A Brief Review of the Research on PCIT for Children with Exposure to Trauma

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Abstract: Parent-Child Interaction Therapy (PCIT) has developed a strong and growing evidence base for treating young children with a history of maltreatment, such as abuse or, neglect.[6] PCIT emphasizes positive parenting skills to reduce disruptive child behaviors, therefore reducing inconsistent or physical discipline strategies and coercive family interactions. PCIT is efficacious and cost-effective in preventing future abuse or neglect from caregivers, but with relatively high attrition[1,3]. Case studies also provide evidence of clinical reductions in behavior problems, decreased stress and depression in parents, and increased differential attention and warmth despite significant environmental stressors[18,20,14,17]. Adaptations such as adding a motivational orientation for parents[5] or making the treatment time-limited[16] may help to decrease drop-out and increase duration of effects for these families. Tailoring PCIT for maltreatment can involve strategies to navigate atypical custody arrangements or prevent re-offending (e.g., the "swoop and go" procedure[19]). There is very preliminary evidence supporting PCIT for children exposed to other types of trauma, including domestic violence, community violence, medical trauma, and loss[12,15]. Future research should aim to further assess PCIT for these types of trauma, as well as additional ways to tailor and adapt PCIT to enhance treatment effects for various trauma populations and related barriers to treatment success.

Background

Child maltreatment: Child maltreatment is defined as the behaviors or lack of behaviors, perpetrated by someone in a position of power in a child's life, that lead to actual or potential harm to a child's well-being and future trajectory[2]. Most perpetrators are parents but maltreatment may also result from the behaviors of other caregivers, family members, or teachers. Child maltreatment encompasses a range of types, such as physical abuse, sexual abuse, psychological and emotional abuse, and neglect. Less salient forms include acts such as verbal abuse, isolation, and failure to provide adequate shelter or food, but these forms are also significantly detrimental to a child's development[2]. Child maltreatment primarily affects children age six and younger, especially those youngest children who are most vulnerable and most likely to perish as a result of abuse or neglect (e.g., 1,500 children were killed by a parent in 2010)[19]. In addition to death, the negative sequelae of maltreatment include mental health problems such as anxiety and depression, academic and cognitive deficits, conduct problems, contact with the criminal justice system, and medical problems (e.g., cancer, obesity, heart disease)[6]. For these reasons, it is crucial to identify interventions that can help prevent young children from experiencing such outcomes by addressing the root causes of child maltreatment. In turn, it may be possible to disrupt the intergenerational cycle of abuse, such that youth with maltreatment histories are less likely to become abusers themselves later as caregivers or role models.

Common predictors of maltreatment provide important context for clinicians working with such families. Maltreating parents often lack parenting knowledge, use controlling discipline strategies, and respond inconsistently to the same child behaviors. These parents also often have their own mental health problems, or had abusive parenting models in their own past[6].The coercive parent-child interaction is formed by children learning how to avoid parental demands

through disruptive behavior, causing parents to respond more harshly to receive immediate short-term compliance, and over time parenting becomes overly critical and negative[11].

In general, training caregivers in parenting and anger management skills is a productive way to reduce abusive caregiving behaviors, but not all parent training interventions are created equally or deemed effective[3]. Parent-Child Interaction Therapy (PCIT) has been investigated as one particularly promising intervention for child maltreatment since the 1990s, and its evidence base has grown significantly over the past three decades. PCIT emphasizes positive parenting skills to reduce disruptive behaviors across numerous populations and presentations of children, with the overarching goal of capitalizing on the powerful parent-child dynamic in order to promote attachment and prosocial learning. This treatment serves to change parenting responses and foster strong caregiver-child relationships by helping parents reinforce positive behaviors and reduce negative behaviors through live coaching techniques. First, the parent or caregiver is coached in nondirective play techniques to focus on bonding and differential attention, and then they learn commands and consequences that are most likely to result in child compliance. In the context of child maltreatment, PCIT has the potential to reduce coercive family interactions that exacerbate externalizing problems by reducing negative parenting behaviors and increasing positive behavior management skills, with some tailoring and adaptations needed to match the family's needs and address treatment barriers specific to traumatized youth[7].

In contrast to other programs, PCIT targets the source of maltreatment by increasing the number of positive interactions caregivers have with their child, directly altering inconsistent or physical discipline strategies, highlighting appropriate developmental expectations, and promoting parental self-reflection[17]. In this way, therapeutic focus is on improving caregiver behaviors, therefore children need not meet the clinical threshold for behavior problems that is typical in PCIT enrollment[1]. This shift towards the parent as the recipient has required several novel assessments of PCIT's success for parent outcomes, begging the question of how implementation should also shift for this population.

The available literature reviews of quantitative findings reveal a range in recidivism rates from 17% to 47% after PCIT, as measured by caregiver abuse reports to child welfare, representing significant variability in how well this intervention prevents recurrence of maltreatment. As for child abuse risk, some randomized controlled trials have shown improvements in parental expectations and parenting stress, but stress unrelated to the parent-child dynamic is less likely to decrease. As expected, positive parenting behaviors (e.g., specific praise, sensitivity to child's needs) increase and negative parenting behaviors (e.g., sarcasm) decrease with PCIT, but with inconsistent statistical significance across studies. Lastly, clinically significant child behavior problems are often present in studies with maltreating caregivers, suggesting that PCIT should target both parent and child functioning. Parent perceptions of behavior problems may be more relevant to assess than teachers, as they tend to perceive these issues as more severe[1].

While quantitative findings are somewhat tentative, case studies on PCIT for maltreatment cases provide qualitative evidence of clinical reductions in behavior problems, decreased stress and depression in parents, and increased differential attention and warmth despite significant environmental stressors[18,20,14,16,8]. These treatment gains can last up to 16 months and are not limited to a specific disorder or abuse exposure. Typical caregivers in these studies consist of biological parents, grandparents, or foster parents, and typical child presentations include Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, Reactive Attachment Disorder, and fetal alcohol effects[6].

Other types of trauma: Trauma is not limited to child maltreatment, but can also include more indirect experiences of witnessing or hearing about violence or death, experiencing a natural disaster, or undergoing intense medical procedures. PCIT is endorsed by the National Child Traumatic Stress Network as an effective treatment for behavioral problems related to trauma in young children, yet preliminary research beyond maltreatment is sparse. Within a study of nine non-perpetrating caregivers at an urban domestic violence shelter, PCIT led to reduced behavior severity in children as well as improved consistency in discipline, perceptions of control, mental health symptoms, and treatment satisfaction in parents[12]. In another study of community implementation of PCIT across many trauma types for 53 families, researchers found significant improvements in child behavior, trauma symptoms, and dissociative characteristics, as well as caregiver stress[15]. The Child-Adult Relationship Enhancement (CARE) prevention program was developed in order to increase dissemination of basic PCIT skills training to any adult that interacts with a young child, such as the bus driver or a receptionist, but this program is still in the evaluation phase[10]. These findings are promising thus far, but are not yet replicated or well-understood.

Problem Statement

High attrition: There is some evidence suggesting PCIT is efficacious and cost-effective in preventing future abuse or neglect from caregivers, but this is limited by high attrition[1,3]. Many parents mandated to complete treatment have experienced limited success with previous treatments, which can lead to decreased hope and motivation to change their behavior[1]. Parents who are mandated to attend treatment may demonstrate lower commitment to actively engage in treatment relative to treatment-seeking parents. It is also difficult to have parents implement skills daily when their child is removed from their custody, visits are supervised, or when the family does not have the financial resources to attend treatment consistently.

Limitations to current research: There are also several concerns regarding how effective PCIT may truly be for child maltreatment cases based on the current state of the evidence. Given the focus of PCIT on attentional and emotional cues from the child, neglectful caregivers are by nature less likely to benefit from treatment. Additionally, certain risk factors such as low maternal sensitivity and general parent stress do not consistently improve with PCIT across trials. This suggests improved attachment may not be sustained over time and higher-risk families may not always see positive treatment effects. Research design limitations such as attrition, sampling bias, lack of comparison groups, and flawed outcome assessment limit the generalizability and explanatory power of current findings. For example, it is unclear whether behavior problems in maltreated children objectively decrease after PCIT, or whether this is simply a change in parents' perceptions of behaviors. Similarly, re-referral to child welfare depends on police or child welfare reports, likely making this measure of recidivism both under-reported and biased toward more severe cases[1]. Lastly, there is simply not enough evidentiary support to confidently recommend PCIT for traumatic experiences separate from maltreatment.

Solutions

Tailoring treatment: Therapists can identify valuable targets for coaching and caregiver feedback at the beginning of treatment by carefully assessing current discipline practices, abuse potential and other risk factors, parent functioning, and child trauma symptoms. Such tailoring may include explicit praising of "brave" behaviors for anxiety during special time, or providing psychoeducation geared towards caregiver misconceptions about child capabilities. Assessment of ongoing family stressors can provide poignant context for changes in treatment progress, such as sudden regression in CDI skills. There is also a push for more examination of process variables (e.g., expectations and readiness for treatment, congruence of treatment with parenting beliefs, demands of treatment, and therapeutic alliance) that likely impact treatment

success so that these factors can be addressed in advance or during treatment in order to tailor treatment to fit the family. Outcome measurement is important for demonstrating whether an intervention has worked across numerous domains and can be tailored to fit trauma populations. For maltreatment cases, such outcomes may involve comparing objective assessments of behavior problems with parent-perceived behavior ratings, using careful definitions of recidivism and the context for measuring re-referrals, and measuring change in attachment over time[6,1].

Clinicians will also likely require helpful strategies to navigate atypical custody arrangements or prevent re-offending. Families in the child welfare systems will be most successful when the intervention is timed well with the child's return to their biological parents[1], since involving the true primary caregivers is always crucial in a parent training intervention[6]. These families may also benefit from limiting of the demands of participating in multiple types of interventions simultaneously, or performing PCIT in the home if feasible[3,9]. The "swoop and go" procedure (or removal of privileges for older youth) can be used in place of the time-out room to reduce the potential for child abuse during high pressure discipline situations[19]. In this way, the caregiver must only remove themselves from the room without physical contact with the child. Addressing these and other unique barriers to treatment success will promote sustainable disruption of coercive family processes.

Adaptations: Many adaptations to PCIT content and structure are recommended to maximize effects for maltreating caregivers and encourage consistent attendance and graduation from treatment, while still maintaining treatment fidelity as much as possible. For instance, making the treatment time-limited may help to decrease drop-out and increase longevity of effects for these families with maltreatment histories. Some researchers have found that while previous studies have included up to 53 sessions, this adaptation does not increase efficacy and is likely to foster attrition[17]. Instead, the traditional 12-14 session model is more likely to be feasible and efficacious for high-risk populations with fewer resources. For foster parents without significant psychological distress (e.g., depression), a two-day workshop has demonstrated success in maintaining treatment effects, indicating that even very short PCIT dosage adaptations can work for those with fewer complicating factors.

Adding a motivational orientation for parents with the lowest levels of initial motivation has been shown to decrease recidivism rates[3,4,5]. These six sessions incorporated motivational interviewing techniques such as decisional balance and self-efficacy exercises to isolate parenting goals, which is especially important for families mandated to participate in PCIT. Interestingly, *enhancing* PCIT to offer several additional services for the family (e.g., employment services, drug treatment) has been shown to be less effective than traditional PCIT. This may suggest that families experience difficulty managing the demands of multiple interventions, or the provision of several simultaneous services reduces the essential focus on parenting skills[3]. In sum, motivational interviewing sessions on their own may be a most powerful addition to traditional PCIT, even if they lengthen treatment. Clinicians should be cautious when adding this component for highly motivated families, as it may be unnecessary or counter-productive[4].

PCIT has also been adapted for use with older children exposed to maltreatment up to 12 years of age. Given that parents are the primary target for behavior change, this adaptation involves very similar techniques regardless of abuse history. These techniques include reducing the frequency of PRIDE skills needed for CDI mastery, adapting PRIDE skills and Special Time activities to be genuine and developmentally appropriate, lengthening daily Special Time, using

removal of privileges or an incentive chart during PDI, and use of effective command training without the time-out procedure[3,13].

In addition to tailoring discussions to meet the concerns that coincide with maltreatment, caregivers may require actual adaptations to treatment through the addition of modules for psychoeducation on child maltreatment and normative child development. For example, parents may receive a specific information session on the progression of emotion regulation abilities, or the impact that sexual abuse has on a child's functioning[8]. Additionally, caregiver perpetrators can receive explicit instruction in emotion identification, relaxation strategies, and self-monitoring in order to enhance their own emotion regulation skills, making it easier for therapists to help them through challenging behavioral situations during coaching[6].

Conclusions and Recommendations

The existing literature offers preliminary evidence for the efficacy of PCIT for treating children exposed to trauma, but the vast majority of these studies focus on disrupting coercive family interactions to reduce future child maltreatment by caregivers. For these cases, improving parenting skills is more important than reducing externalizing behaviors, therefore youth may not present with clinical behavior problems. There is significant variability in the success of PCIT for decreasing recidivism, which is reflective of high attrition rates in maltreating populations and flawed research designs that limit the number of strong recommendations that can be made. There is very little evidence regarding how PCIT plays a role in ameliorating the negative sequelae of other types of traumatic experiences, but there is some data to support positive outcomes, particularly for children exposed to domestic violence.

Based on current available research, we encourage PCIT practitioners to maintain the core features of PCIT, including observation and coding of the parent-child dyad and coaching the parent towards more positive parenting behaviors. At the same time, we encourage clinicians to consider ways in which the typical delivery of PCIT could be adjusted to best serve this population, including minimizing treatment burden for families and employing flexible service delivery models. This is especially important for perpetrating caregivers, who may be less motivated to participate.

Clinicians can draw upon several strategies to tailor or adapt service delivery to meet families' needs, such as making treatment time-limited or home-based, adding motivational or psychoeducational components when necessary, and choosing PCIT techniques that minimize re-offending by caregivers.

Future research should aim to compare the efficacy of PCIT for different types of trauma exposure (direct and indirect), both with and without clinical behavior problems in the child. Even more specifically, trauma research studies should aim to gather multiple collateral reports, compare PCIT dosage levels (i.e., duration and intensity) using RCT methodology, actively monitor recidivism to assess maintenance of treatment gains, examine attachment quality and location of services as potential predictors of success, and compare treatment outcome for substantiated vs. at-risk maltreating families. Finally, more thorough investigation of individual family risk factors, process variables, and appropriate outcome measures for this population will provide clinicians with direct targets for tailoring and adapting treatment, so that incremental validity can be established.

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