2

Children in Foster Care

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UNIQUE ASPECTS OF THE FOSTER CARE POPULATION

Children in foster care have significantly higher rates of trauma exposure and trauma-related symptoms than the general population as well as high rates of behavioral problems (Kolko et al., 2010; Pecora et al., 2003). These clinical concerns make trauma-focused cognitive-behavioral therapy (TF-CBT), which includes both specific trauma treatment components as well as a parenting component, a particularly relevant treatment approach for the foster care population. However, there are a few unique features and considerations that often raise questions for clinicians in terms of how to implement TF-CBT with both children and adolescents in foster care and with their foster and biological parents. These include:

- Multiple, chronic, trauma exposure histories
- Significant behavioral problems
- High levels of emotional dysregulation
- Multiple presenting problems and diagnoses
- Difficulty engaging the primary caregiver (foster parent)
- Complexities regarding the involvement of biological parents

Our goals in this chapter are to address these concerns and to offer practical clinical suggestions and resources. In most ways, providing TF-CBT to children in foster care is not significantly different from provid-

ing TF-CBT to other children; however, in some cases, children and adolescents in foster care who present for treatment have multiple diagnoses and presenting problems, have prior experience with therapy, may be on multiple medications, and may have attachment difficulties. This combination of factors can be daunting to clinicians and can result in hesitancy in providing TF-CBT. Cognitive-behavioral therapy (CBT), generally, has been found to be effective for diverse cultural and ethnic groups (Huey & Polo, 2008) and is considered a frontline treatment for depression and anxiety as well as behavioral problems, when the emphasis is on the "B" in CBT (i.e., behavioral, parenting skills). Even when children have significant attachment difficulties, which many in foster care do as part of a normal reaction to inconsistent caregiving and disrupted placements, the best tools for treatment include CBT, a targeted focus on skills that can be beneficial across a number of areas (e.g., posttraumatic stress disorder [PTSD], depression, anxiety, behavior problems), consistent foster parent involvement, and concentration on reinforcing the child's and foster parent's use of skills at home and in the community. In a review of more than 70 studies of interventions designed to improve attachment security in children (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003), the more effective interventions had common characteristics, including being shorter term, goal oriented, and focused (like TF-CBT) versus more extensive and broader in focus.

EVIDENCE FOR TF-CBT WITH CHILDREN AND ADOLESCENTS IN FOSTER CARE

In addition to the general evidence for CBT and targeted, structured approaches detailed previously, TF-CBT, specifically, has been found to be effective with children in foster care. All TF-CBT studies have included some children and adolescents in foster care, and two studies—one published and one underway—have found that TF-CBT has been effective specifically with this population (Dorsey, Cox, Conover, & Berliner, 2011; Lyons, Weiner, & Schneider, 2006; Weiner, Schneider, & Lyons, 2009). In the Weiner and colleagues (2009) study, ethnically diverse children in foster care who received TF-CBT, when compared with those who had received treatment as usual through the systems of care, reported significantly greater reductions in trauma symptoms and significantly fewer placement changes and runaway attempts (Lyons et al., 2006). In an ongoing randomized controlled trial of standard delivery of TF-CBT compared with TF-CBT plus evidence-based engagement strategies with youth in foster care, TF-CBT was found to be effective in both conditions for significantly reducing PTSD symptoms, based on both child and foster parent report (Dorsey et al., 2011). The TF-

CBT plus evidence-based engagement strategies resulted in fewer dropouts during treatment, suggesting the importance of focused engagement strategies for this population.

These findings should be generalizable to community-based practice: Both of these studies were effectiveness trials that included few study exclusionary criteria and included ethnically and culturally diverse children and adolescents. Clinicians were predominantly masters'-level clinicians, all of whom were employed in community mental health settings. Additionally, despite the fact that children were in foster care, the average number of sessions provided by community-based mental health clinicians in the Dorsey, Cox, and colleagues (2011) trial was 16 to 17, which is in the suggested range (i.e., 8–20 sessions), noteworthy also because most clinicians were providing 50- to 60-minute sessions (vs. 90-minute sessions).

COLLABORATION WITH CHILD WELFARE

Child welfare social workers play an important role in the lives of children in foster care and thus can be a critical source of support for the TF-CBT therapist. These workers are important collaborators who can provide information about the children's history, reunification, or permanency plans and updates, and can offer support and encouragement for both child and foster parent participation in treatment. In our work with youth in foster care, connecting with the child welfare workers has been critical for staying informed about any upcoming court dates, visitation plan changes, and placement changes and for incentivizing foster parents to participate in treatment. Child welfare workers who are supportive of evidence-based practices have been able to creatively encourage foster parents to be more involved in treatment, sometimes providing incentives such as mileage reimbursement, licensure hours for therapy participation, and reinforcement of treatment participation during home and safety visits (Dorsey, Kerns, Trupin, Conover, & Berliner, 2011).

As part of this collaborative effort, the child welfare workers, who are typically the state "representative guardians," should also be generally informed about their clients' progress in treatment (as should foster parents, who are the day-to-day caregivers). In our experience, when clinicians provide regular, brief treatment updates (e.g., once a month) about child and foster parent attendance and treatment progress (e.g., on trauma narrative), caseworkers greatly appreciate the effort and can then support the therapy in any decisions related to the children's care. When child welfare workers are not involved, they may inadvertently make recommendations or other referrals that are counter to the CBT approach to treating trauma (e.g., avoiding vs. facing trauma reminders).

Another important role of social workers is in helping clinicians determine whether, when, and how to involve biological parents in treatment (see additional discussion later in this chapter). Although the children may be in foster care, clinicians should consider the role of the biological parents up front—most children continue to see their parents either formally (court-ordered visits) or informally (in the community), and a substantial number will reunify. Social workers can help clinicians understand the parents' current role, and their involvement with the children—information that is key in determining the biological parents' level of involvement in treatment. In some cases, a meeting early in the process between clinician and biological parent—and not necessarily including the child (see later discussion for guidelines for conjoint sessions)—can do much to reduce resistance to treatment and defensiveness later when it is clear that parent and child will reunify and that biological parent involvement will, therefore, be essential.

FOSTER PARENT INVOLVEMENT

One primary challenge often mentioned by clinicians when providing TF-CBT to children and adolescents in foster care involves engaging foster parents. In TF-CBT, the day-to-day caregivers are ideally involved in treatment to support the children's acquisition and practice of skills and to offer emotional support throughout the therapy process. Caregiver involvement is particularly important when the children have significant behavioral problems, as is the case with many children and adolescents in foster care, as behavioral problems are predominantly addressed through behavior management strategies covered in the parenting component of TF-CBT.

Research on predictors of engagement indicates that perceptual barriers to engagement appear to be just as significant as concrete barriers, if not more so (McKay, Pennington, Lynn, & McCadam, 2001). For many foster parents, primary barriers to engaging in therapy are related to past negative experiences and to perceptions that mental health therapy will not be helpful. McKay, Stoewe, McCadam, and Gonzales (1998) have developed specific evidence-based engagement strategies that were applied to TF-CBT with youth in foster care, resulting in greater retention in treatment (Dorsey et al., 2011). These strategies, described briefly here and in more detail in McKay and Bannon (2004), focus on addressing prior negative experiences with mental health, increasing expectations that therapy can be helpful, identifying foster parents' perception of why children might need treatment, and beginning active treatment in the initial telephone contact and in the first in-person meeting (vs. focusing solely on appointment scheduling and completing intake paperwork).

In TF-CBT, an important part of building expectations that therapy can be helpful involves describing the model, the research on its effectiveness, how treatment will be structured, and expectations about treatment (e.g., attend sessions weekly, practice skills in session and at home), while also soliciting questions, concerns, and hesitations about participation so that these can be discussed in session. In our qualitative work, some foster parents have indicated that it is important as well to clarify that the therapy involves providing support to the foster parent.

In some cases, clinicians are hesitant to involve foster parents because of their own past negative experiences with foster parents not wanting to be involved or being unsupportive. However, foster parents are the day-to-day, 24-hour caregivers for the children in their homes, are often inadequately prepared by foster parent training programs to handle behavioral and emotional problems (Dorsey et al., 2008), and to respond supportively to trauma-related discussions and symptoms.

In cases in which a foster parent cannot be engaged, identifying and engaging another adult who is important in the child's life (e.g., aunt, mentor, fictive kin) is an option. When working with foster families, one should be aware of differences in the experiences of nonrelative and kinship foster parents. For example, when foster parents are relative caregivers, they may be much more likely to be emotionally affected by the child's trauma. Kinship caregivers may have experienced additional stress related to taking the child into the home (e.g., strained extended family relationships, disruption in their immediate family). As one kinship caregiver reported, after taking her cousin's children into her home, "You get a call late at night, and you can either take in these children or they go into the system. You don't get to take a class or make a decision that you want to be a foster parent. You don't get to prepare your own children. Your family changes overnight." Kinship caregivers may greatly benefit from the cognitive coping and processing techniques that are part of TF-CBT in order to cope with their own thoughts and feelings regarding the child's trauma, often inflicted by their own family member.

ENGAGING CHILDREN AND ADOLESCENTS IN FOSTER CARE

Foster children, having often grown up in disorganized, chaotic, and/or violent family environments, benefit a great deal (as do all children) from structure and predictability in the therapy environment. Thus, beginning and ending session in consistent ways and creating very clear session rules and end-of-session rewards can effectively encourage active session participation while also helping to reduce avoidance and noncompliance. Therapists can

identify session rewards that are particularly meaningful to their clients, such as a favorite song, game, or activity (e.g., basketball). Clinicians can also encourage foster parents to praise the children for participation in therapy and to identify small rewards that can be used to incentivize participation.

COMPONENT-SPECIFIC ADDITIONS/ CONSIDERATIONS FOR TF-CBT WITH CHILDREN IN FOSTER CARE

In addition to the considerations already discussed, there are other applications, specific to children in foster care, for some of the TF-CBT components, discussed next.

Psychoeducation

Depending on the child's situation, it can be beneficial to supplement the psychoeducation provided as part of TF-CBT with psychoeducation on the foster care system. For some older children, it is important to clarify the role of child welfare workers, clinicians, and the court in terms of making decisions about their reunification or adoption as well as visits with parents and siblings. Two resources that clinicians have found helpful are *Maybe Days: A Book for Children in Foster Care* (Wilgocki & Wright, 2002), which provides general information about foster care, and *Murphy's Three Homes: A Story for Children in Foster Care* (Gilman & O'Malley, 2008), which focuses on multiple placements and related feelings and thoughts. Although not specific to foster care, another book that has been helpful for understanding and treating children's reactions to traumatic events and that was used frequently in one of the foster care studies is *A Terrible Thing Happened* (Holmes & Mudlaff, 2000).

Additionally, because many children enter foster care subsequent to neglect and abuse related to parental substance use, it can be helpful to provide some education on substance use and how and why substance use makes it challenging for parents to care for and parent children appropriately. In addition to often having been hurt by a parent through abuse and neglect, as have many children who receive TF-CBT, foster children also struggle with understanding why their parents were unable or chose not to do whatever was necessary to retain custody of them. Explaining substance use—addictive qualities (e.g., hard to resist and refuse) complicates parental ability to make appropriate decisions—can assist children in understanding and coping cognitively with why parents were, or still are, unable to meet expectations in order to gain custody (e.g., "My mom loves me, but she can't make good decisions when she is using drugs").

Some additional areas of psychoeducation with foster parents that may be important to cover include (1) the child's trauma exposure history; (2) the child's relationship and attachment to biological parents and siblings; and (3) normalizing some behaviors (e.g., normative sexual behaviors) and explaining other seemingly "odd" behaviors that result from abuse and neglect experiences (e.g., hoarding food, stealing, clinginess, low expressed need for emotional support). We have repeatedly heard from foster parents that they are unaware or have limited knowledge of the trauma history for the foster child in their home (Dorsey, Burns, et al., in press). The TF-CBT therapist can help the foster parent understand the child's experiences from their assessment of the child's trauma exposures and symptom presentations and from collaborative contacts with the child's welfare worker. This education is an important first step that continues through the narrative and processing phase so that the foster parent can understand and support the child more effectively, particularly with respect to the trauma history and related difficulties. Moreover, a greater understanding of the traumatic experiences suffered by the child in their care often helps foster parents to empathize with and respond to the child's emotional and behavioral reactions with greater consistency, sensitivity, and compassion.

Despite the fact that biological family members may have caused emotional or physical pain, most children still love their family and hope for a relationship. Some foster parents struggle to understand this, given the hurt they perceive the family has caused the child. It can often be helpful to normalize this experience—both that the child may remain attached to, and defensive of, his or her parents and their actions and that foster parents may find it hard to understand. In foster care, as in cases of divorce, it is best that the foster parents not talk negatively about the child's biological family. However, the therapist can validate the foster parents' feelings of anger and frustration, particularly when biological family members miss visits, act inappropriately in visits, or talk negatively about the foster parents. TF-CBT includes skills for emotion regulation and cognitive coping, and clinicians can encourage the foster parents to use these skills to cope with their own feelings and thoughts about the biological parents. It can also be important to provide some psychoeducation to foster parents about family visits with parents and siblings—how these visits are often important for maintaining family contact, despite some difficulties surrounding them, including family no-shows, child distress, and behavior problems before and after visits.

Parenting

Children in foster care have high rates of behavioral problems that often reach clinical levels and warrant intervention. Behavioral problems of children and adolescents are responsible for 20% of unplanned placement changes

(James, 2004; James, Landsverk, & Slymen, 2004). Behavior problems both lead to and are exacerbated by placement changes. For these reasons, when children in foster care who are receiving TF-CBT have behavioral difficulties, it is even more critical that clinicians engage foster parents and include a significant and targeted focus on parenting skills early in treatment. Focusing on parenting can address behavioral problems and, in turn, stabilize the placement. In TF-CBT, the early parenting focus is on positive parenting strategies—using praise, attention, and rewards to reinforce positive behavior or the opposite of the behavioral problem (e.g., listening when given a direction; presenting oneself to unknown adults by saying "hello" vs. jumping into their lap and hugging them immediately). Given their inconsistent or negative past parenting experiences, an initial focus on positive parenting skills is particularly important for children in foster care.

For example, one TF-CBT therapist worked with a 7-year-old boy who threw repeated temper tantrums approximately three times a day. In his first foster placement, the foster mother repeatedly questioned the boy about why he had tantrums and would give him a lot of attention when the tantrums occurred, offering candy, hugs, video games, or anything she thought might stop the tantrum. The foster mother could not be engaged in using positive parenting skills, ignoring, and offering praise for times when he stayed calm and did not throw tantrums. She eventually requested that the child be removed from her home because the behavior did not improve. The child's next foster parents were highly receptive to the clinician's suggestion of offering praise and rewards for times when he stayed calm and did not throw tantrums and ignoring him when he did throw tantrums. With a focus on positive parenting, the tantrums decreased to only three to four times per week.

Often, foster parents may not be interested in trying specific parenting strategies, having successfully raised their own children. To overcome foster parents' resistance to trying positive parenting and behavior management strategies, it is helpful to explain that, unlike children parented since birth or early adoption, children in foster care may have had inconsistent or negative parenting experiences, which may require the addition of particular tools to their existing parenting skill toolbox. We have also used the common CBT technique of asking foster parents to experiment with the positive parenting strategies, even if they are unsure whether they will be effective. In addition, it is often necessary to help foster parents understand how to apply the same behavior management strategies to behaviors related to neglect or abuse (i.e., hoarding, stealing, lying, sexualized behavior). Positive parenting strategies are also effective for behaviors that result from insecure attachments. Although there are many approaches to addressing behaviors that are consistent with insecure or disorganized attachment, the American Professional Society for the Abuse of Children recommends

CBT treatments that teach positive parenting strategies, like TF-CBT, as the frontline approach (Chaffin et al., 2006).

A resource that has been found to be particularly helpful for parenting children in foster care is *Off Road Parenting* (Pacifici, Chamberlain, & White, 2002), a book and DVD package that includes short chapters and cartoons describing basic behavior management strategies. In the video vignettes, parenting strategies are acted out, with demonstrations of the child responding positively and negatively to the various techniques and how the parent or foster parent handles each scenario. For foster parents interested in additional training in behavior management strategies, specifically for some of these challenging behaviors, the same group that published *Off Road Parenting* has developed an online program, *Foster Parent College* (*www.fosterparentcollege.com*), that offers training in addressing these particular behaviors ($10 per course). Some research (nonexperimental design) supports the effectiveness of the Foster Parent College courses in improving foster parent behavior management skills (Pacifici, Delaney, White, Nelson, & Cummings, 2006).

Parenting of children in foster care may also require additional reassurance and safety rituals, given that the children have had repeated trauma exposure and continue to live in a state of uncertainty ("Will I go home to my mom?", "What will happen in my next visit with my dad? If he even comes, he'll probably only play with my brother"). Some of the challenging behaviors exhibited by youth in foster care may be related to anxiety (e.g., bedtime refusal, school refusal), and may not only be noncompliance. Clinicians will need to work with foster parents to conduct a thorough functional analysis of problematic behaviors in order to understand the factors that trigger them. This information is critical in identifying appropriate positive behaviors (to replace the problem behaviors), behavior management skills that would support an increase in those positive replacement behaviors, and/or appropriate coping skills (e.g., relaxation, affective regulation, problem solving).

Relaxation and Affective Expression and Modulation

Given the repetitive and chronic nature of their trauma exposure, some youth in foster care may need additional time focused on learning and practicing skills in order to regulate their emotions. However, as mentioned earlier in the chapter, in a number of cases, duration of treatment was no longer than that for children living with their biological or adoptive families. Decisions to spend more time on relaxation and affective modulation should be made based on clinical assessment and on the children's ability to use skills (e.g., deep breathing, listening to music) to cope with difficult or distressing emotions or tension in session and between sessions.

It can be important also to work with both the child and the foster parent on using their skills at foster care–specific times that are distressing: for example, preparing for and coming home from visits with parents, siblings, and other family or upcoming parent court dates and placement decisions (when children are aware of them and are experiencing distress). Many foster parents report that children are emotionally distressed or that behavioral problems are exacerbated before and after visits. Clinicians can work with children and foster parents to develop a coping and transition plan that includes relaxation and affective modulation strategies, which can be used consistently to build a coping routine before and after the visit. For some children, developing a safety plan for visits is one way to reduce distress before, during, and after the visits. Cognitive coping strategies can also be beneficial as part of this plan, and are addressed in the "Cognitive Coping" section. Some children like to carry a "favorite coping strategies" card that they created to refer to when they are feeling distressed and to have with them on their visits as a reminder. TF-CBT therapists can laminate these coping cards to make them sturdy and durable.

As for any youth receiving TF-CBT, during the session it is beneficial to demonstrate that using relaxation and affective modulation strategies work, and that the child can change his or her feelings and their intensity. One activity implemented with success involves having the child write down or draw current feelings, rate their intensity, and then watch a funny video on YouTube (e.g., twin babies talking) or play a fun game for a few minutes. Following this, the child re-rates the feelings and writes or draws any new feelings. This type of activity provides an excellent springboard for demonstrating the child's efficacy in changing feelings and/or their intensity.

Case Example

A 9-year-old girl in foster care was missing her biological father, who she witness being stabbed by her mother. She had frequent nightmares about the stabbing. In conducting the affective modulation component, the first strategy the child identified that would help when she had nightmares was having her biological father sing to her, which was not possible because she was in foster care. The clinician validated and normalized this desire and then asked if there was anyone in her foster home who could sing to her. She identified her foster mom as someone who could sing her a song and, working with the foster mother, a plan was created whereby she could knock on her foster mother's door and listen to a short song when she was having nightmares. The foster mother also implemented a calming routine with the child before bedtime. After singing a gentle song, the foster mother also would give the child a hug and help her do some cognitive coping ("I am safe. My dad is OK"). After a period of time, the nightmares decreased.

Cognitive Coping

Cognitive coping is an incredibly helpful strategy for all children in learning that, although we cannot always control what happens or happened, we can control how we think about it. This often decreases children's feelings of helplessness and empowers them to feel some control over the impact of particular events or situations. For children in foster care, there are a number of important events and decisions that are often out of their control, including past traumatic experiences and inconsistent caregiving, where and with whom they live in the short term (e.g., placement changes and disruptions) and in the long term (reunification vs. long-term foster care or adoption), as well as visits with family. When parents or siblings do not show for or cancel family visits, additional distress and/or fear can result (e.g., "Something bad must have happened to my mom"; "My dad doesn't love me enough to come"). Helping children identify different ways to think about missed visits that help them feel better, blame themselves less, and worry less can be important (e.g., "My mom sometimes misses visits, and she has always been OK. She takes care of herself pretty well"; "My dad misses visits sometimes because he's drinking and forgets, but he doesn't miss them because of me").

These children can also apply cognitive coping skills to handle difficult thoughts and feelings related to their relationship with their biological parents. In one case, a 17-year-old girl was experiencing a lot of anger and was engaging in physically aggressive behavior in her foster home and at school. The clinician was working with the foster mother on behavioral management strategies, and at the same time was conducting cognitive triangle exercises (i.e., helping her to connect thoughts, feelings, and behavior) with the client to identify what was going through her mind at times when she was angry and most likely to be aggressive. The client reported that she was often thinking about her mom and how angry she was that her mom had become "addicted to drugs" after injuries from a car accident. Since the accident, her mother had not cared for her and her sister, which resulted in their placement in two different foster care homes. In the cognitive coping activity, the clinician worked with the client to identify a more helpful thought for when she would think about her mom and become angry (see Figure 2.1). This activity was immediately helpful for the client in recognizing the role her thoughts played in her aggressive behavior and her feelings of anger.

Trauma Narrative Development and Processing

One important component of TF-CBT with children in foster care is helping them identify which of the typically many traumatic events should be discussed as part of the trauma narrative (TN). For all children, the TN

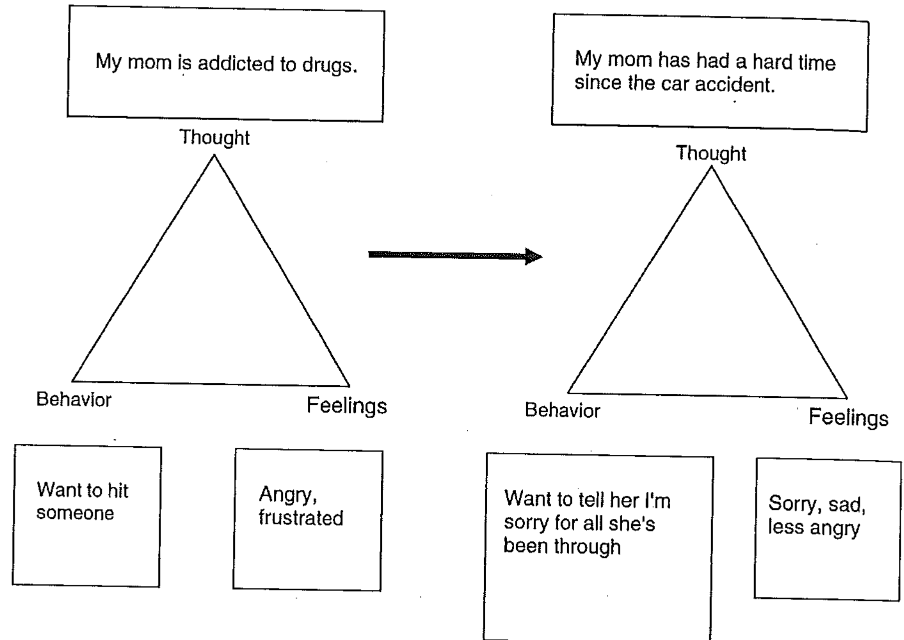

FIGURE 2.1. Cognitive triangle exercise.

can include multiple traumatic events of different types (e.g., sexual abuse, neglect, witnessing domestic violence), but it does not need to be, and should not be, entirely comprehensive (because of the time this would necessarily involve). Instead, the goal is for the children to talk about and become desensitized to some of their worst and the most distressful memories. The children should also be allowed the option of beginning the TN with a less difficult memory, and working toward the more difficult ones, so that the TN is gradual in nature.

For some children, the process of entering foster care and/or particularly troublesome placement changes may be included in the more difficult memories. For children in foster care trauma exposure is typically chronic in nature, and they often have had multiple different foster and kinship placements and sometimes disrupted reunification or failed adoption. To help children organize their experiences and decide what to include in the TN, many clinicians have found a table of contents or timeline to be a helpful strategy. Evidence suggests that individuals who have more organized and coherent trauma memories are less prone to developing PTSD.

One helpful resource that can be used earlier in psychoeducation but also may help to prepare children to develop their TN is Levy's *Finding the*

Right Spot (2004). This book is a useful tool for children who have experienced significant distress dealing with foster care or with parents who do not follow through with visitation or contact. Reading books about foster care not only helps children bring up their own thoughts and feelings about similar experiences (thereby supporting the goal of gradual exposure), but also provides a model for how they might write a book about their own experiences.

Cognitive Processing

Helping children to make meaning of and contextualize their trauma exposure is one of the most important aspects of TF-CBT, especially for those in foster care who have not yet had resolution for their experiences (e.g., as a result of trauma exposure, lack of permanent placement). Clinicians should address children's thoughts as recommended in TF-CBT and be on the lookout for thoughts related to self-worth, ability to be loved, and perspective on the future. Children in foster care often have had repeated negative experiences with caregivers and abuse or stability-related experiences (e.g., failed placements) and, therefore, are prone to developing negative beliefs about themselves. In TF-CBT, identifying negative self-beliefs and helping the children develop a more positive or less self-blame-oriented perspective about their past experiences and future is important. Unfortunately, some experiences in foster care can seem to confirm children's negative beliefs (e.g., "See? I'm not a kid people like. I told you what happened with my parents, and the last two foster families I had didn't want me for more than a few weeks"). The goal, as much as possible, is to help children avoid self-fulfilling prophecies, such as "I won't be loved" or "It doesn't matter if I try to act right or fit in. Nobody wants me around for long."

Additionally, thoughts related to beliefs about their parents' love for the child can be particularly distressing when parents have given up custody voluntarily or have repeatedly missed visits or when the children are old enough to recognize that their parents are not complying with expectations to regain custody. It may be challenging for even the clinician to find a more helpful, positive perspective. In one case, an 11-year-old boy who was sexually and physically abused and neglected by his father and then placed in foster care had difficulty making sense of why his father had given up his parental rights voluntarily and was not pursuing custody of his children. The client struggled with understanding why his father did not want to try to get custody of him and his younger brother and how he could have hurt them. During cognitive reprocessing, the therapist used logical/Socratic questioning to help the child reflect on the psychoeducation regarding neglect provided earlier in treatment (e.g., What is a parent's job? What should parents do for children? Do parents know the rules about sexual abuse and physical

abuse?) and helped him think about the situation in a different way: that, by giving up custody, the father was also involved in making sure the children would be cared for by someone who, unlike himself, *would* fulfill parental expectations—feed the children, clothe them appropriately, and be home for them. This new thought (e.g., "My dad knows it's best for other adults to take care of us") helped the client focus on some of the more positive aspects of the situation, although he still, as would be expected, reported sadness about not having a dad who wanted to "do a parent's job" and keep his children at his home. The foster father was involved and in conjoint sessions was instrumental in reinforcing that this child was loved, that nothing that happened was his fault, and that the dad just did not have the ability to care for his children himself.

Conjoint Parent–Child Sessions

As with other children who receive TF-CBT, ideally a caregiver is involved in each session and is prepared to be involved in conjoint sessions, including a conjoint TN sharing session. In some cases, these conjoint TN sessions are similar to any other conjoint TN session. Ideally children share all of their TN but can choose whether or not they want to discuss certain aspects (e.g., because of a low sense of emotional closeness to the foster parent, privacy reasons). Our goal is to assess *why* the child does not want to share the TN to ensure that reasons are not related to self-blame, shame, or other unhelpful cognitions ("If my aunt hears this part, where I talk about how I went over to his house even though my mom repeatedly told me not to, she will be angry and think part of it was my fault").

In some cases, when either a caregiver has not been involved or the child does not want to share with the caregiver for appropriate reasons (e.g., the foster parent has not been emotionally supportive of the child's traumatic experiences), the clinician can help the child think creatively about someone with whom it would be appropriate to share the TN and who could offer ongoing emotional support. We have had some children share with an adult sibling, a teacher, a mentor, or a former foster parent. In all situations, the therapist took the same time as one would with a caregiver to provide psychoeducation about trauma exposure and common reactions and to allow the individual time to hear and desensitize to the TN prior to the conjoint TN sharing session.

INVOLVING BIOLOGICAL/ADOPTIVE PARENTS FROM WHOM CHILDREN HAVE BEEN REMOVED

Clinicians often ask about how and when to involve biological parents in treatment. In our experience, this varies case by case and special consider-

ation should be given to (1) reunification plans, status, and timing (e.g., is this child going to be reunified with his/her parents and when?); (2) parent's role in the abuse (was the parent the perpetrator?); (3) abuse type (sexual abuse vs. other types); and (4) parental receipt of and response to their own treatment. In considering parental involvement, consultation with the child welfare social worker is important. When a child will reunify with parents, we often involve the parents in learning the PRAC components of TF-CBT so that they know the skills the child has learned and can reinforce these skills in the home when the child returns. We also often work with the biological parents on safety. We recommend that decisions about sharing the child's TN with the parent, even when the child wants to do so, include careful consideration of the factors just presented. In some situations, when the parent was the perpetrator or contributed to the abuse (e.g., did not monitor other adults in the home because of his or her own substance use) but has received treatment, has taken responsibility for the abuse, and developed a plan for safety in the future, the parent can be involved in conjoint sessions for the TN. Two CBT treatments are available that incorporate or build on TF-CBT skills that specifically include the physically abusive parent: alternatives for families CBT (Kolko, 1996; Kolko & Swenson, 2002) and combined parent–child CBT (Runyon, Deblinger, & Steer, 2010). If the parent was involved in perpetration but has not yet received treatment and has not taken responsibility for the abuse, sharing the TN is not advised because of concerns that the parent may reinforce child blame or deflect responsibility and may be unable to provide emotional support to the child.

In cases in which the parent has received treatment and participated in TF-CBT, children can share their TN with both their foster parents and their biological parents—the share does not have to happen only once with one caregiver. We had one client who first shared her TN with her grandmother (her kinship caregiver who participated in TF-CBT each week). Then, after two to three conjoint sessions in which the therapist met with the client's biological mother as well as her therapist, during which the mother was oriented to TF-CBT and prepared for the share, the client was also able to share her TN with her biological mother, who had been the victim of the domestic violence to which this client was exposed. The share was very effective in reestablishing the mother's ability to offer support to her daughter, but only after it was clear she could be emotionally supportive during the TN share.

CLINICAL CASE DESCRIPTION

Ten-year-old Thomas was placed in foster care for the third time after his 26-year-old biological mother was hospitalized following a violent domestic dispute with Thomas's biological father, whose whereabouts were unknown.

In his two prior foster placements, Thomas exhibited significant acting out and attempted to run away numerous times, once successfully, getting as far as 5 miles.

Because of his trauma history, suspected PTSD, and acting-out behaviors, Thomas was referred for TF-CBT at a local outpatient clinic. Thomas and his foster mother, Ms. Bell, participated in the initial assessment, which consisted of interviews, observations, and the completion of standardized measures. Although Thomas was cooperative in completing the measures, he was highly reticent to talk about any of the violence to which he was exposed, including the physical abuse by his father, which had been substantiated by the child protection agency on two occasions. He was more willing, however, to talk about the drug use by his parents that he witnessed and his negative experiences in prior foster placements, including being bullied by a foster teenager in his last home.

On the basis of the assessment, Thomas was rated in the clinical range on the Externalizing and Internalizing scales of the Child Behavior Checklist, and he met *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revision) criteria for oppositional defiant disorder as well as for PTSD. Thomas also reported some symptoms of depression and feelings of shame.

During the initial treatment session, Ms. Bell was provided with information from the assessment about Thomas's trauma exposure as well as his emotional and behavioral functioning. Ms. Bell was surprised to learn the extent of the violence Thomas experienced and reported that it helped her understand some of his behavioral reactions and discomfort being around her husband. She further indicated that she had not been asked to participate in therapy with her prior foster child and would be willing to do so with Thomas if it would help him. She acknowledged that she had requested that her prior foster daughter be removed from her home because she could not manage the teenager's behaviors, and she was worried that she might not be able to tolerate Thomas's behaviors much longer if something did not change. The therapist validated Ms. Bell's feelings of regret concerning her prior foster child and the challenges involved in being a foster parent, and praised her efforts on behalf of Thomas. The therapist also reviewed the proposed treatment plan, pointing out that she would be meeting with Ms. Bell each week in addition to meeting with Thomas and that there would also be conjoint sessions. The therapist explained that this approach was highly effective and would greatly assist Ms. Bell in understanding and managing Thomas's emotional and behavioral difficulties, and that they would start immediately on developing a plan to improve Thomas's behavior, particularly his refusal to listen to her directions. In addition, the therapist discussed the nature, characteristics, prevalence, and common effects of family violence on children, including the increased aggression that Thomas had

been demonstrating, as well as the stressors associated with placement in foster care.

Thomas engaged readily in casual conversation with the therapist from the start and easily shared a detailed, positive narrative about a recent adventure in the park with his friends in the new neighborhood. However, when asked to share what had brought him to Ms. Bell's home, he responded with "Read my file." The therapist indicated that she could do that but preferred to hear his thoughts on why he was placed with Ms. Bell or maybe what his first day at Ms. Bell's home was like for him, just like he had told her about his adventure exploring the new neighborhood. Thomas insisted that he did not know why he was "taken from" his mom, but he briefly shared his first day with Ms. Bell, with minimal details and emotions compared with his earlier narrative. Thomas explained, "My worker picked me up and brought me to a big red house. Ms. Bell came to the door and said 'Hi.' I said nothing 'cause I was mad. Then she showed me my room and it was green—I don't like green, but I did like the car picture on the wall. Then I tried to sleep because it was late, but I couldn't for a long time." The therapist reflected back a summary of what Thomas shared, and validated his feelings, praising him for helping her understand what that day was like for him. During the sessions that followed, the therapist taught Thomas relaxation skills to help him relax in the evening before bed, a time when Thomas worried a lot about his mom. The therapist inquired about a place Thomas considered most relaxing. Using his favorite place, the beach, the therapist engaged in a guided imagery exercise incorporating ocean and beach images and sounds.

During the weekly individual sessions with Thomas and his foster mother, the therapist introduced affective expression and modulation and cognitive coping skills. It was particularly important to help Thomas expand his identified emotions beyond "mad" and "angry" to include, for example, "scared," "sad," and "ashamed." In the course of considering all the different feelings kids might have when placed in foster care or if they experience any kind of violence within their families or in their community, Thomas was able to create a long list of emotion words. When asked simply to circle any feelings he had experienced himself, after initially only circling *mad* and *angry*, he acknowledged that he had also felt sad and scared. Still, he insisted that most often he felt angry and sometimes he did not even know why. The therapist explained that she could help Thomas to understand better what might be causing him to get angry so frequently and to manage those feelings better to avoid getting in trouble. Thomas showed some interest, but reminded the therapist that he had not been in trouble for almost a week, so he had figured that out himself. This provided a starting point to help Thomas identify how he had kept himself out of trouble in the past week and led to the identification of some useful impulse-control and

affect regulation skills, such as ignoring those who teased him and problem-solving alternatives to fighting, including making friends with the nicer kids who would protect him. He also insisted that he had the right to be mad about being away from his mom, and the therapist agreed and suggested that there were many ways he could express those feelings—in drawings, poems, or even by writing rap, like many celebrities have done about things in their lives that were difficult. The rap song idea appealed to Thomas, who wondered if any celebrity had ever been in foster care "because of his stupid dad."

Conjoint sessions began early in treatment in order to assist Ms. Bell with the parenting and behavior management skills she was learning. Ms. Bell complained that Thomas did not cooperate with her the way her sons did when they were young. The therapist explained that Thomas had not learned to cooperate with his parents; rather, in order to survive in his family environment he learned to be aggressive toward others, but he could unlearn these behaviors with her help. In the conjoint therapy sessions, Ms. Bell had an opportunity to practice the behavior management skills to increase Thomas's compliance, starting with sessions in which she would praise Thomas for cooperative behaviors. Thomas was also encouraged to prepare specific praise to share with Ms. Bell during conjoint sessions (e.g., he thanked for picking him up everyday after school). This ritual of ending sessions with a mutual exchange of praise became a highlight of the sessions that led to an important daily ritual that Ms. Bell insisted she would continue after therapy had ended because she enjoyed hearing praise from Thomas so much.

In parent-only sessions, the therapist and Ms. Bell role-played how to praise Thomas each time he listened or cooperated and how to minimize the attention she gave him when he talked back to her. As sessions progressed, the therapist and Ms. Bell developed a rewards plan for Thomas to reinforce his listening to her instructions the first time or with a subsequent warning. Each week, Ms. Bell practiced these skills with Thomas and reported back to the therapist about how the skills had worked or not worked, allowing modification of the behavior management plan. Ignoring Thomas's talking back was challenging for Ms. Bell, who viewed it as disrespectful. In the first week that Ms. Bell had planned to ignore the talking back, she reported to the therapist that she had not followed through with this practice, and that it was particularly challenging to ignore the disrespect—respect for adults was an important principle in her home. The therapist and Ms. Bell worked to reframe her thoughts about his talking back—that it was a way Thomas had learned to get attention, both in his previous placements and with her. Working with Ms. Bell to view the talking back through this lens (e.g., attention seeking) allowed her to feel less frustrated by Thomas's behavior and better able to use active ignoring and praise for respectful behavior. The

more she ignored the talking back, the less Thomas engaged in this behavior and showed more respect.

At times, Ms. Bell reported that practicing the parenting skills, although helpful, was a lot of work. When the therapist asked about the amount of time Ms. Bell felt she had spent trying to manage Thomas's noncompliance and her former foster daughter's noncompliance, Ms. Bell reported that it had taken all of her energy. The therapist validated how challenging it can be to use the new behavior management skills consistently, but that the investment of time now should decrease the energy she would have to spend managing Thomas's noncompliance in the future.

After about six sessions and some success with using the parenting skills for managing noncompliance, Ms. Bell reported that, although Thomas seemed happier and more comfortable in her home and was listening better, he had missed several days at school in the past week, refusing to go because of headaches and stomachaches. Moreover, he insisted that his biological mom frequently allowed him to stay home from school. Ms. Bell reported that the mornings were extremely frustrating, so she sometimes lost her patience and would simply give in and send Thomas back to bed, but eventually would allow Thomas to watch TV in the family room. The therapist explored with Ms. Bell possible reasons why certain days might be particularly anxiety provoking at school, and she indicated that Thomas seemed to hate gym and complained most about going to school on those days.

Initially, the therapist did not let on with Thomas that she was aware of his avoidance of school, but simply taught Thomas about the cognitive triangle and how thoughts influence feelings and behaviors. The therapist indicated that when we wake up in the morning we often have a thought before we say anything out loud. She asked Thomas what thought popped into his head when his alarm went off in the morning. Surprisingly, seemingly caught off guard, Thomas indicated that this morning he thought, "I hate school and I feel sick. So I'm not going." The therapist validated his feelings, acknowledging that many kids hate school and inquiring what he hated most about school. Thomas immediately reported that gym was what he hated most. After asking many open-ended questions about school, Thomas eventually acknowledged that he hated gym the most because in his class the boys might see the scars on his legs and would "know I was beat by my Dad for being a bad kid." The therapist helped Thomas process his feelings and his thoughts. The therapist showed Thomas pictures from medical books of people with scars on their legs—some worse than Thomas's. She asked Thomas to guess what caused the scars. Even before guessing, Thomas seemed to understand that he had "no idea" what happened but guessed anyway and was wrong each time. Although he was still concerned that the other boys might tease him, Thomas felt better knowing that if he did not tell the children, they would likely not know how he got his scars.

During the conjoint session, the therapist and Ms. Bell acknowledged that it took a lot of courage for Thomas to go to new schools so often and to make new friends. Ms. Bell praised Thomas for his assertiveness skills, and also explained that each day that he went to school cooperatively in the morning, she would let him play video games on Mr. Bell's computer in the evening after homework.

Thomas continued to be reticent about discussing anything relating to his parents, although he seemed more than happy to talk about Mr. and Ms. Bell and his previous foster parents. When the therapist asked Thomas if he would like to read a book about kids in foster care, Thomas was interested. After reading *Maybe Days,* the therapist suggested that Thomas could write a similar book about his experiences. Thomas said that he would like to draw pictures for the book but did not like writing. When the therapist offered to type his story and create a fancy book based on his experiences, Thomas seemed cautious but willing. First, Thomas was asked to create a timeline of events he might like to include in his book in the form of chapters titles. The initial chapters included:

1. "Thomas and My Maybe Days"
2. "My First Time in Foster Care"
3. "My Second Time in Foster Care and the Teenage Bully"
4. "My Third Time in Foster Care"
5. "The End"

After some coaxing to include additional experiences that might help other kids understand why kids have to be in foster care sometimes, Thomas included a chapter about his parents using drugs and a chapter about the "scary" night before he went to Ms. Bell's house.

When the narrative was almost complete, the therapist praised Thomas for being so brave and writing about many things that were confusing and scary for kids. She explained when kids and adults talk and write about things like he did, it not only helps them but also helps to stop the secrets that keep violence in families going. She encouraged him to write one or two more chapters about anything else that happened to him that he thought he would never want to talk about before he got so brave. The therapist waited out a long silence until Thomas said he wanted to write one chapter about the beatings he got from his dad. After completing that chapter, Thomas and his therapist reread his entire book, highlighting the many accurate and important feelings he expressed while also identifying and correcting dysfunctional thoughts, including the cognitive distortion that he was placed in foster care because of his misbehavior in school. With these lessons learned in mind as well as with encouragement and guidance from his therapist, Thomas wrote his final chapter:

I am 11 years old now and I still live with Ms. Bell. I used to be mad at her and everyone all the time. I don't get mad that much anymore. When I get mad, I take a few deep breaths and say to myself "Chillax" and it works most of the time. I used to think if I could take care of my mom she would not do drugs, but now I know kids can't stop people from doing drugs—only doctors, therapists, and maybe hospitals can help my mom with this. My mom and dad had problems with drugs, anger, and violence. I don't know why they were so angry, but sometimes people don't know why, they just need help to stop fighting. When my father was angry, he hurt me and said very mean things to me—probably this was because he was on drugs, because other times he was nice. I don't see my Dad anymore because no one knows where he is. I hope he is OK, but I'm glad he can't hurt me or my mom anymore. My mom is working hard to get better and she loves me. We don't want any more violence. Ms. Bell is my mom too and I really like Mr. Bell too. I want to be a teacher and a dad like Mr. Bell. He doesn't hit, just says "1, 2, 3" and he tries to make me laugh with his funny voices. Maybe I will stay with Ms. Bell and maybe I will not, but I will always be in her heart. If you ever have to go to foster care—don't worry it won't be that bad, especially if you get the Bells.

The therapist prepared Ms. Bell for a conjoint session in which Thomas would present his narrative by sharing sections of Thomas's narrative with her as he was developing it. This sharing enhanced Ms. Bell's compassion for Thomas's circumstances and experiences that were markedly different from her own children's. She reported that this helped her to have greater patience and willingness to persevere with Thomas. This seemed to be particularly important when Thomas's behavior problems worsened temporarily because of an extinction burst when Ms. Bell was beginning to implement behavior management (i.e., praise and active ignoring) and Thomas was really testing the limits in the Bell home. Toward the end of treatment, Thomas spontaneously asked if he could share his entire narrative with his foster mom, and Ms. Bell seemed very well prepared emotionally and pleased that Thomas was excited to share it with her. In preparing for this conjoint session, the therapist encouraged Ms. Bell to practice her active listening and praise skills in a role play during an individual parent session in which the therapist played the role of Thomas reading the narrative. The therapist also explained that Thomas had some questions that he wanted to ask her after sharing his narrative, including, "Do you think my dad wouldn't have hit me so much if I had listened better?"; "Will I always get to stay with you if I want to?"; "Do you think my dad thinks about me sometimes?" With the help of the therapist, Ms. Bell carefully prepared answers to these questions that were honest but also therapeutic for Thomas. Finally, during this session, the therapist encouraged Thomas and his foster mom to think about how they would like to celebrate their therapy graduation.

Ms. Bell expressed that she was pleased that they did not have to continue in therapy endlessly, but would really miss the support and guidance she had been receiving and hoped she could call from time to time or drop in. The therapist encouraged her to call not only for an occasional booster session but also with good news about Thomas's progress as well. This seemed to relieve Ms. Bell's anxiety about termination and allowed her to look forward to and plan an elaborate (i.e., graduation cap, balloons, music, and special "Bell classic" double chocolate cake) graduation celebration with greater enthusiasm.

CONCLUSION

As noted earlier, children placed in foster care have high rates of trauma exposures and related emotional and behavioral difficulties (Kolko et al., 2010; Pecora et al., 2003). The escalation of such difficulties often leads to placement disruptions that are highly predictive of additional adjustment problems in adolescence and adulthood. Thus, it is imperative that foster children receive mental health services that are efficient and effective in addressing their unique and individualized needs. This chapter describes the implementation of TF-CBT, which has been demonstrated to be effective with this population, with special attention to their unique concerns and circumstances. In addition, methods for enhancing the active engagement of foster parents in treatment are highlighted, along with suggestions and factors to consider concerning the involvement of biological/adoptive parents from whom children were removed. TF-CBT has shown great promise in serving the needs of foster children; however, much still needs to be learned through collaborative clinical and research efforts to ensure that we are optimally caring for the comprehensive needs of these children.

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