

Parent-Child Interaction Therapy (PCIT)

<p>Treatment Description</p>	<p>PCIT is an evidenced-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver-child patterns. The goals of treatment are</p> <ul style="list-style-type: none"> • an improvement in the quality of the parent-child relationship; • a decrease in child behavior problems with an increase in prosocial behaviors; • an increase in parenting skills, including positive discipline; and • a decrease in parenting stress.
<p>Target Population</p>	<p>PCIT was initially targeted for families with children ages 2-to-7 with oppositional, defiant, and other externalizing behavior problems. It has been adapted successfully to serve physically abusive parents with children ages 4-to-12. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. Caregiver and child must have regular, ongoing contact to allow for daily homework assignments to be completed.</p>
<p>Intensity</p>	<p>Treatment generally lasts 12-to-20 weeks and is mastery-based rather than time-limited. Generally, sessions are equally divided between relationship-enhancing skills and positive discipline and compliance skills. Homework sessions of 5-to-10 minutes each day are part of the treatment. These sessions are designed to reinforce skills coached in session. To enhance long-term maintenance of PCIT benefits, parenting skills, and associated behavioral and parent-child relationship improvements, a schedule of booster sessions has been developed. Therapists generally recommend that the family participate in one-month, three-month, six-month, and one-year booster sessions.</p>
<p>Essential Components</p>	<p>The intervention uses a two-stage approach aimed at relationship enhancement and child behavior management. The parent is taught and coached in relationship-building skills: Praise, Reflection, Imitation, Description, and Enthusiasm (PRIDE.) The parent/caregiver is coached while interacting with the</p>

<p>Essential Components Cont'd</p>	<p>child during relationship-enhancement treatment sessions until criteria are reached. The parent is then instructed and coached in a positive discipline program including effective delivery of commands, with an appropriate parent response for child compliance and strategies designed to increase compliance. The skills are gradually expanded for use from a structured implementation in treatment sessions to structured sessions in the home to more unstructured situations and finally to use in public situations. Skills are observed and coached through a one-way mirror at each treatment session. Specific behaviors are coded and charted on a graph at each session, and parents are provided with immediate feedback about progress and mastery of skills. Parents are given homework assignments to complete to enhance their skills between sessions. Efforts are made to incorporate ethnic and cultural practices and values.</p>
<p>Assessment Measures Used</p>	<p>A core battery of assessment procedures include:</p> <ul style="list-style-type: none"> • Semi-structured intake interview • Child Behavior Checklist – parent form • Eyberg Child Behavior Inventory • Parenting Stress Index (short form) • Dyadic Parent-Child Interaction Coding System-II • Sutter-Eyberg Student Behavior Inventory (as appropriate)
<p>Outcome Measures Used</p>	<p>PCIT concludes with a post-treatment evaluation. In most cases, the pretreatment assessment procedures are repeated, including parent reports, teacher report, child report, and direct observation measures. The Dyadic Parent-Child Interaction Coding System-II observations are repeated at the end of the last discipline coaching session. Parents also complete a parent-report measure of consumer satisfaction called the Therapy Attitude Inventory. Parents and child return for post-treatment feedback sessions where pre- and post-treatment videotapes and accomplishments are reviewed. Brief parent report measures (Eyberg Child Behavior Inventory, Parenting Stress Index) can be completed at booster sessions to assist in tracking maintenance of behavioral improvements or for long-term follow-up of treatment.</p>
<p>Training Requirements</p>	<p>The training is for mental health professionals with a minimum of a master's degree in psychology or a related field. It involves 40 hours of direct training with ongoing supervision and consultation for approximately the next four-to-six months. The latter can be accomplished through conference calls, videotapes, and distance-learning technology. Competency criteria will be assessed at the completion of the 40-hour training with fidelity checks throughout the supervision and consultation period. Assessment instruments and scoring forms as well as the step-by-step clinician guide are needed for training (Hembree-Kigin, T, & McNeil, C.B., Parent-Child Interaction Therapy. New York: Plenum, 1995) Manuals for detailed implementation of the treatment program, coding of sessions, and handouts for use in treatment will complement the guide.</p>

<p>Fidelity Monitoring Procedures</p>	<p>Session-by-session protocols and fidelity checklists filled out by the therapist and parent are essential. During the four to six months of supervision and consultation, the session-by-session protocols and fidelity checklists should be reviewed on a continual basis.</p>
<p>Implementation Requirements and Readiness</p>	<p>Implementation involves two rooms, one for treatment, and one for observations and coaching. Generally this is accomplished through use of a one-way mirror system, “bug in the ear” device, video camera, and monitor, although in-room therapist coaching is also possible. The therapist is extremely active and directive during the sessions and must be able to commit to the family for up to 22 sessions. The therapist should have a referral network in place to address issues not covered by PCIT.</p>
<p>Contraindications of Treatment</p>	<p>PCIT is contraindicated as the first intervention when the following conditions exist:</p> <ul style="list-style-type: none"> • Severe, untreated adult psychopathology • Severe marital discord • Children outside of the PCIT age range • Severe ADHD without medication consultation • Parents/caregivers who are known perpetrators of sexual abuse <p>In many instances, PCIT may be successfully added to a comprehensive treatment plan if the above conditions are addressed first.</p>
<p>Outcomes/ Evaluation</p>	<p>Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson, Lensgraf, and Bonner (2004) randomly assigned physically abusive parents (N = 110) to one of three intervention conditions: (a) PCIT, (b) PCIT plus individualized enhanced services, or (c) a standard community-based parenting group. At a median follow-up of 850 days, 19 percent of parents assigned to PCIT had a re-report for physical abuse compared with 49 percent of parents assigned to the standard community group. Additional enhanced services did not improve the efficacy of PCIT. The relative superiority of PCIT was mediated by greater reduction in negative parent-child interactions consistent with the PCIT change model.</p> <p>Hood & Eyberg (2003) examined the long-term maintenance of changes following PCIT for young children with Oppositional Defiant Disorder (ODD) and associated behavior disorders. Three to six years after treatment, 29 of 50 treatment completers were located for this study. Results indicated that the significant changes that mothers reported in their children’s behavior and their own locus of control at the end of treatment were maintained at long-term follow-up.</p>

**Adaptations
for Special
Populations or
Settings**

- PCIT adaptations have been made for treatment settings that lack one-way mirrors and/or “bug-in-ear” devices by using walkie-talkies or having the therapist sit in the room.
- PCIT has been used and evaluated with foster parents and in Head Start settings for parents of at-risk African American children. Some Network centers are adapting and using PCIT in residential treatment settings and shelters.
- PCIT is being used and evaluated with children with prenatal exposure to alcohol and other drugs and their families.
- PCIT is currently being adapted for use in home as part of a larger intervention.
- PCIT has been adapted for use in a group treatment.
- PCIT has been adapted for use with children 8-to-12 years of age.
- PCIT has been used with families where child abuse has occurred.
- PCIT has been translated into Spanish.
- PCIT has been adapted for use with children with medical conditions.
- PCIT has been evaluated for use with physically abusive families.
- PCIT is currently being adapted for use with Native American families.
- PCIT is also in the process of being adapted from a distance-learning perspective.

**Recent
Publications**

Bagner, D. M., Fernandez, M. A., & Eyberg, S. M. (2004). Parent-Child Interaction Therapy and chronic illness: A case study. *Journal of Clinical Psychology in Medical Settings, 11*(1), 1-6.

Borrego, Jr., J., Urquiza, A.J., Rasmussen, R.A., & Zebell, N. (1999). Parent-Child Interaction Therapy with a Family at High Risk for Physical Abuse. *Child Maltreatment, 4*(4), 331-342.

Brestan, E., Jacobs, J., Rayfield, A., & Eyberg, S.M. (1999). A consumer satisfaction measure for parent-child treatments and its relationship to measures of child behavior change. *Behavior Therapy, 30*, 17-30.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3).

Eyberg, S.M., Boggs, S., & Algina, J. (1995). Parent-child interaction therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin, 31*, 83-91.

Eyberg, S.M., Funderburk, B.W., Hembree-Kigin, T.L., McNeil, C.B., Querido, J.G., & Hood, K. (2001). Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family. *Child & Family Behavior Therapy, 23*, 1-20.

Gallagher, N. (2003). Effects of Parent-Child Interaction Therapy on young children with disruptive behavior problems. *Bridges, 1*(4), 1-17.

<p style="text-align: center;">Recent Publications Cont'd</p>	<p>Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Parent-Child Interaction Therapy: New directions in research. <i>Cognitive and Behavioral Practice</i>, 9, 9-16.</p> <p>Hood, K. K., & Eyberg, S. M. (2003). Outcomes of Parent-Child Interaction Therapy: Mothers' reports of maintenance three to six years after treatment. <i>Journal of Clinical Child and Adolescent Psychology</i>, 32(3), 419-429.</p> <p>Neary, E.M., & Eyberg, S.M. (2002). Management of disruptive behavior in young children. <i>Infants and Young Children</i>, 14, 53-67.</p> <p>Runyon, M. K., Deblinger, E., Ryan, E. E., & Thakkar-Kolar, R. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. <i>Trauma, Violence, and Abuse</i>, 5(1), 65-85.</p> <p>Ware, L. M., Fortson, B. L., & McNeil, C. B. (2003). Parent-child interaction therapy: A promising intervention for abusive families. <i>The Behavior Analyst Today</i>, 3(4), 375-382.</p>
<p style="text-align: center;">Treatment Developers</p>	<p>PCIT was originally developed by Sheila Eyberg in the late 1970s incorporating components of behavior therapy, play therapy, family systems, and social learning theory. Cheryl McNeil and Toni Hembree-Kigin published a step-by-step guide for clinicians in 1995. Anthony Urquiza developed a treatment manual and videotapes for working with high-risk and maltreating families. Robin Gurwitch and Beverly Funderburk have developed a similar manual with videotapes as well as manuals for PCIT for use in a group format and for use with older children. Gurwitch and Funderburk have also developed criteria for PCIT therapists to ensure coaching skill acquisition and treatment fidelity.</p>
<p style="text-align: center;">Network Contact Information and Websites</p>	<p>For consultation regarding Network training opportunities and implementation assistance for this model within the Network, contact Charlene Allred (callred@psych.duhs.duke.edu) or Cassie Kiesel at UCLA (ckiesel@mednet.ucla.edu).</p> <p>Network sites where PCIT training is currently being provided:</p> <ol style="list-style-type: none"> 1. Lisa Connelly, MA, (Frank Putnam, MD, PI) Trauma Treatment Replication Center, Cincinnati Children's Hospital Medical Center (513) 636-0041 Lisa.Connelly@cchmc.org 2. Dolores Subia Bigfoot, PhD, Indian Country Child Trauma Center, University of Oklahoma Health Sciences Center, (405) 271-6824, ext. 45138. dee-bigfoot@ouhsc.edu. <p>Websites with more information on PCIT are:</p> <ol style="list-style-type: none"> 1. Website: www.pcit.org (Sheila Eyberg, PhD, at the Child Study Lab, Department of Clinical and Health Psychology, University of Florida) 2. Website: www.ucdmc.ucdavis.edu/caare/research/researchmain.html (Anthony Urquiza, PhD, University of California Davis Medical Center) 3. Website: www.as.wvu.edu/psyc/Faculty/CMcNeil/index.htm (Cheryl McNeil, PhD, West Virginia University, Child Clinical Program)