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: 12-20

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)*: Can be delivered at home.

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

PCIT is an evidenced-based treatment model 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:

- An improvement in the quality of the parent-child relationship or, in residential treatment centers and foster homes, the caregiver-child relationship
- A decrease in child behavior problems with an increase in prosocial behaviors
- An increase in parenting skills, including positive discipline
- A decrease in parenting stress

Target Population

Age range: 2 **to** 12

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.

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 walkie-talkies or having the therapist sit in the room.
- PCIT has been used and evaluated with foster parents and in Head Start settings for parents of at-risk African American children. Some Network centers are adapting and using PCIT in residential treatment settings and shelters.
- PCIT is being used and evaluated with families and children with prenatal exposure to alcohol and other drugs.

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Target Population continued	• PCIT is currently being adapted for use in the home as part of a larger intervention. • PCIT has been adapted for use in a group treatment. • PCIT has been adapted for use with children 8-to-12 years of age. • PCIT has been used with families where child abuse has occurred. • PCIT has been adapted for use with children with medical conditions. • PCIT has been evaluated for use with physically abusive families. • PCIT is currently being adapted for use with Native American families (University of Oklahoma Health Sciences Center). • PCIT is also in the process of being adapted from a distance-learning perspective.
Essential Components	**Theoretical basis:** Developmental; Social Learning Theory; Attachment **Key components:** The intervention uses a two-stage approach aimed at relationship enhancement and child behavior management. The parent is taught and coached in relationship-building skills: Praise, Reflection, Imitation, Description, and Enthusiasm (PRIDE.) The parent/caregiver is coached while interacting with the child during relationship-enhancement treatment sessions until criteria are reached. The parent is then instructed and coached in a positive discipline program including effective delivery of commands, with an appropriate parent response for child compliance and strategies designed to increase compliance. The skills are gradually expanded for use from a structured implementation in treatment sessions to structured sessions in the home to more unstructured situations and finally to use in public situations. Skills are observed and coached through a one-way mirror at each treatment session. Specific behaviors are coded and charted on a graph at each session, and parents are provided with immediate feedback about progress and mastery of skills. Parents are given homework assignments to complete to enhance their skills between sessions. Efforts are made to incorporate ethnic and cultural practices and values.
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** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** Matos, Torres, Santiago, Jurado & Rodriguez, 2006

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Clinical & Anecdotal Evidence continued	**Has this intervention been presented at scientific meetings?** ☒ Yes ☐ No **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?** *(please list)* Hong Kong, England, Russia, Canada, The Netherlands, Australia **Other clinical and/or anecdotal evidence** *(not included above)*: PCIT needs little modification to be effective with children with developmental disabilities. Techniques for adapting PCIT for children with DD are presented (McDiarmid & Bagner, 2005).	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies		Bagner, Fernandez & Eyberg, 2004; Borrego, Anhalt, Terao & Urquiza, 2006; Borrego, Urquiza & Rasmussen, 1999; Dombrowski, Timmer & Blacker, 2005; Fricker-Elhai, Ruggiero & Smith, 2005; Timmer, Urquiza, Herschell, McGrath, Zebell, Porter & Vargas, 2006
Randomized Controlled Trials	**N=**110	Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson & Bonner, 2004.
Studies Describing Modifications		McCabe, Yeh, Garland & Lau, 2005 Pincus, Eyeberg & Choate, 2005; Choate, Pincus, Eyberg & Barlow, 2005
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** Core battery of assessment procedures include: • Semi-structured intake interview • Child Behavior Checklist (parent form) • Eyberg Child Behavior Inventory • Parenting Stress Index (short form) • Dyadic Parent-Child Interaction Coding System • Sutter-Eyberg Student Behavior Inventory (as appropriate)	

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Outcomes continued	PCIT concludes with a post-treatment evaluation. In most cases, the pre-treatment assessment procedures are repeated, including parent reports, teacher report, child report, and direct observation measures. The Dyadic Parent-Child Interaction Coding System observations are repeated at the end of the last discipline coaching session. Parents also complete a parent-report measure of consumer satisfaction called the Therapy Attitude Inventory. Parents and child return for post-treatment feedback sessions where pre- and post-treatment videotapes and accomplishments are reviewed. Brief parent report measures (Eyberg Child Behavior Inventory, Parenting Stress Index) can be completed at booster sessions to assist in tracking maintenance of behavioral improvements or for long-term follow-up of treatment. **If research studies have been conducted, what were the outcomes?** Chaffin, Silovsky, Funderburk, Valle, Brestan & Balachova, et al. (2004) randomly assigned physically abusive parents (N = 110) to one of three intervention conditions: (a) PCIT, (b) PCIT plus individualized enhanced services, or (c) a standard community-based parenting group. At a median follow-up of 850 days, 19 percent of parents assigned to PCIT had a re-report for physical abuse compared with 49 percent of parents assigned to the standard community group. Additional enhanced services did not improve the efficacy of PCIT. The relative superiority of PCIT was mediated by greater reduction in negative parent–child interactions consistent with the PCIT change model. Hood & Eyberg (2003) examined the long-term maintenance of changes following PCIT for young children with Oppositional Defiant Disorder (ODD) and associated behavior disorders. Three to six years after treatment, 29 of 50 treatment completers were located for this study. Results indicated that the significant changes that mothers reported in their children's behavior and their own locus of control at the end of treatment were maintained at long-term follow-up.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** One way mirror or monitor (optimal but not required); 2-way radio system to coach caregiver **Supervision requirements** *(e.g., review of taped sessions)***?** It involves 40 hours of direct training with ongoing supervision and consultation for approximately the next four-to-six months. The latter can be accomplished through conference calls, videotapes, and distance-learning technology. **To ensure successful implementation, support should be obtained from:** Implementation is most successful in settings in which agency management and supervisors are familiar with this intervention and fully supportive of staff who undertake it.

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.
Assessment instruments and scoring forms as well as the step-by-step clinician guide are needed for training (Hembree-Kigin & McNeil, 1995). Manuals for detailed implementation of the treatment program, coding of sessions, and handouts for use in treatment will complement the guide.

How/where is training obtained? There are a number of settings within the Network that train PCIT, including the University of Oklahoma Health Sciences Center and the Trauma Treatment Training Center (Cincinnati Children's Hospital). Other sites include Dr. Sheila Eyberg of the University of Florida and the University of California, Davis CAARE Center. Go to www.pcit.org for more information about non-network trainings and other resources.

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

Other training materials &/or requirements *(not included above)***:**
The training is for mental health professionals with a minimum of a master's degree in psychology or a related field. Competency criteria will be assessed at the completion of the 40-hour training with fidelity checks throughout the supervision and consultation period.

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)***?**
Original PCIT protocol developer, Dr. Sheila Eyberg, has stated that PCIT can be described as parent-child interaction training, rather than as parent-child interaction therapy, for populations for whom mental health treatment may be stigmatized. Engagement with caregivers avoids a deficit model of prior parenting and instead describes PCIT as offering special skills for caregivers who are dealing with children or situations that pose special challenges. PCIT can and has been delivered in home settings for those families who have transportation issues.

What are the cons of this intervention over others for this specific group *(e.g., length of treatment, difficult to get reimbursement)***?**
This is a mastery-based rather than a time-limited treatment, and treatment length can vary depending on parental skill acquisition. PCIT requires extensive parental involvement, and some parents are unable or unwilling to provide this.

Other qualitative impressions:
Because PCIT offers concrete, practical parenting skills transmitted using live coaching in caregiver interactions with children, it can be effective with many kinds of families and other caregivers: single parents, foster parents, families with cognitive limitations, two-parent families, and ethnically and culturally diverse families.

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