Child Trauma and the Effectiveness of PCIT

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Presentation Overview

1. Tell you a brief story about PCIT and trauma treatment
2. Describe the symptom presentation of young children exposed to traumatic events.
3. Present current data on the application of PCIT to young traumatized children.
4. Describe possible ideas related to why PCIT may contribute to the treatment of traumatized children.
5. ‘PCIT for Traumatized Children’ (later today)
UC Davis CAARE Center: A Simple Story

- CAARE Center = Child abuse treatment program
- Treat approximately 500 children/families per week (~100 in PCIT)
- Multiple EBPs (e.g., PCIT, TF-CBT, DBT)
- All clients get an intake interview, then a battery of standardized assessments – specific to the type of program

- Several years ago we had a problem with assessment packets…
- Decided to make all the intake assessment packets the same
  - Began giving trauma measures to PCIT/ODD children

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Sometimes the best ideas come from good luck!
‘PCIT and Traumatized Children’

Our clients experience traumatic events and come from families with a range of adverse life experiences…

Child Physical Abuse  Child Neglect
Child Sexual Abuse  Domestic Violence
Parent Substance Abuse  Parent Mental Health

These adverse life characteristics often lead to child trauma and disruptive behavior problems

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When you have an abused and traumatized child, from a chaotic family that has an CBCL Externalizing T score; this may be a ‘PCIT for Traumatized Children’ case…
While warmth in the parent-child relationship has been established as mitigating the effects of trauma, it may be that the added benefit of learning a system to handle disruptive behavior problems also helps reduce child trauma symptoms.

What are we trying to do...

**Exploratory study**

Comparing the magnitude of change in target (e.g. disruptive behaviors) and non-target (e.g., internalizing) trauma symptoms from pre- to post-PCIT in children entering with normal-range vs. clinical range of trauma symptoms - controlling caregivers’ pre-treatment emotional availability.
Sample Description

- **Sample Size**: 133 caregiver-child dyads who completed PCIT
- All children have a history of abuse, neglect, or domestic violence
- 37% elevated trauma symptoms at pre-treatment
- **Child Age**: 2 – 8 years  Mean= 4.32 years (1.5 SD)
- **Gender**: 61% boys
  39% girls
- **Caregivers**
  - 62% Biological parents, 38% foster caregivers
  - 89.5% female
  - Aged 18 – 65 yrs (Mean= 36.1 (10.7 SD))
- **Ethnically diverse** (approximately 50% non-white)
How trauma groups are defined?

**Traumatized children:**
Per caregiver report, elevated on either the:
- CBCL Trauma scale (Dehon & Scheeringa, 2006)
- Trauma Symptom Checklist for Young Children (Briere et al, 2001) (PTS-Total scale)

**Non-traumatized children:**
In the normal range on the CBCL Trauma scale and TSCYC (PTS-Total scale)
Descriptive Differences

- Similar proportions of boys/girls, ethnic composition, types of caregivers, risk history

- Sample Differences:
  - Traumatized children older than non-traumatized
  - Caregivers of traumatized children older than those of non-traumatized
  - Caregivers of traumatized children less likely to be single
Description of Emotional Availability

- **Emotional Availability Scales (EAS; Biringen, 2000)**
  Observational measure of the quality of the parent-child relationship. Parent EA based on judgments of sensitivity, hostility, intrusiveness, and structuring in a 15 min observational assessment. Reliability was above r= .90 for all scales. Scores were ratios of total/ total possible points (24).

- **No differences between groups pre-treatment:**
  - Non-traumatized: .74 (.10)  Traumatized: .74 (.10)
Description of Outcome Measures

- **Child Behavior Checklist (CBCL)**
  School age form and Pre-school form
  (Achenbach, 1994, 2001; Achenbach & Rescorla, 2000)

- **Parenting Stress Index – Short Form (PSI)**
  (Abidin, 1995)

- **Trauma Symptom Checklist for Young Children (TSCYC)**
  (Briere et al., 2001)
## Description of Risk by Trauma Group

<table>
<thead>
<tr>
<th>Suspected or documented:</th>
<th>Non-Traumatized</th>
<th>Traumatized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse history</td>
<td>41.7%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Neglect history</td>
<td>77.4%</td>
<td>75.5%</td>
</tr>
<tr>
<td>Sexual abuse history</td>
<td>12.0%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>62.8%</td>
<td>69.6%</td>
</tr>
<tr>
<td>Prenatal exposure to drugs</td>
<td>68.8%</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Cumulative risk</strong></td>
<td>5.05(1.9)</td>
<td>4.90(2.0)</td>
</tr>
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</table>

Sum of 11 different adverse case characteristics:
(e.g., Physical Abuse, Neglect, DV, Mo or Fa Criminal Hx, Mo Mental Health Hx)

See? They are both high risk.
Analyses of Pre- to Post-Treatment Change

- Repeated measures multivariate analysis of covariance of caregivers who completed PCIT.
- If post-treatment assessment was missing, carried forward last assessment (i.e., mid-assessment). Covaried whether assessment was missing at post.
- Covaried age of child, age of caregiver, caregiver’s single marital status.
- Covaried caregiver’s observed emotional availability at pre-treatment.
Treatment Effects: Pre- & Post-PCIT Means on CBCL Scales by Trauma Group

<table>
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<tr>
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<th>Pre-tx</th>
<th>Post-tx</th>
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<tr>
<td>Non-trauma</td>
<td>47.8</td>
<td>42.3</td>
</tr>
<tr>
<td>Trauma</td>
<td>64</td>
<td>53.3</td>
</tr>
<tr>
<td>Non-trauma</td>
<td>51.2</td>
<td>44.6</td>
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<tr>
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<td>70.8</td>
<td>58.2</td>
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Treatment Effects: Pre- & Post-PCIT Means on PSI Scales by Trauma Group
Treatment Effects: Pre- & Post-PCIT Means on TSCYC Scales by Trauma Group

- **Non-trauma**
  - PTS-Total: 44.5 Pre-tx, 43.6 Post-tx
  - Anxiety: 43.2 Pre-tx, 43.2 Post-tx
  - Depression: 45.9 Pre-tx, 44.0 Post-tx
  - Dissociation: 47.2 Pre-tx, 45.8 Post-tx
  - Sexual Concerns: 49.2 Pre-tx, 48.1 Post-tx

- **Trauma**
  - PTS-Total: 74.4 Pre-tx, 58.0 Post-tx
  - Anxiety: 65.7 Pre-tx, 51.5 Post-tx
  - Depression: 66.5 Pre-tx, 53.4 Post-tx
  - Dissociation: 64.0 Pre-tx, 53.6 Post-tx
  - Sexual Concerns: 64.2 Pre-tx, 57.8 Post-tx
What does this all mean?

• What is trauma in young children?
• Are trauma symptoms directly addressed in PCIT?
• Is PCIT a trauma treatment?
• Can children have both disruptive behavior and trauma symptoms?
• Is it necessary to address trauma content directly?
• If yes, which do we treat first?
  - trauma symptoms?
  - disruptive behavior?
  - both?
## ‘PCIT for Traumatized Children’

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<th>Affective Symptoms</th>
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<td>aggression</td>
<td>crying/whining</td>
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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

**A Partner in**

**NCTSN The National Child Traumatic Stress Network**
‘PCIT for Traumatized Children’

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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
‘PCIT for Traumatized Children’

Trauma
Symptoms
Nightmares
Anxiety

Behavioral
Disturbance
non-compliance
aggression

Affective
Dysregulation
temper tantrums
criing/whining

A. Decreased child behavioral problems
B. Acquisition of child coping skills (affective expression, breathing, relaxation)
C. Parental reinforcement for appropriate expression of distress
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.
Thank you!

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