

## Parent–Child Interaction Therapy

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Parent–Child Interaction Therapy (PCIT) was originally developed in the 1970s by Sheila Eyberg for families of children ages 2 to 7 diagnosed with disruptive behavior disorders. Since that time, PCIT has evolved into a widely used, evidence-based treatment.

PCIT includes two sequential phases and requires an average of 15 weekly sessions. Goals of the first phase, the Child-Directed Interaction (CDI), are to improve the quality of the parent–child relationship and strengthen attention and reinforcement for positive child behavior. In the CDI, parents learn to follow their child's lead in dyadic play and provide positive attention combined with active ignoring of minor misbehavior. They are taught to use the PRIDE skills—Praise, Reflection, Imitation, Description, and Enthusiasm—to reinforce positive, appropriate behaviors. Parents also learn to avoid leading or intrusive behaviors—commands, questioning, criticism, sarcasm, and negative physical behaviors. This phase forms the foundation for effective discipline training in the second phase, the Parent-Directed Interaction (PDI). In the PDI, parents learn to lead their child's activity, first in dyadic play situations and later in real-life situations when it is important that their child obey. They learn to give effective instructions and to follow through with consistent consequences, including praise for compliance and a timeout procedure for noncompliance.

One distinguishing feature of PCIT is its intensive delivery—direct coaching of parent–child interactions. Live skills coaching of the parent during parent–child interactions is the hallmark of PCIT. For both the CDI and PDI phases, the principles and skills are introduced in one teaching session with the caregiver(s) alone. In subsequent coaching sessions, after a homework review, therapists coach each parent–child dyad in turn. In clinic-based PCIT, coaching is done via a wireless earphone through a one-way mirror. The parent and child interact in the therapy room while the therapist coaches from an adjacent room behind the one-way mirror.

### EARLY DEVELOPMENT OF PCIT

PCIT was designed in the early 1970s at the Oregon Health Sciences University to integrate two prominent but theoretically distinct child treatments of the day into a sound intervention that retained important therapeutic elements of each. The first treatment was play therapy in which, as described by Virginia Axline (1947), the therapist followed and reflected the child's

behavior and emotions during play to convey acceptance of the child. With the child able to express emotions safely through fantasy play, and with the child's emotions out in the open, the therapist helped the child in the immediacy of the child's play experience to try out alternative solutions to achieve inner resolution.

The second child treatment, then in its infancy but spreading rapidly, was child behavior therapy. This model focused on the child's parent as the direct change agent. The therapist and parent met weekly to design "programs"—that is, plans outlining concrete behavior change techniques based on learning theory that the parent would apply to specific behavior problems at home. The parent recorded the frequency of the problem behavior each day, and each week the frequency data were graphed for review. If the problem was decreasing, the plan would continue; if not, the plan was revised. The graphs were expected to show progress each week until each problem was resolved, defining treatment success.

Both play therapy and behavior therapy had unique strengths that PCIT sought to retain. One was the emotional calm produced by the play therapy experience. However, the calming effects of play therapy are a function of the bond that develops between therapist and child, which, for children with disruptive behavior, is often lacking in the parent-child relationship. Benefits for the child of a therapeutic interaction 1 hr a week with the therapist may be overshadowed by many contrasting hours of negative interaction experienced at home with their parents. By training the child's parents to deliver the treatment, as in behavior therapy, treatment benefits may be more lasting. Moreover, teaching parents to use play therapy skills could provide greater exposure to the calming play therapy and further enhance its benefits. Having parents conduct play therapy with their own child would not only strengthen the parent-child attachment but also reduce the underlying anger of children with disruptive behavior disorders; such changes were expected to attenuate behavior problems at home. Even if parents became highly skilled in play therapy interactions, though, these positive accepting behaviors would be difficult to sustain in the context of disciplinary interactions. Parents would still need the skills, provided by behavioral parent training, for setting limits and reversing coercive discipline.

This collection of play therapy and behavior therapy techniques was an intervention coalescing in the context of an outpatient clinic—an intervention in need of a unifying theory and structure. The theory appeared in the work of Diana Baumrind (1967), a developmental psychologist who studied parenting styles. Her research demonstrated that the authoritative parenting style, which combines nurturant and responsive interactions with clear communication and firm limit-setting, leads to the healthiest outcomes for children as they move into adolescence. This set of parenting behaviors bridged

the gap between the prevailing child and behavior therapies of the time and added importantly to the foundation of PCIT.

The unifying structure of PCIT was found in the work of Constance Hanf (1969), a psychologist who developed a behavioral program for improving compliance in developmentally disabled children. She trained mothers in two stages: first to apply differential attention to the child's cooperative and uncooperative behavior, and then to use "controlling behavior"—to give the child direct commands and follow through with time out for noncompliance. She used bug-in-the-ear technology to cue and reinforce the mothers' use of the procedures while they played with their children in the clinic.

Hanf's program provided an overarching structure that was well suited to teaching the authoritative parenting style. Parents could be taught the play therapy skills directly with their child in treatment sessions and practice them at home to provide the child play therapy experience every day. Placing play therapy skills within a differential attention paradigm provided more guidance to parents for timing skill application as well as a more direct but still nonintrusive method of child behavior change. The same overarching structure provided a controlled means of ensuring the correct application of child management skills and the consistency in limit-setting that is essential to authoritative parenting.

This period of initial development of the treatment took place in the context of real-life clinical experiences with low-income families living in difficult, stressful circumstances and without exclusionary criteria. The treatment was named *PCIT* in 1974 in an application to the Alcohol, Drug Abuse, and Mental Health Administration to conduct a formal pilot study of its effectiveness. To that point, individual cases had been assessed only with behavior counts by parents at home and therapists in the clinic, and few standardized measures of treatment progress and outcome existed in the field.

The need to demonstrate change formally led to the development of three assessment tools: a behavioral coding system to assess changes in children's behavior and parents' skills in the clinic—the Dyadic Parent-Child Interaction Coding System (Eyberg & Robinson, 1983; Eyberg, Nelson, Duke, & Boggs, 2005), a parent rating scale to monitor and evaluate parents' report of behavior change at home—the Eyberg Child Behavior Inventory (Eyberg & Ross, 1978; Eyberg & Pincus, 1999), and a consumer satisfaction measure to assess the acceptability of treatment to families—the Therapy Attitude Inventory (Eyberg, 1974; 1993). The first decade of PCIT research involved standardizing these instruments and reporting early results on PCIT efficacy (Eyberg & Matarazzo, 1980; Eyberg & Robinson, 1982).

## GROWTH OF PCIT

The second decade of PCIT was devoted to efficacy and generalization studies, many originating at the University of Florida Child Study Lab. Outcome studies demonstrated important changes in parents' interactions with their child at treatment completion, including increased reflective listening, physical proximity, and prosocial verbalization as well as decreased criticism and sarcasm, and children showed decreases in noncompliance and disruptive behaviors with parents and teachers (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993). Rating scale measures also showed positive changes in parent psychopathology, personal distress, and parenting locus of control.

The success of these preliminary findings led, in the third decade of PCIT research, to funding by the National Institute of Mental Health (NIMH), enabling the first randomized controlled trial of treatment efficacy (Eyberg, Boggs, & Algina, 1995) and further examination of treatment generalization within the family (Brestan, Eyberg, Boggs, & Algina, 1997) and across time. A series of studies demonstrated maintenance of treatment gains up to 6 years (Hood & Eyberg, 2003). NIMH funding has supported continuing study at the University of Florida examining treatment maintenance strategies (Fernandez & Eyberg, 2009) and application of PCIT to children with disruptive behavior and comorbid mental retardation (Bagner & Eyberg, 2007).

In its third decade, PCIT extended significantly beyond the University of Florida laboratory and was adapted for application to diverse diagnostic and cultural groups. The PCIT website (<http://www.pcit.org>) currently lists more than 150 research studies related to PCIT. At the University of Oklahoma Child Study Center, researchers conducted the first randomized controlled trial of PCIT with physically abusive families. Results demonstrated significantly reduced recidivism during 2½ years after treatment compared with standard community parenting group intervention (Chaffin et al., 2004). PCIT has been designated an evidence-based practice in addressing child abuse (Chadwick Center, 2004) and was listed with the National Registry of Evidence-based Programs and Practices (NREPP) in 2009 (<http://www.nrepp.samhsa.gov/listofprograms.asp>; NREPP is a service of the Substance Abuse and Mental Health Services Administration).

## DISSEMINATION OF PCIT

The mounting evidence base for PCIT has spurred national and international interest in its dissemination and application. The PCIT group at the University of California, Davis, Medical Center hosted the first PCIT conference in 2000, which has developed into a biennial national conference

with several hundred participants, and the Second Norwegian Conference on Parent-Child Interaction Therapy was held in October 2007. The increasing demand on child mental health practitioners and agencies worldwide to provide evidence-based treatments for troubled children likely foretells increased use and research for PCIT in the decades to come.

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