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

Relevant Background

- 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)

Relevant Background

- 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

Relevant Background

- 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?



Relevant Background

- 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)

Relevant Background

- 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

Relevant Background

- 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)

Relevant Background

- 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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Suggestions for Minor Alterations

McDiarmid & Bagner (2005)	Additional Suggestions
Short, concrete and repetitive verbalizations	Increase education about misbehavior in the context of intellectual disability
Emphasis on 3 skills: Praise, Behavior Descriptions, and Commands	Eliminate unnecessary verbalizations, and focus on skills and limited teaching opportunities
Labeled praise is always the same for compliance; add a physical gesture/touch to praise for emphasis.	Emphasize reflections also as an opportunity to increase correct word usage/teach language
Focus on correct word use during Behavior Descriptions and pair with a point.	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
Appropriate commands to cognitive level; commands rather than house rules and if using house rules, repeat the rule each time it is broken	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

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!