Working With Intellectual Disabilities in PCIT

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Overview of Presentation

- **Relevant Background**
  - Mental health and disruptive behavior disorders for children with intellectual disabilities (ID)
    - Findings from the Collaborative Family Study at UCLA & UCR
    - Parent-Child Interaction Therapy (PCIT) for children with ID
- **Case Example Using PCIT with ID**
  - Challenges & Successes
    - What happens when the participating caregiver also exhibits cognitive delays?
- **Suggestions for Minor Alterations**
- **Group Discussion**
Children with intellectual disabilities (ID) demonstrate higher rates of psychiatric disorders than typically-developing (TD) youth.

- Greater than 30-50% of cases have a comorbid diagnosis (Cormack, Brown & Hastings, 2000; Emerson, 2003; Linna, et al., 1999; Molteno, Molteno, Finchelescu & Dawes, 2001)

- Disruptive behavior disorders are the most common with 20-25% meeting criteria (Dekker & Koot, 2003; Emerson & Hatton, 2007)
  - In contrast to ~4% among TD youth (Emerson, 2003; Emerson & Hatton, 2007)
Collaborative Family Study

- Multi-site, longitudinal study of families of children with and without developmental delays
  - Participants were 236 families
  - Followed from child age 3 through child age 15

- Principal Investigators
  - Bruce Baker, Ph.D. (UCLA)
  - Jan Blacher, Ph.D. (UCR)
  - Keith Crnic, Ph.D. (ASU)
Relevant Background

Findings from the Collaborative Family Study

- 58% of children with developmental delays meet criteria for a comorbid disorder at age 5 (Baker, Neece, Fenning, Crnic and Blacher, 2010)
  - Rates of:
    - 43.2% for Oppositional Defiant Disorder
    - 38.9% for Attention-Deficit/Hyperactivity Disorder
    - 13.7% for Separation Anxiety Disorder
    - 5.3% for Social Phobia
    - 3.2% for Major Depressive Disorder
    - 2.1% for Dysthymic Disorder
  - Rates are 2-3x that of typically developing children
• Exploring the validity of these disorders
  ○ Are these disorders the same as those for children with typical development?
    ➢ Examining the clinical presentation (prevalence, gender differences, symptom presentation, stability over time) of these disorders for children with and without ID
  ○ Evidence to suggest that the clinical presentation is the same
    • ADHD (Neece, Baker, Crnic & Blacher, 2012)
    • Oppositional Defiant Disorder (Christensen, Baker & Blacher, 2013)
Relevant Background

Next logical question:
- If these disorders appear the same for children with and without ID....
  - Can empirically validated treatments for children with disruptive behavior disorders and typical development be applied effectively with the ID population?
Parent-Child Interaction Therapy (PCIT) has substantial empirical support:

- Demonstrated efficacy for typically developing children with:
  - **Externalizing behavior problems** (for a review: Brestan & Eyberg, 1998; Brinkmeyer & Eyberg, 2003)
    - Due to trauma as well as a result of deficits in parental discipline/behavior management techniques (Timmer, Urquiza, Zebell & McGrath, 2005; Timmer, Ware, Urquiza, Zebell, 2010)
  - **DSM-IV-TR Disruptive Behavior Disorders**
    - Oppositional Defiant Disorder
    - Attention-Deficit/Hyperactivity Disorder

- Demonstrated efficacy in special populations:
  - **Foster Care** (Timmer, Urquiza & Zebell, 2006), **Adoptive Families** (Maltby & Gallagher, 2013)
Parent-Child Interaction Therapy (PCIT) for Children with ID

- McDiarmid & Bagner (2005)
  - Case Study
    - 3 year-old child with moderate intellectual disability
      - Referred to PCIT for behavior problems and diagnosed with Oppositional Defiant Disorder
    - 14 Total Sessions of PCIT – 5 CDI & 9 PDI
      - At completion, child no longer met ODD criteria
      - Caregivers (mother and maternal grandmother) reported high satisfaction; mother also reported significant reductions in parenting stress
Parent-Child Interaction Therapy (PCIT) for children with Intellectual Disabilities

- Bagner & Eyberg (2007)
  - Randomized control trial of 30 mother-child dyads
  - Children ranged in age from 3-6
    - Diagnoses:
      - Oppositional Defiant Disorder AND
      - Mild or Moderate Intellectual Disability
    - Children with Autism Spectrum Disorder and those with major sensory impairments were excluded
  - Maternal IQ > 75 for inclusion
    - (Mean = ~ 99; SD = ~14 in each group)
Parent-Child Interaction Therapy (PCIT) for children with Intellectual Disabilities

- Bagner & Eyberg (2007)
  - 15 Immediate Treatment & 15 Waitlist Control
    - 10 IT and 12 WC families completed the study and all relevant measures
  - The authors found significant increases in CDI “Do” skills, significant decreases in “CDI Don’t” skills, and increased child compliance for the IT group relative to the WC group
  - Also found significant improvement on the Child Behavior Checklist, Eyberg Child Behavior Inventory and the Difficult Child subscale of the Parenting Stress Index
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Case Example

Case of “Kimberly”
- 7-year-old Filipina/Latina female
- Presented with mother and maternal grandmother
- Presenting problems: Oppositionality, non-compliance, difficulties with attention, poor academic functioning
  - Diagnosed with Attention-Deficit/Hyperactivity Disorder and later, mild intellectual disability
- Additional considerations:
  - Mother was diagnosed with intellectual disability,
    - Reported as mild, but at times appeared moderate
  - Pt and mother resided with maternal grandmother, who appeared to be the primary caregiver for both
    - Thus, maternal grandmother participated as the caregiver
Case Example

Case of “Kimberly”

- Assessment Measures & Treatment Progress
  - Total of 15 CDI and 21 PDI Sessions
  - Pre-treatment:
    - CBCL (T Scores): Internalizing – 65; Externalizing – 75*; Total – 75*
    - ECBI: Intensity – 203*; Problem – 14
    - PSI: Parental Distress – 34; PCDI – 37*; Difficult Child – 47*
    - DPICS: Praise – 0; Reflections – 1; Behavior Descriptions – 1
Case Example

- Case of “Kimberly”
  - Assessment Measures & Treatment Progress
    - Treatment spanned 14 months
  - Post-treatment:
    - CBCL (T Scores): Internalizing – 59; Externalizing – 67; Total – 70*
    - ECBI: Intensity – 138*; Problem – 0
    - PSI: Parental Distress – 33; PCDI – 38*; Difficult Child – 33
    - DPICS: Praise – 4; Reflections – 8; Behavior Descriptions – 2
Case Example

- Successes in Treatment
  - Some change as captured by standardized assessments
    - Often not or just barely clinically significant change
  - Notable improvements in child’s engagement with grandmother
    - Fluctuated each week, but increased positivity and engagement was observed
  - Child was 100% compliant when the time-out procedure was implemented correctly
    - Maternal grandmother struggled at times to give clear commands and follow the time-out sequence properly
      - Grandmother often needed reminders to consistently implement this procedure at home
Case Example

- **Challenges in Treatment**
  - Length of treatment
    - 15 CDI Session; 21 PDI Sessions
  - Failure to meet mastery criteria
    - Both CDI and PDI skills
      - Often close to mastery in one skill, but far behind in others
  - Difficulty generalizing skills
    - Uncertainty regarding application of skills during Special Playtime
    - Needed frequent reminders to use “Time-Out” at home
  - Application of skills to behaviors of importance
    - For example, praise often focused on:
      - Neutral behaviors (e.g. “Thank you for showing me.”),
      - Play-related behavior (e.g. “Good idea putting the lid on.”)
      - Mildly negative behaviors (e.g. “Thank you for telling me” when the child had corrected her somewhat rudely)
Case Example

What made it so challenging?

Possible Contributing Factors:

- Child’s cognitive functioning was in the mild ID range
- Maternal grandmother also appeared to have some cognitive deficits

- Difficulties with executive functioning and memory were most frequently observed
  - Tendency to use the same phrases over and over
  - Inappropriate descriptions of child’s behavior
  - At times, repeated unnecessary information from coach to child
  - Difficulty recalling sequences – e.g. for time-out
  - Difficulty generalizing skills to home or recalling that expectation
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- **Group Discussion**
## Suggestions for Minor Alterations

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<tr>
<th>McDiarmid &amp; Bagner (2005)</th>
<th>Additional Suggestions</th>
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<tr>
<td>Short, concrete and repetitive verbalizations</td>
<td>Increase education about misbehavior in the context of intellectual disability</td>
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<tr>
<td>Emphasis on 3 skills: Praise, Behavior Descriptions, and Commands</td>
<td>Eliminate unnecessary verbalizations, and focus on skills and limited teaching opportunities</td>
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<td>Labeled praise is always the same for compliance; add a physical gesture/touch to praise for emphasis.</td>
<td>Emphasize reflections also as an opportunity to increase correct word usage/teach language</td>
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<td>Focus on correct word use during Behavior Descriptions and pair with a point.</td>
<td>Allow parents to lead play if necessary, but keep within identified child interests and child selected toys – for example, parents may suggest ideas and redirect from repetitive play</td>
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<td>Appropriate commands to cognitive level; commands rather than house rules and if using house rules, repeat the rule each time it is broken</td>
<td>Distinguish between necessary teaching and intrusive questions; coach to provide instruction rather than ask questions; limit # of teaching verbalizations to 2 per 5-minute observation period and no more than 20% of total session verbalizations</td>
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Suggestions for Minor Alterations

- Alterations For Parents with Cognitive Limitations:
  - Decreasing mastery criteria for CDI
    - 3 Options:
      - Reduce target verbalization per skill (E.g. 5-5-5)
      - Reduce number of skills parent needs to perform at typical mastery
        - E.g. 2 out of 3 core skills, still 10-10-?
      - Emphasize core deficit skill(s) for mastery
        - Selecting which skill(s) parent must meet mastery on based on child’s treatment targets
          - Praise – behavior problems; Reflection – engagement & language; Behavioral Descriptions – attention & language
  - Drop Imitation and Enjoyment skills
  - Only teach Labeled Praise for target behaviors
    - E.g. Coach “Thank you for listening/sitting/playing gently” and not “Thank you for telling/showing me”
Suggestions for Minor Alternations

- **Alterations For Parents with Cognitive Limitations:**
  - Teach only 1 skill at a time
    - Increased emphasis on the “What” of each skill with practice implementing through additional demonstrations & role-play
  - Provide written prompts for skill stems (e.g. “Thank you....” “Good job for...”) and target behaviors in session
  - Review videos of kids playing and have parents identify when to praise as practice
    - During teaching sessions or as an additional teaching session
    - As an add-on when parents struggle to use skills appropriately
  - Coach parent-child engagement strategies and parent play
    - E.g. Looking at the child, responding to appropriate attention bids, smiling, how to play with particular toys, etc.
Suggestions for Minor Alterations

- **Alterations For Parents with Cognitive Limitations:**
  - If parent is significantly limited or if interactions are highly conflictual:
    - Include another family member/significant other as the primary participant
    - Coach parent’s inclusion in a manner similar to a sibling
      - Participating caregiver can then coach both child and parent in positive interactions and regulate conflicts
  - Examples from case of “Kimberly”
Group Discussion

Our Questions:

- Other clinicians’ experience with children and families with ID and/or cognitive limitations
  - What has been difficult? Other areas of success?

- Recommendations for children with ID and recommendations for parents with cognitive limitations
  - What would be difficult to implement? Are modifications too much of a departure from the PCIT protocol? What areas would still need to be addressed?

- Other thoughts/comments/questions?
Thank you!

- UCLA/UCR Collaborative Family Study – Faculty, Graduate Students, Staff and Participants for their contributions to the background research
- UC Davis CAARE Center for training and research on Parent-Child Interaction Therapy
- Harbor-UCLA Medical Center Child Trauma Clinic for providing the opportunity and resources to serve this population
- “Kimberly” and her family for their willingness to work with us and learn PCIT
- To all of you for your attention!