

## Program Overview: Parent-Child Interaction Therapy

Please note that the accuracy of the contents of this inventory cannot be guaranteed until the program director has reviewed this summary for accuracy. Changes may be pending.

Category	Other Therapy Programs	Definitions/ Notes
<b>Program Name</b>	Parent-Child Interaction Therapy (PCIT)	
<b>History of Program</b>	<p>PCIT was originally developed to help parents reduce children's disruptive behaviors (e.g., oppositional and defiant behaviors). Based on attachment and social learning theories, and incorporating operant behavioral principles, parents engage in a two-phase training that helps them replace maladaptive interactions with their children with more effective practices. In phase 1, Child Directed Interaction, parents first taught and then coached how to enhance their relationship with their child and increasing daily positive interactions by using specific praise, non-controlling reflection during play, and selective attention. In Phase 2, Parent Directed Interaction, parents learn how to give specific, effective commands and discipline practices, such as using time-out. With these two phases, parents are first taught the specific skills didactically in individual sessions and are then coached by providers in multiple parent-child conjoint sessions using a one-way mirror and "ear bugs".</p>	
<b>Description of Program as it Relates to addressing Children's Exposure to Violence</b>	<p>PCIT has been adapted for and recently evaluated with families in which there is known physical violence. Findings reveal that the mechanisms used in PCIT for changing parenting practices and parent-child interactions help prevent the reoccurrence of physical abuse in abusive families. Adaptations for physically abusive parents include providing a motivational enhancement group prior to the start of the typical PCIT sessions and includes hearing</p>	

Highlighted text indicates program components are currently under review. Changes may be pending.

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	<p>testimonials from other successful parent completers and completing exercises designed to change self-motivational and self-efficacy cognitions. In addition, children participate in a safety and skill-building group that runs concurrently with parent group. Role plays are also used to further support abusive parents' identification of children's age-appropriate behaviors and use of praise, as well as providing additional support for non-violent disciplinary strategies.</p>	
<b>Service Continuum</b>	<p>Secondary/Selective Intervention Tertiary/Targeted Intervention</p>	
<b>Primary Exposure Type</b>	<p>Maltreatment (non-specific) Psychological/Emotional Abuse</p>	<p>blat</p>
<b>Target Population</b>	<p>Family Systems</p>	<p>blat</p>
<b>Target Age</b>	<p>Early Childhood (3-5) Middle Childhood (6 - 12)</p>	<p>2.5- 7 years. It has been adapted for and used with maltreated children up to 12 years old.</p>
<b>Target Gender</b>	<p>Both</p>	
<b>Appropriate for Unique Ethnic, Cultural, or Linguistic Populations?</b>	<p>Has this program been used or evaluated with minority, cultural, or linguistically diverse groups? Yes</p> <p>If yes, please indicate: Latino/Hispanic African American Indian American Caucasian</p>	
<b>What Adaptations have been made?</b>	<p>Have any adaptations or modifications been made with respect to specific minority, cultural, or linguistic groups? Yes</p> <p>If yes, please describe: PCIT has been adapted/ tailored for use with Mexican American families at the GANA</p>	

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	<p>Program, with Native American families through the Oklahoma Health Sciences Center, and with Puerto Rican families. It has also been used with parents &amp; their children with developmental disorders and mental retardation. Findings indicate that effective use of PCIT with DD and MR populations does not require modifications to the protocol, but that PCIT is flexible enough to incorporate relevant, developmentally appropriate, concrete examples within the treatment structure.</p>	
<b>Primary Settings</b>	Mental Health Community Agency	<p>PCIT is typically delivered and has been evaluated in mental health centers or clinics. However, adaptations have been made for use in residential treatment centers and homes. Evaluations of treatment efficacy of these adaptations are limited.</p>
<b>Persons or Entities in charge of delivering Program</b>	Mental Health Providers (e.g., Social Workers, Therapists)	Bank
<b>Primary Components</b>	<p>Parent Training/Therapy Conjoint parent-child Training/ Treatment</p>	

## Resource & Capacity Planning

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<b>Length/ Duration of Program</b>	Average treatment length is 14 weekly sessions (range=10-20). Treatment completion is dependent upon parents' mastery of pre-set skills and improvement in children's behavior reaching normal levels on assessments. Homework (e.g., 5 minute parent-child interaction practice) is assigned between sessions.	
<b>Required Materials</b>	Manuals/Program materials Video/Audio Equipment Computer Software/ Special Technology Fidelity Checklists/Assessments Technical Assistance	For more information, see "Training Guidelines for Parent-Child Interaction Therapy" (Feb 2009) listed on the PCIT website <a href="http://www.pcit.org">http://www.pcit.org</a>
<b>Are Materials Available in Multiple Languages?</b>	Some of the assessments are available in Spanish.	
<b>Training Requirements</b>	Face-to-face training Supervision Consultation	<p>PCIT Training Sequence involves:</p> <ul style="list-style-type: none"> <li>• 40 hours of face-to-face training</li> <li>• Advanced live training with real cases 2-6 months following first training</li> <li>• Completion of 2 cases while receiving continuous (weekly/bi-weekly) supervision via telephone, online or tape reviews from a PCIT trainer</li> <li>• 4 specific sessions need to be reviewed by a PCIT trainer to be checked for practitioner's skill acquisition and delivery</li> </ul> <p>Training options are available for "in-house" or</p>

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		agency trainers, as well as opportunities to become a certified Master Trainer of PCIT
<b>Provider Certification/ Training/ Requirements</b>	<p>Program Specific Certification/Training Required</p> <p>Special Service Area Required (e.g., Social Worker, Doctor)</p> <p>Professional Licensure Required</p>	<p>Practitioners eligible for PCIT training are:</p> <ul style="list-style-type: none"> <li>• Master's level practitioners in a mental health field</li> <li>• Licensed in service area or supervised by a licensed practitioner trained in PCIT</li> </ul>
<b>System or Agency Recommendations for Serving CEV Populations</b>	<p><b>With-in Agency Support &amp; Infrastructure</b></p> <p>It is recommended that agencies be clinic-based, or that home-based services be supported by a clinic. Agencies must provide appropriate space ("stripped therapy room"; communication &amp; observation system that allow therapist to coach parent in real-time) and provide trainees with the time needed for training and on-going consultation. It is recommended that at least 2 clinicians within an agency be trained and that clinicians identify at least 2 families with whom they will work with prior to the training.</p>	
<b>Costs of Implementation</b>	<p>Training &amp; Consultation: \$3000 for 5 day training</p> <p>Fidelity Monitoring/ Assessments: \$180 for the Eyberg Child Behavior Inventory™ (ECBITM) &amp; Sutter-Eyberg Student Behavior Inventory-Revised™, manuals, and 50 test sheets.</p>	

## Evidence for CEV

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<b>Evaluation Design of Studies with Children Exposed to Violence</b>	<p>Randomized, control experimental design            Quasi-experimental design            Pre- and post-test (no comparison group)</p> <p>Other (describe): Case Studies</p>	
<b>Violence Exposure-Related Outcomes</b>	<p><b>Child</b> (Briefly Describe)            Children with histories of maltreatment showed significant and large improvements in levels of problematic behaviors (e.g., sassiness, internalizing difficulties, aggression and non-compliance) from pre- to post-intervention. The magnitude of pre- to post-intervention improvements is less when compared to a non-maltreatment comparison group, but is largely due to lower initial parent ratings of problem behavior at pretest, and do not significantly differ from comparison groups whose parents receive psychoeducational parent training.</p> <p><b>Parent</b> (Briefly Describe)            Physically abusive parents receiving PCIT were substantially less likely to be re-reported for physical abuse and showed significantly less negative parenting practices after treatment compared to parents receiving a community-standard parent psychoeducation intervention. Findings indicate that the prevention of further abuse is likely due to the PCIT-related reductions in negative parenting practices. Parents of maltreated and non-maltreated children receiving PCIT also showed significant improvements in parental distress and psychological functioning from pre- to post-intervention, including parents' abuse potential and rigidity in parenting practices. These effects appear to hold for both offending and non-offending parents of maltreated children.</p>	

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	<p>As with other treatments serving high risk families with histories of maltreatment, findings indicate that treatment retention and completion differ among culture, parental psychological distress, and maltreatment status. Dyads with histories of abuse were more likely to terminate treatment when parents reported severe (i.e., clinically significant) levels of behavior problems.</p>	
<p><b>Additional Research Information</b></p>	<p>Study 1:</p> <p><b>Design, Setting, Participants:</b> 110 parents of children between the ages of 4-12 with histories of child welfare reports for parental physical abuse participated in the study (37% of the total referred for study recruitment). Recruitment occurred as families entered the child welfare system. Parents had low-incomes and significant levels of mental distress and illness, including depression, substance abuse and antisocial behavior. Non-abusive partners and non-abused siblings were invited to participate, though they did not complete assessments. Participants were randomly assigned to PCIT; Enhanced PCIT with additional clinical services for parental distress, (i.e., depression, and/or substance use); and a community standard parent manualized, psychoeducational group . All groups received services for approximately 6 months (the number and type of individualized services for the Enhanced PCIT group varied, with the most common type focused on management of depression through home-visiting or medication). Participants who met termination criteria completed an average of 22-24 sessions across all intervention groups. All participants completed baseline assessments and completed assessments at treatment completion (approximately 6 months later).</p> <p><b>Outcome Measures:</b> Children's social, emotional, and behavioral adjustment was assessed using the parent-report of the Behavior Assessment System for</p>	<p>Study 1: Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., &amp; Bonner, B. L., (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. <i>Journal of Consulting and Clinical Psychology, 72, (3), 500–510.</i></p>

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	<p>Children (BASC). Parents also completed the Beck Depression Inventory (BDI) as well as a self-report version of the Alcohol &amp; Drug and Antisocial Modules of the Diagnostic Interview Schedule (DIS) to determine levels of parents' own current psychological functioning. The identified abusive parent also completed the Child Abuse Potential Inventory (used to "estimate the risk of committing physical abuse) to provide an estimate of physical abuse risk based on levels of distress, parental rigidity in beliefs about harsh discipline, social isolation and loneliness.</p> <p>Parent's interactions with their children were obtained via observations of parent-child play (Dyadic Parent-Child Interaction Coding System, DPICS-II) and coded to assess verbal behaviors (e.g., praise, specific commands), vocal behavior (e.g., laughs, wines), and physical behaviors (e.g., positive and hostile gestures, such as high-fives and slaps). Recurrence of abuse was identified through the use of a statewide child welfare administrative database using unique family and parent identifiers. Instances of recurrence were manually checked for confirmation. Non-confirmed (i.e., screened or ruled-out) cases were not included in follow-up analyses.</p> <p><b>Study 2:</b>  <b>Design, Setting, Participants:</b>  136 biological parent-child dyads participated in PCIT to assess the effectiveness of PCIT among maltreated children. Dyads were from diverse cultural backgrounds and were referred to a clinic by case workers for externalizing difficulties. The maltreatment group consisted of 91 children and their parents, all of whom had a history of suspected or substantiated maltreatment. 59 (69%) of the maltreatment group dyads included parents who were the perpetrators of the abuse. 45 parent-child dyads with no known or suspected maltreatment were included in the non-maltreatment comparison group. Children</p>	<p>Study 2: Timmer, S. G., Urquiza, A. J., Zebell, N. M., &amp; McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. <i>Child Abuse &amp; Neglect, 29</i>, 825-842.</p>

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	<p>ranged from 2 to nearly 8 years old (66% under 5 years). Participants attended an average of 15 treatment sessions and all completed at least 2 baseline and post-intervention assessments.</p> <p><b>Outcome Measures:</b>  All outcome measures were used at baseline and post-intervention assessments and were completed by parents. Children's behavioral functioning was determined by the Child Behavior Checklist (CBCL), used to assess perceptions of children's externalizing (e.g., noncompliance, aggression) and internalizing (e.g., anxiety, withdrawal) behaviors, and the Eyberg Child Behavior Inventory (ECBI) to determine the levels of more commonly observed problem behaviors in households (e.g., "sassiness", fighting with siblings). The Child Abuse Potential Inventory (CAPI- Abuse and Rigidity subscales) was used to detect potentially abusive parenting practices and attitudes, as well as parental beliefs about parent- and child- familial roles. Parents also completed the Parenting Stress Inventory (PSI) to provide information about their perceptions of children's demanding, non-compliant, and other related behaviors, as well as their own parental competence, stress, and isolation. The Symptom Checklist 90-R was used to assess parents' current levels psychological distress and symptomatology. Children's sex, age, ethnicity, and mother's education were used as control variables, due to differences between maltreatment versus non-maltreatment comparison groups.</p>	
<p><b>Is this Program an Evidence-Based Practice in other Family/ Youth Development Areas?</b></p>	<p>Yes</p> <p>Endorsements  NREPP  California Clearing House Rated</p>	<p>Numerous studies document the effectiveness of PCIT in assisting non-maltreating caregivers to develop positive interactions with their children and effective parent management skills for reducing children's deviant and conduct-behavior problems. These effects extend to observed and reported improvements in</p>

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		<p>children's actual behavior (such as defiance and non-compliance) in the family, as well as at school. Improvements in children's behavioral adjustment have been shown to be maintained over a 6-year period. Positive changes in children's adjustment have been shown to generalize to siblings as well. Initial findings also indicate that PCIT may be an effective intervention for children in foster care. In addition, parents who complete PCIT report decreases in parenting distress and increases in their sense of internal control.</p>
<b>Evaluation Designs of other evaluations</b>	<p>Randomized, control experimental design  Waitlist control (randomized or pseudo randomized)  Quasi-experimental design  Pre- and post-test (no comparison group)  Other (describe): Case Studies</p>	
<b>Sources</b>	<p>Empirical Studies (peer-reviewed journal)  Review Article (peer-reviewed journal)  Evaluation Conducted by Program  NREPP  California Clearing House  Other (describe): De Arellano, M. A., Ko, S. J., Danielson, C. K., &amp; Sprague, C. M. (2008). <i>Trauma-Informed Interventions: Clinical &amp; Research Evidence and Culture-Specific Information Project</i>. Los Angeles, CA &amp; Durham, NC: National Center for Child Traumatic Stress. (<a href="http://www.nctsn.org">www.nctsn.org</a>)</p>	

## Contact Information

For Information on Training & Implementation:

Sheila M. Eyberg, PhD

University of Florida, Department of Clinical & Health Psychology, Gainesville, FL

**Email:** [pcit@phhp.ufl.edu](mailto:pcit@phhp.ufl.edu)

**Phone:** 352-273-6145

**Fax:** 352-273-6156

**Website:** <http://www.pcit.org>

For Information about Implementation with Maltreated Children:

Anthony J. Urquiza

Director of Medical Health Service and Research

Department of Pediatrics, University of California Davis Children's Hospital,

CAARE Diagnostic and Treatment Center

Email: [anthony.urquiza@ucdmc.ucdavis.edu](mailto:anthony.urquiza@ucdmc.ucdavis.edu)

## Selected References & Helpful Links

[www.cincinnatichildrens.org/TTTC](http://www.cincinnatichildrens.org/TTTC); [www.OhioCanDo4Kids.org](http://www.OhioCanDo4Kids.org);

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.

Brestan, E., & Eyberg, S. (1998). Effective psychosocial treatments of conduct disordered children and adolescents: 29 years, 82 studies, and 5272 kids. *Journal of Clinical Child Psychology, 27*, 180-189.

Chaffin, M., Silovsky, J. F., 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*, (3), 500-510.

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Matos, M., Torres, R., Santiago, R., Jurado, M., & Rodriguez, I. (2006). Adaptation of parent-child interaction therapy for Puerto Rican families: a preliminary study. *Family Process, 45*, 205-222.

McCabe, K. M., Yeh, M., Garland, A. F., & Lau, A. (2005). The GANA Program: A tailoring approach to adapting parent child interaction therapy for Mexican Americans. *Education & Treatment of Children, 28* (2), 111-129.

McDiarmid, M. D., & Bagner, D. M. (2005). Parent-child interaction therapy for children with disruptive behavior and developmental disabilities. *Education & Treatment for Children, 28*(2), 130-142.

Schuman, E. M., Foote, R.C., Eyberg, S. M., Boggs, S. R., & Alina, J. (1998). Efficacy of parent-child interaction therapy: Interim report of a randomized trial with short-term maintenance. *Journal of Clinical Child Psychology, 27*(1), 34-45.

Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect, 29*, 825-842.

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