

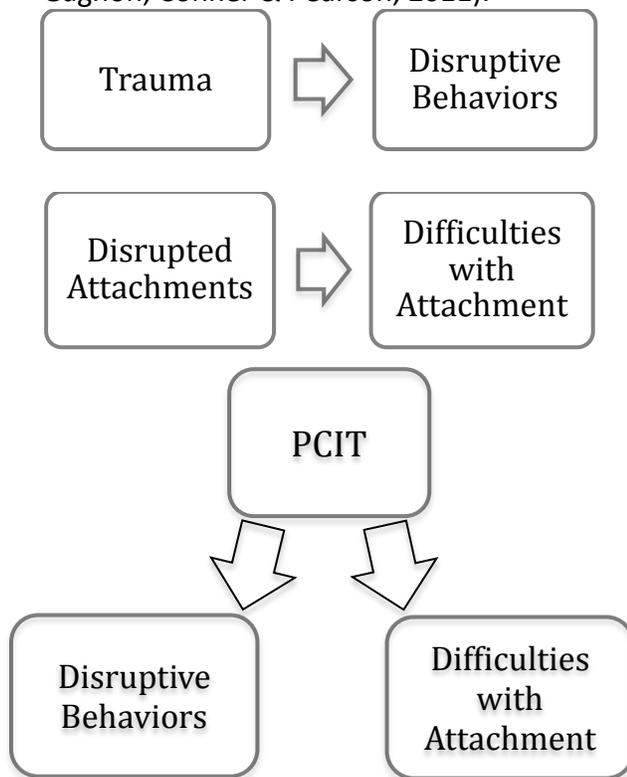
# Effectiveness of PCIT with Adoptive Children in a Los Angeles Community Mental Health Clinic

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## Rationale for Study

The vast majority of children adopted from the foster care system have experienced interpersonal trauma and at times are subject to additional risk factors, including multiple changes in caretaking, prenatal drug exposure, and increased number of placements. The link between trauma and disruptive behaviors in children has been well-documented (Ford, Gagnon, Conner & Pearson, 2011).



The child's trauma history, coupled with the uncertainty of the foster-adoptive situation, often precludes young children and their prospective adoptive parents from forming emotional bonds early in the placement. By the time the adoption is finalized, many young children and their adoptive parents may already be entrenched in a cycle of negative interactions that may evoke or even intensify the child's pre-existing disruptive behaviors.

In PCIT, the emphasis is on restructuring parent-child patterns, not merely on modifying target behaviors. This focus is of particular relevance to our adoptive families, in which attachment difficulties are often on the forefront.

Furthermore, the efficacy of PCIT in reducing child behavior problems has been demonstrated in over 100 empirical studies, including with other high-risk populations, such as physically abused children and foster children. However, the effectiveness of PCIT with children in finalized adoptive homes has not yet been demonstrated.

## Method

### Participants

- Participants were children adopted from child welfare and their adoptive parents who were referred to PCIT due to disruptive behaviors.
- Assessed 15 adoptive parent-child dyads who had completed standardized and observational assessments at a minimum of two assessment points (e.g., pre- and mid- or post-treatment; N=15); Approximately 86% of the 15 dyads completed a full course of PCIT.

- The average age of child participants was 6, with ages ranging from 2 to 9. The sample was ethnically diverse.

## Hypotheses

1. It was hypothesized that levels of pre-treatment child disruptive behaviors in an adoptive sample would be reported at levels similar to those reported in studies with other, similar samples (Self-Brown et al., 2012).
2. It was hypothesized that PCIT would function similarly in the foster-adoptive sample as it does with other, previously researched populations (e.g., foster children); namely, adoptive children will show significant declines in disruptive behaviors from pre- to post-treatment.

## Results

- Hypotheses 1 was not supported. Parent-reported levels of child disruptive behaviors reported at pre-treatment by adoptive parents were lower than those reported in other studies with high-risk populations (Self-Brown et al., 2012).
- Additionally, the adoptive parents in our sample did not report experiencing significant parental distress. Only 20% reported significant distress at pre-treatment, and only 13% reported significant distress at post-treatment.
- Hypothesis 2 was partially supported. PCIT did significantly reduce disruptive behaviors and parent-reported levels of stress on five of the nine scales/subscales collected at pre- and post-treatment.

## Discussion

Timmer, Sedlar, & Urquiza (2004) found that non-kin caregivers rated their foster children's behavior problems as significantly more severe than kin caregivers, but rated themselves as significantly less stressed. This finding is partially replicated in our sample; namely, the adoptive (non-kin) caregivers in this study also rated themselves as less stressed than one might expect given the referral to PCIT (only 20% of caregivers reported significant parental distress at pre-treatment). It may be that adoptive parents are hesitant to disclose any parental distress due to their own dissonance between their great desire to be a parent and the distress that this experience is causing them. Although five of nine treatment scales were significantly reduced from pre- to post-treatment, further research with a larger sample is needed to evaluate the effectiveness of PCIT with this population in a clinic setting.

## References

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