



# Parent–Child Interaction Therapy: A Transdiagnostic Intervention to Enhance Family Functioning

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## Abstract

With more than 40 years of research supporting it, parent–child interaction therapy (PCIT) is a best-practice model for the treatment of conduct problems in children from 2 years and 6 months of age to 6 years and 11 months. PCIT contains the core therapeutic elements associated with larger effect sizes in the improvement of parenting practices and the reduction of children’s disruptive behaviors. Since the 1970s, however, our understanding of how PCIT works and the ways in which it can improve the well-being of children and families has expanded well beyond the treatment of child conduct problems. Through decades of rigorous evaluation, it has become clear that PCIT changes the negative patterns of interaction between parents and children—including the toxic interactions of abusive parents—and creates new patterns that are healthy, warm, and supportive. Strengthening parent–child relationships is associated with lower risk for child abuse and recently has even been shown to help buffer the negative effects of poverty on child brain development. Consistent with this developmental literature, PCIT and

adaptations of PCIT have increasing support for their efficacy in the reduction of childhood anxiety, depression, and other forms of affect dysregulation. PCIT has also been shown to be an appropriate and effective intervention for children who have experienced trauma. This chapter provides an overview of the standard, evidence-based model of PCIT, including the key components of the approach, the foundational research that supports it, and the process of training for PCIT therapists.

When Dr. Sheila Eyberg, developer of parent–child interaction therapy (PCIT), began her work to create an effective parenting intervention for the families of young children, it was 1973. The science of intervention development at the time was moving away from treatments that addressed multiple problems of children’s behavioral and social-emotional functioning and toward treatments designed to address specific diagnoses. The question of the day was the now landmark inquiry by Paul (1967): “What treatment, by whom, is most effective for *this* individual with *that* specific problem, and under which set of circumstances?” In conceptualizing PCIT as an intervention to strengthen the parent–child relationship, a foundational element of healthy child development, Dr. Eyberg suspected PCIT might address a number of child mental health issues.

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Her research focus, however, was childhood conduct problems. Thus, PCIT was originally developed and evaluated for the treatment of conduct disorder and other disruptive behavior disorders (S. Eyberg, personal communication, April 2, 2018). It was an important focus: childhood conduct problems were, and continue to be, one of the most common reasons for which children are brought to mental health providers (Tempel, Herschell, & Kolko, 2015). Left untreated, conduct problems in early childhood are related to persistent and devastating issues such as delinquency, substance abuse, depression, and suicide that impact individuals, families, and communities (Dodge, Greenberg, & Malone, 2008; Fergusson, Horwood, & Ridder, 2005; Obradović, Burt, & Masten, 2010). In the 1970s and early 1980s, treatment models that conceptualized conduct problems by considering both behavioral and attachment theories were lacking. Based on the integration of concepts from child-centered play therapy, attachment theory, and social learning theory, PCIT offered a rare perspective on the treatment of childhood conduct problems. To conceptualize healthy parenting, PCIT also drew from developmental science, paralleling the work of Baumrind, who demonstrated the importance of two dimensions key to positive child development (1) warm, responsive, nurturing parenting, and (2) safe, consistent limits (Baumrind, 1967).

PCIT now has 40 years of research supporting it (Eyberg & Ross, 1978). It is a best-practice model for the treatment of conduct problems in children from 2½ years of age to 6 years-11 months and contains the core elements associated with larger effect sizes in the improvement of parenting practices and the reduction of children's disruptive behaviors (Kaminski, Valle, Filene, & Boyle, 2008). Since the 1970s, however, our understanding of how PCIT works and the ways in which it can improve the well-being of children and families has expanded well beyond the treatment of child conduct problems. Through decades of rigorous evaluation, it has become clear that Dr. Eyberg was correct in her original suspicions: the efficacy of PCIT extends well beyond child conduct. PCIT *changes the*

*negative patterns of interaction* between parents and children—including the toxic interactions of abusive parents—and creates new patterns that are healthy, warm, and supportive (Chaffin et al., 2004; Niec, Barnett, Prewett, & Chatham, 2016; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998; Thomas & Zimmer-Gembeck, 2011). Strengthening parent-child relationships is associated with lower risk for child abuse (Thomas & Zimmer-Gembeck, 2011) and recently has even been shown to help buffer the negative effects of poverty on child brain development (Brody et al., 2017). Consistent with this developmental literature, PCIT and adaptations of PCIT have increasing support for their efficacy in the reduction of childhood anxiety, depression, and other forms of affect dysregulation (Carpenter, Puliafico, Kurtz, Pincus, & Comer, 2014; Chronis-Tuscano et al., 2015). PCIT has also been shown to be an appropriate and effective intervention for children who have experienced trauma (Chaffin et al., 2004; Urquiza & McNeil, 1996).

This chapter provides an overview of the standard, evidence-based model of PCIT (Eyberg & Funderburk, 2011), including the key components of the approach, the foundational research that supports it, and the process of training for PCIT therapists. Subsequent chapters are grouped within five sections, each exploring a novel direction in the adaptation or implementation of PCIT: (1) alternative diagnoses and presenting problems (e.g., anxiety disorders, developmental delays, obesity risk); (2) innovative settings and formats (e.g., in-home, school-based, prevention); (3) diverse populations (e.g., Native American, Latina/o families); (4) assessment in clinical, training, and research settings (e.g., therapist competence, assessment of coaching techniques); and (5) strategies for dissemination (e.g., use of technology, getting to scale).

One note regarding terminology: the PCIT model encourages the participation of any caregivers who have a primary role in a child's life (e.g., biological parents, grandparents, adult siblings, foster parents, nannies). To reduce redundancy, however, throughout this book, we use the term "parents" to include all of these caregivers.

## Overview of the PCIT Model

### Family Assessment

Reliable and valid methods of assessment are a necessary component of any evidence-based intervention. Reliable assessment allows clinicians to determine the specific needs of a family, to guide the family during treatment, and to determine when treatment is successfully completed. PCIT is an assessment-driven intervention, meaning that although the structure and core components are manualized, the treatment is tailored to meet the needs of each individual parent and child (Eyberg, 2005). Assessment in PCIT occurs at multiple time-points: (1) intake, prior to a family beginning treatment, (2) weekly throughout treatment, and (3) at a family’s graduation from treatment. Consistent with best-practice, the assessment process in PCIT includes multiple methods (e.g., rating scales, behavior observation) and multiple sources (e.g., caregivers, therapist observation; Whitcomb, 2017; see Table 1).

All individuals who intend to participate in treatment should be included in the assessment process. By including parents’ reports and standardized observations of actual parent and child behaviors, PCIT therapists develop an understanding of caregivers’ perceptions of their children’s problems, while avoiding the disadvantages inherent in relying only on parent report.

The primary constructs measured in PCIT are directly linked to the goals of the program: strengthening the parent–child bond, increasing parents’ use of positive parenting skills, and reducing child conduct problems. Two standardized and well-validated measures capture these constructs, the Dyadic Parent–Child Interaction Coding System-Fourth Edition (DPICS-IV; Eyberg, Chase, Fernandez, & Nelson, 2014) and the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999). The DPICS-IV includes a set of three standardized parent–child interaction situations and a coding system to interpret the interactions. When administered together, the three situations begin with a 5-min warm-up period, then move to 5 min each of (1) child-led free-play (CLP), (2) parent-led play (PLP), and (3) clean-up (CU). All three situations are administered at intake (prior to a family beginning treatment) and at graduation. During weekly treatment sessions, individual DPICS-IV situations are administered, depending on the treatment phase (see chapter “Dyadic Parent–Child Interaction Coding System: An Adaptable Measure of Parent and Child Behavior During Dyadic Interactions” for an in-depth exploration of the DPICS-IV).

The ECBI is a 36-item parent rating scale that measures the frequency of children’s disruptive behaviors and parents’ tolerance of the problems. Behaviors measured by the ECBI are related to children’s attention deficits, oppositionality, and

**Table 1** Assessment in PCIT

Measure/method	Assessment point	Information source/measure type	Required/recommended
Clinical interview	Pre	Caregivers	Required
ECBI	Pre, Weekly, Grad	Parent rating scale of child conduct problems	Required
DPICS-IV	Pre, Weekly, Grad	Parent–child behavior observation	Required
BASC/CBCL	Pre, Grad	Parent rating scale, child behavioral and socioemotional functioning	Recommended
PSI-SF-IV	Pre, Grad	Parent rating scale, parenting stress	Recommended
SESBI	Pre, Grad	Teacher rating scale, child conduct problems	Recommended

*Pre* pretreatment, *Grad* graduation, *ECBI* Eyberg Child Behavior Inventory, *DPICS-IV* Dyadic Parent–Child Interaction Coding System, *BASC* Behavioral Assessment System for Children, *CBCL* Child Behavior Checklist, *PSI-SF-IV* Parent Stress Inventory Short Form fourth Edition, *SESBI* Sutter-Eyberg Student Behavior Inventory

conduct (Eyberg & Pincus, 1999). Administering the ECBI at the start of weekly therapy sessions allows clinicians to monitor progress and parents to see the connection between the changes in their parenting behaviors and the changes in their children's disruptive behaviors. As with the DPICS-IV, the ECBI scores also provide therapists with key information to tailor the session to the specific needs of the parent and child.

The DPICS-IV and ECBI are both required in order to tailor treatment for each family, to know when families are meeting their treatment goals, and to determine when they are ready to graduate. Several other measures are often useful, and though not required, are recommended. These measures (listed in Table 1), allow therapists to track issues often experienced by families who present with problems of parent-child conflict or

child conduct. These issues include parenting stress, child internalizing symptoms (e.g., anxiety, depression), and school behavior problems, among others.

### Treatment Phase I: Child-Directed Interaction (CDI)

After completion of the intake assessment, families begin the Child-Directed Interaction phase of treatment (See Table 2). The primary goals of CDI are to strengthen/repair the parent-child relationship, increase parents' positive parenting skills, and begin to build children's abilities to regulate their behavior and affect (Eyberg & Funderburk, 2011). Attachment theory and social learning theory are two of the foundational pillars upon which

**Table 2** Structure of PCIT

Session	Content
Intake/Pretreatment Assessment	<ul style="list-style-type: none"> <li>Clinical interview including history of discipline and use of time-out.</li> <li>DPICS-IV behavior assessment of parent-child interactions.</li> <li>Parent-report of behavior problems.</li> </ul>
CDI Teach	<ul style="list-style-type: none"> <li>Didactic introduction of child-centered skills and differential attention.</li> <li>Role-play demonstration and practice of child-centered skills.</li> </ul>
CDI Coach 1 to Mastery	<ul style="list-style-type: none"> <li>DPICS-IV behavior assessment of child-centered-skills.</li> <li>In vivo coaching practice of child-centered skills and differential attention.</li> </ul>
PDI Teach	<ul style="list-style-type: none"> <li>Didactic introduction in effective, consistent, developmentally appropriate limit-setting.</li> <li>Role-play limit-setting procedure.</li> </ul>
PDI Coach 1	<ul style="list-style-type: none"> <li>Demonstrate limit-setting procedure to child using Mr. Bear.</li> <li>In vivo coaching practice of effective, consistent, developmentally appropriate limit-setting.</li> </ul>
PDI Coach 2	<ul style="list-style-type: none"> <li>DPICS-IV behavior assessment of child-centered-skills.</li> <li>In vivo coaching practice of effective, consistent, developmentally appropriate limit-setting.</li> </ul>
PDI Coach 3	<ul style="list-style-type: none"> <li>DPICS-IV behavior assessment of child-centered and limit-setting skills.</li> <li>In vivo coaching practice of effective, consistent, developmentally appropriate limit-setting.</li> </ul>
PDI Coach 4	<ul style="list-style-type: none"> <li>In vivo coaching practice of child-centered skills, differential attention, and effective, consistent, developmentally appropriate limit-setting with in vivo coaching.</li> <li>Introduce house rules.</li> </ul>
PDI Coach 5	<ul style="list-style-type: none"> <li>In vivo coaching practice of child-centered skills.</li> <li>DPICS-IV behavior assessment of limit-setting skills.</li> <li>In vivo coaching practice of effective, consistent, developmentally appropriate limit-setting.</li> <li>Introduce public behavior outing.</li> </ul>
PDI Coach 6	<ul style="list-style-type: none"> <li>DPICS-IV behavior assessment of child-centered and limit-setting skills.</li> <li>In-clinic in vivo coaching practice of public behavior.</li> </ul>
PDI Coach 7+	<ul style="list-style-type: none"> <li>DPICS-IV behavior assessment of child-centered and limit-setting skills.</li> <li>In vivo coaching practice of child-centered and limit-setting skills.</li> <li>If applicable, include siblings in session.</li> </ul>
Graduation/Posttreatment Assessment	<ul style="list-style-type: none"> <li>DPICS-IV behavior assessment of parent-child interactions.</li> <li>Parent-report of child behavior.</li> </ul>

the CDI phase was developed. Attachment theory articulates *why* the parent–child relationship is important to child development (e.g., Lewis, Feiring, McGuffog, & Jaskir, 1984; Sroufe, 2000; Urban, Carlson, Egeland, & Sroufe, 1991; Bowlby, 1969/1982), and social learning theory explains *how* to help parents improve their bond with their children (e.g., Bandura, 1977; Dishion & Patterson, 2016; Eyberg & Funderburk, 2011). To say that John Bowlby, father of attachment theory, was a behaviorist is an exaggeration; however, it is no exaggeration to say that attachment theory describes the parent–child bond as a construct that develops over time after repeated interactions between parent and child in which the child *learns* what to expect from others in times of need or distress (Bowlby, 1969/1982). Parent responsiveness is one important factor in this learning process (e.g., Raval et al., 2001). The parent–child relationship impacts children’s functioning across the developmental span (e.g., Masten & Cicchetti, 2010). For this reason, the focus of PCIT is on strengthening the parent–child bond (i.e., the long-term bond) rather than the therapist–child bond (i.e., short-term bond). Using skills derived from child-centered play therapy, the CDI phase of PCIT teaches parents to interact with their children in child-centered ways. That is, PCIT increases parents’ responsiveness. Through repeated parent–child interactions, parents develop new, healthy interaction patterns and children learn new expectations about interactions with their parents.

The first session of the CDI phase of treatment is the CDI Teach session. During the teach session, therapists introduce parents to the child-centered interaction skills (e.g., reflecting children’s appropriate verbalizations, describing children’s appropriate behavior, providing specific social reinforcement), discuss types of interaction patterns that are counter to child-centered interaction (e.g., criticism, commands, questions), and provide parents with a nonconfrontational and powerful technique based on the concept of differential attention to increase children’s behavior regulation (selective ignoring). The format of the teach session is primarily didactic and includes discussion with parents about how their family’s needs will be

addressed with the new skills. Role-play of the skills in the teach session helps to prepare parents to practice in 5-min play interactions with their children at home.

### **In Vivo Feedback: A Powerful Mechanism of Change**

Subsequent to the CDI Teach session, each session in the CDI phase focuses on therapists’ in vivo coaching of parents during interactions with their children. That is, parents practice using positive interaction skills and receive immediate feedback from the therapist. In vivo coaching is a powerful mechanism of behavior change that can help parents to develop new parent–child interaction patterns even without an extensive didactic session (Shanley & Niec, 2010). PCIT therapists use behavioral principles such as modeling, social reinforcement, and differential attention to guide their coaching strategies and increase parents’ skill acquisition (Barnett, Niec, & Acevedo-Polakovich, 2014). The tone of a therapist’s coaching is always supportive, and the focus remains positive. Thus, in coaching the parent, the therapist models a similar nurturing and responsive style that parents are being taught to use with their children. In addition to being an effective learning technique, this positive approach can engage parents and may reduce the defensiveness of caregivers who feel embarrassed by their children’s behaviors or feel a sense of blame or shame for the parent–child conflict (Barnett et al., 2014, 2015).

The coaching situation is optimally set up so that parents and children can interact in a room by themselves, while the therapist coaches the parent by observing the interaction through a two-way mirror and communicating through a microphone and bug-in-the-ear device. This situation empowers the parent to enjoy an intensive, therapeutic time with their child and reduces distractions. When necessary, coaching can also be conducted effectively with the therapist in the room and speaking softly in the parent’s ear (Briegel, Walter, Schimek, Knapp, & Bussing, 2015); however, this arrangement offers some

additional challenges, particularly in the second phase of treatment.

Parenting interventions, such as PCIT, that include live coaching have larger effects than interventions that do not include coaching (Kaminski et al., 2008). Therapist coaching builds parents' skills from session to session, influences parents' speed of treatment completion, and impacts parents' engagement in treatment (Barnett et al., 2014, 2015). The research on coaching is consistent with what parents report anecdotally: that is, it is easier to learn new ways of interacting with their children when practice occurs in a real-life situation (e.g., parent-child play) and when feedback occurs in-the-moment. New interaction patterns are learned more quickly through active practice, rather than through discussion or role-play. Imagine, for a moment, learning how to play a musical instrument without ever actually picking up the instrument and practicing, only discussing with an instructor how to play it or pretending to play it without the instrument in the room.

Effective in vivo coaching helps prepare a parent to move from one phase of treatment to another. In the CDI phase, as in the rest of the PCIT model, families are empowered to be in control of the pace of their own treatment, as progress from one phase of treatment to another depends on the parents' skill acquisition. When parents have demonstrated mastery of the child-centered skills, as measured with the DPICS-IV child-led play situation, they move to the second phase of treatment, the Parent-directed Interaction phase (PDI).

## Treatment Phase II: Parent-Directed Interaction

By the time parents begin the PDI phase of PCIT, they have learned many positive parenting skills that not only have strengthened the parent-child relationship but have also started to increase children's psychosocial competencies and decrease problem behaviors. For children with conduct problems, however, the CDI phase of treatment is typically insufficient to return behavior to within-normal limits (Eisenstadt, Eyberg,

McNeil, Newcomb, & Funderburk, 1993). Thus, the goal of PDI is to teach parents how to set consistent, predictable, and developmentally appropriate limits for their children. Developmentally appropriate limits and safe, effective consequences foster healthy child development (e.g., Baumrind, 1967; Masten & Cicchetti, 2010). Permissive parenting has been associated not only with early childhood conduct problems (e.g., Baumrind, 1967; Patterson, DeBaryshe, & Ramsey, 1990), but also with a greater risk for childhood anxiety (Williams et al., 2009). For children who have experienced maltreatment or other types of trauma, it is particularly important for parenting to include consistent and predictable limits (Cohen, Mannarino, & Deblinger, 2017).

Similar to the start of the CDI phase, the first session of PDI is the PDI Teach session. During this session, parents are introduced to the primary factors that make directions (sometimes called "commands") more effective and facilitate child compliance. For instance, children are more likely to follow directions when they are positively stated, specific not vague, and are given one at a time (Eyberg & Funderburk, 2011). Emphasis is placed on parents' continued use of the child-centered skills to continue the development of a positive parent-child relationship, and parents are taught only to give directions to their children when necessary. Within that context, parents are introduced to an effective consequence for children when they break limits, time-out.

### Time-Out in PCIT

"Time-out" is a behavioral construct so named because it involves the removal of a child from all reinforcing activities (e.g., television, toys, active parental attention) for a brief period of time subsequent to the child's breaking a developmentally appropriate limit (Donaldson & Vollmer, 2011). When implemented correctly, time-out is a safe, effective consequence for child misbehavior that has been endorsed by the American Academy of Pediatrics (AAP, 1998) and the Centers for Disease Control and Prevention (CDC, 2009). The positive impact of teaching parents how to use time-out



goes beyond merely teaching children healthy limits, as described by the CDC below.

Teaching parents disciplinary skills such as the correct use of time-out and consistent responses is helpful not only for the current interactions with their children but for the future as well. When parents learn to use time-out correctly, they allow themselves and the child a moment to calm down. In addition to calming down, children learn what is desirable and undesirable behavior. Similarly, consistent responding eventually takes strain off of the parent because they no longer have to negotiate each infraction with the child. (Centers for Disease Control and Prevention, 2009, p. 6).

Parenting interventions that include a time-out protocol are more effective than interventions that do not, and are more effective than interventions that provide parents information about child development without including live practice of parenting skills or the effective use of time-out (Kaminski et al., 2008). The time-out protocol in PCIT contains the components determined to be key to effectiveness (Everett, Hupp, & Olmi, 2010). Time-out is 3 min long; it ends after 3 min plus 5 sec when the child is quiet. Ending time-out when a child is quiet prevents superstitious learning from occurring in which the child believes his or her disruptive behaviors (e.g., yelling while on the time-out chair) caused the end of time-out, and it helps children to learn to regulate themselves during the process. Time-out is not a method through which children can escape from compliance: after successfully completing the 3 min and 5 sec of quiet, children are guided to complete the original task.

As in the CDI phase, in each session subsequent to the PDI Teach session, parents are coached in their use of the new skills. Coaching by therapists in the PDI phase differs from the CDI phase in that it includes a greater proportion of directive techniques (Schoonover & Niec, 2016). Directive techniques such as modeling (i.e., telling parents what to say to their children) are important to help parents and children to have successful experiences when learning the new procedure. Coding of parents' interactions with their children also continues during the PDI phase. In PDI, the coding scenario changes across sessions based in part on the parents' skill devel-

opment (e.g., some PDI coach sessions do not include coding, some include CLP and PLP coding). During PDI coding, therapists assess the parents' use of the discipline procedure. As in the CDI phase, measuring parents' actual behavior (rather than relying only on parent report) allows therapists to determine which skills parents are mastering and for which skills they still require coaching and practice.

An overarching aim of PCIT is for parents to generalize the therapeutic relationship-building and behavior management skills to their everyday interactions with their children, so that the new skills become routine and natural. Multiple steps are built into both phases of treatment in order to accomplish this aim. At each step, parents start with practicing the skills in the session and during brief (e.g., 5 min) special time interactions with their children at home, and then gradually begin to implement the skills at other times of the day. PCIT therapists facilitate generalization of skills by prompting and reinforcing parents in their skill use not only during the therapeutic coaching time but also before and after coaching, throughout the clinic, and eventually in public settings.

When parents demonstrate mastery of the CDI and PDI parenting skills (through standardized DPICS observations), report their children's behaviors are within normal limits (ECBI Intensity Scale raw score < 114), and express feeling confident about their ability to manage their children's behaviors, families are prepared to graduate from PCIT. Graduation includes a celebration of the gains made by the family, a conversation about how to address problems if they arise in the future, and completion of a post-treatment assessment.

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## Treatment Outcomes for Children and Families

One of the goals of this book is to provide a review of the most recent evaluations of PCIT as it has been adapted to address novel problems in alternative formats. In this section, therefore, we provide a summary of the foundational research

that supports the PCIT model. The research base supporting the efficacy of PCIT is substantial and includes a range of studies from individual case studies (e.g., Armstrong, David, & Goldberg, 2013; Gordon & Cooper, 2016; Stokes, Scudder, Costello, & McNeil, 2017) to rigorous, well-controlled, randomized trials (e.g., Niec et al., 2016; Schuhmann et al., 1998).

Empirical studies demonstrate that parents who complete PCIT show significant and meaningful increases in their nurturing, responsive interactions with their children (Niec et al., 2016; Schuhmann et al., 1998). Not only does PCIT help parents to develop healthier interactions with their children, it also reduces parent stress (Eyberg, Boggs, & Jaccard, 2014; Hood & Eyberg, 2003; Niec et al., 2016; Schuhmann et al., 1998) and symptoms of depression (Gardner, Hutchings, Bywater, & Whitaker, 2010; Hood & Eyberg, 2003; Timmer et al., 2011). Further, PCIT increases parents' sense of self-efficacy (Hood & Eyberg, 2003).

Because the original studies of the PCIT model targeted the reduction of child conduct problems, the foundational evaluations of efficacy primarily included samples of children who were manifesting severe levels of disruptive behaviors or who met criteria for a disruptive behavior disorder. However, even relatively early in the development of PCIT, because of the strong focus on the parent-child relationship, clinicians and researchers recognized the potential value of the intervention to treat families in which abuse had occurred (Urquiza & McNeil, 1996). Shortly after, PCIT was evaluated in a rigorous randomized controlled trial for the treatment of parents who were referred to PCIT subsequent to physically abusing their children. Physically abusive parents who completed PCIT were significantly less likely to re-abuse their children than parents who received treatment as usual (Chaffin et al., 2004).

Evaluations of the treatment outcomes for children find that children who complete PCIT with their primary caregivers demonstrate fewer conduct problems and have better behavior regulation (Niec et al., 2016; Schuhmann et al., 1998; Thomas, Abell, Webb, Avdagic, & Zimmer-Gembeck, 2017; Thomas & Zimmer-Gembeck,

2012). Participating in PCIT also leads to the reduction of children's internalizing symptoms, such as symptoms related to anxiety and depression (e.g., Chase & Eyberg, 2008; Schuhmann et al., 1998). The reduction of children's problem behaviors generalizes not only from the clinic to home but also to the school setting (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991). Further, the siblings of children who participate in PCIT also show positive effects (Brestan, Eyberg, Boggs, & Algina, 1997).

Treatment gains in PCIT have good long-term maintenance (Eyberg et al., 2001; Hood & Eyberg, 2003). Among families who completed PCIT 3–6 years prior, child behavior on average, remained within the range of typically developing children (Hood & Eyberg, 2003). Positive treatment outcomes for parents and children in PCIT have been demonstrated across cultures within the US and internationally (e.g., Abrahamse, Junger, van Wouwe, Boer, & Lindauer, 2016; BigFoot & Funderburk, 2011; McCabe, Yeh, Garland, Lau, & Chavez, 2005).

Taken as a whole, PCIT demonstrates robust effects that generalize across settings and demonstrate good maintenance over time (Eyberg, Boggs, & Jaccard, 2014). Meta-analyses, which evaluate the outcomes of PCIT across multiple studies, show that the positive treatment gains for parents and children are moderate to large in magnitude. When compared in a meta-analysis to another evidence-based parenting intervention (Triple P-Positive Parenting Program; Sanders, Cann, & Markie-Dadds, 2003), the effect sizes of PCIT were found to be larger (Rae & Zimmer-Gembeck, 2007).

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## Sustaining Programs and Maintaining Fidelity: PCIT Training

No matter how large the effects of a treatment model may be, if the training process for therapists is not effective or is not feasible to implement, then families will be unable to benefit from the model. Although it is true of parenting interventions in general that the evaluation of dissemi-



nation and implementation outcomes (e.g., training effectiveness, program maintenance) has lagged behind the evaluation of treatment outcomes (Baumann et al., 2015), increasingly researchers are exploring questions important to PCIT training such as, “What components make training more efficient?”; “What barriers do therapists experience throughout training?”; “How can agencies best sustain their PCIT programs?” (Herschell, Reed, Person Mecca, & Kolko, 2014; Christian, Niec, Acevedo-Polakovich, & Kassab, 2014; Niec, Abrahamse, Egan, Coelman, & Heiner, 2018; see chapters “Training and Supervision Around the World” and “Getting Parent–Child Interaction Therapy to Scale”).

As is increasingly the case for evidence-based interventions, a professional organization headed by the developer of the treatment model is responsible for promoting the fidelity of PCIT. PCIT International, Inc. is a global organization that accomplishes its mission by (1) developing and promoting PCIT training requirements, (2) overseeing therapist and trainer certification, (3) providing continuing education, and (4) promoting quality PCIT research.

The requirements for training PCIT therapists were developed by a task force of expert PCIT trainers and were based both on the existing training literature and trainers’ experiences. An early, small-scale study on PCIT training found that therapists who participated in self-directed learning (e.g., reading the treatment manual without receiving guidance from a trainer) did not learn to use the PCIT skills at the level set as mastery for parents (Herschell, 2004). A subsequent review of training formats for therapists found that even participation in a workshop—without ongoing support or consultation—does not typically result in changes in therapists’ skills or the techniques used in treatment (Herschell, Kolko, Baumann, & Davis, 2010). Regarding the training modalities preferred by therapists, when experienced cognitive behavioral therapists were asked about their perceptions of the effectiveness of various training techniques, they reported that although didactic formats (e.g., lecture) were useful for acquiring factual knowledge, to acquire or improve thera-

peutic skills, active/experiential learning was best (Bennett-Levy, McManus, Westling, & Fennell, 2009). Community-based therapists also expressed a preference for experiential rather than didactic training formats (Herschell et al., 2014) and for ongoing consultation and supervision (Christian et al., 2014). PCIT training for therapists, therefore, includes a range of training techniques (e.g., lecture, modeling, role-play, active practice), with an emphasis on experiential learning. The details of the training process are discussed in depth in chapter “Training and Supervision Around the World”. In brief, PCIT therapist training is an approximately year-long process that includes face-to-face workshops as well as ongoing consultation with review of recorded therapy sessions. Fidelity monitoring during training and after certification is embedded within the PCIT protocol. That is, detailed fidelity checklists exist for each treatment session. Self-monitoring of fidelity is ongoing as therapists complete the checklists for each session. External review of fidelity can be completed by trainers, supervisors, or program evaluators who use the checklists to evaluate recorded treatment sessions. The overarching goals of PCIT therapist training are both to develop therapists’ ability to deliver the model effectively and to sustain their fidelity over time.

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## Conclusions: PCIT as a Transdiagnostic Intervention

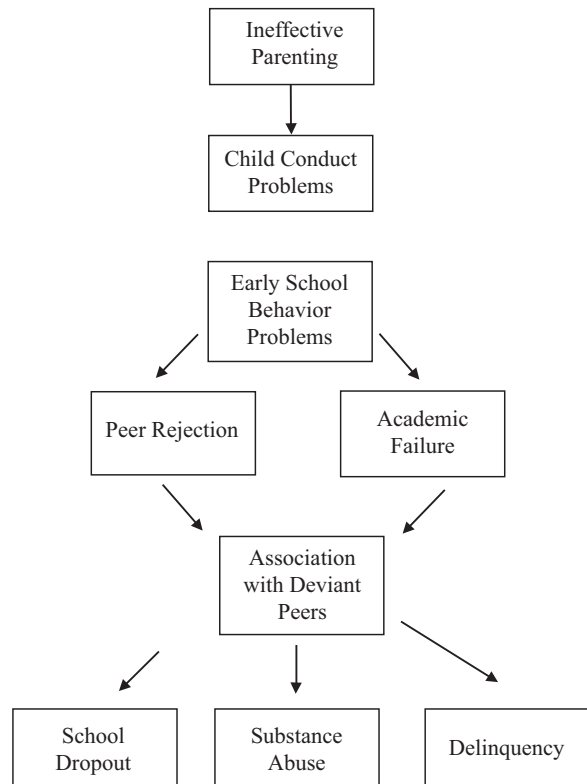
From early in the development of PCIT, Dr. Eyberg considered the model to have the potential to address multiple childhood problems (personal communication, April 2, 2018). Many of the investigations described in this volume support the conceptualization of PCIT as a transdiagnostic intervention. The mechanisms through which the model may be transdiagnostic are related to the construct of developmental cascades. Developmental cascades refer to the links by which certain risk factors (e.g., early childhood conduct problems) or buffering factors (e.g., positive parent–child relationships) make more likely a series of negative or positive developmental out-

comes (Gonzalez & Jones, 2016; Masten & Cicchetti, 2010; van Lier & Koot, 2010). The manifestation of conduct problems in early childhood is one risk factor related to negative developmental cascades (Masten & Cicchetti, 2010). That is, when children manifest clinical levels of problem behaviors prior to beginning school, they are significantly more likely to experience a host of other adjustment problems throughout development (Fig. 1). Imagine, for example, the 5-year-old child who is oppositional and noncompliant with adults and aggressive with peers. This child is more likely to develop poor peer relationships and experience conflict with teachers. In the context of such conflict, a child may begin to disengage from school and thereby demonstrate problems with school achievement. Rejection by prosocial peers may lead to associating with deviant peers, which may then lead to delinquent behavior and involvement in the court system (Frick, 2012; Patterson et al., 1990). Individuals who manifest conduct disorder are also at greater risk for experiencing

depression, substance abuse, and suicidal ideation (Dodge et al., 2008; Sourander et al., 2009).

By definition, developmental cascades are linked to multiple child outcomes, either positive or negative. Review of the links between ineffective parenting and child functioning supports the influence of parent behavior, not only on children's externalizing symptoms but also on internalizing symptoms (McKee, Colletti, Rakow, Jones, & Forehand, 2008). Thus, preventing or ameliorating the manifestation of risk factors related to negative developmental cascades has the potential to prevent children from experiencing multiple negative developmental outcomes, including the serious dysfunction associated with diagnoses such as conduct disorder, depression, and anxiety. By addressing two core factors related to developmental cascades (i.e., parent-child relationship, child behavior), theory suggests that PCIT is inherently a transdiagnostic intervention with the potential to prevent or ameliorate a range of diagnoses. In the following

**Fig. 1** Developmental cascades related to early childhood conduct problems (e.g., Frick, 2006; Masten & Cicchetti, 2010; van Lier & Koot, 2010)



chapters, research is reviewed that supports this proposition and demonstrates the efficacy of PCIT in addressing multiple, serious childhood behavioral and emotional problems.

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