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

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ABSTRACT

• 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 adopted from foster-care has not yet been demonstrated.
• Data were collected on a sample of 15 foster-adopted dyads that received PCIT at a Los Angeles-based community mental health clinic. 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), and that foster-adoptive children would show similar, significant declines in disruptive behaviors from pre- to post-treatment.
• Results indicated that parent-reported levels of child disruptive behaviors at pre-treatment by adoptive parents were lower than those reported in other studies. Additionally, although statistically significant reductions were observed in five of the nine treatment scales from pre- to post-treatment, a majority of children remained in the clinically significant range of behaviors at post-treatment assessment.
• Results are interpreted in light of the unique factors affecting adoptive dyads, and recommendations for enhancingimplementation and treatment fidelity with this population are provided.

BACKGROUND

• In the 2012 fiscal year, there were 5,938 adoptions from the child welfare system in California alone (U.S. Dept. of Health and Human Services, 2012)
• Although the families that adopt from the child welfare system are incredibly diverse, research on adoptive families has yielded some common findings relevant to young children. Namely, parents who sought adoption had a higher prevalence of "insecurely attached" infants than similar groups of children in foster care, perhaps due to the uncertainty in foster-to-adopt situations (Cole, 2005). Cole believed that the lack of control over placement discouraged families who wished to adopt from the child welfare system from forming emotional attachments to the children in their care.
• The link between interpersonal trauma and disruptive behavior disorders in children has been well-documented (Ford, Gagnon, Conner & Pearson, 2011). The children adopted from the foster care system have experienced interpersonal trauma and at times are subject to additional risk factors, including multiple changes in care taking, prenatal drug exposure, and increased number of placements.
• This, 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 even intensify the child's pre-existing disruptive behaviors.
• Therefore, adoptive resource parents and their children are similarly likely as other high-risk populations (physically abusing parents/children; depressed mothers; etc.) to find themselves in need of treatment for both disruptive behaviors and parent-child relational problems. However, adoptive parent-child dyads also have many unique features that may influence treatment outcome. In light of the growing population of foster-adoptive children in Los Angeles County, ensuring effective mental health treatment for these children is of the utmost importance.

HYPOTHESES

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

METHOD

Participants:
• Participants were children adopted from child welfare and their adoptive parents who were referred to Parent Child Interaction Therapy (PCIT) due to disruptive behaviors.
• The treatment setting was a community mental health clinic in Los Angeles County with a special emphasis on facilitating adoptive families. The Los Angeles Biomedical Research Institute IRB approved this study.
• 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.
This diversity is consistent with Service Area 8 in LA County, which has no ethnic majority.

Demographics

Descriptor	Percentage	n
Sex of Child		
Male	46.7%	7
Female	53.3%	8
Ethnicity		
African American	20%	3
Latino/Hispanic	27%	4
Mixed/Other	33%	5
White	20%	3
Diagnosis		
AD/HD	33.3%	5
Disruptive Bhx D/O NOS	20%	3
D/O Of Infancy/Childhood NOS	26.7%	4
PTSD, Autism, Anx, Misc.	20%	3

Measures:
• The Parent Stress Inventory Short Form (PSI-SF; Abidin, 1995) is a standardized parent-report form used to identify parent-child dyadsexperiencingstress andat-riskfordeveloping parenting and child behavior problems. This assessment yields four main scales: Parental Distress, Parent-Child Dysfunction, Difficult Child, and Total Stress.
• The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) is a 36-item scale that measures common disruptive behavior problems exhibited by children aged 2 to 16.
• The Child Behavior Checklist (CBCL; Achenbach, 2001) is a standardized parent-report form measuring a broad range of child problems, and yields numerous scales. Broadband scales were used in the present study, which included the Internalizing, Externalizing, and Total Symptoms scales.

RESULTS

• Hypothesis 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). The levels of pre-treatment disruptive behaviors reported in our sample was most similar to the report of disruptive behaviors by the fathers in Nixon et al.'s study (2003).
• 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.
• Although there were statistically significant changes from pre- to post-treatment in disruptive behaviors and parent-reported levels of stress, the majority of post-treatment scores remained clinically significant (see table). Thus, while children are improving over the course of treatment, the amount of improvement was less than what has been reported in other studies. When comparing the changes in disruptive behaviors pre- and post-treatment reported on the ECBI to the changes reported in benchmark studies, the current sample displayed much smaller changes over the course of treatment (Intensity reduced by 23.7 and Problem reduced by 7.7 in our study; see table for comparison).
• The behavior problems in the current study, although they occurred less frequently, remained problematic for parents. Parents in the current study reported the lowest problem score at pre-treatment compared to the benchmark studies, but had one of the highest problem scores at post-treatment. It appears that the parent perceptions of the child's behaviors as problematic changed less when compared to other studies over the course of treatment.

Percentage of Children Still Clinically Significant at Post-Treatment

Scale	Percentage Clinically Significant at Post-Treatment
PSI-SF: Parental Distress	20%
PSI-SF: Parent-Child Dysfunctional Interaction	33.3%
PSI-SF: Difficult Child	46.7%
ECBI: Problem	46.7%
ECBI: Intensity	40%
CBCL: Internalizing Symptoms	14.3%
CBCL: Externalizing Symptoms	35.7%

PSI: Pre- and Post-Treatment Descriptive Statistics and t-test Results

	Pretest		Posttest				
	M	SD	M	SD	n	t	df
Parental Distress	26.9	8.01	26.9	8.5	15	0.00	14
Parent-Child Dysfunctional Interaction	27.1	7.8	22.4	7.8	15	2.68*	14
Difficult Child	38.6	8.7	32.3	10.2	15	3.81**	14
Total Tress	91.1	17.8	81.3	17.9	15	2.29*	14

* p < .05; **p < .01; *** p<.001

ECBI: Pre- and Post-Treatment Descriptive Statistics and t-test Results

	Pretest		Posttest				
	M	SD	M	SD	n	t	df
ECBI Intensity	143.1	36.8	121.3	42.6	15	3.53**	14
ECBI Problem	19.3	9.6	13.3	9.8	15	2.56*	14

* p < .05; **p < .01; *** p<.001

CBCL: Pre- and Post-Treatment Descriptive Statistics and t-test Results

	Pretest		Posttest				
	M	SD	M	SD	n	t	df
CBCL Internalizing Symptoms	57.5	10.2	55.5	7.8	14	0.35	13
CBCL Externalizing Symptoms	69.2	9.7	62.9	8.9	14	0.80	13
CBCL Total	64.1	10.8	60.9	12.1	14	1.87	13

* p < .05; **p < .01; *** p<.001

Pre- and Post-Treatment ECBI Scores for Current Study and Benchmark Studies Identified by Self-Brown, et al. (2012)

		ECBI Intensity			ECBI Problem		
	n	M_{pre}	M_{post}	SD	M_{pre}	M_{post}	SD
Current Study	15	143.1	121.3	11.3	19.3	13.3	3.93
Eyberg et al. (1995)	10	159.5	117.5	16.6	20.7	6.6	4.8
Brestan et al. (1997)							
Mother	16	173	133	29.5	23	11	5.8
Father	9	169	137	24.1	22	14	3.3
Schumann et al. (1998)							
Mother	22	170.3	117.6	26.4	21.9	10.9	6.5
Father	12	159.6	126.8	25.2	20.5	10.2	5
Nixon (2001)	17	166.6	125.3	18.9	-	-	-
Nixon et al. (2003)							
Mother	17	166.6	125.2	18.8	-	-	-
Father	17	148.3	124.0	24.5	-	-	-

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.
• When compared to other studies, the adoptive parents in our sample experienced less reduction in their perception of the child's behavior as problematic. It may be that adoptive parents have high expectations for their adopted child, and are then confronted with the discrepancy between their ideal, or hoped-for child, and reality.

RECOMMENDATIONS

• Because many treatment measures in the present study did not reflect clinically significant gains, it is recommended that clinicians administer and discuss post-treatment measures with the caregiver before deciding to terminate treatment. Considering the unique factors impacting adoptive dyads, including the myriad of reasons why families chose to adopt, it is necessary to assess whether scores are elevated due to parent expectations, continued child behavior problems, a combination of these factors, or other treatment barriers.
• In addition to parent measures, it may be beneficial for the therapist to have a standardized way to assess the parent-child relationship, particularly if the parent's perception of the child is being influenced by other factors and is less objective. The Parent-Child Interaction Quality Index (PCIQ; Timmer, Boys, & Forte, 2013) is a 28-item rating scale in which the therapist codes the quality of the parent-child relationship. This assessment yields scores across five domains: Parent Sensitivity, Parent Warmth, Parent Control, Parent Passivity, and Child Responsiveness and Involvement.
• It may also be beneficial to objectively measure the parent-child attachment when administering pre-, mid-, and post-treatment measures, particularly with the foster-adoptive population. The Devereux Early Childhood Assessment (DECA), a standardized measure of attachment, or the Emotional Availability Scales (EAS) which have been correlated with infant attachment styles, are two such measures which could assist not only in assessing the dyad's strengths and areas for growth to target in treatment, but also by providing data regarding how PCIT may mediate attachment.

LIMITATIONS

• The small sample size significantly reduced power and may have obscured other notable findings in this population. Further research with a larger sample size is recommended.
• The present study utilized a slightly older sample than is typically recommended for PCIT (the sample included a 9-year-old), which may have had some effect in decreasing clinically significant gains.
• Additionally, the present sample contained two children whose primary diagnosis was Autism Spectrum Disorder. Although significant improvements were found in these two cases, many of their scores remained clinically significant for reasons other than disruptive behaviors (e.g., parent perceives that child has greater needs than other children, which while accurate, resulted in the Difficult Child subscale remaining elevated).