

## Effects of Parent-Child Interaction Therapy on Young Children with Disruptive Behavior Disorders

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The behavioral and social-emotional consequences of Parent-Child Interaction Therapy (PCIT) were examined in 17 studies of preschool-age children identified as exhibiting a disruptive behavior disorder. These studies included 628 children, 368 of whom participated in parent-child interaction therapy. Study findings revealed that involvement in PCIT results in statistically and clinically significant improvements in child behavior functioning. While there is some evidence that PCIT positively impacts social-emotional development, this evidence is less compelling. Implications for practice are described in terms of core relationship-building and discipline skills that parents should implement in order to optimize child behavior functioning.

### Purpose

The American Psychological Association's Division 12 Task Force on Effective Psychosocial Interventions recently designated Parent-Child Interaction Therapy (PCIT) as a "probably efficacious treatment" for children with conduct problem behavior (Brestan & Eyberg, 1998). The primary purpose of this research synthesis is to verify the effectiveness of PCIT for improving the behavior of young children exhibiting disruptive behavior disorders. In addition, the research synthesis will examine empirical findings regarding child social-emotional outcomes resulting from participation in PCIT.

The conduct of the synthesis is guided by a framework that focuses on the degree to which variations in the PCIT intervention are associated with variations in behavioral and social-emotional outcomes (Dunst, Trivette, & Cutspec, 2002). In general terms, a practice-based research synthesis differs from more traditional meta-analyses by systematically examining and unpacking the characteristics of practices that are related to differences in outcomes or consequences. Specifically, this type of analysis focuses more on an understanding of *how* the same or similar characteristics exert the same or similar observable effects and not solely on statistical or observation-based relationships between or among these variables.

### Background

Disruptive behavior in preschool-age children is the most common reason for referral to child mental health services (Kazdin, 1995; Schuhmann, Durning, Eyberg, &

Boggs, 1996). Recent studies have reported prevalence rates as high as 23% for clinically significant disruptive behavior among toddlers (O'Brien, 1996). In addition to its high prevalence, disruptive behavior exhibits a high degree of stability over time if not treated (Campbell & Ewing, 1990; Lahey et al., 1995; Rose, Rose, & Feldman, 1989). Disruptive behavior disorders of early childhood pose significant challenges—not only for the affected child, but also for their family and for society as a whole. The presence of disruptive behavior disorders in young children appears to be a common pathway for a wide range of psychiatric disorders in adolescence and adulthood, as well as for delinquency and criminal behavior (Farrington, 1995).

Given the enormous potential long-term societal costs of childhood disruptive behavior disorders, the need for early intervention is strongly indicated. The preschool years appear to be an optimal time for treating disruptive behavior disorders for several reasons. First, behavior problems in young children are less entrenched relative to older children and, second, parents have more of an influ-

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ence on their child's behavior at this young age (Capage, Foote, McNeil, & Eyberg, 1998). In addition, available evidence suggests that interventions are more effective with this population at the preschool age vs. later ages (Dishion & Patterson, 1992; Ruma, Burke, & Thompson, 1996).

The prominent role of dysfunctional parent-child interaction in the development of disruptive behavior problems (Campbell, 1997; Olson, Bates, & Bayles, 1990; Patterson, 1982) suggests the need for interventions aimed at modifying the contingencies that shape these dysfunctional interactions. Parent-Child Interaction Therapy (PCIT) represents one such intervention. PCIT was developed by Sheila Eyberg at the Oregon Health Sciences University as a treatment for behaviorally disturbed preschool children and their families (Eyberg & Robinson, 1982). It employs a two-stage treatment approach, based on Hanf's model of parent management training (Hanf, 1969). The development of PCIT was influenced by Baumrind's research on the authoritative parenting style—one in which parents are both highly responsive and highly demanding (Baumrind, 1967). This line of research demonstrated that young children whose parents do not adequately meet the child's dual needs for nurturance and limits are likely to exhibit poor outcomes. In addition to social-learning theory, the conceptual foundation of PCIT is based on attachment theory (Ainsworth, 1969). Attachment theory posits that young children whose parents demonstrate a high degree of warmth, responsiveness, and sensitivity to their signals are more likely to develop a secure working model of their relationships with others and to develop more effective emotional regulation.

Therefore, PCIT draws upon both social-learning and attachment theories in order to modify maladaptive parent-child interactions into ones that characterize authoritative parenting. Parents are taught one specific set of skills that promote a nurturing and secure relationship with their child and a second set of skills designed to increase the child's prosocial behavior and decrease negative behavior (Neary & Eyberg, 2002).

### ***Description of the Practice***

PCIT is an intensive intervention that involves training parents in behavioral management techniques within a play-therapy context using a combination of didactic, modeling, and interactive coaching techniques. A critical element of PCIT is that the practitioner works with the parent and child together during the majority of the treatment sessions, since the emphasis is on changing interaction patterns within the dyad. Another defining characteristic of this intervention is "live" coaching, in which the practitioner provides parents with immediate feedback while observing parent-child interactions behind a one-way mirror and communicating to the parent via a bug-in-the-ear device. Assessment is another key characteristic

of PCIT, since it guides clinical decision making throughout the course of treatment. A number of assessment instruments have been developed specifically as a result of PCIT. The most prominent of these instruments is the Dyadic Parent-Child Interaction Coding System-II (DPICS-II; Eyberg, Bessmer, Newcomb, Edwards, & Robinson, 1994). The DPICS-II is a behavioral observation coding system that is used to measure the frequency of specific parent skills at the start of each session. Parents and practitioners review graphs of DPICS-II data each week to evaluate progress towards skill mastery and to decide which skills need further attention (Herschell, Calzada, Eyberg, & McNeil, 2002a).

Typically, PCIT is conducted in weekly 1-hour treatment sessions. Each of the two phases of PCIT (described below) begins with a didactic session that parents attend alone. During this session, the practitioner introduces the skill set to be learned for that phase and engages the parent in a role-play during which the parent begins to practice the skills. Subsequently, the parent and child attend coaching sessions, during which parents are coached in the application of the skills as they interact with their child in a play setting. At the beginning of each coaching session, the practitioner reviews homework from the previous week and observes the parent in a standardized 5-minute play situation using the DPICS-II. During this observation period, the practitioner codes the frequency of the particular skills that the parent is in the process of learning so that skills requiring further practice can be identified.

PCIT is divided into two distinct treatment phases: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). Parents typically receive instruction in CDI skills first. This set of traditional play-therapy skills is intended to strengthen the parent-child relationship and increase the child's prosocial behaviors. Once CDI skills are mastered, the parent receives instruction in PDI skills. These skills consist of behavior modification/discipline techniques designed to decrease negative child behavior. The rationale for implementing CDI first is that children will be less resistant to the limits and rules that parents will begin to impose on them during PDI if these rules are applied in the context of the positive relationship that is established during CDI (Neary & Eyberg, 2002).

In addition to practicing newly learned skills during the treatment sessions, parents are instructed to practice CDI/PDI skills between sessions in order to hone their skills. Ideally, practitioners should avoid using a time-limited treatment method (i.e., a pre-set limit to the number of sessions) and, instead, employ a criteria-based treatment method in which advancement through phases and treatment termination is based on when the parent has achieved a specified level of skill mastery. When a criteria-based method is used, the average length of PCIT treatment is 12

sessions (Rayfield, Monaco, & Eyberg, 1999). In research studies that utilize a pre-set session limit (in order to standardize treatment across participants or reduce study costs), the session limits are typically set at seven CDI and seven PDI sessions. The major skills to be learned in the CDI and PDI phases of PCIT are described below.

*Child-directed interaction.* In this phase, the parent and child engage in “special play time,” during which parents are instructed to allow their child to lead the play session. Parents are also instructed to avoid asking questions, giving commands, or criticizing the child. Instead, parents are coached in the implementation of PRIDE skills: (1) Praise appropriate behavior (e.g., “I like the way you are playing so gently with the toys.”), (2) Reflect appropriate talk (e.g., Child: “I like to play with blocks.” Parent: “These blocks are fun.”), (3) Imitate appropriate play (e.g., parent draws circles on a piece of paper after a child performs the same action), (4) Describe appropriate behavior (e.g., “You are making a tower.”), and (5) be Enthusiastic (e.g., “You REALLY are being gentle with the toys!”). Parents are instructed to utilize these skills at an extremely high frequency rate during special play time. During this phase, parents are also taught to selectively ignore inappropriate behaviors that do not place the child in immediate danger.

Appropriate toys for CDI include those that encourage creativity (such as constructional toys) and that are developmentally appropriate for the child. Toys that are messy (e.g., paint), conducive to aggressive play (e.g., guns), or have preset rules (e.g., board games) are avoided (Rayfield et al., 1999).

Typical criteria for CDI skill mastery require that the parent emit at least 10 behavioral descriptions, 10 reflections, and 10 labeled praises during the course of a 5-minute CDI observation. Additionally, total commands, criticisms, and questions must be no more than three during the observation period (Herschell et al., 2002a). Once these criteria are met, the PDI phase of treatment is initiated.

*Parent-directed interaction.* In this phase of PCIT, parents are instructed on how to give clearly stated commands and to systematically deliver a consequence following every instance of child compliance or noncompliance. Parents are taught to give commands that are direct, specific, age-appropriate, positively stated, and respectful/calm. In addition, commands are only given one at a time and only when necessary. The rationale for a command is also explained either before they are given or after they are obeyed.

First, the child is taught to comply with simple instructions during “minding exercises” (e.g., “Please put the red crayon in my hand.”). As the child becomes more accustomed to these simplistic commands, more “real-life” commands are introduced (e.g., “Please pick up the crayon

that you dropped.”). Parents are coached to provide a specific praise following child compliance (e.g., “Thank you for picking up the crayon. Because you listened to me, you do not have to go to time-out. We will keep playing.”). If the child refuses to comply with the command, the parent gives a single reminder that the child must obey or go to the time-out chair. If the child does not comply within 5 seconds, the parent administers a highly specialized and effective time-out procedure (time-out chair) in which time-out does not end until the child complies with the parent’s original command. A backup for time-out is utilized to eliminate unacceptable time-out behavior (e.g., a “time-out room”).

The PDI procedure follows an algorithm that parents are taught to follow precisely (see Neary & Eyberg, 2002). Practitioners provide a diagram with specific words to use when implementing the steps of the time-out procedure. Parents initially practice the PDI skills at home during 5-10 minute daily clean-up sessions following the 5-minute daily CDI practice sessions. Over the course of time, parents extend their commands to other times of the day.

Typical criteria for PDI skill mastery require that parents give at least four commands, of which 75% must be “effective” (e.g., direct, positively stated, etc.) within a 5-minute PDI observation period. In addition, parents must demonstrate at least 75% correct follow-through after effective commands (i.e., labeled praise after compliance and warning after noncompliance). Finally, if a time-out occurs during the observation period, the parent must successfully follow through with the time-out procedure and the interaction must terminate with compliance to the original command (Herschell et al., 2002a).

## Search Strategy

### Search Terms

Identification of relevant studies was accomplished by using the keywords parent-child interaction therapy, parent child interaction therapy, and PCIT. An author search (Sheila Eyberg) was also conducted.

### Sources

A computer-assisted bibliographic search was conducted using: Psychological Abstracts (PsycINFO), Educational Resources Information Center (ERIC) database, Social Science Citation Index (SSCI), MEDLINE, The Cochrane Database of Systematic Reviews, The Cochrane Database of Abstracts of Reviews of Effectiveness, The Cochrane Controlled Trials Register, Cumulative Index to Nursing and Allied Health Literature (CINAHL), InfoTrac Expanded Academic ASAP, Academic Search Elite, and Books in Print. An online search via the Google search engine was also conducted. In addition, the tables of contents for all 2002 issues of five relevant journals were manually searched in an attempt to retrieve sources that may

not have been identified by bibliographic searches, due to their recent publication date. The reference lists of all acquired sources were also reviewed in order to locate additional sources that may have been omitted from the bibliographic search findings. Finally, a bibliography of PCIT literature located at the University of Florida's Child Study Lab was also reviewed.

### **Selection Criteria**

Studies were included in the research synthesis if they met all of the following criteria: (1) the focus of the study was to establish the effectiveness of PCIT for children with disruptive behavior disorders; (2) the study sample was comprised primarily of preschool-age children (ages 2 through 5) at the time of baseline assessment; (3) the PCIT intervention was described in sufficient detail to ascertain that the intervention applied in the study was the same intervention described in the *Description of Practice* section of the synthesis; (4) children in the study sample exhibited a disruptive behavioral disorder as evidenced by a DSM diagnosis of Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and/or Attention-Deficit Hyperactivity Disorder (ADHD), or by scoring in the clinical range on the Eyberg Child Behavior Inventory (ECBI; Eyberg & Ross, 1978) Problem Scale and Intensity Scale; (5) the study included at least one child-level behavioral or social-emotional outcome measure.

### **Exclusion criteria**

It was necessary to exclude certain studies that appeared to have met all of the inclusion criteria during the initial phase of the search process. Close inspection of these studies revealed certain characteristics of the PCIT intervention that differed significantly from the standard PCIT implementation methodology so as to warrant their exclusion. Specifically, excluded studies were those in which the PCIT intervention was administered via a group didactic format (as opposed to a practitioner working one-on-one with a parent/child dyad) (e.g., Pollock, 1996) and those in which the PCIT intervention omitted either the CDI or PDI phase (e.g., Sosna, 1992).

### **Search Results**

A total of 17 studies met the selection criteria and were included in the research synthesis. Thirteen studies were published in peer-reviewed journals, three studies were unpublished dissertations, and the remaining study was obtained from the University of Florida's Child Study Lab website.

It should be noted that two of the studies in this synthesis constitute follow-up investigations of original studies that are also contained within the synthesis. Specifically, the Eyberg et al. (2001) study presents follow-up data on a subset of families who participated in the Eisenstadt, Eyberg, McNeil, Newcomb, and Funderburk

(1993) study. Similarly, the Funderburk et al. (1998) study presents follow-up data on a subset of families who participated in the McNeil, Eyberg, Eisenstadt, Newcomb, and Funderburk (1991) study.

### **Participants**

Tables 1 and 2 summarize, respectively, the characteristics of both the child and parent study participants. The 17 studies included 628 children, of whom 368 underwent PCIT and 260 served as control participants. As seen in Table 1, participant drop-out rates were highly variable, ranging from 0% to 53% for pre-post assessments and 0% to 55% for follow-up assessments.

Children's gender was reported in 16 (94%) of the studies. The vast majority of child participants were male (mean of 86% across studies). Participants' age at pre-treatment assessment ranged from 2 to 8 years across studies, with a mean age of 4.6 years (average of reported study means) across the 16 studies that provided information on child age.

Child participants were defined as exhibiting a disruptive behavior disorder using one of three methods: (1) scoring in the clinical range on the Eyberg Child Behavior Inventory (ECBI; Eyberg & Robinson, 1982) (five studies); (2) meeting DSM criteria for Oppositional Defiant Disorder (five studies); or (3) meeting DSM criteria for either Oppositional Defiant Disorder, Conduct Disorder, or Attention-Deficit/Hyperactivity Disorder (seven studies). Nineteen (19) percent of child participants met disruptive behavior disorder criteria via Method 1, 29% met criteria via Method 2, and 52% met criteria via Method 3. Examination of Table 1 reveals that participants assessed via Method 3 frequently exhibited multiple comorbid disruptive behavior disorder diagnoses.

Descriptive information about the families participating in the study was not always provided (see Table 2). From the information that was available, it appears that the vast majority of families were Caucasian (70% to 100% across studies) and approximately half of the parents were married. The limited information regarding family income/SES that was available suggested that these were typically low-income families in which the parents were high school graduates.

Only 10 (59%) of the studies specified which parent participated in the PCIT intervention. In most cases, PCIT was implemented with the mother only (70% across the 10 studies), while in 30% of cases, both parents were participants in the PCIT intervention. Almost all studies reported participant attrition rates for the pre- to post-treatment assessment, as well as for follow-up assessments when studies utilized a longitudinal design.

### **Research Designs**

Table 3 summarizes the research design employed by each study. Two studies (12%) used single-participant

designs (Bahl, Spaulding, & McNeil, 1999; Borrego, Urquiza, Rasmussen, & Zebell, 1999), while the remaining studies (88%) used a between- and within-group design.

*Single-participant designs.* Both studies employing single-participant designs used a pre-treatment ( $O_1$ ), treatment (X), post-treatment ( $O_2$ ) design. Both studies incorporated a longitudinal follow-up assessment component with either one ( $O_3$ ) or two ( $O_3, O_4$ ) follow-up assessments. Length of time between post-treatment and first follow-up ranged from 1 to 5 months. For the study that included two follow-up time points, length of time between post-treatment and second follow-up was 16 months.

*Group designs.* Among the studies utilizing a group design, a variant of the  $O_1XO_2$  within-group design was used in six studies (40%). One of these studies incorporated two longitudinal follow-up assessments at 12 and 24 months (Eyberg et al., 2001) and another employed a single follow-up assessment at 1.5 months (Eisenstadt et al., 1993).

There were nine group design studies (60%) that combined between-group contrasts with  $O_1XO_2$  within-group comparisons. Of these, four compared a PCIT group to a group of waitlist control participants (Brestan, Eyberg, Boggs, & Algina, 1997; Eyberg, Boggs, & Algina, 1995; McNeil, Capage, Bahl, & Blanc, 1999; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998), one compared a PCIT group to a group receiving alternative treatment (Terao, 1999), two compared a PCIT group to a social-validation group(s) comprised of participants who did not exhibit disruptive behavior disorder (Funderburk et al., 1998; McNeil et al., 1991), one compared a PCIT group to both a waitlist control group and a social-validation group (Nixon, 2001), and one compared a PCIT-Standard Implementation group to a PCIT-Abbreviated Implementation group, a waitlist control group, and a social-validation group (Nixon, Sweeney, Erickson, & Touyz, 2003). Random assignment to groups occurred in all studies with a waitlist control group, but not in studies employing an alternative-treatment group or a social-validation group.

Only 4 of the 9 between-within group design studies (44%) implemented a longitudinal follow-up component (Funderburk et al., 1998; Nixon, 2001; Nixon et al., 2003; Schuhmann et al., 1998). Length of time between post-treatment and first follow-up ranged from 4 to 12 months. For the study that included two follow-up assessments (Funderburk et al., 1998), length of time between post-treatment and second follow-up was 18 months.

In 77% of studies that employed outcome measures that require observational coding, interrater reliability data was also presented. Most of the time (54%), individuals serving as observational coders were blind to group assignment and intervention stage (i.e., pre- vs. post-treatment).

### **Characteristics of PCIT Intervention**

The settings in which PCIT was delivered included university-based psychology clinics, hospital-based clinics, and community mental health centers. In the vast majority of cases, the practitioner serving as the PCIT practitioner was a doctoral-level clinical psychology graduate student or psychology intern who had undergone extensive training in the implementation of the intervention. In one study (Switzer, 1997), master's-level psychologists/social workers employed by a community mental health center served as practitioners.

With two exceptions, all studies reported engaging in weekly treatment sessions that were one hour in length. In the Nixon (2001) and Nixon et al. (2003) studies, weekly sessions ranged from 1 to 2 hours in duration. In all but two studies, the traditional phase sequence (i.e., CDI followed by PDI) was utilized. In the study conducted by Eisenstadt et al. (1993) and its corresponding follow-up study (Eyberg et al., 2001), a primary focus of the investigation was to determine whether phase sequence impacted treatment effectiveness. Therefore, half of the participants received the traditional phase sequence, while the remaining half received the PDI component first. Because phase sequence manipulation only resulted in minor differences between groups, both studies combined the data and reported on treatment outcome for the group as a whole.

Selected characteristics of the PCIT intervention implemented in each study are presented in Table 3. Five studies (29%) utilized a criteria-based treatment method in which the number of PCIT sessions varied across families and was based on the speed at which parents demonstrated mastery of CDI/PDI skills. The average number of sessions for criteria-based studies was 12.6. In the remaining studies (71%), the researchers instituted a time-limited treatment method in which a predetermined number of treatment sessions were implemented uniformly across participants. In most of the time-limited studies, the number of sessions was set at 14, which is greater than the average number of sessions for criteria-based studies. Therefore, it is assumed that this liberal number of predetermined sessions would be sufficient to allow participants to achieve mastery of CDI/PDI skills.

*Treatment fidelity.* Some form of clinician-level, treatment-fidelity information was reported in nine (53%) studies. In some cases, the authors simply indicated that practitioners used a treatment manual containing session-content outlines to ensure fidelity to treatment. In other cases, clinicians were required to complete checklists documenting adherence to treatment-manual session content. The most compelling form of treatment-fidelity data occurred in studies in which an independent observer coded videotapes of sessions to establish degree of adherence to treatment-manual session content (Brestan et al., 1997;



Eyberg et al., 1995; Nixon et al., 2003; Schuhmann et al., 1998).

Nine studies (53%) provided evidence of treatment fidelity with regard to the parent's implementation of CDI/PDI skills. This evidence took the form of required completion of daily homework monitoring sheets, required mastery of predetermined criteria as observed during sessions, the documentation of significant pre-post treatment differences in targeted parent skills (i.e., increased praise, decreased commands), and the presentation of graphical trends that illustrate increases/decreases in targeted parent behavior frequencies across time. DPICS or DPICS-II data (Eyberg et al., 1994; Eyberg & Robinson, 1983) were typically used to assess the degree of parent implementation of CDI/PDI skills.

### **Outcomes**

Although most studies included parent-level outcomes (e.g., parenting stress, locus of control), these outcomes are omitted due to the research synthesis' focus on child-level outcomes. Child behavioral outcomes were measured in 65% of the studies, while 35% of the studies measured both behavioral and social-emotional outcomes. Table 3 provides a summary of the specific child-level outcome measures used in these studies.

*Behavioral outcomes.* The instruments used to assess behavioral outcomes encompass a range of data-collection methods (self-report, behavioral observation, structured clinical interview) and a range of respondents (parents, teachers, study personnel). The vast majority of these measures were standardized instruments with documented psychometric properties, although a few were created by the authors specifically for use in their investigation.

The behavioral outcomes assessed by these instruments include parent and teacher reports of behavior problem frequency and intensity, parent and teacher reports of inattention/hyperactivity, rates of observed compliance, and rates of observed negative behavior/verbalizations. In addition, several studies examined the percentage of children meeting diagnostic criteria for disruptive behavior disorder at post-treatment and follow-up assessment.

*Social-emotional outcomes.* The measures used to assess social-emotional outcomes also varied in terms of information source (child, parent, teacher, study personnel) and methodology (observation and self-report). These measures also tended to be commonly used instruments with known psychometric properties. The social-emotional outcomes assessed by these measures include child-rated self-esteem, non-verbal affection displayed between parents and children, teacher-rated social competence, and parent-rated disposition/temperament and hostility/withdrawal.

### **Synthesis Findings**

Table 4 summarizes the findings regarding the child behavioral and social-emotional consequences of PCIT reported across studies. In addition, the table contains information regarding the degree to which change in behavior and/or social-emotional status was demonstrated to be a direct result of the PCIT intervention (i.e., specificity). There was considerable variation across the 17 studies regarding the specificity of documenting the appropriate implementation of (a) treatment (i.e., therapists adhering to session-content guidelines) and (b) CDI/PDI skills (i.e., parents' skill mastery).

For the purposes of this research synthesis, studies that lacked data demonstrating parent's mastery of CDI/PDI skills were categorized as having Low Specificity (N = 8, 47%). Studies that provided evidence of parent's mastery of CDI/PDI skills, but did not report any practitioner treatment-fidelity procedures were categorized as having Moderate Specificity (N = 3, 18%). Finally, studies that provided data regarding both appropriate practitioner treatment delivery and parent skill mastery were classified as High Specificity studies (N = 6, 35%). The latter studies provided the strongest evidence that change in behavioral/social-emotional outcomes are a direct consequence of the PCIT intervention.

### **Results**

*Behavior change.* Some form of positive child behavior change was documented in all of the studies. Most studies (76%) implemented multiple measures of child behavior change, whereas four studies (24%) relied on a single measure. The most commonly reported behavioral consequences of PCIT included: (1) a reduction of parent-/teacher-rated intensity/frequency of behavior problems (reported in 94% of studies), (2) an increase in clinic-observed compliance rates (reported in 53% of studies), (3) a reduction in inattention/hyperactivity as measured by parent/teacher report or classroom observation (reported in 29% of studies), (4) a decrease in clinic-observed negative behavior such as whining/crying (reported in 24% of studies), and (5) a reduction in the percentage of children who qualify for a DSM diagnosis of disruptive behavior disorder (reported in 24% of studies).

The improvements from pre- to post-treatment were statistically significant across all studies, and clinically significant (i.e., scores moved from the clinical range to the normal range) in 14 (82%) studies. For studies that compared PCIT participants against a waitlist or alternative-treatment control group, the PCIT participants exhibited significantly greater behavioral improvements relative to the control group. Furthermore, 6 of the 8 longitudinal studies (75%) reported that behavioral gains obtained at the time of post-treatment were maintained

through all follow-up periods.

**Social-emotional change.** Six of the 17 studies (35%) included some measure of child-level, social-emotional change. The Eisenstadt et al. (1993), Eyberg and Robinson (1982), McNeil et al. (1991), and Nixon (2001) studies each presented original data, while the Eyberg et al. (2001) study presented longitudinal follow-up data from the original Eisenstadt et al. (1993) investigation. Similarly Funderburk et al. (1998) presented longitudinal follow-up data on the original McNeil et al. (1991) investigation. Improvement in social-emotional status from pre- to post-treatment was reported in all of the four studies presenting original data. Of the two “original data” studies that employed a control group, one study reported differential rates of improvement between groups favoring the PCIT group (Nixon, 2001). Follow-up assessments (Eyberg et al., 2001; Funderburk et al., 1998; Nixon, 2001) indicated that, with a few exceptions, post-treatment gains in social-emotional development were not maintained over time.

#### **Rival Explanations**

A number of rival explanations might explain the positive findings reported by study authors. As a consequence of the generally high quality of the research designs, however, many of these rival explanations can be refuted.

The possibility of maturation accounting for pre-post treatment improvements in behavioral functioning is mitigated by strong evidence in the literature that disruptive behavior disorders do not spontaneously remit over time if untreated (e.g., Campbell & Ewing, 1990). In addition, the inclusion of a control group(s) in 53% of the studies serves to separate the effects of maturation and treatment. Participant mortality or attrition could also explain positive findings. Significant attrition posed a problem for 5 of the 17 studies reviewed in this synthesis. However, the majority of these studies reported a lack of differences on demographic characteristics and/or symptom severity measures across treatment dropouts and completers.

The demand characteristics of the treatment-outcome study may have resulted in observer or rater bias, since all of the outcome measures involved the use of self-report and experimenter observation methods. The typical employment of multiple outcome measures utilizing multiple methods of data gathering within studies serves to attenuate concerns that positive findings are simply the result of observer/rater bias. Furthermore, observational data coders were typically blind to group assignment and intervention stage (i.e., pre- vs. post-treatment), thereby minimizing the probability of observer bias in the clinic setting.

Because a number of studies selected participants for inclusion in the study based on highly elevated scores on the ECBI, documented improvements using this measure may be a product of regression to the mean. How-

ever, several studies reported a clear differential improvement on the ECBI between a PCIT group and a waitlist/alternative-treatment control group, which provides evidence that improvement on this measure cannot be solely attributed to a statistical artifact.

In summary, a number of common threats to internal validity were addressed within the research designs of these studies. The use of control groups, blind raters, multiple methods of measurement, and appropriate statistical techniques diminishes the plausibility of rival explanations and strengthens the contention that observed effects are directly attributable to participation in the PCIT intervention.

#### **Conclusion**

This research synthesis examines claims that Parent-Child Interaction Therapy is a “probably efficacious treatment” for the treatment of children with conduct problem behavior (Brestan & Eyberg, 1998). The primary focus of this synthesis is to summarize findings regarding the effectiveness of PCIT for improving the behavior of young children exhibiting disruptive behavior disorders. A secondary focus is to examine empirical findings regarding child social-emotional outcomes resulting from the PCIT intervention.

The evidence base for PCIT’s effectiveness stems from studies that (1) assessed level of adherence to a standardized treatment protocol (i.e., treatment fidelity); (2) utilized multiple assessment methods and research designs; (3) used measures with well-established psychometric properties to assess outcomes; (4) employed a variety of control groups; (5) used “real world” samples of participants in which children suffered from comorbid disorders and were from low-income, single parent families; and (6) employed a longitudinal component to demonstrate the stability of treatment effects. Furthermore, studies documenting the efficacy of PCIT have been replicated by several independent research groups.

Taken together, these studies provide strong evidence for the effectiveness of PCIT. The evidence reviewed in this synthesis supports claims that PCIT is effective in improving behavior outcomes in preschool-age children with disruptive behavior disorder; therefore, PCIT is recommended as an evidence-based intervention for this purpose. The utility of PCIT for impacting social-emotional outcomes in this population, however, is tenuous and requires further investigation. A reduction in disruptive behaviors should logically lead to improved relationships with caregivers and peers, which in turn, should result in improved child social-emotional outcomes. However, these outcomes have not yet been a focus of investigation in the PCIT treatment-outcome literature.

There are several caveats regarding the recommendation of PCIT as an evidence-based intervention. First, none of the studies reviewed in this synthesis examined father-child dyads (i.e., families in which the sole caregiver participating in the intervention was the father). There is no reason to postulate that father-only implementation of CDI/PDI skills would result in different behavioral/social-emotional consequences. Despite this, there is currently no available evidence to support the use of PCIT without incorporating the child's mother in the intervention. Although most of the study participants have been male (which likely is a reflection of the greater prevalence of disruptive behavior disorders in males), none of the studies reviewed reported differential rates of improvement for females and males. Therefore, the available evidence suggests that PCIT is equally effective with females and males.

Since the vast majority of PCIT treatment effectiveness research has been conducted using Caucasian children, it is an erroneous assumption that PCIT is effective for improving behavior/social-emotional outcomes for children of other ethnicities. Indeed, the exploration of cultural variables on PCIT outcome has recently been identified as a key direction for future research studies in this area (Herschell, Calzada, Eyberg, & McNeil, 2002b). Cultural variations in acceptable parenting practices cannot be ignored. It may be that the skills that PCIT requires parents to engage in with their child may fall outside the range of acceptable parenting practices for parents of particular ethnic groups. Therefore, PCIT is recommended as an evidence-based intervention only for those families who consider the implementation of CDI/PDI skills as consistent with their cultural parenting norms.

One last caveat concerns the external validity of the research findings. Since all studies of PCIT effectiveness were conducted in clinical settings using master's-/doctoral-level therapists who underwent substantial training in PCIT, the generalizability of findings to less controlled settings appears limited.

### **Implications for Practice**

For practitioners working with families of children with severe levels of disruptive behavior, the formalized Parent-Child Interaction Therapy protocol appears warranted. Implications for practice, however, can also be derived from this research synthesis for children with more typical levels of challenging behavior. For these children, the presence of a warm and nurturing parent-child relationship, combined with the use of consistent discipline and clear limit-setting, optimizes child behavioral functioning. A positive parent-child relationship can be cultivated by implementing regular child-led playtimes, during which parents avoid giving commands or criticism and engage in a high frequency of labeled praise using an enthusiastic tone of voice. Consistent discipline is attained when

parents give direct commands in a calm, respectful way, and systematically deliver a consequence following each instance of child compliance or noncompliance in the context of everyday activities.

The companion to the *Bridges* is a *Bottomlines* (Vol. 1, No. 7) report that describes the major findings from this practice-based research synthesis in understandable, user-friendly language. The *Bottomlines* summarizes what we know about Parent-Child Interaction Therapy specifically for parents and practitioners. Also included is a lively vignette illustrating what the practice looks like for a young child and his mother.

For more detailed information concerning implementation of PCIT components, the reader is referred to the PCIT *Solutions* Practice Guide. *Solutions* are designed by staff of the Research and Training Center on Early Childhood Development as a compliment to research syntheses concluding that sufficient research evidence exists to support the practice under study. The PCIT *Solutions* Practice Guide is prepared in a "how to" format that provides practitioners and parents with the information necessary to use PCIT techniques to decrease disruptive behavior problems. This practice guide will be available to readers in either electronic versions at our website ([www.researchtopractice.info](http://www.researchtopractice.info)) or written, video, and/or PowerPoint versions that can be obtained by writing us at our Research and Training Center address.

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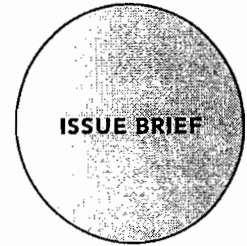
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# Child Welfare Information Gateway

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## Parent-Child Interaction Therapy With At-Risk Families

### What's Inside:

- What makes PCIT unique
- Key components
- Effectiveness of PCIT
- What to look for in a therapist
- Resources for further information

This issue brief was developed by Child Welfare Information Gateway, in partnership with the Chadwick Center for Children and Families at Rady Children's Hospital San Diego. Contributing authors include Mark Chaffin, Ph.D., Nicole Taylor, Ph.D., Charles Wilson, M.S.S.W., and Robyn Igelman, Ph.D.

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Parent-child interaction therapy (PCIT) is a family-centered treatment approach proven effective for abused and at-risk children ages 2½ to 12 and their biological or foster caregivers. During PCIT, therapists coach parents while they interact with their children. Sitting behind a one-way mirror and coaching the parent through an “ear bug” audio device, therapists guide parents through strategies that reinforce their children’s positive behavior. Research has shown that as a result of PCIT, parents learn more effective parenting techniques, the behavior problems of children decrease, and the quality of the parent-child relationship improves.

This issue brief is intended to build a better understanding of the characteristics and benefits of PCIT. It was written primarily to help child welfare caseworkers and other professionals who work with at-risk families make more informed decisions about when to refer parents and caregivers, along with their children, to PCIT programs. This information may also help biological parents, foster parents, and other caregivers understand what they and their children can gain from PCIT and what to expect during treatment. This brief also may be useful to others with an interest in implementing or participating in effective parent-training strategies.

## What Makes PCIT Unique

Introduced in the 1970s as a way to treat children with serious behavioral problems, PCIT has since been adapted successfully for use with populations who have experienced child maltreatment. The distinctiveness of this approach lies in the use of live coaching

and the treatment of both parent and child together. In randomized testing, including families identified by the child welfare system, it has consistently demonstrated success in improving parent-child interactions. Benefits of the model, which extend to physically abusive and at-risk biological parents as well as foster parents, are described below.

## Reduces Behavior Problems in Young Children by Improving Parent-Child Interaction

PCIT was designed to treat serious behavior problems in children ages 2 to 7. This includes children with disruptive or externalizing behavior problems, including conduct and oppositional defiant disorders. These children are often described as negative, argumentative, disobedient, and aggressive.

PCIT addresses the negative parent-child patterns that may contribute to the disruptive behavior of young children (Bell & Eyberg, 2002). Through PCIT, parents learn to bond with their children and develop more effective parenting styles that better meet their children’s needs. For example, parents learn to model and reinforce constructive ways for dealing with emotions, such as frustration. Children, in turn, respond to these healthier relationships and interactions. As a result, children treated using PCIT typically show significant reductions in behavior problems at home and at school (Brinkmeyer & Eyberg, 2003; Gallagher, 2003; Hembree-Kigin & McNeil, 1995; McNeil, Eyberg, Eisenstatdt, Newcomb, & Funderburk, 1991; Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998).

## Decreases the Risk for Child Physical Abuse and Breaks the Coercive Cycle

PCIT also has been found effective for physically abusive parents with children ages 4 to 12 (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Chaffin et al., 2004). PCIT is appropriate where physical abuse occurs within the context of child discipline, as most physical abuse does. While child behavior problems and child physical abuse often co-occur, PCIT may help change the behavior of physically abusive parents regardless of child behavior problems.

Many complex factors contribute to abusive behaviors, including a coercive relationship between the parent and child (Fisher & Kane, 1998; Patterson, 1995). Abusive and at-risk parents frequently interact in negative ways with their children, use ineffective and inconsistent discipline strategies, and rely too much on punishment. These same parents rarely interact in positive ways with their children (e.g., rewarding good behavior). At the same time, some physically abused and at-risk children tend to be aggressive, defiant, noncompliant, and resistant to parental direction (Kandel, 1992; Larzelere, 1986). The reciprocal negative behaviors of the parent and child create a harmful cycle that often escalates to the point of severe corporal punishment and physical abuse. The negative behaviors of the parent—screaming and threatening—reinforce the negative behaviors of the child—such as unresponsiveness and disobedience, which further aggravates the parent's behavior and may result in violence. PCIT helps break this cycle by encouraging positive interaction and training parents in how to implement consistent and nonviolent discipline techniques.

Parents and caretakers completing PCIT typically:

- Show more positive parenting attitudes and demonstrate improvements in the ways that they listen to, talk to, and interact with their children (Hembree-Kigin & McNeil, 1995)
- Report less stress (Timmer, Urquiza, Zebell, & McGrath, 2005)
- Use less corporal punishment and physically coercive means to control their children (Chaffin et al., 2004)

In addition, parent satisfaction with PCIT is typically high (Chaffin et al., 2004; Schuhmann et al., 1998).

## Offers Support for Caregivers Including Foster Parents

Children in foster care often exhibit high levels of behavior problems (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998). Foster parents frequently need help in managing the difficult behavior of foster children and infrequently receive training on how to deal with such problems (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005). PCIT is currently being recognized as a way to help support foster parents caring for children with behavioral problems by enhancing the relationship between foster parents and foster children and by teaching foster parents behavior management skills. In addition to reporting decreases in child behavior problems, foster parents frequently report less parental stress following PCIT and high levels of satisfaction with the program (McNeil et al., 2005; Timmer, Urquiza, & Zebell, 2005).



## Uses Live Coaching

PCIT is a behavioral parent-training model. What makes PCIT different from other parent training programs is the way skills are taught, using live coaching of parent-child interactions. Live coaching provides immediate prompts to parents while they interact with their children. During the course of this hands-on treatment, parents are guided to demonstrate specific relationship-building and discipline skills.

The benefits of live coaching are significant:

- Parents are provided with opportunities to practice newly taught skills.
- Therapists can correct errors and misunderstandings on the spot.
- Parents receive immediate feedback.
- Parents are offered support, guidance, and encouragement as they learn.

## Treats the Parent and Child Together

While many treatment approaches target either parents or children, PCIT focuses on changing the behaviors of both the parent and child together. Parents learn to model positive behaviors that children can learn from and are trained to act as “agents of change” for their children’s behavioral or emotional difficulties (Herschell & McNeil, 2005).

In addition, PCIT therapists are able to tailor treatment based on observations of parent-child interactions. As such, PCIT can help address specific needs of each parent and child.

## Adaptations for Various Populations

PCIT has been adapted for use with various populations and cultures, including:

- Families where child abuse has occurred
- Children with prenatal exposure to alcohol and other drugs
- Older children
- African American families
- Mexican American families
- Native American families

## Limitations of PCIT

While PCIT is very effective in addressing certain types of problems, there are clear limitations to its use. For the following populations, PCIT may not be appropriate, or specific modifications to treatment may be needed:

- Parents who have limited or no ongoing contact with their child
- Very young children (less than 2½ years old)
- Parents with serious mental health problems that may include auditory or visual hallucinations or delusions
- Parents who are hearing impaired and would have trouble using the ear bug device, or parents who have significant expressive or receptive language deficits
- Sexually abusive parents or parents engaging in sadistic physical abuse

## Key Components

PCIT is typically provided in 14 to 20 sessions, each lasting about 1 hour. Occasionally, additional treatment sessions are added as needed.

The PCIT curriculum uses a two-phase approach addressing:

- (1) Relationship enhancement
- (2) Discipline and compliance

Initially, the therapist discusses the key principles and skills of each phase with the parents. Then, the parents interact with their children and try to implement the particular skills. The therapist typically observes from behind a one-way mirror while communicating with the parent, who wears a small wireless earphone. Although not optimal, clinicians who do not have access to a one-way mirror and ear bug may provide services using in-room coaching. Specific behaviors are tracked on a graph over time to provide parents with feedback about the achievement of new skills and their progress in positive interactions with their child.

### Phase 1: Relationship Enhancement (Child-Directed Interaction)

The first phase of treatment focuses on improving the quality of the relationship between the parent and the child. This phase emphasizes building a nurturing relationship and secure bond between parent and child. Phase I sessions are structured so that the child selects a toy or activity, and the parent plays along while being coached by the therapist. Because parents are taught to follow

the child's lead, this phase also is referred to as child-directed interaction (CDI).

During Phase I sessions, parents are instructed to use positive reinforcement. In particular, parents are encouraged to use skills represented in the acronym "PRIDE":

- **Praise.** Parents provide praise for a child's appropriate behavior—for example telling them, "good job cleaning up your crayons"—to help encourage the behavior and make the child feel good.
- **Reflection.** Parents repeat and build upon what the child says to show that they are listening and to encourage improved communication.
- **Imitation.** Parents do the same thing that the child is doing, which shows approval and helps teach the child how to play with others.
- **Description.** Parents describe the child's activity (e.g., "You're building a tower with blocks") to demonstrate interest and build vocabulary.
- **Enthusiasm.** Parents are enthusiastic and show excitement about what the child is doing.

Parents are guided to praise wanted behaviors, like sharing, and to ignore unwanted or annoying behaviors, such as whining (unless the behaviors are destructive or dangerous). In addition, parents are taught to avoid criticisms or negative words—such as "no," "don't," "stop," or "quit"—and instead concentrate on positive directions.

In addition to the coached sessions, parents are given homework sessions of 5 to 10 minutes each day to practice newly acquired skills with their child. Once the parent's skill

level meets the program's identified criteria, the second phase of treatment is initiated.

## Phase II: Discipline and Compliance (Parent-Directed Interaction)

The second phase of PCIT concentrates on establishing a structured and consistent approach to discipline. During this phase, also known as parent-directed interaction (PDI), the parent takes the lead. Parents are taught to give clear, direct commands to the child and to provide consistent consequences for both compliance and noncompliance. When a child obeys the command, parents are instructed to provide labeled, or specific, praise (e.g., "Thank you for sitting quietly"). When a child disobeys, however, the parents initiate a time-out procedure. The time-out procedure typically begins with the parent issuing the child a warning and a clear choice of action (e.g., "put your toys away or go to time-out"), and may advance to sending the child to a time-out chair or time-out room as needed.

Parents are coached in the use of these skills during a play situation where they must issue commands to their child and follow through with the appropriate consequence for positive and negative behaviors. In addition, parents are provided with strategies for managing challenging situations outside of therapy (for example, when a child throws a tantrum in the grocery store or hits another child). Parents also are given homework in this phase to aid in skill acquisition.

## Assessments

In addition to clinical interviews, PCIT uses a combination of observational and standardized assessment measures to assess interactions between parent and child, child

behaviors, and parental perception of stress related to being a parent, as well as parents' own perceptions of the difficulty of their child's behaviors and their interactions with their child. Assessments are conducted before, during, and after treatment.

## Effectiveness of PCIT

The effectiveness of PCIT is supported by a growing body of research and increasingly identified on inventories of model and promising treatment programs.

## Demonstrated Effectiveness in Outcome Studies

At least 30 randomized clinical outcome studies have found PCIT to be useful in treating at-risk families and children with behavioral problems. Research findings include the following:

- **Reductions in the risk of child abuse.** In a study of 110 physically abusive parents, only one-fifth (19%) of the parents participating in PCIT had re-reports of physically abusing their children after 850 days, compared to half (49%) of the parents attending a typical community parenting group (Chaffin et al., 2004). Reductions in the risk of abuse following treatment were confirmed by another recent study among parents who had maltreated their children (Timmer, Urquiza, Zebell, & McGrath, 2005).
- **Improvements in parenting skills and attitudes.** Research reveals that parents and caretakers completing PCIT typically demonstrate improvements in reflective listening skills, use more prosocial

verbalization, direct fewer sarcastic comments and critical statements at their children, improve physical closeness to their children, and show more positive parenting attitudes (Hembree-Kigin & McNeil, 1995).

- **Improvements in child behavior.** A review of 17 studies that included 628 preschool-age children identified as exhibiting a disruptive behavior disorder concluded that involvement in PCIT resulted in significant improvements in child behavior functioning. Commonly reported behavioral outcomes of PCIT included both less frequent and less intense behavior problems as reported by parents and teachers, increases in clinic-observed compliance, reductions in inattention and hyperactivity, decreases in observed negative behaviors such as whining or crying, and reductions in the percentage of children who qualify for a diagnosis of disruptive behavior disorder (Gallagher, 2003).
- **Benefits for parents and other caregivers.** Examining PCIT effectiveness among foster parents participating with their foster children and biological parents referred for treatment because of their children's behavioral problems, researchers found decreases in child behavior problems and caregiver distress for both groups (Timmer, Urquiza, & Zebell, 2005).
- **Lasting effectiveness.** Follow-up studies report that treatment gains are maintained over time (Eyberg et al., 2001; Hood & Eyberg, 2003).
- **Usefulness in treating multiple issues.** Adapted versions of PCIT also have been shown to be effective in treating other issues such as separation anxiety, depression, self-injurious behavior, attention deficit hyperactivity disorder (ADHD), and adjustment following divorce (Johnson, Franklin, Hall, & Preito, 2000; Pincus, Choate, Eyberg, & Barlow, 2005).
- **Adaptability for a variety of populations.** Studies support the benefits of PCIT across genders and across a variety of ethnic groups (Capage, Bennett, & McNeil, 2001; Chadwick Center on Children and Families, 2004; McCabe, 2005).

### Recognition as an Evidence-Based Practice

Based on systematic reviews of available research and evaluation studies, several groups of experts and Federal agencies have highlighted PCIT as a model program or promising treatment practice, including:

- *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices* (Chadwick Center, 2004) [www.chadwickcenter.org/kauffman.htm](http://www.chadwickcenter.org/kauffman.htm)
- The National Child Traumatic Stress Network (Empirically Supported Treatments and Promising Practices, supported by The Substance Abuse and Mental Health Services Administration, 2005) [www.nctsn.org/nccts/nav.do?pid=ctr\\_top\\_trmnt\\_prom](http://www.nctsn.org/nccts/nav.do?pid=ctr_top_trmnt_prom)
- *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders, Berliner, & Hanson, Eds., National Crime Victims Research and Treatment Center and The Center for Sexual Assault and Traumatic Stress; Office for Victims of Crime, U.S. Department of Justice, 2004) [http://mus.edu/ncvc/resources\\_prof/OVC\\_guidelines04-26-04.pdf](http://mus.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf)

- Evidence-Based Treatment for Children and Adolescents (The Society of Clinical Child and Adolescent Psychology, a division of the American Psychological Association, and the Network on Youth and Mental Health)  
www.effectivechildtherapy.com
- *Youth Violence: A Report of the Surgeon General* (Elliott, Hatot, & Sirovatka, Eds., U.S. Department of Health and Human Services, 2001)  
www.surgeongeneral.gov/library/youthviolence/
- The California Evidence-Based Clearinghouse for Child Welfare (2006)  
www.cachildwelfareclearinghouse.org/

## What to Look for in a Therapist

Caseworkers should become knowledgeable about commonly used treatments before recommending a treatment provider to families. Caregivers should receive as much information as possible on the treatment options available to them. If PCIT is an appropriate treatment model for a family, seek a provider who has received adequate training, supervision, and consultation in the PCIT model. If feasible, both the caseworker and family should have an opportunity to interview potential PCIT therapists prior to beginning treatment.

### PCIT Training

Mental health professionals with at least a master's degree in psychology, social work, or a related field are eligible for training in PCIT. Training involves 40 hours of direct training,

with ongoing supervision and consultation for approximately 4 to 6 months. Fidelity to the model is assessed throughout the supervision and consultation period. See Training and Consultation Resources, below, for contact information.

### Questions to Ask Treatment Providers

In addition to the appropriate training, it is important to select a treatment provider who is sensitive to the individual and cultural needs of the child, caregiver, and family. Caseworkers recommending a PCIT therapist should ask the treatment provider to explain the course of treatment, the role of each family member, and how the family's cultural background will be addressed. Family members should be involved in this discussion to the extent possible. The child, caregiver, and family should feel comfortable with, and have confidence in, the therapist with whom they will work.

Some specific questions to ask a potential therapist regarding PCIT include:

- What is the nature of your PCIT training? When were you trained? By whom? How long was the training? Do you have access to follow-up consultation? What resource materials on PCIT are you familiar with? Are you clinically supervised by (or do you participate in a peer supervision group with) others who are PCIT trained?
- Why do you feel that PCIT is the appropriate treatment model for this child? Would the child benefit from other treatment methods at the same time or after they complete PCIT (i.e., group or individual therapy)?



- What techniques will you use to help the child manage his or her emotions and related behaviors? How will the parent be involved in this process?
- Do you use a standard assessment process to gather baseline information on the functioning of the child and family and to monitor their progress in treatment over time?
- Do you have access to the appropriate equipment for PCIT (one-way mirror, ear bug, video equipment)? If not, how do you plan to structure the sessions to ensure that the PCIT techniques are used according to the model?
- Is there any potential for harm associated with treatment?

## Conclusion

PCIT is an innovative parent-training strategy with proven benefits for:

- Children with serious behavior problems (ages 2½ to 8)
- Parents, foster parents, and other caregivers caring for children with behavior problems (ages 2½ to 8)
- Physically abusive or at-risk parents (with children ages 4 to 12)

PCIT's live coaching approach guides parents while they develop needed skills to manage their children's behavior. As parents learn to reinforce positive behaviors, while also setting limits and implementing appropriate discipline techniques, children's behavioral problems decrease. Notably, the risk for re-abuse in these families also declines.

While the empirical support and established track record for PCIT is impressive, the model is not yet widely implemented. Challenges to more widespread availability include (1) the high costs for the room set-up and audio and visual equipment; (2) the time-intensive training program; and (3) resistance among service delivery systems to implement new approaches. In addition, many professionals whose clientele would benefit from participation in PCIT remain unaware of its advantages. Nevertheless, availability and awareness are growing along with the research base. With increased use, PCIT holds much promise to continue helping parents and caregivers build nurturing relationships that strengthen families and provide healthy environments for children to thrive.

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## Internet Resources

National Child Traumatic Stress Network  
*Empirically Supported Treatments and Promising Practices*  
[www.nctsn.org](http://www.nctsn.org)

Chadwick Center on Children and Families  
*Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices*  
[www.chadwickcenter.org/kauffman.htm](http://www.chadwickcenter.org/kauffman.htm)

Medical University of South Carolina  
*Guidelines for Treatment of Physical and Sexual Abuse of Children*  
[www.musc.edu/cvc/](http://www.musc.edu/cvc/)

University of Florida Department of Clinical and Health Psychology  
PCIT website  
[www.pcit.org](http://www.pcit.org)

The Society of Clinical Child and Adolescent Psychology  
*Evidence-Based Treatment for Children and Adolescents*  
[www.effectivechildtherapy.com](http://www.effectivechildtherapy.com)

The California Evidence-Based Clearinghouse for Child Welfare  
[www.cachildwelfareclearinghouse.org/](http://www.cachildwelfareclearinghouse.org/)

## Training and Consultation Resources

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## Child Welfare Information Gateway


PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Child Welfare Information Gateway  
Children's Bureau/ACYF  
1250 Maryland Avenue, SW  
Eighth Floor  
Washington, DC 20024  
703.385.7565 or 800.394.3366  
Email: [info@childwelfare.gov](mailto:info@childwelfare.gov)  
[www.childwelfare.gov](http://www.childwelfare.gov)



## PARENT-CHILD INTERACTION THERAPY Child Directed Interaction Handout

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PRIDE RULES	REASON	EXAMPLES 
<u>PRAISE</u> appropriate behavior	<ul style="list-style-type: none"> <li>• Causes your child's good behavior to increase</li> <li>• Lets your child know what you like</li> <li>• Increases your child's self-esteem</li> <li>• Makes you and your child feel good</li> </ul>	<ul style="list-style-type: none"> <li>• Good job of putting the toys away!</li> <li>• I like the way you're playing so gently with the toys.</li> <li>• Great idea to make a fence for the horses.</li> <li>• Thank you for sharing with me.</li> </ul>
<u>REFLECT</u> appropriate talk	<ul style="list-style-type: none"> <li>• Lets your child lead the conversation</li> <li>• Shows your child that you are listening</li> <li>• Demonstrates that you accept and understand your child</li> <li>• Improves your child's speech</li> <li>• Increases verbal communication between you and your child</li> </ul>	<ul style="list-style-type: none"> <li>• Child: I drew a tree. Parent: Yes, you made a tree.</li> <li>• Child: The doggy has a black nose. Parent: The dog's nose is black.</li> <li>• Child: I like to play with the blocks. Parent: These blocks are fun.</li> </ul>
<u>IMITATE</u> appropriate play	<ul style="list-style-type: none"> <li>• Lets your child lead.</li> <li>• Shows child you approve of his/her game</li> <li>• Makes the game fun for your child</li> <li>• Increases the child's imitation of the things that you do</li> <li>• Teaches your child how to play with others and take turns</li> </ul>	<ul style="list-style-type: none"> <li>• Child: I put a nose on the potato head. Parent: I'm putting a nose on Mr. Potato Head too.</li> <li>• Child: (drawing circles on a piece of paper). Parent: I'm going to draw circles on my paper just like you.</li> </ul>
<u>DESCRIBE</u> appropriate behavior	<ul style="list-style-type: none"> <li>• Lets your child lead</li> <li>• Shows your child that you are interested</li> <li>• Teaches your child concepts</li> <li>• Models speech for your child</li> <li>• Holds your child's attention on the task</li> <li>• Organizes your child's thoughts about the activity</li> </ul>	<ul style="list-style-type: none"> <li>• You're making a tower.</li> <li>• You drew a square.</li> <li>• You are putting together Mr. Potato Head.</li> <li>• You put the girl inside the fire truck.</li> </ul>
Be <u>ENTHUSIASTIC</u>	<ul style="list-style-type: none"> <li>• Lets your child know that you are enjoying the time you are spending together</li> <li>• Increases the warmth of the play</li> </ul>	<ul style="list-style-type: none"> <li>• Child: (carefully placing a blue Lego on a tower).</li> <li>Parent: (gently touching the child's back) You are REALLY being gentle with the toys.</li> </ul>

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## PARENT-CHILD INTERACTION THERAPY CHILD DIRECTED INTERACTION

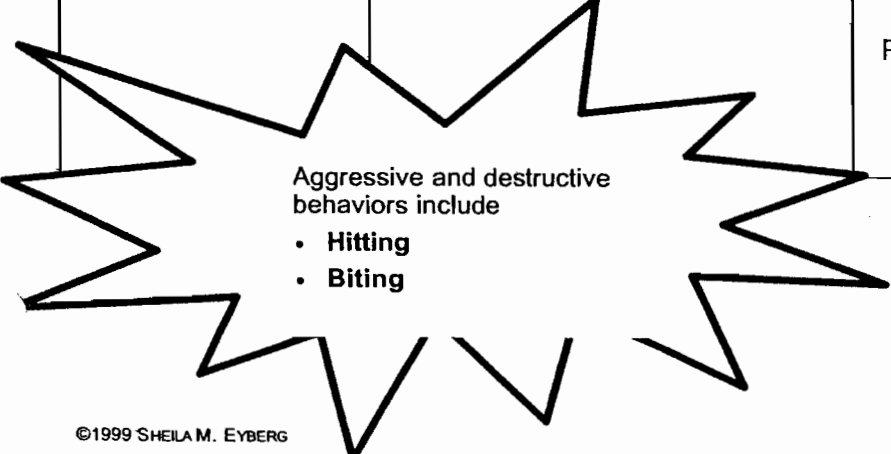


MORE RULES	REASON	EXAMPLES
Avoid <u>COMMANDS</u> .	<ul style="list-style-type: none"> <li>• Takes the lead away from your child.</li> <li>• Can cause unpleasantness.</li> </ul>	<p><u>Indirect Commands:</u></p> <ul style="list-style-type: none"> <li>• Let's play with the farm next.</li> <li>• Could you tell me what animal this is?</li> </ul> <p><u>Direct Commands:</u></p> <ul style="list-style-type: none"> <li>• Give me the pigs.</li> <li>• Please sit down next to me.</li> <li>• Look at this.</li> </ul>
Avoid <u>QUESTIONS</u> .	<ul style="list-style-type: none"> <li>• Leads the conversation.</li> <li>• Many questions are commands and require an answer.</li> <li>• May seem like you aren't listening to your child or that you disagree.</li> </ul>	<ul style="list-style-type: none"> <li>• We're building a tall tower, aren't we?</li> <li>• What sound does the cow make?</li> <li>• What are you building?</li> <li>• Do you want to play with the train?</li> <li>• You're putting the girl in the red car?</li> </ul>
Avoid <u>CRITICAL STATEMENTS</u> and sarcasm	<ul style="list-style-type: none"> <li>• Often increases the criticized behavior.</li> <li>• May lower your child's self-esteem.</li> <li>• Creates an unpleasant interaction.</li> </ul>	<ul style="list-style-type: none"> <li>• That wasn't nice.</li> <li>• I don't like it when you make that face.</li> <li>• Do not play like that.</li> <li>• No, sweetie, you shouldn't do that.</li> <li>• That animal doesn't go there.</li> </ul>



## PARENT-CHILD INTERACTION THERAPY CHILD DIRECTED INTERACTION

BEHAVIOR MANAGEMENT	REASON	EXAMPLES
<p><u>IGNORE</u> negative behavior (unless it is dangerous or destructive),</p> <ol style="list-style-type: none"> <li>a. Avoid looking at the child, smiling, frowning, etc.</li> <li>b. Be silent.</li> <li>c. Ignore every time.</li> <li>d. Expect the ignored behavior to increase at first.</li> <li>e. Continue ignoring until your child is doing something appropriate.</li> <li>f. Praise your child immediately for appropriate behavior.</li> </ol>	<ul style="list-style-type: none"> <li>• Helps your child to notice the difference between your responses to good and bad behavior.</li> <li>• Although the ignored behavior may increase at first, <u>consistent</u> ignoring decreases many behaviors.</li> </ul>	<ul style="list-style-type: none"> <li>• Child: (sasses parent and picks up toy). Parent: (ignores sass; praises picking up).</li> </ul>
<p><u>STOP THE PLAY</u> for aggressive and destructive behavior.</p>	<ul style="list-style-type: none"> <li>• Teaches your child that good behavior is required during special time.</li> <li>• Shows your child that you are beginning to set limits.</li> </ul>	<ul style="list-style-type: none"> <li>• Child: (hits parent). Parent: (CDI STOPS. This can't be ignored.) Special time is stopping because you hit me. Child: Oh, oh, oh Mom. I'm sorry. Please, I'll be good. Parent: Special time is over now. Maybe next time you will be able to play nicely during special time.</li> </ul>



# SPECIAL TIME

★ Praise

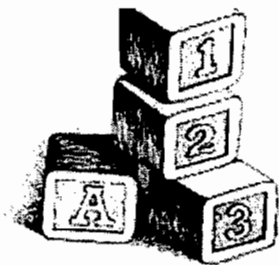
★ Reflect

★ Imitate

★ Describe

★<sup>BE</sup> Enthusiastic





## Suggested Toys for CDI

Creative, constructive toys, like:

Building Blocks  
Legos  
Tinker Toys  
Magnetic Blocks  
Lincoln Logs  
Constructo-Straws  
Mr. Potato Head  
Crayons and Paper  
Chalkboard and Colored Chalk  
Erector Set

## Toys to Avoid During CDI

- Ones that encourage rough play, like:
  - bats, balls, boxing gloves, punching bag
- Ones that lead to aggressive play, like:
  - toy guns, toy swords, toy cowboys and indians, super-hero figures
- Ones that could get out of hand and require limit setting, like:
  - paints, markers, bubbles, scissors, play dough, hammer
- Ones that have pre-set rules, like:
  - board games, card games
- Ones that discourage conversation, like:
  - books, video games
- Ones that lead to parent or child imagining they are someone else, like:
  - puppets, costumes



## CDI Homework Sheet

Mother \_\_\_ Father \_\_\_

Child's First Name \_\_\_\_\_

Date	Did you spend 5 minutes in Special Time today?		Activity	Problems or questions in Special Time
	Yes	No		
Monday _____				
Tuesday _____				
Wednesday _____				
Thursday _____				
Friday _____				
Saturday _____				
Sunday _____				

## Eight Rules of Effective Commands in PDI

<i>RULE</i>	<i>REASON</i>	<i>EXAMPLES</i>
1. <i>Commands should be <u>direct</u> rather than indirect.</i>	<ul style="list-style-type: none"> <li>• Leaves no question that the child is being told to do something.</li> <li>• Does not imply a choice, nor suggest that the parent might do the task for the child.</li> <li>• <i>Reduces confusion for the young children.</i></li> </ul>	<ul style="list-style-type: none"> <li>• Please hand me the block.</li> <li>• Put the train in the box.</li> <li>• Draw a circle.</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Will you hand me the block?</li> <li>○ Let's put the train in the box.</li> <li>○ Would you like to draw a circle?</li> </ul>
2. <i>Commands should be <u>positively stated</u>.</i>	<ul style="list-style-type: none"> <li>• Tells child what <u>to do</u> rather than what <u>not to do</u>.</li> <li>• Avoids criticism of the child's behavior</li> <li>• Provides a clear statement of what the child can or should do.</li> </ul>	<ul style="list-style-type: none"> <li>• Come sit beside me.</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Don't run around the room!</li> </ul> <ul style="list-style-type: none"> <li>• Put your hands in your pocket.</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Stop touching the crystal.</li> </ul>
3. <i>Commands should be given <u>one at a time</u>.</i>	<ul style="list-style-type: none"> <li>• Helps child to remember the whole command.</li> <li>• <i>Helps parent to determine if child completed entire command.</i></li> </ul>	<ul style="list-style-type: none"> <li>• Put your shoes in the closet.</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Put your shoes in the closet, take a bath, and brush your teeth.</li> </ul> <ul style="list-style-type: none"> <li>• Put your shirt in the hamper.</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Clean your room.</li> </ul>
4. <i>Commands should be <u>specific</u> rather than vague.</i>	<ul style="list-style-type: none"> <li>• Permits children to know exactly what they're supposed to do.</li> </ul>	<ul style="list-style-type: none"> <li>• Get down off the chair</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Be careful.</li> </ul> <ul style="list-style-type: none"> <li>• Talk in a quiet voice.</li> </ul> <p style="text-align: center;"><b><i>Instead of</i></b></p> <ul style="list-style-type: none"> <li>○ Behave!</li> </ul>

EFFECTIVE COMMANDS (continued)

RULE	REASON	EXAMPLES
<p>5. <i>Commands should be <u>age-appropriate</u>.</i></p>	<ul style="list-style-type: none"> <li>Makes it possible for children to understand the command and be able to do what they are told to do.</li> </ul>	<ul style="list-style-type: none"> <li>Put the blue Lego in the box. <i>Instead of</i></li> <li>Change the location of the azure plastic block from the floor to its container.</li> <li>Draw a square. <i>Instead of</i></li> <li>Draw a hexagon.</li> </ul>
<p>6. <i>Commands should be given <u>politely and respectfully</u></i></p>	<ul style="list-style-type: none"> <li>Increases the likelihood that the child will listen better.</li> <li>Teaches children to obey polite and respectful commands.</li> <li>Avoids child learning to obey only if yelled at.</li> <li>Prepares child for school.</li> </ul>	<ul style="list-style-type: none"> <li>Child: (banging block on table). Parent: (in a normal tone of voice) Please hand me the block. <i>Instead of</i></li> <li>Parent: (said loudly) Hand me that block this instant!</li> </ul>
<p>7. <i>Commands should be explained <u>before they are given or after they are obeyed</u>.</i></p>	<ul style="list-style-type: none"> <li>Avoids encouraging child to ask "why" after a command as a delay tactic.</li> <li>Avoids giving child attention for not obeying.</li> </ul>	<ul style="list-style-type: none"> <li>Parent: Go wash your hands. Child: Why? Parent: (ignores, or uses time-out warning if child disobeys). <i>Instead of</i></li> <li>Child: (obeys). Parent: Now your hands look so clean! It is good to be clean when you go to school.</li> </ul>
<p>8. <i>Commands should be used <u>only when necessary</u>.</i></p>	<ul style="list-style-type: none"> <li>Decreases the child's frustration (and the amount of time spent in the time-out chair).</li> </ul>	<p>(Child is running around)</p> <ul style="list-style-type: none"> <li>Please sit in this chair. (Good time to use command) <i>Instead of</i></li> <li>Please hand me my glass from the counter. (Not a good time to use a <i>direct command</i>)</li> </ul>

## Using a Time-Out Room in Your Home

During the PDI discipline phase of Parent-Child Interaction Therapy (PCIT), a time-out room is used as a back-up whenever your child is unable to stay on the time-out chair. The time-out room is a temporary procedure that teaches your child to stay on the time-out chair. Children quickly learn to stay on the time-out chair once they learn that their parent will consistently follow-through with the time-out whenever they off the chair. Once your child learns that getting off the chair always results in going to the time-out room, your child will rarely get off the chair and the time-out room will rarely have to be used.

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### How Does It Work?

When your child gets off the time-out chair, you should gently but firmly lead your child to the time-out room. While leading your child to the time-out room, you should say,

“You got off the chair before I said you could, so you have to go to the time-out room.” Once the child is in the time-out room, the parent should close the door and keep close track of time so that the child stays in the time-out room for 1 minute plus 5 seconds of quiet before the door is opened. The parent should then lead the child back to the time-out chair and say“

“Stay on the chair until I tell say you can get off.”

### Choosing Your Time-Out Room

Your PCIT therapists will carefully discuss with you the possible places that you can safely and effectively used as a time-out room in your home. The time-out room needs to be well lit and have a minimal square footage of 4 feet by 4 feet of clear space.

### Child-Proofing Your Time-Out Room

You also need to child-proof your time-out room so that breakable items or other objects that could harm your child (such as heavy books in a closet) are removed or are out of your child's reach. Medicines or other poisons should also be removed from the time-out room. If you use a bathroom or utility room, hot water should be turned down to warm so your child cannot get burned by accident. Rooms with breakable glass windows or doors must also be avoided.

## CDI Homework Sheet

Mother \_\_\_\_ Father \_\_\_\_

Child's First Name \_\_\_\_\_

Date	Did you spend 5 minutes in Special Time today?		Activity	Problems or questions in Special Time
	Yes	No		
Monday _____				
Tuesday _____				
Wednesday _____				
Thursday _____				
Friday _____				
Saturday _____				
Sunday _____				

## Time Out Diagram

Example: "Please put the red block in the box."

*"If you don't [put the red block in the box] you will have to go to the time-out chair."*

Take child to the chair while saying:  
*"You didn't do what I told you to do, so you have to go to the chair."*  
Back away from chair and say:  
*Stay here until I say you can get off.*  
(3 min + 5 sec quiet)

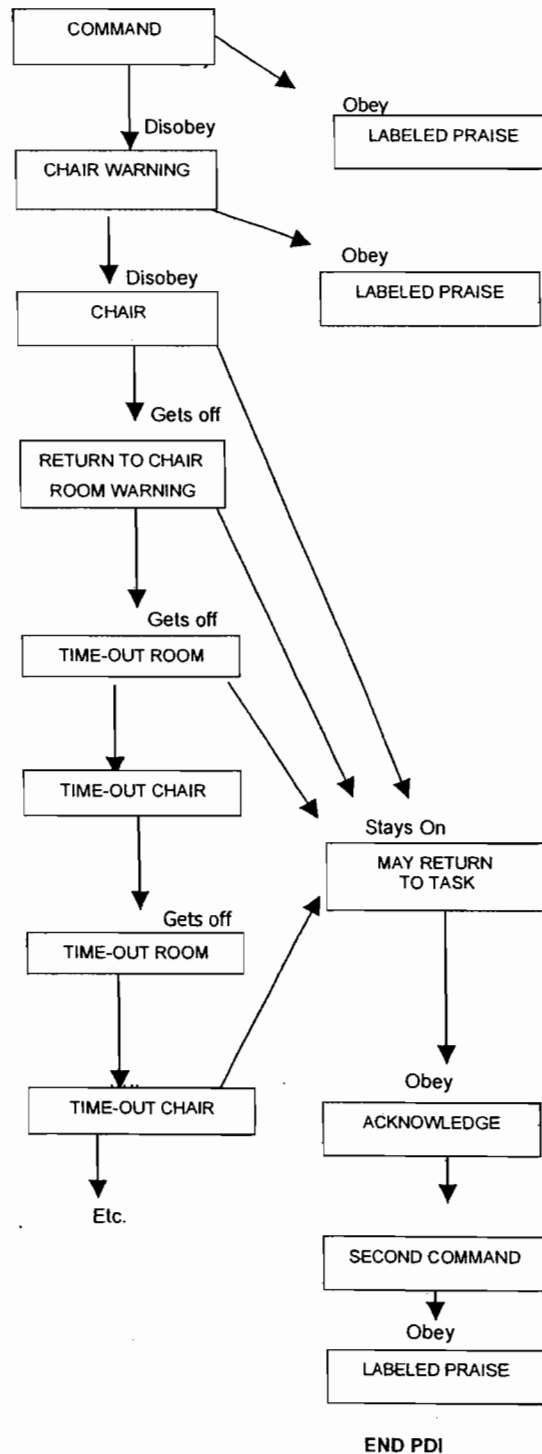
Take child back to chair while saying:  
*"You got off the chair before I said you could. If you get off the chair again, you will have to go to the time-out room."*  
Back away from chair and say:  
*Stay on the chair until I say you can get off.*  
(this room warning occurs only once)

Take child to the time-out room while saying:  
*"You got off the chair before I said you could, so you have to go to the time-out room."*  
(1 min + 5 sec quiet)

Return child to chair and say:  
*"Stay here until I say you can get off."*  
(re-start timing 3 min + 5 sec quiet)

Take child directly to time-out room while saying:  
*"You got off the chair before I said you could, so you have to go to the time-out room."*  
(1 min + 5 sec quiet)

Return child to chair and say:  
*"Stay on the chair until I say you can get off."*  
(re-start timing 3 min + 5 sec quiet)



Example: "Good minding."

Example: "I like it when you do what I tell you to."

Go to chair and say:  
*"You are sitting quietly in the chair. Are you ready to come back and put the red block in the box?"*  
If no, *"All right, then stay on the chair until I say you can get off."*  
If yes, *"All right"*  
(Back to table; point; repeat command if necessary)

Example: "Thank you."

Example: Now give me a blue block.

Example: Thank you so much for listening right away and giving me the blue block!"

Note: If your child does not obey second command, give a warning and continue PDI procedure.

## DPICS Coding Sheet for Therapist

Date \_\_\_\_\_

Child's name \_\_\_\_\_  Mother  Father  Other \_\_\_\_\_

**TREATMENT SESSION (CHECK ONE)**

<input type="checkbox"/> CDI Teach	<input type="checkbox"/> CDI Coach #1	<input type="checkbox"/> CDI Coach #2	<input type="checkbox"/> CDI Coach #3
<input type="checkbox"/> CDI Coach #4	<input type="checkbox"/> CDI Coach #5	<input type="checkbox"/> CDI Coach #6	<input type="checkbox"/> CDI Coach #
<input type="checkbox"/> PDI Teach	<input type="checkbox"/> PDI Coach #1	<input type="checkbox"/> PDI Coach #2	<input type="checkbox"/> PDI Coach #3
<input type="checkbox"/> PDI Coach #4	<input type="checkbox"/> PDI Coach #5	<input type="checkbox"/> PDI Coach #6	<input type="checkbox"/> PDI Coach #

**Coding CDI in Session**

POSITIVE	TALLY CODES	TOTAL	MASTERY
TALK (TA) (ID + AK)			—
BEHAVIOR DESCRIPTION (BD)			10
REFLECTION (RF)			10
LABELED PRAISE (LP)			10
UNLABELED PRAISE (UP)			—

AVOID	TALLY CODES	TOTAL	MASTERY
QUESTION (QU)			0
COMMANDS (DC + IC)			0
NEGATIVE TALK (NTA) (CR + ST)			0

POSITIVE	CHECK ONE		
IMITATE	SATISFACTORY	NEEDS PRACTICE	
USE ENTHUSIASM	SATISFACTORY	NEEDS PRACTICE	
IGNORE DISRUPTIVE BEHAVIOR	SATISFACTORY	NEEDS PRACTICE	NOT APPLICABLE

OTHER (SPECIFY)	

TURN OVER TO CODE PDI SKILLS IN SESSION