PCIT for Non-Traditional Families: Strategies to Enhance Attachment Post-Trauma

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Overview of Workshop

- Attachment Theory & Trauma
  - How PCIT Addresses Attachment
- Evidence for PCIT with Non-traditional Families
- Case Examples
- Suggestions for Promoting Healthy Attachment
Attachment Theory & Trauma

• **Attachment Theory**
  – Caregiver(s) serve as the “secure base” for a child.
    • Children seek proximity to their caregiver(s), particularly during times of distress.
      – Over time, having a “secure base” allows the child:
        » To explore the environment and develop new skills
        » To develop their own emotion regulation skills
        » To develop internal working models of themselves, the world around them, etc.
  • Children can have different styles of attachment.
    – Secure vs. Ambivalent, Avoidant and Disorganized
      » Secure attachment is supported by sensitivity and responsivity on the part of the caregiver.
Attachment Theory & Trauma

• Trauma
  – Nearly 700,000 children are abused in the U.S annually.
  – Neglect is the most common form of maltreatment.
    • Of the children who experienced maltreatment, three-quarters suffer neglect; 17.2% suffered physical abuse; and 8.4% suffered sexual abuse.
      – Some children are polyvictimized—they have suffered more than one form of maltreatment.
  – About 4 out of 5 abusers are the victims’ parents.
    • A parent of the child victim was the perpetrator in 78.1% of substantiated cases of child maltreatment.

Attachment Theory & Trauma

- Attachment & Trauma
  - Trauma exposure affects many areas of development:
    - Attachment, mood regulation, behavioral control, cognition, and self-concept
      - Attachment disturbances are common in cases of child maltreatment.
        » Insecure attachment with the maltreating caregiver(s)
        » Need to form new attachments in foster/adoptive care
          - One study found that ~1/3 of 1 to 4-year-old children removed from their parents and placed in foster care had limited or no attachments (Zeanah et al., 2004).
Attachment Theory & Trauma

• Attachment & Trauma
  – Support from caregivers is a key factor in children’s psychological recovery from traumatic events (NCTSN, 2013).
  • Many theories of trauma emphasize a disruption in one’s schemas about safety, relationships, etc.
    – Healthy, secure attachments are theorized to buffer the impact of trauma on such schemas.
Attachment Theory & Trauma

- Attachment-based Treatment
  - Allen (2011) posited treatment principles based on attachment theory.
  - Treatment should:
    - Aim to establish an adequate relationship with a defined attachment figure (if not already established).
    - Enhance the caregiver(s)’ ability to identify and respond to the child’s emotions and behaviors.
    - Be present-focused and attempt to improve the child’s functioning in his/her current context.
    - Be cognizant of the child’s cognitive and other developmental abilities.
Attachment Theory & Trauma

• PCIT as an Attachment-Based Intervention
    • Child-directed Interaction (CDI) helps build a positive relationship between child and caregiver(s).
    • PCIT emphasizes supportive, empathetic and non-coercive ways of responding to a child.
      – Particularly when implementing disciplinary strategies (e.g. during Parent-directed Interaction (PDI))
    • The emphasis on practice at home/in the community recognizes the child’s current context, and focuses on changing parent-child interactions within that context.
    • PCIT is sensitive to the child’s developmental level, and coaches help caregiver(s) adapt skills to their child.
PCIT with Non-Traditional Families

• Foster/Adoptive/Kinship Care
  – Efficacy of PCIT with kin and non-kin foster parents (Timmer et al., 2004, Timmer et al., 2005, N’zi et al., 2016)
  – Efficacy of PCIT with adoptive parents (Maltby & Gallagher, 2013, Allen et al, 2014)
  – May experience different levels of distress
    • Timmer et al., 2004 -
      – Non-kin foster parents reported more behavior problems.
      – Kin foster parents reported greater levels of parenting-related and personal distress.
        » Kin foster parents reporting high levels of distress were the most likely to remain in treatment.
PCIT with Non-Traditional Families

• Families with Disabilities
  – Efficacy of PCIT with children with intellectual disabilities (McDiarmid & Bagner, 2005, Bagner & Eyberg 2007) and autism spectrum disorders (Solomon et al, 2008; Hatamzadeh et al., 2010; Zlomke et al., 2017)
  – Mother’s intellectual functioning may predict attrition. (Hood & Eyberg, 2003, Fernandez & Eyberg, 2008)
  – No research to-date on the efficacy of PCIT for parents with intellectual and developmental disabilities.
    • What about physical disabilities?
PCIT for Non-Traditional Families

- Non-traditional Families
  - Few studies have examined the efficacy of PCIT with older parents, single parents, and LGBT-identified caregivers.
  - Older parents, single parents, and LGBT-identified caregivers face unique issues and strengths that require additional tailoring.
    - E.g. Fewer peer models of parenting, less social support, others’ views of the parent-child relationship
      - For older parents, health issues, decreased stamina, and generational norms may impact interactions with the child.
Case Studies - “Cindy”

- **Child** -
  - 4-year-old female; unknown race
  - Detained at 1-day-old for maternal substance use and a positive drug screen at birth
    - Attempted reunification; placed in foster care
    - Removed from foster home, and placed in a foster-adopt home at 18 months of age
      - Adoption finalized at age ~3
- **Caregivers** -
  - Heterosexual Caucasian couple in 50’s
    - No biological children; first-time parents
    - Mom is in the mental health field; both parents value social justice.
Case Studies - “Cindy”

• Presenting Concerns -
  – Behavior problems - tantrums and outbursts, non-compliance, “strong-willed” and questions authority
    • Has been destructive towards objects in the past
    • No aggression towards people
• Treatment -
  – Self-referred for services in August 2016
    • Began PCIT treatment in October 2016
    • Terminated weekly PCIT in August 2017; still receiving booster sessions
    – Significant decreases in oppositional/defiant behaviors, increased compliance, improved sleep and irritability
Case Studies - “Cindy”

- **Challenges -**
  - **Age and foster-adoptive role**
    - Caregivers experienced anxiety as new parents.
      - **Expectations that they should already know how to parent; lack of models within their community**
        » Resulted in some push-back against the therapist
        - Perhaps more so than in other therapeutic models because of the direct coaching
  - Caregivers had concerns about the re-emergence of child’s biological parents, even after the adoption was finalized.
    - **Resulted in parents researching biological mother’s whereabouts via social media**
      » Reflective of an insecure parent-to-child attachment
Case Studies - “Cindy”

• Challenges -
  – Age and foster-adoptive role
    • Despite having had “Cindy” in the home since age 18 months, parents were hesitant to implement disciplinary strategies for fear of disrupting the attachment.
      – Resulted in a permissive approach, and more oppositional/disruptive behaviors
        » Caregivers were very hesitant to implement PDI techniques, specifically time out.
          • Even more so as a result of mother’s mental health training
Case Studies - “Quinn”

• Child -
  – 7-year-old male; unknown race
  – Exposed to substances in utero, and experienced neglect in his biological family
    • Detained at age ~X; placed in kinship care in another state
    • Allegations of physical abuse led to a second detention
      – Placed in a foster-adopt home with current caregivers

• Caregivers -
  – Gay-identified male couple in late 50’s/early 60’s
    • No biological children; first-time parents
  – Participating parent identified as Caucasian
    • Had own trauma history involving physical, verbal abuse
Case Studies - “Quinn”

• Presenting Concerns -
  – Behavior Problems - oppositionality, defiance and non-compliance, tantrums, anxiety symptoms, irritability, and difficulties with attention
    • No aggression towards others.
    • Concerns regarding symptoms of FASD
  – Inappropriate boundaries/overly friendly with strangers

• Treatment -
  – Referred from foster-care hub for PCIT in April 2016
    • Completed PCIT and booster sessions in May 2017
      – Reduction in symptoms of anxiety and irritability, improved compliance, better attention and a more secure attachment
Case Studies - “Quinn”

• Challenges -
  – Age, foster-adoptive role, gender/sexual-orientation-based social norms
    • Resulted in discomfort with typical play activities
      – E.g. playing with dolls, reactions to representations of heterosexual families
        » Worsened by caregiver’s trauma history; triggered by aggressive or loud play
    • Resulted in problematic expectations re: physical affection
      – E.g. caregiver equated attachment with physical affection, and had difficulty understanding child’s rebuffs
        » Worsened by child’s trauma history
    • Difficulties attaching to child, given parental age and concerns regarding possible FASD diagnosis
Case Studies - “Violet”

• Child -
  – 7-year-old female, mixed Filipina/Latina
    • Mother and father separated early in her life
    • Mother diagnosed with mild-to-moderate intellectual disability (ID)

• Caregivers -
  – Maternal grandmother
    • Caretaker for both mother and child
      – Appeared to have some cognitive limitations as well, although not diagnosed
  – Father
    • Difficult to engage in therapy; unclear why
Case Studies - “Violet”

• Presenting Concerns -
  – Behavior Problems - oppositionality, non-compliance, difficulties with attention, poor academic functioning
    • Diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) and later, mild intellectual disability

• Treatment -
  – Maternal grandmother self-referred to Harbor-UCLA Child & Adolescent Psychiatry
    • Completed PCIT in August 2013 (~14 months of treatment)
      – Improved compliance, better attention and decreased parenting distress
Case Studies - “Violet”

• Challenges -
  – Age, cognitive functioning, role of mother
    • Maternal grandmother appeared to have some cognitive deficits, specifically executive functioning and memory.
      – Resulted in her use of the same phrases over and over, inappropriate descriptions of the child’s behavior, difficulty recalling sequences (e.g. for time-out), and difficulty generalizing skills to home
    • Incorporated mother into sessions as a sibling.
      – Given her cognitive limitations and frequent conflicts between mother and child
Suggestions for Promoting Healthy Attachment

• General Suggestions
  – Spend time clarifying roles and labels.
    • Do not assume gendered pronouns.
    – Share therapists’ pronouns and inquire what the caregiver(s) prefer.
      » Caregivers may have preferred pronouns that do not accord with what one might assume based on appearance.
      » Non-binary individuals may prefer alternative pronouns.
        • E.g. they/them/their or ze/zim/zir
  • Ask what the child calls each caregiver, and if this is his/her/their/zir preferred term.
Suggestions for Promoting Healthy Attachment

• General Suggestions
  – Prior to beginning PCIT, explore parenting challenges and any obstacles in the development of a close attachment to the child.
    • E.g. “What has it been like to parent ____ (beyond the specific concerns that brought you into treatment)?” “What is your support network like?” “Do you have a community of other parents?”
      – Provide support related to challenges such as being seen as the child’s grandparents or as unrelated to the child.
      – Validate difficulties related to labels, racism and assumptions about the family composition.
        » How has the child reacted in such moments? How have the caregiver(s) reacted?
Suggestions for Promoting Healthy Attachment

• Case Study - “Cindy”
  – Explain that PDI is also a technique for relationship enhancement.
    • A secure attachment is only achieved if the child feels safe, which is not possible if there are no clear boundaries, rules, expectations, consequences, etc.
      – Metaphor of the fence/brick wall
    – Provide additional psychoeducation.
    • Discuss trauma and attachment throughout PCIT sessions.
      – Explore narrative(s) about the child’s trauma.
      – Discuss the caregiver’s view of his/her/their/zir own role as the child’s guardian.
      – Reframe the child’s behavior in light of the trauma.
Suggestions for Promoting Healthy Attachment

• Case Study - “Quinn”
  – Acknowledge differences in exposure to play due to age, gender norms, etc.
    • Spend time explicitly teaching play strategies.
    • Consider home-based/community-based CDI sessions to help male-identified parents or those less comfortable with traditional play activities to learn the skills in an environment/activity that feels more comfortable.
      – Or assign community-based practice for homework
    – Use trauma-based strategies to coach the parent on his/her/their/zir response to triggering play themes, behaviors, etc.
    • Parallel play to demonstrate alternatives/coping strategies
Suggestions for Promoting Healthy Attachment

• Case Study - “Violet”
  – Consider incorporating parents with intellectual disabilities into treatment as siblings, with another family member serving as the primary caregiver.
  – For caregiver(s) with cognitive limitations:
    • Coach engagement strategies and parent play as needed.
    • Focus PRIDE skills on target behaviors.
      – Drop/minimize focus on imitation and enjoyment skills.
      – Only teach Labeled Praise for target behaviors.
        » Provide written prompts for skill stems (e.g. “Thank you....” “Good job for...”) and target behaviors in session.
  • Teach only 1 skill at a time.
Our Questions:

• Other clinicians’ experience with non-traditional families:
  – What has been difficult?
  – What has helped?
  – Would the aforementioned suggestions have helped?

• Other thoughts, comments or questions?
Thank you!

- Children’s Hospital Los Angeles - University Center for Excellence in Developmental Disabilities - Project Heal.
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- “Cindy” “Quinn,” “Violet” and their families - for their willingness to work with us and learn PCIT.
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