



Parent-Child Interaction Therapy With At-Risk Families

Parent-child interaction therapy (PCIT) is a family-centered treatment approach proven effective for abused and at-risk children ages 2 to 8 and their caregivers—birth parents, adoptive parents, or foster or kin caregivers. During PCIT, therapists coach parents while they interact with their children, teaching caregivers strategies that will promote positive behaviors in children who have disruptive or externalizing behavior problems. 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.

What's Inside:

- What makes PCIT unique?
- Key components
- Effectiveness of PCIT
- Implementation in a child welfare setting
- Resources for further information



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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 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 young children with serious behavioral problems, PCIT has since been adapted successfully for use with populations who have experienced trauma due to child abuse or neglect. The distinctiveness of this approach lies in the use of live coaching and the treatment of both parent and child together. PCIT is the only evidence-based practice in which the parent and child are treated together throughout the course of all treatment sessions. As a result, it is a more intensive parenting intervention and most applicable for children with serious behavioral problems, parents with significant limitations (e.g., substance abuse, limited intellectual ability, mental health problems), and/or parents at risk for child maltreatment. In randomized testing, including families identified by the child welfare system, PCIT has consistently demonstrated success in improving parent-child interactions. Benefits

of the model, which have been experienced by families along the child welfare continuum, such as at-risk families and those with confirmed reports of maltreatment or neglect, are described below.

“Parent-child interaction therapy is one of the most effective evidence-based practices in the field today. Using an *in vivo* training technique, parents acquire more effective parenting skills, children’s behavioral problems improve, and together they develop a more positive and affectionate relationship. The positive affiliative nature developed as a result of participation in PCIT strengthens attachment and builds resilience in at-risk families.”

Anthony Urquiza, Ph.D., Director of Mental Health Services and Clinical Research at the University of California at Davis CAARE Center

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

PCIT was originally designed to treat children ages 2 to 8 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 interaction patterns that 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; McNeil, Eyberg, Eisenstatdt, Newcomb, & Funderburk, 1991; McNeil & Hembree-Kigin, 2010; Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998).

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). 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. 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.

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

PCIT has been found effective for physically abusive parents with children ages 2 to 12 (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Chaffin et al., 2004; Chaffin et al., 2009; Hakman, Chaffin, Funderburk, & Silovsky, 2009; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011). 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 parental response to challenging child behaviors, regardless of the type of behavior problem.

Foundational research has shown that many complex factors contribute to abusive behaviors, including a coercive relationship between the parent and child (Fisher & Kane, 1998; Urquiza & McNeil, 1996). Abusive and at-risk parents often 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 learn 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 between parent and child and training parents in how to implement consistent and nonviolent discipline techniques when children act out.

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 (McNeil & Hembree-Kigin, 2010)

- Report less stress (Timmer, Urquiza, Zebell, & McGrath, 2005)
- Use less corporal punishment and physically coercive means to control their children (Chaffin et al., 2011)

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

Offers Support for Caregivers Including Foster Parents

PCIT is now 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, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Timmer, Urquiza, & Zebell, 2005). One benefit of providing foster parents with PCIT skills is that they can use these same effective parenting skills with future generations of foster children.

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 parents and children together. 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.
- Treatment gains (e.g., increases in child compliance) are recognized by the parent “in the moment”—which supports continued use of effective parenting skills.

Research is currently underway to determine if PCIT training can be administered via the Internet with Remote Real-Time (RRT) training. The University of Oklahoma is piloting these studies (see <http://www.oumedicine.com/pediatrics/department-sections/developmental-behavioral-pediatrics/child-study-center/programs-and-clinical-services/parent-child-interaction-therapy/information-for-professionals/pcit-research-at-ouhsc>).

Adaptations for Various Populations

While PCIT was originally applied to Caucasian families, it has been adapted for use with various populations and cultures, including:

- Families in which child abuse has occurred (Chaffin et al., 2011; Timmer, Urquiza, Zebell, & McGrath 2005)
- Trauma victims/survivors (The National Child Traumatic Stress Network, n.d.; Urquiza, 2010)
- Children with prenatal exposure to alcohol (e.g., Bertrand, 2009)
- Children aged 18–60 months with externalizing behaviors who were premature births (Bagner, Sheinkopf, Vohr, & Lester, 2010)

- Children with developmental delays and/or mental retardation (Bagner & Eyberg, 2007)
- Older children (McNeil & Hembree-Kigin, 2010)
- Foster parents and maltreated children (Timmer, Urquiza, & Zebell, 2005)
- African-American families (Fernandez, Butler, & Eyberg, 2011)
- Latino and Spanish-speaking families (Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; McCabe & Yeh, 2009)
- Native American families (Bigfoot & Funderburk, 2011)

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
- 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, or parents with substance abuse issues

Key Components

PCIT is typically provided in 10 to 20 sessions, with an average of 12 to 14 sessions, each lasting about 1 to 1.5 hours. 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 about his or her relationship with the parent.
- **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.
- **Behavioral Description.** Parents describe the child's activity (e.g., "You're building a tower with blocks") to demonstrate interest and build vocabulary.
- **Enjoyment.** 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," "Quit," or "Not"—and instead concentrate on positive directions.

In addition to the coached sessions, parents are given homework sessions of 5 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 timeout procedure. The timeout 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 timeout") and may advance to sending the child to a timeout chair.

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 compliance/noncompliance. 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 and more than 10 true randomized trials have found PCIT to be useful in treating at-risk families and children with behavioral problems. Research findings include the following:

- **Trauma adaptation.** PCIT is now commonly referred to in the cluster of trauma-informed strategies. Trauma adaptation to the model was examined in a study of PCIT in meeting the needs of mother-child dyads exposed to Interpersonal Violence (IPV) by reducing children's behavior problems and decreasing mothers' distress (Timmer, Ware, Urquiza, & Zebell, 2010).
 - **Reductions in the risk of child abuse.** In a study of 110 physically abusive parents, only one-fifth (19 percent) of the parents participating in PCIT had re-reports of physically abusing their children after 850 days, compared to half (49 percent) of the
- **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 (McNeil & Hembree-Kigin, 2010).
 - **Improvements in child behavior.** A review of 17 studies that included 628 preschool-aged 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 qualified 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, a number of expert groups have highlighted PCIT as a model program or promising treatment practice, including:

- The California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org/program/parent-child-interaction-therapy>)
- The National Child Traumatic Stress Network (http://www.nctsn.org/sites/default/files/assets/pdfs/pcit_general.pdf)

- 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 (http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf)

Implementation of PCIT in a Child Welfare Setting

When introducing PCIT as a referral option that child welfare workers may consider for children and families in their caseload, administrators will want to ensure that workers have a clear understanding of how PCIT works, the values that drive it, and its effectiveness. Training for child welfare staff on the basics of PCIT, how to screen at-risk children with behavior problems, and how to make appropriate referrals can expedite families' access to effective treatment options.

A free online training on the fundamentals of PCIT, the "PCIT for Traumatized Children Web Course" can be accessed from the UC Davis PCIT Training Center website (<http://pcit.ucdavis.edu/>). This is a 10-hour web course with eight separate modules that discuss and show the basics of PCIT treatment and three supplemental modules on cultural considerations of treatment, parent factors affecting PCIT provision, and strategies for engaging parents in treatment. Module 2, "Overview of PCIT," was designed to educate professionals who work with children in the child welfare system. This training may help a child welfare professional decide whether to refer a family to a qualified therapist for PCIT.

Finding 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 before 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, working with at least two PCIT cases through completion. Fidelity to the model is assessed throughout the supervision and consultation period.

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:

- How will the parent be involved in this process?
- 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 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?
- 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 a parent-training strategy with benefits for many families with child welfare involvement. 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. PCIT holds much promise to continue helping parents and caregivers build nurturing relationships that strengthen families and provide healthy environments for children to thrive.

Resources

The California Evidence-Based Clearinghouse for Child Welfare

<http://www.cachildwelfareclearinghouse.org/>

Chadwick Center on Children and Families

<http://www.chadwickcenter.org>

Child Welfare Information Gateway

<https://www.childwelfare.gov/>

National Child Traumatic Stress Network

<http://www.nctsn.org>

Parent Child Interaction Therapy International

<http://www.pcit.org/>

Parent Child Interaction Therapy Training Center PCIT for Traumatized Children Web Course

<http://pcit.ucdavis.edu/pcit-web-course/>

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