

# **TITLE: REVIEW OF PCIT'S INFLUENCES ON INDICATORS OF PARENTAL WELL-BEING**

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**Abstract:** Parent-Child Interaction Therapy (PCIT) is a well-established treatment for disruptive behavior disorders in preschool-aged children. Treatment gains are made by reducing negative parent-child interactions and increasing parental warmth and consistency. While the current literature focuses mainly on child outcome variables, it stands to reason that PCIT may also lead to changes in well-being for caregivers, including improvements in marital quality, parental self-efficacy, personal stress, and parental depression. This research brief will summarize the existing literature on change of parental well-being variables during the course of standard PCIT and will have important clinical implications for clinicians working with parents experiencing personal distress.

## **BACKGROUND**

Parent-Child Interaction Therapy (PCIT) is an evidence-based behavioral parenting intervention for treatment of disruptive behavior disorders in preschool-aged children. PCIT has strong roots in several theories including Social Learning Theory, specifically Patterson's (2002) Coercive Model for the development of problematic behavior. According to this model, negative parent-child interactions evolve as a result of coercive interactive cycles. For example, a child's disruptive behavior is maintained via negative reinforcement when parents 'give up' on attempts to control the child's behavior. With each unsuccessful attempt by the parent to maintain control, the child learns that his behavior must become slightly more extreme to achieve desired outcomes. When parents withdraw demands and the child's negative behavior (i.e. tantrums) stop, the parent is also negatively reinforced. Alternatively, the parent may respond to the child's misbehavior by raising their voice or yelling. When the child complies with the yelling parent's demands, the parent is negatively reinforced to yell again by the withdrawal of the tantrum. Over time, children become more disruptive, parents become more inconsistent, and parent-child interactions become increasingly more negative. However, in PCIT, parents first learn skills to avoid conflict and promote more positive interactions. Later, through calm, consistent implementation of developmentally appropriate consequences for negative behavior, parents taking part in PCIT prevent escalation and gain control (McNeil & Hembree-Kigin, 2013; Herschell, Calzada, Eyberg, & McNeil, 2003).

As emphasized by the Coercive Model, there is a bidirectional relationship between parent and child behavior. Additional research also suggests that these bidirectional effects of disruptive child behavior can be seen in relation not only to parenting behaviors, but also to a number of other parent variables including marital quality, self-efficacy, stress, and depression (Goodman et al, 2011; Cui, Donnellan & Conger, 2007). Parents of children with disruptive behavior may experience negative mood in response to child behavior as well as increased marital problems as a result of disagreements regarding parenting behaviors (Cui et al, 2007; Goodman et al, 2011).

There are multiple ways in which PCIT may benefit improve low mood in parents. First, the therapist often engages the parent in the beginning of session by checking in. During check in, the therapist may provide empathic support for a variety of difficult situations that the child's parents may have encountered. Furthermore, the therapist's continual modelling of the PRIDE skills (Praise, Reflect, Imitate, Describe, Enjoy) in their interaction with parents provides ongoing positive reinforcement which may have positive mood benefits. Additionally, as child behavior improves and the parent-child relationship is strengthened over the course of treatment, positive interactions with the child may further support improvements in parental mood.

For parents experiencing marital discord, PCIT may also offer benefits. PCIT offers a concrete plan for management of misbehavior which may relieve disagreements regarding childrearing between caregivers. Further, improvements in marital satisfaction have been demonstrated in other parent-training programs (Ireland, Sanders, & Markie-Dodds, 2003; Bullard et al., 2010). Thus, it is possible that PCIT may also result in similar improvements.

Given the theoretical support for PCIT's potential benefit for parents experiencing depression and marital dissatisfaction, the current research in brief will review the literature examining PCIT's impact on these indicators of parental well-being.

## PROBLEM STATEMENT

Previous research suggests that disruptive child behavior is associated not only with problematic child outcomes but also with a number of negative parental outcomes. In regards to depression, a study conducted by Timmer and colleagues (2011) examined PCIT in a sample of mothers displaying clinically significant depressive symptoms. Of note, the clinic where these participants were recruited predominantly treats children with a history of maltreatment, suggesting that participants may not have been seeking treatment by choice. The purpose of this study was to determine if mothers' depressive symptomology would impede children's progress in PCIT. Thus, a non-depressed control group was utilized. While significantly fewer mothers in the depressed group experienced clinically elevated depressive symptoms, and mean depression scores were significantly lower post-treatment, it is unclear if this finding occurred as a result of PCIT. Thirty percent of participants in the depressed group discontinued treatment and were not included in analysis, suggesting a possible bias introduced by attrition of depressed mothers. Further, due to a lack of a depressed control group, it is possible that these results demonstrate the episodic nature of major depressive disorder rather than a response to treatment (Kendler, Walters, & Kessler 1997).

An open pilot of PCIT in a community mental health center was conducted and examined the percentage of their sample who met the clinical cutoff for depression on a standardized measure at pre- and post- treatment (Phillips, Morgan, Cawthorne, & Barnett, 2008). The percentage of parents with significant depressive symptomology decreased by approximately 7% (from approximately 9% to 2%) following PCIT; however, this finding was not significant. Additionally, if PCIT therapists determined that parents would benefit from individual psychotherapy, they were referred and may have received this treatment during the course of the study. This suggests that this small, non-significant effect may have resulted from other treatment programs.

In regards to marital satisfaction, little research has been conducted. In addition to the previously stated null findings, an early pilot study of the effects of PCIT on family functioning found a non-significant increase in marital adjustment in their small sample of seven families of children with disruptive behavior. However, this study also included parents that exhibited predominantly normal marital functioning (Eyberg & Robinson, 1982).

Though no full articles have been published showing significant improvements in marital satisfaction following PCIT, a brief report indicated that PCIT effectively improves marital satisfaction in military families compared to a waitlist control. Unfortunately, there is limited information regarding these families' marital satisfaction at baseline, and recruitment methods are unknown. However, by tapping into a population of individuals with multiple risk factors for marital discord (i.e. parenting a disruptive child and military deployment), this study may have included participants who had more room for improvement in this variable of interest (Allen, Rhoades, Stanley, & Markman, 2010; Cui, Donnellan & Conger, 2007). However, the full report of this study is not, to our knowledge, available.

At present, the literature examining PCIT's effect on parental depression and marital satisfaction does not provide concrete evidence of a significant effect. However, because the majority of studies did not include parents who exhibited clinically significant difficulties in either of these areas, the possibility remains that this parent training program may have benefits for parents experiencing depressive symptomology and/or marital dissatisfaction.

One possible explanation for the current findings is selection bias. With the exception of Timmer and colleagues' (2011) study of depressive mothers, each study of parental depression examined families with non-clinical parental depressive symptoms who were seeking treatment by choice. Similarly, full studies examining marital satisfaction also included treatment-seeking participants with normal marital satisfaction at baseline.

Individuals with significant marital dissatisfaction or depression may be unlikely to seek treatment or remain in treatment. That is, while parents included in the study may have had disagreements regarding child-rearing, they either both agreed to attend therapy or only one parent attended, which would likely not resolve parenting disagreements. While they may have exhibited slight low mood related to negative parent-child relationships, they had the motivation necessary to attempt to fundamentally change the way they interact with their children. This theory is supported by literature suggesting that mothers with depression are more likely to drop out of treatment as well as additional studies indicating relatively normal marital satisfaction among families seeking parent training (Firestone & Witt, 1982; Reyno & McGrath, 2006).

## **SOLUTIONS**

At present, there is no strong evidence to indicate that PCIT results in significant decreases in parental depressive symptoms or marital satisfaction. However, because these issues were not the primary focus of prior research studies, the question of PCIT's effectiveness in improving parental depression and marital satisfaction remains unanswered.

In order to fully address the question of whether marital satisfaction or parental depression actually improve following parent-training, methods of recruiting families who exhibit difficulties in these areas should be incorporated and efforts to reduce bias should be employed.

Selection bias must be addressed by any study. In recruiting families to examine PCIT's effectiveness in improving parental depression and marital satisfaction, concrete steps must be taken to assure that the findings are applicable to parents experiencing these difficulties. This may include outreach to adult mental health and primary care providers. This problem may also be mitigated by using community outreach methods, such as flyers or advertisements, which would expand the recruitment of participants beyond the walls of the clinic.

Reporter bias may also play a role in these findings. Participants might be hesitant to divulge more sensitive information regarding their own mental health or their marital relationship for fear of perceived judgement or belief that this information is irrelevant. Thus, normalizing these experiences and explaining the relevance of the information to their child's behavior may improve their likelihood of responding more accurately.

In regards to clinical solutions, parental psychoeducation and referrals are prominent adjuvants to PCIT. Evidence now shows us that mental health follows a generational pattern. Whether this prevalence is due to genetic predisposition or stress-related is inseparable. Some studies show that the incidence of depression is up to 35% in mothers with young children (Smith, 2004). It is important that referrals for evidence-based treatments be provided to families who present for parent training while exhibiting depression or marital difficulties. Referrals should be made before parent training begins if it is clear that the parents' symptoms will impede treatment. However, some research suggests that simultaneous engagement in PCIT and services targeting parental psychopathology may negatively influence parents' acquisition of skills in PCIT (Chaffin et al, 2004). Thus, providers may recommend that parents engage in individual treatment either before beginning or after completing PCIT. A randomized controlled trial was

conducted on 140 families of children with autism being placed into intervention (n=70) and control (n=35) groups. The intervention group was then split into two, 35-family group. The first group consisted of a 20-week manual-based parent education and skills training, and the second received a manual-based education and counseling intervention. At the 6-month follow-up, the parents in the intervention groups showed higher response of reduction in known mental health issues compared to the control group (Tonge et al, 2006). Therefore, parent focused treatment prior to or following engaging in PCIT may lead to fewer barriers related to parental mental health.

## **CONCLUSIONS AND RECOMMENDATIONS**

There is a bi-directional relationship between parent and child behavior; negative parent-child interactions evolve as a result of coercive interactive cycles. These cycles are broken in PCIT by teaching the parents healthy parent management skills and promoting positive interactions with their children. By providing a plan for managing their child's disruptive behavior and increasing the positive reinforcement in a parent's environment, PCIT to build parenting skills in may further improve parental mood and marital satisfaction.

Current research on the impact of PCIT on parental depression and marital satisfaction has not yielded significant findings. However, these studies have been limited by lack of comparison groups and non-clinical difficulties at baseline. Moving forward, further research in this area is imperative to allowing therapists to provide evidence-based recommendations to parents.

Given the interrelationship between parental well-being and child behavior, it is recommended that the clinician spend time assessing the parents' emotional functioning and relationship with each other. This can be done in an interview format as well as providing self-report measures, such as the Beck Depression Inventory (BDI) and the Marital Satisfaction Inventory (MSI-R). Parents may feel more comfortable truthfully answering a self-report measure than talking to a clinician about their experiences. Prefacing this assessment with normalization, empathic support, and non-judgemental psychoeducation on the relationship between their own well-being and their child's behaviors may also yield more information. When parents present with clinically significant depressive symptoms or marital difficulties, appropriate referrals as well as the benefits and costs of seeking these services while engaging in PCIT should be discussed.

## CITATIONS

1. Allen, E. S., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2010). Hitting home: relationships between recent deployment, posttraumatic stress symptoms, and marital functioning for Army couples. *Journal of Family Psychology, 24*(3), 280.
2. Bagner, D. M., & Eyberg, S. M. (2007). Parent–child interaction therapy for disruptive behavior in children with mental retardation: A randomized controlled trial. *Journal of Clinical Child and Adolescent Psychology, 36*(3), 418-429.
3. Bullard, L., Wachlarowicz, M., DeLeeuw, J., Snyder, J., Low, S., Forgatch, M., & DeGarmo, D. (2010). Effects of the Oregon model of Parent Management Training (PMTO) on marital adjustment in new stepfamilies: A randomized trial. *Journal of Family Psychology, 24*(4), 485.
4. Cui, M., Donnellan, M.B., & Conger, R.D. (2007). Reciprocal influences between parents' marital problems and adolescent internalizing and externalizing behavior. *Developmental Psychology, 43*, 1544–1552
5. Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., ... & 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), 500.
6. Eyberg, S. M., Boggs, S. R., & Rodriguez, C. M. (1992). Relationships between maternal parenting stress and child disruptive behavior. *Child and Family Behavior Therapy, 14*(4), 1-9.
7. Eyberg, S. M., & Robinson, E. A. (1982). Parent–child interaction training: Effects on family functioning. *Journal Of Clinical Child Psychology, 11*(2), 130-137.
8. Firestone, P., & Witt, J. E. (1982). Characteristics of families completing and prematurely discontinuing a behavioral parent-training program. *Journal of Pediatric Psychology, 7*(2), 209-222.
9. Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analytic review. *Clinical child and family psychology review, 14*(1), 1-27.
10. Hembree-Kigin, T. L., & McNeil, C. (2013). *Parent—child interaction therapy*. Springer Science & Business Media.
11. Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2003). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice, 9*(1), 9-16.
12. Ireland, J. L., Sanders, M. R., & Markie-Dodds, C. (2003). The impact of parent training on marital functioning: A comparison of two group versions of the Triple P-Positive Parenting Program for parents of children with early-onset conduct problems. *Behavioural and Cognitive Psychotherapy, 31*(2), 127-142.
13. Kendler, K. S., Walters, E. E., & Kessler, R. C. (1997). The prediction of length of major depressive episodes: results from an epidemiological sample of female twins. *Psychological medicine, 27*(01), 107-117.
14. Phillips, J., Morgan, S., Cawthorne, K., & Barnett, B. (2008). Pilot evaluation of parent–child interaction therapy delivered in an Australian community early childhood clinic setting. *Australian and New Zealand Journal of Psychiatry, 42*(8), 712-719.
15. Schuhmann, E. M., Foote, R. C., Eyberg, S. M., Boggs, S. R., & Algina, J. (1998). Efficacy of parent-child interaction therapy: Interim report of a randomized trial with short-term maintenance. *Journal of clinical child psychology, 27*(1), 34-45.
16. Timmer, S. G., Ho, L. K., Urquiza, A. J., Zebell, N. M., Garcia, E. F., & Boys, D. (2011). The Effectiveness of Parent–Child Interaction Therapy with Depressive Mothers: The Changing Relationship as the Agent of Individual Change. *Child Psychiatry & Human Development, 42*(4), 406-423. doi:10.1007/s10578-011-0226-5
17. Nixon, R. D., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2004). Parent–child interaction therapy: One-and two-year follow-up of standard and abbreviated treatments for oppositional preschoolers. *Journal of abnormal child psychology, 32*(3), 263-271.

18. Pannucci, C. J., & Wilkins, E. G. (2010). Identifying and avoiding bias in research. *Plastic and reconstructive surgery*, 126(2), 619–625. doi:10.1097/PRS.0b013e3181de24bc
19. Tonge, B., Brereton, A., Kiomall, M., Mackinnon, A., King, N., & Rinehart, N. (2006). Effects on Parental Mental Health of an Education and Skills Training Program for Parents of Young Children With Autism: A Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(5), 561–569. doi: 10.1097/01.chi.0000205701.48324.26
20. Smith, M. (2004). Parental mental health: disruptions to parenting and outcomes for children. *Child Family Social Work*, 9(1), 3–11. doi: 10.1111/j.1365-2206.2004.00312.x