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Parent-Child Interaction Therapy: A Primer for Child Welfare Professionals

Parent-child interaction therapy (PCIT) is a family-centered treatment approach for children ages 2–7 with disruptive behavior and has also been used with abused and at-risk children ages 2–12. It is also an appropriate therapy for all caregivers—birth parents, adoptive parents, or foster or kin caregivers. During PCIT, parents learn strategies that will enhance the parent-child relationship and promote positive behaviors in children. To achieve this goal, they also interact with their child while simultaneously receiving coaching from the PCIT therapist. Research has shown that, because of PCIT, parents learn more effective parenting techniques, the behavior problems of children decrease, the quality of the parent-child relationship improves, and risk for child maltreatment is reduced. This factsheet is intended to help child welfare professionals gain a better understanding of PCIT, including which clients should be referred for PCIT, how it is implemented, and resources for additional information.

WHAT'S INSIDE

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OVERVIEW

PCIT is a behavioral parent training approach that was introduced in the 1970s to treat young children (generally ages 2–7) with externalizing behavior problems. It has since been successfully delivered to support families of children who have experienced or are at risk of experiencing maltreatment (Thomas & Zimmer-Gembeck, 2012) as well as children exhibiting internalizing behavior problems (Osofsky, Stepka, & King, 2017).[1] PCIT addresses negative parent-child interaction patterns that can contribute to problem behaviors in young children. What sets PCIT apart from other parent training approaches is the treatment of both the parent and child together, coupled with live coaching. (For more information, see the Key Components section of this factsheet.)

PCIT addresses many of the complex factors that can contribute to negative parenting or parent-child relationships. Parents who are abusive, or at risk for being abusive, often interact in negative ways with their children; use harsh, ineffective, and inconsistent discipline strategies; and rely too much on punishment (rather than giving positive attention to desired behaviors). Children in these families may be temporarily compliant due to the sporadic harsh discipline but also learn to be defiant or noncompliant overall due to inconsistent limit setting, which can create a negative cycle of behaviors by both the parent and child (Kennedy, Kim, Tripodi, Brown, & Gowdy, 2016). This cycle of negative behaviors can escalate to the point of severe physical punishment and physical abuse. PCIT helps by encouraging positive interactions between parents and children and by training parents how to implement consistent and nonviolent discipline techniques when children act out. Children, in turn, respond to these healthier relationships and interactions with more positive behaviors.

Another application of PCIT in child welfare is its inclusion in foster parent training. Child behavior problems are a risk factor for foster care placement instability (Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011), and PCIT can provide valuable skills foster parents can use to help alleviate these problems.

TARGET POPULATION

PCIT has been successfully used or adapted for a wide range of child and caregiver populations. Children typically are ages 2–7, but the age range can be increased for child welfare-involved children when ineffective parenting skills, rather than the child's disruptive behavior, are the referring concern. (See the Considerations When Using PCIT With Child Welfare Populations section of this factsheet for more information.) Examples of child populations who have benefited from PCIT include those with developmental delays, separation anxiety, and histories of child maltreatment (Wilsie, Campbell, Chaffin, & Funderburk, 2017). Additionally, foster, adoptive, and kinship caregivers are all appropriate recipients of PCIT. PCIT has been successfully used with diverse racial and cultural groups.

[1] Externalizing behavior problems are those directed outward toward other people or things, such as aggressive actions, disobedience, or being disruptive. This is in contrast to internalizing behavior problems, such as anxiety or depression, which are directed inward or "kept inside."

While PCIT is very effective in addressing certain types of problems, there are limitations to its use. For the following populations, PCIT may not be appropriate, or specific modifications to treatment may be needed:

- Parents who have limited or no ongoing contact with their child
- Parents with serious mental health problems that prevent active participation in treatment, such as auditory or visual hallucinations or delusions, or active substance use disorders
- Parents who are hearing impaired and would have trouble using the earpiece, or parents who have significant expressive or receptive language deficits
- Sexually abusive parents or parents engaging in sadistic physical abuse

KEY COMPONENTS

PCIT is typically provided in 10–20 weekly sessions, with an average of 15 sessions. Each session lasts about 1 to 1.5 hours. Occasionally, additional treatment sessions are added as needed. The PCIT curriculum uses a two-phase approach: child-directed interaction (CDI), which focuses on relationship enhancement, and parent-directed interaction (PDI), which focuses on effective discipline techniques. Each phase typically begins with one parent-only session for orientation to the approach followed by multiple sessions in which the therapist coaches the parent to master the targeted skills during interactions with the child.

While many other treatment approaches target either parents or children, PCIT focuses on changing the behaviors of *both* the parent and child together. Parents learn to model positive behaviors that children can learn from and are trained to better respond to their children's behavioral or emotional difficulties. PCIT also incorporates live coaching, in which the therapist typically observes the parent-child interactions from behind a one-way mirror while communicating with the parent, who wears a small wireless earpiece. (Although not optimal, clinicians who do not have access to a one-way mirror or earpiece may provide services using in-room coaching or other methods.) The live coaching allows the therapist to provide immediate feedback, including support, guidance, and encouragement, to parents regarding specific relationship-building and discipline skills learned during PCIT sessions.

Additionally, the therapist uses a combination of observational and standardized assessment measures to assess parent-child interactions, child behaviors, parental perception of stress related to being a parent, and parents' perceptions of the difficulty of their child's behaviors before, during, and after treatment. The therapist conducts a brief assessment at every session to determine progress and set goals for that session.

PCIT can be delivered effectively in either a clinic setting or at home (Fowles et al., 2018). Additionally, providing services through remote technologies (e.g., the internet) has become more frequent in the mental health field, and at least one study has shown that delivering PCIT using real-time video teleconferencing holds promise (Comer et al., 2017).

PHASE 1: CHILD-DIRECTED INTERACTION

This phase emphasizes building a nurturing relationship and secure bond between the parent and child. During CDI sessions, the parent follows the child's lead in a play situation while being coached by the therapist. In particular, parents are encouraged to use skills represented in the acronym PRIDE:

- **Praise:** Provide specific praise for the child's appropriate behavior (e.g., saying, "Good job cleaning up your crayons!") to encourage the behavior and make the child feel good about his or her relationship with the parent
- **Reflection:** Repeat and build upon what the child says to show that the parent is listening and to encourage improved communication
- **Imitation:** Mimic what the child is doing, which shows approval and helps teach the child how to play with others
- **Description:** Describe the child's activity (e.g., "You're building a tower with blocks.") to demonstrate interest and strengthen mutual play skills
- **Enjoyment:** Be engaged and authentic in the play interaction

The therapist guides parents to use selective attention—giving full attention to desirable behaviors (e.g., sharing) and withholding attention from unwanted or annoying behaviors (e.g., rudeness). For example, if a child is cleaning up toys by slamming them into the box while loudly complaining, the parent could either give attention to the child's positive act of cleaning up the toys (e.g., "Thanks for picking up even though it would be more fun to keep playing.") or to the bad attitude (e.g., "Why can't you be nice with the toys? Stop banging!"). If the behaviors are destructive or dangerous, however, play is briefly halted. The therapist also teaches the parents to avoid directive play, questioning the child, and criticisms or negative words.

In addition to the coached sessions, parents are given 5-minute homework assignments each day to practice the newly acquired skills with their child. Once a parent's skill level meets the program's identified mastery criteria, the second phase of treatment is initiated.

PHASE II: PARENT-DIRECTED INTERACTION

During PDI, the therapist teaches the parent to give clear, direct instructions to the child and to provide consistent consequences for both compliance and noncompliance. When a child obeys the instruction, the parent is told to provide labeled or specific praise (e.g., "Thank you for doing what I asked"). When a child disobeys, however, the parent should initiate a timeout procedure. The timeout procedure begins with the parent issuing the child a warning and a clear choice of action (e.g., "If you don't put your toys away, you will have to sit in timeout"). If necessary, the parent may advance to sending the child to a 3-minute timeout in a chair. As with CDI, parents are assigned daily homework to practice the skills outside of the sessions.

CONSIDERATIONS WHEN USING PCIT WITH CHILD WELFARE POPULATIONS

PCIT has been proven to be effective with child welfare populations, including with parent-child dyads (pairs) that include an offending parent or a nonoffending birth, foster, or adoptive parent (Lieneman, Brabson, Highlander, Wallace, & McNeil, 2017). (See the Benefits section of this factsheet for additional information about outcomes associated with PCIT.) Because of the unique circumstances of child-welfare involved families, however, caseworkers and PCIT therapists may need to take several factors into consideration.

Therapeutic focus. When the treatment includes a caregiver who was the perpetrator of maltreatment, the focus of the therapy often shifts to parent behavior change rather than child behavior change. In these cases, the child's behaviors may not necessarily need to fall within the clinical range for a behavioral problem diagnosis in order to initiate treatment (Wilsie et al., 2017).

Age. Because the focus of the treatment typically is on the parent rather than the child in cases involving a parent who is a perpetrator, PCIT with these families can be adapted to include children up to age 12 (rather than age 7), which does not appear to affect parent outcomes (Wilsie et al., 2017). Age-related adaptations include adjusting the types of discipline discussed with the parents and increased inclusion of the child in explaining treatment goals and plans.

Skills practice. Parents whose children are in out-of-home placements may not have access to the child for daily homework practice, which is an important component of PCIT. Similarly, if a child remains in out-of-home care beyond the course of treatment, the parents' newly developed skills may degrade before the child returns home. In order to include a noncustodial parent in PCIT, the parent should have access to the child at least three times per week in addition to the PCIT therapy session (Campbell, Chaffin, & Funderburk, 2014).

Group sessions. PCIT can be effective for both parents and children when provided in a group context for various populations, including foster parents (accompanied with phone consultations) (Mersky, Topitzes, Grant-Savela, Brondino, & McNeil, 2016) and families with a risk for or history of maltreatment (Foley, McNeil, Norman, & Wallace, 2016). When adapted for a group, parents from multiple families may participate in the learning session, participate in role-playing activities with each other, and even observe other parent-child dyads during live coaching sessions. In addition to the typical positive outcomes of PCIT, group sessions may offer a sense of community for the participants and allow parents to observe other children's behaviors, which may normalize their own children's behaviors (Foley et al., 2016).

Additional services. Child welfare and other professionals should make sure they are not overwhelming families participating in PCIT with too many services or treatments. There is some evidence that PCIT may be more effective when families are not participating in other simultaneous treatments (Wilsie et al., 2017).

Parent engagement. Given that many families involved with child welfare may be participating in services involuntarily, engagement may be a challenge. Additionally, some parents may be ambivalent or hesitant about services recommended by the child welfare system. Pairing motivational interviewing techniques with PCIT has been shown to reduce child welfare recidivism in families with a history of maltreatment (Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011). Caregivers also may face practical barriers to attending treatment, such as transportation or competing demands from the child welfare or other systems.

For additional information about motivational interviewing, refer to *Motivational Interviewing: A Primer for Child Welfare Professionals*.

BENEFITS

Multiple randomized clinical studies have found PCIT to be effective in treating children with behavioral problems and their families (Osofsky, Stepka, & King, 2017). It was also given the highest scientific rating (well-supported) by the California Evidence-Based Clearinghouse for Child Welfare. PCIT has been shown to decrease behavior problems in children, increase children's compliance with parental instruction, reduce parental stress, improve parenting behavior and functioning, and improve the parent-child relationship (Wilsie et al., 2017; Thomas & Zimmer-Gembeck, 2007). Additionally, research has shown that PCIT tends to have lasting benefits (Wilsie et al., 2017).

Studies have also shown positive outcomes specific to child welfare populations participating in PCIT. It has been found to be effective for physically abusive parents with children ages 2–12, including reducing rates of maltreatment recurrence, child behavior problems, parental stress regarding the parent-child relationship, and negative parenting practices (Chaffin et al., 2011; Kennedy et al., 2016; Thomas & Zimmer-Gembeck, 2012). Additionally, group-based PCIT training with foster parents has been associated with decreases in child behavior problems (both externalizing and internalizing) (Mersky et al., 2016) as well as improvements in parenting stress and parenting behaviors (Mersky et al., 2015).

WHAT TO LOOK FOR IN A PCIT THERAPIST

If PCIT appears to be an appropriate treatment for a family, you should look for a provider who has received adequate training, certification, supervision, and consultation in PCIT. If feasible, both you and the family should have an opportunity to interview potential PCIT therapists prior to beginning treatment. The child and parents should feel comfortable with and have confidence in the therapist with whom they will work.

The following are some specific questions to ask a therapist regarding PCIT:

- How will the parent be involved in this process?
- What is the nature of your PCIT training? When were you trained? By whom? How long was the training? Do you have access to follow-up consultation? What resource materials on PCIT are you familiar with? Are you clinically supervised by (or do you participate in a peer supervision group with) others who are PCIT trained?

- Why do you feel that PCIT is the appropriate treatment for this family?
- What techniques will you use to help the child manage his or her emotions and related behaviors?
- What techniques will you use to help the parent develop improved skills and understanding?
- Do you use a standardized assessment process to gather baseline information on the functioning of the child and family and to monitor their progress in treatment over time?
- Do you have access to the appropriate equipment for PCIT (one-way mirror, earpiece)? If not, how do you plan to structure the sessions?
- Is there any potential for harm associated with treatment?

For more information about PCIT training, as well as find a list of certified PCIT therapists, refer to PCIT International.

CONCLUSION

PCIT is a parent-training strategy with benefits for many families with child welfare involvement. PCIT's live coaching guides parents while they develop needed skills to manage their children's behavior in a relatively short-term treatment (average of 15 hourly sessions). As parents learn to reinforce positive behaviors, while also setting limits and implementing appropriate discipline techniques, children's behavioral problems decrease. Notably, the risk for recurrence of maltreatment in these families also declines. PCIT is an effective strategy for helping parents and caregivers build nurturing relationships that strengthen families and provide healthy environments for children to thrive.

ADDITIONAL RESOURCES

PCIT International

California Evidence-Based Clearinghouse for Child Welfare: Parent-Child Interaction Therapy (PCIT)

PCIT & Parent Child Care (PC-CARE) Training Center

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