproportionately likely to be exposed to traumatic events. Fortunately, EBTs are available to help alleviate the ill effects of trauma exposure early in life. The increased availability of training in EBTs for children following early childhood trauma exposure has brought to light the need to provide clinicians with guidance regarding the treatment selection process. This paper highlights child, caregiver, and environmental factors that are important for clinicians to consider when making treatment selection decisions. The composite case descriptions offered illustrate the application of this decision making framework and may be used in graduate training programs and trainings for TF-CBT, PCIT and CPP to aid clinicians in making treatment selections.

Compliance with Ethical Standards

Conflict of Interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

References

Bjorseth, A., & Wichstrom, L. (2016). Parent-child interaction therapy (PCIT) in the treatment of young children's behavior problems: A randomized controlled study. *PLoS One, 11*, e0159845. https://doi.org/10.1371/journal.pone.0159845.

Brestan, E. V., Eyberg, S. M., Boggs, S. R., & Algina, J. (1997). Parent-child interaction therapy: Parents' perception of untreated siblings. *Child & Family Behavior Therapy, 19*, 13–28.

Campbell, C., Chaffin, M., & Funderburk, B. (2014). Parent-child interaction therapy (PCIT) in child maltreatment cases. In R. Reece, J. Sargent, & R. Hanson (Eds.), *Handbook of child abuse treatment* (2nd ed.). Baltimore: Johns Hopkins University Press.

Carpenter, A. L., Puliafico, A. C., Kurtz, S. M., Pincus, D. B., & Comer, J. S. (2014). Extending parent-child interaction therapy for early childhood internalizing problems: New advances for and overlooked population. *Clinical Child and Family Psychology Review, 17*, 340–356. https://doi.org/10.1007/s10567-014-0172-4.

Chadwick Center for Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating BEST practices*. San Diego: Author.

Chadwick Center for Children and Families & Child and Adolescent Services Research Center. (2018). *The California Evidence-Based Clearinghouse for Child Welfare*. Retrieved May 12, 2018 from http://www.cebc4cw.org/

Chaffin, M., Silovsky, J. F., Funderburk, J. F., Valle, L. A., Breston, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 500–510. https://doi.org/10.1037/0022-006X.72.3.500.

Chase, R. M., & Eyberg, S. M. (2008). Clinical presentation and treatment outcome for children with comorbid externalizing and internalizing symptoms. *Journal of Anxiety Disorders, 22*, 273–282. https://doi.org/10.1016/j.janxdis.2007.03.006.

Chinitz, S., Guzman, H., Amstutz, E., Kohchi, J., & Alkon, M. (2017). Improving outcomes for babies and toddlers in child welfare: A model for infant mental health intervention and collaboration. *Child Abuse & Neglect, 70*, 190–198. https://doi.org/10.1016/j.chiabu.2017.05.015.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring. *Journal of Abnormal Psychology, 28*, 135–148. https://doi.org/10.1023/A:1005118713814.

Cicchetti, D., Rogosch, F. A., Toth, S. L., & Sturge-Apple, M. L. (2011). Normalizing the development of cortisol regulation in maltreated infants through preventative interventions. *Development and Psychopathology, 23*, 789–800. https://doi.org/10.1017/S0954579411000307.

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 42–50. https://doi.org/10.1097/00004583-199601000-00011.

Cohen, J. A., & Mannarino, A. P. (1997). A treatment study of sexually abused preschool children: Outcome during one year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 1228–1235. https://doi.org/10.1097/00004583-199709000-00015.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004a). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393–402. https://doi.org/10.1097/00004583-200404000-00005.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2004b). Treating childhood traumatic grief: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(10), 1225–1233. https://doi.org/10.1097/01.chi.0000135620.15522.3.

Cohen, J. A., Mannarino, A. P., & Staron, V. R. (2006). A pilot study of modified cognitive-behavioral therapy for childhood traumatic grief (CBT-CTG). *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(12), 1465–1473. https://doi.org/10.1097/01.chi.0000237705.43260.2c.

Cohen, J. A., Mannarino, A. P., & Murray, L. K. (2011). Trauma-focused CBT for youth who experience ongoing traumas. *Child Abuse & Neglect, 35*, 637–646. https://doi.org/10.1016/j.chiabu.2011.05.002.

Cohen, J., Oser, C., Quigley, K., & Stark, D. R. (2013). *Nurturing change: State strategies for improving infant and early childhood mental health.* Washington D.C.: Zero To Three.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). New York: Guilford.

Danko, C. M., Garbacz, L. L., & Budd, K. S. (2016). Outcomes of parent-child interaction therapy in an urban community clinic: A comparison of treatment completers and dropouts. *Children & Youth Services Review, 60*, 42–51. https://doi.org/10.1016/j.childyouth.2015.11.007.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*, 310–321. https://doi.org/10.1177/1077559596001004003.

Deblinger, E., Steer, R., & Lippmann, J. (1999). Maternal factors associated with sexually abused children's psychosocial adjustment. *Child Maltreatment, 4*, 13–20. https://doi.org/10.1177/1077559599004001002.

Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 1474–1484. https://doi.org/10.1097/01.chi.0000240839.56114.bb.

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*, 67–75. https://doi.org/10.1002/da.20744.

Deblinger, E., Mannarino, A.P., Runyon, M. K., Pollio, E., & Cohen, J.A. (2017). Trauma-focused cognitive behavioral therapy for children in Foster Care: An implementation manual.

Dozier, M., Meade, E. B., & Bernard, K. (2014). Attachment and biobehavioral catch-up: an intervention for parents at risk of maltreating their infants and toddlers. In S. Timmer, & A. Urquiza (Eds.), Evidence-based approaches for the treatment of child maltreatment (pp. 43–60). New York, NY: Springer.

Enlow, M. B., Blood, E., & Egeland, B. (2013). Sociodemographic risk, developmental competence, and PTSD symptoms in young children exposed to interpersonal trauma in early life. *Journal of Traumatic Stress, 26*, 686–694. https://doi.org/10.1002/jts.21866.

Eyberg, S. M., & Funderburk, B. (2011). *Parent-Child Interaction Therapy protocol*. Gainesville, FL: PCIT International, Inc.

Fantuzzo, J. W., & Fusco, R. A. (2007). Children's direct exposure to types of domestic violence crime: A population-based investigation. *Journal of Family Violence, 22*, 158–171. https://doi.org/10.1007/s10896-007-9105-z.

Funderburk, B. W., & Eyberg, S. (2011). Parent-child interaction therapy. In J. C. Norcross & G. R. Vanden Bos (Eds.), *History of psychotherapy: Continuity and change* (2nd ed.). Washington, DC: APA.

Gershater-Molko, R. M., Lutzker, J. R., & Welsh, D. (2002). Using recidivism to evaluate project SafeCare: Teaching bonding, safety, and health care skills to parents. *Child Maltreatment, 7*, 277–285. https://doi.org/10.1177/1077559502007003009.

Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse and Neglect, 35*, 504–513. https://doi.org/10.1016/j.chiabu.2011.03.009.

Grossman, D. C. (2000). The history of injury control and the epidemiology of child and adolescent injuries. *The Future of Children, 10*, 23–52.

Gurwitch, R. H., Messer, E. P., & Funderburk, B. W. (2017). Parent-child interaction therapy. In M. A. Landolt, M. Cloitre, & U. Schnyder (Eds.), *Evidence-based treatments for trauma related disorders in children and adolescents* (pp. 341–361). Cham: Springer International Publishing.

Herschell, A., Calzada, E., Eyberg, S. M., & McNeil, C. B. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice, 9*, 9–16. https://doi.org/10.1016/S1077-7229(02)80034-7.

Iwaoka-Scott, A., & Lieberman, A. (2015). Moving from dyads to triads: Implementation of child-parent psychotherapy with fathers. *Zero To Three, 35*, 18–24.

Keiley, M. K., Howe, T. R., Dodge, K. A., Bates, J. E., & Pettit, G. S. (2001). The timing of child physical maltreatment: A cross-domain growth analysis of impact on adolescent externalizing and internalizing problems. *Development and Psychopathology, 13*, 891–912.

Kennedy, S. C., Kim, J. S., Tripodi, S. J., Brown, S. M., & Gowdy, G. (2016). Does parent–child interaction therapy reduce future physical abuse? A meta-analysis. *Research on Social Work Practice, 26*, 147–156. https://doi.org/10.1177/1049731514543024.

Kohlhoff, J., & Morgan, S. (2014). Parent-child interaction therapy for toddlers: A pilot study. *Child & Family Behavior Therapy, 36*, 121–139. https://doi.org/10.1080/07317107.2014.910733.

Kolko, D. J. (1996). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*, 322–342. https://doi.org/10.1177/1077559596001004004.

Lieberman, A. F. (1991). Attachment theory and infant-parent psychotherapy: Some conceptual, clinical and research considerations. In D. Cicchetti & S. L. Toth (Eds.), *Rochester Symposium on*

Developmental Psychopathology, Vol. 3. Models and integrations (pp. 261–287). Rochester: University of Rochester Press.

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241–1248. https://doi.org/10.1097/01.chi.0000181047.59702.58.

Lieberman, A. F., Gosh Ippen, C., & Van Horn, P. (2015). Don't hit my mommy: A manual for child-parent psychotherapy with young children exposed to violence and other trauma (2nd ed.). Washington, D. C.: Zero To Three.

Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-focused cognitive-behavioral therapy for children: Sustained impact of treatment 6 and 12 months later. *Child Maltreatment, 17*(3), 231–241. https://doi.org/10.1177/1077559512451787.

McNeil, C. M., & Hembree-Kigin, T. L. (2010). *Parent-child interaction therapy* (2nd ed.). New York: Springer.

Mongillo, E. A., Briggs-Gowan, M., Ford, J. D., & Carter, A. S. (2009). Impact of traumatic life events in a community sample of toddlers. *Journal of Abnormal Child Psychology, 37*, 455–468. https://doi.org/10.1007/s10802-008-9283-z.

Murray, L. K., Cohen, J. A., & Mannarino, A. P. (2013). Trauma-focused cognitive behavioral therapy for youth who experience continuous traumatic exposure. *Peace and Conflict: Journal of Peace Psychology, 19*(2), 180–195. https://doi.org/10.1037/a0032533.

National Registry of Evidence-Based Programs and Practices (2010). Intervention summary: Child-parent Psychotherapy. Retrieved June 6, 2018 from http://legacy.nreppadmin.net/ViewIntervention.aspx?id=194

Osofsky, J. D., & Lieberman, A. F. (2011). A call for integrating a mental health perspective into systems of care for abused and neglected infants and young children. *American Psychologist, 66*, 120–128. https://doi.org/10.1037/a0021630.

Osofsky, J. D., Stepka, P. T., King, L. S. (2017). Treating infants and young children impacted by trauma: interventions that promote healthy development. Washington D.C.: American Psychological Association.

Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J., & Putnam, F. (2012). Effectiveness of community dissemination of parent-child interaction therapy. *Psychological Trauma: Theory, Research, Practice, & Policy, 4*, 204–213. https://doi.org/10.1037/a0022948.

Pears, K., & Fisher, P. A. (2005). Developmental, cognitive, and neuropsychological functioning in preschool-aged foster children: Associations with prior maltreatment and placement history. *Developmental and Behavioral Pediatrics, 26*, 112–122. https://doi.org/10.1097/00004703-200504000-00006.

Runyon, M. K., & Deblinger, E. (2014). *Combined parent-child cognitive behavioral therapy (CPC-CBT): An approach to empower families at-risk for child physical abuse*. New York: Oxford University Press.

Saunders, B.E., Berliner, L., & Hanson, R.F. (Eds.). (2004). *Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.

Scarborough, A. A., & McCrae, J. S. (2010). School-age special education outcomes of infants and toddlers investigated for maltreatment. *Children and Youth Services Review, 32*, 80–88. https://doi.org/10.1016/j.childyouth.2009.07.015.

Scheeringa, M. S., Zeanah, C. H., Myers, L., & Putnam, F. W. (2003). New findings on alternative criteria for PTSD in preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 561–570. https://doi.org/10.1097/01.CHI.0000046822.95464.14.

Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry, 52*(8), 853–860. https://doi.org/10.1111/j.1469-7610.2010.02354.x.

Scudder, A. T., Taber-Thomas, S. M., Schaffner, K., Pemberton, J. R., Hunter, L., & Herschell. (2017). A mixed-methods study of system-level sustainability of evidence-based practices in 12 large-scale implementation initiatives. *Health Research Policy and Systems, 15*, 102–114. https://doi.org/10.1186/s12961-017-0230-8.

Sigel, B. A., Benton, A. H., Lynch, C. E., & Kramer, T. L. (2013). Characteristics of 17 statewide initiatives to disseminate trauma-focused cognitive-behavioral therapy (TF-CBT). *Psychological Trauma: Theory, Research, Practice, & Policy., 5*, 323–333. https://doi.org/10.1037/a0029095.

Silverman, W., Ortiz, C., Viswesvaran, C., Burns, B., Kolko, D., Putnam, F., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescent Psychology, 37*, 156–183. https://doi.org/10.1080/15374410701818293.

Stern, D. N. (1995). *The motherhood constellation: a unified view of parent-infant psychotherapy*. New York: Basic Books.

Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse and Neglect, 29*, 825–842. https://doi.org/10.1016/j.chiabu.2005.01.003.

Timmer, S. G., Ware, L. M., Urquiza, A. J., & Zebell, N. M. (2010). The effectiveness of parent-child interaction therapy for victims of interparental violence. *Violence and Victims, 25*, 486–503. https://doi.org/10.1891/0886-6708.25.4.486.

Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology, 74*(6), 1006–1016. https://doi.org/10.1037/0022-006X.74.6.1006.

U.S. Department of Health and Human Services (2018). Child maltreatment 2016. Washington, DC: U.S. Government Printing Office.

Ward, M. A., Theule, J., & Cheung, K. (2016). Parent–child interaction therapy for child disruptive behaviour disorders: A meta-analysis. *Child & Youth Care Forum, 45*, 675–690. https://doi.org/10.1007/s10566-016-9350-5.

Ware, L. M., & Herschell, A. D. (2010). Child physical abuse. In C. McNeil & T. Hembree-Kigin (Eds.), *Parent-child interaction therapy* (2nd ed., pp. 255–284). New York: Springer.

Weisz, J. R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Mirand, J., Bearman, S. K., et al. (2012). Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth. *Archives of General Psychiatry, 69*, 274–282. https://doi.org/10.1001/archgenpsychiatry.2011.147.

Zero To Three (2016). Michigan's Pioneer Spirit offers professional opportunities for its early childhood mental health system. Retrieved November 4, 2018 from https://www.zerotothree.org/resources/839-michigan-s-pioneer-spirit-offers-professional-opportunities-for-its-early-childhood-mental-health-system