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

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

Part I: Theoretical Issues

Friends? Enemies? Frenemies?

Myth 1: CPP & PCIT Are Theoretically Exclusive

- Child-Parent Psychotherapy:

- Parent-Child Interaction Therapy:
Myth: CPP & PCIT Are Theoretically Exclusive

<table>
<thead>
<tr>
<th>CPP</th>
<th>PCIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fundamentally “psychodynamic” or object-relations; assumes the existence of an unconscious/implicit/internalized something that continues to exert influence on current relationships.</td>
<td></td>
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<tr>
<td>☐ Fundamentally “behavioral” or the idea that all behaviors are acquired through learning/conditioning (operant, classical, social, etc.).</td>
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<td>☐ See Baumrind for more information…</td>
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</tbody>
</table>

Theoretically Exclusive?

Dual needs of young children:

- **Nurturance**
- **Limit setting**

Theoretically Exclusive? Attachment & PCIT

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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)

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…)

Myth 3: All Disruptive Behaviors Are Due To Trauma

Disruptive Behavior Symptoms:
- Aggression
- Opposition
- Noncompliance

Trauma Symptoms:
- Intrusive re-experiencing
- Avoidance
- Physiological Arousal
- Poor Concentration
- Irritability
- Hyperactivity

And in need trauma treatment with some exposure component…
Myth 4: PCIT Doesn’t Treat Trauma

Symptoms of Anxiety and Depression
Timmer (2006)

Pre Post

Anxiety/Depression (CBCL internalizing)

Pre: 48 50 52 54 56 58 60

Post: 52 54 56 58 60

Timmer, et al. 2006

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Myth 4: PCIT Doesn’t Treat Trauma

‘PCIT for Traumatized Children’

Trauma

Behavioral
Disturbance
dissociation

Affective
Dysregulation
crying/whining

Nightmares

non-compliance

Anxiety

temper tantrums

A. Improved child relationship security/stability
B. Decreased neg. interactions/increased pos. interactions
C. Increased positive affective behaviors (warmth)
D. Teaching parents child treatment skills
E. Reconnecting child/distance
F. Appropriate response to child distress
G. Acquisition of narrative information related to past traumatic experiences

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Trauma

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Anxiety

temper tantrums

A. Decreased child behavioral problems
B. Acquisition of child coping skills (effective 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 attachment 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

- “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

- 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

- 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?

RE-ASSESS!

Myth 7: You Want 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
<table>
<thead>
<tr>
<th>CPP versus PCIT Decision Tree: Child &amp; Family Factors</th>
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<tbody>
<tr>
<td>□ CPP: 0-5</td>
<td>□ Standard PCIT Measures:</td>
</tr>
<tr>
<td>□ PCIT: 2-7 (with PCAT 0-2)</td>
<td>□ ECBI</td>
</tr>
<tr>
<td>□ PCIT and CPP only overlap for 3 years:</td>
<td>□ CBCL</td>
</tr>
<tr>
<td>▪ 2-5</td>
<td></td>
</tr>
<tr>
<td>▪ Alt. 0-5 (with PCAT)</td>
<td></td>
</tr>
<tr>
<td><strong>Child Aged 2 to 7</strong></td>
<td><img src="image1" alt="Diagram" /></td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td><img src="image2" alt="Diagram" /></td>
</tr>
<tr>
<td><strong>YES</strong></td>
<td><img src="image3" alt="Diagram" /></td>
</tr>
<tr>
<td>□ Standard PCIT Measures:</td>
<td>□ Preserve placement at (almost) any cost:</td>
</tr>
<tr>
<td>□ TSCYC</td>
<td>□ Poor Outcome</td>
</tr>
<tr>
<td><strong>Trauma Sx (TSCYC Pts tot &gt; 40)</strong></td>
<td>□ DBDs</td>
</tr>
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<td><strong>NO</strong></td>
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60% of disruptions in disruptive kids (Meichen, 2016)

60% of placements due to disruptive kids
Or family receiving family maintenance
reunification from DCF

Preserve placement at (almost) any cost!

For the Dyad/Reunification

For the Child

Bx problems + foster care = 1/3 as likely to reunify
- (Goldberg, Bax, Geraghty, and Mescon, 1993).

For The Child

For the Dyad/Reunification

60% of placements due to disruptive kids
Or family receiving family maintenance
reunification from DCF
PCIT reduces recidivism rates for families with documented physical abuse histories.

CPP reduces return to documented DV relationships.

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.

“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
### 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 cpr 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

ECBI & CBCL

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

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

Applying The Decision Tree: