Widening the Reach of Clinical Interventions to Reduce Psychological Maltreatment

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Psychological maltreatment (PM) is a significant and insidious form of child maltreatment with long-lasting effects. Whereas the effects of physical forms of maltreatment may be immediately visible, psychological maltreatment affects the internal world and well-being of child victims, contributing to a persistent pattern of negative parent–child interactions. *Psychological maltreatment* is defined as “a repeated pattern or extreme incident(s) of caretaker behavior that thwart the child’s basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another’s needs, and/or expendable” (Hart, Brassard, Baker, & Chiel, 2017, pp. 147). A thorough review of the American Professional Society on the Abuse of Children’s (APSAC) definition of psychological maltreatment, including clear delineation of psychologically maltreating caregiver behaviors, assessment considerations, risk factors, and interventions, can be found at Brassard, Hart, Baker, and Chiel (2019).

Whereas families may become involved with child welfare agencies only after the concerns with caregiver behaviors rise to the level of being identified and reported to state agencies (for example, a persistent pattern of physical threats and abuse may only be reported after a child comes to school with visible bruises), APSAC’s *Practice Guidelines* titled “The Investigation and Determination of Suspected Psychological Maltreatment” (APSAC Taskforce, 2017) advocate for a public health approach to preventing PM and delivering early psychosocial interventions to families at risk. A three-tiered systems approach can more effectively address prevention and treatment of PM (Fiorvanti & Brassard, 2014). In three-tiered models, tier 1 focuses on universal practices to promote well-being and prevention of maltreatment, tier 2 aims to deliver targeted interventions to people identified to be at risk, and tier 3 provides intensive interventions as needed to populations for whom the first two tiers are insufficient.

In support of a three-tiered model of intervention, the present article focuses on methods for widening access to evidence-based clinical interventions. We seek to promote practices for clinicians to provide preventative care to families long before the severity of maltreatment rises to the level of involvement by child protective services. Integrated care models, specifically school-based and pediatric primary care settings, provide mechanisms for increasing access to evidence-based interventions in settings that are familiar and comfortable to families and can provide interventions in a three-tiered approach, addressing a range of needs.

Accessibility of Care

Multiple systemic barriers can interfere with families’ access to mental and behavioral health care.

Barriers to intervention may include the following: cultural stigma around seeking help; uncertainty regarding which child-rearing issues may benefit from professional guidance, such as developmentally appropriate expectations and discipline strategies; and structural barriers, such as long waitlists, inadequate insurance coverage, transportation, or childcare concerns (O'Brien, Harvey, Howse, Reardon, & Creswell, 2016; Owens et al., 2002).

Integrated behavioral health and mental health allow for early identification and early intervention/prevention by meeting families in settings where they are already established and comfortable. Statistics indicate that 79%–90% of young children in the United States attend well-child visits with a pediatrician, making it one of the best places to universally access and support families of children at all ages (U.S. Department of Health and Human Services, 2014; Child Trends Databank, 2018). Furthermore, as children above age 5 spend the majority of their time in school settings, school-based mental health programs provide advantageous opportunities to integrate mental and behavioral health treatment into a familiar setting that many families trust for more effective, comprehensive, and lasting outcomes (Rones & Hoagwood, 2000). Both school-based and pediatric settings provide opportunities for individuals to access care at a range of intensity levels, as will be discussed further in the context of the recommended three-tiered models. A combined, lifespan approach of supporting families of children birth through adulthood in the pediatric setting, with the addition of school-based mental health once children enter school, is optimal.

Risk Factors as Targets for Prevention and Intervention

Psychological maltreatment can be understood by way of four categories of individual or psychosocial factors that may increase risk of caregiver perpetuation of psychologically maltreating behaviors: community, family, caregiver, and child factors (e.g., Bronfenbrenner, 1979, Cicchetti & Toth, 2016). Community factors may include inadequacy of systematic support, limited support for childcare, high levels of violence and criminal activity, and poverty. Family factors may include high familial stress, low income, and inadequate social support or connection to community resources, such as schools, religious centers, or recreation. On an individual level, caregivers with psychiatric disorders, unrealistic expectations for their children, and lack of knowledge of appropriate parenting skills, difficulty attending to children's strengths, high stress, and low social support may be at higher risk for engaging in PM behaviors. Finally, although children are never responsible for maltreatment that they experience, certain factors may make them more vulnerable to harm, such as difficult temperament or a mismatch of temperament relative to their caregiver, disruptive behaviors, disability, and developmental level (see Brassard et al., 2019).

With increased awareness of risk factors at various levels, integrated interventions can be designed to more effectively target specific communities and families. For example, from a public health perspective, communities and neighborhoods with multiple community-level risk factors, such as high rates of violence and poverty, should be identified as desirable hosts for integrated and preventative clinical care initiatives.

Furthermore, caregiver and family risk factors can be addressed at a universal level. For example, community workshops or parenting groups in highly frequented settings can offer support to caregivers by offering psychoeducation regarding developmentally appropriate expectations for children, can increase knowledge of positive parenting and effective discipline approaches, and can provide opportunities for increased social support in parenting contexts. Finally, with awareness of risk factors related to individual children, care providers may be better able to guide caregivers towards effective approaches to parenting, while also equipping children with skills that may serve as protective factors. In consideration of factors that increase risk for PM, a discussion of evidence-based practices that address these vulnerabilities in clinical contexts follows.

Evidence-Based Practices in Integrated Settings

Pediatric Primary Care

Integrated behavioral health programs in primary

care are in a prime position to deliver preventive and proactive mental health services to families in a convenient, family-friendly setting. Pediatric offices are universally accessed on a consistent and frequent basis from birth through the adolescent years, meaning these settings are in a unique position to identify need within the general population and offer targeted interventions. In many cases, pediatricians form long-term, trusting relationships with the families they serve. Contrary to the negative stigma that is often associated with mental health care, pediatric care has a positive stigma that can be leveraged to focus on child and family well-being. HealthySteps is an example of an integrated behavioral health intervention using a tiered approach to support families at risk for psychological maltreatment and other forms of abuse (Briggs, 2016). HealthySteps focuses on the role of prevention and early intervention by working with families of young children 0–5 years old. Designed as a dyadic intervention, HealthySteps directly works to build strong parent–child relationships, making it ideal for targeting and addressing potential PM.

The first tier of HealthySteps involves universal screening for all pediatric patients during well-child visits on a variety of child and family measures. Screening measures may explore parental depression, parent and child trauma exposure (for one example of a trauma screening used in primary care, see the Adverse Childhood Experiences (ACEs) Questionnaire, Felitti et al., 1998), social determinants of health, child development, and child social-emotional functioning and well-being. Universal screening allows the HealthySteps specialist to focus more comprehensive interventions on families at higher risk for behavioral health issues and utilize limited clinicians to make the largest impact. A study conducted at Montefiore Medical Group in the Bronx, New York, found that mothers with a history of childhood abuse were more likely to have children with social-emotional concerns on a screening at 36 months when no intervention was provided. However, when HealthySteps was provided during the first three years of life, a comparison group of similar families with mothers with a history of childhood abuse was found to have sub-threshold social-emotional screening ratings at 36 months (Briggs et al., 2014). More broadly, research on childhood exposure to trauma, negative events, and toxic stress underscores the potential long-term impact on physical health and social-emotional well-being (e.g., Felitti et al., 1998; Horwitz, Widom, McLaughlin, & White, 2001; Thomas, Hypponen, & Power, 2008). Universal screening for family, caregiver, and child risk factors for PM in primary care can help address the intergenerational transmission of trauma.

The first tier can also involve transforming the pediatric clinic through universal education for all staff members. By bringing awareness to the impact of parent and child trauma exposure (e.g., ACEs) and stress on family functioning and by having a mental health professional available for consultation and "warm hand off," all staff members are exposed to, and become part of, the promotion of well-being. For example,

> having blood drawn is a difficult but often necessary part of pediatric well-child visits. A parent's own negative experience or fear of needles may make it difficult for them to be emotionally available to their child and may even result in psychological maltreatment (such as, a parent laughing while a child's blood is drawn; criticizing a child's appropriate reaction by saying, "Boys don't cry," or "No crybabies"; a parent walking out of the room leaving child alone with a grandparent for the procedure). HealthySteps specialists can model for nurses how to gently nurture and coach a parent to emotionally support a child during scary or painful procedures, which in turn allows many more children to have a positive experience at the doctor, a positive parent–child interaction, and a parent to model how to support the child through a stressful experience.

The second tier in HealthySteps involves brief, targeted interventions offered to parents and families in the pediatric clinic with an identified question or concern, often through a warm hand off on the same day that the problem is identified. HealthySteps specialists use a variety of interventions and strategies informed by a range of evidence-based approaches and one's own

areas of expertise, including (in this provider's case) functional behavior assessment (FBA), early childhood mental health consultation (ECMHC; Georgetown University Center for Early Childhood Mental Health, n.d.), motivational interviewing (MI; Miller & Rollnick, 2013), Parent–Child Interaction Therapy (PCIT; Eyberg & Funderburk, 2011), Circle of Security (COS) Parenting (Powell, Cooper, Hoffman, & Marvin, 2014), and Child–Parent Psychotherapy (CPP; Lieberman & Van Horn, 2008). Through consultation and short-term treatment (1–8 sessions typically), the HealthySteps specialist addresses a mild to moderate concern to potentially prevent it from becoming a more serious concern when possible. With regards to psychological maltreatment, these timely, brief interventions have significant impact by interrupting the development of negative parent–child interaction before it becomes a persistent pattern. For example,

> a common clinical situation involves parents of young toddlers who report that their child "does not listen" and that the only way to get them to follow a direction is to say, "Bye, I am leaving without you." While parents can see that this strategy is effective, they often do not consider *why* it is effective, which is related to their young child fearing separation from the caregiver. A non-judgemental conversation about the child's developmentally appropriate fears, validation of the parent's frustration when the child does not listen, and a discussion about ways to give effective commands to toddlers (without threatening separation) are often enough to impact the quality of parent–child interaction and reduce PM. This intervention involves well-timed and thoughtful developmental guidance and psychoeducation, an approach utilized in Child–Parent Psychotherapy (CPP).

The third tier of HealthySteps involves a long-term intervention offered to parents and families identified to have more risk factors that increase the likelihood for the child to develop social-emotional and mental health concerns. This more comprehensive intervention involves the HealthySteps specialist joining with the pediatrician for integrated well-child visits, which assess social-emotional well-being along with medical health. Importantly, the long-term intervention is offered before any problems are identified in the child, as a proactive and preventive model, and often begins as early as the 2-month-old well-child visit, offering the opportunity to support a positive parent–child relationship from the very beginning. The HealthySteps comprehensive model addresses and targets community, family, caregiver, and child risk factors for psychological maltreatment through a range of interventions (see references for specific interventions above within tier 2) delivered through the important relationship between the caregiver and the HealthySteps specialist. Assessment and support are provided for parental mental health and a parent's own history of trauma and experience of caregiving, for example, by drawing more deeply from the approaches of child–parent psychotherapy and Circle of Security parenting. Anticipatory guidance and normalization are provided about expected, sometimes challenging, aspects of early childhood development, such as temperament, tantrums, stranger anxiety, and limit testing, as well as the ways in which one's history may impact parenting behaviors and how to notice or address those tendencies. In addition to reflection upon one's own upbringing and parenting goals, psychoeducation, modeling, and live coaching are offered to support parents in the development of effective positive parenting skills. Perhaps more important than any specific intervention, the long-term nature of the intervention allows for the development of a trusting, supportive relationship between the parent and HealthySteps provider, in which parents can openly explore the type of parents they want to be and the relationship they want to have with their child.

School-Based Mental Health

School-based mental health programs are uniquely situated to provide multiple tiers of supports and interventions, capitalizing on the benefits of an integrated model through a child- and family-centered approach. A three-tiered model can optimize the capacity of effective prevention and early intervention efforts, particularly in communities where financial and human resources may be limited relative to the level of community needs. A grant-funded school-based mental health program in an urban setting with high rates of chronic stress, trauma, poverty, and

community violence seeks to address this growing need by implementing a three-tiered model.

The first tier focuses on a universal prevention curriculum, described in *Cam's Classroom: A Trauma-Informed Positive Classroom Behavior Management and Emotion Regulation Manual for Elementary School Classrooms* (Kleinman, Kerner, & Chiel, 2018; other examples of school-based universal interventions include Dorado, Martinez, McArthur, & Leibovitz, 2016; Jaycox, Langley, & Hoover, 2018; Pincus & Friedman, 2004). Cam's Classroom is focused on trauma-informed teacher training in classroom behavior management, with an additional component of teaching early elementary students cognitive behavior therapy (CBT)-informed emotion regulation skills. Through this universal prevention program, students learn skills in emotion identification, and cognitive and behavioral coping skills, while also building a relationship with Cam the chameleon, a stuffed animal that students care for and, through symbolic representation in play, use to practice their emotional expression, prosocial caretaking, and coping skills. Teachers are trained in universal trauma-informed practices so that they may interact with students with increased emotional responsivity, while coaching their students to implement behavior and emotion regulation skills. In the context of PM, this preventative program aims to strengthen children's protective factors and build resilience, including prosocial skills, connection to school (Brackett, Reyes, Rivers, Elbertson, & Salovey, 2011; Stewart, Sun, Patterson, Lemerle, & Hardie, 2004), formation of a positive interpersonal relationships with an adult figure (Flores, Cicchetti, & Rogosch, 2005), ability to problem solve and self-regulate emotions (Buckner, Mezzacappa, & Beardslee, 2003), and increase home–school connection (Barnard, 2004).

A common example of the universal program's positive and immediate outcomes, reported anecdotally by teachers, focuses on students who may have historically demonstrated oppositionality or low frustration tolerance when faced with difficult academic tasks. Teachers boast about successful coaching of students to identify their automatic thoughts, often related to low self-esteem (e.g., "I'll never get this"), determine whether it is a "helpful or unhelpful thought," and subsequently call upon Cam's Thinking Machine to turn an unhelpful thought into a helpful thought (e.g., "I can try my best") that will encourage them through the challenging task. In the context of PM, children may internalize messages that cause them to question their self-worth or sense of competence; as such, there are immediate observed benefits of the opportunities for teachers to provide coaching in CBT-informed cognitive coping techniques in the classroom. Notably, cognitive coping techniques are key components of many evidence-based psychotherapeutic practices (e.g., Trauma-Focused Cognitive Behavior Therapy: Cohen, Mannarino, & Deblinger, 2006; Coping Cat: Kendall, 1994) – Cam's Classroom increases access to effective therapeutic practices by providing the intervention to all students at the universal level.

Teachers also are equipped to help understand students' emotional experiences that they may carry from home into the classroom. For example, in lessons focused on increasing emotional awareness, students may share with their teachers that they feel sad or nervous when yelled at by their parents. Though we do not expect teachers to serve as therapists, teachers are in a unique position to help students cope with their emotions throughout the school day. They can also identify families who may need a referral for services; often these are families who would not have been identified without the teachers' training in universal trauma-informed emotion regulation practices. Furthermore, trauma-informed teaching includes educating teachers about trauma triggers and how students' fight or flight stress response may activate in the classroom, aiming to improve teachers' understanding and conceptualization student behavior within the context of trauma rather than intrinsic qualities.

The first tier also includes bilingual (English and Spanish) family engagement events, focused on disseminating skills from the universal prevention program, as well as psychoeducation workshops for caregivers, focused on topics such as positive parenting and discipline practices (Kazdin, 1997; Webster-Stratton & Reid, 2003), developmental expectations, and signs and symptoms of common mental health disorders. By providing community-wide

psychoeducational workshops, equipping teachers and children with trauma-informed behavior management and emotion regulation skills and providing resources to caregivers in high-risk communities, the program aims to ameliorate the risk and effects of PM at a preventative level, while identifying individuals with a greater need for more intensive intervention.

The second tier focused on prevention for families at risk. Elementary school caregivers are invited to participate in evidence-based parent management groups. Though participants are often self-selected, continuity between the universal prevention program at tier 1 allows schools to offer an option to caregivers seeking additional support. Participation in parenting groups, such as Incredible Years (Webster-Stratton & Reid, 2003) and parent management training (PMT) (Kazdin, 1997) have been shown to improve caregivers sense of social support (Marcynyszyn, Maher, & Corwin, 2011), awareness of developmental expectations (Kazdin, 1997), increased positive parenting practices and decreased harsh parenting behaviors (Webster-Stratton, Reid, & Hammond, 2004). A case example illuminates the power of the Incredible Years parenting groups offered in the school-based context:

> A single mother, whose child received Cam's Classroom universal prevention program, regularly attended weekly parenting groups, focused on topics of positive parenting and discipline strategies. Several weeks into the group, the mother disclosed her prior misconceptions about parenting practices, including providing harsh attention for inappropriate behavior and using a belt to threaten and physically punish her child. She relayed her experiences implementing skills she learned in the parenting group, including positive parenting and discipline practices at home, and shared her astonishment—and immense gratitude—that the newly learned strategies were effective. In school, her child presented as socially and academically average student, and therefore would not have been identified solely by observation as in need of additional intervention.

By providing groups focused on evidence-based parenting practices in school, a familiar and comfortable setting, families receive access to information and training that they may not otherwise access. The first and second tier of prevention and intervention delivered in a school-based mental health clinic allows for delivery of evidence-based interventions to a broader population.

Finally, the third tier of intervention in the school-based mental health program provides individualized interventions for children with a psychiatric diagnosis. Many children referred for third tier intensive psychotherapeutic treatment have either previously experienced PM or may be at increased risk for experiencing PM due to increased vulnerability associated with their psychiatric condition (Turner, Vanderminden, Finkelhor, Hamby, & Shattuck, 2011). Clinicians commonly offer trauma focused–CBT (Cohen et al., 2006), alternatives for families–CBT (Kolko, Iselin, & Gully, 2011), Parent–Child Interaction Therapy (Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001), Coping Cat (Kendall, 1994), and other evidence-based treatment approaches. Treatment plans include collateral parent or family components, which focus on strengthening relationships and empowering families by developing parenting skills that best support their children's needs and mitigate the likelihood of increased harm. For example, for a hyperactive child who has difficulty regulating behavior, caregivers will learn effective behavior management techniques and learn to replace harsh verbal reprimands that do not change behavior in the long term, can strain the caregiver-child relationship, and harm the child's self-esteem. Home-based crisis intervention and medication management services are also available when indicated. By offering psychotherapeutic interventions in school settings, there is increased collaboration between clinician, family, and school staff. Particularly for children in classrooms that received the universal prevention program, individual and family therapy are enhanced through individualized reinforcement and application of classroom skills. For example,

> a child who had received Cam's Classroom in first grade was referred for tier 3 interventions in second grade. With a history of chronic

stressors, including housing instability, inconsistent involvement from his father, and witnessing domestic violence, his mother presented as resilient although easily frustrated by her unrealistic expectations of her son. The child began individualized treatment at tier 3 for generalized anxiety disorder. Advantageously, his prior knowledge of basic emotion regulation and coping skills from his previous involvement in Cam's Classroom could be activated, and his ongoing participation in the program allowed teachers to have foundational knowledge for ease of collaboration with the clinician to help manage the child's anxiety in the classroom. Moreover, the collaborative approach encouraged the child's mother to feel empowered to effectively become a part of her child's treatment team, by learning to change her own expectations, cognitive attributions, and behaviors to best support her child. Whereas at the start of treatment, the mother mocked her child for his avoidant behavior and blamed him for being "lazy" and "stubborn," she gained greater understanding of the underlying anxiety driving his reactions. Additionally, as a single parent with another younger child, the mother often relied on her 8-year-old son as a co-parent and partner, confiding in him with her concerns about the family's financial challenges and relying on him for advice in an inappropriate manner for a child his age. With treatment targeting mother's negative attributions, as well as developmentally appropriate expectations and parent–child interactions, the clinician observed reductions in the mother's negative language regarding her child's behavior and his symptomatology, which previously had unintended negative consequences for the child.

Conclusion

Mental and behavioral health services offered in integrated care settings, such as pediatric primary care and schools, provide increased opportunities for families at risk to access high-quality interventions. As recommendations for prevention and intervention of PM move toward a three-tiered public health approach (Brassard et al., 2019), models of three-tiered, evidence-based clinical care in accessible settings—particularly in high-risk communities—should be promoted. Through establishing clear, specific protocols for identifying families at risk in familiar settings, clinicians will be able to extend their reach, providing preventative care when risk of PM is identified. Three-tiered models in integrated settings increase access to preventative tools and provide interventions at a range of intensity levels to more effectively and efficiently reduce the risk and adverse consequences of PM.

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