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Parent-Child Interaction Therapy (PCIT): Why You Need to Know About It

Gordon R. Hodas MD

Introduction

It is important for educators, child care staff, mental health practitioners and other human service professionals, pediatricians, and parents to recognize that evidence-based interventions now exist to help young children and their families. The time when there were no effective interventions for preschoolers and early elementary school-aged children is long gone.

Effective treatment for young children with challenging behaviors needs to be organized around the parent or other primary caregiver (hereafter, *parent*). Therapy and the subsequent change process is implemented through the parent, enhancing the parental capacity to provide nurturance, limit-setting, and everything in between, consistent with the needs of the situation. An effective parent is attuned to the child and is able to maintain self-control during challenging moments. In the presence of strong parent-child attachment, the child feels safe and confident and is more likely to be emotionally well-regulated.

This article discusses how Parent-Child Interaction Therapy (PCIT) offers an upstream approach to early childhood mental health, by strengthening attachment between parents and children ages 2½ to 7 years old presenting challenging behaviors, especially disruptive, externalizing behaviors. Regardless of the cause, children who are overactive, oppositional, defiant, aggressive, and/or vulnerable to significant emotional and behavioral dysregulation frustrate most parents. As a result, there is a risk of harsh parental responses and, at times, even maltreatment. Anger and harshness by the parent only exacerbate the child's dysregulation, leaving the parent even more frustrated and the child even more overwhelmed. Unless the cycle is interrupted, mutual escalation is likely over time, disrupting the attachment process and leaving the child poorly equipped to navigate the tasks of normal psychosocial development.

PCIT Basics

PCIT was originally developed in the 1970's by Sheila Eyberg (Funderburk & Eyberg, 2011). In the decades since then, the approach has been refined, the evidence base has grown, and the potential target groups of children and families have also expanded. Today, PCIT is an evidence-based, early childhood treatment, recognized internationally in 14 countries as well as in the United States. Fortunately, as discussed later, PCIT is now an available service in Pennsylvania.

In its most common form, PCIT is delivered in an Outpatient setting and involves the parent and child in the treatment room, with the therapist observing and offering input to the parent from behind a one-way mirror via a listening device often referred to as a "bug in the ear." Since treatment duration is based on parental mastery, there is flexibility in treatment length. The average duration is 14 hour-long, weekly sessions.

With the therapist observing from behind the one-way mirror and offering ongoing guidance to the parent, the parent receives input in real time. In

effect, the therapist serves as a "coach" to the parent, which expands the scope and influence of the PCIT therapist beyond that of the usual clinician. Parental behavior and the child's responses are monitored according to standardized criteria at each session, and relevant data is shared with the parent at the beginning of sessions. The goal of modifying the child's problematic behaviors is achieved by strengthening the parent-child attachment relationship, helping the parent learn new skills, and in turn helping the child gain greater self-control and capacity for self-regulation.

PCIT has two distinct phases (California Evidence-Based Clearinghouse for Child Welfare):

- The first phase of PCIT involves Child-Directed Interaction (the CDI phase), and typically lasts for approximately 7 sessions or until the parent masters specific skills. The purpose of the CDI phase is relationship enhancement. The child directs the process and the parent follows the child's lead, typically by joining the child's play. This process helps the child feel safe and calm, by fostering warmth and security between parent and child. The parent learns how to communicate with a child who might have a limited attention span, who in addition may be angry and oppositional in the beginning. Using positive attention, the parent helps decrease the child's frustration and anger, improve their organizational and play skills, and enhance their self-esteem. The child also learns such social skills as sharing and cooperation, which the parent models calmly and enthusiastically.

  A common acronym used during CDI and later is that of *PRIDE*, which stands for the following effective parental actions: *praise, reflection, imitation, description*, and *enthusiasm*.

  In learning CDI skills, the parent is taught to give labeled praise in response to positive child behavior – specific behavioral descriptions rather than generalized compliments are used to describe the child's positive behavior. At other moments, the parent reflects or paraphrases the child's appropriate talk. During the CDI phase, the parent avoids using commands, criticisms, or questions, because the process during this phase is non-directive and seeks to highlight child competence while minimizing attention to negative behavior. In addition to in-session teaching, the PCIT therapist gives the parent weekly homework, the outcomes of which are reviewed at the following session.

- The second PCIT phase involves Parent-Directed Interaction (the PDI phase). The purpose of the PDI phase is behavior management. Now the parent leads the interactions, learning specific ways to implement calm, age-appropriate directives and discipline. PDI builds on the increased parent-child rapport resulting from the earlier CDI phase. However, there are also new skills for the parent to master, and it typically takes time for the child to come on board. Additional in vivo learning by the parent, guided by the therapist and supplemented by data review, is helpful. Persistence is needed in the face of initial struggle, so that the child can come to see the parent as an authority needing respect and cooperation.

  During PDI, the parent learns how to effectively direct the child's behavior when it is important that the child obey an instruction. Parental behavior towards the child is intentional and consistent with specific guidelines. Instructions and commands have the following characteristics: they are direct, specific, positively stated, polite, given one at a time, and given only when essential. In addition, a rationale for the instruction is offered either immediately prior to the instruction or after it has been followed. As in CDI, labelled praise helps reinforce the child's cooperation and strengthens the parent-child relationship.

  Since the PDI phase is usually rocky at least initially, the parent is supported by the therapist to remain calm, clear and firm, so that the child experiences the parent as an

effective limit-setter and leader. This, in turn, increases the child's sense of safety. There is, within the treatment room, a way to enforce a brief time-out procedure, for when the child disregards a direct parental instruction and then ignores a subsequent warning that provides the child another opportunity to cooperate. The details of the time-out procedure are beyond the scope of this discussion. Importantly, when time-out is necessary, it is implemented calmly without harshness.

As with CDI, therapy during the PDI phase includes homework for the parent, not just in-session learning. Homework helps reinforce the learning, while also helping to generalize the PCIT program in the home setting. Barriers that arise can then be actively addressed in treatment, so that the gains can be sustained over time.

One challenge of PCIT in the Outpatient setting, as with all Outpatient treatment, is that of treatment attrition – e.g., not all families complete the entire treatment process. While efforts are underway to better understand and address this dilemma, it is relevant to note that even families that do not complete the entire PCIT process still tend to benefit from the sessions attended.

Although many PCIT interventions are based on behavior management principles, PCIT also impacts the social, emotional, and relational domains of child and parent. While specific skills are essential, the treatment succeeds because the parent-child attachment is strengthened.

PCIT Applicability

Depending on the situation, PCIT can be used with children living with their birth family, in foster care, or in an adoptive home. PCIT can be used in families where the child is at risk of maltreatment, or after maltreatment has occurred, so long as the issue of basic safety has been addressed. PCIT has relevance for children in or at risk of placement in foster care (Chaffin et al, 2004; Timmer et al, 2006). Use of PCIT can also help strengthen an at-risk foster care placement, thereby preserving existing relationships and preventing the need for a new placement. Use of PCIT in the family of origin can potentially prevent out-of-home placement in the first place. It can also help the biological family, when the child's return home is part of the family service plan. As a type of trauma treatment, PCIT can help children subjected to past trauma strengthen their relationship with their caregiver and regain a sense of safety.

In recent years, PCIT has also been used with families who have a child with special needs involving disruptive behavior, children with Autism Spectrum Disorder. While research is ongoing, a recent article provides a case study involving the use of PCIT for a family with a six-year-old child with Autism, who was noncompliant to his mother (Sheperis et al, 2015).

PCIT Evidence Base

PCIT has been recognized as an evidence-based childhood mental health treatment by the prestigious National Child Traumatic Stress Network (2008), as well as by other research entities. While effective in addressing child disruptiveness in any family, it is especially valuable for children who have experienced harsh parenting or actual maltreatment, whether living with their biological family, a foster family, or an adoptive family.

According to a brochure developed by PCIT Across PA (2018), documented benefits of PCIT for families involved in child welfare include the following:

- Increases in proactive, positive parenting skills and effective parenting practices, with decreases in child behavior problems.
- Strengthened mother-child relationships, with reductions in internalizing and externalizing behavior problems for children.
- Reduced rates of child abuse re-reports for families receiving PCIT.
- In addition, in one state child welfare system, PCIT was associated with significant long-term savings – nearly $3,500 per child – compared to the cost of treatment as usual in that system.

PCIT in PA

A positive outcome of a recently concluded Pennsylvania research grant on PCIT training, funded by the National Institute of Mental Health, is that Pennsylvania now has a trained workforce for PCIT

throughout the state. Recent figures indicate that 126 Pennsylvania Outpatient programs across 61 of the 67 counties have been trained to provide PCIT. There are an impressive 304 PCIT clinicians statewide (2017).

On the horizon is an intriguing adaptation of PCIT in Pennsylvania, involving in-home delivery of this program via a PCIT-supervised Mobile Therapist. Already a pilot project across four Pennsylvania counties, this innovative adaptation can enable less healthy and mobile caregivers, among others, to receive the benefits of PCIT as an integrated in-home service.

In order to promote the long-term sustainability of PCIT in Pennsylvania, The Early Childhood Innovations Center has been created. The Early Childhood Innovations Center can help train and credential therapists, promote treatment fidelity, and promote quality improvement. In addition, PCIT in Pennsylvania continues to be guided by a PCIT Implementation Statewide Steering Committee, consisting of a diverse group of professional and family stakeholders.

Discussion

PCIT offers an effective, evidence-based treatment for children ages 2½ -7 and their parent or other caregiver, when the child engages in disruptive, dysregulated behaviors. If the parent engages in harsh parenting – or if past maltreatment has occurred and the parent is motivated to change – PCIT can be especially valuable.

What I believe makes PCIT effective is its recognition that changing a child's behavior is meaningful only if the primary attachment relationship with the parent is also strengthened. Children gain safety and stability through their primary attachments. They behave appropriately not only as a result of behavior management techniques but also because they have learned appropriate behavior through the parent's positive modeling and because they now actively want to please their parent. Adversarial parent-child relationships are antithetical to a child's healthy development. PCIT, which is a data-driven, in vivo, highly intentional process with a therapist who is active and encouraging, helps the parent change. The child then changes as well. PCIT's behavioral approach is embedded in a humanistic framework that recognizes and enhances the attachment relationship. For me, this is key.

PCIT can help children with a variety of mental health diagnoses, and diagnosis per se is less significant to a PCIT therapist than the child's specific behaviors and the interactions between parent and child. As a child and adolescent psychiatrist, I strongly believe that children with challenging behaviors should receive effective psychosocial treatment prior to the use of psychotropic medication. For children between the ages of 2½ and 7, PCIT should be strongly considered. Even if psychotropic medication is still needed – and some childhood mental health disorders are biologically based and may require the judicious use of psychotropic medication – PCIT may enable the dose to be lower or fewer medications to be used, especially those with the most significant side effects.

While PCIT is recognized and used by some already, it remains to be used more often as a valuable treatment resource. It could be used more often by the child welfare system – helping children at risk of out-of-home placement to remain safely with their family and helping to stabilize otherwise precarious foster placements. It could become a greater resource for staff in early childhood programs, where many children with disruptive behavior are now being asked to leave, and for pediatricians who regularly encounter mothers challenged by a child who acts out and seemingly refuses to listen.

PCIT can be considered an upstream approach because it addresses a childhood challenge early on, when negative behaviors and interactional patterns are more subject to change. In addition, PCIT is upstream because its beneficiaries extend beyond

just the child and parent participating in the treatment. Other children in the family can benefit indirectly, as can other caregivers and intimate partners. Finally, extended family, now better able to understand and support the child and family, can benefit as well.

In conclusion, there are many reasons why it is important for you to learn more about PCIT, regardless of your specific role. Collectively, we need to encourage both child-serving and adult human service systems to educate their workforce about PCIT, and we need to spread the word in the community as well.

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Additional Resources

PCIT International. www.pcit.org. This website provides information for families and information on research and training guidelines for therapists.
PCIT Webcourse, free from UC Davis.
https://pcit.ucdavis.edu/pcit-web-course

For families with a child covered by Medicaid in Pennsylvania, information on a local PCIT provider can be obtained by contacting the applicable behavioral health-managed care organization or by contacting Breanna Lipchak of the Early Childhood Innovations Center at breannalipchak@innovations.org.

Families with private insurance can also contact Breanna Lipchak for assistance in obtaining a PCIT therapist.

To view a 5-minute video of a father and son in Philadelphia receiving PCIT, with comments by the therapist, go to www.youtube.com/watch?v=-1fuT3mpfyg

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Gordon R. Hodas MD is statewide child psychiatric consultant to the Pennsylvania Office of Mental Health and Substance Abuse Services.