PA CASSP Newsletter

Pennsylvania Child and Adolescent Service System Program

A comprehensive system of care for children, adolescents and their families

Volume 21, Number 4 *December 2012*

Parent-Child Interaction Therapy: Working with Latino Families

By Gwen Burkholder

When Walmart opened a new supercenter in a residential section of Mexico City in the early 1990s, an enormous sheet cake cut into hundreds of pieces welcomed everyone just inside the front door. Walmart sales associates also roller-skated throughout the store offering customer assistance. At that time some of my Mexican friends informed me that there is no other Latino culture as festive as the Mexican culture because you celebrate every holiday and you also find a reason to celebrate on the days when there is no holiday. Since then, I have learned that people from other Latino cultures may dispute the claim that the Mexicans are the most festive. However, just as Walmart adapts their products and presentation to connect with the culture of the people where the store is located, behavioral health service providers also need to adjust their treatment protocol to connect with the cultural norms and values of their clients.

Community Services Group, Inc. (CSG), a provider of a continuum of behavioral healthcare services in several counties in Pennsylvania, began offering Parent-Child Interaction Therapy (PCIT) to the Lancaster County community in 2010. Numerous Latino families – both English and non-English speaking – have participated in PCIT at CSG since then. This article will feature the story of one family.

As of 2011, the total population of people in Lancaster County is estimated to be 523,594, of whom 8.9 percent are of Hispanic or Latino origin (quickfacts.census.gov). According to the Harrisburg *Patriot-News*, the Hispanic population has now surpassed the Amish population in Lancaster County. In Lancaster City, more than 55 percent of the students in the School District of Lancaster are Latino. The CSG outpatient therapy office is located within the borders of this school district.

When providing PCIT for Latino families, clinicians need to know about the cultural values of the family with whom they are working. Common Latino cultural values include familismo, respeto, fatalismo, personalismo and simpatia, defined by Marcia Carteret (see http://www.dimensionsofculture.com/2011/03/cultural-values-of-latino-patients-and-families/). Familismo is the idea that the opinions of the extended family are of more importance than the opinions of the individual. Respeto has to do with the utmost importance of treating everyone with formal respect especially those who are older than one's self. It is a cultural taboo to "faltarle el respeto" or treat someone with disrespect. Fatalismo is the belief that the individual can do little to change his or her fate. Personalismo has to do with the emphasis that is placed on the warmth of an interpersonal relationship apart from attention to task accomplishment. Simpatia is the value of being kind within the context of personal relationships.

So how does all of this translate to PCIT with Latino families? Dr. Cheryl Bodiford McNeil and Dr. Toni L. Hembree-Kigin included a section in their book, Parent-Child Interaction Therapy (2nd ed., 2010), regarding PCIT research that has been done with Hispanic families in Southern California and Puerto Rico. While PCIT research with Hispanics is still in its infancy, the results appear promising. In order to enhance the therapeutic

continued on page 11

December 2012
Volume 21, Number 4

Tom Corbett
Governor

Gary D. Alexander
Secretary of Public Welfare

Ronald J. Tomalis
Secretary of Education

Michael Wolf
Acting Secretary of Health

Julie K. Hearthway
Secretary of Labor and Industry

James E. Anderson
Juvenile Court Judges' Commission

Children's Committee of the Office of Mental Health and Substance Abuse Services Advisory Committee
Co-chairs
Bernadette Bianchi
Sharon LeGore

Vacant
Deputy Secretary for Mental Health and Substance Abuse Services

Stan Mrozowski
Director, Bureau of Children's Behavioral Health Services

Harriet S. Bicksler
Newsletter Editor

Department of Public Welfare
Office of Mental Health and
Substance Abuse Services
Bureau of Children's Behavioral
Health Services
DGS Annex Complex
Beechmont Building, 2nd floor
P. O. Box 2675
Harrisburg, PA 17105
Telephone: (717) 772-7984
Fax: (717) 705-8268
E-mail: c-hbicksle@pa.gov
Website: www.dpw.state.pa.us

Subscription information:
The *PA CASSP Newsletter* is distributed exclusively in electronic format and online. Subscribe to the CASSP News listserv to receive e-mail notification when a new edition is available at *http://listserv.dpw.state.pa.us/cassp-newsletters.html.* Access back issues since 2002 by clicking on the "2011" link. For issues before 2002, contact the editor. Please feel free to print, copy and distribute the newsletter freely.

Parent-Child Interaction Therapy in Pennsylvania

This larger edition of the newsletter is a sign of the excitement about expanding access in Pennsylvania to Parent-Child Interaction Therapy (PCIT), an evidence-based treatment program for young children. For too long, when young children with behavioral problems needed treatment, there was nowhere to go, and no one with the necessary skills and training to serve young children. Now, with more provider agencies in Pennsylvania adding PCIT to their array of treatment interventions, that is changing.

Some providers decided on their own to invest in the rigorous PCIT training program for qualified clinicians and the special equipment and room requirements. Ten more providers received assistance from a grant that the Heinz Endowments gave to the Pennsylvania Key. From 2009-2011, two clinicians from each of the 10 agencies from all over the state were trained in PCIT and began offering PCIT services to children and families. Two additional clinicians from each agency also then received training. Dr. Cheryl McNeil from the University of West Virginia, one of the country's foremost experts in PCIT and the co-author of *Parent-Child Interaction Therapy* (Springer 2011, 2nd ed.), was the trainer. Dr. Amy Herschell from the University of Pittsburgh, our resident Pennsylvania PCIT expert, has provided clinical supervision and additional training, evaluation and data collection.

In August 2011, the first meeting of a new statewide PCIT Network was held, bringing together clinicians, agency administrators, and representatives from behavioral health, the Pennsylvania Key, the Office of Child Development and Early Learning and the Office of Mental Health and Substance Abuse Services. The goals of the statewide network include: supporting refinement of clinical skills; supporting high quality implementation of the model with emphasis on fidelity; providing a forum for clinicians to share creative ways to expand the model; providing a forum for asking questions about clinical practice, financing and administration; and sharing information from state program offices. The Network met again in September 2012.

Now, PCIT is poised to expand to more than 70 additional providers across Pennsylvania as the result of another grant, this time from the National Institute of Mental Health to the University of Pittsburgh. The steering committee for the grant met for the first time in early December and will meet again in March 2013. (See the end of the next article for more information about this grant.)

When I set out to plan this issue of the newsletter, I enlisted Amy Herschell's help, and she in turn reached out to several agencies that are providing PCIT services to children and families in their communities. The articles in this issue highlight the variety of settings in which PCIT is being implemented and tell the stories of children and families whose lives have been significantly improved as a result of the therapy they have received. In addition, Dr. Herschell has written an informative overview of PCIT, its evidence-base, and how it is being implemented in Pennsylvania.

Harriet S. Bicksler, editor

More information about PCIT:

- *www.pcit.org*
- *http://pcit.phhp.ufl.edu/* (click on the Literature link at the left for articles about PCIT)

An Overview of Parent-Child Interaction Therapy

by Amy Herschell

Parent-Child Interaction Therapy (PCIT) is a nationally-recognized, evidence-based parent training program for families who have children with externalizing behavior problems. The program is unique in that it involves coaching parents as they interact with their young child (ages 2.5 to 7 years). There are two phases to PCIT: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). For each phase, parents attend one teaching session without their child present during which the PCIT therapist reviews with the parent specific skills that will be 'coached' in subsequent sessions. This teaching session is used to build rapport as well as to provide detailed descriptions and rationales for each skill. In fact, each skill is modeled for and role-played with parents to facilitate their learning. Following the initial teach session, parents attend weekly sessions with their child and they are coached in how to apply the skills taught.

During CDI parents are encouraged to use the PRIDE (Praise, Reflection, Imitation, Description, and Enjoyment) Skills and to avoid questions, commands, and criticism. Parents are coached in how to apply the skills so that they can increase appropriate child behaviors (e.g., sharing, using good manners) and decrease challenging child behaviors (e.g., grabbing, being bossy or rude) by providing attention to appropriate and ignoring mildly inappropriate behaviors. Once parents' skill level meets a predetermined level, typically in six or seven session, the second phase of PCIT begins, PDI. During PDI parents are taught to provide clear, direct commands, assess compliance versus noncompliance, and to provide consistent consequences for both compliance (labeled praise) and noncompliance (time-out). In response to repeated noncompliance, parents are taught a sophisticated time-out procedure that emphasizes shaping and teaching appropriate behavior. Critical clinical components of PCIT have been identified and include: involving the child and parents together in treatment, establishing the parent as the central figure within the family, coaching parents, using assessment to guide treatment, and tailoring treatment to the child's developmental level (Herschell, Calzada, Eyberg, & McNeil, 2002a). For most families, the full course of treatment is conducted in 12 to 20 weekly, one-hour, clinic-based sessions.

The Evidence Base

Consistent with a scientist-practitioner approach, studies of PCIT have sought to answer clinically-meaningful questions: How is PCIT helpful for parents and their children? Do the results generalize to untreated settings and children? How long do treatment benefits last? Can the model be adapted to help other families? A significant body of literature is now available to support that PCIT is an effective intervention for increasing parenting skills and improving child behavior.

How is PCIT helpful for parents and their children?

Treatment outcome studies demonstrate improvements in parent skill and child behavior (for reviews see Gallagher, 2003: Herschell, Calzada, Eyberg, & McNeil, 2002b). More specifically, behavior observations of parent-child interactions indicate pre-post changes in parent behavior such as increased rates of praise, descriptions, reflections, and physical proximity as well as decreased rates of criticism and sarcasm (e.g., Eisenstadt et al., 1993). Additionally, parents report lower parenting stress, more internal (rather than external) locus of control, and increased confidence in parenting skills after completing PCIT. Similarly, observations of child behavior have demonstrated decreases in disruptive behavior and overactivity as well as increases in compliance (Herschell & McNeil, 2005). Parents report their child's behavior to improve from the clinical range to within normal limits (McNeil, Clemens-Mowrer, Gurwitch, & Funderburk, 1994; Schuhmann, et al., 1998; Eisenstadt, et al., 1993). In addition to being highly satisfied with the outcome of treatment, parents also report high satisfaction with the process of PCIT (e.g., Schuhmann, et al., 1998).

Generalization: Do the results generalize to other settings and untreated children?

Studies have indicated that the treatment results of PCIT generalize to un-

treated siblings (Brestan, Eyberg, Boggs, & Algina, 1997) as well as home and school settings (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991). Children who experience behavioral difficulties at home often experience these same difficulties as school. Some have suggested that school problems have to be directly addressed in order to successfully reduce them (Breiner & Forehand, 1981); however, McNeil, et al., (1991) found that preschool children who completed PCIT demonstrated behavioral improvements at school without any direct classroom intervention. In a follow-up study, Funderburk, Eyberg, Newcomb, McNeil, Hembree-Kigin, and Capage (1998) found that these school gains maintained up to 12-months post-treatment; however, at 18-months post-treatment, only compliance (rather than attentional) gains maintained.

Maintenance: How long do treatment benefits last?

A series of studies have been conducted to understand the endurance of treatment benefits (Boggs et al, 2005; Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001; Funderburk et al, 1998; Hood & Eyberg, 2003). At 2-years post-treatment, the majority of children (69 percent) maintained gains on measures of child behavior problems, child activity level, and parenting stress as well as remained free of disruptive behavior disorder diagnosis (54 percent; Eyberg et al., 2001) . In comparison to completers of treatment, those who did not complete treatment reported significantly more symptoms of disruptive behavior disorders 10 to 30 months after pre-treatment assessment. At 3 to 6 years post-treatment mothers reported the frequency of child externalizing behavior and their parenting confidence to be unchanged compared to post-treatment (Hood & Eyberg, 2003).

Adaptations: Can the model be adapted to help other families?

PCIT has been applied to a wide array of childhood disorders including separation anxiety disorder (Choate, Pincus, Eyberg, & Barlow, 2005), chronic pediatric illness (cancer; Bagner, Fernandez, & Eyberg, 2004), developmental disorders (Eyberg & Matarazzo, 1975), Attention Deficit Hyperactivity Disorder (Matos et al., 2006), general child maltreatment (Fricker-Elhai, Ruggerio, & Smith, 2002), and child physical abuse (Chaffin et al., 2004). It also has been adapted to fit younger (Dombrowski, Timmer, Blacker, & Urquiza, 2005) and older (Chaffin et al., 2004) children. To fit different treatment modalities, PCIT has been successfully abbreviated (Nixon, Sweeney, Erickson, & Touyz, 2003; Nixon, Sweeney, Erickson, & Touyz, 2004) and adapted to be used as a group (Niec, Hemme, Yopp, & Brestan, 2005) and home-based (Ware, McNeil, Masse, & Stevens, 2008).

Cultural Relevance: Is PCIT appropriate for socially and culturally diverse families?

Studies of the efficacy of PCIT have included more diverse samples than traditional trials. While additional studies are needed, the existing literature provides support for the use of PCIT with African American (Capage, Bennett, McNeil, 2001; Querido & Eyberg, 2002; Werba et al., 2004), Latino (i.e., Dominican, Puerto Rican, Mexican American; Calzada & Eyberg, 2002; Matos, Bauermeister, & Guillermo, 2009), and Chinese families (Leung, Tsang, Heung, & Yiu, 2009) as well as others in that PCIT has been implemented internationally (e.g., Australia, Germany, Japan, Norway).

PCIT in Pennsylvania

Over the last three years substantial progress has been made in implementing PCIT across Pennsylvania. Currently, 109 Pennsylvania clinicians from 45 organizations and 23 counties have completed or are in the process of completing training in PCIT. Hundreds of families have received PCIT services and thousands of sessions have been completed. Information collected on some of these families (n = 295) indicates that the majority of children seen in PCIT are male (66 percent) and are on average 4.2 years old (range 2 – 7 years). They are presenting with behaviors that PCIT has been successful in changing including defiance (63 percent of children), aggression (38 percent), tantrums (25 percent) and difficulty with emotion regulation (15 percent). Most children who have received PCIT are Caucasian (63 percent), followed by African American (12 percent), Hispanic/Latino (6 percent), Bi-racial (3 percent) and Other (16 percent).

New Grant

On September 18, 2012 the National Institute of Mental Health awarded a research grant to our Pennsylvania PCIT team (NIMH R01 MH095750 PI: Herschell). This is a 5-year, 3.3 million dollar project which will help us to understand what implementation (training) methods are most effective for implementing an evidence-based treatment like PCIT. The grant will allow us to develop PCIT Programs in 72 new outpatient mental health clinics across the commonwealth. If you are interested in learning more about or participating in this exciting project, please contact our PCIT Project Coordinator, Shelley Hiegel at HiegelSA@upmc.edu or 412-246-5886.

Amy Herschell, Ph.D. is assistant professor of psychiatry and psychology at Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine. She serves as the principal investigator for the NIMH grant.

Notes:

A complete list of references for this article is available at *http://listserv.dpw.state.pa.us/cassp-newsletters.html.*

A map and list of the counties and providers currently offering PCIT is available at *www.parecovery.org/services_child.shtml#PCIT*

Jack and Zach: Two PCIT Success Stories

Nothing Else Worked

Jack, age 8, is one of four boys; he has two older brothers, ages 12 and 10, and one younger, age 6. His mother Linda reports that as a young child, he was fun-loving and happy. He was also very neat and orderly. So it came as something of a surprise to his parents when he started acting out in kindergarten if he made any mistakes on his work. First grade brought more problems. His interactions with his teacher were always negative, and his papers full of "red ink." He was being punished constantly and wasn't allowed to participate in any special events the entire year. Eventually he was pulled out of the classroom to work one-on-one with an aide.

Jack's second grade teacher was more nurturing than his first grade teacher, but his behavior problems persisted. Linda heard about Parent-Child Interaction Therapy (PCIT) from a friend and was able to enroll Jack in the program. Once a week, at the end of the school day, Jack and Linda went to a special room designated for PCIT. Before they started working together with a therapist, Linda went to classes to learn the PCIT method—the preferred language and how to give commands effectively. During their play time in therapy, Linda made a special effort to listen to Jack, observe what he was doing, and comment using the PRIDE technique—Praise, Reflect, Imitate, Describe, and use Enthusiasm. Linda says, "It seemed silly at first, but Jack soon realized I was really paying attention to him and approving of what he was doing."

When she moved to the next stage of making "demands" of Jack, she finally understood what was happening at school the last two years because at first he responded negatively. However, Linda said it was amazing how he began to respond to the commands; eventually he would immediately stop what he was doing and follow her instructions exactly. Linda also reinforced what they were learning in the sessions by practicing them at home. In addition, the PCIT therapist talked to Jack's teachers and coached them in using the correct terminology and techniques. Jack responded well.

Because she was afraid that Jack would regress and respond negatively when he went to third grade where the expectations would be higher, she kept him in second grade for another year. He has a different teacher who runs a more structured classroom and Jack is doing very well. He has gained confidence in himself, and has learned that any punishment he receives will end, in contrast to before when he felt like he was always being punished.

Jack and Linda graduated from PCIT in July after about nine months in the program. Linda continues to use the techniques with Jack at home, and they have also been helpful with her other sons. She says that PCIT works when nothing else did, with the key being that expectations and consequences are clear and consistent—that is, Jack doesn't have to guess what will happen if he misbehaves. Now it's hard to imagine that he ever acted out. PCIT was a very positive experience for them, and Linda would highly recommend it for other children.

Linda and Jack and their family live in Allegheny County. This article is based on a telephone interview with the editor.

Learning How to Play

Elaine has seen a huge difference in Zach's behavior and temperament since they began Parent-Child Interaction Therapy (PCIT). Zach, age 5, is Elaine's grandson who she's raising. Elaine is a cancer survivor on Social Security disability, living with her 86-year-old mother who has dementia and her 37-year-old son, Zach's father. Because Zach was addicted to drugs, Elaine's son took the baby and brought him to Elaine. After several attempts by Zach's mother to take over raising her son and an incident when Zack was suspiciously hurt, Elaine requested and was granted full custody of Zach.

As a result of the upheaval caused by his mother's attempt to keep him, Zach began having sleep problems and was afraid to go into buildings. He also had behavior issues when he started day care. He screamed, hit other people, and refused to go to school. Elaine called the crisis network and they repeatedly sent a mobile crisis team to the house. Outpatient therapy didn't go well, the local psychiatric hospital didn't want to admit him because he was too young, and the mobile crisis team continued to come to the house almost every day. Eventually, one of the social workers who came to the house told Elaine about PCIT and explained how it worked.

Elaine has been working with Zach in PCIT once a week at the local elementary school for about six months. Zach has a vivid imagination and loves to pretend he's a super hero, which would almost always end up in a fight. During their PCIT sessions, he learned how to play appropriately. For her part, Elaine practiced praising him when he played nicely and showed good manners. Soon his play time changed, and he enjoyed sitting beside his grandmother to play and looked forward to going to the therapy sessions. Once they mastered the play phase of therapy, they moved on to the second phase—how to do time-outs effectively when he has difficulty. He is also learning how to play with his peers.

Zach is thriving on the structure Elaine is learning to provide for him. She enrolled him in Kung Fu, which gives him the opportunity to work out some of his aggression, and he loves it. His instructor has seen a big difference in his behavior; Elaine believes the Kung Fu is helping to teach him respect and discipline.

Zach also sees a psychiatrst every two months, and he's been taking melatonin at bedtime to help him settle down. (The melatonin is a substitute for psychotropic medications since Zach is still so young.) Elaine has not had to call the crisis team for several months, although a mobile therapist still comes every week to check in with Elaine and Zach. Zach no longer hits or tries to choke his grandmother. When he starts screaming, he goes to his room to calm down and then comes back to apologize. Elaine values the skills she's learning, such as ignoring what he's doing wrong, and then when he calms down, praising him for what he's doing well. He still doesn't go outside much to play on his own with other children because of the problems that creates in the neighborhood. Elaine takes him to a local park or field where he can ride his bike. He has friends at school, one of whom is also in his Kung Fu class. He's also had some play dates that have gone well.

Zach is now in kindergarten, and while he has had a few scuffles, he's able to calm himself. His teacher has a race car behavior management system for the class. Zach knows it's his job to keep his race car on green, and not do anything to put it on yellow or red. He takes that job very seriously.

Elaine and Zach and their family also live in Allegheny County. This article is based on a telephone interview with the editor.

Embedding PCIT in School

By Diana Borges and Shelley Hiegel

Diana Borges is director of pupil services at for the Steel Valley School District in Allegheny County. She is also the parent of a five-year-old son and knows firsthand about the effectiveness of Parent-Child Interaction Therapy. She and Shelley Hiegel, formerly on staff with Allegheny Children's Initiative and now project coordinator for PCIT at the University of Pittsburgh, worked collaboratively to make PCIT a part of the school culture at Steel Valley. They knew they were successful when PCIT became a household term and was firmly embedded in the school district's already-existing School-Wide Positive Behavioral Interventions and Supports (SWPBIS) program.

The Steel Valley School District is part of the Steel Valley Community Task Force that was formed in 2007 with the support of a school-based behavioral health grant from the Department of Education. The task force brought together the school district's pupil services department, Allegheny Children's Initiative and Turtlecreek Valley MH/MR Center as local behavioral health provider agencies, as well as community representatives such as police, faith-based organizations, before- and after-school programs, shelters, the library and local businesses. The mission of the task force includes three specific goals: 1) to identify community assets, 2) to develop and provide a process for families new to the community to receive resources and services, and 3) to identify existing services and programs and explore the need for additional services appropriate for children ages 0-5.

This last goal—providing appropriate services for young children—was an additional reason for Steel Valley School District and Allegheny Children's Initiative (ACI) to collaborate. Increasing numbers of behavioral health referrals were coming to ACI for younger children; many children were being expelled from their daycare programs for aggressive and noncompliant behaviors. When ACI started researching evidence-based interventions for young children, they almost literally ran into Dr. Amy Herschell who was working on another project at ACI at the time. Dr. Herschell helped ACI receive funding to develop a PCIT program and train two cohorts of clinicians from ACI, the Women's Center and Shelter of Greater Pittsburgh, Milestone Centers, and Matilda Theiss. At the same time, the school district was laying the groundwork for piloting SWPBIS at Barrett Elementary School.

There is almost a built-in synergy between PCIT and SWPBIS, making the linkage of the two programs in one location a logical choice. SWPBIS is an evidence-based framework that provides a safe, effective and supportive learning environment. Features include prevention, defining and teaching positive social expectations, acknowledging positive behavior, arranging consistent consequences for problem behavior, collecting data for decision-making, a continuum of intensive individual interven-

tions, and administrative and team-based leadership and implementation. It is a three-tiered model designed to meet the needs of all students: Tier 1 focuses on universal prevention is effective for about 80-90 percent of all students; Tier 2 is secondary intervention for those students who need additional help and serves an additional 5-10 percent; Tier 3 is for the 5 percent of students with more challenging needs who require more intensive interventions. (For more information about SWPBIS in Pennsylvania, see the December 2011 edition of the newsletter or www.papbs.org).

PCIT is an evidence-based intervention used primarily with younger children that falls under Tiers 2 or 3 of the SWPBIS framework, depending on the individual needs of the students and the length of intervention needed. Just like the overall goals for SWPBIS, PCIT identifies and teaches young children the behavior that is expected of them. A parent is the primary teacher. PCIT requires a playroom with a one-way mirror for a trained clinician to observe and coach the parent in child-directed interaction. In the Steel Valley School District, Barrett Elementary School was identified as the location where PCIT would be most likely to be successful. The playroom was completed at the school with in-kind funds and a small grant award from the Pittsburgh Foundation.

The school district markets PCIT each year at Parent-Teacher Organization events, open houses, and meet-the-staff nights. Diana Borges has been one of the district's best spokespersons because she and her son have completed PCIT. She shares her experience with parents and makes the service seem normal. She says, "It's so practical and realistic for a therapist to coach parents during a PCIT session. This is the best way to learn how to manage the behavior of our children. Although PCIT was developed to work with children with emotional or behavioral disorders, every young child and parent can benefit from learning positive parent-child interactions and responding with more appropriate behavior. Since we have gone through PCIT, my son responds more quickly and we don't have to fight about what I'm asking him to do!"

Diana Borges is director of pupil services in the Steel Valley School District, and Shelley Hiegel is project coordinator for the PCIT project at the University of Pittsburgh.

Adding PCIT to a Comprehensive Array of Services

By Priscilla Zorichak and Denise Namowicz

If Katie and her mother had not received Parent-Child Interaction Therapy (PCIT), she might have been diagnosed with a developmental delay plus any number of other diagnoses. By the time she graduated from the PCIT program, Katie was able to initiate social contacts, verbalize freely, obey her mother's direct commands the first time given, and was many times happier and more confident than she had been initially. Without PCIT, Katie may have been prescribed psychostimulants for impulsivity, mood stabilizers for her emotional outbursts and referred for mobile therapy and therapeutic support staff services to manage her behaviors in the home and community. More than likely, her mother would not have felt nearly as empowered and competent to manage her daughter's behaviors as she does now.

Katie, age 3, with blond hair and blue eyes, came to PCIT with her mother because of her tantrums in all settings, violent aggression toward peers and adults, sleep problems, mood swings, toileting issues, and destruction of property. In the Children's Service Center waiting room for therapy, Katie was observed throwing herself down steps and holding her breath until she was purple because she was told "no" to her request for candy. Her verbal skills were very limited and speech therapy seemed warranted. She had very poor eye contact, did not respond to verbal prompts or social cues, and her play was extremely distracted. During the Child-Directed Interactions, when most children are cheerful and cooperative, this youngster could rarely attend to play for longer than 15 minutes without destroying toys, throwing items, and having an emotional "melt-down."

Her mother was clearly exasperated, exhausted and anxious as she attempted to rein her daughter in and engage her in what should have been a very pleasant activity. Over the course of many weeks, Katie settled down and was able to remain attentive and appropriate during play time, simply as a result of her mother's focused, positive attention and

encouraging verbal techniques. Her own verbalizations increased and the level of eye contact and affection increased, while the crying, screaming and violence decreased. Once Parent-Directed Interaction coaching began, Katie's mother developed her own quiet confidence, persistence, and maturity. The contrast in our sweet little blonde girl was astounding!

Children's Service Center of Wyoming Valley is celebrating its 150th Anniversary as an organization that cares for the special needs of children, adolescents, and their families. As a community behavioral health provider, Children's Service Center offers a wide array of services to a broad spectrum of clients in Northeast and Central Pennsylvania. Those services include, but are not limited, to community outpatient therapeutic services, medication and diagnostic services by board-certified child and adolescent psychiatrists, school-based behavioral health services, partial hospitalization program for K-12, autism behavioral health rehabilitation services, adolescent group homes, blended case management, family-based treatment, juvenile sex offender program, juvenile fire setter program, crisis services, behavioral health rehabilitation services and Robinson Counseling Center (private practice).

With these services in mind, PCIT was added to our continuum of care as an evidenced-based, least restrictive option for the very young children like Katie coming to Children's Service Center for care. PCIT has provided an evidence-based solution to the presentation of disruptive behavior disorders in young children, ages 2-7. PCIT has been an excellent alternative for parents who are committed to their children's well-being and would prefer to avoid medication or more restrictive methods as a first option.

Clear diagnoses of very young children can be complicated by a number of confounding variables, such as trauma, learning disabilities, developmental delays, parental temperament and techniques, as well as family crisis and genetic predisposition. PCIT provides both the clinician and the parent the opportunity to observe and treat the child in a controlled setting while working to resolve presenting behaviors via the first line of action: the parents! Over the course of treatment, PCIT helps to refine parental techniques and temperament while a clearer sense of the cause of the child's behavior is obtained. In Katie's case, PCIT effectively addressed her behavioral problems, gave her and her mother new skills, improved their relationship and interactions with each other, and prevented more intensive, intrusive and long-term services.

Priscilla Zorichak, LPC is director of partial hospitalization and Denise Namowicz, LCSW is associate director of clinical services at Children's Service Center in Wilkes-Barre.

Integrating PCIT in a Primary Care Setting

by Lisa McCay

Jennifer is a sweet and bubbly 3-year-old who was placed in her grandmother Kate's care when she was 20 months old, with Kate receiving full custody of her several months ago. Kate told her own therapist about the challenges in managing Jennifer's defiant, impulsive, irritable behaviors and her sleep difficulties. Kate expressed frustration that she did not feel she knew how to play with her granddaughter. She also acknowledged that rather than battle Jennifer's tantrums she tended to give Jennifer what she wanted. The therapist, having become familiar with our agency's PCIT program, recommended that this might benefit Kate and Jennifer.

Parent-Child Interaction Therapy is an empirically supported treatment for young children with emotional and behavioral disorders. In recent years, while the availability of PCIT in Pennsylvania has increased significantly, spreading the word about this program to families and increasing the likelihood of their following through on the recommendation remains one of the biggest challenges. One way our agency has begun to do this is through integrating PCIT with a large pediatric primary care practice in the community. When the first therapists at the agency received training in PCIT, it became clear that marketing the program to those working with young children was a necessity. When we met with local pediatricians, their interest in the program was immediate.

Pediatricians are frequently the first point of access to mental health services, particularly because many families have received the message that their children are "too young" to need services and they should "wait out this phase." As a result, they are reluctant to come to their community mental health center, choosing instead to speak to their child's doctor. The local pediatricians were excited to have this new resource available to them and encouraged a number of families to seek us out.

Yet many families who might benefit from PCIT choose not to follow up on this referral. There are a number of possible reasons for this lack of follow through including stigma, challenges with accessing the clinic, uncertainty about bringing their young child to a new provider they have never met, and worries about their family or their child being labeled negatively. In the case of Jennifer, Kate's own anxiety presented challenges in bringing her to the satellite clinic where PCIT was offered. She expressed worry about working with a therapist who did not know her or her family.

One year ago we began a new program with a therapist from our agency who specialized in infant mental health providing therapy for young children and intakes for depressed new mothers at the pediatrician's office. This collaboration is beneficial for us as providers, as the therapist and pediatrician are able to directly consult about cases and discuss possible referrals. It is also beneficial to families because they can access mental health screening and treatment in a facility that is familiar to them and in a streamlined manner. If a doctor feels there is a need for a mental health evaluation, they sim-

ply schedule this as they check out, just as though they are scheduling a follow up appointment with their doctor. Providing follow-up therapy in this setting allows families to continue to receive high quality treatment with reduced worry about stigma and labels.

When our agency decided to expand PCIT by training additional therapists, it seemed logical to train the therapist already embedded in the pediatrician's office. Doing so has allowed children like Jennifer to receive services more readily. Kate was not anxious about attending appointments because she was already familiar with bringing Jennifer to this office for well-child and sick appointments. Jennifer was also familiar with the offices, allowing her to more quickly acclimate and demonstrate typical behaviors. Although Kate and Jennifer had never worked directly with the PCIT therapist, Kate quickly became comfortable due to the association with treatment providers she already knew and trusted. While Kate and Jennifer are still in the early stages of their PCIT treatment, Kate has already shown improvements in her parenting skills and has also noticed improvements in Jennifer's behaviors.

As with any new beginning, there have been challenges associated with this new venture. Here are some things to consider when establishing a similar service:

- Establish a strong relationship with pediatricians in the practice and make sure they understand the benefits of PCIT. In our case, I was able to spend 15 minutes speaking with the pediatricians at their monthly staff meeting and answering their questions. This greatly increased their understanding of and excitement about PCIT.
- Consider the space available. Pediatricians' offices, while child-friendly, are often not child-proof. For example, many consulting offices have sinks and computers that could present a challenge with an impulsive or angry child. We were able to design a partition to wrap around this section of the office.
- Consider whether you will be able to use the same office each time and whether an adjoining office is available as an observation room. The pediatrician's office in our case was kind enough to allow use of two rooms in a back corner of the practice, but at times when the clinic is very busy these rooms may be needed. As such, all PCIT materials, including video equipment, must be moveable.
- Provide regular feedback to the pediatricians about response to the program and be open to their feedback about ways to make this program more acceptable in their environment. Creativity is key!
- Recognize that establishing optimal procedures and room set-up may take longer than you expect. Therapists working in this setting must be comfortable with in-room coaching in case technological glitches or space challenges preclude the use of an observation room.
- Advertise the availability of this service not only to pediatricians, but also to mental health professionals and early childhood educators who might direct individuals to ask their child's pediatrician about it. As in the case of Kate and Jennifer, not every referral benefitting from this service will initially come from the pediatrician.

Providing PCIT services in a pediatric primary care setting comes with its own unique challenges, but the benefits for families, children, and professionals make this endeavor worthwhile.

Lisa McCay, Ph.D. is a staff member at Family Counseling Center of Armstrong County

PCIT in Rural Communities

By Jannine Tyler

Tania is a 25-year-old single mother of two young boys. She contacted the agency after hearing about Parent-Child Interaction Therapy (PCIT) during a local Head Start parent-staff meeting. She was worried about her 5-year-old son, Samuel. Samuel does not talk much, throws things, hits, spits, breaks toys, especially when he is told to do something he does not want to do. Her younger son, Donald, age 3, is starting to show similar behaviors. Tania is especially stressed when they go out in public, as she feels both the boys "run wild" and she cannot control them. She ends up not being able to get any of her shopping done and she feels like all she does is "yell, and they still don't listen." Children and Youth Services were involved with her at the time.

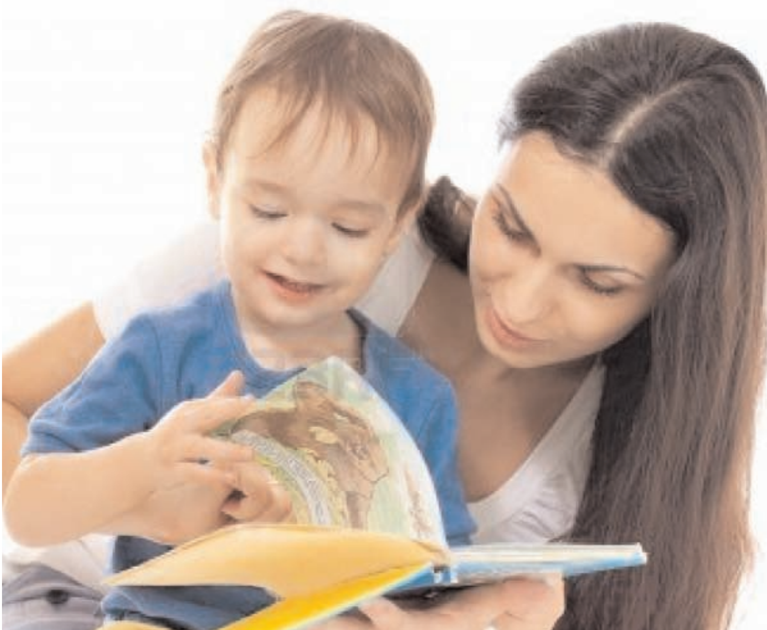
The PCIT assessment revealed that Tania was under a significant amount of stress and felt inadequate as a parent. She was very frustrated and she and Samuel didn't seem to enjoy being around each other for very long. Samuel was very attention-seeking and able to push his mother's buttons quickly. She voiced she was not sure that "anything would help."

Tania and Samuel graduated after 22 weekly sessions. There were some illnesses. They also faced some other barriers to treatment. First, Tania had some difficulty finding a sitter on a weekly basis. She was able to engage a few family members, but they were often not reliable. When she could not find a sitter, the therapist and Tania planned for her to have both boys present during the session. This was a challenge, but Tania was able to learn to apply the skills with both boys present. Secondly, Tania did not have reliable transportation. The therapist worked with Tania to access public transportation. In a rural community, there are not many buses, and the ATA will only run at certain times, as does the medical assistance transport. Scheduling became difficult for Tania, especially since Samuel had also started kindergarten. Tania qualified for blended case management services, and the therapist helped her access the service. The therapist and Tania's case manager worked closely with scheduling so the case manager could transport Tania if necessary.

As Tania played with Samuel during the first session, there was little enthusiasm; mostly, Tania watched the play, in-

stead of being actively engaged. She was distant. Samuel didn't speak very much, and neither did his mother. She disclosed she really did not know how to play with her son. With the coaching that is part of PCIT, Tania's skills blossomed and she became active and upbeat throughout the play session. Tania came with Samuel to almost every session she could, and when she couldn't, she had good reason. She looked forward to her special playtime with Samuel and more often than not was early for their appointments. The more Tania used the PCIT skills, the more Samuel spoke, made eye contact, and sought his mother out to show her things! There was more energy coming from Tania, and Samuel responded in kind. They began to giggle, laugh, and hug!

One day, Samuel sat on Tania's lap, and she began to cry, stating that he would always push away from her in the past. Now, Samuel often sits on her lap, and they hug each other quite a bit. Tania appears more confident and loves the special playtime she spends with Samuel and Donald. She doesn't yell as much and appears less harried and frustrated. She says she loves to be around her kids now, playing with them. Samuel responds very quickly to his mother's directives, and has learned that he loves to please her. This has carried over to school, as he is now compliant and likes to please his teachers too. He will now also play with the other kids, whereas before PCIT treatment, he preferred to play by himself.



Tania is confident that she can manage her boys' behaviors, even on a recent trip to Wal-Mart. She reported back that she had to discipline, but she did so according to what she has been taught in PCIT, and the boys responded well. The staff here at the agency have noticed the changes too: there are no longer little boys named Samuel and Donald running around the waiting room, while loud and stern voices boom in the background. Samuel and Donald are seen sitting quietly watching a movie, reading, or coloring with their mother while they wait for their appointment. Tania is sitting right with them, actively involved – a stark contrast to their first appointment with the PCIT therapist, when it was not really clear which adult in the waiting room these little boys were with. Children and Youth Services are no longer involved with the family.

Samuel and his mother have improved their relationship. Tania understands how important she is to Samuel and that he will get attention one way or the other, either the good kind or the negative kind. They are fun to watch. They both are very enthusiastic and anyone could tell how much they love to be together. Tania has learned that her actions and words hold such great meaning for Samuel and he will imitate her. During one session, he began to use some of the skills his mother uses during this special playtime. He said, "Mommy, now you're building a big tower." He then added a perfect labeled praise for her, "Wow, Mommy, your tower is nice and I really like playing with you when you share with me!" At 3-month follow up, Tania continues to provide her special playtime at home with each of the boys. She is happy to say that Samuel continues to follow her directions, mostly the first time she gives them to him. He is happy to report that he and Mommy "like each other a lot now."

This kind of rapid progress is not uncommon. Focusing on the child and the positive things about the child with such intensity, coupled with the caretakers/parents being the actual agents of change, make this type of therapy so successful. Parents and kids experience each other in such a different, positive way that it's hard for them not to respond to each other in better ways. The positive things start to happen very quickly, and before you know it, have become habit. The work is not always easy, and children do not like to be told what to do most of the time, especially during the second phase of treatment or the compliance-training phase. However, they learn to respond to their parents in a different way, and they learn that they receive more attention and play by behaving than by misbehaving. Their behavior starts to settle down, they can let go of old ways, and become more compliant. The child no longer has a need to get attention in negative ways, and caretakers/parents can relax, and see their child does like them, they do matter to their child, they can handle whatever problem comes their way, and that they are good effective parents, and that truly, their children are good children.

Jannine Tyler, M.S.W., L.S.W. is a Parent-Child Interaction therapist at The Guidance Center in Bradford, McKean County, PA. All names have been changed to protect confidentiality and privacy. Parent(s) are referred to throughout the article; however, any caretaker can participate, including foster parents, grandparents, aunts, uncles, etc.

continued from page 1

outcome of PCIT, the clinician needs be aware of the family's culture of origin and speak the Spanish or English language dialect the same way the parent speaks to his or her child. The family's level of acculturation is significant in tailoring the therapy approach. Spending more time during the check-in each week and possibly during phone calls is also likely helpful for building rapport and a warm personal relationship with the child's caregivers. Including more of the extended family in the coaching sessions would also be helpful for some families.

In PCIT, the clinician actively coaches the parent to do specific skills to enhance the relationship between the parent and child and to decrease the child's disruptive behavior. PCIT also includes concurrent processes where the clinician uses some of the same skills with the parent that the parent is being coached to use with his or her child, such as giving specific praise, reflecting what was said and describing what one is doing. Descriptive praise clearly helps to enhance the relationship between the clinician and the caregiver. To enhance communication and to join in with the parent's way of speaking to his or her child, the clinician will reflect or paraphrase what a parent has just said to the child as part of the coaching process. This is a great way to use the family's language dialect in the therapy.

Julio and Maria (not their real names) met as students while living in another state. Even though it was love at first sight for Julio, it took about four weeks for Maria to become romantically interested in Julio. Three years later, the couple married and five years later, Maria became pregnant with Papito (term of affection for little papa in Spanish). With the baby on the way, the couple decided to move to Lancaster, Pennsylvania to be close to Maria's extended family. After Papito's birth and their move the Lancaster, Julio and Maria became increasingly aware of their differences and relationship conflicts. Julio's parents were Mexican American and had lived in the same state near the Great Lakes for more than 30 years. Maria's parents were both born in Puerto Rico and she had grown up in New York City, Puerto Rico, and Lancaster, Pennsylvania, living in each area for about six years. Julio's family was Catholic while Maria's parents were Pentecostal pastors. In addition, Julio is 12 years older than Maria.

Maria's father advised them to seek couples' counseling and they came to the CSG outpatient program to see me for therapy. Later when they heard about the new Parent-Child Interaction Therapy that we were going to offer, they decided to bring Papito when he turned two years old. Although they had raised other older children, they were concerned with how they were going to manage Papito's temper tantrums in public settings, and his physical aggression and non-compliance with requests from adults. They were also concerned about his limited speech. Papito's disruptive behavior was very different from Maria's older daughter's more compliant personality. A victim of childhood physical and emotional abuse, Julio was uncertain about how to relate to his young son. Clearly he did not want to repeat the harm that had been done to him. Maria also was experienced in working with preschool age children since she had been employed in a daycare setting for four years; however, she noticed that her own child could "push her buttons" like no other child that she ever worked with in a professional setting. Maria's father also felt that they should bring Papito for some type of therapy.

Julio and Maria participated in both the Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI) portions of PCIT with me as their clinician for six months. Related to her preschool age work experience, Maria was able to achieve mastery in CDI during the second coaching session. It took longer for Julio because it was a relatively new set of skills for him. Julio also takes medication for bipolar symptoms and hallucinations and so there were some days when he did not feel up to participating in a coaching therapy session. Both parents were also enrolled in classes at the local community college and so had other responsibilities in addition to parenting.

During therapy, Papito's language skills advanced quite rapidly as a result of his parents doing the CDI skills of labeled praise, reflections and behavior descriptions both in the office and at home. It became much easier to understand what he was saying. His compliance with requests made by his parents increased greatly and they became more comfortable taking him out in the community to go shopping or to attend a church activity. He became less physically aggressive towards other children.

When I met with Julio and Maria to prepare to write this article, I was thrilled to hear Julio spontaneously talking with three-year-old Papito and using labeled praise and behavior descriptions, just as they were taught during PCIT. When a parent is still using the techniques eight months after therapy has ended, this shows that it really does work!

When I asked what they liked about PCIT, Maria responded, "It was good because it taught us how to speak to him… like a little person, to respect his wants and his space as opposed to constantly telling him what to do. In my culture… I was taught that children are to do as they are told and that the parent is always right. It was kinda different to think of Papito having needs and wants." Julio added, "What I really like about this was being able to socialize with my son through the play. It was great to see him express his feelings [of excitement] about coming to CSG to play. It was great to see that he can express himself if asked to do so." When I asked what was uncomfortable about PCIT or what felt like it did not fit with their culture, Julio talked about how he was taught that the way you correct your child is to "get in the child's face, raise your voice, give an order and threaten the child with a 'pow pow'" if the child does not immediately do what he or she has been asked to do. Maria added that it was different "to get used to doing the time-out procedure" while staying very calm and neutral as a parent. Julio added, "I'm very happy with the results of PCIT and learning another way to communicate with my child. Maria joined in, "Papito complies with what we ask him to do."

Gwen Burkholder, LCSW, CAADC is a bilingual PCIT clinician for Community Services Group, Inc. in Lancaster.

PA CASSP Newsletter

published by
Pennsylvania Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Bureau of Children's Behavioral Health Services

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Implementing PCIT in the Foster Care System

In 2008, researchers from PolicyLab at the Children's Hospital of Philadelphia (CHOP) partnered with the City of Philadelphia to track children ages 2-10 in the foster care system to better understand factors that contribute to stability and well-being. Consistent with national data showing that 40-80 percent of children entering foster care have significant mental health or behavioral problems, this study found that behavioral concerns were often cited as a reason for the significant displacement of children in foster care. In response, the Child Stability and Well-Being Pilot Intervention Project (CSAW PIP) was developed with the goal of implementing a sustainable evidence-based mental health program focusing on the relationship between caregiver -child dyads within a large city child welfare system to improve the stability and well-being of these children. Parent-Child Interaction Therapy (PCIT) was chosen as the evidence-based treatment model at the core of this intervention.

The PolicyLab researchers set about to create a clinical program that the city could adopt when the research project ended. The Philadelphia Departments of Human Services (DHS) and Behavioral Health (DBH) worked together to create a joint funding stream to support the clinical and training services delivered through this program. CSAW PIP was piloted over the past two years in two foster care agencies in Philadelphia, Bethanna and Jewish Family and Children Services. Two doctoral level clinicians from a community mental health agency, Children's Crisis Treatment Center, were co-located at those foster care agencies to provide clinical service and consultation, namely PCIT and the related training, Child Adult Relationship Enhancement (CARE). Because PCIT is time and resource-intensive and not all children served by child welfare need this level of intervention, the CHOP researchers worked to scale the group training model CARE. CARE is based on the principles of PCIT but is briefer and, for this program, was designed specifically for use with foster caregivers and agency staff. CARE provides these professionals with information about trauma and teaches them skills similar to those taught during PCIT for working with the children in their care.

The CHOP team trained six trainers from the foster care agencies, in addition to the two lead clinicians from Children's Crisis Treatment Center to provide the CARE training. These trainers have in turn trained all foster care agency staff, and more than 90 percent of all caregivers with children in the designated age range in CARE. Feedback from these trainings has been very positive. The CSAW PIP team also created tools for infusing CARE language and skills throughout the agencies to encourage staff and caregivers to use the skills they learned in everyday interactions with children and families. The CARE training has had a positive impact on hundreds of children in foster care since it began.

PCIT is provided to the children in these agencies and their caregivers when the children are experiencing more significant emotional and behavioral problems. The CHOP team has worked with the city's Department of Behavioral Health to develop and implement a streamlined referral system to help eliminate barriers for mental health services for these children who need them. So far, 14 children and their caregivers have successfully completed PCIT. Anecdotal reports from the clinicians show that all participants experienced positive benefits including improved relationships, decreased behavior problems, and decreased caregiver stress. CHOP is validating these findings through the research data that was collected over the course of the two year pilot. Ten more cases are currently actively involved in PCIT, and more are expected to be served when the project expands in January 2013 to additional child welfare populations and agencies. CHOP and the City of Philadelphia also continue to work at addressing some of the barriers related to access, transportation and child care, and sustaining the progress after the grant ends. With the partnerships that have already been established among the city, provider agencies and CHOP, more children in foster care in Philadelphia should soon be able to benefit from PCIT.

This article is based on information provided by Susan Dougherty, Ph.D. a psychologist and research scientist at the PolicyLab at Children's Hospital of Philadelphia. For more information about the original Child Stability and Well-Being Study, see the December 2011 edition of the PA CASSP Newsletter.