A Clinical Description of Parent-Child Interaction Therapy

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Abstract

Parent-Child Interaction Therapy (PCIT) was originally developed by Dr. Sheila Eyberg to address early childhood behavior problems and promote pro-social and emotional development in young children. PCIT is a two-stage, behavioral parent training program which guides caregivers to develop authoritative parenting skills that balance a warm relationship with the child and effective limit setting. PCIT targets patterns of parent-child interaction rather than focusing on specific target behaviors by having a therapist actively coach a caregiver during real-time interactions with the child. PCIT was designed to provide a developmentally sensitive treatment format for young children, featuring play-based learning opportunities as the primary medium to facilitate behavior change. PCIT has an extensive evidence base for a range of early childhood problems, and PCIT repeatedly receives the highest rankings among reviews of evidence-based treatments. This chapter is designed to provide information on the theoretical and historical underpinnings of PCIT, review the core features, describe the format of treatment, and illustrate how PCIT has been utilized in different settings to meet the needs of children and families.

13.1 Impact of Early Childhood Behavior Problems

Early occurrence of childhood behavior problems is associated with a host of long-term significant impairments, including academic and social difficulties that impact adjustment into adulthood (Frick & Nigg, 2012). Thirteen percent or more of preschoolers are estimated to have a disruptive behavior disorder (Lavigne, Lebailly, Hopkins, Gouze, & Binns, 2009). Further, preschoolers are more likely than any other age group to be suspended and expelled from educational programs (Gilliam, 2005; Gilliam & Shahar, 2006). The interplay between childhood behavior problems and early academic adversity places children with disruptive behavior disorders at extreme risk for dropping out of high school as well as increased involvement with the justice system (American Psychological Association, 2008; Lamont et al., 2013; Petras, Masyn, Buckley, Ialongo, & Kellam, 2011). It is clear that childhood behavior problems are a public health concern and the most common reason that caregivers seek mental health services for their children (Loeber, Burke, Lahey, Winters, & Zera, 2000).

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Children with autism spectrum disorder (ASD) are three times more likely than their peers to experience childhood behavioral problems (Einfeld & Tonge, 1996; Hartley, Sikora, & McCoy, 2008; Mazurek, Kanne, & Wodka, 2013; Shawler & Sullivan, 2017). The most prevalent comorbid childhood behavior problems in children with ASD are noncompliance, oppositional behavior, and aggression (Baker & Feinfield, 2003). For children with ASD, ongoing behavior problems impact family well-being, educational interventions, placement decisions at home and school, social-emotional development, and use of antipsychotic medication (Brereton, Tonge, & Einfeld, 2006; Hartley et al., 2008; Lauderdale-Littin, Howell, & Blacher, 2013; Lecavalier, 2006; McGill & Poynter, 2012; Storch et al., 2012). Furthermore, these problems are exacerbated by child maltreatment, which can occur at high rates for children with ASD (Mandell, Walrath, Manteuffel, Sgro, & Pinto-Martin, 2005). Children with ASD and co-occurring behavior problems need intervention to limit the debilitating impact of difficult behaviors on health, safety, learning, and social relationships (Pearson et al., 2006); early intervention, involving the whole family, is key to circumventing downstream detrimental consequences on the most vulnerable children.

One treatment developed and widely used to address early childhood behavior problems and promote pro-social and emotional development in young children is Parent-Child Interaction Therapy (PCIT). Over the years, PCIT has garnered widespread support for several populations, including children involved in child welfare (Chaffin et al., 2004; Wilsie, Campbell, Chaffin, & Funderburk, 2017). This chapter is designed to provide information on the theoretical and historical underpinnings of PCIT, review the core features of treatment, and describe how PCIT has been utilized in different settings to meet the needs of children and families.

13.2 Introduction to PCIT

PCIT is an evidence-based treatment designed to assist families of children, from age two-and-a-half years up to 7 years, who present with a range of early childhood behavioral difficulties (see Chap. 14 of this handbook; Eyberg & Funderburk, 2011). Given the research documenting PCIT's effectiveness and utility for a range of early childhood problems, PCIT repeatedly receives the highest rankings among reviews of evidence-based treatments (e.g., California Evidence-Based Clearinghouse for Child Welfare, 2017; www.samhsa.gov/treatment/). PCIT is typically conducted in 1-h, weekly sessions at community outpatient mental health clinics. The average length of treatment is 15 sessions in controlled research trials. However, community clinicians have reported average treatment duration of 20 sessions.

Dr. Sheila Eyberg developed PCIT as a treatment to directly impact patterns of parent-child interaction rather than focusing on specific target behaviors. As such, a core feature of PCIT consists of a therapist actively coaching a caregiver during real-time interactions with his/her child. Further, PCIT was designed to provide a developmentally sensitive treatment format for young children, featuring play-based learning opportunities as the primary medium for facilitating behavior change.

PCIT consists of two distinct intervention phases. The first phase, Child-Directed Interaction (CDI) , lays the foundation for enhancing the parent-child relationship, fostering mutual warmth, and increasing positive attention for pro-social behaviors. The second phase, Parent-Directed Interaction (PDI), trains parents in skills to build structure for children through appropriate limit setting. Each phase begins with a session in which skills are taught to parents, and in subsequent sessions therapists directly coach parents in the skills. CDI precedes PDI, and the skills in each phase are complementary and additive. CDI skills include teaching caregivers how to deliver differential attention for positive child behaviors while minimizing attention provided for minor misbehaviors. Differential attention is a fundamental behavioral skill that is paired with targeted and selective use of additional caregiver skills that include praising, reflecting, imitating, and describing a child's behavior, with attention also given to nonverbal expressions of warmth and enjoyment (also known as the PRIDE skills).

These skills allow the caregiver to master traditional play therapy skills designed to enhance the caregiver-child relationship. Coaching assists the caregiver in enjoying time with his/her child and strengthening the attachment by enhancing emotional attunement between caregiver and child.

The second phase, PDI, involves teaching the caregiver skills to improve child compliance and reduce disruptive behavior. Skills include delivering effective commands (i.e., specific instructions), providing contingent reinforcement for compliance, and establishing a structured and developmentally sensitive discipline procedure to develop child compliance. Caregivers are coached to carry out procedures in a calm, clear, and consistent manner, allowing the caregiver to set limits that are predictable to the child. While PCIT is a short-term intervention, it traditionally is not time limited. In other words, progression through treatment is not based on a certain number of sessions attended or material presented. Instead, progression is based on parental mastery of skills and measured childhood behavior. Below, we describe the theoretical underpinnings of PCIT and follow with a detailed description of the intervention.

13.2.1 Theoretical Underpinnings

PCIT is one of several treatments developed in the 1970s at Oregon Health Sciences University, which was a fertile ground for innovative approaches to the treatment of childhood disruptive behaviors. The two-stage model developed and practiced there by Dr. Connie Hanf, a largely unpublished clinician and teacher, inspired a number of scientist-practitioners who trained during her tenure (Reitman & McMahon, 2013). Treatment developers inspired by Hanf's model included Drs. Eyberg, Cunningham, Barkley, Webster-Stratton, Forehand, and McMahon (Reitman & McMahon, 2013). The two-stage treatment model integrated the two prevalent child treatments of the time, individual play therapy and behavior therapy based on operant conditioning principles.

The first treatment approach incorporated into PCIT was traditional play therapy, in which the therapist follows the child's behavior and emotions during play to help the child express emotions safely through fantasy play (Axline, 1947). This downward extension of Rogerian therapy for young children relies on the therapist-child relationship to facilitate healing and change. The second phase of treatment in the Hanf model utilized the techniques of another child therapy technique, behavior therapy. In contrast to individual play therapy, which has its roots in psychodynamic and client-centered adult psychotherapy, behavior therapy was developed largely from techniques for the treatment of challenging behaviors related to developmental disabilities. Behavior therapy relied on operant conditioning paradigms, with techniques applied and carefully tracked by paraprofessionals under the guidance of the therapist. In Hanf's method, parents were taught to apply both the bonding techniques of play therapy and the social learning principles of behavior therapy. Progress was monitored and graphed, contingencies modified based on the observed data, and outcome success based on objective measures of improvement.

The transfer of the healing relationship from the therapist-child bond over to the caregiver-child bond was a major innovation of the Hanf model. It recognized that parent-child interactions are often strained when the child has disruptive behaviors, and in fact parent-child interaction patterns often are instrumental in developing and maintaining the disruptive behaviors. The beneficial effects of a weekly session with a play therapist could easily be overshadowed by the many hours of negative interactions in the home, and play therapy with a therapist did little to affect change in the parent-child relationship.

Teaching, modeling, and direct coaching of skills using a bug-in-ear microphone introduced the live coaching element implemented in PCIT. These components help caregivers to master the techniques that integrate the relationship-strengthening aspects of play therapy with behavior management skills to increase compliance and reduce disruptive behaviors. The

calming effects of play therapy were transferred into the home setting by capitalizing on the most important relationship in the young child's life, the parent-child relationship. While the parent-child relationship has the capacity to promote healthy social-emotional development and self-regulation, it equally has the capacity to shape dysfunctional patterns of development. Another strong influence coming from the Oregon Social Learning program was the work of Patterson and colleagues (Forgatch, Bullock, & Patterson, 2004; Patterson, 1982). Patterson described a coercive cycle in which child noncompliance or negative behavior was sustained by the parent's withdrawing demands, and periodic negative parenting strategies such as yelling or hitting were reinforced by a temporary decrease in the child's disruption. The child's noncompliance and the parent's use of ineffective or harsh parenting techniques were mutually reinforced in an escalating cycle of increasingly negative interactions. Behavior problems were often inadvertently developed and maintained by patterns of interaction that progress as the child and parent exert bidirectional influence in innumerable moment-by-moment interchanges. Hanf's model recognized that the selective attention and positive regard that characterized the play therapy skills could be difficult to sustain in disciplinary situations based on practiced patterns of negative parent-child interactions; caregivers of young children also needed skills for appropriate limit setting.

Of the behavioral parenting approaches that follow Hanf's two-stage model, Eyberg placed relatively heavier emphasis on the play therapy phase and on live coaching techniques in the development of PCIT (Reitman & McMahon, 2013). The establishment of a warm and safe therapeutic relationship to foster and support change was weighted heavily, with the understanding that "play is the primary medium through which children develop problem-solving skills and work through developmental problems" (Eyberg, 1988, p. 38). Adding the behavior therapy techniques of differential attention and behavioral contingencies based on social learning principles gave caregivers the ability to interrupt and reshape negative patterns. In addition, the PDI phase of treatment involves a predictable, positive discipline program. The parent becomes a more predictable partner for the young child, offering clear limits and supporting the child's developing emotional and behavioral regulation. The use of the bug-in-ear microphone for in vivo coaching marks PCIT as an intensive format; this method relies on immediate feedback as the caregiver interacts with the child, which later research has shown to be associated with larger effect sizes (Kaminski, Valle, Filene, & Boyle, 2008). Hanf's two-stage model provided a format and techniques that were formative for PCIT and the other behavioral parent training approaches.

Diana Baumrind's work on parenting typology is foundational for parenting theory (Baumrind, 1967; Baumrind & Black, 1967). Based on Baumrind's work, parenting styles (i.e., authoritative, indulgent, authoritarian, neglectful) can be characterized on dimensions of demandingness and responsiveness. An authoritative parenting style tends to be high on both dimensions. The indulgent parenting style reflects low demandingness and high responsiveness, the authoritarian style of parenting reflects high demandingness with low responsiveness, and the neglectful parenting style is low on both dimensions. The two phases of PCIT neatly overlay the dimensions identified by Baumrind, with the CDI phase focusing on responsiveness and the PDI phase targeting the dimension of demandingness. The structure of the two-stage model is well suited to teaching the authoritative parenting style that Baumrind's research on child development found to be associated with positive outcomes in many facets of social and emotional adjustment (Baumrind, 1989). The ability to coach live interactions gives the therapist the ability to help parents move along the dimensions of responsiveness and demandingness to match the desirable authoritative style.

Eyberg crafted PCIT with the goal of obtaining the best outcomes identified by the child development literature for families of young children. PCIT uses the best available treatment

techniques to offer the strongest lasting effects. The result was a robust treatment format that has been supported by decades of rigorous research.

13.2.2 Overview of the PCIT Protocol

13.2.2.1 Assessment Period

A standardized protocol (Eyberg & Funderburk, 2011) for delivering PCIT and meeting training competencies is available from PCIT International© (www.pcit.org). The protocol outlines treatment procedures, and also includes session-specific integrity checklists to promote treatment fidelity. As with other evidence-based treatments, PCIT starts with a pretreatment assessment composed of a clinical interview and standardized measures to assess presenting concerns. In addition to survey-based measurements, PCIT utilizes structured behavioral observations of parent-child interactions using an empirically validated behavioral coding system, the Dyadic Parent-Child Interaction Coding System, Fourth Edition (DPICS-IV; Eyberg, Chase, Fernandez, & Nelson, 2014).

The DPICS-IV is the framework for tracking parent and child behaviors over the course of PCIT. The structured observation adds important information that may not be obtained in an interview or through other measurement instruments to help guide treatment and monitor family skill progression. The assessment period provides a baseline of parent-child interactions in situations comprised of varying levels of demandingness, and starts a series of real-time functional assessments that allow therapists to modify factors maintaining problematic behaviors.

To assist in real-time functional assessment, the pretreatment DPICS-IV includes three 5-min observational tasks. All tasks are conducted in a child-friendly room with 3–5 toys. In the first task, the parent is instructed to follow the child's lead and play along with activities the child chooses (Child-Led Play). This situation is designed to observe the parent-child dyad in a low-demand scenario where the child has control. The second task is a moderate-demand situation in which the parent is instructed to choose an activity and have the child play according to the parent's rules (Parent-Led Play). Finally, the third task is a high-demand situation in which the parent is instructed to have the child clean up the toys in the room (Clean Up). All interactions are coded based on the DPICS-IV's operationally defined variables. The structured observations at the therapy intake assessment provide a baseline of parental skill, child compliance, and quality of the parent-child interaction.

13.2.2.2 Structure of Treatment Sessions

Following the initial assessment period, PCIT is structured into two distinct intervention phases to strengthen positive parent-child interactions and manage child behavior. Each phase begins with a "teach" session where the caregiver is introduced to the new skills. Apart from the two teach sessions, the remaining sessions largely focus on coaching. After the initial teach session, each "coaching" session begins with the caregiver completing a standardized assessment of his/her child's behavior (i.e., Eyberg Child Behavior Inventory [ECBI]; Eyberg & Pincus, 1999). In addition, most sessions include structured parent-child behavioral observations. The completion of the ECBI allows a systematic and standardized approach to monitor child behavior; the behavioral observation and coding from the DPICS-IV allow a systematic way to track caregiver skill acquisition over time. Coding also assists therapists in determining coaching goals in each session to guide the caregiver toward mastery of skills.

Historically (and most commonly), therapists provide coaching in session behind a one-way mirror. Therapists use a microphone to speak to caregivers through a hearing aid or Bluetooth receiver, called a bug-in-the-ear device. The caregiver and child dyad are instructed to play in a therapy room where a therapist can observe behind the one-way mirror to promote more naturalistic interactions. The therapist communicates in real time through *coaching statements* with the caregiver during these interactions. This in vivo coaching style of the caregiver is a hallmark of PCIT. Importantly, Kaminski et al. (2008) found

in a meta-analysis of parenting interventions that skill practice with a parent and their own child is one of the most powerful predictors of reductions of child behavior problems. Therefore, therapist coaching is essential in assisting the caregiver to learn new skills for improving the parent-child relationship and reducing child problem behaviors. Meanwhile, the child perceives the caregiver as the central adult in the session and the therapist as a more peripheral figure.

Commonly, PCIT sessions are broken down as follows. The family will come into an outpatient treatment clinic to receive PCIT services. Before starting the session, the parent will be asked to fill out an ECBI. Next, the therapist meets with the parent for a brief check-in (e.g., 5 min) to review homework and any particular stressors the family has had since last session. The therapist then conducts the first task of the DPICS-IV assessment and spends the next 30–40 min directly coaching the parent skills. If more than one caregiver is present, time is divided, with each caregiver coached one on one with the child. Caregivers not actively being coached have the opportunity to observe the other parent being coached and can learn vicariously through observation. Therapists should reinforce that PCIT is a transparent intervention in which the therapist partners with each of the caregivers to achieve treatment goals. The session concludes with the therapist reentering the treatment room to review treatment progress and assign skill-based homework exercises. In this final 5–10 min of the session, the therapist reviews with the caregivers a graph of ECBI scores tracking child behavior and the DPICS-IV coding data measuring progress toward skill mastery.

13.3 PCIT Phases

13.3.1 Phase 1: Child-Directed Interaction

The first phase of treatment, CDI, targets strengthening the parent-child relationship and increasing child pro-social behavior. The foundation of CDI is to establish a positive environment where a parent can reinforce a child's appropriate behavior through traditional behavioral play therapy techniques. After the initial assessment is completed, CDI begins with a teach session for the parent to learn and practice the skills with a therapist. To establish a positive environment, parents are instructed to follow the child's lead in play without imposing demands. In this process, parents are explicitly taught how to provide differential attention to child behavior: ignoring inappropriate behavior, and providing praise and positive attention when the child engages in a positive opposite behavior. Specifically, this process involves parents actively ignoring negative behaviors that are not a safety concern such as temper tantrums, yelling, or rough play. As soon as a child engages in an appropriate behavior, the parent selectively attends to that behavior, providing social reinforcement in the form of the parent's warm attention. Using these skills, parents can strengthen pro-social child behavior such as sharing and playing gently with toys while also reducing negative attention-seeking behaviors. As such, CDI helps smooth the path for the limit setting that is introduced in the second phase of treatment.

CDI skills are broken into two broad categories consisting of behaviors parents should use and behaviors to be avoided. To strengthen caregivers' ability to provide effective differential attention, a specific set of skills are taught known as the "PRIDE" skills. These skills enhance the parent-child relationship, reinforce appropriate child behaviors, and increase the frequency of those behaviors. The skills include (1) *Labeled* **P***raise:* behavior-specific praise that recognizes and encourages the child's use of pro-social behaviors; (2) **R***eflection*: an active listening skill to provide attention to the child's appropriate verbal behavior and enhance verbal communication; (3) **I***mitation*: physically doing what the child is doing to promote positive behaviors and improve attunement; (4) *Behavioral* **D***escription*: pointing out what the child is doing to sustain interest in positive behaviors and increase attention and focus; and (5) **E***njoymen*t: playing warmly, genuinely, and enthusiastically with the child.

Parents are taught to avoid using certain behaviors in CDI to allow for the child to maintain the lead in play. Certain parental behaviors can take the lead from the child or negatively impact the parent-child interaction. For instance, parents are taught to avoid using commands, questions, and critical statements. Commands take the lead from a child and often cause conflict or noncompliance. Questions often require a child to answer, shift attention away from play, and function as an indirect command (e.g., "Are you ready to clean up?'). Finally, critical statements provide attention to negative behavior and create a negative interaction between the parent and child.

Parents are recognized in PCIT as the critical agents of change. Skills learned and fine-tuned in therapy sessions are expected to be practiced in the home between coaching sessions. CDI skill practice consists of a 5-min therapeutic dose of behavioral play therapy between a parent and child known as "special time." Skill practice is purposely limited to 5 min as it is hard to maintain high fidelity of skills past 5 min, and consistent short practice intervals are sufficient for skill advancement. Parents are asked to practice every day and typically need to complete the skill practice at least 4 days a week to make good progress toward mastery. Further, child behavior and parent-child relationship will only improve if the parent is consistently using the skills. While the skill practice is set for 5 min, it is expected that parents will naturally begin to generalize the skills beyond the 5-min play-based task as the parent recognizes the positive change in his/her child and the parent and child are mutually reinforced by their increasingly positive interactions.

As noted above, CDI coaching sessions begin with a brief check-in followed by the 5-min Child-Led Play task of the DPICS-IV. The therapist completes the behavior observation at each CDI coach session to measure skill development and set goals for that day's coaching. As PCIT is assessment driven and mastery based, progression to the second phase of treatment requires that parents meet mastery of the CDI skills. Mastery criteria involve the parent demonstrating at least ten labeled praises, ten behavioral descriptions, ten reflections, and no more than a total of three questions, commands, and critical statements to the child during the 5-min observation period. The quantitative measurement of skills serves as a proxy measure of positive parent-child interaction and parental warmth that fosters secure attachment. Once a parent has demonstrated mastery of CDI skills, the parent and child transition to the next phase of treatment.

13.3.1.1 Coaching in CDI

To assist parents with mastery criteria, clinicians focus on select coaching statements. Coaching statements should be concise (ideally, just a few words), offered immediately after a behavior, positive, and supportive. Similar to skills the parents are instructed to use with children, clinicians focus on maintaining a positive relationship with parents through the use of differential attention, with an emphasis on specific praise for desired behavior. For instance, if a parent states to his/her child, "You put a red flag on the top of your tower," a coach would immediately respond with something like "That was a great behavioral description. You are helping to keep him focused." Coaching statements deliver immediate feedback and positive reinforcement to parental use of skills. Common coaching statements include labeled praises (e.g., "Perfect choice to ignore that"), observations of the child (e.g., "He just gave you a labeled praise") or parent (e.g., "You are modeling gentle play"), cues to use the CDI skills (e.g., "Praise her for that" or "What could you praise her for now"), higher order statements that link skills being applied to the parent's effect (e.g., "You praised him for good manners and now he's being more polite"), and occasional gentle correctives (e.g., "Next time let's try to ignore that behavior"). Early in treatment, clinicians may provide more direct coaching through the use of line-feeding phrases (e.g., "Say, '*You are putting the man on the house*'") to help the caregiver establish the skills. Additionally, clinicians may selectively attend to certain skills and ignore use of certain phrases such as parental questions. The coach must establish a steady pace of feedback for the

ignoring technique to be effective, and statements that follow the parents' skills have been shown to be more effective to encourage change than directive coaching statements (Barnett, Niec, & Acevedo-Polakovich, 2014). Coaching focuses on helping the parent gradually develop the skills from just feeling comfortable in the play situation at first to eventually meeting mastery criteria.

Common coaching practices involve select skill practice. For instance, if a parent is having a hard time meeting mastery criteria for reflections, a coach may focus on increasing reflections by telling a parent to reflect every statement the child makes and by offering whatever support is necessary to help the parent succeed in the allotted time. In summary, coaching in CDI should be highly engaging, provided in a timely fashion, positive, parent led, and attentive to principles of differential social attention.

13.3.2 Phase 2: Parent-Directed Interaction

The second phase of PCIT, PDI, is designed to teach parents to give specific kinds of instructions known to increase child compliance (i.e., effective commands), apply consistent and appropriate limits on child behavior, and provide a developmentally sensitive discipline procedure that parents can implement in a predictable manner. In turn, children are taught to comply with parental demands, develop impulse control, as well as improve their ability to manage feelings of frustration and anger in socially appropriate ways. PDI continues to emphasize the fundamental importance of the parent-child relationship strengthened within the CDI phase of PCIT. CDI skills are important to maintain throughout PCIT, and they continue to be addressed in every session throughout the second phase of treatment. For instance, if a parent does not meet mastery criteria for CDI skills in the initial observation of a PDI session, additional CDI coaching time is devoted prior to coaching PDI. A high level of CDI skills supports a warm parent-child relationship that increases the likelihood of willing child compliance and the maintenance of other pro-social child behaviors. Creating an environment in which the child is likely to comply with parental commands allows a child to be reinforced for appropriate behavior and limits the need for additional discipline. It is also important to note that parents are expected to continue to have daily special time with their child using the CDI skills throughout PDI and after treatment is completed.

As in CDI, PDI begins with a teach session prior to resuming coaching sessions with the child. As mentioned, parents are taught how to deliver a specific kind of instruction known as an effective command. An effective command is one that is direct, specific, developmentally appropriate, and positively stated. Commands are to be given one at a time to increase the likelihood for child compliance. Additionally, parents are taught a specialized time-out procedure that can be implemented in a calm, neutral, clear, and consistent manner for child noncompliance and severe misbehavior (e.g., aggression, destruction of property). The time-out procedure begins with the parent using an effective direct command with the child (e.g., "Please put the blue block in the box"). Parents provide social reinforcement for compliance through the use of a labeled praise (e.g., "Thank you for listening"). If a child does not comply, the parent is instructed to give the child a warning that if he/she does not comply, he/she will have to go to time-out. The warning is stated with the same words each time to cue the child that the parent will follow through. If the child does not comply, the parent continues with a structured time-out procedure in which the child is expected to sit on a chair for 3 min plus 5 s of silence. The time-out procedure concludes with a return to the original command that the child must obey to complete the time-out. Compliance with the original command is immediately followed with a second, follow-up command. The second command is delivered to ensure child learning and to over-practice compliance. The PDI procedure has planned responses for all the loopholes that some young children use to escape the boredom of time-out and the need to complete the original command. These "loopholes" include escape from the

time-out chair, accessing toys or other objects of entertainment during time-out, or capturing the parent's attention. The coach helps the caregiver learn not to respond to attention-seeking behaviors as long as the child remains safely in the time-out chair. Once the child obeys the follow-up command, the parent delivers an emphatic labeled praise for minding and listening, the parent and child return to playing, and the parent utilizes CDI skills to deescalate the child and return to a positive equilibrium. Importance is placed on having a positive play period following a time-out to emphasize the parent's responsiveness while maintaining the demandingness that expects appropriate behavior from the child. This procedure also demonstrates to the child that the parent loves the child but will not bend to noncompliance or inappropriate behavior.

The initial steps of PDI (protocol sessions PDI Coach 1–3) involve the parent and child practicing compliance within play-based situations. As PDI progresses, an increased emphasis is placed on the generalization of compliance outside the clinic environment to the home setting. For instance, children will move from play-based compliance practice immediately following special time at home to practicing PDI at home in select situations. Once these steps have been mastered with the child demonstrating compliance and the parent appropriately implementing the discipline procedure, parents move to using commands as needed throughout the day at home. Later steps in PDI (protocol sessions PDI Coach 4–7) are introduced when the parent and child have made progress with the skills to the extent that the parent is following the PDI procedures with relative independence, the child is largely complying after the warning statement (rather than needing a time-out), and the child is able to sit in the time-out chair (without trying to escape) when a time-out is needed. The later steps of PDI promote further generalization of skills by introducing "house rules" that involve automatic time-out for selected aggressive or seriously disruptive behaviors (e.g., hitting, spitting on people) and extend the range of discipline skills to public locations (e.g., grocery store, restaurant).

As in CDI, the progression of PDI is also based on data and mastery criteria. For PDI mastery, parents must correctly demonstrate the delivery of at least 75% effective commands as well as 75% effective follow-through with the appropriate consequences (e.g., labeled praise for compliance, delivery of the warning for noncompliance) in the discipline procedure. Parents are expected to memorize and use specific phrases in the discipline procedure. Use of the verbatim phrases assists with predictability for the child. Further, it reduces stress for parents as they have prepared and overlearned responses ready for challenging situations.

13.3.2.1 Coaching in PDI

Coaching in PDI may seem very different for clinicians than CDI coaching. Specifically, a clinician must lead (rather than follow) the parent's behavior. Leading the parent to carry out the PDI procedures correctly on every trial provides the young child with an optimal environment to learn the new discipline procedure (and makes it predictable). Clinicians can better anticipate child behaviors, prepare parents for next steps (mentally, verbally, and physically), and prevent potentially confusing parental errors. Therefore, clinicians start PDI by line feeding parents a direct command and the correct discipline procedure phrase. This allows errorless learning for the parent, improving his/her ability to remember the procedure correctly and effectively carry out the procedure outside of session. Therapists guide the caregiver through the flow of the discipline procedure. For instance, a coach may need to clarify if a child understood the command and how to progress if it is unclear. A coach may offer suggestions for clarity (e.g., "Point to the object and motion to your hand"). As treatment progresses, coaches allow the parent to gradually take the lead, but are ready to quickly correct the parent if he/she strays from the structured protocol.

During PDI, clinicians should continue to provide their coaching statements and feedback by utilizing CDI coaching techniques (e.g., labeled praises, observations) when they can. Since most parents' CDI skills are now at

mastery level, coaches can cue the parent to apply CDI skills between commands while focusing most of their effort on coaching discipline procedures. It is important that coaches remain calm and warm during PDI to (1) teach the time-out procedure with clarity, (2) help the parent regulate his/her own emotions, and (3) maintain a positive relationship with the parent during the potentially trying procedure. More specifically, the PDI coach should offer supportive statements to help the parent remain composed during the sometimes upsetting experience of an unhappy or protesting young child (e.g., "It is hard to ignore him on the timeout chair when he says that, but he is just trying everything to get your attention and avoid following through with your command. Take a deep breath. You are being a great mom by teaching him how to listen"). Remaining composed may look different across parents. For example, some parents may feel hesitant about carrying out a discipline procedure due to parental anxiety, and a coach should be attuned to caregivers' feelings and perspectives when coaching. Other parents might become impatient or angry when the child does not comply, and again the therapist must help the parent to remain composed and adherent to the procedures. The warmth and responsiveness of CDI remains a touchstone throughout PDI, both in the parent's interactions with the child and the coach's communication with the parent.

Coaching in PDI requires managing the environment. It is important to maintain a positive environment, alternating CDI skills with PDI skills. Prompting caregivers to use approximately one command a minute tends to allow enough practice opportunities in session while maintaining a positive environment. In particularly challenging cases, a clinician may need to step into the room and assist the caregiver to calm down or manage a situation in which the child becomes aggressive and the parent is struggling to manage the situation. As PDI advances, it is the clinician's responsibility to assist in the generalization of skills outside the therapy room by incorporating practice in places such as the lobby, the playground, or the hallways of the clinic. Every PCIT case should include some practice outside of the treatment room to promote generalization. Some therapists schedule outings with the family for practice in public, while other therapists remain in their setting but can practice within the agency and help parents plan for public outings on their own.

13.3.3 Graduation from PCIT

Before families can officially graduate from PCIT, they are required to meet a specific set of graduation criteria. First, parents must demonstrate mastery criteria of both CDI and PDI skills. Second, ratings of child behavior must be within normal limits (as measured by the ECBI). Specifically, scores on the ECBI must be within half a standard deviation away from the normative mean (i.e., 114 or below). Third, parents must express confidence in their abilities to appropriately manage child behavior without the need of ongoing support from a clinician. To assess for graduation readiness, the three situations of the DPICS-IV (i.e., Child-Led Play, Parent-Led Play, Clean Up) are then conducted (as was originally done at pretreatment). If the above criteria are met, the clinician and family review the family's progress toward treatment goals. Importantly, the clinician assists the parents in "next steps" on how to maintain consistent skill use over time. Additionally, the clinician should have a discussion with parents on how to manage future child behavior problems; this discussion is guided by a handout provided in the PCIT protocol. Lastly, the family is praised for their dedication to treatment, their continued efforts, and the positive changes they have accomplished over the course of PCIT. It is customary for clinicians to celebrate the family's graduation from treatment by providing a certificate of success for the caregivers and a blue ribbon or some small token of recognition for the child.

13.4 Delivery Setting of PCIT

13.4.1 Meeting Needs of Families

PCIT has historically been delivered in clinic-based settings, most commonly through the bug-in-the-ear device and a one-way mirror setup. However, some clinics lack standard PCIT rooms with one-way mirrors and communication equipment. When these barriers occur, coaching will take place in the room with the clinician positioned behind the parent (coaching "over the shoulder"); although this may seem awkward for some families at first, parents and children generally accommodate to this quite well.

Given the success of PCIT in clinic, PCIT is pioneering delivery in new frontiers. For instance, some providers have secured funds to purchase and deliver PCIT in mobile clinics through modified recreational vehicles (Girard, 2011). Others have suggested an intensive clinic model, bringing families into the clinic multiple times a week to enhance parental skill acquisition, quicken the pace of treatment, and rapidly change child behavior (Graziano et al., 2014). In addition, PCIT has been delivered successfully in group treatment modalities and demonstrated the potential to serve a greater number of families at one time (e.g., Niec, Barnett, Prewett, & Shanley Chatham, 2016).

Enhancing the availability of PCIT is an important endeavor as research suggests that only 3% of young children in need of mental health treatment receive it (Kataoka, Zang, & Wells, 2002; Lavigne et al., 2009). Additionally, attrition in clinic-based mental health care for children is alarming, ranging from 30% to 70% (Eyberg, Boggs, & Jaccard, 2014; Warnick, Bearss, Weersing, Scahill, & Woolston, 2014). The latest empirically supported expansions for PCIT that focus on disseminating treatment include home-based PCIT (Fowles et al., 2017) and Internet-delivered PCIT (I-PCIT; Comer et al., 2015). Home-based PCIT and I-PCIT have the potential to enhance participation, spread reach, and simultaneously reduce family-based attrition factors (e.g., transportation, childcare). For instance, home-based PCIT has seen increased attention and produced positive results (see Masse and McNeil, 2008, for full considerations of home-based PCIT). A recent statewide implementation study tested standard clinic-based delivery to an intensive home-based model of PCIT with wraparound services for high-risk families (Fowles et al., 2017). The quasi-experimental design demonstrated that families in home-based PCIT were twice as likely to complete services compared to participants in clinic-based PCIT (64.66% vs. 33.15%). In addition to being home based, I-PCIT (see Comer et al., 2015, for full considerations of I-PCIT) has particular promise to reach families via video teleconferencing (Cooper-Vince, Chou, Furr, Puliafico, & Comer, 2016). Whether in-home, group, clinic, or Internet based, PCIT has demonstrated improvements in parenting skills, improved parent-child relationships, and demonstrated large reductions in child disruptive behavior problems (Chaffin et al., 2004; Fleming, Kimonis, Datyner, & Comer, 2017; Foley, McNeil, Norman, & Wallace, 2016; Galanter et al., 2012; Gresl, Fox, & Fleischmann, 2014; Lanier et al., 2011; Ware, McNeil, Masse, & Stevens, 2008).

13.5 Conclusion

Parent-Child Interaction Therapy, developed by Sheila Eyberg, is a variant of Hanf's two-stage model of behavioral parent training. The goal of PCIT is to restructure ineffectual patterns of parent-child interactions to promote a more authoritative parenting style and optimize social and emotional adjustment in children. The first phase of treatment, CDI, incorporates techniques of play therapy as the parent learns to be highly responsive to the child and strengthen the parent-child bond. The assessment-driven treatment requires mastery of the CDI skills to proceed to the second phase of treatment, PDI; PDI focuses on training the parent in effective discipline procedures based on social learning principles. This discipline phase encourages the high levels of structure and expectations that match the high level of demandingness defined in Baumrind's

authoritative style. Parents gradually build positive parenting skills as they play with their child and are coached by PCIT therapists. Coaching is typically done from behind a one-way mirror using a bug-in-ear microphone to give the parent immediate feedback on their use of PRIDE skills and effective discipline techniques. This live coaching format produces large and lasting effects that include improved parenting behaviors and reductions in children's disruptive behavior. This robust treatment has demonstrated success in a variety of treatment formats and settings, and continues to evolve based on constantly expanding empirical evidence and clinical applications.

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