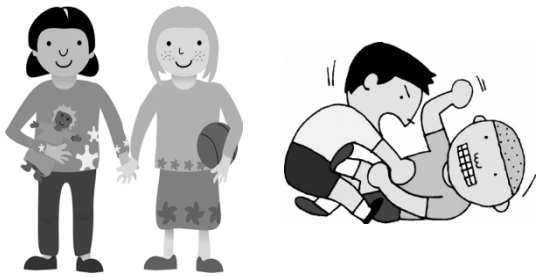
# PCIT & CPP: ASSESSING AND TREATING THE MANY NEEDS OF TRAUMATIZED CHILDREN IN THE CHILD WELFARE SYSTEM

Lauren Maltby, Ph.D., Janine Shelby, Ph.D., Larisa Litvinov, Ph.D.

## Friends? Enemies? Frenemies?



## Part I: Theoretical Issues

## Myth 1: CPP & PCIT Are Theoretically Exclusive

- Child-Parent Psychotherapy:
  - Lieberman, A.F. & Van Horn, P. (2005). *Don't hit my mommy! A manual for child-parent psychotherapy with young witnesses of family violence*. Washington, D.C.: ZERO TO THREE Press.
  - Lieberman, A.F. & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York: The Guilford Press.
- Parent-Child Interaction Therapy:
  - McNeil, C.B. & Hembree-Kigin, T.L. (2011). *Parent-child interaction therapy*. New York: Springer.

## Myth: CPP & PCIT Are Theoretically Exclusive

**CPP**

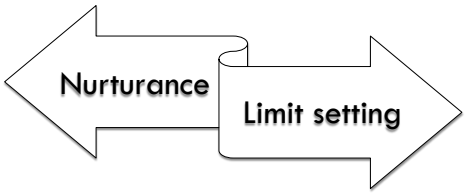
- Fundamentally "psychodynamic" or object-relations; assumes the existence of an unconscious/implicit/ internalized *something* that continues to exert influence on current relationships.
- See Shedler (2006 & 2010) for more information.

**PCIT**

- Fundamentally "behavioral" or the idea that all behaviors are acquired through learning/conditioning (operant, classical, social, etc.)
- See Baumrind for more information…

## Theoretically Exclusive?

Dual needs of young children:

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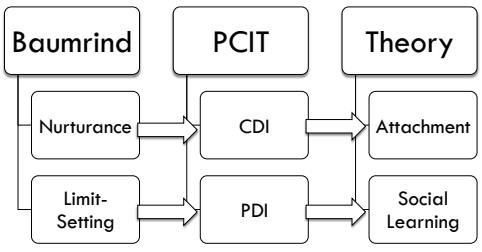
## Theoretically Exclusive?

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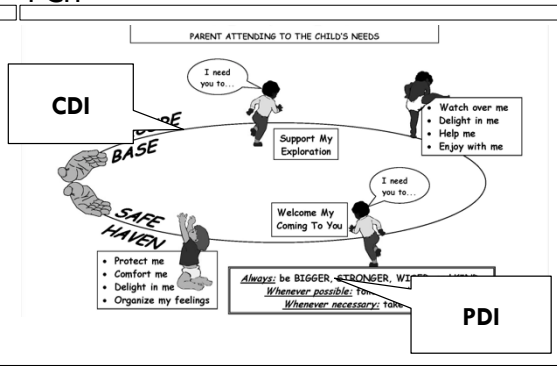
## Theoretically Exclusive? Attachment & PCIT



## Myth 2: All Children In The Child Welfare System Are Acutely Traumatized

DSM-IV TR Definition of Traumatic Events:

1. Events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. Response to the event involves intense fear, helplessness, horror, or disorganized/agitated behavior.

Definition of "traumatized":

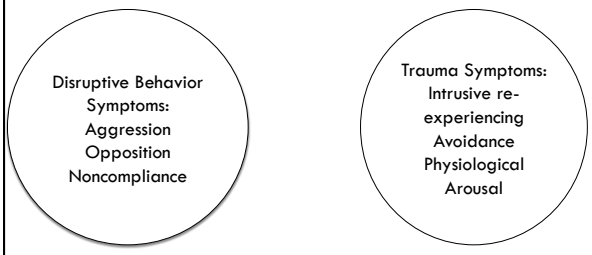
1. A pattern of cognitive, affective, and behavioral responses that occur consequent to exposure to traumatic events that are physical, psychological, or both, in nature. (Duckworth & Follette, 2012 )

## Myth 2: All Children In The Child Welfare System Are Acutely Traumatized

- How can a child end up in DCFS without being traumatized?
  - Detained for exposure to a specific type of trauma (e.g., child abuse) OR
  - Detained for inability to protect a child from exposure to trauma (e.g., siblings in sexual abuse/DV cases)
  - Prenatal physical trauma leading to detainment
  - Neglect (on the fence…)

…And in need trauma treatment with some exposure component…

## Myth 3: All Disruptive Behaviors Are Due To Trauma

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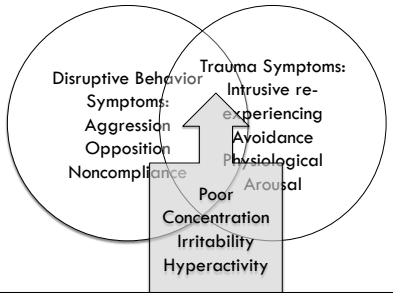
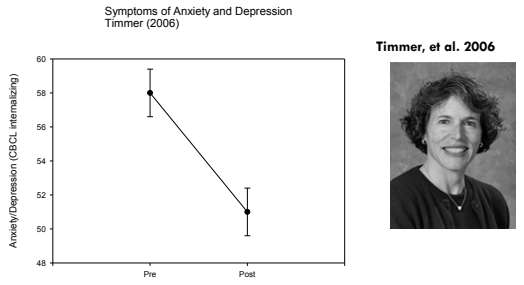


## Myth 4: PCIT Doesn't Treat Trauma




**Timmer, et al. 2006**



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## Myth 4: PCIT Doesn't Treat Trauma

**'PCIT for Traumatized Children'**

| | | |
|---|---|---|
| Trauma | Behavioral | Affective |
| Symptoms | Disturbance | Dysregulation |
| Nightmares | non-compliance | temper tantrums |
| Anxiety | aggression | crying/whining |

A. Improved child relationship security/stability
   1) Decreased neg. interactions/increased pos. interactions
B. Increased positive affiliative behaviors (warmth)
C. Teaching parents child treatment skills
   1) Recognizing child distress
   2) Appropriate responses to child distress
D. Acquisition of normative information related to past traumatic experiences

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A. Improved parenting skills
B. Increased consistency in parenting skills
C. Increased parental responsivity to appropriate child behavior
D. Changes in parent perception of child (i.e., more positive attributes of child's behavior)
E. Discipline strategy for non-compliance/defiance

Management of disruptive behavior *may be* treating trauma symptoms

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**'PCIT for Traumatized Children'**

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|---|---|---|
| Trauma | Behavioral | Affective |
| Symptoms | Disturbance | Dysregulation |
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A. Decreased child behavioral problems
B. Acquisition of child coping skills (affective expression, breathing, relaxation)
C. Parental reinforcement for appropriate expression of distress

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## Myth 4: PCIT Doesn't Treat Trauma

**Is PCIT a Trauma Treatment?**

- If you view trauma symptoms as including disruptive behavior, then 'YES'
- If you view resilience to be a product of a positive, consistent, and warm relationship with a parent, then 'YES'
- If you perceive trauma treatment to include overcoming barriers to child recruitment, then 'YES'
- If you view trauma treatment as directly attending to trauma symptoms, then 'NO'

***Positive attunement is the foundation for growth… and healing.***

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## Myth 5: CPP Doesn't Address Behavior Problems/Parenting Issues

- CPP is a flexible treatment with the over-arching principle that you **do what the client needs**.
- If a parent is expressing a desire for help in managing their child's behaviors, then it is within the CPP frame to give them this help.
- As recently as one month ago, the CPP trainer for the staff at For The Child explicitly stated this same thing, and encouraged a clinician to teach PRIDE skills to a parent in CPP ☺

## Myth 6: The Only Way To Benefit From Tx Is To Complete It

PCIT

- "To the extent that children's challenging behavior is a result of disruptions in the parent-child relationship alone, children's behavior problems may be resolved after completing the first phase of treatment." (Timmer, Ware, Urquiza, Zebell, 2010, p. 497)
- Of 510 bio-parent/child dyads, 82% are either below the clinical cutoff or have dropped at least 10 points on the ECBI Intensity Scale from Pre- to Mid-Tx (Timmer, 2014, personal communication)

## Myth 6: The Only Way To Benefit From Tx Is To Complete It

CPP

- Personally unaware of data to show gains at mid-tx, but anecdotal evidence is suggestive of this.

- Behavioral problems may increase by mid-tx for a variety of reasons.
- As parent resolves their own trauma, they
  - Become more attentive to the child's bx that they've had all along
  - The child implicitly feels that the parent has more emotional space to tolerate their bx disruptions
  - Other contextual changes

## Myth 6: The Only Way To Benefit From Tx Is To Complete It

**RE-ASSESS!**

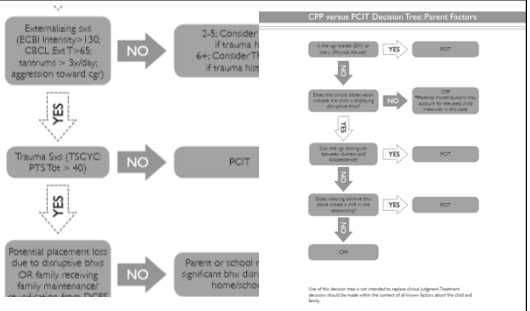
- Is this tx working?
- Is it working fast enough?
- What is the risk of providing this tx, or of NOT providing it?
- What is the risk of NOT resolving parental trauma?
- Have their needs changed?

## Myth 7: YouWant To Take Away My Freedom To Use My Clinical Judgment

- **USE YOUR TRAINING.**
- Purpose of decision tree: to help you think through the issues we **KNOW** are relevant to making tx decisions
- There is no way to make an **EXHAUSTIVE** list of factors/predictors

## Part II: Elements Of The Decision Tree

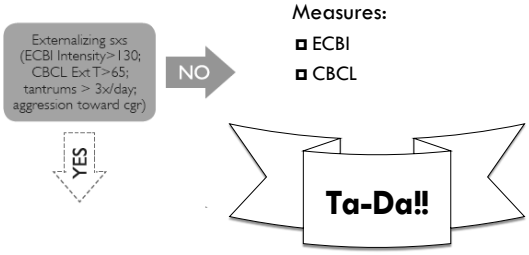
## Two-Page Decision Tree



## CPP versus PCIT Decision Tree: Child & Family Factors

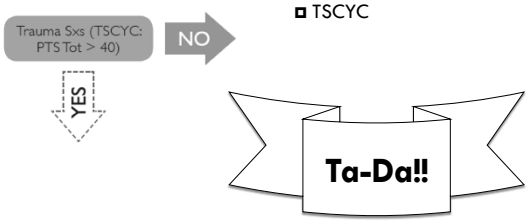

- CPP: 0-5
- PCIT: 2-7 (with PCAT 0-2)
- PCIT and CPP only overlap for 3 years:
  - 2-5
  - Alt. 0-5 (with PCAT)

## CPP versus PCIT Decision Tree: Child & Family Factors



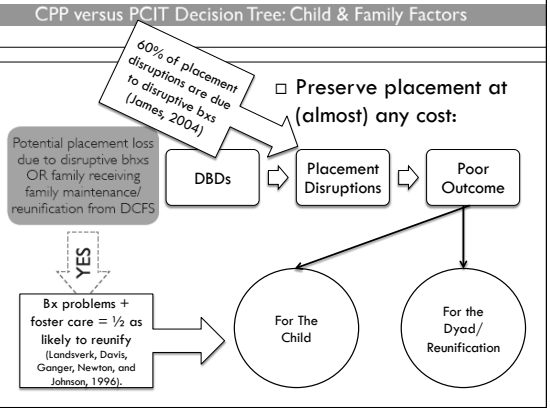

- Standard PCIT Measures:
  - ECBI
  - CBCL

## CPP versus PCIT Decision Tree: Child & Family Factors




- Standard PCIT Measures:
  - TSCYC

## CPP versus PCIT Decision Tree: Child & Family Factors



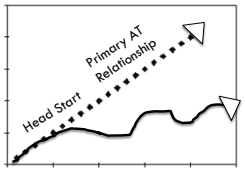

- Preserve placement at (almost) any cost:

## CPP versus PCIT Decision Tree: Child & Family Factors

Parent or school reporting significant bhx disruptions at home/school?

NO

YES




## CPP versus PCIT Decision Tree: Child & Family Factors

NO

Documented history of physical abuse by participating parent?

YES

- PCIT reduces recidivism rates for families with documented physical abuse histories
- CPP reduces return to documented DV relationships

## CPP versus PCIT Decision Tree: Parent Factors

- If trauma is on-going (e.g., DV) or caregiver is unstable, it can be iatrogenic to begin trauma txs that include exposures.
- Trauma txs are inherently taxing → decompensation if inadequate coping → risk for physical abuse or return to unsafe circumstances

Is the cgr scared (DV) or scary (Physical Abuse)?

YES

NO

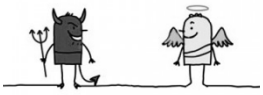
## CPP versus PCIT Decision Tree: Parent Factors

- "Ok, clean up the toys. All of them. Now."
  - "Ok, mom." (child cleans up right away)
  - WHAT?!
- Two incongruent possibilities:
  - Parent reports a lot of problems, but child displays none
  - Parent denies problems, but child displays many

Does the clinical observation indicate the child is displaying disruptive bhxs?

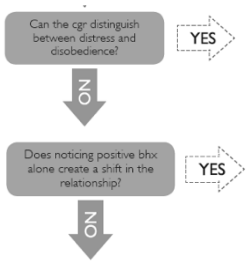
NO

YES



## CPP versus PCIT Decision Tree: Parent Factors

- *Why* does the caregiver have inaccurate attributions about the child, and
- Can those attributions be changed without treating the caregiver's trauma?




## Part III: Case Example

## Reason for Referral:

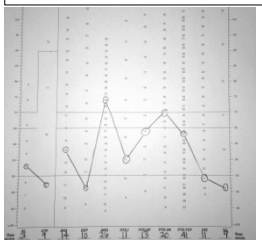
- 3-year-1-month Latino male
- Referred by DCFS social worker b/c caregiver felt unable to manage his bxs
  - Noncompliance
  - Tantrums (20-30m)
  - Aggressive with cgr and peers
  - Expelled from Head Start

## History:

- Prenatally exposed but without a positive toxicology screen at birth
- Maternal substance abuse on/off from 0-2 years
- Domestic violence between mo and mo's boyfriend
  - At 2-years-11-months, mo went to ER due to significant injuries, referral to DCFS
- Mo and mo's boyfriend + for methamphetamine
- Apartment excessively dirty, inadequate food
- Developmental concerns
- Placed with maternal grandmother

## Pre-Tx Data:

**TSCYC**



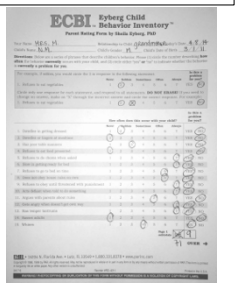
- Valid:
  - RL: T=53
  - ATR: T=47
- ANG: T=74
- PTS-AV: T=64
- PTS-AR: T=70
- PTS-TOT: T=63

## Pre-Tx Data:

**ECBI & CBCL**

- Intensity: T=65 (148)
- Problem: T=63 (17)

- CBCL:
  - Externalizing: T=71
  - Aggression: T=81




## Applying The Decision Tree: