Child Welfare Information Gateway
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ISSUE BRIEF

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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

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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":

- **P**raise. 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.
- **R**eflection. Parents repeat and build upon what the child says to show that they are listening and to encourage improved communication.
- **I**mitation. Parents do the same thing that the child is doing, which shows approval and helps teach the child how to play with others.
- **D**escription. Parents describe the child's activity (e.g., "You're building a tower with blocks") to demonstrate interest and build vocabulary.
- **E**nthusiasm. 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
- 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
- *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://musc.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

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

Medical University of South Carolina
Guidelines for Treatment of Physical and Sexual Abuse of Children
www.musc.edu/cvc/

University of Florida Department of Clinical and Health Psychology
PCIT website
www.pcit.org

The Society of Clinical Child and Adolescent Psychology
Evidence-Based Treatment for Children and Adolescents
www.effectivechildtherapy.com

The California Evidence-Based Clearinghouse for Child Welfare
www.cachildwelfareclearinghouse.org/

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