NCTSN The National Child Traumatic Stress Network

PCIT: Parent-Child Interaction Therapy

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** PCIT

Average length/number of sessions: 14-25

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)*: Has been scientifically evaluated with different cultures and races (e.g., Native Americans, African Americans, Mexican Americans) and delivery with different settings (e.g., clinic and home-based)

Trauma type *(primary)*: Interpersonal complex traumas (i.e., physical, sexual, and emotional abuse and neglect)

PCIT is one of the strongest evidenced-based treatment models for young children with behavioral challenges due to a variety of reasons, including trauma, ADHD, and ODD. It is an assessment-driven and criterion-based intervention. PCIT is unique in with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns.

The goals of treatment are:

- Strengthening the parent/caregiver-child relationship
- Improvement in child's pro-social behaviors
- Decrease in child's negative behaviors
- Improvement in frustration tolerance and anger management
- Decrease in parenting stress
- Effective implementation of a positive discipline program

Treatment outcomes include (see selected publications below and pcit.org for additional publications):

- Improved child pro-social skills
- Decreased child negative behaviors
- Improved child compliance
- Improved parental positive skills
- Reduced parenting stress
- Improvement in trauma symptoms
- Improvement in attention
- Reduction in child maltreatment re-occurrence
- Improvement in maternal depression
- Improvement in school behaviors
- Improvement in untreated siblings
- Improvement in speech-language skills
- Improved survival rates for families with significant child maltreatment histories
- Improved marital satisfaction in military families

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Target Population

Age range: 2 **to** 7

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All

Other cultural characteristics *(e.g., SES, religion)***:** All

Language*(s)***:** English; PCIT has been translated into Spanish, German, Japanese, Dutch.

Region *(e.g., rural, urban)***:** All

Other characteristics *(not included above)***:** PCIT adaptations have been made for treatment settings that lack one way mirrors and/or "bug-in-ear" devices by using closed circuit video feedback systems. Systems range in price from inexpensive to expensive. As feedback systems are being implemented, the therapist can coach from inside the room.

Other populations with an evidence-base:

- Children with history of child maltreatment
- Children in foster care
- Children with Autism Spectrum Disorders
- Children with prenatal substance exposure/FASD
- Children with anxiety disorders
- Military families
- Children with developmental disorders
- Children with speech/language disorders
- Children born prematurely
- Children who witness domestic violence
- Mexican-American families
- African American families
- Native American families

PCIT Adaptations:

- Home-based
- Autism Spectrum Disorders
- Severe Separation Anxiety
- Military Families
- Mexican American Families
- Native American Families
- Group
- Children 7-12 with history of child maltreatment; children have minimal behavioral problems
- Tele-health delivery is currently being studied
- PC-CARE

PCIT: Parent-Child Interaction Therapy

GENERAL INFORMATION

Target Population cont'd	Other programs related to PCIT: • Teacher-Child Interaction Therapy (TCIT): multiple models • PCIT-Toddler (12-24 months) • Abbreviated PCIT • Child Adult Relationship Enhancement (CARE)
Essential Components	**Theoretical basis:** Attachment Theory, Social Learning Theory, Behavior Modification, Systems Theory **Key components:** The intervention uses a two-stage approach aimed at improving parent/caregiver-child relationship by changing patterns of interactions and implementation of a positive discipline program. In the first phase of the treatment, the Child Directed Interaction, the parent/caregiver is taught relationship-building skills: Praise, Reflection, Imitation, Description, and Enthusiasm (PRIDE.) and receives live coaching and feedback as skills are practiced with the child in session. When the relationship and behaviors improve based on validated measures and skills mastery is attained, the second phase of treatment (Parent Directed Interaction) is started. In this phase of PCIT, the parent/caregiver is taught and coached in a positive discipline program including effective delivery of commands, with an appropriate parent response for child compliance/noncompliance. All skills are gradually expanded for use in a structured home setting to unstructured home setting to public settings. Live coaching, a unique feature of PCIT, is conducted through a one-way mirror or closed circuit live video system. Using a validated coding system, parents/caregivers are provided immediate feedback of skill mastery and provided coaching to improve skills. Homework is assigned each session (length is between 5-10 minutes per day, depending on phase of treatment). Understanding of development, trauma, motivational interviewing techniques, attention to cultural and ethnic variables, and other engagement strategies are incorporated into coaching, discussions, and feedback.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** There are over 300 publications (scientific articles and book chapters related to PCIT)

Clinical & Anecdotal Evidence continued

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**

If YES, please include citation:

Selected Citations related to satisfaction and attrition:

Boggs, S.R., Eyberg, S.M., Edwards, D., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. (2004). Outcomes of parent-child interaction therapy: A comparison of dropouts and treatment completers one to three years after treatment. Child & Family Behavior Therapy, 26(4), 1-22.

Brestan, E., Jacobs, J., Rayfield, A., & Eyberg, S.M. (1999). A Consumer Satisfaction Measure for Parent-Child Treatments and Its Relation to Measures of Child Behavior Change. Behavior Therapy, 30, 17-30.

Chaffin M. Valle LA. Funderburk B. Gurwitch R. Silovsky J. Bard D. McCoy C. Kees M. (2009) A motivational intervention can improve retention in PCIT for low-motivation child welfare clients.

Child Maltreatment, 14(4), 365-368.

Hood K K Eyeberg SM. (2003) Outcomes of parent-child interaction therapy: mothers' reports of maintenance three to six years after treatment. Journal of Clinincal Child Adolescent Psychology, 32 (3), 419-429. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/12881030

Fernandez, M.A., & Eyberg, S.M. (2005). Keeping families in once they've come through the door: Attrition in parent-child interaction therapy. Journal of Early and Intensive Behavior Intervention, 2, 207-212.

N'zi, A. M., Lucash, R. E., Clionsky, L. N., & Eyber, S. M. (2016). Enhancing Parent–Child Interaction Therapy With Motivational Interviewing Techniques. Cognitive and Behavioral Practice.

Webb, H. J., Thomas, R., McGregor, L., Avdagic, E., & Zimmer-Gembeck, M. J. (2016). An Evaluation of Parent–Child Interaction Therapy With and Without Motivational Enhancement to Reduce Attrition. Journal of Clinical Child & Adolescent Psychology, 1-14.

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

More than 500 professional presentations.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ **Yes** ❒ **No**

Has the intervention been replicated anywhere? ☒ **Yes** ❒ **No**

Other countries? Australia, Canada, China, England, Germany, Hong Kong, Japan, Russia, The Netherlands

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Published Case Studies		There are over 300 scientific articles and book chapters on PCIT. These can be found at www.pcit.org. Selected Articles and Book Chapters relevant to NCTSN: Allen, B., Timmer, S. G., & Urquiza, A. J. (2014). Parent–Child Interaction Therapy as an attachment-based intervention: Theoretical rationale and pilot data with adopted children. *Children and Youth Services Review, 47*, 334-341. doi: 10.1016/j.childyouth.2014.10.009 Bagner, D. M., & Eyberg, S. M. (2007). Parent–child interaction therapy for disruptive behavior in children with mental retardation: A randomized controlled trial. *Journal of Clinical Child and Adolescent Psychology, 36*(3), 418-429. Bertrand, J. [On behalf of the Interventions for Children with Fetal Alcohol Spectrum Disorders Research Consortium] (2009). Interventions for children with fetal alcohol spectrum disorders (FASDs): Overview of findings for five innovative research projects. *Research in Developmental Disabilities, 30*(5), 986-1006. BigFoot, D., & Funderburk, B. (2011). Honoring Children, Making Relatives: The Cultural Translation of Parent-Child Interaction Therapy for American Indian and Alaska Native Families. *Journal of Psychoactive Drugs, 43*(4). 309 – 318. Brestan, E. V., Eyberg, S. M., Boggs, S. R., & Algina, J. (1997). Parent-child interaction therapy: Parent perceptions of untreated siblings. *Child & Family Behavior Therapy, 19*, 13-28. Campbell, C., Chaffin, M, and Funderburk, B (2014). Parent-Child Interaction Therapy (PCIT) in child maltreatment cases. In Reece, R., Sargent, J., & Hanson, R. (Eds.). *Handbook of Child Abuse Treatment, 2nd Edition*. Baltimore, MD: Johns Hopkins University Press.

Published Case Studies cont'd

Chaffin, M., Funderburk, B., Bard, D., Valle, L., & Gurwitch, R. (2011). A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79*(1), 84–95. doi:10.1037/a0021227

Chaffin, M., Silovsky, J., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 500-510.

Chaffin, M., Valle, L. A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., et al. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment, 14*(4), 356-368.

Galanter, R., Self-Brown, S.,Valente, J.R.,Dorsey, S., Whitaker, D.J., Bertuglia-Haley, M., Prieto, M. (2012). Effectiveness of Parent-Child Interaction Therapy Delivered to At-Risk Families in the Home Setting, *Child & Family Behavior Therapy, 34*(3) p177-196.

Ginn, N. C., Clionsky, L. N., Eyberg, S. M., Warner-Metzger, C. M., & Abner, J. P. (2015). Child-Directed Interaction Training for young children with Autism Spectrum Disorders: Parent and child outcomes. *Journal of Clinical Child and Adolescent Psychology*. 1-9. DOI:10.1080/15374416.2015.1015135

Gurwitch, R. H., Fernandez, S., Pearl, E., & Chung, G. (2013). Utilizing parent-child interaction therapy to help improve the outcome of military families. *Children, Youth, and Families Newsletter.* http://www.apa.org/pi/families/resources/newsletter/2013/01/parent-child-interaction.aspx. Accessed March 6, 2015.

Gurwitch R.H., Messer E.P. (2018) Parent–Child Interaction Therapy for Military Families: Improving Relationships. In: Niec L. (eds) *Handbook of Parent-Child Interaction Therapy.* Cham, Switzerland: Springer International Publishing, 71-84.

Gurwitch, R.H., Messer, E.P., & Funderburk, B.W. (2017). Parent-Child Interaction Therapy. In M.A. Landolt, M. Cloitre, & U. Schnyder (Eds.). *Evidence-based Treatments for Trauma Related Disorder.*

Published Case Studies cont'd

Kaufman Best Practices Project. (2004). Kaufman Best Practices Project Final Report: Closing the quality chasm in child abuse treatment; identifying and disseminating best practices. http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf. Accessed February 1, 2015.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36*, 567-589. doi: 10.1007/s10802-007-9201-9.

Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls Reutz, J. A. (2009). Psychosocial Interventions for Children and Adolescents in Foster Care: Review of Research Literature. *Child Welfare, 88*(1), 49-69.

Lanier, P., Kohl, P. L., Benz, J., Swinger, D., & Drake, B. (2014). Preventing maltreatment with a community-based implementation of Parent–Child Interaction Therapy. *Journal of child and family studies*, 23, 449-460 DOI: 10.1007/s10826-012-9708-8

Lenze, S. N., Pautsch, J., & Luby, J. (2011). Parent-child interaction therapy emotion development: A novel treatment for depression in preschool children. *Depression and Anxiety, 28*, 153-9. doi: 10.1002/da.20770

Masse, J. J & McNeil, C. B. (2008) In-home parent-child interaction therapy: Clinical considerations. *Family Behavior Therapy, 30*(2), 127-135.

McCabe, K., & Yeh, M. (2009). Parent–child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child & Adolescent Psychology, 38*(5), 753-759.

McNeil, C., Herschell, A. D., Gurwitch, R., & Clemens-Mowrer, L. C. (2005). Training foster parents in parent-child interaction therapy. *Education and Treatment of Children, 28*(2), 182–196.

Published Case Studies cont'd

Nelson, M. M., Shanley, J. R., Funderburk, B. W., & Bard, E. (2012). Therapists' attitudes toward evidence-based practices and implementation of Parent-Child Interaction Therapy. Child Maltreatment, 17, 47-55. DOI: 10.1177/1077559512436674

Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J. & Putnam, F. (2012). Effectiveness of Community Dissemination of Parent-Child Interaction Therapy. *Psychological Trauma: Theory, Research, Practice, and Policy,4*(2), 204-213.

Puliafico, A. C., Comer, J. S., & Pincus, D. B. (2012). Adapting parent-child interaction therapy to treat anxiety disorders in young children. *Child and adolescent psychiatric clinics of North America, 21*(3), 607-619. doi: 10.1016/j.chc.2012.05.005

Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for parent–child interaction therapy in the prevention of child maltreatment. *Child development, 82*(1), 177-192. doi:10.1111/ j.1467-8624.2010.01548.x

Thomas, R., & Zimmer-Gembeck, M. J. (2012). Parent Child Interaction Therapy: An evidence based treatment for child maltreatment. *Child Maltreatment, 17*(3), 253–266. doi:10.1177/1077559512459555

Timmer, S. G. & Urquiza, A. J. (2014). Parent-Child Interaction Therapy for maltreated children. In S. Timmer & A. Urquiza (Eds.) *Evidence-based approaches for the treatment of maltreated children*. New York: Springer.

Timmer, S. G., Urquiza, A. J., & Zebell, N. (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of parent-child interaction therapy. *Children and Youth Services Review, 28*(1), 1–19. doi:10.1016/j.childyouth.2005.01.006

Timmer, S. G., Urquiza, A. J., Zebell, N., & McGrath, N. M. (2005). Parent-Child Interaction Therapy: Application to maltreating parent-child dyads. *Child Abuse and Neglect, 29*(7), 825–842. doi:10.1016/j.chiabu.2005.01.003

PCIT: Parent-Child Interaction Therapy

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Required instruments include:

- Semi-structured intake interview
- Eyberg Child Behavior Inventory
- Dyadic Parent-Child Interaction Coding System/Observation

Recommended assessment instruments:

- Sutter-Eyberg Student Behavior Inventory (as appropriate)
- Trauma Symptom measure (e.g., Trauma Symptom Checklist for Young Children)
- Child Behavior Checklist
- Parenting Stress Index (short-form)
- Ages and Stages Questionnaire
- Strengths and Difficulties
- Child Abuse Potential Inventory

If research studies have been conducted, what were the outcomes?

Treatment outcomes include (see selected publications below and pcit.org for additional publications):

- Improved child pro-social skills
- Decreased child negative behaviors
- Improved child compliance
- Improved parental positive skills
- Reduced parenting stress
- Improvement in trauma symptoms
- Improvement in attention
- Reduction in child maltreatment re-occurrence
- Improvement in maternal depression
- Improvement in school behaviors
- Improvement in untreated siblings
- Improvement in speech-language skills
- Improved surv ival rates for families with significant child maltreatment histories
- Improved marital satisfaction in military families

Training Materials & Requirements

Individuals with a Master's degree or higher in a mental health field are eligible to become PCIT therapists. Basic Training in PCIT is approximately 40 hours of face-to-face training with 2/month consultation calls and 4 session reviews (live or videotaped). Therapists are expected to begin seeing cases as soon as the first face-to-face training session is completed. Therapists generally take one year to complete all requirements needed to become a PCIT therapist, certified by PCIT International. For more information on training requirements, please see http://www.pcit.org/therapist-requirements.html

Training Materials & Requirements cont'd	**What is the cost of training?** Costs vary. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ☐ **No** **If YES, what languages?** Materials have been or are being translated into Spanish, German, Dutch, and Japanese
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** • Extremely effective short-term, strength-based treatment for young children with behavior challenges due to a variety of reasons, including trauma • Results are lasting (follow-up now at 7 years) • Objective criteria for treatment progress (ideal for court-involved families); this is shared weekly with parents/caregivers • Parent/Caregiver and child are seen together at all but 2 sessions; parents/ caregivers are not asked to do anything in the home without first being coached and supported in the clinic setting • Live coaching with immediate feedback from the therapist • High client satisfaction • With behavior problems addressed, young children that may need additional treatments are more "available" to additional work. However, many children do not require additional referrals for treatment. • Over 300 publications with various populations, cultures, ethnicities, diagnoses, formats, and delivery platforms • Sustainability is built-in to PCIT through advancements to in-house trainer (Level 1) to State trainer (Level 2) to global trainer (Master Trainer). • Certification to assure therapist fidelity and integrity to the model • Some states now have higher rates of reimbursement for therapists certified in PCIT **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** • Therapist training from initial training to certification is approximately 1 year • Cost for training is higher for PCIT than some other treatments • Time commitment for therapists in training includes twice a month consultation calls which can not be reimbursed through billing • Technology required for PCIT (one-way mirror or closed video feedback with communication system) Note: although PCIT can be completed without such technology, it is strongly recommended and required by many trainers prior to implementation in an agency setting. • Parent/Caregiver and child are seen together at all but 2 sessions, which is different than usual perception of treatments (i.e., child only) • Caregiver/parent must have contact with child at least 3 times per week + therapy session • Consistent attendance is required for benefits

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GENERAL INFORMATION

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