

## **Barriers to Graduation: Evidence-Based Solutions to Common Treatment Hurdles**

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**Abstract:** With an average treatment length of 15 sessions, engaging families in PCIT long enough to produce positive outcomes remains a significant challenge. Research has identified many sources of treatment attrition, which reportedly ranges from 16 to 72% in pediatric mental health interventions such as PCIT. We present three empirically-supported solutions to treatment adherence that have impacted our implementation of PCIT. The solutions discussed in this *Research In Brief* (RIB) include the high quality pre-treatment assessment, motivational interviewing (MI) to increase buy-in, and treatment adaptations to work effectively with diverse families. First, we aim to provide readers examples of psychometrically-sound, pre-treatment assessment tools that assist in troubleshooting potential treatment barriers, as well as parental factors that have been correlated with premature dropout (e.g., parenting stress/mental health concerns). Second, benefits of using MI skills to increase parents' motivation for PCIT will be reviewed, including recommendations for identifying families that may benefit from this approach. Lastly, we will review recent studies exploring the successful adaptation of PCIT for families of diverse cultural backgrounds, including American Indian, Latino/a, and African American families, and discuss the use of scaffolding with parents with cognitive difficulties. Although our primary goal is to provide an overview of current research related to surpassing treatment barriers, we also aim to provide readers with clinical examples of how we have applied this research to our own PCIT practice.

### **Background**

High attrition rates among families receiving behavioral health interventions, such as PCIT, is an ongoing concern for many researchers and clinicians. In fact, Thomas and Zimmer-Gembeck's (2007) meta-analysis (n=13) noted attrition rates ranging from 18 to 35% in PCIT studies published between 1980 and 2004 that included at least one parent outcome measure and the inclusion of empirical data needed for meta-analysis.<sup>1</sup> Attrition rates vary by setting and may be higher in different settings. For example, Lanier et al. (2011) reported an attrition rate of 69% in community-based outpatient treatment centers.<sup>2</sup> Researchers have identified numerous factors related to attrition.<sup>2</sup> Some of these factors include caregivers' disagreement with the treatment approach, outside stressors (e.g., busy schedule, logistical concerns), the relationship between the parent and the therapist, socioeconomic status, ethnicity, and lower maternal intellectual functioning.<sup>2-4</sup>

### **Problem Statement**

In this RIB, we further explore three factors that have been linked to attrition both in research, as well as our clinical practice, before providing readers with creative solutions to these treatment problems.

**Disagreement with Treatment and Outside Stressors.** PCIT is an effective, but demanding treatment. It is unsurprising that families who disagree with the treatment approach

of PCIT or are experiencing significant life stressors, would be at greater risk of dropout. Although it is impossible to consistently predict whether a family will drop out, the administration of high quality pre-treatment assessment measures may help clinicians identify the goodness of fit to treatment for families. It can also help predict which families may be at higher risk for dropout, thus allowing for preventative measures to help decrease this possibility.

**Low Client Motivation.** Despite increased familial stress due to the presence of childhood behavioral concerns, engaging in PCIT requires a strong parental commitment not just to therapy, but also to daily practice at home. Some families may present to PCIT to “fix” child behavior but have low motivation to change parenting practices or engage fully in the PCIT process. Motivational interviewing is one positive option for increasing engagement with PCIT.

**Facilitating PCIT with Diverse Families.** Racial and ethnic minority groups in the U.S. in comparison to non-Hispanic Whites tend to underutilize mental health services, to prematurely dropout, and to receive poor care.<sup>5</sup> Additionally, parents with intellectual disability face many parenting challenges that may affect their ability to effectively manage their child’s behavior,<sup>6</sup> as well as be successful in PCIT without some protocol modification. These families also are more likely to struggle in maintaining PCIT skills over time and generalizing PCIT strategies to other situations. Anecdotally, working with parents with an intellectual disability may increase the number of needed coaching sessions and the need for additional skill building exercises, before families meet criteria for graduation. In an effort to make headway on addressing mental health disparities, positive strides have been made in adapting PCIT for diverse groups of people and clinical disorders.

## **Solutions**

As clinicians continue to move PCIT from the “bench to the trench,” it is important to develop strategies that maintain families’ engagement in treatment as well as overcome aforementioned treatment barriers that are often unique to clinical or community settings. We aim to provide clinicians with creative, practical, and effective solutions to address these treatment barriers. Many of these strategies are grounded in research, while other methods are based on our clinical experience.

**Use Pre-Treatment Assessment.** Although an ideal set of pre-treatment measures that will help clinicians predict and prevent treatment attrition has not yet been identified, research has highlighted two predictors of attrition that can be gauged through pre-treatment assessment: caregivers’ disagreement with the treatment approach and outside stressors (e.g., busy schedule, transportation). With the knowledge that PCIT is effective in treating many young children exhibiting behavioral and emotional concerns associated with attention-deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD),<sup>7</sup> as well as a range of comorbid concerns, it may be helpful to quantitatively capture these parental concerns (e.g., hyperactivity, inattention, defiance) in pre-treatment data. Pre-treatment data that highlights additional emotional concerns in the child, such as posttraumatic stress and anxiety, may encourage the clinician to tailor treatment from that start to ensure that the family’s needs are met. Broadband measures, such as the *Behavior Assessment System for Children, Third Edition* (BASC-3)<sup>8</sup> and *The Child Behavior Checklist* (CBCL)<sup>9</sup>, may help increase caregiver buy-in by connecting the elevated symptom scales to the behaviors targeted in PCIT. For example, while providing the family with pre-treatment assessment feedback, the clinician can elucidate how PCIT can help children with ADHD sustain attention better on tasks or help oppositional children follow directions. These measures also provide data on various norm-referenced groups (e.g., same-age youth with ADHD), which can help caregivers better understand how their child compares to other youth of the same age and gender, as well as youth with similar

diagnoses. Seeing these comparisons can further build motivation for treatment. These psychometrically-sound instruments can be re-administered during treatment if the clinician feels as though the caregiver would benefit from “proof” of progress (if weekly administration of the Eyberg Child Behavior Inventory [ECBI<sup>10</sup>] is insufficient). Of note, some clinicians may be hesitant to use broadband measures, such as the BASC-3 and the CBCL, due to cost. It is important to note that free domain screening tools, such as the *DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptoms Measure—Child Age 6-17*<sup>11</sup> and the *NICHQ Vanderbilt Assessment Scale*<sup>12</sup> may be helpful alternatives.

To better assess whether stressors unrelated to treatment may interfere with continuity of services, it may be helpful to administer the *Barriers to Treatment Participation Scale*.<sup>13</sup> In addition to this scale yielding high levels of internal consistency, this measure has documented success in predicting whether families will drop out of treatment. Using this tool to identify families that are at-risk for attrition can help clinicians supplement treatment with additional support, problem solve barriers up front, and improve retention of families in treatment. Although most clinicians verbally assess for treatment barriers during the intake appointment, we have anecdotally noticed that some families are more transparent on formal assessment measures than during a clinical interview especially if they are initiating treatment with a clinician with whom they have yet to establish rapport. Furthermore, families may not be aware of potential barriers to treatment until highlighted by standardized measurements. Completing a pre-treatment assessment allows families to review and contemplate possible barriers, as well as provides the clinician with an opportunity to facilitate the families’ buy-in by providing support as the team collaboratively troubleshoots identified concerns before they become real barriers to treatment success.

**Incorporate Motivational Interviewing (MI) into PCIT.** Motivational interviewing involves several therapeutic principles including using open ended questions, affirmations, reflections, and summaries (OARS); empathizing with families; highlighting discrepancy between goals and current behavior; rolling with resistance rather than confronting it explicitly, and supporting parent self-efficacy.<sup>14</sup> Spending time utilizing motivational interviewing principles at the start of treatment, such as families hearing positive testimonials from previous families, completing decisional balance exercises, and emphasizing discrepancy between current parenting practices and personal parenting goals, has been found to be helpful in decreasing attrition,<sup>15</sup> reducing recidivism of child maltreatment in families,<sup>16</sup> and increasing readiness to change in ambivalent families.<sup>17</sup> Benefits were most robust when motivational interviewing practices were used selectively for families who presented with initial low motivation. Families that may be appropriate for MI practices to increase PCIT engagement/adherence include families involved with child welfare or mandated into treatment, families reporting severe child behavior concerns at intake as they have been found to be at highest risk of attrition,<sup>18</sup> and any family that reports resistance to change, negative talk, or ambivalence regarding their commitment to the PCIT series. Motivational interviewing is a nice approach to engagement as it can be utilized at intake or at any point in therapy. MI can be tailored to the variety of barriers that prevent families from engaging or finishing treatment (e.g., lack of confidence, disagreement with PCIT principles, lack of homework completion) and can be incorporated into any session during check in/out by simply using MI principles in the therapist’s clinical interactions with the parent.<sup>19</sup> Addressing ambivalence will likely increase success for families and therapists (e.g., less no-shows, more family buy-in, strengthened alliance with the therapist, improved behavioral outcomes).

**Individualize PCIT.** Eyberg (2005) notes that PCIT “is by definition tailored to the individual family in treatment, both in process and content” (p. 200).<sup>20</sup> For example, in

considering a parent's cognitive ability, a clinician can vary their use of abstract versus concrete descriptions to teach parenting skills. However, when looking to tailor treatment based on the unique features of an individual case, it is important to look to research on cultural adaptation. Cultural adaptation includes "systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values."<sup>21</sup> This definition highlights that in order to provide culturally adapted treatment, the focus should go beyond surface level adaptations such as changes in language or simple awareness of cultural affiliation. Rather, adaptations must go to a deeper level and permeate the treatment with the client's way of being. For example, in working with a multilingual family with varying proficiency in English, it was important to not only provide translated and simplified materials but to generate a mutually understood vocabulary for parents to aid with parenting skills as well as consider each parent's unique cultural perspective and how it impacts their co-parenting skills.

Due to increasing efforts over the last decade, PCIT has been tailored and adapted to new children and family populations including culturally diverse populations<sup>22-23</sup> and a number of clinical disorders like mood and anxiety<sup>23</sup> and developmental delays.<sup>24</sup> Matos et al. (2006) adapted PCIT for Puerto Rican families by translating materials to Spanish, ensuring the language highlighted the sociocultural context of the families.<sup>22</sup> Additional culturally consistent modifications included using colloquial expressions to explain concepts; extended sessions to address parents stressors; discussions on how to include extended family members in the treatment process; and adaptation of time-out procedures (e.g., loss of privileges was proposed for children that actively refused to go to the time-out chair or room and demanded the use of excessive force by the parent). These parents demonstrated a good understanding and acceptance of PCIT, but some difficulties were reported about being able to actively ignore negative behavior, as this was viewed as doing nothing, and willingness to use the time-out room, due to experiencing provoking feelings of distress and abandonment. McCabe and Yeh (2009) compared the effectiveness of a culturally modified version of PCIT for Mexican American families, called *Guiando a Niños Activos (GANA)*, to the effectiveness of treatment as usual (i.e., working with a therapist who was not trained in PCIT), and standard PCIT.<sup>23</sup> Some tailoring and adaptation procedures for GANA included increasing session time, providing an orientation to therapy, translating and simplifying written handouts, and implementing an engagement protocol. Findings indicated that GANA and standard PCIT produced greater symptom reduction than treatment as usual. Based on the unique features of individual cases, clinicians can use such research studies to tailor the focus or delivery style of PCIT, only when needed, to promote comfortable participation for all types of families.

Recent work highlights the efficacy of PCIT with parents with low cognitive abilities, such that PCIT was effective in increasing positive parenting behaviors and the use of consistent discipline.<sup>6</sup> The modality's use of performance-based training is effective in enhancing the parenting abilities of caregivers, especially those with low cognitive abilities. To further assist in the maintenance and generalization of skills, we have used a few strategies in our own clinical practice that have been successful. We have found that providing families with visual cues, such as a card with pictorial descriptions of the PRIDE skills during CDI and a small laminated cue card with the sequence of time out to be carried with the family in their pocket/purse during PDI, is helpful. It has also been helpful to schedule multiple public outings to increase generalization of skills.

### **Conclusions and Recommendations**

In this RIB, we reviewed three barriers to graduation from PCIT treatment—families' disagreement with treatment modality and outside stressors, low client motivation to complete treatment, and

appropriately facilitating treatment with diverse families. We encourage clinicians to use pre-treatment assessment as a way of introducing quantitative data to highlight the effectiveness of this treatment in addressing the families' primary concerns. Also, gathering pre-treatment information regarding potential barriers to treatment provides the clinician with an opportunity to solicit buy-in by supporting the family to proactively troubleshoot identified barriers. We identified MI as a strategy to use when clients present with low motivation. This therapeutic technique has documented success in literature, as well as our own clinical experience, in helping families graduate treatment and can be applied as early as the intake session. When working with diverse families the following changes to treatment have been found to be helpful: providing an orientation to therapy; offering extended sessions or devoting a session to addressing parents' stressors or concerns; discussing if and how to include extended family members in the treatment process; and addressing families' views and beliefs of time-out. Specifically, therapists working with Latino families should initially focus on building a close relationship by conversing and engaging in social pleasantries. Matos et al. (2006) suggests that during that initial phase, instead of focusing on procedures, therapist should display interest in the family and how they define and cope with their problems.<sup>22</sup> Lastly, providing additional visual cues throughout treatment and increasing the number of public outing activities may improve attrition rates, as well as the maintenance and generalizations of skills, when working caregivers with low cognitive abilities.

After exhausting some of the above options to increase engagement, therapists ultimately will use their good clinical judgment to collaboratively determine whether PCIT is a good fit for each family, and if not, link families with an alternative treatment plan. While families that complete the full course of PCIT (e.g., meet full criteria for graduation) show the best outcomes (i.e., large effect sizes), families who engage in at least four sessions of PCIT exhibit some clinically meaningful improvement (i.e., medium to large effect sizes).<sup>18</sup> Likely, these families have, at minimum, learned some positive parenting strategies (e.g., CDI Teach). While we work to prevent attrition, we can also reframe our current views on treatment success/failure and "meet each family where they are."

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