Research Brief

What we know

This study explored the relationship between childhood victimization and adversity (CVA) and behavioral health outcomes (depression, anxiety, trauma symptoms, delinquency, and aggressive behaviors) of youth involved in Child Welfare (CW). Previous research has focused primarily on a small part of CVA (child abuse and neglect), but this study used a Cumulative Risk Model which included not only maltreatment but also crime, peer victimization, sexual victimization, household stressors, and witnessing violence or struggles in the home and community.

What this study adds

CW involved youth experience double the amount of CVAs when compared to a national study. Over half of children being served by CW experienced 3 or more domains of the CVA scale and a quarter experienced 4 or more. Children who experienced 4 CVA domains were 6 times more likely to experience internalizing behaviors (withdrawn, anxiety, and depression), externalizing behaviors (aggression and delinquent behaviors), and PTSD symptoms at clinically significant levels than youth who reported 0 or 1 domain.

What this means for practice or policy

By broadening what is defined as a CVA, those concerned with the care of CW involved youth can create more comprehensive evaluations that allow for better treatment of behavioral health diagnoses caused by CVAs and also help identify children who need behavioral health intervention in CW placements. The outcomes of this study were comparable to the outcomes of similar studies with youth involved in the Justice System, adolescent mothers, and youth in psychiatric care. This means that programs for these groups could also be used for CW involved youth.

How do we know this is a good study

The authors used the National Survey of Child and Adolescent Well Being (NSCAW) II (2009) which included over 5,800 children and collected data from the child, caregiver, and caseworker. A subsample of youth aged 8 to 17 (n = 1,887) was used from NSCAW. CVA included six domains: (1) Maltreatment, including physical abuse, emotional abuse, or physical neglect; (2) Peer Victimization, including bullying, gang violence, peer or sibling assault; (3) Sexual Victimization, including forced sexual contact by per or adult; (4) Home and Community Violence, including caregiver domestic violence, witnessing violence in the home, and lack of safety in the neighborhood; (5) Household Stressors, including caregiver substance use problem and caregiver with serious mental health problem; and (6) Conventional Crime, including assault or being threatened by a stranger and gunshot wound. Behavioral health was assessed using the Child Depression Inventory, Trauma Symptom Checklist, and the internalizing and externalizing subscales of the Child Behavior Checklist. Logistic regression was used to explore the association between the number of CVA reported and the risk of clinical–range behavioral health symptoms.

What we know

Traumatic childhood experiences – abuse and neglect, parental incarceration, and parental substance abuse and mental health problems – are public health concerns. Children who are currently being served by child protective services (CPS) have a much higher prevalence of these histories. Therapists and child welfare workers use an array of strategies and evidence-based practices to relieve the harm of past abuse and improve the coping and social skills of children and adolescents with these histories. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) has been identified as a promising intervention for reducing symptoms associated with trauma exposure. Since its first trial, CBITS has been adapted and used in schools for students from 1st through 5th grade.

What this study adds

This is the first study of CBITS conducted on older adolescents (12–19 years old) involved in child welfare systems and delivered in a non-school community setting, including in family homes and group homes. Although CBITS was originally developed for younger adolescents, the study found that older adolescents are just as receptive to the program as younger generations. CBITS was found to be an appropriate and acceptable child welfare treatment model for adolescent girls being served by CPS. Although the intervention did not significantly improve depression or post-traumatic stress symptoms above usual care, social problem-solving skills did improve and retention and satisfaction with the program was high.

What this means for practice or policy

Results showed that the services provided as usual care (inpatient psychiatric care, residential treatment, outpatient therapy, and drug and alcohol treatment) were also effective; these services reduced depression and PTSD at the same rate as CBITS. For future research, it is suggested that CBITS be used on other populations, including adolescent males, to further determine the extent to which it is effective.

How do we know this is a good study

The study used a randomized controlled trial comparing an adapted version of CBITS with usual care services. Participants aged 12–19 were recruited through referrals from state child welfare offices and other agencies serving youths in the child welfare system. Data collection included face-to-face interviews in which the participants' symptoms of PTSD, depression, and social problem-solving skills were assessed at pre, post (3 months), and follow-up (6 months) intervals. A Linear mixed model was used to compare states due to time interactions using all available data. Analysis of the correlations of the outcome variables over time indicated a relatively small number of possible covariance structures to explain the correlation error due to the repeated measures.