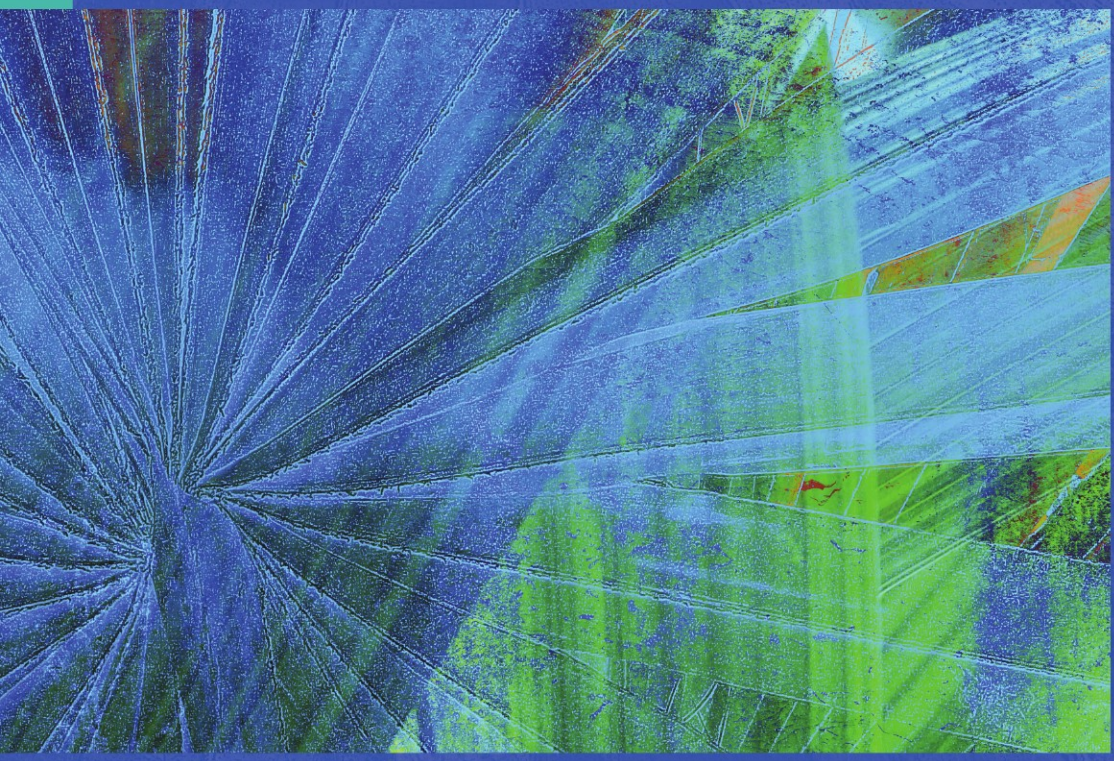
Issues in Clinical Child Psychology

Cheryl Bodiford McNeil
Toni L. Hembree-Kigin

Parent-Child Interaction Therapy



Second Edition

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Issues in Clinical Child Psychology

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Cheryl Bodiford McNeil · Toni L. Hembree-Kigin

Parent-Child Interaction Therapy

Second Edition

With Contributions by Karla Anhalt, Åse Bjørseth, Joaquin Borrego, Yi-Chuen Chen, Gus Diamond, Kimberly P. Foley, Matthew E. Goldfine, Amy D. Herschell, Joshua Masse, Ashley B. Tempel, Jennifer Tiano, Stephanie Wagner, Lisa M. Ware and Anne Kristine Wormdal

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For the developer of Parent-Child Interaction Therapy...
our mentor and friend,
Dr. Sheila M. Eyberg
...and to our loving families,
who share in all of our accomplishments,
my husband Dan, our sons Danny and Will, and Mom and Dad (C.B.M.)
and
my husband Tim, our children Molly, Sean, and Patrick, and Mom, Dad, Tim, & Jon (T.L.H.)

Preface

Why a Second, Expanded Clinical Edition?

The first edition of this book, *Parent-Child Interaction Therapy,* was published in 1995 as part of a series called "Issues in Clinical Child Psychology." As the first book written about PCIT, it was designed to be a readable clinical guidebook describing how to conduct the therapy. At the time the original text was written, PCIT was used in only a few clinical child psychology research laboratories. Having experienced great success with this treatment approach in our own clinical work, we felt an urgent need to make PCIT more available to families. It was our hope that the treatment would be embraced by mental health professionals from a variety of theoretical orientations. Indeed, the book – along with Sheila Eyberg's programmatic research effort – sparked a tremendous amount of interest and served as a catalyst for more than a decade of rapid dissemination and empirical evaluation of PCIT.

In 2008, circumstances have changed tremendously. Instead of being available only in university-based clinics in a few states, PCIT is now being provided to families across the country in community mental health settings, private practices, hospital-based clinics, and head start programs. In addition to clinical child psychologists, providers of PCIT now include social workers, counselors, marriage and family therapists, play therapists, and other masters-level clinicians. For example, in California alone, approximately 100 agencies provide PCIT, and there is even a mobile unit delivering PCIT in a 35-foot long Winnebago! In addition to widespread delivery in the United States, PCIT is now available in many other countries including Norway, Australia, Hong Kong, Russia, South Korea, England, The Netherlands, Taiwan, and Canada. PCIT's strong empirical base also has grown tremendously resulting in both academic and governmental recognition. PCIT currently is recognized as an evidence-based program by numerous professional groups and state and federal agencies including the Kauffman Foundation's Best Practices Project, Society of Clinical Child and Adolescent Psychology, and the National Child Traumatic Stress Network.

As a result of the rapid dissemination of PCIT, much more information has been generated regarding both clinical applications and treatment effectiveness. The scope of PCIT has broadened greatly with published reports of its use with a variety of children other than oppositional preschoolers. PCIT has shown

promising results with victims of maltreatment, anxious children, children with ADHD, and those with developmental disabilities. The body of empirical data available on PCIT has grown exponentially. Whereas in our first book, we devoted three paragraphs to describing the outcome literature, the new edition requires a full chapter to overview the wealth of outcome data now available. In the second edition of *Parent-Child Interaction Therapy,* our goal is to compile this rich new clinical and research information into a readable sourcebook for therapists and researchers.

Organization of the Second Edition

The second edition is broadly divided into two sections. In Part I, we describe the fundamentals of PCIT as it was developed by Dr. Sheila Eyberg and is described in her 1999 manual entitled, "PCIT: Integrity Checklists and Session Materials." We strongly recommend that therapists obtain Dr. Eyberg's manual and use the checklists to guide each therapy session. The treatment integrity checklists and other session materials currently are available for download on Sheila Eyberg's web site (www.pcit.org). With regard to the first section of the second edition, you will find that this part of the book greatly resembles our original PCIT text, with some important modifications. Notably, we have updated the text to reflect the current research-based treatment protocol being used in Dr. Eyberg's laboratory at the University of Florida. For example, Dr. Eyberg's mastery criteria have changed since the publication of the original book. Also, the use of a backup time-out room is now the standard for teaching children to stay in the time-out chair. It is critical for both clinicians and researchers to know about changes to the treatment protocol and to update their own practices accordingly. It is important for clinicians to know that the changes made by Dr. Eyberg are based on solid empirical and theoretical rationales. Over the past decade of dissemination, we have seen many therapists make their own changes in procedures based on personal preference and experience. In many cases, their therapies have evolved into treatments that bear little resemblance to standard PCIT. When this occurs, effectiveness is generally diluted and research findings on PCIT are no longer applicable to the work being conducted in their clinics.

With respect to the dangers of therapeutic drift, we find it helpful to consider a boating analogy. Let us imagine that Dr. Eyberg's research-based protocol is the "mother ship" anchored off the coast of Florida. In order to provide a therapy that resembles the evidence-based anchor, it is important for therapists to be knowledgeable about and adhere to the standard protocol. The cumulative effects of multiple small changes to the treatment protocol (i.e., letting out some line) may cause such substantial drift that the therapist ends up off the coast of Mexico providing a version of PCIT that looks almost nothing like the "mother ship" protocol anchored near Florida. The danger to letting out so much line is that the new treatment may not work as well as standard PCIT. Ultimately, widespread drift could undermine our efforts to disseminate this potent treatment to families. When therapists provide ineffective treatments under the guise of PCIT, they erode its standing as an evidence-based intervention. Therefore, Part I of the book serves as our

PCIT "anchor" encouraging therapists to provide PCIT with the greatest treatment integrity.

Part II of the book goes beyond the fundamentals of PCIT to present rich clinical examples of how one can expand PCIT to address a spectrum of child and parent concerns in diverse settings. For example, in Part II, we discuss the application of PCIT to special populations other than the preschoolers with oppositional defiant disorder addressed by the standard protocol presented in Part I. We are excited to share with our readers recent developments in the use of PCIT as a prevention model with babies and toddlers. We also highlight interesting work being conducted in the adaptation of PCIT to older elementary school age children and siblings. A PCIT protocol has been developed and evaluated for young children with anxiety disorders. To illustrate, we provide the reader with a case example to demonstrate the addition of an exposure phase to PCIT, which Donna Pincus termed, "bravery-directed interaction." Ground-breaking research demonstrating the success of PCIT in reducing future incidents of abusive parenting is presented in this section of the book. We enumerate specific clinical guidelines for working with parents who have anger control problems and their children with trauma histories. In addition, the second part of the book provides clinicians with helpful insights and tools for working with culturally diverse and multi-problem families. New approaches are outlined for the use of PCIT in varied settings such as residential treatment facilities, schools, and homes. The book concludes with a discussion of training issues including minimum qualifications and skills necessary to represent oneself as a PCIT therapist.

Contributors to the Book

When we were invited to write *Parent-Child Interaction Therapy: Second Edition*, we grappled with whether to write the book entirely ourselves or to make it an edited book compiling chapters written by our PCIT colleagues. On the one hand, we have heard from readers that a strength of the original PCIT book was that it was written with a clinical voice. They appreciated that the book incorporated language that we actually use in our interactions with clients. We wanted to preserve that practical clinical tone in the expanded edition. On the other hand, we wanted to present cutting edge work that is being conducted with special populations. In some instances, we felt that particular chapters might be better written by individuals immersed in this specialized work. In the end, we decided to combine the best of both approaches by writing the majority of the book ourselves, while inviting select experts to contribute certain chapters. We are grateful for the contributions of the following colleagues: *Karla Anhalt, Åse Bjørseth, Joaquin Borrego, Gus Diamond, Kimberly P. Foley, Matthew Goldfine, Amy D. Herschell, Joshua Masse, Ashley Tempel, Jennifer D. Tiano, Stephanie Wagner, Lisa M. Ware, and Anne Kristine Wormdal.* Additionally, we want to thank Melanie Nelson for reading several chapters from this book and providing us with valuable feedback about treatment integrity.

Acknowledgments

Much of what we have learned about working with families of young preschoolers has been taught to us by the thousands of parents and children we have seen in PCIT. We are indebted to these families. The energy and resources for completing this book would have run dry long ago if not for the ever-present love and encouragement of our husbands, Dan McNeil and Tim Kigin. We appreciate their patience in taking care of our children while we worked through snow storms, corneal abrasions, car accidents, back injuries, and many childcare crises. We also want to thank our amazing children Danny (13), Will (10), Molly (13), Sean (10), and Patrick (7) for giving up so much "mom time" to support this endeavor over the past year.

Finally, this book would never have been written without the tutelage and support of our mentor and colleague, Sheila Eyberg. We hope this book does justice to her work. Dr. Eyberg is to be credited for all that shines in PCIT, and we bear full responsibility for all shortcomings of this book.

Morgantown, West Virginia — Cheryl Bodiford McNeil
Mesa, Arizona — Toni L. Hembree-Kigin

Reference

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April, 2, 2008, from www.pcit.org

Contents

Part II Adaptations of Parent-Child Interaction Therapy

Part I
Fundamentals of Parent-Child Interaction Therapy

Chapter 1
Overview of Parent-Child Interaction Therapy

A 3-year-old boy, "Christopher," ran recklessly around the playroom overturning chairs and tables, stopping just long enough to poke a Lincoln Log in his mother's face and yell, "Stupid bitch! I'm gonna kill you! Pottyhead." She had come for help after awakening from a nap to find her young son hovering over her with a kitchen knife. Christopher's mother had a history of being abused by her step-father and was now in a violent relationship with her spouse. Christopher had witnessed many confrontations between his parents including incidents in which his father choked his mother, a vase was thrown and shattered on a wall, and both of his parents shouted obscenities at each other. Christopher was exhibiting serious aggression both at home and toward other children at daycare. His mother felt little self-worth and no sense of control over her life, and she interpreted her son's behavior problems as further evidence of her personal inadequacy.

"Mr. Cheng" was a chemical engineer while his wife worked as a receptionist in a dental practice. They presented with a 5-year-old girl who was bossy, non-compliant, sassy, and disrespectful at home. Mrs. Cheng tearfully reported, "I just don't get what we're doing wrong. Her teacher says she's fine at school, and she behaves for my mom." The parents admitted that they have a tendency to spoil "Sela," giving in to her demands for toys and candy. They reported that when they do say "no" to Sela, she argues, stomps her feet, slams doors, and even spits at them. Sela's behavior had begun to interfere with their social life. The parents stopped bringing her to their friends' homes because they were so embarrassed by the scenes she made. Additionally, Mrs. Cheng stopped volunteering in her class at Chinese School on the weekend because the teacher expressed concern that Sela only threw tantrums when her mother was present.

By age 6, "Antonio" had been involved with both the fire department and the police for vandalism. He was lucky to escape injury when he took a cigarette lighter

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Throughout this book, we present many case examples. All of these case examples are fictional and represent composites of numerous clients we have worked with over our careers. We did not use the real names of any actual clients. Case examples also were carefully chosen such that no identifying information was provided (e.g., actual last names, addresses, specific or unusual medical history). We thank our clients for providing us with a wealth of experience that hopefully helps PCIT come to life for the readers of this book.

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from his home and set a neighbor's discarded Christmas tree on fire. On another occasion, he was brought home in a police car after throwing rocks at a passing minivan. The driver stopped and called police when Antonio refused to give his name or say where he lived. When the police questioned him, he initially insisted that he was from Mars and had no home on earth. Antonio's mother presented as a young, overwhelmed mother working two jobs to support her four children. She often had to leave the younger children in the care of her 13-year-old latch key son. The mother's biggest concern was the fear that Antonio would turn out like his father, who was serving time in prison for theft. She finally sought help after a "really bad week" in which Antonio was caught stealing some money from his teacher's desk and drowned his sister's hamster in the toilet.

These families are representative of the types of clients referred for parent training (please see footnote below describing client confidentiality for this book). A common sentiment expressed by these parents is, "I love my child, but I just don't like him very much." Referred parents often feel incompetent in their parenting role and acknowledge that anger, despair, and depression interfere with their ability to provide nurturance to their young children. The treatment approach described in this volume, Parent-Child Interaction Therapy (PCIT), was designed specifically for families such as these with young children who are experiencing acting-out behavior problems. We view PCIT as a basic framework for treating many of the disruptive behaviors that arise in children aged 3–6 years.

What Is PCIT?

PCIT is an evidence-based behavioral parent training program developed by Dr. Sheila Eyberg that involves working with parents and their young children (ages 3–6). In this approach, the therapist coaches the parent during real-time interactions with the child. Most often, the therapist coaches from behind a one-way mirror, communicating with the parent through a hearing aide type device called a bug-in-the-ear. Parents are coached in two sets of skills. In Child-Directed Interaction (CDI), parents learn to use traditional play therapy skills to enhance the parent-child relationship. The skills of CDI include praising, reflecting, imitating, describing, being enthusiastic, and providing contingent attention. In Parent-Directed Interaction (PDI), parents learn skills for improving child compliance and decreasing disruptive behaviors. PDI skills include giving good commands, praising compliance, using time-out in a chair for non-compliance, and establishing standing house rules. PCIT is a short-term intervention that usually requires approximately 12 one-hour weekly sessions. Although short-term, PCIT is not time-limited. Progression through the treatment program is based on skill mastery (assessed via a standardized coding system) so that treatment length varies across families. PCIT is concluded when the parent masters both the CDI and PDI skills and the child's behavior improves to within normal limits.

Typical Course of Treatment

PCIT always begins with a pre-treatment assessment session in which interview information is gathered on history and presenting problems, questionnaires are given, and the therapist observes (and may videotape) a sample of how the parents and child relate to one another. Feedback regarding assessment results and treatment planning is provided to families either at the end of the pre-treatment assessment session or in a separate "therapy orientation session." The typical course of treatment is described to the family, emphasizing the ways in which PCIT can address the specific concerns that brought them in for treatment and any additional areas of concern that may have emerged from the evaluation.

Treatment begins with CDI. A teaching session is conducted in which the therapist meets only with the parents and teaches them the CDI basics using didactic presentation, discussion, live modeling, and role-playing. Parents are active participants. They are encouraged to generate numerous questions and process how the principles discussed fit with their own parenting philosophies. After the teaching session, the parents and child are seen together for several sessions of CDI skills coaching. The specific number of sessions needed depends on how rapidly parents are able to acquire the skills and the nature of the child's presenting problems, but we find that most families are ready to move on to the discipline stage after approximately four coaching sessions. Pre-determined skill criteria are used to assist the therapist and family in deciding when it is time to move ahead to the discipline component of PCIT.

After mastering the CDI criteria, the caregivers again meet alone with the therapist for a session to learn the basics of the discipline stage of treatment. This PDI teaching session consists of didactic information, discussion, and role-playing. In the sessions that follow, the parents are again seen together with the child for several sessions of direct skills coaching. These sessions begin in the clinic setting and may be extended to community settings (e.g., the grocery store) to enhance cross-setting generalization. Treatment is concluded with a "graduation session" when all of the presenting problems have been resolved or substantially improved. Upon graduation, parents receive a certificate and children receive a prize (e.g., blue ribbon) to acknowledge their successes. We find that most families meet their treatment goals after approximately six discipline sessions.

A post-treatment evaluation session is held in which the measures that were administered before therapy are repeated. At the end of this session, feedback is provided to the family in which pre- to post-treatment improvements are reviewed. This session helps parents to solidify their recognition of improvements that have been occurring gradually over several weeks of treatment. For most families, the full course of treatment can be conducted in approximately twelve sessions (see Table 1.1), and is consistent with the short-term treatment philosophy adhered to by many health maintenance organizations. A booster session is usually scheduled at 3 months but may occur earlier if needed. Additional booster sessions may be scheduled to enhance maintenance of parenting skills and address problems that arise as children face new developmental challenges.

Table 1.1 Steps of parent-child interaction therapy

Step 1:	Pre-treatment assessment of child and family functioning (1–2 sessions)
Step 2:	Teaching Child-Directed Interaction skills (1 session)
Step 3:	Coaching Child-Directed Interaction skills (3–4 sessions)
Step 4:	Teaching Parent-Directed Interaction skills (1 session)
Step 5:	Coaching Parent-Directed Interaction skills (4–6 sessions)
Step 6:	Post-treatment assessment of child and family functioning (1–2 sessions)
Step 7:	Boosters (as needed)

Theoretical and Historical Underpinnings

When Dr. Sheila Eyberg developed PCIT, she drew from her broad background in operant theory, traditional child psychotherapy, and early child development (Eyberg, 1988). The theoretical basis of PCIT lies in Diana Baumrind's work (1966, 1967) regarding parenting styles. In the following excerpt, Sheila Eyberg (n.d.) described the influence of Baumrind's work on the development of PCIT.

> Baumrind demonstrated the importance of parents meeting young children's dual needs for nurturance and for limits, which she described as authoritative parenting. Her research showed that to promote optimal child outcomes, we must focus on promoting optimal parenting styles and parent-child interactions. PCIT draws on both attachment and social learning theories to achieve authoritative parenting. Attachment theory asserts that sensitive and responsive parenting provides the foundation for the child's sense of knowing that he or she will be responded to when necessary. Thus, young children whose parents show greater warmth, responsiveness, and sensitivity to the child's behaviors are more likely to develop a secure sense of their relationships and more effective emotional and behavioral regulation.

Eyberg emphasized that the two aspects of Baumrind's authoritative parenting, nurturance and limit-setting, parallel the two stages of Parent-Child Interaction Therapy (Child-Directed Interaction and Parent-Directed Interaction). Whereas Eyberg drew heavily from attachment theory in conceptualizing the effects of the child-directed phase of the program, she refers to social learning theory, particularly Patterson's coercion theory (1982), when conceptualizing the parent-directed (limit-setting) aspect of PCIT. According to this theory, disruptive child behavior is developed and maintained through parental reinforcement such as providing negative attention and allowing children to escape demands. In the second phase of PCIT, parents are taught to set limits and provide consistent consequences while avoiding escalating, coercive interactions with the child.

Historically speaking, Dr. Eyberg (2004) was heavily influenced by the work of her colleague, Dr. Constance Hanf, who had developed a two-stage operant model for modifying the problematic behavior of multiply handicapped young children (Hanf, 1969). In the first stage of treatment, mothers were taught the technique of differential reinforcement. In other words, they were taught to give their attention to their child's positive behaviors and to ignore negative behaviors. In the second stage, parents were taught to give clear directions, consistently reward compliance with praise, and provide a time-out consequence for non-compliance. Perhaps the most

appealing aspect of Hanf's approach was that she worked with the parent and child together, doing coaching parenting skills on-the-spot. Eyberg is one of several researchers who have developed and evaluated aspects of Hanf's original model (e.g., Barkley, 1987; Forehand & McMahon, 1981; McMahon & Forehand, 2003; Webster-Stratton, Reid, & Hammond, 2004).

Although Hanf's approach produced clear and rapid behavioral change, Eyberg recognized that traditional play therapy also had much to offer these families, with its emphasis on developing a warm and safe therapeutic relationship. She found that just as parents could be taught the operant skill of differential attention, they could be taught the traditional play therapy skills of following the child's lead, providing undivided attention, describing play activities, reflecting and expanding upon child verbalizations, and imitation. PCIT was "born" in 1974 when Sheila Eyberg wrote her first grant examining the effectiveness of the model (Eyberg, 2004).

Eyberg's integration of operant methods and traditional play therapy techniques took place within a solid developmental framework. That is, PCIT is conducted in the context of dyadic play situations largely because "play is the primary medium through which children develop problem-solving skills and work through developmental problems" (Eyberg, 1988, p. 35). A developmental perspective is essential to providing effective PCIT. Many of the problems that arise in parent-child dyads are related to developmental struggles for autonomy or inappropriate developmental expectations held by parents.

Key Features of PCIT

Working with the Parent and Child Together. We believe it is critical that any therapeutic work done with a preschooler directly involves the child's caregivers. Parents have enormous influence over their young children's behavioral and emotional development, and some parenting practices may cause or exacerbate their young children's problems. According to Eyberg (1988, p.35),

> . . .many of the behavioral problems young children present are established through their earliest interactions with their parents. Even in those cases where the child's problems seem to originate because of biological characteristics, such as difficult temperament, or neurological defects suspected in autistic, hyperactive, or developmentally impaired youngsters, many of the problem behaviors seem to be intensified by the interaction patterns between parent and child. (p. 35)

Just as parents may negatively influence their children's behavior and the parent-child relationship, they have enormous power to influence their preschoolers in a positive way. In early childhood, parents are the center of the child's world, providing nurturance, sustenance, safety, and learning opportunities. Preschool-age children are not cognitively sophisticated enough to reason independently, and the influence of peers is minimal. At no other time in childhood or adolescence are parents in a position to influence their children in such a dramatic and pervasive way as they are during the preschool years. In later childhood and adolescence, the influence of parents is overshadowed by the substantial influence of peers, teachers,

romantic partners, and developmental needs for autonomy. The therapist's power to influence a young child in a one-to-one therapeutic relationship pales in comparison to the power of parents to produce change through their interactions with their children.

Sometimes the parents we work with express disappointment that they cannot simply drop off their child for an hour of "magical" therapy with us each week and expect their problems to be resolved. We explain to these parents that what we can do in 1 h of individual child therapy once a week is a mere drop in the bucket in comparison to what we can accomplish if the parent becomes a "therapist" for their child at home, every day of the week. We also help some parents to recognize the economic reality that individual therapy is a very long, expensive proposition, whereas most problems of early childhood can be effectively treated in a relatively short time period using PCIT.

Direct Coaching of Parent-Child Interactions. We believe that the feature of PCIT that makes it so effective is the use of direct coaching of parent-child interactions. In indirect approaches, skills are taught individually to parents, are practiced at home, and then the parents report back any problems they had at the following therapy session. Direct coaching of dyads presents several advantages over the indirect method.

The first advantage of direct coaching is that parental errors can be corrected promptly, before they become well ingrained through a week of home practice. Second, every child presents his or her own unique challenges and the creative clinician can use the direct coaching method to make quick modifications as problems arise, modeling good problem-solving skills for parents. Third, many parents lack the confidence to use the new skills without the initial encouragement and support offered by the therapist-coach. Fourth, because the therapist is able to shape parenting skills by rewarding successive approximations, direct coaching results in faster learning. And fifth, parents are not always accurate reporters of their own or their young children's behavior. Relying on parent report of the skills they use and the child's response can result in inaccurate perceptions of treatment progress.

When explaining the importance of direct coaching to parents, we sometimes use a tennis analogy. We often tell parents:

> Learning new skills is challenging. For example, let's consider tennis. Suppose that you want to improve your tennis skills. Would it make sense to meet once a week with your tennis pro in his office to discuss your tennis game? No, it won't work. The tennis pro needs to watch your strokes and give you immediate feedback on how to hit a better backhand or forehand, and you need to over-practice a particular stroke through drills so that it comes naturally when you're in a real game. It's the same with parenting. It will not do you much good for us to just talk in my office about parenting because I need to see you and your child together in action. Then I can coach you in the use of new skills. When your child throws a Mr. Potato Head at you, whines, spits, disobeys, and tells you to "shut up," I will coach you in exactly what to say and do. You will have the opportunity to over-practice special skills here in the clinic until they become habits. Then, when you are in real-life parenting situations outside of my office, these skills will come naturally.

Direct coaching is both the heart and the art of PCIT. Nearly any beginning therapist can quickly learn the mechanics of conducting PCIT and will be able to

teach the core skills outlined in Chapter 4 and Chapter 6. However, the challenging and creative aspect of this therapy is recognizing the subtle qualities of parent-child interactions that characterize dysfunctional or more adaptive parent-child relationships, and then translating those observations into clinically sensitive and effective coaching strategies. We find that the more we do PCIT, the more we learn about families and the more we add to our coaching repertoires. In Chapter 5 and Chapter 7, we present a vision for how a skilled PCIT clinician might go beyond coaching the standard set of PCIT skills to coaching parents in a range of complex interactions (e.g., recognizing and working at their child's level of development, making use of body language and voice qualities, encouraging child autonomy within developmental norms, supporting self-acceptance and problem-solving efforts, de-escalating tantrums).

Using Data to Guide Treatment. Although PCIT is a manualized program with clear objectives for each session, it is not a cookbook approach. (Bahl, Spaulding, & McNeil, 1999; Greco, Sorrell, & McNeil, 2001; McNeil, Filcheck, Greco, Ware, & Bernard, 2001). The therapy is individualized for each child and family based on data that are gathered each session. Parent-child interactions are coded at the beginning of each session to determine a family's progress toward the pre-established mastery criteria. This information guides the emphasis of coaching in that session. For example, one of the PDI mastery criteria is that 75% of the parent's commands must be "effective" (e.g., direct, positively stated). If during the coding a parent is found to have used a large percentage of indirect commands, the therapist will focus coaching on increasing the use of direct commands. Parents must master the CDI criteria before progressing to the PDI phase of treatment. And, the parents must meet mastery criteria for the PDI skills for therapy to be terminated. Thus, although PCIT is most often a short-term intervention, it is *not* time-limited. The number of sessions may vary widely among families, but each family receives their optimal number of sessions.

Sensitivity to Developmental Concerns. Many young children engage in non-compliant, aggressive, and highly active behavior during the course of normal development. In most children, behavior problems peak at about age 3 and decline during the remaining preschool years. The nature of behavior problems displayed by typical preschoolers is clearly related to the particular developmental hurdles facing the child (Forehand & Wierson, 1993). For example, at ages of 2–3, young children begin seeking independence and autonomy. As they work on these developmental tasks, they are likely to be non-compliant with parents and to have temper tantrums when they do not get their way. Doing things oneself, without parental assistance, is very important to a 3-year-old. This developmental need can precipitate confrontations between the parent and child. Parents who resist allowing the child to pour his or her own juice or who cannot allow their child to wear a favorite summer outfit during the cold of winter may experience the strength of such autonomy needs firsthand.

Rates of child compliance in normally developing children vary as a function of how they are measured, but most preschoolers obey between 50 and 75% of their parents' requests (Schroeder & Gordon, 1991). As preschoolers develop greater

verbal competence, the nature of their non-compliance changes from simple direct defiance to more complex negotiation to avoid or defer compliance (Kinzynski, Kochanska, Radke-Yarrow, & Girnius-Brown, 1987). Excuses for not obeying a parent's request often mirror the excuses children have heard from parents, including: "I can't, I have a headache," "I don't have enough time," "I'm too busy right now," or "I'll do it after I'm done playing."

At ages 4–5, young children are expected to begin learning to play cooperatively with other children and normative behavior problems include aggression, difficulty sharing, and difficulty taking turns. Aggression toward other children declines as preschoolers learn more sophisticated means of solving problems through verbal negotiation and begin to learn to regulate their own emotions. These critical preschool experiences in learning how to interact effectively with peers set the stage for social adjustment in kindergarten and early elementary school.

Throughout PCIT, we educate parents about appropriate developmental expectations. At times we notice that parents seem to have unrealistic expectations for what their child should be able to do (e.g., preschoolers cleaning their own rooms independently). At other times, we find that parents do too much for their young children, hampering the development of age-appropriate self-help skills (e.g., dressing a 4-year-old). A PCIT coach must have a keen sense of each child's developmental capabilities. For example, when coaching PDI, it is important for the therapist to suggest only commands for behaviors that the child is capable of performing. It would be inappropriate to tell a 3-year-old to draw a dragon or to use commands with vocabulary that is above the child's level. By educating parents to use language that their child can comprehend, we teach them to set their children up for success. It is important for parents to understand that all young children act out at times. This helps parents to be more tolerant of common behavior issues that occur during the preschool years (e.g., whining, temper tantrums, occasional biting, bed wetting).

Intervening Early. A common belief is that most problems that occur during the preschool years will be outgrown as the child passes through a difficult developmental phase. This is generally true for children whose behavior and developmental problems fall within normal limits of individual variability. However, there is mounting evidence that serious problems persist, placing these children at risk for adjustment problems in elementary school and beyond (e.g., Campbell & Ewing, 1990; McGee, Partridge, Williams, & Silva, 1991). Although a wide variety of oppositional and aggressive behaviors occur during the course of normal development, very few preschoolers display these behaviors at extreme levels. When behavior problems occur across caregivers and with extreme frequency or intensity, they are unlikely to be transient and, when they occur, are indicative of serious and persistent conduct problems (Farrington, 1995; Lahey et al., 1995; Loeber, 1990). There are some serious conduct problems that are rarely exhibited by preschoolers (e.g., persistent stealing outside the home, using a weapon such as a knife) and these are clearly indicative of a conduct problem that requires intervention (Campbell, 1990, 2002). Other indicators that problems are likely to persist across the preschool years and into elementary school include significant conflict in the

parent-child relationship, ongoing family stress and disruption, and multiple problems of great intensity.

For children with serious conduct problems, intervention during the preschool years is critical. Untreated problems displayed by preschoolers tend to get worse over time, interfering with their development of self-help skills, socialization, and early academic skills. Also, therapy during the preschool years may be more effective than treatments initiated after age 7. There are several possible explanations for this. First, problem behaviors in preschoolers tend to be less well-ingrained than in older children who have longer learning histories. Second, intervening through the parents is much more potent with young children as they do not have many of the competing external influences (e.g., peers, school) experienced by older children. Third, young children have fewer cognitive resources for questioning and challenging behavioral interventions. Compared to older children, preschoolers are more accepting of new behavioral expectations, and less skeptical when parents suddenly begin providing large amounts of positive attention. Finally, very young children with significant conduct problems still exhibit affection toward their parents as well as cooperative behaviors which can be shaped to occur more frequently. After several years of behavior problems without effective intervention, older children display fewer of these positive qualities upon which to build. A strength of PCIT is that it is an early intervention model targeting high-risk children during the critical preschool years.

Targeting a Range of Behavior Problems. PCIT is an early intervention approach that may be applied to a broad range of behavior problems in young children (see Table 1.2). Generally speaking, PCIT is appropriate for young children demonstrating (1) externalizing problems such as non-compliance, defiance, verbal and physical aggression; (2) pre-conduct-disordered behaviors such as cruelty to animals, stealing, lying, and fire-setting; (3) inattention and over-activity; (4) internalizing problems such as sad affect, low self-esteem, and perfectionism; and (5) parent-child relationship problems in the context of divorce and adoption.

Table 1.2 Some presenting problems that may be addressed using PCIT

Non-compliance
Verbal and physical aggression
Over-activity
Cruelty to animals
Stealing
Lying
Fire-setting
Destructive behavior
Perfectionism
Low self-esteem
Sad mood
Bonding in blended families
Post-divorce adjustment
Whining

Specialized Space and Equipment. Standard PCIT is conducted with a particular type of space and equipment. The therapist typically coaches from an observation room through a one-way mirror using a hearing aid device while the family interacts in an adjoining playroom. The playroom should be large enough for at least four people (i.e., therapist, mom, dad, child) to sit comfortably. The room needs to be carefully childproofed, to minimize the potential for danger and the need for limit-setting. The room should not include furniture that can tip over, working sinks, sand tables, artwork, plants, venetian blind cords, computers, uncovered electrical outlets, floor lamps, swivel chairs, or toys that are inappropriate for PCIT (e.g., toy weapons, balls, bobo dolls). The ideal playroom is sparsely furnished, including only a table and chairs, has covered light switches, and contains constructional and creative toys. The playroom is typically linked to an observation room with a one-way mirror (using unbreakable glass), although some facilities without one-way mirrors use video monitoring in which the therapist coaches from another room while viewing a real-time video feed. A third room, ideally adjoining the first two, is used as a time-out back-up room. The perfect time-out back-up room is small (e.g., $5' \times 5'$), can be accessed by both the observation room and the playroom, has two small unbreakable windows in each door (so that both the parent and the therapist can see the child), is lighted and ventilated, contains no furniture or objects of any sort, and does not have electrical outlets or light switches. It is helpful for the playroom, observation room, and time-out back-up room to be constructed with extra sound proofing/insulation out of consideration for other nearby offices. Please see Fig. 1.1 for a sample schematic for how to configure a PCIT clinic.

The playroom must be equipped with a sound system that allows the therapist in the observation room to hear both the parent and child through a speaker. To coach unobtrusively, a behind-the-ear (BTE) receiver and microphone device is used. The best technology available is a small wireless hearing aid worn by the parent. The therapist talks to the parent from the observation room through a microphone and transmitter device. This wireless technology is available through SSL Industries, P.O. Box 3113, Diamond Springs, CA 95619, 530–644-0233, http://www.sslinc.net/pcit.php. The approximate purchase price of two BTE receivers (hearing aids) and a wireless transmitter is US $2400. For more information about the total cost of setting up a PCIT program, see Goldfine, Wagner, Branstetter, and McNeil (2008).

We recognize that many community agencies do not have the resources to begin a PCIT program using the ideal set-up described above. Until resources can be garnered, there are less expensive ways to conduct the therapy. In place of a sophisticated speaker system, we have been successful using a baby monitor to provide sound from the playroom to an observation room. Also, when no observation window or video monitoring is available, it is possible to coach in the playroom with the family (see Chapter 23 for a description of in-room coaching). Walkie talkies connected by a wire to ear buds, wireless telephone head sets, and cell phones with blue tooth technology can be used in lieu of the more expensive but less cumbersome BTE and transmitter devices. Finally, if the ideal time-out back-up room described above cannot be constructed, it is possible to use a different room as a time-out area. This might include a conference room, office, or testing room that the

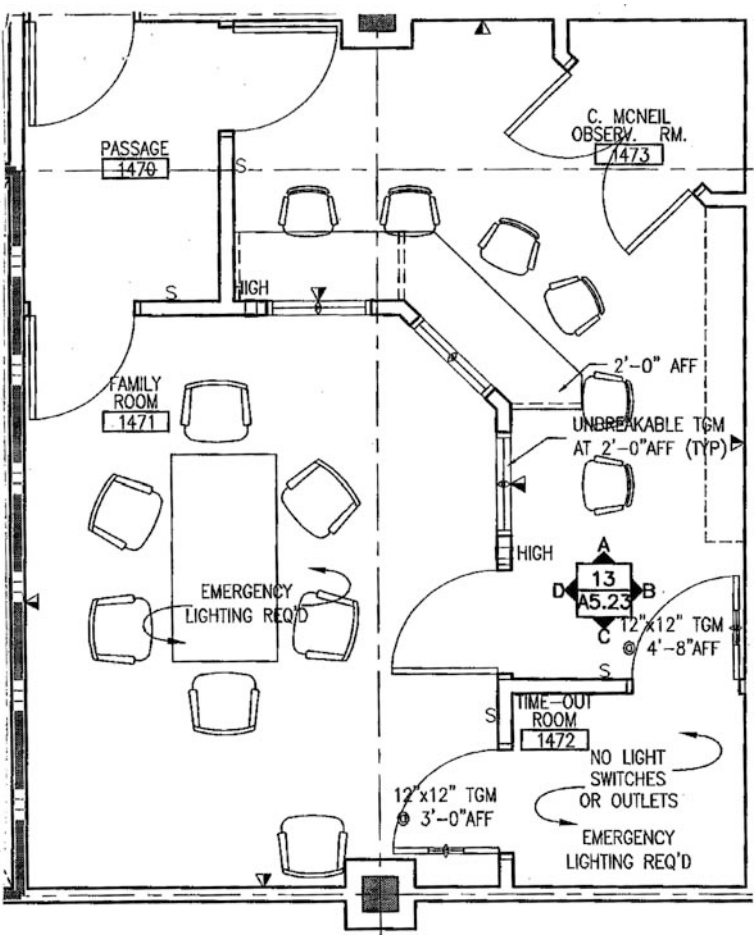

Fig. 1.1 Schematic of a PCIT clinic

therapist childproofs before the session. When seclusion is not permitted or accepted (e.g., in some agencies serving children with histories of abuse and neglect), a back-up room can be constructed using a half-door or Dutch door, allowing the child to be contained without being isolated.

Targeting Patterns of Interaction Rather than Discrete Behaviors. Unlike many behavioral parent training approaches that target discrete behaviors, PCIT focuses on changing broader patterns of interaction. A traditional behavior analytic approach might target one operationalized behavior at a time such as whining. The therapist would conduct a functional assessment to identify and change antecedents, consequences, and setting events that maintain the problem behavior. Treatment plans often involve reinforcing alternative behaviors using tangible reinforcers in a sticker chart type system. These systems work, but can be impractical for addressing the full range of behavior problems in a typical PCIT referral. We have never had a

child referred for PCIT who displays only one or two disruptive behaviors (e.g., a "spitting referral"). More typically, referred children are rated outside normal limits on twenty or more discrete problem behaviors. Imagine having to formulate twenty separate treatment plans for a host of behavior problems including spitting, hitting, whining, arguing, throwing tantrums, cussing, talking back, defying rules, screaming, breaking things, stealing, lying, writing on the walls, putting a slice of cheese in the DVD player, etc. In PCIT, we recognize that these behaviors serve two general functions for our clients. First, children engage in many of these behaviors to access attention and stimulation (e.g., whining to get a reaction from mother). Second, children engage in other misbehaviors to escape parent demands (e.g., arguing to avoid cleaning up). And many times, a particular behavior can simultaneously serve both the functions of getting attention and escaping a demand (e.g., temper tantrum when asked to go to bed). The two phases of PCIT address the two primary functions of misbehavior. In CDI, parents learn to use contingent attention, increasing pro-social behavior with attention and decreasing inappropriate behavior with ignoring. In PDI, we teach parents to provided consistent consequences for non-compliance such that children are not allowed to escape demands. Rather than attempting to modify a series of individual behavior problems, PCIT targets two broader patterns of dysfunctional behavior: negative attention-seeking and non-compliance. By reducing negative attention-seeking and non-compliance, PCIT more efficiently addresses the large number of behavior problems present in preschoolers with externalizing disorders.

Positive, Non-judgmental Philosophy. As PCIT therapists we use the same behavioral principles with parents that we teach parents to use with their children. Just as parents are taught to give their children specific labeled praise, we look for many opportunities in each session to use labeled praise with parents. As a general philosophy, we assume that parents are doing the best they know how and we convey respect for their efforts. We are careful to avoid judging and blaming parents. Instead, we accept them as they are and praise them for what they are doing correctly (e.g., caring enough to get help). Rather than communicating that we believe the parent to be deficient in their skills, we present PCIT as a method of training them to become expert behavior therapists. We avoid referring to our therapy as "parent training" because it implies that it is a remedial treatment for people who are failing as parents. Just like we teach parents to avoid criticism and give positively stated commands to their young children, we provide constructive feedback to parents, telling them what "to do," instead of what "not to do." This positive approach causes parents to feel good about coming to treatment and motivates them to work cooperatively with the therapist (see Chapter 3).

Using the Second Edition

This book is divided into two parts. Part one presents the fundamentals of PCIT as developed and practiced by Sheila Eyberg at the University of Florida. Dr. Eyberg (1999) has written a treatment manual that is composed of

session-by-session integrity checklists and other session materials. We strongly recommend that therapists wishing to conduct PCIT obtain and use Dr. Eyberg's manual. At present, it is available to be downloaded from Dr. Eyberg's website (www.pcit.org). Eyberg's treatment manual will be updated regularly. Therapists are expected to obtain and use the most recent version of the treatment manual. When discrepancies exist between the Eyberg treatment manual and this text, therapists should follow Dr. Eyberg's treatment integrity checklists. We recommend that therapists bring the treatment integrity checklists to each PCIT session, using them as an outline to insure adherence to all aspects of the protocol. Part One of our *Second Edition* provides a rich clinical description of how to implement the procedures outlined in Dr. Eyberg's integrity checklists. Part Two of our text, presents exciting, cutting-edge developments in the application of PCIT to special populations and settings. This section of the book includes advancements and exploratory work that has been conducted since the original text was published in 1995. In the last 14 years, the scope of PCIT has widened dramatically. PCIT was initially developed as a clinic-based program for disruptive 3-to 6-year-olds. Since the publication of our first PCIT book, PCIT is now being conducted in schools, group homes, shelters, private homes, and in mobile units. It is no longer conducted only with preschoolers, but has been used as a prevention model for infants and toddlers as well as an intervention for older elementary school-age children. Disruptive behaviors are not the only presenting problems now targeted by PCIT. It is now considered one of only two evidence-based interventions for physically abusive parents and has been disseminated widely by the National Child Traumatic Stress Network as an intervention for children with a history of trauma. Exciting work has been done demonstrating the potential for PCIT as an intervention for children with separation problems and other anxiety issues. And, PCIT is now being conducted with children who have ADHD, as well as those with developmental disorders, such as Mental Retardation and high-functioning Autism. Whereas we previously knew little about the cultural sensitivity of PCIT, recent trials have suggested that it is an acceptable intervention for U.S. children of Hispanic, Native American, and African-American backgrounds. The international community has shown interest in PCIT with programs now established in Europe, Asia, and Australia. It is our hope that this *Second Edition* will assist clinicians to conduct the standard, evidence-based PCIT with integrity, as well as inspire them to explore ways to make PCIT work with the variety of complex clinical scenarios therapists confront in their practices.

References

Bahl, A. B., Spaulding, S. A., & McNeil, C. B. (1999). Treatment of noncompliance using parent-child interaction therapy: A data-driven approach. *Education and Treatment of Children*, *22*, 146–156.

Barkley, R. A. (1987). *Defiant children: A clinician's manual for parent training*. New York: Guilford.

Baumrind, D. (1966). Effects of authoritative parental control on child behavior. *Child Development*, *37*(4), 887–907.

Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs*, *75*(1), 43–88.

Campbell, S. B. (1990). *Behavior problems in preschool children*. New York: Guilford Press.

Campbell, S. B. (2002). *Behavior problems in preschoolers: Clinical and developmental issues*. New York, NY: Guilford Press.

Campbell, S. B., & Ewing, L. J. (1990). Follow-up of hard to manage preschoolers: Adjustment at age 9 and predictors of continuing symptoms. *Journal of Child Psychology and Psychiatry*, *31*, 871–889.

Eyberg, S. M. (n.d.). *Theoretical underpinnings of PCIT*. Retrieved April 3, 2008, from http://www.pcit.org

Eyberg, S. M. (1988). Parent-child interaction therapy: Integration of traditional and behavioral concerns. *Child & Family Behavior Therapy*, *10*, 33–46.

Eyberg, S. M. (1999). *Parent-Child Interaction Therapy: Integrity Checklists and Session Materials*. Retrieved April, 2, 2008, from www.pcit.org

Eyberg, S. M. (2004). The PCIT story (part 1): Conceptual foundations of PCIT. *PCIT Pages: The Parent-Child Interaction Therapy Newsletter*, *1*, 1–2.

Farrington, D. P. (1995). The development of offending and antisocial behavior from childhood: Key findings from the Cambridge study in delinquent development. *Journal of Child Psychology and Psychiatry*, *36*, 929–964.

Forehand, R. L., & McMahon, R. J. (1981). *Helping the noncompliant child: A clinician's manual to guide parent training*. New York: Guilford Press.

Forehand, R. L., & Wierson, M. (1993). The role of developmental factors in planning behavioral interventions for children: Disruptive behavior as an example. *Behavior Therapy*, *24*, 117–141.

Goldfine, M. E., Wagner, S. M., Branstetter, S. A., & McNeil, C. B. (2008). Parent-child interaction therapy: An examination of cost-effectiveness. *Journal of Early and Intensive Behavioral Interventions*, *5*, 119–141.

Greco, L. A., Sorrell, J. T., & McNeil, C. B. (2001). Understanding manual-based behavior therapy: Some theoretical foundations for parent-child interaction therapy. *Child and Family Behavior Therapy*, *23*, 21–36.

Hanf, C. A. (1969). *A two-stage program for modifying maternal controlling during mother–child (M–C) interaction*. Paper presented at the meeting of the Western Psychological Association, Vancouver, Canada.

Kinzynski, L., Kochanska, G., Radke-Yarrow, M., & Girnius-Brown, O. (1987). A developmental interruption of young children's noncompliance. *Developmental Psychology*, *23*, 799–806.

Lahey, B. B., Loeber, R., Hart, E. L., Frick, P. J., Applegate, B., Zhang, Q., et al. (1995). Four-year longitudinal study of conduct disorder in boys: Patterns and predictors of persistence. *Journal of Abnormal Psychology*, *104*, 83–93.

Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. *Clinical Psychology Review*, *10*, 1–41.

McGee, R., Partridge, F., Williams, S., & Silva, P. A. (1991). A twelve-year follow-up of preschool hyperactive children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *30*, 224–232.

McMahon, R. J., & Forehand, R. (2003). *Helping the noncompliant child: Family-based treatment for oppositional behavior* (2nd ed.). New York: Guilford Press.

McNeil, C. B., Filcheck, H. A., Greco, L. A., Ware, L. M., & Bernard, R. S. (2001). Parent-child interaction therapy: Can a manualized treatment be functional? *The Behavior Analyst Today*, *2*, 106–114.

Patterson, G. R. (1982). *Coercive family process*. Eugene, OR: Castalia Publishing Company.

Schroeder, C. S., & Gordon, B. N. (1991). *Assessment and treatment of childhood problems*. New York: Guilford.

Webster-Stratton, C., Reid, J. M., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. *Journal of Clinical Child and Adolescent Psychology. 33*, 105–124.

Chapter 2
Research on PCIT

Stephanie Wagner

Early PCIT Research

Establishing an evidence-based treatment often involves single-subject studies, program evaluations, and randomized controlled trials. However, after research demonstrates the efficacy of a particular treatment through these methods, there are many additional areas to investigate before the intervention is disseminated and widely employed. PCIT, like other evidence-based interventions, has been developed in a similar way, beginning with early research demonstrating changes in disruptive behavior at post-treatment in comparison to waitlist children (e.g., McNeil, Capage, Bahl, & Blanc, 1999; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). In addition to demonstrating efficacy, this research suggested additional benefits such as generalization to other settings (e.g., school) (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and other individuals (e.g., untreated siblings) (Brestan, Eyberg, Boggs, & Algina, 1997). Furthermore, many of these beneficial results observed immediately after treatment were found to be maintained 1–6 years following PCIT (Boggs et al., 2004; Eyberg et al., 2001; Hood & Eyberg, 2003).

Herschell, Calzada, Eyberg, and McNeil (2002) reviewed the research on PCIT and offered suggestions for furthering the literature. Research was grouped into different categories including effectiveness, diagnostic variables, cultural variables, therapist variables, delivery of treatment, maintenance, and dissemination. The current review utilizes a similar organization to highlight progress in different lines of recent PCIT clinical research and also offers suggestions for future research endeavors. The goal of this chapter is to provide an update on PCIT research; and therefore, does not include a comprehensive review of the early PCIT literature.

Recent Research Initiatives

Diagnostic Groups. Since the review conducted by Herschell and colleagues (2002), examining the effects of PCIT with new diagnostic groups has received considerable

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empirical focus. At the time of the review, Herschell and colleagues emphasized that the theoretical principles underlying PCIT apply to many different childhood disorders; however, limited literature existed on PCIT with diagnostic groups other than disruptive behavior disorders. Further work has been conducted on the use of PCIT with internalizing populations. In particular, Choate, Pincus, Eyberg, and Barlow (2005) examined standard PCIT in three children who met criteria for Separation Anxiety Disorder (SAD) and found that these children did not meet diagnostic criteria for SAD following treatment. Other research suggests that PCIT benefits both internalizing and externalizing symptoms in children with co-morbid SAD and Oppositional Defiant Disorder (ODD) (Chase & Eyberg, 2008).

The principles underlying PCIT also conceptually apply to families of children with developmental disabilities such as mental retardation and autism (Masse, McNeil, Wagner, & Chorney, 2008; McDiarmid & Bagner, 2005). Therefore, researchers have tested this intervention with children who are developmentally and cognitively delayed. Bagner and Eyberg (2007) randomly assigned children with mental retardation to PCIT or a waitlist control group and detected improvements in child disruptive behavior and parenting skills in the PCIT group. Furthermore, a recently completed study by Josh Masse and Cheryl McNeil at West Virginia University demonstrated the efficacy of PCIT for improving compliance in children with autism (Masse, McNeil, & Wagner, 2009).

Children with chronic illness or medical problems represent another population that has received limited focus in the PCIT literature. Bagner, Fernandez, and Eyberg (2004) reported positive child and parent behavioral change in a case study of a young child with cancer and ODD. PCIT was tailored slightly in this case so that the parents received help providing positive reinforcement for adaptive medical behaviors. Further research is needed to better understand the effectiveness of PCIT in pediatric settings for children with various medical conditions.

Cultural Groups. Additional research has specifically looked at PCIT outcomes with different cultural groups to help understand how to maximize treatment efficacy while maintaining cultural sensitivity (Butler & Eyberg, 2006). Borrego, Anhalt, Terao, Vargas, and Urquiza (2006) translated PCIT materials into Spanish and documented a successful case involving a Mexican family. Similar positive findings were found in a study translating, implementing, and evaluating PCIT in Puerto Rico (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006) and in a modified version of PCIT for Mexican-American families termed Guiding Active Children (GANA Program; McCabe, Yeh, Garland, Lau, & Chavez, 2005). Based on these preliminary findings, it appears that many treatment components are acceptable to a range of parents and that this intervention may be efficacious with different Hispanic cultural groups.

Another culture that has been qualitatively and quantitatively studied in PCIT research is Chinese families in Hong Kong (Tsang, Leung, Chan, & Choi, 2007). Study findings indicated that PCIT led to significant decreases in child disruptive behavior and increases in effective parenting skills in Chinese families of children with behavior problems. Generally, these families were accepting treatment, although some skills such as praise may be less congruent with parenting practices in Hong Kong.

The research and utilization of PCIT in Hispanic and Chinese cultures suggest that it is a promising intervention for families located in many different regions and with various cultural backgrounds. However, it is likely that PCIT will need to be tailored slightly for widespread use with these cultures (See Chapter 19 and 24). For example, both Hispanic and Chinese cultures may benefit from systematic efforts by PCIT therapists to involve extended family members in treatment (i.e., Matos et al., 2006; Tsang et al., 2007).

Other Parent Characteristics. Early PCIT research often examined parent and child behavior changes after treating the *mother*–child dyad, which is consistent with methods commonly employed in the behavioral parent training literature (Tiano & McNeil, 2005). However, there is increased recognition of the need to include other individuals, particularly fathers, in research and clinical practice (Tiano & McNeil). PCIT researchers have attempted to extend research findings to other parental characteristics by investigating not only fathers, but physically abusive parents, parents who have experienced intimate partner violence (IPV), and foster parents.

An examination of family composition in several PCIT treatment outcome studies found different effects in families with involved fathers, uninvolved fathers, and absent fathers (Bagner & Eyberg, 2003). Although these researchers did not find many group differences at post-treatment, children in families with an involved father exhibited greater maintenance of treatment gains compared to other families. This study highlights the importance of engaging fathers in PCIT and conducting further work on treatment outcome and maintenance with involved fathers.

Recently, many PCIT researchers have been interested in utilizing this intervention with abusive parents. Since Urquiza and McNeil (1996) discussed how the principles underlying PCIT and the format of the intervention could apply to maltreating parents, empirical research has confirmed the usefulness of treatment in this population. For instance, Chaffin et al. (2004) compared standard PCIT, enhanced PCIT, and standard parenting program in groups of physically abusive parents. Results demonstrated that there were fewer drop-outs in the PCIT groups and that standard PCIT significantly reduced the reoccurrence of physical abuse in comparison to the other groups (Chaffin et al.). Also, Timmer, Urquiza, Zebell, and McGrath (2005) compared PCIT outcomes in families with and without maltreating caregivers, finding that PCIT decreased child behavior problems, parenting stress, and risk for abuse in families in both groups.

A characteristic of many abusive families is the presence of IPV. Children exposed to IPV often have internalizing and externalizing behaviors as well as problems in the bond with their parent (See Chapter 13). Therefore, theoretically, PCIT will likely be an efficacious intervention for children exposed to IPV (see Borrego, Gutow, Reicher, & Barker, 2008). To date, controlled research has not been used to directly address PCIT's effects with this population, however, a published case study demonstrated success following PCIT (Pearl, 2008) and research is underway at West Virginia University comparing PCIT versus treatment as usual (Foley & McNeil, 2009).

In addition to examining the effects of PCIT on maltreating caregivers and children exposed to IPV, research has also focused on maltreated children in foster care (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005). Several researchers have published successful cases of PCIT with children placed in foster care (Fricker, Ruggiero, & Smith, 2003; Timmer, Urquiza, Herschell, et al., 2006). Also, Timmer, Urquiza, and Zebell (2006) conducted a more rigorous test of PCIT with foster families by comparing the effects of PCIT in foster parents and non-abusive biological parents with findings suggesting that the treatment is equally effective for the two groups.

Therapist Characteristics and Behavior. Compared to other areas of treatment development and investigation, less PCIT literature exists on therapist behaviors that enhance or hinder outcome. However, specific research on the interaction between the therapist and the client or therapy-process variables is imperative. Research has established that therapy-process variables are important for successful completion and outcome following intervention for child psychopathology (e.g., Kazdin, Holland, & Crowley, 1997; Shirk & Karver, 2003).

Harwood and Eyberg (2004) examined the relation between therapist behavior early in PCIT and treatment completion, which was defined as meeting the PCIT mastery criteria. These researchers found that therapist verbalizations (e.g., therapist support, questioning, and facilitation) during the assessment and first CDI coaching session predicted treatment drop-out. These findings are consistent with other research showing the importance of using skills to engage clients (Herschell, Capage, Bahl, & McNeil, 2008); however, more research on therapist–client interaction in PCIT is warranted to better understand the effects of therapeutic alliance on adherence and outcome.

Intervention Format. Considerable advances have been made in the area of the PCIT format including research on age range, group treatment, number of sessions, location of intervention (i.e., home-based services and classroom), and intensity of intervention. Although these innovations are still in the preliminary stages of design, implementation, and research, they may be promising adaptations that promote widespread use in a variety of contexts, while at the same time preserving many core components of treatment.

Parent-Child Attunement Therapy (PCAT) employs many behavioral techniques utilized in PCIT but was specifically designed to address needs and concerns of younger children (ages 12–30 months) (Dombrowski, Timmer, Blacker, & Urquiza, 2005). Differences between PCAT and PCIT include: (1) PCAT places a greater emphasis on physical praise (hugs) and enthusiasm, (2) PCAT does not include a phase comparable to PDI, and (3) PCAT is typically conducted in shorter sessions. Dombrowski and colleagues reported successful treatment with a mother and her 23-month-old child. Just as PCAT has been developed for younger children, there also have been attempts to extend PCIT's age range to older children (Chaffin et al., 2004). See Chapter 9 and 10 for information regarding the adaptation of PCIT for children outside of the 2–7 age range.

Other research has examined more subtle changes to traditional PCIT. In particular, Nixon, Sweeney, Erickson, and Touyz (2003) developed an abbreviated version

of PCIT that incorporated didactic videotapes and telephone consultation. A comparison of standard PCIT, the abbreviated version which consisted of five sessions and five consultations, and a waitlist comparison group demonstrated that both treatment groups significantly improved and maintained behavioral change. Although this change appears relatively minor, the abbreviated format did not contain criteria for mastery, which is a critical feature of PCIT. Creativity in adapting traditional PCIT may be necessary in order to incorporate key components in altered versions, such as abbreviated treatment.

Another format variation that also faces the problem of integrating mastery criteria into the treatment is an intensive, brief PCIT workshop. Although both standard and abbreviated PCIT have clinical utility in treating children referred for disruptive behavior disorders, providing less intensive services may be an appropriate and sufficient method of prevention. McNeil et al. (2005) reported findings from a 2-day workshop that incorporated many of the core elements of PCIT with the exception of skill mastery (i.e., didactic and coaching). Findings indicated that foster parents were satisfied with the intervention and reported significant positive changes in child disruptive behavior following the workshop. Additional treatment adaptations and subsequent research would inform researchers and policy-makers as to whether PCIT can be an effective and efficient prevention program for populations of children at risk for developing behavior problems. Given the current structure of PCIT, which involves considerable time for families to learn and demonstrate skills, this treatment may not be well suited for prevention. However, it is possible that with changes that preserve core components (i.e., coaching, feedback, data-driven progression), PCIT in a shorter format has the potential of being an effective method of prevention.

Another exciting PCIT adaptation involves developing protocols for group treatment. Group treatment has several advantages over individual treatment including being more efficient and cost-effective to implement and providing the opportunity of increased social support (Niec, Hemme, Yopp, & Brestan, 2005). However, the coaching and mastery criteria in PCIT pose unique challenges to providing this treatment in group format (Niec et al.). Investigators interested in group treatment are still devising and empirically testing different mastery requirements.

Given the efficacy of PCIT in traditional clinic settings, research has begun to test the effects of PCIT conducted in other settings. Settings such as the home or schools may help reduce some common barriers to treatment such as transportation or availability (Ware, McNeil, Masse, & Stevens, 2008). Ware and colleagues examined the effects of PCIT provided in the home on parenting behavior and child behavior problems. Although study results suggest that home-based PCIT is efficacious, unique challenges are present in home-based interventions often stemming from the lack of environmental control (Masse & McNeil, 2008).

A version of PCIT has been designed for school settings termed Teacher–Child Interaction Therapy (TCIT). A case study demonstrated that teachers increased the frequency of positive skills utilized as well as decreased child disruptive behaviors and increased child compliance following TCIT (McIntosh, Rizza, & Bliss, 2000). Additionally, comparison of head start classrooms receiving training in TCIT

skills and comparison classrooms indicated that TCIT- trained teachers utilized the skills and child disruptive behaviors decreased (Tiano & McNeil, 2006). Budd et al. (2007) employed a multiple baseline design to examine the effectiveness of TCIT in a low-income, ethnically diverse daycare, finding some improvements in the majority of teachers' behavior immediately following treatment. However, these gains diminished at a 4-month follow-up. Therefore, classroom-modified versions of PCIT likely need refinement to enhance treatment outcome and maintenance.

Attrition. Drop-out from psychotherapy is a serious problem when working with many populations and utilizing a variety of therapies (Wierzbicki & Pekarik, 1993). Parent training interventions are also subject to high rates of attrition (e.g., Kazdin, Mazurick, & Siegel, 1994; Prinz & Miller, 1994). Early termination of treatment is a concern in PCIT and research documents attrition rates ranging from 0–53% (Gallagher, 2003). Attrition is particularly concerning given that families who terminate early do not improve over time from their pre-treatment level of functioning (Boggs et al., 2004). Therefore, recent work has been conducted to identify variables predictive of drop-out (Werba, Eyberg, Boggs, & Algina, 2006). Werba and colleagues found that waitlist status predicts drop-out prior to starting treatment and that parenting stress and inappropriate parenting behaviors (parental sarcasm and criticism) predict drop-out in families who have begun PCIT. Although drop-out from waitlists has implications for clinical research, understanding drop-out in families who have begun treatment has enormous applied value. In particular, even though Werba and colleagues were able to identify several variables predicting drop-out, many factors contributing to early termination of PCIT remain unclear. Additionally, Chaffin and colleagues have been examining the effectiveness of a motivational enhancement add-on for decreasing attrition with clients with a history of child maltreatment (Chaffin et al., 2009).

Effectiveness/Dissemination Research. A major challenge for treatment outcome researchers, including PCIT researchers, is to replicate findings observed in university clinics in community settings. Many hurdles need to be overcome when attempting to transport an evidence-based treatment, including therapist motivation, training, and caseloads, as well as agency and community resources (Franco, Soler, & McBride, 2005; Sukumar, Johnson, McNeil, Brooks, & Manteuffel, 2008). Maintaining and measuring treatment integrity and fidelity is another challenge in community settings (Franco et al.). However, despite these obstacles, effectively disseminating PCIT has the potential to help more families and prevent future disruptive behavior problems in young children. Pade, Taube, Aalborg, and Reiser (2006) implemented a modified version of PCIT in a community setting, finding positive short-term and long-term treatment effects. However, the majority of families enrolled in the study utilized other interventions between the time that they completed PCIT and when they were contacted for follow-up (Pade et al.). Therefore, it is unclear whether functioning measured at follow-up occurred as a result of PCIT or another intervention. More work is needed to address implementation issues and investigate short- and long-term effectiveness in community settings.

Training. Successful dissemination cannot occur in the absence of training competent PCIT therapists. There is a paucity of research on training PCIT clinicians; however, findings indicate that neither solely reading the PCIT manual nor attending a 2-day didactic training workshop is sufficient preparation to facilitate therapist mastery of the PCIT skills (Herschell et al., 2009). Current recommendations set forth by the PCIT National Advisory Board include 40 h of initial training with advanced training and supervision (Herschell & McNeil, 2007; See Chapter 25). However, more research on training is warranted to develop efficient and effective training methods.

Cost-Effectiveness. Evaluating the cost-benefits and cost-effectiveness of specific interventions is imperative in order to convincingly argue for widespread treatment dissemination. Given the efficacy and new developments in PCIT, it is not surprising that several cost-effectiveness analyses have been conducted (i.e., Aos, Lieb, Mayfield, Miller, & Pennucci, 2004; Goldfine, Wagner, Branstetter, & McNeil, 2008; Krivelyova, Sukumar, Stephens, & Freeman, 2007). These examinations calculated similar cost of treatment per child; specifically costs ranged from $1,025 to $1,296 (Aos et al., Goldfine et al.). Furthermore, Krivelyova and colleagues found that the cost of PCIT was $600 less per child than providing services as usual in a system of care program. These costs are all substantially less than the cost to society for persistent disruptive behavior throughout life and the incarceration of individuals whose problems progress into Antisocial Personality Disorder (Goldfine et al.). These favorable monetary results are certainly promising; however, additional cost examinations are warranted.

Suggestions for Future Research

In recent years, many exciting areas have been investigated in PCIT expanding the knowledge in regard to what types of clients benefit from PCIT and how the treatment can be packaged and delivered. Questions regarding what obstacles hinder treatment dissemination and whether the treatment is cost-effective have been posed by investigators. Research is beginning to provide insight into some of these inquiries. Specifically, findings suggest that this treatment is beneficial for many young children including children with a variety of concerns and problems such as mental retardation, developmental disorders, internalizing problems, and chronic illness. Studies also suggest that the treatment is appropriate for families with different cultural backgrounds and parents who are physically abusive. Research has shown support for treatment delivered in an abbreviated format, a workshop format, in classroom settings, and in the home environment. Additionally, the cost of treatment is quite low in comparison to the cost of untreated disruptive behavior disorders that persists throughout life and result in criminal behavior.

Despite these advances in PCIT research, there are many additional questions in need of investigation. Furthering the evidence base with regard to training and dissemination has the potential to benefit many families. However, current models

of training and dissemination are time-intensive and do not result in the same effects in the community as are obtained in university clinics. Therefore, it is evident that more work needs to be done to promote the widespread use and effectiveness of PCIT.

In order to disseminate successfully, additional research is necessary in many of the areas highlighted in this review (e.g., diagnostic, cultural groups, format, and training of clinicians). For instance, clearly specifying which diagnostic, cultural, and age groups the intervention works for helps clinicians select the most appropriate intervention for individual clients. It is likely that PCIT will not be the optimal intervention with certain populations (e.g., teenagers); more research is needed to guide clinical decisions on which families are likely to benefit from treatment.

Although there is a necessity for further research on PCIT with different groups, conducting format and training research is also of utmost importance. This research has the potential to both enhance community effectiveness and maximize cost-effectiveness. Therefore, this area of scientific inquiry is of particular interest to policy-makers.

One format option warranting further empirical scrutiny is the efficacy of in-room coaching. Traditional PCIT utilizes coaching from behind a one-way mirror with bug-in-the ear technology. However, this equipment and costs to modify the structure of a therapy room are fairly expensive (with rough estimates of $14,000 to start-up PCIT) with the bulk of these costs consisting of technology and therapist training (Goldfine et al., in press). Due to the high price tag, standard coaching may not be feasible in the real world (e.g., Sukumar et al., 2008). Although some research suggests in-room coaching results in favorable outcomes (Rayfield & Sobel, 2000; Ware, McNeil, Masse, & Stevens, 2008), there is limited research comparing the two formats.

In addition to evaluating in-room coaching, there is a need for research on the length of PCIT. Specifically, several abbreviated or shortened adaptations of PCIT (e.g., Franco et al., 2005; Nixon et al., 2003) appear promising. However, many of these adaptations do not contain one of the integral components of PCIT, which is data-driven progress through treatment. More research is needed examining whether data-driven progression through treatment can be adapted for shortened formats and whether these formats have similar outcomes and adherence.

Another area lacking in research that has implications for treatment length and cost-effectiveness is component research. The need to evaluate individual components is most obvious in treatments that include many different elements (e.g., school interventions, parent training, social skills training, medication, and problem-solving training) that are often referred to as "kitchen-sink treatments" (Hoza, Kaiser, & Hurt, 2007). Although PCIT is not considered a multimodal treatment, the therapy does utilize many skills, some of which have not been subject to scientific scrutiny. Early PCIT research examined the order of treatment phases by comparing CDI-first and PDI first (Eisenstadt [Hembree-Kigin], Eyberg, McNeil, Newcomb, & Funderburk, 1993) and methods of training children to stay in time-out (McNeil, Clemens-Mowrer, Gurwitch, & Funderburk, 1994). Recent examination of change during CDI demonstrated that significant positive changes in parenting stress, parenting practices, and the child's disruptive

behavior occur during this relationship-enhancing phase of treatment (Harwood & Eyberg, 2006). However, some of the skills taught in PCIT are based largely on theory and clinical observations such as parental use of reflections and behavioral descriptions. Currently, ongoing projects are experimentally examining the effects of these components. Obtaining empirical evidence on the utility of individual skills will aid researchers in attempts to maximize efficacy and cost-effectiveness of PCIT.

Even though discovering how to maximize costs and benefits by researching different formats and adaptations is a necessary step to successful dissemination, therapist training also is a critical element in widespread use of PCIT. Therapist training also significantly contributes to PCIT start-up costs (Goldfine et al., in press). Currently, there is much debate regarding training, yet little evidence to guide decisions about training requirements. The research that does exist and requirements of different trainers suggest that intensive training incorporating didactic and experiential components with follow-up supervision is necessary (Herschell et al., 2009). However, more research is warranted comparing different training formats. For instance, it is possible that combining education on the behavioral principles underlying PCIT with technical training on the PCIT manual would enhance clinicians' understanding and mastery of PCIT. Given the concerns and controversies surrounding treatment manuals, this represents a relevant area to pursue scientifically.

Research in these areas is necessary to determine what treatment elements are mandatory for positive and clinically significant outcomes. Development in these areas could be used in a "bare-bones" empirically supported version of PCIT (Goldfine et al., 2008), which could be useful for community agencies with limited budgets. Increasing efficiency and reducing cost are key steps in bridging the gap between research and clinical practice.

Additionally, there is a need for researchers to think "outside of the box" to design and test models of delivery. For instance, some researchers have incorporated athletic training and sports skills in behavior parent training in attempts to engage fathers (e.g., COACHES; Fabiano, 2007). Developing novel formats may also enhance widespread PCIT prevention programs. Specifically, the Triple P Positive Parenting Program utilizes different levels of intervention depending on family needs with the lowest level of intervention implemented at a population-level through the media (e.g., mailings, articles about positive parenting, popular television shows about parenting, radio advertisements) (Prinz & Sanders, 2007). Utilizing the media as a tool in PCIT dissemination may aid prevention and intervention efforts.

Lastly, novel delivery methods may help enhance cost-effectiveness and reduce attrition. It is plausible that the once-a-week session schedule is not flexible enough for both clients and treatment providers. Urban environments may be able to capitalize on this need by offering PCIT walk-in clinics. For instance, treatment centers could offer different sessions (CDI didactic, PDI didactic, CDI coaching, etc.) at several different days and times during the week. Additionally, attrition may be reduced by adding incentives for parents and children to attend sessions (e.g., gift certificates, toys). This would enable families to pick the time that works for their

schedule based on what session they needed to attend. A method of tracking family progress such as providing certificates of session completion and mastery requirements would preserve key features while allowing this increased flexibility. Another potential advantage to this approach is that therapists could serve a greater number of clients and would not suffer from costs associated with families who do not attend scheduled appointments.

These research suggestions do not fully encompass every area in which PCIT research can be furthered, and these suggestions also do not guarantee solutions to problems of dissemination and drop-out. However, the ideas presented are intended to spur interest, discussion, and research. Since PCIT was developed in the 1970 s, this intervention has been empirically validated, extended to many new populations, and adapted to better fit unique needs (e.g., TCIT in school settings). All of these findings suggest that PCIT has general utility. Therefore, the expansion of PCIT is as limitless as the innovation and creativity of clinicians and researchers.

References

Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth*. Olympia: Washington State Institute for Public Policy.

Bagner, D. M., & Eyberg, S. M. (2003). Father involvement in parent training: When does it matter? *Journal of Clinical Child and Adolescent Psychology*, *32*, 599–605.

Bagner, D. M., & Eyberg, S. M. (2007). Parent-child interaction therapy for disruptive behavior in children with mental retardation: A randomized controlled trial. *Journal of Clinical Child and Adolescent Psychology*, *36*, 418–429.

Bagner, D. M., Fernandez, M. A., & Eyberg, S. M. (2004). Parent-child interaction therapy and chronic illness: A case study. *Journal of Clinical Psychology in Medical Settings*, *11*, 1–6.

Boggs, S. R., Eyberg, S. M., Edwards, D., Rayfield, A., Jacobs, J., Bagner, D., et al. (2004). Outcomes of parent-child interaction therapy: A comparison of dropouts and treatment completers 1–3 years after treatment. *Child and Family Behavior Therapy*, *26*, 1–22.

Borrego, J., Anhalt, K., Terao, S. Y., Vargas, E. C., & Urquiza, A. J. (2006). Parent-child interaction therapy with a Spanish-speaking family. *Cognitive and Behavioral Practice*, *13*, 121–133.

Borrego, J., Jr., Gutow, M. R., Reicher, S., & Barker, C. H. (2008). Parent-child interaction therapy with domestic violence populations. *Journal of Family Violence*, *23*, 495–505.

Brestan, E. V., Eyberg, S. M., Boggs, S. R., & Algina, J. (1997). Parent-child interaction therapy: Parents' perceptions of untreated siblings. *Child and Family Behavior Therapy*, *19*, 13–28.

Budd, K. S., Gershenson, R., Lyon, A., Farahmand, F., Behling, S., Thaxler, P., et al. (2007, September). *Effectiveness of group TCIT: Adapting PCIT to an urban daycare for ethnic minority children*. Paper presented at the 7th National Parent-Child Interaction Therapy Conference, Oklahoma City, OK.

Butler, A. M., & Eyberg, S. M. (2006). Parent-child interaction therapy and ethnic minority children. *Vulnerable Children and Youth Studies*, *1*, 246–255.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*, 500–510.

Chaffin, M., Valle, L. A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., et al. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment*, 1–13.

Chase, R. M., & Eyberg, S. M. (2008). Clinical presentation and treatment outcome for children with comorbid externalizing and internalizing symptoms. *Journal of Anxiety Disorders*, *22*, 273–282.

Choate, M.L., Pincus, D.B., Eyberg, S.M., Barlow, D.H. (2005). Parent-child interaction therapy for treatment of separation anxiety disorder in young children: A pilot study. *Cognitive and Behavioral Practice*, *12*, 126–135.

Dombrowski, S. C., Timmer, S. G., Blacker, D. M., & Urquiza, A. J. (2005). A positive behavioural intervention for toddlers: Parent-child attunement therapy. *Child Abuse Review*, *14*, 132–151.

Eisenstadt [Hembree-Kigin], T. H., Eyberg, S. M., McNeil, C. B., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem child: Relative effectiveness of two stages and overall treatment outcome. *Journal of Clinical Child Psychology*, *22*, 42–51.

Eyberg, S. M., Funderburk, B. W., Hembree-Kigin, T. L., McNeil, C. B., Querido, J. G., & Hood, K. K. (2001). Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family. *Child and Family Behavior Therapy*, *23*, 1–20.

Fabiano, G. A. (2007). Father participation in behavioral parent training for ADHD: Review and recommendations for increasing inclusion and engagement. *Journal of Family Psychology*, *21*, 683–693.

Foley, K., & McNeil, C. B. (2009). *Parent-child interaction therapy versus treatment as usual for child physical abuse and neglect: The impact on recidivisim and intimate partner violence*. Manuscript in preparation.

Franco, E., Soler, R. E., & McBride, M. (2005). Introducing and evaluating parent-child interaction therapy in a system of care. *Child and Adolescent Psychiatric Clinics of North America*, *14*, 351–366.

Fricker, A. E., Ruggiero, K. J., & Smith, D. W. (2003). Parent-child interaction therapy with two maltreated siblings in foster care. *Clinical Case Studies*, *2*, 1–27.

Gallagher, N. (2003). Effects of parent-child interaction therapy on young children with disruptive behavior disorders. *Bridges: Practice-Based Research Syntheses*, *1*, 1–17.

Goldfine, M. E., Wagner, S. M., Branstetter, S. A., & McNeil, C. B. (2008). Parent-child interaction therapy: An examination of cost effectiveness. *Journal of Early and Intensive Behavior Intervention, 5(1)*, 119–141.

Harwood, M. D., & Eyberg, S. M. (2004). Therapist verbal behavior early in treatment: Relation to successful completion of parent-child interaction therapy. *Journal of Clinical Child and Adolescent Psychology*, *33*, 601–612.

Harwood, M. D., & Eyberg, S. M. (2006). Child-directed interaction: Prediction of change in impaired mother–child functioning. *Journal of Abnormal Child Psychology*, *34*, 335–347.

Herschell, A., Calzada, E., Eyberg, S. M., & McNeil, C. B. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice*, *9*, 9–16.

Herschell, A. D., Capage, L. C., Bahl, A. B., & McNeil, C. B. (2008). The role of therapist communication style in parent-child interaction therapy. *Child and Family Behavior Therapy*, *30*, 13–35.

Herschell, A. D., & McNeil, C. B. (2007). Parent-child interaction therapy with physically abusive families. In J. M. Briesmeister & C. E. Schaefer (Eds.), *Handbook of parent training: Helping parents prevent and solve problem behaviors* (3rd ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Herschell, A. D., McNeil, C. B., Urquiza, A. J., McGrath, J. M., Zebell, N. M., Timmer, S., et al. (2009). Evaluation of a treatment manual and workshops for disseminating Parent-child interaction therapy. *Administration and Policy in Mental Health*, *36,*, 63–81.

Hood, K., & Eyberg, S. M. (2003). Outcomes of parent-child interaction therapy: Mothers' reports on maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology*, *32*, 419–429.

Hoza, B., Kaiser, N. M., & Hurt, E. (2007). Multimodal treatments for childhood attention-deficit/hyperactivity disorder: Interpreting outcomes in the context of study designs. *Clinical Child and Family Psychology Review*, *10*, 318–334.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, *65*, 453–463.

Kazdin, A. E., Mazurick, J. L., & Siegel, T. C. (1994). Treatment outcome among children with externalizing disorder who terminate prematurely versus those who complete psychotherapy. *Journal of the American Academy of Child and Adolescent Psychiatry*, *33*, 549–557.

Krivelyova, A., Sukumar, B., Stephens, R., & Freeman, K. (2007, March). *Treatment costs for children and families receiving parent-child interaction therapy or services as usual in a system of care setting*. Poster presented at the 20th Annual Research Conference, Tampa, FL.

Masse, J. J., McNeil, C. B., & Wagner, S. M. (2009). *Examining the efficacy of parent-child interaction therapy with high-functioning autism*. Manuscript in preparation.

Masse, J. J., & McNeil, C. B. (2008). In-home parent-child interaction therapy: Clinical considerations. *Child and Family Behavior Therapy*, *30*(*2*), 127–135.

Masse, J. J., McNeil, C. B., Wagner, S. M., & Chorney, D. B. (2008). Parent-child interaction therapy and high functioning autism: A conceptual overview. *Journal of Early and Intensive Behavior Intervention*, *4*, 714–735.

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

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

McDiarmid, M. D., & Bagner, D. M. (2005). Parent-child interaction therapy for children with disruptive behavior and developmental disabilities. *Education and Treatment of Children*, *28*, 130–141.

McIntosh, D. E., Rizza, M. G., & Bliss, L. (2000). Implementing empirically-supported interventions: Teacher–child interaction training. *Psychology in the Schools*, *37*, 453–462.

McNeil, C. B., Capage, L. C., Bahl, A., & Blanc, H. (1999). Importance of early intervention for disruptive behavior problems: Comparison of treatment and wait-list control groups. *Early Education and Development*, *10*, 445–454.

McNeil, C. B., Clemens-Mowrer, L., Gurwitch, R. H., & Funderburk, B. W. (1994). Assessment of a new procedure to prevent timeout escape in preschoolers. *Child and Family Behavior Therapy*, *16*, 27–35.

McNeil, C. B., Eyberg, S., Eisenstadt, T. H., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology*, *20*, 140–151.

McNeil, C. B., Herschell, A. D., Gurwitch, R. H., & Clemens-Mowrer, L. (2005). Training foster parents in parent-child interaction therapy. *Education and Treatment of Children*, *28*, 182–196.

Niec, L. N., Hemme, J. M., Yopp, J. M., & Brestan, E. V. (2005). Parent-child interaction therapy: The rewards and challenges of a group format. *Cognitive and Behavioral Practice*, *12*, 113–125.

Nixon, R. D. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-child interaction therapy: A comparison of standard and abbreviated treatments for oppositional defiant preschoolers. *Journal of Consulting and Clinical Psychology*, *71*, 251–260.

Pade, H., Taube, D. O., Aalborg, A. E., & Reiser, P. J. (2006). An immediate and long-term study of a temperament and parent-child interaction therapy based community program for preschoolers with behavior problems. *Child and Family Behavior Therapy*, *28*, 1–28.

Pearl, E. S. (2008). Parent-child interaction therapy with an immigrant family exposed to domestic violence. *Clinical Case Studies*, *7*, 25–41.

Prinz, R. J., & Miller, G. E. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology*, *62*, 645–650.

Prinz, R. J., & Sanders, M. R. (2007). Adopting a population-level approach to parenting and family support interventions. *Clinical Psychology Review*, *27*, 739–749.

Rayfield, A., & Sobel, A. (2000) *Effectiveness of "in-room" coaching of Parent-child interaction therapy*. Sacramento, CA: Paper presented at the First Annual Parent-Child Interaction Therapy Conference.

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

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*, 452–464.

Sukumar, B., Johnson, S., McNeil, C. B., Brooks, M., & Manteuffel, B. (2008). Implementation of parent-child interaction therapy in community mental health settings. *Manuscript submitted for publication*.

Tiano, J. D., & McNeil, C. B. (2005). The inclusion of fathers in behavioral parent training: A critical evaluation. *Child and Family Behavior Therapy*, *27*, 1–28.

Tiano, J. D., & McNeil, C. B. (2006). Training head start teachers in behavior management using parent-child interaction therapy: A preliminary investigation. *Journal of Early and Intensive Behavior Intervention*, *3*, 220–233.

Timmer, S. G., Urquiza, A. J., Herschell, A. D., McGrath, J. M., Zebell, N. M., Porter, A. L., et al. (2006). Parent-child interaction therapy: Application of an empirically supported treatment to maltreated children in foster care. *Child Welfare*, *85*, 919–938.

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

Timmer, S. G., Urquiza, A. J., & Zebell, N. (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of parent-child interaction therapy. *Children and Youth Services Review*, *28*, 1–19.

Tsang, S., Leung, C., Chan, M., & Choi, T. (2007, September). *Good practices in applying parent-child interaction therapy (PCIT) on Chinese families with children having serious behavior problems*. Paper presented at the 7th national parent-child interaction therapy conference, Oklahoma City, OK.

Urquiza, A. J., & McNeil, C. B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment*, *1*, 134–144.

Ware, L. M., McNeil, C. B., Masse, J., & Stevens, S. (2008). Efficacy of in-home parent-child interaction therapy. *Child and Family Behavior Therapy*, *30*(2), 99–126.

Werba, B. E., Eyberg, S. M., Boggs, S. R., & Algina, J. (2006). Predicting outcome in parent-child interaction therapy: Success and attrition. *Behavior Modification*, *30*, 618–646.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, *24*, 190–195.

Chapter 3
Intake Assessment and Therapy Orientation Session

What to Bring. . .

(1) Your Agency's Consent to Treat Form
(2) HIPAA Form
(3) Your Agency's Release of Information Form
(4) Your Agency's Cancellation Policy
(5) A Structured Intake/History Form of Your Choosing
(6) Eyberg Child Behavior Inventory
(7) Sutter-Eyberg Student Behavior Inventory
(8) Dyadic Parent-Child Interaction Coding System Form
(9) CDI Homework Sheets
(10) Sheila Eyberg's Treatment Integrity Checklists/Manual

With new case referrals, we always begin PCIT with an evaluation of child and family functioning. We think this is important for several reasons. First, PCIT is not a "cookbook" approach to child treatment in which therapy procedures are the same with all families regardless of presenting problems. Instead, the particular emphasis and treatment components are tailored to meet the special needs of each family, and the way that we learn about those special needs is through our initial evaluation. The initial evaluation can also elucidate factors that may interfere with treatment progress so that they can be addressed prior to or concurrent with PCIT.

The second reason we begin with an evaluation is that the results of our testing serve as a baseline measure of child behavior and parenting skills against which we judge the family's progress during the course of treatment. We code parent-child interactions and collect rating scale data in every coaching session so that we can evaluate weekly changes in both the parent and the child. If we consistently do not see improvements over our baseline ratings, we consider this a "red flag" for us to stop and assess why treatment is not progressing as expected. Sometimes adjustments need to be made in our teaching strategies. At other times, we find that we missed a key piece of information about family functioning at the time of our initial evaluation and that this particular factor (e.g., substance abuse, severe parental depression) is interfering with treatment progress.

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The third reason we believe it is important to begin with an evaluation is accountability. Clinical judgments concerning treatment effectiveness, no matter how strongly held, are subject to many biases and should not be the exclusive source of information about treatment results. Also, in this climate of managed healthcare, mental health professionals are expected to objectively document the effectiveness of services rendered in order to obtain third party reimbursement.

Who Should Attend the Intake Session?

There are several issues to consider in deciding whether this should be a single session with the child in attendance, or whether it is broken down into two sessions with the child attending only the second session. Obviously, coding of parent-child interactions cannot occur without the child, and it is important for the clinician to meet and observe the child before initiating treatment. However, it can be counter-productive to have the child present during the intake interview. Parents often unleash a barrage of complaints and criticism about their child and can be tearful as they express hopelessness and guilt. Also, they are prompted to discuss sensitive topics such as whether it was a planned pregnancy, parental substance use, non-custodial parents, sexual abuse, family trauma, and adoption issues. It would be highly inappropriate to discuss such topics in the child's presence.

It may be possible to conduct the assessment in one session if another caregiver is available to watch the child during the interview. This caregiver could be a grandparent or other relative, co-therapist, student assistant, or office receptionist. If no such person is available, the child may be invited to play on his own in the playroom while the adults conduct the interview in the observation room. That way, the child can be monitored through the one-way mirror without being exposed to sensitive intake information.

Many therapists prefer to break the assessment and therapy orientation session into two parts because of its length. It often takes over 2 h to accomplish all of the goals of this session including completing necessary paperwork, conducting a thorough interview, completing rating scales, coding parent-child interactions, providing feedback on measures, and orienting the family to PCIT. For billing purposes, it may be difficult to obtain reimbursement for more than 1 h of service on a single day. Agencies may also have internal guidelines limiting the length of sessions to allow for a larger caseload. Finally, some of our acting-out child clients may become extremely disruptive over a long clinic visit.

When the child is present at the assessment session, it is important for the therapist to begin developing rapport with the child. The therapist should show respect for the child by providing a developmentally appropriate explanation of who we are, why the child is there, and what will happen. We have been shocked by some of the misperceptions children have shared with us during this first session. We have had young clients express fear that we would give them shots. After one boy observed his infant sister having blood drawn from her heel the previous day, he asked at the intake appointment, "Are you the kind of doctor that hurts babies?" Another girl was

told by her mother that she was being picked up from school to go shopping. Upon presenting at the clinic, the kindergartener said, "You tricked me. That was mean!" From the first contact, we use our CDI skills to form a positive relationship with the child. We find things to praise them for such as their attire, episodes of good behavior, bright smile, creative ideas in play, and polite manners. We reflect back when they speak to us and we describe their appropriate behavior. To help parents view their children in a more positive light, we point out the children's appealing qualities including sense of humor, physical attractiveness, great vocabulary, athleticism, and strong fine motor skills.

Flexible Battery Approach

We recommend using the core set of assessment procedures outlined in Table 3.1. We use a semi-structured intake interview to collect information regarding the child and family's history and current functioning. Even though we have conducted thousands of intake interviews, we still bring an intake questionnaire to the session to ensure that we do not omit important information. The Eyberg Child Behavior Inventory (ECBI) is an essential measure for determining whether the child's behavior is in the clinical range and to track behavior change over time. Similarly, for children in preschool/daycare and early elementary school, the Sutter-Eyberg Student Behavior Inventory (SESBI), completed by the teacher, serves as a measure of behavior in the school setting. In addition to the parent and teacher report, we use the Dyadic Parent-Child Interaction Coding System – Third Edition (DPICS – III) as an observational measure of parent and child behavior. These measures serve as our core pre-treatment assessment and are repeated at the conclusion of treatment.

Table 3.1 Parent-child interaction therapy core assessment procedures

Semi-structured intake interview (approx. 45 min)
Eyberg child behavior inventory (5–10 min)
Sutter-Eyberg student behavior inventory (if child is in school; 5–10 min)
Dyadic parent-child interaction coding system observation (allow 15 min for each parent)

Although we always administer the measures in Table 3.1, we do use a flexible battery approach, including additional measures of child, parent, and family functioning depending upon the needs of the individual family. Many young children referred for PCIT have co-morbid conditions that need to be evaluated. These conditions include mental retardation, autism, anxiety, depression, and hyperactivity. Similarly, many parents have mental health issues that may interfere with treatment success. It is helpful to know from the outset if there is significant marital conflict (including domestic violence), and/or problems with depression, anxiety, substance abuse, stress, or limited cognitive functioning. See Table 3.2 for a listing of supplemental areas of assessment.

Table 3.2 Supplemental areas of assessment

Child functioning
Emotions (e.g., anxiety, depression, bipolar)
Self-esteem
Cognitive ability
Academic achievement
Adaptive behavior
Social skills
Development (e.g., autism spectrum)
Attention, activity level, & impulse control
Parent functioning
Parenting stress
Depression
Marital discord
Anxiety
Cognitive ability
Substance abuse

Semi-structured Intake Interview

After completing intake paperwork (i.e., consent forms, release of information forms, HIPAA forms, other agency-specific forms), we cover the limits of confidentiality (e.g., child abuse and neglect, duty to warn, subpoena for records). Our evaluation begins with a semi-structured intake interview. A variety of semi-structured interview formats are available that are suitable for use in PCIT; we use one that is similar in format to the one published by Barkley (1990, pp. 262–277). For a listing of the elements covered in a thorough intake interview, please see Table 3.3. When conducting an interview with a couple, we set the expectation for equal involvement by both parents and prompt the less vocal member of the pair to share his or her observations and concerns.

In addition to the questions asked in a typical semi-structured intake, we solicit information more specific to PCIT concerns. During the course of the interview, we collect detailed information concerning the family's experiences using time out. Most families referred to us for disruptive child behavior have used time out and found it ineffective. On inquiry, we can nearly always identify problems in the way they were using time out, which compromised its effectiveness. It is important to collect this information up front during the intake interview. Later, when time out is introduced as a discipline method, the therapist will be able to reassure parents that the new form of time out is different from the unsuccessful one they used previously. Given the focus in PCIT on improving child compliance, we ask parents to estimate for us what percentage of time their children comply with the first command given. A simple way to elicit this information is to ask: "If you give your child ten simple things to do throughout the day such as 'go get your shoes,' 'put the sock in the hamper,' or 'brush your teeth,' how many would she do right away without you having to repeat yourself?" We know that typical children who are not referred to treatment comply with an average of approximately 60% of commands first time

Table 3.3 Elements of the semi-structured intake interview

Prenatal history
Birth information
Infant temperament
Developmental milestones
Medical history (e.g., conditions, accidents, injuries, hospitalizations, surgeries)
Genetic history
Sleep problems
Eating problems
Toileting issues
Abuse history
School experiences
Peer relationships
Prior family mental health treatment
Stressful life events
Sibling interactions
Marital history
Primary concerns at home
Discipline strategies used
Child's strengths/interests

given. Referred parents typically report that their children comply at a rate of less than 30%.

Other questions that might be a part of a PCIT intake include the following: (a) What are your child's most challenging behaviors? (b) What are your child's most endearing behaviors? (c) What do you like about your parenting? and (d) What would you like to change about your parenting? (Eyberg, 1999).

Eyberg Child Behavior Inventory (ECBI)

The Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999; Eyberg & Ross, 1978) is an empirically supported, brief parent-report measure of child behavior problems that is appropriate for use with children between the ages of 2 and 16. The Intensity Score provides an estimate of how frequently the child displays each of 36 problem behaviors, and the Problem Score allows the parent to rate whether or not he or she perceives the behavior to be "a problem" for the child in question. The clinical cut-off scores are 131 (60T or higher) for the Intensity Score and 15 (60T or higher) for the Problem Score (Eyberg & Pincus, 1999). We administer the ECBI at pre- and post-treatment as well as at the start of every session as a way of measuring treatment progress.

The ECBI is particularly useful in identifying parents who may have inappropriately high and inappropriately low expectations concerning their children's behavior. For example, one mother we worked with reported that she considered twenty of thirty six behaviors to be problems. However the frequency with which the

child displayed these behaviors was well within normal limits, suggesting that this mother may have had little tolerance for the normal but sometimes irritating behaviors displayed by young children. In contrast, we worked with an overly tolerant father who reported that his son frequently engaged in a large number of problem behaviors, but he indicated that he considered none of them to be problems. He expressed the attitude that "boys will be boys," and he felt that his wife and his son's preschool teacher were overreacting to his son's disruptive behavior. The Problem Score tends to be higher in single-parent versus intact families and high Problem Scores have been associated with marital distress (Eyberg, 1992).

Sutter-Eyberg Student Behavior Inventory – Revised (SESBI – R)

The format of the Sutter-Eyberg Student Behavior Inventory – Revised (SESBI – R; Eyberg & Pincus, 1999; Funderburk & Eyberg, 1989) is similar to that of the ECBI. However, the items have been adjusted to be more appropriate for the classroom setting and the measure is to be completed by the child's daycare, preschool, or elementary school teacher. Intensity Scores of 151 (60T) or greater and Problem Scores of 19 (60T) or greater are in the clinical range (Eyberg & Pincus, 1999). The SESBI – R distinguishes between preschoolers referred for school behavior problems and non-referred preschoolers, and has been found to be sensitive to improvements in school behavior following PCIT. The teachers we work with especially appreciate the brevity of the SESBI – R, as it can be completed in approximately 5 min. For children in schools or daycares, we administer the SESBI – R at both pre- and post-treatment.

Dyadic Parent-Child Interaction Coding System – III (DPICS – III)

One of the fundamental elements of our pre-treatment evaluation is direct observation of parent-child interactions. We conduct informal observations in which we note how the dyad interacts in the waiting area and while parents complete assessment procedures. In our informal observations we look for the child's ability to play independently, strategies the child uses to engage the parent's attention, parental responsiveness to child overtures, parental limit setting, warmth of parent-child interactions, and evidence of clinginess and separation anxiety.

Children sometimes become quite disruptive during the informal observations. Therapists should avoid the temptation to intervene, unless of course there is imminent danger. As the child has not yet received treatment, the therapist's attempts to get the child to obey or calm down are unlikely to be effective. Instead, the therapist may appear incompetent to the parents, who probably would perceive that the therapist has no better control over the child than anyone else. The best approach is to instruct the parents to manage the behavior as best they can. For example, if

the child runs out of the door, the therapist should ask the parents to retrieve him or her. If the child is throwing toys, the therapist should indicate concern and ask the parents to try to stop the throwing. When parents ask for advice, the therapist can support their desire to learn, but help them realize that the skills are complex. Their questions will be answered in future sessions if they can be patient for a little while longer.

More formally, we conduct a structured observation using the Dyadic Parent-Child Interaction Coding System – III (DPICS – III; Eyberg, Nelson, Duke, & Boggs, 2005). The observation is done in a clinic playroom using a small table, two chairs, a time-out chair (placed in the corner of the room), a large toy box, and five sets of toys (e.g., blocks, Legos, Duplos, Lincoln Logs, Tinkertoys, Mr. Potato Head, and building blocks, puzzles, toy farms). Two of the toys are placed on the table and the others are distributed across the remaining three corners of the room. The toys are taken out of their containers to ensure that there will be enough clean-up to be done at the end to fill the observation time.

Typically, DPICS – III coding is conducted using a one-way mirror and behind-the-ear (BTE) hearing aid device. We find that young children are much more likely to display the behaviors that initiated the referral if the therapist is out of the room. If an observation mirror and BTE device are not available, the DPICS – III is coded with the therapist in the playroom, seated as far away and unobtrusively as possible. The instructions can be provided to the parents by whispering, providing them ahead of time outside the child's earshot, or in written form. If observing from within the playroom, we suggest explaining to the child: "My job is just to sit and watch you and your mom (dad) play. Sometimes I might write something down, but I can't talk to you, not even a little. Your job is to play with your mom (dad) and pretend like I'm not even here, like I'm invisible." In order to avoid becoming a participant in the interaction, the therapist-evaluator must completely ignore any of the child's overtures. After a minute or so, nearly all children will begin ignoring the unresponsive therapist and will interact exclusively with the parent.

Most parents feel somewhat nervous about the observations initially. It helps to anticipate this anxiety, reassuring parents that "most people feel a little nervous about this at first, but just try to relax and play with (child's name) like you would at home." Most 3-and 4-year-olds will be unaware that they are being observed unless they are brought into the observation room. However, older children who are not developmentally delayed usually realize they are being observed. To diffuse curiosity, we often bring the older child into the observation room briefly prior to the formal observation. We find that once the play observation is begun, children quickly forget they are being observed as they become engrossed with the play activity. It is also helpful to show curious children the bug-in-the-ear device. We usually hold the hearing aid up to their ears and are honest about the fact that we will use this to talk to their parents about ways to play with them. Children also are instructed that the hearing aid is not a toy and can break easily. As such, they will not be permitted to play with it. You may wish to allow the family a 5-min warm-up period during each of the first two situations (not clean-up) to allow for anxiety to diminish before coding begins (Eyberg et al., 2005).

We recommend that the pre-treatment observation be videotaped (with written parental consent and child assent) whenever possible. Videotaping allows for the interactions to be reviewed multiple times, especially important for therapists who are inexperienced in observing parent-child interactions. We save the videotape and make it part of our review of treatment progress at the conclusion of therapy. To ensure that the playroom lights stay on during the videotaping, switches can be protected by mounted lock boxes or hidden by electrical tape. We recommend testing audio levels on the recording prior to conducting the observation.

We observe the parent and child interacting in each of three standard 5-min DPICS situations that vary in the degree of parent control required: Child-Led Play, Parent-Led Play, and clean-up. The exact instructions given to parents are reprinted in Table 3.4 (Eyberg et al., 2005). The Child-Led Play situation, in which the child is allowed to play with whatever he or she chooses and has his parent's undivided attention, usually brings out the child's most positive behavior and allows the therapist to see how the parent and child relate to one another under optimal conditions. The Parent Led Play situation, in which the parent gets to pick the activity and asks the child to play along, is more challenging for the child with behavior problems. It provides an opportunity to see what strategies the parent uses to engage the child's cooperation, how the child responds to parental directions, and what particular disruptive and non-compliant behaviors the child exhibits. The clean-up situation is the most challenging of all, and if the child has significant behavior problems, they often are displayed during this final situation. Sometimes the clean-up is not completed within the 5-min observation period. If the child has begun the clean-up, we typically allow the parent to continue to enforce the clean-up instructions after we stop coding. However, with some defiant young children the interaction becomes a

Table 3.4 Dyadic parent-child interaction coding system – III instructions for parents

Child-led play (5 min)
In this situation, tell (child's name) that he/she may play whatever he/she chooses. Let him/her pick any activity he/she wishes. You just follow his/her lead and play along with him/her
Parent-led play (5 min)
That was fine. Please do not clean up the toys at this time. Now we'll switch to the second situation. Tell (child's name) that it is your turn to choose the game. You may choose any activity. Keep him/her playing with you according to your rules
Clean-up (5 min)
That was fine. Now please tell (child's name) that it is time to leave the playroom and the toys must be put away. Make sure you have him/her put the toys away by him/herself. Have him/her put all the toys in their containers and all the containers in the toy box

Eyberg et al., 2005, pg. 16

stand-off and we recommend ending the interaction after the 5 min so as to avoid an escalation in parental anger and potential embarrassment. Occasionally, an otherwise defiant child will clean up quickly, before the 5 min is completed. In such cases, the therapist can prorate the behavioral rating over the remainder of the 5-min period.

During each of these three 5-min segments, we keep track of a number of child and parent behaviors and verbalizations using tally marks on a coding sheet. The DPICS – III coding form provides space for recording 9 categories of parent behavior plus whether the child complies, does not comply, or has no opportunity to comply with parental commands. See Table 3.5 for a summary of categories coded on the DPICS. A sample coding sheet is available in Appendix 1. We strongly suggest that PCIT therapists access the Abridged Manual for the Dyadic Parent-Child Interaction Coding System, Third Edition (Chase & Eyberg, 2005). It is currently available for download at www.pcit.org. This manual provides complete definitions for each of the coding categories, decision rules, as well as the most up to date coding forms. For researchers, we recommend the use of the complete manual (Eyberg et al., 2005).

Table 3.5 Summary of DPICS – III coding definitions

Category	Definition	Example
Labeled praise	Specific statement expressing a favorable judgment	Good job sitting at the table
Reflection	Repeats the child's talk	Child: I made a big square Parent: You made a big blue square
Behavioral description	Describes the child's current activity (usually begins w/"you")	You're drawing the sun
Neutral talk	Describes information other than the child's current activity or provides an acknowledgment	That's a rainbow or okay
Unlabeled praise	Non-specific statement expressing a favorable judgment	Good job
Direct command	A clearly stated order	Please put on your shoes
Indirect command	An implied direction, often asked in question form	Could you put on your shoes?
Question	A comment expressed as a question (could be by inflection)	What are you making? or a dragon?
Negative talk	Expression of disapproval (could be sarcasm)	Don't stand on the table or (sarcastic) that was great

The behavior we see in a clinic observation may or may not approximate the parent's and child's behaviors in other settings. Following the observation, we ask parents to estimate how typical the child's behaviors were in each of the three situations. Many times parents will tell us that the child was on his or her best behavior and we did not see how bad things really get at home. Very rarely will a parent indicate that the child behaved worse than is usual at home. Following the

DPICS – III observations, parents are often worried about how the therapist perceived their parenting. To set them at ease, we make it a point to praise parents for any positive parenting that we observed during the formal coding (e.g., "I liked the way you got down on the floor with him").

Joining with and Motivating Parents

The pre-treatment assessment and therapy orientation session is more than just an evaluation. It is our first therapeutic contact with the family and it sets the stage for the entire treatment. Joining with and motivating families is critical in this session because PCIT cannot work if families do not come back. It is our job to hook families in, setting expectations that we are going to be very helpful to them. For us, the primary goal of this session is to get families excited about PCIT and committed to making weekly therapy attendance a priority. If we fail to establish excellent rapport in this session, we may not get another chance. In our experience training many therapists we have found that when drop-out occurs, it most often happens in the first three sessions. We think this is because most therapists are so focused on getting paperwork completed in this session, that they lose sight of the bigger picture: meeting the parents' needs. We ask therapists in training to imagine what it would be like to be a parent contacting a mental health clinic for the first time to seek help. It takes a lot of courage to admit that you cannot handle your child. Parents arrive anxious, defensive, desperate for help, guilty, and often feeling like failures. What they need from the therapist is not a sterile question and answer session. They need much, much more.

They Need to Be Heard. Parents need an opportunity to tell their story to an empathic and non-judgmental listener. Rather than asking a question, getting an answer, and quickly moving on to the next interview question, we think it is very important to reflect back, paraphrase, and summarize the content of their concerns throughout the interview. We say things like, "I can see that aggression is a really big problem both with his sister and with the other children at school," "So you have been dealing with extreme temper tantrums for over 2 years. Wow!" and "It sounds like you're seeing a lot of similarities between the problems your older son had and the acting out that Johnny is doing." We also think it is important to reflect back the feelings behind the client's words. Examples of emotion-focused reflections include, "This must be really stressful for you. I don't know how you do it," "It sounds like you're blaming yourself for him getting kicked out of school," "I can tell that you really love your daughter and only want the best for her," "So you've been feeling really down ever since the baby was born," and "He pushes your buttons to the point that sometimes you worry that you might lose it and hurt him." Many families enter therapy skeptical that a well-educated counselor can really understand their stress. This is particularly true when there are differences in socioeconomic status and ethnicity.

Frequent use of reflections is important for establishing rapport because it sends the message that the therapist truly understands the family's problems.

They Need to Feel Validated. A parent who finally makes the decision to seek help, needs validation that this was a good choice. Often, parents are being told by their spouse, friends, and extended family that the child is just going through a phase and that sending a 4 year old to a "shrink" is ridiculous. To make matters worse, it is not uncommon for the child to be on his best behavior during the first appointment in this novel setting. Parents then worry that the therapist will think they are exaggerating and overreacting to minor problems, much like when the mechanic cannot find the rattle in their car or the fever goes away at the walk-in clinic. We make it a point to communicate to parents that they are absolutely right to seek assistance. At the end of this session, we provide feedback on testing results usually verifying that the child's behavior is outside normal limits and warrants intervention. We praise parents for having the foresight to catch problems early when intervention is the most potent. Having the therapist confirm their suspicion that therapy is needed helps a tentative parent who started with only a toe in the door, end the session with both feet firmly planted in their resolve to work hard in PCIT.

They Need to Be Supported. When parents enter the first session, many feel isolated and embarrassed, thinking that they are the only ones who cannot control the behavior of their preschoolers. They need to know they are not alone. We tell parents that we work with many families experiencing similar difficulties and that they came to the right place. Often, these parents enter the clinic looking like they have been beaten down by criticism and blame. We hear stories about how the grandparents criticize their parenting, suggesting that if the parent used a firmer hand then the child would be perfectly fine. These parents receive almost daily negative feedback on their child's behavior in daycare, with frequent calls about crises and embarrassing reports at pick-up. These parents, particularly the mothers, feel inept, resentful, and hopeless. It is our job to be sure that they leave the intake session feeling built up, not torn down. Throughout the interview, we look for things that they are doing right and provide lots of supportive comments, particularly labeled praise. We make comments like, "He's really lucky to have a mother who cares so much," "What a great insight," "You're using the same kinds of strategies that most parents use and they're good ones. Sarah is just a really tough kid," "Your parents really need to learn to respect your authority and not interfere in your disciplining" "I can tell you're a very loving mother," "You've been doing your best to support the school by giving consequences at home," "With so many people discouraging you from coming in, I'm so impressed that you followed your instincts and did what you knew was right. You were right to get help for him," and "I am amazed that you have the energy to keep up with all four of those children and work two jobs. You should be proud of yourself." These supportive statements serve several purposes: (1) they enhance rapport, making the client want to come back, (2) they build parental self-esteem, (3) they model the positive tone that we want parents to use with their children, (4) they nurture parents, giving them the internal resources to nurture their children in return, and (5) they decrease defensiveness as the parents realize that this is a safe place to talk about concerns without being judged or blamed. Upon entering

treatment, parents fear that the therapist is going to confirm for them that they are indeed bad parents and that they have caused their children's behavior problems. Parents are usually pleasantly surprised to encounter a very different therapist attitude, one in which the therapist conveys respect and praises parents for what they are doing well.

They Need to Hear Positive Things About Their Children. We consider it our job to help parents recognize their children's strengths and appealing qualities. In order to improve the parent-child relationship and strengthen attachment, parents need to learn to like their children again. At the start of treatment, most of our parents react to the stress of dealing with behavior problems by becoming angry, critical, and rejecting toward their children. It can be hard for them to recognize any positives in their children as their good qualities are overshadowed by the biting, hitting, spitting, and other misbehaviors. Indeed, other people in the child's life (teachers, relatives, neighbors) become focused on the negative and provide the parent with a steady diet of child criticism. They are constantly being told that their children are mean, bossy, hyper, annoying, destructive, and rude. As PCIT therapists, we even have to work hard sometimes to find positive qualities in some of these children at the beginning of treatment. It is our mission to look carefully for each child's strengths and to comment aloud about them to parents (in front of the child when possible). We make positive observations such as "What a cute boy," "She's got a great smile. It lights up a room," "His sense of humor cracks me up," "He really knows a lot about dinosaurs," "She speaks her mind. She may make a great lawyer some day," "He has a clear vision of how he wants things to be. He'll make a great leader when he's older," "He's quite the engineer" (during Lego building), "I love his haircut," and "You sure dress her cute." Parents with children with disruptive behavior are seldom given credit for their children's strengths, but they are always blamed for their children's shortcomings. We listen carefully for times when children use polite manners as this is a great opportunity to give parents credit for good parenting. We say, "I noticed that he just said, 'thank you,' You've done a great job of teaching him to be polite. I know he doesn't always use the good manners that you've taught him. But, he knows 'please' and 'thank you' because you have been a good teacher."

They Need to Be Educated. When parents arrive at an intake session, they are eager to ask the expert about why their child is misbehaving. Yet in most intake interviews the therapist asks almost all of the questions. It is important to provide opportunities for parents to ask questions and to provide education throughout the intake. For example, prior to asking questions about the pregnancy, the therapist could explain how prenatal factors affect preschool behavior. Similarly, the contribution of genetics to mental health disorders could be discussed prior to soliciting the familial history. It is our goal for each parent to leave the intake session with questions answered and with a better understanding of the probable etiology and recommended treatment for the child's behavior problems.

They Need to Feel Encouraged and Hopeful. A major fear of parents at the assessment session is that the therapist will be unable to help them. We need to convey to the parent that we have special knowledge and expertise that will help their child.

If the entire intake is spent asking historical questions for the purpose of writing a comprehensive intake report, the parents leave the session not knowing whether the therapist can help or not. It is important for therapists to intersperse their intake questions with encouraging statements forecasting that the family's problems can be effectively treated. Sometimes, at the most emotional point in the session, when parents are telling their story and get teary with despair, we have an opportunity to provide encouragement and hope. For example, we can say, "I am so glad you're here. These are exactly the kinds of problems that respond beautifully to behavior therapy, and I have exactly the right treatment program for your family. I'm really excited to get started. I think I can help." As families discuss presenting problems, we intermittently respond with encouraging and confident comments like, "I've got a great strategy for that," "We deal with that a lot here in this clinic," "He sounds like my kind of kid. This is my specialty," and "I'm making some notes about a plan for that. I know where we need to start." We want parents to leave the session feeling better than when they entered. They should have a little optimistic spring in their step and be eager to start therapy the next week.

Sharing Test Results with Parents

At the end of the initial evaluation session, we meet alone with the parents to answer questions and provide preliminary feedback on the results of testing. Although we may not have all of the formal measures scored and interpreted, we usually have sufficient information from the interview, behavioral observations, and ECBI to determine whether we will be able to provide a helpful service for the family. We go over the results of testing in detail and share our impressions of the child's behavioral and emotional development. We ask parents to share with us their ideas about why their child is experiencing problems. Often, parents will express guilt and wonder aloud whether there was something they should have done differently during the pregnancy or during early child rearing. In most circumstances, we are unable to precisely determine what factors are responsible for the child's problems. We explain to parents that young children's problems are multiply determined and that it is nearly impossible to say that any one factor caused the problems.

Explaining "Specialized Parenting"

We emphasize that even though the parents are probably not directly responsible for the development of their child's problems, they are the only people with the power to successfully resolve them. Our goal is to try to diminish non-productive guilt, while giving parents back the responsibility for treating their children, thus enhancing their motivation to work hard in PCIT.

This process of reducing parental guilt while encouraging responsibility is a tricky one because the therapist must always be non-judgmental. If parents think

that the therapist views their parenting as "bad" or "inadequate," they will "yes, but. . ." the therapist throughout the skills training. Yet, the therapist is advising the parents to undergo parent training, which to many parents implies inadequacy. One way to deal with this problem is to explain the notion of "specialized parenting." We explain to parents that some children are temperamentally more difficult to parent than others because of short attention spans, difficulty handling change, willfulness, or developmental problems. While typical parenting is usually effective for children with easy dispositions, other children have special needs. Rather than viewing PCIT as a remedial program for dysfunctional parents, we then can view it as a mechanism for helping parents to form a better fit with their children. This "fitting process" involves teaching highly specialized skills that enable parents to manage children who do not seem to respond well to "typical parenting." The message here is that we accept and respect the parents' current skill levels, but we still aim to elevate their parenting to the level of "expert." We motivate parents to work with us in PCIT by telling them that our goal in therapy is to teach them to be experts in behavior modification. We even say, "By the end of treatment, you'll probably have relatives and friends coming to you for parenting advice."

Introducing PCIT to Parents and Children

After sharing with parents the results of testing and answering their questions concerning the causes and expected course of behavioral and emotional problems, we introduce them to PCIT. The goal of this introduction is to get parents excited and hopeful about treatment, and to establish the expectation that PCIT will require an intensive effort on their part. We explain that we offer a service that was designed specifically for young children with problems similar to the ones displayed by their child. We then provide an overview of PCIT with brief rationales for the importance of both the Child-Directed Interaction and the Parent-Directed Interaction components. Parents are told that PCIT takes approximately 12 sessions, and the structure of PCIT is explained to parents. Specifically, we explain that there will be only two sessions without the child, one in the first part of treatment to teach the CDI skills and one in the second part to teach PDI. We explain that the other sessions involve direct skills coaching using the bug-in-the-ear device. We tell parents that if they work very hard and their child responds like most of our other clients, they can expect significant improvements in cooperative behavior, happier mood, more affectionate interactions, and improved behavior in the classroom. Here is an example of what we might say when introducing PCIT to a new client:

> I'm going to be recommending a program called Parent-Child Interaction Therapy or PCIT. This program has been used with thousands of children across the country who have behavior problems just like Roberto's. Many research studies have been conducted on this program and they show that children's behavior goes from severe levels to normal levels, so that they behave like most children at the end of treatment. PCIT is unique in that we won't just talk about parenting and ways to manage Roberto's aggression, defiance, and tantrums. Instead, I will actually coach you, telling you exactly what to say and exactly what to do

> to handle his misbehavior while it is happening right here in this clinic. We'll do this by using this little hearing aid device. This allows me to coach you from another room. This is helpful because children tend to show their true colors when I am not in the room. PCIT will take about 12 sessions, once a week, for 1 h each session. And, it will take a commitment from you. In particular, you will need to find 5 min a day to do homework with Roberto. Although that might not seem like much right now, it is actually a very big commitment because I need you to do it almost every single day for the next 12 weeks. Is that something you can make a commitment to right now? I need for you to be sure about this because the program will not work without the commitment of 5 min each day for practicing the PCIT skills at home with Roberto.
>
> There are two parts to PCIT. The first half focuses on making your relationship with Roberto even stronger than it is right now. We need for the relationship to be very, very close so that Roberto wants to please you. This will set the stage for helping him succeed with the second part of the program which is a very firm discipline program. Researchers studied hundreds of children with behavior problems even more severe than Roberto's. They tried lots of different discipline approaches and they found *one* that worked better than all the rest. This discipline program focuses on over-training Roberto to follow your directions, to do exactly *what* you tell him to do, *when* you tell him to do it. So, when we get to the first discipline coaching session, I can make a promise to you. I will not stop that session until Roberto is obeying your commands. If I have to stay here late and bring in pizza, I will, because we will not stop that session until he has learned to listen. How does this sound?

If the parents indicate that they would like to participate in PCIT, we bring the child back into the room and provide him or her with a developmentally appropriate explanation about treatment. For example, for an oppositional 4-year-old boy, we might use the following explanation:

> Sometimes you get mad at your mom and dad, and sometimes they get mad at you. I′m somebody that helps moms and dads learn how to play better with their boys. I also help little boys learn how to listen better to their mommies and daddies. From now on, you′ll get to come here with your mom and dad each week. You′ll play with my fun toys while you learn to get along better with your mom and dad. Does that sound okay to you? What toy should I have out for you when you come to play next time?

Expectations for Attendance

Many of the clients we work with come from impoverished backgrounds and rely on government assistance for their medical care. They are used to attending free clinics on a first come, first served basis. These clinics usually do not have expectations that clients show up on time or call ahead to cancel. We cannot assume that these families understand our need for formal scheduling. They probably have never considered the fact that the therapist is holding an entire hour open on the schedule just for them. It is our job to educate these parents about the importance of keeping their appointments, arriving on time, and calling in advance when needing to cancel. Often, we ask that they sign an attendance policy to formalize our expectations.

A sample attendance contract is presented in Table 3.6. Attendance policies will vary based on agency guidelines. To view the attendance policy used in Dr. Eyberg's clinic, please see the PCIT Treatment Manual (Eyberg, 1999).

Table 3.6 Sample attendance contract

PCIT attendance expectations
PCIT is a powerful program for children with behavior problems. Research shows that most children who complete PCIT no longer have problems with aggression, non-compliance, and temper tantrums. And, these improvements can be seen up to 2 years after treatment is over
However, PCIT only works if parents can commit to coming in for treatment once a week for approximately 12 weeks. We understand that this is a big commitment. So, we are going to start with smaller expectations
To get the program off to a strong start, we ask that you agree to come to *4 sessions.* At the end of those 4 sessions, you should see a nice change in your child and in yourself. Then, we will ask you if you would like to commit to 4 more sessions
If you agree to this treatment, it is important that you call ahead of time if an emergency arises and you cannot come to your session. This is necessary because it saves your therapist a lot of time and allows another family to be seen during that hour
Before each session, your therapist takes time to review notes, develop handouts, and set up the room. By calling ahead when you cannot make it, you are allowing your therapist to use that time to help other families. Also, your therapist will work with you on trying to schedule another appointment as soon as possible to keep your child from losing gains in therapy
I, _____, agree to come to 4 sessions of Parent-Child Interaction Therapy. I also agree to call ahead of time if an emergency arises and I cannot make my appointment. I understand that if I do NOT attend as expected, my therapist may have to discontinue PCIT with me and my child to make room for other families who also need the help
_____ _____
Signature Date

Reducing Barriers to Treatment

Particularly for stressed, multi-problem families, it is important in the first session to identify barriers to treatment. Many of these families rely on buses or friends or family for transportation to therapy. Others risk losing their jobs if they must take off time from work on a weekly basis. Still others have difficulty attending because of childcare issues. If we can identify these barriers early on, we may be able to work to reduce them. For example, some agencies have transportation funds in which a taxi can be provided to bring the family to sessions. We have completed family leave forms for employers so that parents can take off work without fear of sanction. Sometimes, we are able to schedule sessions in the evenings or on Saturday mornings to accommodate work schedules. For families who travel a great distance, we will sometimes schedule lengthier and less frequent sessions. When parents are unable to secure childcare for siblings, it may be possible to arrange for childcare within the clinic. By accommodating parents we both build rapport and reduce factors that contribute to treatment attrition.

Explaining the First Homework Assignment

From the outset, we instill expectations that families will have daily homework to do between each of their sessions. This first week, we ask parents to find 5 min each day to spend one-on-one time with their child doing "whatever you might ordinarily do together – you can play together with your child's toys, or read a bedtime story to your child, or go for a walk outside" (Eyberg, 1999, p. 8). The purpose of this homework is for parents to identify a time each day that will later turn into their play therapy time. We want to send a message to parents that they will be accountable for completing homework. To accomplish this, we send them home with a homework sheet on which to record their daily home practice (see Appendix 2).

Summary

The pre-treatment assessment and therapy orientation session(s) involves a number of key components. Parents must complete administrative forms and rating scales. Parent-child interaction observations are conducted and the therapist conducts a thorough intake interview. We share with parents the results of testing and talk with them about how PCIT can help their family. After parents agree that they would like to participate in PCIT, we try to identify any barriers to regular attendance and explain our attendance policy. Finally, the first homework assignment is presented. Yet, with all of the procedures that need to be conducted in this first session, it is easy to lose sight of the most important goal, namely engaging parents. If we do not effectively join with parents and motivate them, they will not return for treatment and we will have missed our opportunity to help that child. Table 3.7 lists a series of questions to help therapists evaluate the effectiveness of this critical first PCIT session. We hope that this chapter helps therapist to better engage multi-problem families and reduces the attrition that may occur early in treatment.

Table 3.7 Was this an effective therapy orientation session?

(1)	Did I praise the parents, pointing out ways that they are parenting well?
(2)	Did I make positive comments about the child to the parents?
(3)	Did I reflect the parents concerns?
(4)	Did I educate the parents about their child's behavior problems?
(5)	Did I instill positive expectations that the treatment will work?
(6)	Did I tell the parents about my experience and expertise?
(7)	Did I validate for the parents that these problems are significant and need intervention?
(8)	Did I help the parents understand that they are not alone and that other parents also struggle with these problems?
(9)	Did I conduct all of the assessment procedures and provide parents with feedback on the results?
(10)	Did I reduce parental blame by explaining PCIT as a program that teaches "specialized parenting?"
(11)	Did I explain the structure of PCIT?
(12)	Did I help to reduce barriers to treatment, such as providing assistance with securing transportation and childcare?

Table 3.7 (continued)

(13)	Did I review the no-show/cancellation policy and convey an expectation that the family should attend all scheduled sessions or call to cancel?
(14)	Did I give the parents a homework assignment to spend 5 min of one-on-one time with their child each day?

References

Barkley, R. A. (1990). *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment*. New York: Guilford.

Chase, R., & Eyberg, S. M. (2005). *Abridged manual for the dyadic parent-child interaction coding system* (3rd ed.). Available on-line at www.PCIT.org.

Eyberg, S. M. (1992). Parent and teacher behavior inventories for the assessment of conduct problem behaviors in children. In L. VandeCreek, S. Knapp, & T. L. Jackson (Eds.), *Innovations in clinical practice: A source book* (pp. 261–270, Vol. 11). Sarasota, FL: Professional Resource Exchange.

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April, 2, 2008. Available online at www.pcit.org

Eyberg, S. M., Nelson, M. M., Duke, M., & Boggs, S. R. (2005). *Manual for the dyadic parent-child interaction coding system* (3rd ed.). Available on-line at www.PCIT.org.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory and Sutter-Eyberg student behavior inventory – Revised. Professional manual*. Odessa, FL: Psychological Assessment Resources.

Eyberg, S. M., & Ross, A. W. (1978). Assessment of child behavior problems: The validation of a new inventory. *Journal of Clinical Child Psychology*, *7*, 113–116.

Funderburk, B. W., & Eyberg, S. M. (1989). Psychometric characteristics of the Sutter-Eyberg student behavior inventory: A school behavior rating scale for use with preschool children. *Behavioral Assessment*, *11*, 297–313.

Chapter 4
Teaching Child-Directed Interaction

What to bring. . .
(1) Toys for demonstrating CDI
(2) ECBI
(3) Suggested Toys for CDI – parent handout
(4) CDI PRIDE Skills – parent handout
(5) CDI Homework sheet
(6) Sheila Eyberg's Treatment Integrity Checklists/Manual

After the initial PCIT evaluation and feedback have been completed, parents are asked to attend a "teaching" session in which the therapist introduces the family to the basic skills of Child-Directed Interaction play therapy. Because a great deal of information is shared and it is important to have the parents' undivided attention, we request that parents arrange for child care during this session. Most often, the teaching session lasts at least 60 min to allow for the many questions that arise in response to the material presented. Before this session begins, we have the parents complete the ECBI. Then, later in the session, we show the parents the changes that have taken place in the ECBI (either positive or negative) since the last session.

Overview of Teaching Session

In this session, we review the homework from the last session. We then provide a description of the goals of this part of PCIT, emphasizing how Child-Directed Interaction may help resolve the specific problems that were identified during the intake evaluation. Parents are told that they should not worry about taking notes or trying to memorize material because they will be given a handout at the end of the session including all of the information. The rationale for use of brief daily home "play therapy" sessions is described. Next, the therapist presents a set of "Avoid" skills and a set of "Do" skills. Each skill is described along with its rationale, examples are given, and the skill is briefly demonstrated by the therapist. The best

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teaching sessions are interactive, with the therapist inviting the parents to comment on how they think the skills will help their child, how they believe their child will respond, and any problems they foresee. Because relationship-building is an important goal of this part of treatment, *both* parents should individually conduct daily home play therapy sessions with their child.

By the end of the presentation, we want the parents to be able to name all of the "Do" and "Avoid" skills, so we use a repetitive teaching style in which we summarize all of the previously presented skills before moving on to the next skill. A mnemonic aid regarding the "Do" skills is the acronym "PRIDE," combining the first letter of each of the "Do" skills (i.e., Praise, Reflect, Imitate, Describe, and use Enthusiasm). After covering all of the "Avoid" and the "Do" skills, the therapist presents the concepts of "strategic attention" and "selective ignoring" for shaping behavior. The therapist then models using all of the skills in combination, often with the parent or a co-therapist playing the part of the child. Finally, parents are invited to role-play with the therapist providing some gentle in-the-room coaching.

At the end of the session, parents are given a handout summarizing the behavioral play therapy skills and their rationales (see Appendix 3). We save the handout for the end of the session so that parents are not distracted by reading ahead. In addition to the skills handout, parents are given a "homework sheet" on which to record their daily practice and any problems that come up so they can be addressed in the next session (see Table 4.1 for an overview of the CDI teaching session).

Table 4.1 Steps for teaching Child-Directed Interaction skills

1. Review homework
2. Describe goals of Child-Directed Interaction
3. Discuss 5 min of daily home practice
4. Present and model the "Avoid" skills
5. Present and model the "Do" skills
6. Discuss use of strategic attention
7. Discuss use of selective ignoring
8. Model all skills in combination
9. Coach parents as they role-play skills
10. Discuss logistics of play therapy at home
11. Assign new homework

We have sometimes been asked by parents if it would be okay to record the teaching session so they can listen to it again at home. There are several advantages to taping. First, it is good to have a tape available when there is a reluctant spouse at home who may be convinced to listen. Second, there may be other caregivers who were unable to attend the session but would like to learn the material (e.g., grandmother, head start teacher). Third, many people learn best through repetition and their retention of the information is enhanced if they can review it on tape one or more times. And fourth, sometimes we work with parents with reading difficulties who are able to make better use of a tape than a written handout.

Review Homework

The session begins with a review of the homework assigned in the pre-treatment assessment and therapy orientation session. We set a precedent that parents are expected to complete their daily homework and to remember to bring their homework sheet with them to sessions. This is done by beginning every session by asking parents to turn in their homework sheet. If the parent brought the sheet and completed most of the daily practice sessions, we praise them (e.g., "It was wonderful that you made time to fit in the homework most days. Your daughter is lucky that you care enough about her to make this a priority"). If they brought in the homework sheet but it is evident that they did minimal homework, the therapist praises them for bringing in the sheet, reminds them of the importance of daily practice, and problem-solves with them about possible solutions (e.g., a reminder note on the refrigerator, do it during the baby's nap time). For parents who forget to bring their homework sheets, we bring out a new form and get it completed before continuing with the session.

Presenting the Goals of Child-Directed Interaction

Next, we remind parents of the overall structure of PCIT (i.e., CDI and PDI) and its goals. We explain to them that the relationship enhancement work of CDI sets the stage for the firm discipline program of PDI to be effective. We often use the analogy of building a house. For the house to be structurally sound, there must first be a strong foundation. That foundation is the solid attachment and warm relationship that develops during the CDI phase of treatment. We forecast for parents that this foundation-building phase takes time and patience and is not as glamorous as the PDI phase when we quickly and directly address behavior problems. Yet, we explain that the house will not stand without a strong, well-built foundation. We ask parents to be patient with this slower, more subtle phase of therapy and reassure them that we expect to see dramatic and rapid change once PDI begins.

There are many more specific possible goals for Child-Directed Interaction, and the goals that are emphasized for any particular family should be based on the presenting problems identified during the intake evaluation. We find that Child-Directed Interaction often improves children's self-esteem, improves the parent-child relationship, helps children to attend longer to play activities, makes oppositional children less angry, and improves frustration tolerance and perfectionism. As presented in Part II of this text, Child-Directed Interaction may be tailored for children with developmental problems, foster and adopted children, children with internalizing problems, and abuse survivors.

Explaining the Five Minutes of Homework Each Day

The skills presented in this chapter are to be used by parents in a daily 5-min "special playtime" at home. Five minutes may seem brief, but it offers several advantages.

First, the brief amount of time removes much of the resistance to home practice that comes with longer practice periods. Parents cannot in good conscience tell us that 5 min is not available in their busy schedules each day to devote to their young children. Second, by using a brief practice period, parents are able to sustain a high degree of quality during their special playtime, making them less likely to just "go through the motions." Third, although 5 min does not sound like a great deal of time, it is perceived as a long time by novice play therapists who are concentrating hard on using their skills correctly. Longer practice periods early in therapy often lead to fatigue and diminished enthusiasm for treatment. Fourth, a major reason why behavioral play therapy is child-directed is to set up a situation in which the child is most likely to display pro-social behaviors. For children who have behavioral problems, the longer the play session, the more likely it is that their good behavior will deteriorate, detracting from parent-child relationship building. And finally, very young children have a different sense of the passage of time than do adults. To preschoolers, 5 min feels like a long time when you are driving in the car, waiting for the food to come, or the parent is on the telephone. It also feels like a sufficiently long time to have their parents' undivided attention.

We explain the 5-min home sessions to parents by saying,

> The rules that I will be describing are to be used during a daily 5-min special play period at home. I certainly don't expect that you or anyone would be able to keep up this high-quality, condensed therapeutic time for extended periods each day. In fact, I find that parents who try to spend longer than the 5 min actually burn out on play therapy because it takes so much energy. I don't want that to happen to you. So, the key to making play therapy work is to do a little bit consistently every day, not to do it irregularly but for longer periods.

We explain to parents the importance of a 5-min play session, explaining that providing sporadic longer sessions (e.g., 15 min) can lead children to feel cheated on days when they receive their standard 5-min special playtime. Because we emphasize the use of a 5-min play session, some parents become overly focused on preventing themselves from running overtime. Some even ask us if they should set a kitchen timer to go off at the end of playtime. We discourage such rigid adherence to time rules because it is distracting to both the parent and the child, and detracts from the naturalness and pleasure of the playtime. Furthermore, ending the session abruptly at 5 min may prematurely cut off an activity that the child has worked hard on and nearly completed, causing unnecessary frustration. Instead, we encourage parents to look for a natural breaking point after about 5 min, even if playtime is extended by 2 or 3 min. At the end of the playtime, parents are encouraged to praise their child for the positive qualities they observed during the session and to express their own pleasure in having shared the time together.

As power struggles can easily develop around the issue of putting the toys away, we encourage parents to handle clean-up in one of two ways (1) to say, "I'm going to pick up the toys now. You can help if you want" or (2) to allow the child to continue playing by saying, "Special playtime is over now. You can continue playing with the toys if you want. But, I have to do some other things right now." Therapists can help parents accept these non-confrontive suggestions for picking up the toys by

reminding them that clean-up strategies will be covered extensively in the discipline part of the program.

It is important to make it clear to parents from the beginning that play therapy should not be viewed as a "privilege" that is contingent on good behavior from the child. Highly stressed and/or punitive families have a tendency to withhold play therapy when they have had a difficult day with their child, unless this point is addressed directly in the teaching session. We emphasize that special play time is actually more important on days when the child has displayed a great deal of misbehavior. On those days, the play therapy can help to interrupt the negative cycle by allowing the parent and child to have a very warm and positive time together.

"Selling" CDI to Skeptical Parents

Highly stressed parents may not be particularly motivated to improve their relationships with their children. They typically do not see the importance of playing with children, allowing children to lead conversations, and looking for positives in children's behavior. They usually have no model for nurturing, responsive parenting, as it was not a part of their own upbringing. These stressed parents are seeking punitive strategies to quickly reduce acting-out behavior. They may be coming to the clinic with a child who has been kicked out of daycare for choking and biting classmates, cussing, spitting, hurting the class pet, and breaking toys. The highly stressed parent often views the therapist as naïve and clueless when the therapist suggests that these problems will get better by playing with the child for 5 min each day. These parents will often tell the therapist, "I already play with my child all the time and he's still bad." With these parents, we cannot simply list off the goals and skills of therapy and then expect them to buy in. If these families are going to return for the first CDI coaching session, the therapist must *sell* CDI.

CDI Is "Therapy" Not "Play." First, we must make it clear that CDI is "therapy" not play. Parents must see that it is very different from any other way that they have interacted with their children before.

> Suppose that you brought Rocky to me for individual therapy. I went to college for a long time to learn special techniques for working with children who have behavior problems. In my sessions with Rocky, I would use those skills to teach Rocky to behave better. I could get Rocky to obey *me*, to be polite to *me*, to share his toys with *me*, and to try to please *me*. But, when I brought him back to you in the waiting room, his rude and defiant behaviors would return because you would not know the special techniques. So rather than have you bring Rocky to me once a week so I can teach him how to behave with me, I am recommending that *you* learn the special techniques and become Rocky's therapist. Then, rather than having therapy just once a week, you can be his therapist all day, every day. The skills therapists use with young children Rocky's age are called "play therapy skills." In the next hour, I am going to give *you* a crash course on how to be a play therapist.

Thus, it is important to convey that special playtime is a therapeutic intervention. If parents perceive this as "just playing," they will discount the importance of this

portion of PCIT, and will either drop out or display only minimal compliance with homework.

To sell stressed parents on the notion that only 5 min per day really could have an impact on their children's behavior, we use an exercise analogy. Exercise is effective when conducted consistently over time. With consistency, small changes can produce large cumulative effects. We might tell "Rocky's" mother:

> I want you to do play therapy with Rocky for 5 min each day. Now, 5 min may not sound like very much. In fact, 5 min is not very much time unless you do it consistently every single day. Imagine that you are trying to strengthen your bicep muscle. If you lift weights with that arm for 5 min one day, it will not do much good. But, if you exercise that muscle a little every single day for a couple of weeks, you will see a noticeable change. Play therapy is the same way. If you spend 5 min on Monday, and then you don't do the practice again until Friday, and then maybe you wait another week before you practice again, I do not expect you to see any improvements. But, just imagine how much more positive your relationship with Rocky would be if you spent 5 min every single day telling him how special he is. Imagine that for 2 weeks in a row, every single day you had this very intense connection with Rocky in which you told him how much you love him and reminded him of all the things that make him a wonderful kid.
>
> Parents who come to see me typically say that their kids act out all day. Their time with their children is spent yelling at them and correcting them with words like, "stop that," "don't run with that stick," "leave him alone," and "I said 'no'!" In the midst of all that conflict, it is very hard for them to remember to say something nice. By setting aside 5 min every day, it guarantees that a day will never go by without Rocky hearing that you love and care for him, that you think he is a neat kid, and that you are happy to be his mom. So even though the rest of the day may have been awful, with lots of screaming and nagging, the play therapy will ensure that you and Rocky will have a special connection each day. It's true that doing this on Monday will not make much difference. But if you do this almost every day of the week for weeks at a time, those little daily connections will add up. Over time he will begin to work for your positive attention outside of the 5- min playtimes. Rocky will develop into a child who works hard to please you.

Have Parents Reflect on How Their Own Self-Esteem Might Have Been Different if Their Parents Provided Daily CDI. Sometimes we find it helpful to sell CDI by having parents reflect on their childhood relationships with their own parents. We typically hear that these parents had childhoods in which they were criticized, misunderstood, and emotionally neglected. As adults, their feelings are often still raw and many express resentment toward their parents. We help parents to see that they have an opportunity not to repeat the same mistakes and to parent their children differently. A discussion like this might motivate an otherwise skeptical parent:

> I want you to imagine how your life would be different if your mother set aside 5 min every day to spend with you. In those 5 min, she did not answer the phone, dust the table top, pick up clutter, or wash dishes. She devoted that time entirely to you. So every single day you could count on having 5 min with your mom in which you were the center of attention. In those 5 min she complimented you, did what you wanted to do, smiled at you, hugged you, and let you know how happy she was to be your mother. During that time, she really listened to every word you had to say and told you over and over again what she liked about you. Imagine that you had a little bit of high-quality time with your mother every day of your life from the time you were 3 years old. How would your relationship with your mother have been different and how do you think you would have felt about yourself growing up?

This exercise helps parents recognize the relationship between messages they give their young children and the development of self-esteem. We tell parents that we want their children to grow up liking themselves, being confident, feeling secure, and always knowing that they have a parent who will listen. These are characteristics that help protect children later in life against the influence of drugs and alcohol, gangs, abusive relationships, and teen pregnancies. Daily Child-Directed Interaction is a start along the pathway to responsive parenting and raising successful, resilient children.

Over-Learning of Skills Until They Become Habits. To sell the idea of daily special playtime to a resistant parent, we point out that the 5 min serve as a practice period to over-learn skills to the point that they generalize effortlessly throughout the day. We might explain this idea to Rocky's mother in the following way:

> Your homework for Child-Directed Interaction is to do special playtime with Rocky for 5 min each day. You may think that isn't a lot of time, but you haven't heard yet what I'm asking you to do during those 5 min. It is short, but it is intense. During that 5-min period, I am going to have you overuse the types of skills that are used in play therapy. You will use them at such an extremely high level that they will become over-learned. By over-practicing them in an exaggerated way, they will become habit and you will find yourself using those skills outside of the 5-min special playtime. You won't have to work at it or concentrate on it. It will just happen naturally.
>
> Now, I'm about to teach you how to use a skill called "labeled praise." A labeled praise involves telling Rocky exactly what you like about what he is doing. I'm not going to ask you to praise him just a little bit. I am going to ask you to praise him 10 times in 5 min! That amounts to one labeled praise every 30 s. So, once every 30 s you'll be saying things like. . ."I like the way you shared the toys with me,". . ."That was a beautiful boat you built,". . .and "Nice job of using your manners." Compare that to how many labeled praises Rocky received all day yesterday. Now I don't expect you to give him a labeled praise every 30 s throughout the whole day. That would be weird. The purpose of doing the play therapy skills in such an extreme way for 5 min each day is that they will become a habit. You will find yourself giving Rocky labeled praises at the dinner table, in the car, at the doctor's office, and while he's playing with his sister. All you have to concentrate on right now is your 5 min a day, and the skills will spill out naturally. In a few weeks, you will find yourself being a "therapist" much of the rest of the day as well.

With a lot of the families that we work with, it is unrealistic to expect that we can just launch into a description of the skills of play therapy and expect them to just buy in to the basic premise that playing with their child for 5 min a day is going to help with the presenting problems. Instead, the parents need help getting motivated to do CDI by having the therapist explain the rules and rationales in language they can understand. Using real-life analogies and simple explanations, the therapist must actively and passionately "sell" CDI to skeptical parents.

Explaining the Overriding Rule of Letting the Child Lead

Parents are told that the most fundamental rule of Child-Directed Interaction is to allow the child to lead the activity. We explain to parents that children are at their best when they get to choose the activity, and we want them to get a great

deal of high-quality attention while they are behaving well. We also point out that there are few naturally occurring opportunities for young children to be in the lead. All day long they are told what to do by adults, and they are often perceived as the least capable members of their families. Having a brief period of time each day in which they get to be the ones who are most knowledgeable about the activity and make most of the decisions helps to relieve some of the frustrations inherent in early struggles for autonomy.

Teaching the "Avoid" Skills of Child-Directed Interaction

Commands. The first "Avoid" is "Avoid Commands." Commands take the lead away from the child and set the stage for unpleasantness if the child disobeys. We talk about two specific categories of commands: direct and indirect. Direct commands are obvious demands made of the child, such as: "Hand me that crayon," "Sit on your chair," and "Hold my hand." Indirect commands are less obvious and are often phrased as a question. Many parents use them without realizing they are subtle forms of commands. Examples of indirect commands include: "How about using the pink now?" "You might want to sit down to do that," and "Could you sing me a song?" Both direct and indirect commands take the lead away from the child and should be avoided during CDI.

Questions. The second "Avoid" is perhaps the hardest of all of the CDI skills to learn: "Avoid Questions." Questions direct the conversation instead of following and tend to take the lead away from the child. Many questions are indirect commands in disguise, and asking questions can also lead the child to believe that the parent is not really paying attention or disagrees with what the child is doing. For example, "Are you sure you really want to play with Mr. Potato Head?" is a leading question implying that the parent thinks the child should play with a different toy and suggesting disapproval of the child's original choice.

Questions may begin with an interrogative such as "who," "what," "when," "why," "where," or "how." Alternatively, statements may be turned into questions by the inflection in the parent's voice or by a question tag. For example, "You want to put that there?" (voice rising at end of statement) becomes a question because of voice inflection. Similarly, "That's a rainbow, isn't it?" becomes a question due to the tag on the end. Many parents have particular difficulty eliminating the voice inflection questions and question tags because they do not hear or recognize the subtle changes in inflection and semantics. Examples of common question tags to avoid include "isn't it?" "right?" "huh?" "aren't they?" "didn't it?" "okay?" and "alright?" It can be helpful to briefly model and have parents rehearse various statements alternating declaratives versus interrogatives to maximize the contrast.

In explaining the rationale for avoiding questions during special playtime, we tell parents the following:

> Adults ask children far too many questions. If you were to go to a shopping mall, and eavesdrop on conversations adults are having with children, you would find that almost 75% of what an adult says to a child comes out in question form. Adults ask so many questions because they want children to talk with them. Unfortunately, excessive questioning usually

has the opposite effect. Imagine what it would be like if you were constantly bombarded with questions. After awhile, you would probably start to feel interrogated and would just give very brief, perhaps one-word responses. Many parents complain that when they ask their children questions about their school day, they get brief, uninformative answers. Often this is caused by a pattern of excessive questioning from early childhood.

Sometimes we do an exercise in which we demonstrate for parents what it would sound like to ask questions at a high rate during CDI. It might go something like this:

Is that a snowman you're drawing? Are you going to give him a carrot nose? Are those buttons going up the front? Do you remember making a snow man at Granny Jean's house? What color is that scarf going to be? Wouldn't it be cool to make it striped? Is he missing something from the top of his head? What are you going to draw next? This is pretty fun, huh?

We then ask parents how many of those questions they think their child would actually answer and how comfortable it felt to be questioned at that rate. Most parents recognize themselves in that example and quickly become more aware of their rate of questioning. Of course, there are times throughout the day when it is important for parents to ask questions of their young children. We agree that questions are great for eliciting important information, stimulating creativity, developing conversational skills, and enhancing language development. We want parents to use questions outside of special playtime. However, we discourage the use of rapid-fire questions that provide no opportunity for the child to answer. And during the 5 min of special playtime, we ask parents to give children "a break" from all questions. We tell parents that in a few minutes, we will talk with them about a much more effective strategy for encouraging their children to talk with them.

Criticism and Sarcasm. The third "Avoid" skill is "Avoid Criticism and Sarcasm." There are several reasons why criticism is discouraged during CDI (as well as in all parent-child interactions). First, criticism is not effective for decreasing problem behaviors, and it may even increase some undesirable behaviors. We explain to parents that nearly all young children strive for attention from adults. While they would prefer positive attention, they will work for negative attention if they don't know how to get positive attention. For example, we might say:

Imagine that you are at a restaurant with Ross and one of his calmer friends. It is taking a long time for the dinner to arrive. Ross and his friend are getting bored and they begin to make designs with the ketchup on their placemats. In annoyance, you resort to a skill that all parents use to teach right from wrong, criticism. You say to both Ross and his friend, "That's gross. You're making a mess." How will the calmer friend feel? That's right. He probably will feel uncomfortable, embarrassed, and sorry that he disappointed you. And what will happen to the ketchup behavior? That's right, he will probably stop making designs. Now remember that you used exactly the same skill with Ross, telling him that the ketchup was gross and messy. What do you think is likely to happen to Ross' behavior? That's right; he's likely to pour out even more ketchup and get even sillier with the designs. So when you criticized him, the behavior increased. That means that criticism was a reward for him, like giving him an M&M or some money. Whereas criticism might decrease the problem behavior of typical children like his friend, it actually worsens and reinforces the problem behavior of disruptive children like Ross.

In this way, we help parents understand that criticism is ineffective for decreasing the problem behaviors of children who are referred for PCIT. We also make it a point to reassure parents that we will teach them skills that are much better than criticism at reducing disruptive behavior.

A second reason to avoid criticism is that it causes unpleasantness during the interaction, and we want the special playtime to be enjoyable for both the child and the parent. The third and most important reason for parents to avoid criticism is that it may result in self-esteem problems. We explain that,

> Young children do not have the cognitive ability to reason critically and independently. Their attitudes and beliefs are heavily influenced by the things that adults tell them, particularly statements made by trusted adults like parents. If a parent tells a preschool child that horses fly then as far as the child is concerned, horses *do* fly. Most preschoolers do not have the ability to hear this statement, think back on what a horse looks like, realize that wings are needed to fly, recognize that horses have no wings, and come to the conclusion that their trusted parent has made an error. Similarly, if a parent tells a preschool girl she is dumb, then the girl incorporates that information into her self-image without scrutiny. She does not have the cognitive sophistication to think back to earlier in the day when she was successful at putting together a difficult ten-piece puzzle and realize that the parent is wrong and she is pretty smart after all.

We consider criticism to be any negative or contradictory statement about the child or what the child is doing. Some criticisms are blatant and uttered only during times of considerable parent consternation. Examples of blatantly critical remarks include "That was a dumb thing to do," "Don't act like such a jerk," and "You sure are ugly when you whine like that." Few parents we work with admit to saying such things to their children, yet we have observed them making these comments when embarrassed by their child's disruptive behavior in the waiting area before or after a session. Thus, even when parents assure us that they do not criticize their children, we still feel it is important to give examples of blatant criticism and to discuss its ill effects.

In addition to obvious forms of criticism (e.g., "dumb," "mean," "idiot"), we teach parents to avoid the more subtle forms of criticism that often are expressed in the words: "no," "don't," "stop," "quit," and "not." These words tell the child what "not to do," instead of what "to do." For example, phrases beginning with "Don't" are typically negatively stated commands and take the lead away from the child. Inherent in a negative command is disapproval of the child's activity or behavior. We know that negative commands do not work well with young children who are oppositional, because words like "no" trigger defiance and cause many of these children to feel almost honor bound to do the misbehavior one more time. Similarly, negative correction is a subtle form of criticism that nearly all parents use. A negative correction occurs when the child makes an error and the parent points out the mistake before offering corrective information. For example, a child may color the dog purple and say "I'm gonna make him blue." A negative correction would be "That's not blue. You're making him purple." The first three words in this parental response are subtly critical and serve no purpose other than to call attention to the child's mistake. Instead, we encourage parents to leave off the first part, while retaining the

noncritical second part of the correction. In this way, parents are able to teach their young children during special playtime without leading or criticizing.

Another form of subtle criticism is sarcasm where otherwise neutral or even positive statements can be made critical through a parent's tone of voice. Parents are asked to avoid using a sarcastic tone while making comments such as, "Nice going," "Now isn't that just lovely?" "Like that will really work," "Swell," "Smooth move!" and "Thanks a lot." Young children pick up on sarcasm at an earlier age than many would think, and they perceive their parents' disapproval. Also, we like to remind parents that their young children imitate them, and they need to watch out for sarcasm unless they want to teach their children to use a sarcastic tone.

Teaching the "Do" Skills of Child-Directed Interaction

After presenting all of these "Avoid" skills, parents are often left wondering what is left for them to say and do during special playtime. Sometimes we have parents say, "What do you want me to do, just stare at her for 5 min?" We assure them that we have plenty of things for them to do! There are five "do" skills. When the beginning letters of the five words are compiled, they spell out the acronym, "PRIDE." See Table 4.2 for an overview of the "avoid" and "do" skills.

Table 4.2 The "Avoid" and "Do" skills of Child-Directed Interaction

Avoid commands
Avoid questions
Avoid critical statements and sarcasm
Do praise pro-social behavior
Do reflect appropriate verbalizations
Do imitate appropriate play
Do describe appropriate behavior
Be enthusiastic!

Praise. The first "Do" skill is "Praise." We encourage parents to provide numerous praises during special playtime, an average of one praise every 30 s! Two particular types of praise we discuss are unlabeled (general) and labeled (specific) praise. Unlabeled praises are ones that convey approval or affection without specifying exactly what it is that the parent likes. Examples of unlabeled praises include "Terrific," "Nice Job!" "You're so sweet," "I'm proud of you!" and "Good." In contrast, labeled praises tell the child exactly what it is that the parent likes. Unlabeled praises can be converted to labeled praises as follows: "Terrific counting!" "Nice job of playing so quietly," "You're so sweet to share with me," "I'm proud of you for being polite," and "Good choice of colors." While both unlabeled and labeled praises are good for children and add to the warmth of the parent-child relationship, labeled praises are particularly valuable teaching tools. Labeled praises are so important that they are the only type of praise included in the mastery criteria. Thus, parents must provide one *labeled* praise every 30 s.

Young children will work hard for praise. Whatever behavior or quality the parent praises is more likely to be displayed by the child in the future. Labeled praises are more efficient than unlabeled praises at conveying to the child exactly what can be said or done to earn praise in the future. We explain this concept like this:

> Suppose that Sally is coloring a heart. If you provide an unlabeled praise, like "That's pretty," Sally will feel good about herself, but she probably won't know exactly what she did that earned the praise. But, if you say, "That's pretty the way you colored inside the lines," she will try very hard to color inside the lines again. If you say, "That's pretty the way you colored softly with the crayon," Sally will softly shade her pictures in the future. If you say, "That's pretty the way you used several different colors," a different behavior will increase. Similarly, if you say to Sally, "You were good at McDonalds," she will feel good about that, but her behavior may not change. But, if you say, "You were good at McDonalds because you stayed close to me when we were in the long line," she will probably stay close to you the next time. If you say, "You were good at McDonalds because you ate your whole cheeseburger," you will get an increase in cheeseburger eating behavior. In this way, we can use labeled praise to strategically increase certain good behaviors.

We also teach parents that labeled praise can be used to prevent and reduce problematic behavior. This is accomplished by teaching parents to first identify the negative behavior that they would like to have diminished. Then, they are asked to think of what their child could be doing instead that would make it impossible to do the negative behavior. For example, if a parent would like to see whining decrease. The next step is to determine a behavior that is the opposite of whining, which might be "using a big boy voice." A powerful tool to get whining to diminish is the use of labeled praise for the incompatible behavior. As the parent praises the big boy voice, the child will use the big boy voice more, thereby reducing the frequency of whining. Here's what we say:

> Did you know that you can improve *problem* behaviors with labeled praise? The way we do that is by identifying the opposite of the problem behavior and providing a labeled praise for the opposite. So, you mentioned that Jacob has a problem with hurting the dog. When he first wakes up in the morning and comes to the living room with bed head and sleep in his eyes, has he hurt the dog yet? This is a great opportunity to praise the opposite. You can tell Jacob that you are proud of him for being a good friend to the dog. Then, Jacob will try to be gentle with the dog from his first interaction. As gentle behaviors go up, hurting behaviors go down. We call this "proactive" parenting. Rather than being a "reactive" parent who waits for bad behavior to occur and then criticizes and punishes, a "proactive parent" anticipates problem behavior and praises the opposite before the child has a chance to misbehave.

Praising incompatible, pro-social behaviors is a very positive strategy for reducing problematic behavior without needing to give commands, yell, punish, or criticize.

In addition to increasing behavior, an important goal of labeled praise is to improve self-esteem. Because preschoolers believe what adults tell them, self-esteem at this age is fluid. It basically varies as a function of the feedback the child receives from people in his environment. Children referred for PCIT are at risk for self-esteem problems because their behavior inspires so much criticism and correction. Unless they receive very large amounts of praise to offset the criticism, these children tend to think of themselves as "bad" kids.

We explain to parents that,

> Although praise is one of the most powerful tools available for improving young children's behavior, it is equally powerful for improving your child's self-esteem. As explained earlier when we discussed criticism, preschoolers believe what their parents tell them in a very profound way. They do not yet have the cognitive sophistication to reason analytically and reject false information. If a preschool boy consistently hears from his mother that he is "smart" and a "good helper," he is likely to incorporate that information into his self-image. Thinking of himself as a boy who is smart and knows how to do things is likely to make him persist longer in problem-solving efforts and increase his confidence in trying new and difficult tasks. Similarly, thinking of himself as the kind of boy who is a good helper will make him more likely to volunteer to help with tasks at home and at preschool or kindergarten.
>
> I'd like for you to think about a scale. On one side of the scale is criticism and on the other side of the scale is praise. If your son receives more praise than criticism, he will have positive self-esteem. It is your job to try to keep the scale tipped in the positive direction by giving as many labeled praises as possible each day. In this way, your daily special playtime is very important. If you do your 5 min each day, you will have ten labeled praises in the bank to help you keep the scale tipped in the right direction.

To help parents increase their use of praise outside the special playtime, we sometimes give praising exercises in which parents are asked to put 10 pennies in one pocket. Their job is to transfer a penny to their other pocket each time they give a labeled praise. Their goal should be to get all 10 pennies into the other pocket within an hour. By increasing the number of labeled praises used both within and outside of special playtime, we hope to build a more positive atmosphere in the home that will in turn promote positive self-esteem.

Sometimes, parents share with us their observations that praise seems to backfire with their children. They have noticed that their children tend to respond to praise by immediately doing the opposite of what was praised. For example, when a parent says, "Thank you for putting the Legos back in the box so quietly," the child immediately begins to noisily slam the Legos into the box. Or, the parent might praise the child for chewing with his mouth closed with the result being that the child immediately laughs and displays the partially chewed contents of his mouth. We know that stimulation-seeking children often display this puzzling response to praise early in treatment. But, we also know that we can easily make labeled praise work for them by ensuring that they receive no negative attention when they misbehave when praised. Here is what we say to parents:

> Many parents tell us that praise does not work for their children. And we may even see that happen with Jackson next week during our first coaching session. You may say to Jackson, "I like the way you are coloring inside the lines." Jackson may respond by scribbling all over the paper, looking at you and laughing. It would be easy to conclude that praise makes Jackson worse instead of better, but that is not true. When a child scribbles all over the paper like that, it is natural for a parent to respond angrily with, "I said something nice. Why do you have to go ruining it?" Remember that children like Jackson work for stimulation. So when the child in our example was coloring inside the lines, he got only a little bit of stimulation in the form of a labeled praise. But, when he scribbled on the paper, he got a lot of stimulation from his mother's criticism, her red face, and her raised voice.
>
> If given the choice, children like Jackson will always choose the more stimulating criticism over the less stimulating praise. We can make labeled praise work by making sure

> that you ignore or under-react when he responds to praise by increasing misbehavior. So when he is coloring inside the lines, you say, "I like it that you colored inside the lines." Then when he scribbles on the paper, I want you to say nothing. In my experience, children respond to this by saying, "I'm coloring inside the lines now. I'm coloring inside the lines now." If the choice is between a *little* bit of stimulation from a labeled praise and *a lot* of stimulation from criticism, children like Jackson will choose to behave negatively and get the criticism. But if the choice is between a *little* bit of labeled praise or *nothing*, they will start working for the labeled praise.

Praise comes more easily to some parents than others. Sometimes parents have a difficult time praising their young children because they are not demonstrative people by nature. Such individuals seem to benefit from the direct coaching of how to praise. Other parents have difficulty praising their young children because of tensions associated with the coercive nature of the parent-child relationship. Some are so angry with their children that they have difficulty recognizing positive child behaviors and attributes that are praiseworthy. When a "praise-able" behavior is recognized, some parents express the attitude that "He should have been doing that all along. Why should I make a big deal out of it when he's been so bad all day long?" Of course, we help them to understand that it is on these difficult days that their praise is especially important. For these parents, initial praises may sound less than genuine and be given in a begrudging fashion. However, we find that with consistent practice and coaching in Child-Directed Interaction, the parent learns to focus more and more on the child's positive attributes and praises come much naturally.

Reflect. The second "Do" skill is "Do Reflect." By reflect, we mean that the parent should repeat the basic message of what the child has said, a form of verbal imitation. The message can be extended, elaborated on, or subtly corrected through reflection. For example, if the child says "I builded a house," the parent might respond with any of the following: "You built a house" (grammar correction), "You built a house with a front door" (grammar correction with elaboration), or "You built a green and blue house" (grammar correction with elaboration of pre-academic concept). Parents may also use reflections to gently correct phonological process errors such as omitting the last consonant sound of a word (saying "mow" for mouse"), devoicing consonants (saying /p/ for /b/), stopping consonants (saying /t/ for /th/), and omitting unstressed syllables (saying "ghetti" for spaghetti).

Initially, many parents are able only able to "parrot back" the exact content of the child's message, without elaboration. Although these literal reflections sound less natural than elaborative reflections, they are still beneficial, particularly for very young preschoolers. Five- and 6-year-olds will often appear puzzled when parents first begin to reflect their verbalizations. However, most adapt quickly as parents become more skillful at elaborating and extending reflective communications.

Reflections communicate acceptance and understanding and let the child know that the parent is really listening. Adults often get into the pattern of simply acknowledging young children's statements with a head nod or nondescript verbalization such as "Uh-huh," while their attention is clearly elsewhere. While it may not be practical for parents to give their children their undivided attention upon demand

throughout the day, parental attention should be clearly communicated during Child-Directed Interaction. Acknowledgments such as "Yeah," "I see," "Uh-huh," and "How about that" are considered missed opportunities for something more therapeutic. Acknowledgments should be replaced with reflective statements clearly communicating understanding of the child's message. In teaching parents to reflect, we encourage them to become aware of times when their child repeats a phrase over and over such as, "Mommy, look at my star. Do you see my star? Here's a star I made." Repetition can be a signal to parents that the child wants a reflection.

Reflective statements also keep the child in the lead during conversation, encouraging the child to elaborate. As mentioned earlier, the most effective verbal stimulation for young children comes in the context of an ongoing activity of interest to the child. Reflection allows the parent to provide an immediate reward for the child's verbal initiations, encouraging the child to speak more and more often. Reflections are much more effective for encouraging children to speak than are questions, and we ask parents to reflect nearly all appropriate verbalizations the child makes during special playtime.

When using reflections, it is important that they be phrased as a statement. When parents repeat children's words with a questioning inflection, children may perceive that parents are not listening, do not believe them, do not approve of them, or do not understand them. We tell parents:

> When reflecting, I want you to be careful to avoid making it sound like a question. For example, if Tara says, "Mr. Potato Head is jumping to the moon." I want you to avoid asking, "Is Mr. Potato Head jumping to the moon?" When you ask it that way, Tara might think that you don't believe her. Or, she might think that you weren't listening very carefully and that you didn't understand her. Instead, I want you to reflect with absolute certainty in your voice: "Mr. Potato Head *is* jumping to the moon." When you say it definitively like that it sends a message to Tara that you agree with her and that you understand her. This will help your overall communication with Tara, helping the two of you to be on the same wavelength.

Imitate. The third "Do" skill is "Do Imitate." It is important that parents be active participants in the play activity and not just passive onlookers. By imitating the child, the parent demonstrates that he or she is paying attention to the child's activity and thinks it is interesting enough to do also. Imitation is indeed the sincerest form of flattery, and being imitated by powerful grown-ups is a self-esteem boost to young children. Imitation of the child also enhances the child's imitation of the parent (Roberts, 1979) and forms the basis for one of the most important social skills for young children, turn-taking. Parents should keep in mind that any behavior they imitate is likely to be repeated by the child and to increase. Therefore, good judgment should be used in selecting appropriate child behaviors to imitate.

By imitation, we mean that the parent should play with the same or a similar toy and attempt to manipulate the toy in a way that approximates what the child is doing. We do not mean for the parent to imitate in a literal sense, with every action and every block color perfectly replicated. Basic imitation is a form of parallel play in which the parent approximates the child's activity, always a step or two behind, but keeps the focus of attention on the child's play. For example, if the child is

building a tower with the blocks, the parent should also build a tower, making sure to keep it shorter and perhaps less well balanced than the child's tower. The parent may occasionally draw the child's attention to the imitation by saying "Yours looks great. I want to try and build mine like yours." However, the parent should continue to keep his or her attention primarily on the child's activity, maintaining the running commentary.

Imitation is very useful for parents who are not accustomed to playing in a developmentally appropriate way with young children. It removes the burden of thinking up an engaging activity that is appropriate for their child's developmental level. Instead, the child teaches them how to play at the appropriate level. Some perfectionistic and high-achieving parents have difficulty with imitation. Some lose sight of goals of imitation and have a tendency to want to create the "Taj Mahal" rather than a modest structure that is within the child's developmental capability. We have found this more often in fathers who are accustomed to playing the role of builder and toy assembler/repairer at home. Thus, we caution parents to be sure that it is their child who comes up with the novel, creative ideas during play and to be sure that their "replication" does not appear more attractive than the child's original. Otherwise, the special playtime rapidly deteriorates, with frustration on the part of the child and a loss of interest in the too-advanced activity.

Depending on the child's level of development, the parallel play that is encouraged through imitation may be shifted toward more interactive play, with the parent placing a block on the child's tower and initiating turn-taking. However, if the child resists interactive play, we encourage the parent to select a different toy and casually manipulate it while continuing to focus on the child's solitary activity. Depending on the goals we have for a particular family, we evaluate whether it is more important to maintain the positive, warm tone of the interaction and avoid attempts at interactive play, or to gradually shape basic social skills. Appropriate shifts from parallel to interactive play are difficult to teach didactically, and we usually reserve this topic for direct coaching sessions.

Describe. "Do Describe." Parents are encouraged to watch their child's activity closely and to comment on the child's appropriate play. Specifically, Eyberg (1999) and Eyberg, Nelson, Duke, and Boggs (2005) coined the term "behavioral description" to refer to a running commentary of the child's ongoing activities. To be coded as a behavioral description, the comment has to refer directly to the child's behavior, usually including the word "you." Examples include, "You're drawing with red marker," "You put the chimney on the house," "You're sitting in the chair," and "You're looking at all the toys." In contrast, Eyberg uses terms like "information description" or "neutral talk" to refer to comments that introduce information but do not refer directly to the child's ongoing or immediately completed activity. Neutral talk includes statements such as, "I am building a bridge (parent describes own behavior)," "The doll is sleeping (does not contain the word 'you')," and "You played with the blocks last time we were here (contains 'you' but refers to the past)." We want parents to use a lot of behavioral descriptions, commenting on the child's current behavior, as these allow the parent to join in and show interest without leading the play.

To explain describing, we employ the analogy of a sportscaster broadcasting a play-by-play description of the game. For example, as a child assembles Mr. Potato Head, the parent might say "You're looking at all the pieces. Oh, you put a green cowboy hat on Mr. Potato Head. Now you gave him a mustache. You picked the green glasses that match the green hat (child struggles to put them on). You're trying really hard."

Descriptive statements provide several benefits. First, if a parent is describing the child's activity, the child is always kept in the lead. That way, the child has opportunities to come up with his or her own ideas, to problem-solve with minimal intervention, and is not rushed to keep pace with the parent. Second, continuous descriptions are a clear demonstration that the child has the parent's undivided attention. The child does not need to whine or bang toys on the table to get a response from the parent. Undivided attention can be self-esteem building in that it communicates that the parent thinks the child's choice of activity is interesting. Third, descriptions can be used as a teaching tool for pre-academic or early elementary school concepts. For example, parents can say, "You put one, two, three, four, five blocks on your tower," and "You grouped all of the green beads together." The parent can make observations about the sizes and shapes of toys and describe sorting activities. Descriptions can also be used to model and correct grammar and phonological processes. Simple descriptions of child-centered activities are particularly important for stimulating language development in young children.

A final benefit of descriptions is that they help to organize young children's thoughts about play, increasing the length of time they are able to attend to the task-at-hand. During a running commentary, the child's attention is much less likely to wander because each statement made by the parent maintains the child's focus on the activity. We observe that during special playtime, young children make fewer switches between toys, and they are more likely to persist and problem-solve in the face of a challenge. See Fig. 4.1 for an example of how behavioral descriptions can increase attention to task and productivity. In the first picture, the child was told to draw a Christmas tree and the therapist simply observed quietly. Five minutes later, the therapist told the child to draw another Christmas tree but provided behavioral descriptions throughout the task. The child was more persistent, provided more detail, and stayed with the task longer when behavioral descriptions were provided. We have also observed that after several weeks of consistent Child-Directed Interaction, our clients often describe their playmates' activities during interactive play and describe aloud their own activities during solitary play. Over time, these vocalizations diminish and we believe that children internalize this running commentary as "private speech" so that they continue to do a silent play-by-play, assisting themselves in maintaining their focus.

Be Enthusiastic! The last PRIDE skill is "Be Enthusiastic!" Parents need to display excitement during the play to make Child-Directed Interaction fun and to engage the child. Enthusiasm involves talking with an animated voice with varied inflection. This warm interactional style communicates interest and makes the playtime more enjoyable for both the parent and the child. Some of our parents,

Without Behavioral Descriptions With Behavioral Descriptions

Fig. 4.1 Child's drawing of a Christmas tree with and without the use of behavioral descriptions

particularly those who are somewhat anxious or depressed, struggle with generating the energy to sound enthusiastic during the play. Other parents, particularly fathers who have a history of playing very rambunctiously with their children, may readily pick up the enthusiastic style. Whereas with our depressed and anxious parents, we have to work hard to elicit even a small spark of excitement, we often have to reign in our rambunctious parents to prevent them from over-stimulating their children. To help parents learn to be enthusiastic, we model for them how it sounds to conduct CDI skills with and without inflection. We also encourage them to pick toys for Child-Directed Interaction that they enjoy playing with so that it is easier to be enthusiastic.

Using Strategic Attention

Before PCIT, referred families may be stuck in a negative cycle in which the child frequently misbehaves and the parent responds with negative attention. Here is an excerpt from a typical day in the life of one of our families before treatment:

> Timmy is feeling a little bored so he walks over to his sister and pulls her hair. The sister screams, "Mommy!" and Timmy's mother shouts, "Stop that Timmy!" He then pushes his sister and jumps up on the couch shouting, "You can't catch me." Timmy's mother yells "Get down off the furniture. You're going to break it." Timmy jumps even more on the couch and says, "No. It's a trampoline. Bouncy, bouncy, bouncy!" Mom says, "Get down now or I'm going to tell your Dad how mean you've been all day." Timmy runs away from his mother and goes to his room. While he is in his room, Timmy gets interested in his Legos. He quietly builds spaceships, cars, and helicopters for about 20 min. During this time, Timmy's mother is relieved to have a break from his constant misbehavior. She wipes her brow and takes this rare opportunity to load the dishwasher. When she walks past Timmy's room, Timmy's mother is careful not to talk to him, as she does not want to stir

up trouble. Having been alone for 20 min, Timmy starts to crave his mother's attention. As she ignores him when he is good, he has to misbehave to get her to pay attention to him. So, when his mother walks by his door the next time, Timmy runs after her and spanks her on the back side. She responds by yelling, "That wasn't nice!" He then jumps on the couch again, chanting "Bouncy, bouncy, bouncy!" His mother again screams, "Stop that. You're going to break the couch. Do you know how much that couch cost?"

This negative cycle of the child's misbehavior followed by parental negative attention plays out repeatedly throughout the day. And, as can be expected, the exhausted parent responds to the infrequent periods of positive behavior by withdrawing attention and seizing the opportunity to take a much-needed break from the child. Unfortunately, the only way for the child to then get attention is by misbehaving once again, thereby re-activating the negative cycle.

We can interrupt this negative cycle by teaching parents to use "strategic attention." By strategic attention, we mean using the "Do" skills of Child-Directed Interaction to carefully reward the behaviors or qualities that we would like to see the child display more often. The first step in using strategic attention is to identify those behaviors or qualities that the parent sees as desirable and pro-social, even if the child rarely displays them at first. Often these desirable behaviors become more apparent as parents are encouraged to think of the opposite of problematic behaviors. For example, behaviors or qualities that might be targeted include using polite manners, making good eye contact when speaking, smiling, being gentle with the toys, using an indoor voice, persisting at difficult tasks, playing quietly while the adults talk, sharing, and taking turns.

Once these behaviors are identified, the second step in strategic attention is for the parent to be on the lookout for the targeted behavior to occur, trying to "catch the child being good." For example, "Sarah" was a loud child who played roughly with the toys, banging them on the table. Her father learned to look for even the briefest moment when Sarah was holding a toy gently or placed a toy on the table quietly. Immediately when that occurred, we coached him to say something like "You put that toy down so quietly and softly (descriptive statement). I really like it when you treat the toys nicely (labeled praise). I think I'll play gently with the toys just like you do (imitation)." By the end of the clinic CDI session, Sarah was working very hard to earn her father's praise for being gentle and she was playing with the toys with exaggerated care. Her father was able to accomplish this without ever giving her a command or making a critical statement. We encourage parents to use strategic attention whenever possible through the day, not just during the 5 min of CDI practice.

Using Selective Ignoring

Just as parental attention in the form of the PRIDE skills can be used strategically, many behaviors can be shaped by withdrawing attention strategically. We call this technique "Selective Ignoring." As soon as we bring up the technique of ignoring, most parents tell us that they have already tried it and it simply does not work with

their child. We explain to them that selective ignoring is an advanced skill that few people use effectively without special training. There is a great deal to know about what problems can be reduced with ignoring, what situations are most appropriate for the skill, and how to ignore effectively. Although we encourage parents to use selective ignoring for particular problems during CDI, we make our discussion of the technique more general so that the principles can be applied outside of special playtime.

The first step is for parents to identify child behaviors or qualities that they would like to see diminished; we write these on the chalkboard to aid in further discussion. The types of behaviors often named by parents include whining, talking back, hitting, throwing a tantrum, tearing things up, fighting with siblings, lying, being sad, nagging, and running away in public places.

Ignoring Only Works for Attention-Seeking Behaviors. Unfortunately, not all of these problem behaviors can be diminished through the use of ignoring. The first important principle for parents to understand about ignoring is that it is only effective when the function of the child's misbehavior is to elicit a reaction from the parent. We illustrate this concept by saying,

> If you want your son to stop eating a cookie, will it work to turn your back to him and ignore? No, of course not. The reason he is eating the cookie is because it tastes good, not because you are watching him. If your daughter is jumping up and down on the mattress and box springs, will it work just to leave the room? No, of course not. She's probably not jumping up and down just to "get your goat"; she's probably enjoying the bouncing motion. If your son whines about wanting to go to McDonald's, could it work for you to say "We don't have time to go today" and then leave the room, ignoring any further whining? Yes it could. Children don't whine because whining is fun all by itself. I've never seen a child sitting alone in a room whining. What makes whining rewarding for young children is the reaction they get from the parent. If you consistently deprive him of that reaction (and your presence) when he whines, his whining should dramatically decrease.

After giving these examples, we go through the list of behaviors that the parents would like to see diminished. The therapist helps the parents to analyze whether or not their attention rewards the child for engaging in each of the behaviors and whether removal of attention should be expected to impact the behavior. Many of the behaviors the parents listed will not be appropriate targets for selective ignoring, and will need to be addressed later in the discipline portion of PCIT. We erase those from the chalkboard. Most often sibling conflict is not being rewarded by attention from parents, but instead by the negative attention from the sibling. Lying and stealing are not good candidates for ignoring because they are not reinforced by parental attention. Most preschoolers who lie are doing so to avoid getting into trouble for something they have done, and most young children who steal are rewarded simply by having possession of the desired object.

Ignoring Causes Behavior to Get Worse before It Gets Better. A second important principle for parents to understand about ignoring is that the behavior that is ignored will get worse before it gets better. When a child is accustomed to getting a particular reaction from the parent and one day that reaction does not come, most will respond by escalating to a more disruptive level that has a better chance of

getting the parents' attention. In deciding whether a particular problem can be diminished through ignoring, the parent must make a judgment about whether he or she can tolerate having the behavior get worse before it gets better. We ask parents to look back at the list of remaining behaviors on the chalkboard and help them to decide whether they are ones they can tolerate having get worse. It is never a good idea to ignore behaviors that could escalate and potentially be dangerous to the child or to others. For example, playfully running away in public places and physical aggression should not be ignored.

Some parents will feel able to ignore problem behaviors at home such as whining and talking back, even if they escalate. However, they may not feel prepared to ignore these behaviors when they occur in the presence of relatives or in public places. We encourage them to talk with us about why they feel unable to ignore in public settings. Many express the belief that onlookers will scrutinize them and be critical of their parenting if they simply ignore whining and talking back. Often such fears are markedly exaggerated. Later in PCIT, we will work with parents on disciplining their children in public places and it is helpful to identify early any cognitions that may interfere with follow through on behavior management in public. Some parents tell us that they cannot tolerate having any of their child's problem behaviors get worse before they get better. Such individuals are usually highly stressed and feel considerable anger toward their children. They may require special explanations and extra support to be open to using selective ignoring as a behavior management tool.

Ignoring Must Be Continued Until Child Exhibits Some Positive Behavior. The third principle parents must understand to use selective ignoring effectively is that once they begin to ignore a behavior, they must ignore it all the way through to the end. If the parents give in and reward the child with their attention (even if it is negative attention) after the child's behavior has already escalated, they will teach the child that a higher level of disruptiveness will be necessary to have the desired effect in the future. This principle is explained to parents using the "check-out line" example.

> Imagine that while you are waiting in the check-out line at the grocery store, your daughter asks you nicely for a tootsie-pop. You tell her "no" because she has already had enough candy for one day. She responds by whining softly that she wants "just one, please." You decide to ignore her whining and pick up a magazine and start thumbing through it. Your daughter reacts by whining more and more loudly, becoming increasingly demanding. You notice that she has gotten the attention of people nearby and you are feeling embarrassed. You tell her in an angry tone, "Be quiet. I told you *no*." She throws a full scale temper tantrum and you buy her the tootsie-pop to calm her down. What you have accidentally taught her is that asking politely is not the way for her to get what she wants. But, she can get exactly what she wants if she is loud and obnoxious enough, particularly when you are in a public setting with lots of people around. Next time you take her to the store, you can expect her behavior to escalate even more quickly.

Parents are invited to briefly problem-solve with the therapist about alternatives. Parents need to decide right away about whether they are up to ignoring all the way through. For parents who indicate that they cannot or will not ignore throughout, we discuss the principle of "giving in early." It is better to reward the early-stage

whining than the later-stage tantrum. Given that ignoring is not a strategy for all situations nor for all parents, other discipline strategies are presented later in PCIT.

Ignore, Distract, Model the Opposite Behavior, and Praise the Opposite Behavior. During CDI, most young children are on their best behavior and display only minor problems (e.g., whining, talking back, bossiness, loud voice, rough play with toys). These can be addressed through selective ignoring of problematic behavior with strategic attention paid to incompatible behaviors. The therapist models for parents the use of strategic attention and selective ignoring in rapid succession. When the child (role-played by a parent or co-therapist) is behaving appropriately, the therapist leans toward the child, makes good eye contact, and uses the PRIDE skills (praise, reflection, imitation, description, and enthusiasm). Particular attention is paid to behaviors that are incompatible with identified problem behaviors such as using a big boy voice, asking politely, using an indoor voice, and playing gently with the toys. As soon as the child begins to whine or talk back, ignoring begins with the therapist turning in the chair to face away from the child. No further eye contact is made, no words are exchanged, facial expression stays blank (even if the child is clowning) and the therapist pretends that the child is not there. However, the therapist unobtrusively watches for the first possible moment when attention can be returned to the child, in other words when the child pauses or ceases the disruptive behavior. When that happens, the therapist swings back around in the chair, makes eye contact with the child and says something like "Thank you for playing gently with the toy. It's so much more fun to play with you when you treat the toys nicely."

When ignoring, we want to maximize the contrast between how the parent responds to the child when the child is behaving appropriately and how the parent responds when the child is disruptive. Exaggerating both the attention and the ignoring will help children to learn pro-social behavior more quickly. Sometimes the child's disruptive behavior is prolonged and it is difficult to find a momentary pause during which to return attention. In those situations, we encourage parents to "ignore and distract," which involves moving away, playing with a different toy, and enthusiastically describing their own play, but as though talking to oneself. Most often, the child will quickly cease the disruptive behavior to join the parent in the new and attractive activity. The parent then has the opportunity to provide strategic attention for appropriate behavior. Another skill used while ignoring is "modeling the opposite behavior." For example, while ignoring his child who has begun a barn yard brawl with all of the farm animals, the father can begin to enthusiastically describe how much fun his animals are having because they are good friends who play exciting games together. It is not uncommon for the child to begin participating in the more cooperative play being modeled by the parent. The "ignoring" teaches the child what "not to do," and the "modeling" teaches the child what "to do" instead to obtain the father's attention. For brief and transient misbehaviors, it may not be necessary to turn away from the child. Instead, the parent may simply avert their eyes and either say nothing or describe their own play until the child is behaving appropriately again. Sometimes "Grandma's rule" is best: "If you don't have anything good to say, just say nothing at all."

Handling Disruptive Behaviors That Cannot Be Ignored

Although unusual, some of the children we work with who have severe behavioral disturbances display a variety of conduct problems that cannot be ignored during special playtime because they are dangerous to the child or to others. Such behaviors include standing on top of furniture, throwing or breaking toys, hitting or biting the parent, putting small toys in their mouths, and banging on observation room mirrors. These behaviors are more apt to occur during our coaching sessions in the clinic which last up to an hour than during the very brief daily sessions at home. In both settings, we encourage the parent to intervene as needed to ensure the child's and parent's safety. At home, parents respond to aggressive or dangerous behaviors by discontinuing that day's special playtime session and disciplining the child using any safe method of their choosing. For most children, discontinuation of the play session is sufficiently punishing that repeated episodes of aggression during CDI rarely occur. In the clinic, we do not want to lose out on valuable coaching time by ending the session. Instead, when one of these behaviors occurs, we typically walk into the playroom and ask the parent to leave. We then clearly and firmly restate for the child the safety rules of our playroom. The departure of the parent and the serious voice of the therapist generally gets children's attention and interrupts the escalating behavior. After a minute or two, the parent is brought back into the room and coaching resumes. For a description of additional strategies for managing the behavior of highly aggressive and explosive children, please see Chapter 16.

Modeling Skills in Combination

While describing each of the CDI skills, the therapist briefly demonstrates the skill in isolation. However, this does not give parents an accurate picture of how the skills are used in combination. We have sometimes modeled use of the combined skills with a parent or co-therapist pretending to be the child. At other times, we have used a post-treatment videotape segment of a real parent using the skills with a child who presented with problems similar to those of the referred child, or with a child and parent of similar cultural background (written authorization to use tape for teaching purposes is required for this purpose). Social learning research tells us that modeling is most useful when the parent perceives the model to be similar to him or herself. We also find the videotape particularly helpful in that we can pause it, make observations, and review the segment again.

Role-Plays of Child-Directed Interaction

After demonstrating the combined skills, we ask parents to briefly role-play. For single parents, the therapist can ask a co-therapist to play the role of the child, or if a co-therapist is not available, the therapist can do double-duty as both the child

and the therapist-coach. In two-parent families, we ask one parent to play the part of the child while the other parent plays himself or herself. Most parents experience some performance anxiety during this first role-play. We try to lessen that anxiety by maintaining a positive, praising tone and interjecting anxiety-defusing humor whenever possible. After getting over their initial anxiety, many parents find this the most enjoyable part of the teaching session.

We recommend doing two brief role-plays of about 2 min each. In the first, the child should be perfectly behaved and present no behavior management challenge. In the second, the child should show intermittent minor disruptive behavior but behave appropriately most of the time. These role-plays should be repeated with the spouse if present. The therapist-coach should encourage parents to begin with describing, and gradually add in the other "Do" skills. If the parent is having difficulty getting started, the therapist may suggest specific phrases for the parent to repeat. After nearly every parent verbalization by the parent, the therapist-coach should immediately and quietly provide brief feedback such as "nice description," "good reflection," and "good labeled praise." Because they are concentrating hard on their verbalizations, most parents will need to be gently prompted to imitate. It is not necessary to correct every error that the parents make during these role-plays; there will be plenty of opportunities to correct errors during subsequent coaching sessions. The purpose of the role-plays is to introduce the parents to how it feels to do the skills and what it is like to have someone providing them with frequent, largely positive feedback on their performance. The parents should leave the session recognizing that CDI will be a challenge, but one that is well within their grasp.

Appropriate Toys for Child-Directed Interaction

Parents should have a set of three to five toys that are always available for the child to play with during special playtime. Most parents find that their children already have several appropriate toys and they need not purchase new ones. Other parents have found it helpful to purchase two or three inexpensive toys that are put away and brought down only during special playtime. This strategy helps to preserve the novelty of the toys and adds to the child's anticipation of daily special playtime. However, we do not advise parents to restrict the child's access to toys that he or she already possesses, as this would (justifiably) seem unfair and detract from the goal of enhancing the parent-child relationship.

We give parents a handout summarizing the types of toys that are good for CDI and those that are to be avoided (see Appendix 4). In general, constructional toys without preset rules are best. Examples of constructional toys include Duplos (for 3–5-year-olds), Legos (for 5- or 6-year-olds), Waffle Blocks, building blocks, Tinkertoys, magnetic blocks, Lincoln Logs, Erector Sets, Mr. Potato Head, magnetic picture boards, crayons and paper, and chalkboards and colored chalk. Sets of plastic figurines and building structures are also appropriate for special playtime. Examples include farms and stables, doll houses with miniature people, and

race tracks or garages with toy cars. All of these toys encourage creativity and provide developmentally appropriate opportunities for problem-solving in the context of play. They are calm, pro-social, sit-down activities that set children up to be on their best behavior.

We caution parents to avoid toys that are conducive to rough play like bats, balls, boxing gloves, and punching bags. With these toys, children who are prone toward behavior problems become overly excited, often requiring parental interventions that take the lead away from the child and cause unpleasantness. Similarly, we encourage parents to avoid toys that set the stage for aggressive play. Such toys would include toy guns, swords, cowboys and Indians, and superhero characters. For very disruptive children, toys that are messy and can get out of hand (such as paints, scissors, and Play-Doh) should also be avoided during CDI.

Board games and card games with preset rules do not work well in special playtime. The child may be the loser in the game, have trouble taking turns, or cheat, causing unpleasantness during a time when we want to encourage parent-child bonding, not competition. Although we strongly encourage parents to read to their children daily, we discourage reading during special playtime because it interferes with spontaneous parent-child conversation. Because we want parents and children to talk directly to one another during special playtime, we advise parents to minimize the use of toys that encourage participants to pretend they are other people, speaking through their pretend characters. Examples of these are puppets, costumes, toy telephones, and dolls.

Dealing with One-Parent and Two-Parent Families

CDI is particularly helpful for one-parent families. When parents are highly stressed and overburdened with the responsibilities of single parenthood, quality playtime with children is rare. Special playtime provides a practical mechanism by which a single parent can assure spending some individual, high-quality time with the child each day. In fact, our research suggests that children from single-parent families demonstrate larger gains in self-esteem after PCIT than do children from two-parent families (Eisenstadt [Hembree-Kigin], 1990).

In two-parent families, sometimes we are asked whether the parents can alternate days conducting special playtime. Because one of the goals is to improve the quality of the parent-child relationship, we feel it is important that *each* parent do CDI *every day*. Dynamics in the marital relationship often become apparent during CDI treatment sessions. Some couples are very supportive of one another and are able to serve as effective "coaches" for each other at home. That is, they can observe one another unobtrusively and offer constructive feedback, much as the therapist-coach will do in treatment sessions. Other couples are highly critical of each other or have power imbalances such that it is best if they do not critique one another. We share with parents the potential advantages and disadvantages of observing one another at home and allow them to come to their own decisions about how they will practice. We encourage parents to be positive, constructive, and supportive of their spouses throughout PCIT.

Incorporating Siblings

We suggest that parents also do CDI at home with all of the referred child's siblings who are between the ages of 2 and 6. Children love special playtime. Directing this special attention only to the referred child often causes jealousy in siblings. Moreover, we find that siblings of the referred child often experience clinical or sub-clinical problems and may benefit from the effects of special playtime. Parents can usually generalize use of the skills from the referred child to the siblings with little difficulty. Most often, we recommend that parents begin special playtime at home with all of the children, but bring only the referred child for initial practice sessions in the clinic. If the parents are experiencing difficulty adapting their skills to the siblings, we sometimes schedule an extra session of brief coaching with the siblings. Please see Chapter 11 for more detailed information regarding sibling issues in PCIT.

Adjusting CDI to the Child's Developmental Level

When parents are doing behavioral play therapy with siblings of the referred child, they sometimes need help adapting the skills to the appropriate developmental level. The skills as described in this chapter are appropriate without modification for 4- and 5-year-old children. For children who are 2 and 3 years old, parents should expect the child to play more comfortably on the floor than at a table. The selection of toys should be adjusted to the toddler age range, using perhaps stacking rings, soft blocks, toy trucks, and push toys. Hand games like patty-cake may also be used. Toddlers change activities more frequently than do older preschoolers and a sufficient number of toys should be available to maintain the child's interest. Parent verbalizations should be shortened and simplified to provide the most effective stimulation. If the child has few words, any attempts at verbalization or sound-making should be reflected and imitated and praise should be specifically directed at verbal communication attempts. To maintain toddlers' interest, parental affect should be exaggerated, with highly animated praise and even hand-clapping (see Chapter 9). For 6- and 7-year-olds, we recommend that parents concentrate on a very natural tone, as exaggerated animation and overly enthusiastic praise will sound artificial and condescending (see Chapter 10). Reflections with older children should never sound "parroted." Instead, they should be highly elaborative without directing the topic of conversation.

Problem-Solving with Parents on Logistical Issues

Parents need to make decisions about where they will conduct their home play sessions and at what time of day they will occur. Rather than leaving parents to sort these problems out for themselves, we prefer to spend a few minutes assisting them

with their problem-solving. CDI should be conducted in a place that is quiet, private, and free of interruptions and distractions. It should not be done in a room with the television playing or with siblings intruding. Nor should it be done in the child's bedroom if there are toys in sight that would be inappropriate for special playtime but tempting to the child. Many parents find that the kitchen or dining room table works best, while others prefer playing on the floor in the parent's bedroom or a guestroom.

We recommend that the play sessions occur at about the same time each day and be incorporated into the family's daily routine. When special playtime occurs at differing times each day, young children often become anxious about missing out on their time with their parents. They can sound like a broken record, continuously nagging the parent to play with them. This situation certainly detracts from the pleasure experienced by both the parent and the child and does not contribute to relationship enhancement. Many parents use special playtime as a way to calm children down before bedtime. We find that bedtime preparations often go more smoothly when children know that special playtime always comes after brushing teeth, putting on pajamas, and so forth.

Some children have difficulty accepting the end of their playtime and try to manipulate the parent into spending extra time. If the parent wishes to extend the interaction, we recommend discontinuing the specific skills of CDI and engaging in another activity that is appealing to the child such as playing with dolls, reading a book, or tossing a ball in the backyard. In this way, the child continues to enjoy the parent's company but the parent does not "burn-out" on the play therapy skills. Another way to help children accept the end of special playtime is to schedule it at a time immediately preceding another desirable activity such as a favorite television show, snack time, or story time. Most scheduling problems occur in families with two or more young children. If it is a two-parent family, they may choose to take turns providing childcare for one another during play therapy sessions. When only one parent is available, special playtime can often be accommodated by staggering naptimes or bedtimes.

Assigning Child-Directed Interaction Homework

Each parent is asked to commit to practicing special playtime at home with their child for 5 min every day for 1 week until the next clinic session. They are reminded that they are not expected to become "play therapists" overnight. For the next few sessions, they will be coached in how to use these CDI skills. They are given a recording sheet on which to mark whether they got in their practice and the types of toys/activities involved in the playtime (see Appendix 2). For many families, this homework sheet serves as a reminder to practice, although the children are so fond of their special time that they rarely allow the parent to forget. The homework sheet also helps to make parents feel accountable, as it is reviewed with the therapist at the beginning of the next session.

References

Eisenstadt (Hembree-Kigin), T. (1990). *Parent-child interaction therapy with behavior problem children: An evaluation of overall treatment outcome and the relative effectiveness of two treatment phases*. Unpublished doctoral dissertation. The University of Florida., Gainesville.

Eyberg, S. M. (1999). *Parent-Child Interaction Therapy: Integrity Checklists and Session Materials*. Retrieved April, 2, 2008. Available online at www.pcit.org

Eyberg, S. M., Nelson, M. M., Duke, M., & Boggs, S. R. (2005). *Manual for the Dyadic Parent-Child Interaction Coding System (3rd ed.)*. Available on-line at www.PCIT.org.

Roberts, M. C. (1979). The effects on the model of being imitated: A review and critique of the literature. *JSAS Catalogue of Selected Documents in Psychology*, *9*, 7–8.

Chapter 5
Coaching Child-Directed Interaction

What to Bring. . .
(1) ECBI
(2) DPICS – III Coding Sheets
(3) CDI Homework Sheets
(4) PCIT Progress Sheet
(5) Sheila Eyberg's Treatment Integrity Checklists/Manual

When therapists coach CDI skills, we employ the same strategies and philosophies that parents are taught to use with their children during special playtime. Therapists provide labeled praises to parents to increase particular CDI skills. We also use strategic attention and selective ignoring to increase certain parent verbalizations while decreasing others. Just as a goal of special playtime is to improve the parent-child relationship, therapists use coaching strategies that enhance rapport with the parents. For example, therapists avoid criticism when coaching, particularly the words "no," "don't," "stop," "quit," and "not," in order to prevent parents from feeling judged or incompetent. These negative feelings damage our relationships with the parents and lead to treatment attrition. Rather than criticizing, we enthusiastically give attention to their positive behaviors by describing and praising. When correcting the parent, we use constructive feedback telling them what "to do" rather than what "not to do." Just as we teach parents to allow their children to lead the play, we allow parents to take the lead in their use of PRIDE skills. That is, we want parents to use their own words and develop a play style that is comfortable for them within the CDI guidelines. We only use constructive corrections when the parent is having difficulty with a particular skill. In fact, in the first CDI coaching session Sheila Eyberg (1999) discourages use of any correction at all, so as to make rapport a priority. When parents are using the CDI skills well, we follow their lead, using descriptions and praise to demonstrate acceptance. According to Dr. Eyberg, (2005) the basic principles of client-centered therapy (empathy, genuineness, and

C.B. McNeil, T.L. Hembree-Kigin, *Parent-Child Interaction Therapy*,
Issues in Clinical Child Psychology, DOI 10.1007/978-0-387-88639-8_5,

positive regard) should guide our coaching. We want parents to leave coaching sessions feeling good about themselves, good about their child, and good about their progress in treatment.

Novice PCIT therapists can coach the basic Child-Directed Interaction skills with little or no prior experience. However, coaching is an art that continuously develops as the therapist gains experience working with parents from diverse cultural groups, with various communication styles and disparate child-rearing attitudes, and with children who present unique challenges. Although skillful coaching develops from experiences working with dysfunctional parent-child dyads, it is also grounded in an understanding of early childhood development and normative parent-child interactions. We feel it is particularly important for the PCIT therapist to develop and maintain an "internal barometer" for the wide range of interaction styles and communication patterns that characterize healthy, nurturing parent-child relationships. In this way, the therapist will broaden his or her repertoire of coaching strategies and reduce the tendency to develop professional "myopia," in which similar interaction sequences are coached in all families, without regard to the family's unique communication strengths and style.

Overview of a Typical Coaching Session

Table 5.1 presents the steps involved in typical coaching sessions for families in which one or both parents are participating. Upon arrival to each PCIT session, parents complete the ECBI Intensity Scale in the waiting area. The therapist quickly tallies the score and records it on the PCIT Progress Sheet (see Appendix 5) and provides feedback to the parent about changes over time, often using a graph to visually display the changes in ECBI scores. The session begins with a review of the homework. After problem-solving issues that arise with the homework and inquiring about other familial stressors, we observe the parent conducting a 5-min play therapy session with the child, without any direct coaching. Parental use of CDI

Table 5.1 Steps for conducting a Child-Directed Interaction coaching session

One parent participating		
Step 1	Check-in and review of homework	10 min
Step 2	Coding of CDI skills	5 min
Step 3	Coaching of CDI skills	35 min
Step 4	Feedback on progress and homework assignment	10 min
Two parents participating		
Step 1	Check-in and review of homework	10 min
Step 2	Coding of first parent's CDI skills	5 min
Step 3	Coaching of first parent's CDI skills	15 min
Step 4	Coding of second parent's CDI skills	5 min
Step 5	Coaching of second parent's CDI skills	15 min
Step 6	Feedback on progress and homework assignment	10 min

skills during these 5 min is recorded on a Dyadic Parent-Child Interaction Coding System (DPICS – III) recording sheet (see Appendix 1) and later transferred to the PCIT Progress Sheet (see Appendix 5) so that parents can view session-to-session changes. After this 5-min observation period, the parent is directly coached by the therapist while continuing to practice the PRIDE skills with the child. For two-parent families, the coaching session is divided in half so that each parent receives coaching. The parent who is not being coached learns through observation and is often taught to code from behind the mirror. The observing parent should be quiet so as not to interrupt the coaching. The last 10 min of the session is spent providing parents with feedback on their progress (see Appendix 5 for PCIT Progress Sheet) and identifying areas that should receive special focus during the next week's home practice. The therapist may choose to reserve an additional few minutes at the end of each coaching session for individual rapport-building as needed. This individual time can decrease resistance to therapy by encouraging children to view the therapist as an ally rather than as a conspirator with the parents. Although the number of CDI coaching sessions will vary based on how quickly parents master the skills, the basic steps outlined in this chapter are used in each coaching session.

Setting Up for the Coaching Session

The parent and child meet with the therapist in a childproofed playroom equipped with a table, chairs, and three to five toys that are appropriate for special playtime (e.g., creative, construction oriented). The parent and child often play on the floor during CDI, with the parent following the child around the room as the child plays with the toys that are available. However, it is up to the child to choose whether to play on the floor or at the table. For example, if the child chooses to color at the table, the parent should sit at the table as well. A few minutes later, the child may choose to drive cars on the carpet and the parent should move to the floor to join in the play. Toys that are inappropriate for CDI should be removed from the room to avoid the unpleasantness that may occur if the child insists on playing with an inappropriate toy. Because parents will be asked to avoid limit setting during CDI, the playroom should contain no items that may inspire the child to misbehave and require parental intervention. In our playroom, we do not include lamps, glass framed pictures, nicely upholstered furniture, sinks, boxes of tissues, or personal items such as handbags. Light switches are kept in the "on" position using lockable covers or tape.

If the therapist will be coaching via a bug-in-the-ear microphone device, the earpiece should be sterilized with an alcohol wipe and tested prior to the start of the therapy session. Additional materials that will be needed during each session are as follows: one DPICS – III coding sheet for each parent, one homework sheet for each parent, one PCIT Progress Sheet for each parent, and a clock or stopwatch.

Check-In and Homework Review

The session typically begins with the child playing independently nearby while the parent and therapist review the child's home and school adjustment during the previous week, discuss familial stressors unrelated to the child's behavior, and review the week's homework practice. We ask parents to bring in a homework sheet each week indicating whether or not they were able to practice each day and noting any questions, observations, or concerns they had during the course of the week. Because one of the goals for the CDI stage of PCIT is for parents to become more adept at recognizing and praising their child's positive qualities and behaviors, we are careful to prompt parents to note progress and accomplishments by the child, not just problems. We also use this check-in period as an opportunity to teach parents to shape independent play by giving their child intermittent labeled praises for playing quietly while the adults talk.

In order to maximize the amount of time spent in direct coaching of CDI, we restrict this initial "check-in" to 5–10 min. Occasionally, the parents we work with have difficulty sticking to this time limit or bring in concerns about important marital or individual issues. If this occurs on a consistent basis, diverting focus away from the parent training intervention and slowing PCIT treatment progress, we recommend inviting parents to participate in adjunctive interventions such as individual treatment, support groups, or marital therapy. Thus, important concurrent issues may be addressed in a planned manner often enhancing the effectiveness of PCIT. With some parents who tend to offer overly lengthy and detailed descriptions of their child's misbehavior, we choose to sequence the session so that this check-in period is saved for the last 10 min of the session. This limits non-productive focus on child misbehavior both by decreasing the time available for it and by inviting parents to review child behavior only after they have been coached to focus on their child's positive attributes.

During the first CDI coaching session, the check-in period should include a brief review of the "Do" and "Avoid" skills. Most parents feel quite self-conscious about performing these new skills in front of the therapist. It is helpful to directly address this anxiety, letting parents know that it is a common experience that will quickly pass, and reminding them that the therapist does not expect them to be "masters" of play therapy after practicing it for only 1 week. Finally, the check-in period during the first CDI coaching session should be concluded with a developmentally appropriate explanation of the coaching process for the child. If the therapist-coach will be recording and coaching the skills from an observation room and the child is old enough to perceive that the parent is receiving instructions over the bug-in-the-ear, the following explanation might be given:

> It's time for me to leave now so you can have special playtime with your mom (dad). But, I'm going to watch you and your mom (dad) play. I'll be watching from behind that mirror. Do you want to see? [Allow child to enter observation room and briefly view the playroom]. I'm going to help your mom (dad) learn to play in a special way. Sometimes I might say things that she (he) will hear in that funny thing in her (his) ear. That thing is not a toy. You can look at it but you can't play with it. Your job is to just play along with your mom (dad) and have fun, OK?

If the therapist-coach will be recording and coaching from within the playroom, the child might be told something like:

> It's time for you to have special playtime with your mom (dad) now. I'm going to stay here and watch you and your mom (dad) play. My job is to help your mom (dad) learn to play with you in a very special way. Sometimes I will watch quietly and write things down, and sometimes I will say some things to your mom (dad). Your job is to keep playing and pretend like I'm not even here, like I'm invisible! That means you don't look at me or talk to me. You just play with your mom (dad) and pretend like I'm not here, OK?

Both of these explanations should be adapted to fit the cognitive and language development of the individual child, and some therapist-coaches may choose to have the parent repeat the explanation in their own words to enhance the child's understanding. If coaching from within the room, some children will have initial difficulty remembering not to interact with the therapist. The first time this occurs, the therapist should remind the child to pretend that the therapist is not there and subsequently the therapist should completely ignore any further overtures from the child. Most children will quickly learn to tune out the therapist's coaching and to attend to the play with the parent. If the therapist continues to respond to the child's overtures, the latter will become more frequent and coaching will be compromised.

Parental Non-compliance with CDI Homework

Although parents often leave the early CDI sessions with the best of intentions to complete their daily homework, we find that the majority of parents have great difficulty getting their homework done on a consistent basis. Therapists should expect homework non-compliance and be proactive about problem-solving homework issues. Because clinic improvements will not readily generalize to the home without practice, both therapists and parents must view homework as a critical element of the treatment. We recognize that it is rare for families to be able to complete 100% of the assigned homework. And, we find that many families can progress well through treatment if they complete most of their homework. When parents complete homework fewer than 3 times per week, we become seriously concerned that treatment may not progress. In those cases, we analyze the possible reasons for the homework non-compliance and employ strategies to correct the problem. Table 5.2 provides four common functions of homework non-compliance and associated remedies.

Parent Does Not "Buy In" to CDI. Some families enter treatment more motivated for CDI than others. Our highly educated parents are typically convinced easily of the potential benefits of CDI. In contrast, our court-ordered, school-referred, and less educated families tend to be harder to persuade. Homework non-compliance may be an early indicator of treatment resistance in these families. We find it helpful to address the resistance directly. We might say, "I'm sensing that you don't really believe that special playtime is going to make any difference." This opens the door for parents to directly discuss skepticism and provides us with an opportunity to further "sell" CDI. As discussed in Chapter 3, five points to emphasize when

Table 5.2 Functions of homework non-compliance solutions

1. Parent does not "buy in" to CDI	1. Put the issue on the table 2. "Sell" CDI again (see Chapter 3) 3. Introduce idea of an "experiment"
2. Parent is too stressed and disorganized to make homework a priority	1. Give them a folder 2. Night-before reminder call 3. Give them a physical reminder for refrigerator 4. Mid-week reminder call 5. Incentives 6. Help them develop a routine for CDI
3. Therapist has not sent a consistent message that homework should be a priority	1. Avoid inadvertently reinforcing non-compliance with supportive statements such as "It's okay. I can see it was a tough week" 2. Consistently pick up homework sheet with ECBI, making homework sheet a "ticket" to the session 3. Give labeled praises for remembering homework sheet 4. Give labeled praises for completing most of the homework (e.g., 4 out of 7 days) 5. Require parents to re-create the homework sheet if it is forgotten 6. Repeatedly educate the parents about the importance of homework and attribute child changes to home practice (or lack thereof)
4. Parent practice is being sabotaged by others in the home	1. Attempt to engage the significant others in therapy 2. Problem-solve ways for parent to practice with privacy 3. Empower the parent to be assertive with others 4. Educate parent that others who have been criticized for CDI practice have found ways to complete homework 5. Forecast that significant others will stop sabotaging when they see the treatment work

"selling" CDI are (1) the parent must have a strong relationship with the child for the intensive discipline program to work, (2) daily practice leads to faster mastery of CDI so that the family progresses to the discipline program more quickly, (3) CDI is "therapy" not just play, (4) having a short daily connection with the child adds up and leads to the child wanting to please the parent, and (5) by practicing each day, the parent over-learns important behavior management skills that become habits that occur naturally throughout the day. For parents who remain resistant even after receiving the five "selling points" above, we encourage parents to think of CDI practice as an "experiment." As part of the experiment, we have the parent generate the number of CDI practices that they are willing to commit to for the upcoming week. We write the agreed upon number on the top of the homework sheet and introduce the experiment in the following way:

> So you think you can get in 4 times this week. Is that a realistic number? Are you able to commit to that for this week only? Great. Then, when I see you next week, the first thing that I will ask you is whether you were able to do *your* part of the experiment. I will ask you whether you did special playtime 4 times during the week. It is important for you to get in all 4 practices so that we give the play therapy a chance to work. Together we will look at whether the practice time led to any good changes in your child's behavior, your relationship with your child, or your own skills as a play therapist.

We use this "experiment" as a way of shaping homework behavior. If we get the parent to do 1 week of homework, then we have a foot in the door. We can praise the parent for the accomplishment and make observations about how it is helping.

Parent Is Too Stressed and Disorganized to Make Homework a Priority. We find that many of our multi-stressed, disorganized families are sufficiently sold on the merits of CDI but have just been unsuccessful at making it happen at home. These families lack routine, are often just trying to get through their days, are responding to crises, and feel overwhelmed by the addition of one more task. When we recognize a family as disorganized and stressed, we often give them a folder at the beginning of treatment. We tell them to put all of their handouts and homework sheets in this folder. We also help them pick one place in the home to keep the folder, and we emphasize that they need to bring this folder to every session. When possible, we instruct our staff to provide the family with a reminder call the day before their next session. In the call, the family is reminded about the time of the session, who should come to the session, and the need to bring the folder. Sometimes these families benefit from posting a visual reminder to practice special playtime at home. Instead of expecting them to generate the reminder, we may hand them a sign to post on a wall, the door, or the refrigerator. Some therapists may choose to give the family a reminder call midway through the week to get them going on the homework and make them feel more accountable. Finally, therapists and/or agencies may choose to implement an incentive program for homework practice. Examples include the following: (1) collecting a deposit early in treatment that is refunded as parents practice homework, (2) allowing the child to select something from the "homework treat box" whenever a sufficient amount of homework was completed, and (3) awarding raffle tickets for larger prizes based on successful homework practice.

Therapist Has Not Sent a Consistent Message That Homework Should Be a Priority. When training to be mental health professionals, we are taught to be supportive and client-centered with an emphasis on following the client's lead in sessions. We have found that this supportive approach can sometimes undermine our message that homework is critical for treatment progress. When our multi-stressed families present with crises, we can be easily derailed by focusing our efforts on providing support. It is not uncommon for therapists to use active listening, empathic responding, and questioning to encourage parents to talk more about the weekly crises. We often respond by saying, "You've had a really rough week," "You've got a lot on your plate," "What did you do when your ex-husband did not return her on time?" and "What did you say to the teacher when she called you?" Although it is our job to be supportive, we must be careful not to inadvertently send a message to

parents that homework is not very important. For example, in the midst of providing supportive statements and inquiries about crises, we can easily find ourselves halfway through the session before we ever ask about homework. And, sometimes we get so caught up in the crises that we forget to ask for homework at all. At other times, parents report to us that they were unable to do their homework because of stressful life events (e.g., death of a grandparent, a Child Protective Services report, overtime at work, a sick child, out-of-town visitors). Our training in supportive therapy leads us to respond by saying, "That's okay. It was a tough week." Yet, with multi-problem families, *every* week is tough. If PCIT is to progress, we have to avoid giving these families permission to not do their homework because of stressful life events. As good clinicians, we work hard every session to maintain balance between providing support and making it clear to families that we expect them to do their daily homework.

To ensure that we communicate to parents that homework is a priority, we can employ several strategies. First, just as we collect an ECBI from the parents before they enter the session, we can also collect their homework sheet up front. In this way, we can make the homework sheet a sort of "ticket" to the session. Consistently asking for the homework sheet prior to the session has two benefits: (1) it increases the chance that the therapist will remember to ask for the homework, and (2) it sends a message to the client that daily practice is so important that we do not even begin the session without examining the homework sheet. If the parents turn in their homework, they should receive labeled praise for remembering the sheet, regardless of how many times they actually practiced at home. If the parents forget to bring the homework paper, the therapist should require them to recreate the homework sheet in the waiting area prior to the beginning of the session. Completing the homework sheet in the waiting area is aversive to parents because it postpones their access to the therapist and the supportive aspects of the treatment. During sessions, we repeatedly educate parents about the importance of daily practice. We teach them that the 5 min per day of special playtime is critical for (1) the development of their parenting skills, (2) improvement in the parent-child relationship, and (3) generalization of child behavior improvements from the clinic to the home setting. To help parents perceive the link between homework practice and treatment progress, we review ECBI and DPICS results. Behavioral improvements reported on the ECBI and skill improvements coded on the DPICS are directly attributed to how well parents have followed through on their homework. When progress is slow, parents are educated about the need for them to increase homework completion in order to speed up treatment gains. Finally, in those cases in which parents actually succeed in completing all or most of their homework, we make it a point to provide labeled praise for their efforts.

Parent Practice Is Being Sabotaged. Many parents tell us that it is hard to complete homework because significant others in the home observe and interfere. These significant others usually include spouses and extended family members, like grandparents, who are not participating in PCIT. Examples of interference include interrupting, showing non-verbal disapproval (e.g., shaking head, rolling eyes), inducing guilt ("Why are you wasting time playing instead of making

dinner?"), and using blatant criticism ("You're stupid if you think this is going to do any good."). If we do not give parents specific strategies for dealing with interference from family members, there is a good chance that the participating parent will discontinue homework, hampering treatment progress. Our efforts to deal with sabotage include the following: (1) attempt to engage the significant others in therapy, (2) problem-solve ways for parent to practice with privacy, (3) empower the parent to be assertive with others, (4) educate the parent that other clients have encountered the same types of interference and still have found ways to complete their homework, and (5) forecast that significant others will stop sabotaging when they see the treatment work.

Observing and Recording Child-Directed Interaction Skills

As mentioned earlier, we devote a brief period of time at the beginning of each session to recording parental skills progress. This allows us to closely monitor the effectiveness of our previous coaching, provides us with objective information that can be charted and shared with interested parents, and supplies us with information about what skills should receive particular focus during the subsequent coaching.

We get the most accurate picture of how parents are performing their skills at home when we conduct our recording period early in the session, before doing any coaching. If recording is done at the end of the session, after several minutes of skills coaching, nearly all parents are able to perform at a high skill level. However, this performance is artificially enhanced by short-term retention and typically is uncharacteristic of how parents perform independently in home play therapy sessions throughout the week.

We begin the recording period by telling parents:

> I would like for you to go ahead and begin special playtime now. I'll just watch you for 5 min and make some notes to myself before I jump in and begin coaching, OK? Show me your best CDI skills.

We then allow a minute or so to go by so that the parents may warm up and let any initial nervousness subside as they devote their full attention to their child. We begin timing for 5 min and record tally marks in the appropriate boxes on the DPICS – III recording form. At the end of the 5 min, we take a minute or so to make notes about qualitative aspects of the interaction that we would like to address in the coaching or discuss with the parent at the end of the session. We then quickly transfer the data from the recording sheet to the parent's PCIT Progress Sheet. This form makes it easy for the therapist to track the family's week-to-week progress.

Immediately after the 5 min coding, we find it helpful to provide the parent with a "constructive feedback sandwich." The feedback sandwich consists of a hefty slice of labeled praise, followed by a delicately sliced suggestion regarding what the parent could do even better, and finished with another substantial slice of labeled praise.

For example, the therapist might say, "You did a great job of increasing your reflections this week. You went from three to eight. And congratulations, you met mastery on behavioral descriptions with 12 of those. The one thing that you might want to focus on is increasing your labeled praises. I counted four and you need 10 for mastery. But overall, I though that your play was warm, and fun, and you did a good job of letting Sasha lead the play."

The skill progress information we collect also helps us to determine how close the family has come to meeting a pre-determined set of criteria for mastery of CDI skills and progressing to the discipline portion of PCIT. The "gold standard" for mastery of CDI skills established by Eyberg (www.pcit.org) is presented in Table 5.3. Because the mastery criteria involve using 10 each of labeled praises, reflections, and behavioral descriptions, when talking with parents we often refer to the mastery criteria as the "ten–ten–ten." It should be noted that the criteria presented in Table 5.3 were established based on the concept of "over-learning." We know that after treatment is concluded and parents no longer receive weekly coaching, their CDI skills will backslide. However, if they have over-learned the skills, we expect that their skills will still be sufficient to maintain the child's positive behavior over time, even if some backsliding occurs. Over-learning also is important because it enhances generalization outside of the playtime. A goal is for the positive parenting skills to become over-learned habits that occur effortlessly throughout the day. For example, when the child tells an elaborate story in the car on the way home from school, we hope that the parent will automatically provide a reflection of the content. Or, when the two children in the family are playing amiably together in the living room, our goal is for the parent to reflexively provide a labeled praise. It is the over-practicing and over-learning of skills during playtime sessions that lead to the spontaneous use of these skills throughout the day.

Table 5.3 Criteria for mastery of Child-Directed Interaction skills during a 5-min play session

10 Labeled praises
10 Reflections
10 Behavioral descriptions
3 or fewer commands + questions + negative talk (criticism and sarcasm)
Ignore all negative attention-seeking behaviors
Imitate the child's play
Be enthusiastic

Coaching the "Do" and "Avoid" Skills: Tips for Therapists

Skillful coaching of the parent-child interactions requires that the therapist-coach provide frequent, specific feedback to parents while not disrupting the natural flow of the interaction. That is a tall order for novice therapists who feel awkward sandwiching their comments between parent and child verbalizations. The following general principles are important for effective skills coaching.

Make Coaching Brief, Fast, and Precise. The best coaching statements contain few words. Full sentences and lengthy explanations interrupt the flow of the interaction and may cause parents to become flustered as they attempt to divide their attention between the therapist-coach and their child. Not only should the coaching statement contain few words, it should also be fast in that it should be delivered immediately after the parent's verbalization. Because every word must count, the language used should be precise rather than general or vague. Occasionally, a situation will arise in which the therapist-coach needs to provide a longer explanation or observation. In those rare situations, the coach could ask the parent to allow the child to play independently for a moment while the coach provides feedback. Situations in which we have done this include times when a parent is not responding to our coaching (e.g., remains flat for 10 min despite intensive coaching on enthusiasm) and when we are providing instructions for a special exercise (e.g., praise exercise). Another situation in which we have taken a moment to talk to a parent in more detail is one in which a parent becomes emotional during the coaching. For example, we worked with a mother who was so touched by a picture her child drew that she became tearful. Her son, who had seldom seen her cry, became worried that she was hurt or that something bad had happened. The mother became flustered and did not know how to proceed with the special playtime. We talked with her for just a moment while the child played, giving her suggestions for how to explain "happy tears" to her son. Yet, the overwhelming majority of coaching should be brief so that it promotes rather than interferes with rapid skill acquisition. The coaching statements may take the form of labeled praises, gentle corrections, directives, and observations. Table 5.4 presents examples of commonly used coaching statements in each of these four categories.

Coach After Nearly Every Parent Verbalization. Every verbalization the parent makes provides the therapist-coach with an opportunity to teach, and the more input the parent receives, the faster and better the skills will be learned. Also, by providing feedback after each verbalization, parents learn to pause and wait for therapist input. Coaching will proceed more smoothly when the therapist and parent develop this type of pacing. Providing intensive feedback requires that the therapist think quickly and react with an appropriate labeled praise, gentle correction, observation, or direction. For novice therapists (and even very experienced ones!), this requires intense concentration and sustained effort, which can be exhausting. Therapists must resist the inclination to reduce the frequency of their feedback or to coach in a mechanical fashion.

Give More Praise than Correction. Many parents begin therapy feeling incompetent in their parenting roles. It is critical for good outcome in PCIT that parents feel supported and successful from the outset. For that reason, the therapist-coach must stay in tune with the proportion of praise to correction being provided.

Most parents correctly perform many of the skills from the beginning, providing natural opportunities for the therapist-coach to provide a preponderance of labeled praises. If parents are not producing descriptions, reflections, and praises on their own, the therapist should use directives to get the parent to make

Table 5.4 Common Child-Directed Interaction coaching statements

Labeled praises	
Good imitation	Nice physical praise
I like how you're ignoring now	Good description
Great job of following his lead	Good answering his question
Good encouraging his creativity	Great teaching!
Nice timing on giving him back your attention	Terrific enthusiasm!
Nice eye contact	Nice labeled praise
Gentle corrections	
Oops, a question!	Sounds a little critical
Looks like a frown	Was that a command?
A little leading	Might be better to say. . .
You're getting a little ahead of her now	
Directives	
Try to label it	Can you reflect that?
Say "Nice manners!"	More enthusiasm!
Say it again, but drop your voice at the end	Let's ignore until he does something neutral or positive
Say "I like it when you use your big girl voice"	Say "It's so much fun to play with you when you're careful with the toys"
Praise her for sharing	
What can you praise now?	How about a hug with that praise?
Observations	
He's enjoying this	Sounds very genuine
He's sitting nicely now	Now he's imitating you
She wants to please you	He loves that praise
He's talking more now because you're reflecting	She's handling frustration a little better now
She's staying with it longer because of your descriptions	There's a big self-esteem smile!
	You see, anything you praise will increase
That praise is good for her self-esteem	By saying "I'm sorry" you just set a good example for polite manners
That's good practice for fine motor skills	

particular statements, followed by labeled praises after the statements are made, and observations concerning the child's responses. For example:

Parent: (watches child build but does not speak)
Therapist: (gives directive) "Say, 'Good idea to make a zoo!'"
Parent: "I like that zoo you're building!"
Therapist: (gives labeled praise) "Nice labeled praise. (makes two observations) She really lights up when you praise her. She's working even harder now."

Although it is important to provide feedback as frequently as possible, it is not wise to correct every mistake the parent makes, particularly early in treatment when errors are frequent. Correcting every mistake, even if done in a gentle way, can tip the scale in the negative direction, causing a parent to feel criticized, inept, and discouraged. We recommend that therapist coaches strive for a ratio of at least 5

supportive statements for every correction. An alternative to corrections is the use of selective ignoring for incorrect skill use, followed by strategic attention when the skill is used properly. The following is an example:

Parent: "What do you want to do now?"
Therapist: (selectively ignores question)
Parent: "Are you pretending to take the dog for a walk?"
Therapist: (selectively ignores question)
Parent: "Your dog is going for a walk."
Therapist: (provides strategic attention) "Terrific description! You said it as a statement. Good job reducing those questions."

After the first coaching session, most parents are performing so many skills correctly that most of the errors can be gently corrected while still maintaining the overall positive tone of the coaching.

Coach Easier Skills Before Harder Ones. Some of the "Do" and "Avoid" skills are generally easier to learn than others, and parents are more likely to feel immediate success if more focus is placed on the easier skills initially. In our experience, describing is typically the easiest of the CDI skills, followed by imitating, reflecting, avoiding criticism, and avoiding commands. The skills that appear to be most difficult for parents to master are avoiding questions and giving praise. We believe that eliminating questions is particularly difficult because of the very high rate of questions most parents give young children at baseline. Asking questions is a difficult habit to break. For some parents, praising is difficult because they are not comfortable expressing affection verbally. Others may believe that too much praise will spoil their child or cause him or her to become boastful. Many parents resist praising because they are caught up in a coercive cycle in which they do not want to praise during special playtime if the child has displayed disruptive behavior earlier in the day. Still other parents simply have difficulty identifying their child's positive and praiseworthy qualities and behaviors. Most parents find that praise comes more easily and naturally after they have been practicing play therapy for a couple of weeks and have been coached on praise for one or two sessions. If the parent continues to experience difficulty generating praise, we recommend processing this issue with the parent in detail.

Use Special Exercises for Difficult Skills. When the parent is performing many skills at the desired rate but one skill appears to be lagging well behind, we may interrupt the CDI to conduct special exercises in which the parent is encouraged to concentrate on the particular skill. For example, we may tell the parent, "I want to try a little experiment. I want to see how many times in the next minute you can praise Katie, OK? Are you ready? Now begin." During that minute, we stop coaching other skills, and count aloud for the parent the number of praises given. For example,

> Good, there's one... that's two... three... now you're really going... think of another one... four... time is up. That was fantastic! You gave 4 praises in only one minute when you really concentrated on it. I knew you could do it. If you kept up that pace you would have 20 in 5 min, that's 10 more than you need for mastery. Well done!

An exercise such as this one provides encouragement and incentive as well as good practice for parents who are struggling with a particular skill. It is often a better strategy than continuing to provide frequent corrective feedback which can become disheartening for the parent. Other exercises that help parents to focus on particular skills include (1) asking parents to reflect everything appropriate the child says in a 2-min time period, (2) asking parents to catch every question they ask and restate it as a description or reflection, (3) asking parents to turn unlabeled praises into labeled praises, (4) asking parents to practice alternately dropping and raising the inflection of their voices to make a phrase a statement or a question, and (5) giving parents the assignment to be "extra silly" and excited for the next 3 min to promote enthusiasm.

Use Observations to Highlight Effects. Often, we find that abstract discussions of how children respond positively and negatively to particular communications from parents are not sufficiently potent teaching tools. Many times, it is not until the parent actually sees it demonstrated during a coaching session that they are able to recognize and strategically alter their communication patterns to elicit desirable child responses. Therefore, in addition to coaching parental use of "Do" and "Avoid" skills, the therapist-coach should comment on the ways in which the child is responding to the parent. For example, if the parent praises the child for putting the red blocks together and then the child reaches for another red block, the therapist-coach may state an observation such as, "Your praise is powerful. Whatever you praise him for, he'll probably do again." Similarly, after the parent reflects the child's verbalization and the child speaks again, elaborating on the same topic, the therapist-coach may make an observation such as "You've given him positive attention for talking to you without taking his lead away, so he'll keep the conversation going." Because observations can be wordy and may interrupt the flow of the interaction, they should be used strategically. If a particular observation is lengthy or requires an extended discussion, we may choose to review our observations with the parent at the end of the coaching period.

The therapist-coach may also make observations about the child's negative responses to less desirable parental verbalizations and behaviors. For example, if a parent's "imitating" turns into the building of a far more elaborate structure than the one the child is making (despite warnings about this pitfall during the teaching session), the child may be expected to show any of several unfavorable responses: losing interest in the activity and leaving the parent to play with another toy; making negative comments about his or her own ability; or expressing frustration by damaging the parent's structure. Rather than coaching the parent early in the sequence to tone down the complexity of the building, it is sometimes more instructional to allow the parent to continue and the child to respond unfavorably, and then help the parent to recognize how he or she precipitated this negative child response. In this situation, the therapist-coach might offer an observation such as "He's showing you that your building was too advanced for him and took away his chance to lead the play."

One of our goals in PCIT is to help parents improve their attitudes toward their children. One way that this can be accomplished is by pointing out to the parent good

qualities about the child. During coaching, we frequently comment on the child's appearance, manners, intelligence, creativity, curiosity, sense of humor, problem-solving ability, building skills, speed, artistic prowess, and attire. Early in this book we recounted how we often have parents tell us that they love their children but they just do not like them anymore. When parents have given up on finding the good in their children, it is our job to train their eyes to see the positive qualities that we see. We look hard for improvements in the child's behavior and share those observations with parents. We make it a point to comment on how parents are responsible for these improvements. For example, we might say, "He's sharing much more this week. That is because you have been praising sharing." We find that if we do not show parents the direct link between their changes in parenting and their children's behavioral improvements, they often credit the child's changes to extraneous factors, such as sleeping, eating, allergies, the toys in the room, and the phase of the moon. Observations can help parents feel proud of their children and take responsibility for their children's behavioral improvements.

Make Use of Humor. Although coaching and learning Child-Directed Interaction is hard work for both the therapist-coach and the parent, it need not be an overly serious and formal process. In healthy parent-child interactions, most parents and children relax, laugh, and find humor in their activities and interactions. We find that the session is much more enjoyable for all involved if the therapist makes use of humor for reducing parental performance anxiety and helping to increase the warmth of the parent-child interaction.

Progress from More Directive to Less Directive Coaching. A goal of CDI coaching is to empower parents to use the skills autonomously. This can be accomplished by gradually reducing the use of directives and corrections as parents display increased mastery of play therapy skills. For example, in the beginning of a first CDI coaching session, the therapist may need to give parents the exact words for labeled praises. As the session progresses, the therapist may only need to provide a brief prompt, such as "How about a praise?" Toward the end of the session, the parent may have developed the ability to generate his or her own praises. When this happens, the sensitive therapist-coach will step back and simply reinforce the parent's good use of praise and provide observations on its effects. Once parents near mastery of CDI skills, the therapist should rarely need to provide directives or offer suggestions for the words parents say. Toward the end of CDI, the coaching basically sounds like this: "Nice job. You're so good at this. . .. You've got it. Just keep going. . .. Beautiful reflection. . . She's smiling!. . . Your praises are so warm."

Coaching Strategic Attention and Selective Ignoring. To maximize the effectiveness of Child-Directed Interaction, parents must understand the concepts of strategic attention and selective ignoring described in Chapter 4, and they must be able to implement them in tandem to shape desirable child behaviors. The therapist-coach should look for child behaviors that are pro-social, occur with low frequency, and are appropriate targets to increase through strategic attention. Often these behaviors are naturally incompatible with identified problematic behaviors. For example, a child who is bossy may have "asking politely" as a target of strategic attention. Using the double-pronged approach, bossiness in turn may be identified as a target

for decrease through selective ignoring. Examples of problematic behaviors responsive to selective ignoring and their incompatible pro-social behaviors that may be increased through strategic attention are presented in Table 5.5.

Table 5.5 Behavioral targets for strategic attention and selective ignoring

Strategically attend to...	Selectively ignore...
Polite manners	Bossiness, demandingness
Playing gently with the toys	Banging toy on the table
Using a "big boy (girl)" voice	Whining
Talking softly	Yelling
Driving toy cars safely	Repeatedly wrecking cars
Being nice to toy people	Dropping people on floor
Sharing toys	Grabbing toys away
Building pro-social structures	Making toy guns
Trying even when it is hard	Giving up in frustration

When an appropriate target for selective ignoring is presented during the coaching session, the therapist-coach first identifies the problematic behavior, coaches the parent in selective ignoring until the child ceases the problematic behavior, coaches the parent to return attention to the child for positive or neutral behaviors, and coaches the parent to keep an eye out for pro-social behaviors (which are incompatible with the problem behavior) that can be responded to with strategic praise. The following example illustrates the use of selective ignoring and strategic attention in tandem.

Child:	"Pow, pow, pow. You're all dead." (mimics shooting Lego people with a Tinkertoy gun he has made)
Therapist (to the parent):	"That's aggressive. Now is a good time to begin ignoring. Drop your eyes, quickly turn away, and begin building something of your own with some Tinkertoys. Describe out loud what you are making, but speak as though you're just talking to yourself, not to him.
Parent:	(turns away from child and picks up wheels) "I think I'm going to build a swamp buggy. Here's one wheel..."
Child:	(louder this time) "Look mom, I'm killing all of them! Pow, pow."
Therapist:	"Great job of ignoring. Keep looking away. Good describing your own play. Let's see if we can get him interested in what you are doing so he stops the shooting. Be very enthusiastic about your buggy."
Parent:	"I'm going to make the coolest, baddest, freshest swamp buggy in the whole world! It's going to have red wheels. Now, I'm going to put a green seat here. I guess I'd better find a driver for my swamp buggy."

Child:	"Oh, I know, this Lego-man can drive it! Here, I'll show you."
Therapist:	"Perfect! You got his attention away from the aggressive play and now he's playing appropriately with you. Let's give him your full attention now and some labeled praise."
Parent:	(turns to face child) "What a great idea to have the Lego-man drive! Thanks for playing nicely with the toys so I can play with you again."
Therapist:	"Nice labeled praise. You did a great job of getting him back on track."
Parent:	"Now you're adding a back seat so more people can ride."
Therapist:	"Good describing."
Parent:	"I'm really glad you're playing swamp buggy with me. I like gentle play."
Therapist:	"Excellent labeled praise."

Sometimes, during selective ignoring, parents will try to speed up the process by trying to coax children to re-engage in CDI. This looks like the following: While the child is pounding aggressively on the dollhouse, the parent selectively ignores the pounding and starts talking out loud about how they like to play gently with the Tinkertoys (modeling opposite behavior). When the child does not discontinue the pounding immediately, the parent rushes the process by saying, "I sure wish that Freddie would come over here and play gently with the Tinkertoys." This verbalization breaks two of the CDI rules. First, it provides attention to Freddie for his disruptive behavior. And, second, it is an indirect command, making it hard for Freddie to lead the play. We coach parents to be patient and let the selective ignoring work. Parents can combine ignoring with distraction in which they enthusiastically describe their own play activity as though talking to themselves, rather than to the child. But, we do not want parents to use any form of distraction that involves looking at the child, addressing the child by name, or providing either direct or indirect commands.

There are times early in CDI coaching when children have extended tantrums and parents must ignore for up to 20 min. During the ignoring, parents who are not yet fully invested in treatment will give the coach non-verbal cues that they do not approve of this strategy. They roll their eyes, sigh, raise their hands in frustration, look into the observation window skeptically, and sometimes even say out loud "This isn't working people." If the therapist wants these families to return to the next session, it is important to stay confident and use motivational strategies during the extended period of ignoring the tantrum. We anticipate that the parent will have a hard time withholding attention for a prolonged period and prevent them from providing negative attention by continuously talking to them about the need to look away and enthusiastically describe their own play. We also take this opportunity to remind them that CDI is not the entire treatment program. We reassure these parents

that ignoring is not the only strategy that we will be recommending for misbehavior. We remind them that an intensive discipline program, in which we will teach them more direct and hands-on strategies for handling tantrums, will be the next phase. If the session ends on a negative note, we often provide a mid-week call to motivate parents to hang in there with CDI.

Occasionally, we want to target a pro-social behavior that occurs so infrequently that there may be no naturally occurring opportunity to reinforce the behavior during coaching. For example, we worked with a 3-year-old who was extremely bossy and rude, demanding that his mother do things for him (e.g., "Get me a drink," "You sit there," "Give me that!"). After three coaching sessions, we had never heard the child ask appropriately for anything. We decided to "prime the pump." Before we began CDI coaching, we showed the mother how to teach the child the skill of "asking nicely" (e.g., role-playing with the toy people). In this way, we were able to increase the chance that the child would ask nicely for something during the coaching session, and we could then coach the parent to provide labeled praise. With older children, we can prime the pump by simply telling them what we are looking for in the session. We might say, "Today, we are going to be working on using the words 'please' and 'thank you.' Your mom is going to be listening very closely for those words. If she hears you say them, I know she will get very excited, and so will I." Sometimes, after a few CDI sessions, children just need to be told directly (before CDI begins) what behavior we are hoping to see and they will come through with it to please both the parent and the therapist. Once CDI begins, commands and reminders about the identified skill are no longer used because they take the lead away from the child.

Coaching Qualitative Aspects of the Parent-Child Interaction. Although parents are instructed in a set of "Do" and "Avoid" skills for special playtime, these skills do not encompass all relevant aspects of parent-child interactions or the parent-child relationship. Novice PCIT therapists often focus their coaching exclusively on these "Do" and "Avoid" skills, neglecting other qualitative aspects of the interaction. This "tunnel vision" may result in play therapy that meets the letter but not the spirit of the mastery criteria cited earlier in this chapter, and which would not be described by an objective observer as warm, nurturing, or promoting parent-child relationship enhancement. Experienced PCIT therapist-coaches integrate coaching of the core skills with coaching of more qualitative aspects of relationships, including physical closeness and touching, eye contact, vocal qualities, facial expressions, turn-taking, sharing, polite manners, developmentally sensitive teaching, task persistence, and frustration tolerance. For a DVD demonstrating advanced PCIT coaching skills with an actual client, see the American Psychological Association video by McNeil (2008).

Physical Closeness and Touching. There is no "gold standard" for the optimum amount and type of physical closeness during CDI. Healthy parent-child dyads vary widely in the nature and degree of physical closeness and touching exhibited in parent-child interactions. In securely attached parent-child dyads, preschoolers will frequently move from very close physical proximity with their parents (e.g., sitting on parent's lap) to wider and wider exploration of the environment with

frequent returns to the security of "home base." However, when the parent is a participant rather than observer of the child's play, such as occurs during CDI, most securely attached children will play for extended periods of time within two or three feet of their parents, and parents will intermittently touch their children in an affectionate way.

In our work with less functional parent-child dyads, we have observed anxiously attached, clinging children as well as young children who show unusually little interest in interacting closely with their parents. We have also observed parents who hover over their children, engaging in an excessive degree of controlling physical contact, as well as those who appear to be uncomfortable with physical affection (e.g., hugs, sitting on lap) expressed by their young children. Thus, depending on the needs of the particular family, the therapist may coach parents to: (1) praise their children for more independent behaviors incompatible with clinging, like sitting in one's own chair, (2) combine verbal praise with physical praise such as stroking the child's hair, offering a hug, patting the child's knee, (3) refrain from "restraining" gestures such as grabbing the child's hand to prevent a response, or (4) move closer to the child who has distanced him- or herself from the parent, praising the child for allowing the parent to join in the game.

Eye Contact, Facial Expressions, and Vocal Qualities. Among US Caucasian populations, it is expected that the listener will make eye contact with the speaker during conversation, and a lack of eye contact may be interpreted as avoidance of emotional contact or poor social skills. Some of the parents we work with have significant social skills deficits or discomfort with emotional exchanges and profit from direct coaching in how to model good eye-contact during special playtime. Modeling good eye contact is helpful but sometimes insufficient for encouraging young children to improve their own eye-contact patterns. For young children who only occasionally make eye contact, parents are coached to praise their children strategically and enthusiastically for good eye contact. When eye contact is a very low base-rate behavior, we coach parents to shape eye contact by lifting a toy that has captured the child's attention to the parents' eye level while they are speaking, and then strategically praising the child for good eye contact when the parent's and the child's eyes meet (e.g., "I like it when you look at me when we're talking"). This is a helpful strategy for young children with atypical development, such as those with Autism Spectrum Disorders. Please see Chapter 12 for a full description of working with children with developmental disabilities.

Sometimes, parents master the mechanics of the praising, reflecting, imitating, and describing, but the play therapy takes on a monotonous and boring quality. These parents appear to be "going through the motions" but not to have their hearts in it. On reflection, the therapist may notice that he or she is coaching in a monotone as well. When we first notice this occurring, we exaggerate our own animation, then coach parents to play in a more animated fashion, increasing the enthusiasm in their voices, adding clapping to praises for young preschoolers, and exaggerating facial expressions. As the parents add more animation to their play, we offer observations on its effect such as: "He's looking at your face more and making better eye contact now," "Look at her face beam. Your enthusiasm means a lot

to her," and "Now she can really tell you're enjoying this time with her." When a parent does not respond to this coaching by brightening his or her affect, it is sometimes an indicator of depression, substance use, or chronic fatigue. At other times, it is an indicator that the parent is resistant to treatment. When this occurs, we temporarily suspend coaching in order to have a "heart-to-heart" discussion with the parent in which we explore these issues. Sometimes adjunctive interventions for depression or substance abuse are recommended, strategies for stress reduction are presented, and sources of resistance to treatment are identified and addressed.

Turn-Taking, Sharing, and Polite Manners. The "Do" skills of CDI, at a basic level, represent social communication skills that people of all ages use in their interpersonal relationships. Imitation begets imitation, and when parents describe, imitate, praise, and reflect during special playtime, their young children in turn imitate these skills. Over time, young children begin spontaneously praising their parents, reflecting parental verbalizations, and describing their own and their parents' play. For many children, we believe these positive social communication skills generalize to sibling and peer interactions as well. Other valuable social skills for young children that are not listed as "Do" skills for CDI may be targeted and coached, particularly turn-taking, sharing, and polite manners.

The "Do" skill of imitation presents a natural opportunity to coach turn-taking. As the child performs an action, the parent may be coached to label it as the child's turn and then describe it. Then, as the parent imitates the child's action, the parent may be coached to label their own turn in play and to praise the child for allowing them to take a turn. To clarify for the parents how this sequence of interactions may be helpful to the child, the therapist may add an additional observation such as in the example below:

Child:	(puts block on tower)
Therapist:	"Now label his turn and describe it."
Parent:	"You're taking a turn and putting a blue block on the tower."
Therapist:	"Good. Now label your own turn and describe it."
Parent:	(picks up another block) "Now I'll take my turn and add another blue block to the tower."
Child:	"OK, go ahead mom."
Parent:	"Thanks for letting me take my turn! Taking turns is fun."
Therapist:	"Good labeled praise."
Child:	"Yeah, and we're good at it! Now I get to go, right?"
Therapist:	"You've taught him that taking turns can be fun, and if you keep praising him for it, he'll probably do it more when he plays with his sister."

Just as young children can be taught the early social skill of turn-taking during the context of CDI, they can be shaped into sharing and using polite manners. Most young children will offer the parent a toy at some point during the course of a play therapy session. We encourage parents to recognize this as sharing and reward the child with enthusiastic labeled praise followed by a parental act of sharing.

Similarly, many young children will say "please" or "thank you" at least once during a CDI coaching session. Parents are coached to label these verbalizations as good manners, provide labeled praise, and be sure to say "please" and "thank you" as appropriate to the child. For young children who do not spontaneously share or use polite manners, we coach parents to periodically model these early social skills, clearly labeling their own behavior so that the likelihood of imitation by the child is enhanced.

Developmentally Sensitive Teaching. Many parents choose to use CDI as a vehicle for developmental stimulation as well as parent-child relationship enhancement. Unfortunately, during our baseline observations of parent-child interactions, it may become apparent that the parent is not well-tuned into the child's developmental capabilities. With preschoolers, parents may overestimate the child's fine motor ability (e.g., building, drawing), grasp of spatial concepts, ability to remember sequentially presented information, and speed of mental processing. They may also underestimate the child's ability to persevere at a difficult task, to pick up after him- or herself, or to select the next item needed while building. This lack of accurate perception of a child's developmental level may become apparent during coaching. We have seen parents (1) command the child to perform a task that he or she is incapable of, (2) impatiently interfere in the child's problem-solving by taking over and completing a task for the child, (3) fail to recognize and praise the child for small increments of developmental advancement, and (4) model inappropriately advanced levels of play. Errors such as these may cause the child to feel bad about his or her own abilities or to lose interest in performing a play task that is too difficult. In addition, the parent's ability to effectively teach is compromised when input is pitched at either too high or too low a level.

To ensure that play therapy is conducted at the child's level of development, parents are encouraged to adhere to the overriding rule that the child is to remain in the lead. Parents are told that it is at this level that children are most interested in the play activity and most receptive to teaching from parents. The therapist should coach parents to (1) accurately perceive their child's developmental capabilities, (2) introduce new vocabulary when reflecting and describing, and (3) reinforce developmentally appropriate learning by naming colors, counting objects, and identifying shapes.

Task Persistence and Frustration Tolerance. Many of the children we work with are easily frustrated during play as well as during early academic tasks at school. They may show their frustration by giving up when the activity becomes challenging, becoming destructive with materials, whining, crying, or throwing temper tantrums. Once a child has been identified as having difficulty in this area, several coaching strategies may be used to teach parents how to improve their child's frustration tolerance. It is important to note that in many cases, the parents do not have a high degree of tolerance for frustration themselves. This presents a double-edged sword. The parents may find it more difficult to teach positive coping techniques to their own child, but they may also benefit from learning new skills to cope with their own frustration, in turn modeling more appropriate coping skills for their young children.

After mastering basic CDI skills, parents can be coached to provide strategic praise for task persistence, attempting difficult tasks, and staying calm when experiencing frustration. For example, a child who is having difficulty putting a toy together might yell, "Stupid thing. It never goes in. I can't do it." The parent should be coached to ignore the negative talk while modeling the opposite behavior of remaining calm while working on a hard task. When the child ceases the negative talk, the parent should return to the PRIDE skills. The parent should watch carefully for examples of task persistence and coping positively when efforts fail. Parents can be coached to provide labeled praises such as, "I like it when you keep trying even though it is hard," "Nice job of staying calm when the house fell," and "It's great to see that you stayed calm and just started building something else."

Helping Parents Handle Aggressive and Destructive Child Behavior. Most children are on their best behavior during special playtime and are rarely disruptive. After all, they have their parent's undivided attention, are playing with novel toys, and get to be in the lead. However, parents must have a strategy for handling disruptive behavior if it occurs during coaching sessions and during play sessions at home. As mentioned earlier, when children engage in mildly disruptive behavior (e.g., whining, talking back) during CDI in either the clinic or the home setting, parents are coached to address these problems using strategic attention and selective ignoring described earlier in this chapter. For more serious behaviors such as physical aggression and destructive behavior during home play sessions, we encourage parents to immediately end the special playtime. However, if aggressive or destructive behavior occurs during a clinic coaching session, we usually do not choose to suspend CDI because doing so will result in lost session time and inhibit treatment progress. Instead, we coach the parent to give the following warning, "If you _____ (e.g., hit me again, throw another toy), I will leave the room until you calm down." The parent then will follow through on the warning by leaving the room when a repeated dangerous or destructive behavior occurs. Upon the parent's exit, the therapist should enter the room to supervise the child. In the room, the therapist may choose any of the following actions: (1) watch the child out of the corner of the eye while ignoring, (2) review the rules regarding dangerous or destructive behavior, (3) distract escalating behavior with CDI skills, and/or (4) put the room back together (e.g., picking up overturned chairs) and remove any toys that were being misused, thrown, or broken. Once the child ceases the dangerous or destructive behavior, the parent immediately re-enters the playroom and the CDI coaching is resumed. Please see Chapter 16 for additional strategies for coaching parents with extremely aggressive and explosive children.

Coaching Sessions with Siblings. Most parents are able to extend the Child-Directed Interaction skills to the targeted child's young siblings with little difficulty. However, when children are at different developmental levels, generalization of skills can be enhanced by having one session in which the parent is coached with the referred child and with each of his or her siblings in turn. Usually the referred child feels somewhat proprietary about special playtime in the clinic setting. For this reason, we always include some period of coaching for the referred child, even though the greater focus in this session may be on coaching the parent's use of skills

with the siblings. For a more complete discussion of how to incorporate siblings into PCIT, please see Chapter 11.

End of Session Debriefing and Homework Assignment

We reserve the last 10 min of each coaching session for providing feedback to parents on their skills progress and discussing the upcoming week's homework. Many parents are motivated by viewing the PCIT Progress sheet. This is a record of their CDI skill acquisition and ECBI changes across sessions. They are able to view their progress from week to week, as well as monitor how close they are to reaching the mastery criteria for CDI and moving on to the discipline portion of PCIT. Feedback should begin by noting for parents areas of progress in the "Do" and "Avoid" skills, child responsiveness to these skills, and improvements in qualitative aspects of the parent-child interaction. It is important that constructive feedback that highlights areas needing further work be given as well. However, as with the coaching, the therapist must carefully attend to the balance of positive and corrective feedback so that parents leave the session feeling both encouraged by their progress and motivated to work hard in the upcoming week. Between CDI coaching sessions, parents are asked to complete a daily 5-min special playtime at home, and to record their practice on their homework sheet.

Progression of CDI Coaching Sessions

The strategies and procedures described in this chapter apply to all CDI coaching sessions. Yet, there is a typical progression in what is emphasized in each coaching session (Table 5.6 presents the typical progression of CDI coaching sessions). Across CDI coaching sessions, the therapist should use the DPICS coding to identify one or two skills that are in need of improvement during the session. The therapist then should focus coaching on these skills. Later sessions may include specific drills for particular skills that have not been mastered. There is no fixed number of CDI sessions. CDI coaching continues until parents meet the ten–ten–ten set of mastery criteria (with 3 or fewer commands + questions + negative talk). Thus, some families may be coached in CDI for only three sessions, whereas others may require six or more CDI coaching sessions. Occasionally, a parent meets mastery in the first or second CDI coaching session. In those cases, we typically will continue with CDI coaching for a couple of weeks to allow for sufficient home practice so that the following goals can be accomplished: (1) improved child outcomes (e.g., enhanced self-esteem), (2) improvements in the parent–child relationship, and (3) generalization of skills outside of the daily 5-min special playtime. Finally, therapists should realize that the 10-10-10 mastery requirement is designed to promote a warm and engaging relationship. If the parent engages in the required number of verbalizations in each category but does not perform the skills with warmth, genuineness, and enthusiasm, CDI should be continued until the relationship also improves.

Table 5.6 Typical progression of CDI coaching sessions

Session #1
Labeled praise for all PRIDE skills and ignoring
Provide only positive feedback. Do not point out mistakes in this session
In homework, parents are encouraged to focus on decreasing questions and increasing reflections
Session #2
Review "Parents are Models for their Children" handout and discuss anger control
Labeled praise for all PRIDE skills and ignoring
Go over CDI mastery criteria
In homework, parents are encouraged to focus on increasing labeled praise
Session #3
Review "Getting Support" handout and discuss family's social support network
Fine tune all PRIDE skills and ignoring
In homework, parents are encouraged to focus on skills not yet mastered
Session #4 and beyond
Review "Kids and Stress" handout
Labeled praise for all PRIDE skills and ignoring
Conduct 2–3 min coaching drills on whatever skills are weak
If mastery criteria are met, introduce PDI and remind them that child does not attend the next session
In homework, parents are encouraged to focus on skills not yet mastered

For handouts listed above, see Eyberg (1999) available at www.pcit.org

What if a Caregiver Does Not Reach CDI Mastery?

We often are asked how to handle cases in which a caregiver has had numerous CDI coaching sessions (e.g., 10 or more) and still has not reached mastery. The therapist should try coding this type of family more than once during a CDI session to determine whether coaching and anxiety reduction enhance performance. Sometimes a family can meet the mastery criteria at the middle of a session but not at the beginning. Unfortunately, however, these cases often involve families who do not practice CDI at home as prescribed. The first question for a therapist to consider is whether he or she has done everything to motivate the parent to buy in to CDI and to complete homework. Then, the therapist should examine the issues in failing to reach mastery. If the parent is able to follow the child's lead and is missing mastery by only a couple of questions or a few PRIDE statements, it is possible that moving forward is an appropriate step. After all, CDI coding and coaching will continue in the PDI sessions. Sometimes parents have greater CDI buy-in after PDI has begun to work. If the parent simply is "not getting CDI," the therapist should be cautious about moving forward. PDI is likely to be difficult and possibly ineffective without the relationship enhancement. Occasionally, a family may only be motivated by the

consequence that treatment may be suspended or even terminated unless the caregiver is able to commit to the daily homework requirement (e.g., a family with a history of abuse that is doing only the bare minimum to regain parental rights). A similar issue that often arises is in dual-caregiver families when one parent reaches mastery faster than the other parent. Do we move forward with the caregiver who has reached mastery or hold the family until both caregivers attain mastery? With this decision, we usually consider the degree of involvement of the caregiver who has not reached mastery. If that caregiver is the primary caregiver or highly involved in the parenting of the child, we might choose to slow progression to allow that caregiver to "catch up." For us, however, the ultimate issue question is this one: "What is in the best interest of the child?" If a family is getting highly frustrated with the over-abundance of CDI sessions and is at risk of dropping out of treatment, it may be in the child's best interest to move forward to PDI. Whereas PCIT will be less effective when the family does not reach mastery, it may be even more ineffective if the family terminates prematurely. As these decisions are made on a case-by-case basis using clinical experience, we recommend taking advantage of a seasoned PCIT consultant or colleagues on the PCIT listserve (sign up at www.pcit.org) when making such judgments. One of the strongest aspects of PCIT is the large change in parenting skill that occurs when enforcing the high standards of the mastery criteria. Allowing a parent to move forward without mastery should be a rare exception. By valuing and following the mastery criteria, we can ensure that each family receives its optimal "dose" of CDI.

References

Eyberg, S. M. (2005). *Parent-child interaction therapy: Basic coaching guidelines introduction*. A Power Point presentation retrieved April 8, 2008, from http://www.pcit.org

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April 2, 2008, from www.pcit.org

McNeil, C. B. (2008). *Parent-child interaction therapy*. A 2-hour DVD in the APA Psychotherapy Training Video Series hosted by Jon Carlson.

Chapter 6
Teaching Parent-Directed Interaction

What to bring. . .
(1) Toys and time-out chair for demonstrating PDI
(2) ECBI
(3) Giving Good Directions – Parent Handout
(4) Time-out Diagrams – Parent Handout
(5) Large doll or stuffed animal for role-plays
(6) CDI Homework Sheet
(7) PCIT Progress Sheet
(8) Sheila Eyberg's Treatment Integrity Checklists/Manual

Rationale for Why Young Children Should Comply with Parental Commands

The advantages to parents of gaining behavioral control over their young children are obvious. Parents will be less frequently embarrassed and inconvenienced by disruptive behavior, they will not have to leave work as frequently in response to difficult behavior at school or daycare, they will have an easier time obtaining substitute care, and their day-to-day caregiving responsibilities will be much less stressful. However, as advocates for young children, we are less concerned with making life easier for parents than we are with maximizing the happiness, safety, and developmental potential of their children.

There are several compelling reasons why young children benefit from parental control over their behavior. First, an important part of early socialization is learning how to follow rules. Preschoolers who do not learn how to accept limit setting by their parents are at risk for poor adjustment in kindergarten and may be retained because of a "lack of behavioral readiness" for promotion to 1st grade. In order for children to acquire self-discipline, rules must first be externally imposed and enforced. After learning to respond to consistent external limits, young children begin to internalize rules for conduct and to demonstrate rule-governed behavior

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that will facilitate their classroom adjustment. Second, the ability to obey and follow rules is important for the development of early social skills such as following rules in games and turn-taking. Young children who do not develop these skills as preschoolers are at risk for peer rejection when they enter elementary school, and we know that relative standing within the peer group is highly resistant to change even after social skill deficits are remediated.

Third, parents of young children with behavior problems often find it easier to do self-help tasks for their children rather than "do battle" over simple chores. As a result, it is not unusual for preschoolers with oppositional behavior to show mild to moderate developmental deficits in self-help skills such as dressing and undressing, brushing teeth, using utensils properly, and putting away toys. Fourth, although many parents do not recognize this to be true, young children really do want their parents to be in control. Being able to "run the show" is both attractive and highly anxiety-provoking for young children who depend on their parents for safety and nurturance. Fifth, basic safety concerns dictate that young children learn to follow parental rules and respond rapidly to directions from parents. Some of the impulsive and aggressive young children we have worked with have run away from their parents in crowds, run out into busy streets, slipped out of the house during the night, and set the family home on fire while playing with lighters. And sixth, young children with disruptive behavior and those with developmental problems are at enhanced risk for abuse, particularly when other familial risk factors are present. Thus, we feel it is important that clinicians practicing PCIT not lose sight of the fact that the primary goal of the discipline program is to enhance the well-being of young children, and the stress reduction and peace of mind experienced by their parents is viewed as an important bonus.

Structuring the PDI Teaching Session

A great deal of specific information is provided in this session, with approximately 2 h required to cover the discipline skills in depth. Before reviewing the PDI procedures, therapists should collect the ECBI and CDI homework sheet, then discuss the PCIT progress sheet with theparents. An overview of the steps for the Discipline Teaching Session is provided in Table 6.1. Parents are instructed to attend without the child in order to decrease distractions. Although parents are encouraged to ask questions if something is unclear, therapists should not allow themselves to become side-tracked. The series of discipline steps is most understandable when explained chronologically, without jumping ahead. If parents ask questions regarding a step that comes later in the sequence, they should be praised for asking a good question but the answer should be delayed until the earlier steps are understood.

Importance of Consistency, Predictability, and Follow Through

The session begins with an explanation of the basic premise of Parent-Directed Interaction: "Children who have attentional and behavioral problems need a great

Table 6.1 Steps for teaching PDI skills

1. Explain use of compliance exercises (5 min)
2. Discuss how to give effective instructions (25 min)
3. Discuss how to determine if child has obeyed (5 min)
4. Discuss consequences for obeying (5 min)
5. Discuss consequences for disobeying (40 min)
6. Present back-ups for time-out escape (30 min)
7. Coach parents as they role-play discipline skills (10 min)

deal of structure." Structure is defined in terms of consistency, predictability, and follow-through. These terms are explained to parents using examples and analogies. Consistency, for example, suggests that parents will use these discipline skills the same way on a crisp morning picnic as on a dreary afternoon at the mechanic's garage. And, it suggests that parents will strive to respond to misbehavior the same way when they have a headache as they would if they just found a $20 bill in their rose bushes.

Predictability can be discussed by talking about the "robot" approach to discipline. Because children with behavior problems often find it exciting to push the limits and see how the parent will react, it is most effective to respond in a routine and boring fashion. If children know in advance that consequences are always provided with a neutral, robotic expression using pre-established words, much of the stimulation is removed from the procedure.

The analogy of a "brick wall" versus a "rubber band" is often used in discussing the issue of follow-through. This discipline approach depends upon parents learning to "say what they mean and mean what they say". If a child with behavior problems perceives that a parent is flexible about rules or consequences, the limits of the rubber band will be tested until it eventually breaks. Parents are encouraged to establish only a few rules, but to enforce them like a "brick wall."

The first rule of PDI that will be enforced consistently is that children must comply when told to do something. In order to motivate oppositional children to want to listen, parents need to respond very differently to compliance versus noncompliance. When we observe parents before treatment, we find that they provide similar types of attention for compliance and noncompliance. For example, at pre-treatment, when parents give a clean-up command and the child complies, they frequently respond by giving another clean-up command. When the parents give a clean-up command and the child does not comply, the parents again respond by giving another command. During PDI, we teach parents to provide very different consequences for compliance and noncompliance. We tell them that once a command is given, they should stop everything they are doing and first determine whether the child has complied. Compliance is followed by enthusiastic social reinforcement, whereas noncompliance is followed by a robotic, consistent, and aversive sequence of discipline steps.

Importance of Memorizing PDI Diagrams (e.g., Using Exact Words)

To enhance consistency and assist parents in disciplining in a robotic fashion, we encourage parents to memorize the exact words in the discipline diagrams. If the words are not memorized, parents tend to add extra emotion (e.g., raising their voices) and unnecessary words (e.g., "Didn't you hear what I just said. . .?") when stressed. The exact words decided upon by Dr. Sheila Eyberg were developed over many years. These words were carefully chosen to be developmentally sensitive and to provide children with all of the necessary information without providing any extra attention. In meetings with the PCIT training committee (Fall 2008), Dr. Eyberg stressed the importance of all PCIT therapists using the same PDI scripts. The words that parents are expected to use in the PDI diagrams should be the same across all PCIT programs. As a result, this chapter includes the exact words from Eyberg's (1999) treatment integrity manual. Therapists are urged to stay abreast of any changes in Dr. Eyberg's manual over time and teach the scripts to parents exactly as they are laid out in her integrity checklists.

Rationale for Use of "Compliance Exercises"

At this point in the session, parents are asked how many times their child misbehaves on a typical Saturday. Parents of children with conduct problems may estimate over one hundred incidents of misbehavior for the day. We explain that it would be virtually impossible to have adequate consistency, predictability, and follow-through by attempting to improve all behaviors at once. Given that it took years to develop these disruptive behaviors, it makes sense to provide treatment one step at a time. So the question then becomes, "Where do we begin?"

Rather than viewing their children as engaging in 100 separate problem behaviors, parents are taught to view all misbehavior as falling into two categories: noncompliance and disruptiveness. Noncompliance is defined as refusing "TO DO" what one is told. Disruptiveness is defined as doing things that one is told "NOT TO DO." Given that noncompliance has been found to be the central feature of early conduct disturbance, teaching compliance is the first goal of the discipline plan. Disruptive behaviors cannot be addressed until the child first develops a basic respect for the parent as an authority figure.

Noncompliance may be viewed as a "bad habit" that the child has learned over time. The child may have developed a "knee jerk" reflex of saying "no" or "wait a minute" when given a command, often regardless of the nature of the instruction itself. The best way to teach compliance is to treat it as a skill that can indeed be learned through practice. Parents are asked how they would teach a young child a new skill such as writing his or her name. Usual responses include working with the child one-on-one, breaking the task down into smaller parts, and over-practicing. This comparison is used to provide a rationale for compliance exercises.

Parents will teach their children to follow directions by establishing small compliance goals along the way. First, children will learn to follow directions by practicing with "play" commands. Basically, the children will receive praise and the opportunity to continue playing if they follow instructions and a negative consequence if they do not follow instructions. Toys will be placed on the table and children will over-practice compliance through the use of simple, non-threatening tasks such as putting eyes on Mr. Potato Head, placing one block on top of another, and handing things to the parent. By receiving a great deal of enthusiastic praise for these small accomplishments, the child begins to view compliance in a more positive light and the habit of defying simple requests is weakened. As small compliance goals are reached, the child is provided with more challenging tasks. These typically involve instructing the child to do things that the child does not want to do (e.g., cleaning up the toys, performing a boring task, transitioning to a less interesting activity). Once compliance has been improved within an exercise format, parents are coached in more "real-life" situations such as getting their children to take their hands for walks and getting them to come into the room from outside.

Giving Effective Instructions

Given the central role of compliance in Parent-Directed Interaction, teaching parents to give good instructions is quite important. Parents must learn which types of instructions (i.e., commands) are most likely to elicit compliance in oppositional young children. It is explained that children with behavior problems respond differently to instructions than do children with calm and cooperative dispositions. A large portion of the noncompliance problem can be corrected simply by giving well-phrased instructions.

Parents are taught to give good instructions while practicing with the toys that the therapist has brought into the session. This introduces parents to the idea that "play" commands can be effective tools for teaching children to comply. The handout on "Giving Good Directions" (see Appendix 6) is given to the parents as a visual aid to help them better understand the material both in the clinic and at home. The rules for giving instructions to acting-out young children are explained in the following sections.

Make Commands Direct, Not Indirect. Parents are asked to use commands that make it clear that the child is expected to do what the parent has requested. In other words, parents are to tell children what to do instead of asking whether they want to comply. Whereas cooperative children tend to respond quite positively to suggestions such as "Let's clean up now, okay?" or "How about putting on your coat?" defiant children may perceive that the parent is indecisive about whether compliance is required. The child's typical response is to treat the instruction like a rubber band and test the limits. Once the rule is explained to parents, the therapist uses the toys to role-play the types of direct instructions that can be provided during compliance exercises, giving the parents plenty of opportunities to practice turning suggestions

into direct commands. We often encounter resistance to the use of direct commands from more educated and permissive parents who feel that indirect commands are more polite and respectful. In those cases, we might say the following:

> In adult-to-adult communication, it is more polite and respectful to use indirect commands. At home, you might not give your husband a direct command to take out the trash. Instead, you would probably say, "Would you mind taking out the trash? It's really piling up." It is appropriate to use an indirect command with your husband or a co-worker because you are peers. However, your child is not your peer. Within the family there is a hierarchy in which the adults are responsible for directing their children. When you use indirect commands with young children, you inadvertently communicate that they are your peers and that they have equal say in decision making. For children to learn to operate in a hierarchy, such as student–teacher in a classroom setting, they need practice operating well within the hierarchy at home. In fact, teachers must learn early on to establish a hierarchy in the classroom. Imagine a substitute teacher who comes into a class of 15 four-year-olds and asks, "Would you all like to clean up the crayons now?" Although a few very well-behaved children may comply with this request, it is highly unlikely that a child with behavior problems will clean up the crayons. Instead, that child will view the teacher as a big rubber band who is elastic in her limit setting and will not respect her as an authority figure.

Make Commands Single Rather than Compound. Instructions should be provided one at a time, rather than stringing several together. Many preschoolers, particularly those with attentional problems, cannot keep a series of instructions in memory, leading them to respond with either noncompliance or partial compliance. An instruction such as the following would therefore be a setup for failure: "Go in there and wash your hands and then bring me your shoes and socks." One instruction that should be avoided for these reasons is telling the child to "clean up" something. Inherent in the "clean-up" instruction is a string of smaller commands. For example, "Clean up your room" typically involves a series like this: "Put your shoes in the closet. Put the pillows back on the bed. Get those Legos back in the box. Place those books back on the shelf." A disruptive young child's idea of what is expected with a "clean-up" instruction is very different from the parents' expectations. As such, parents are encouraged to use a series of smaller commands, particularly when the child is in the early stages of learning to comply. Breaking requests down into smaller units also provides the child with more opportunities to experience the positive consequences of obeying.

State Commands Positively. Parents are asked to tell the child what TO DO, rather than what NOT TO DO. Children are more likely to comply with positively stated instructions, and their self-esteem will improve as they get to do the "right" thing instead of stopping a "bad" behavior. A "don't" command is often like a red flag to an oppositional child, challenging him or her to proceed with the disruptive behavior. An advantage of positively stated commands is that they save the child the step of having to think of an acceptable activity to do instead. At this point, parents are asked how many times a day their child might be told, "Don't", "No", "Stop", and "Quit." Many parents estimate 100 or more. They then are asked about the self-esteem and attitude changes that could occur if only half of those instructions were phrased more positively.

For example, parents are asked to imagine that their daughter "Karen" is sticking a marker in her ear, and they respond by saying, "Don't do that!" The best that Karen can do is to "stop being bad." If, however, they tell Karen TO DO something that is incompatible with the problem behavior, there is a clear difference in tone: "Karen, please draw me a picture with that marker." Now, Karen has the opportunity to actually improve her self-esteem by getting to do the "right" thing. Parents can then be given some negatively stated instructions to turn into positively stated incompatible commands (e.g., "Stop scribbling" can be restated as "Hand me the pen," "Don't climb on that" can be restated as "Please get down," "Quit kicking her" can be restated as "Keep your feet to yourself," "No, I don't want you touching that" can be restated as "Please hold my hand," and "That's not the way we treat our toys" can be restated as "Play gently with the doll."). After much practice, this process of changing negative instructions into positive ones becomes a habit that requires little extra effort.

Make Commands Specific, Not Vague. Parents are taught to avoid vague commands such as "Be good," "Come on," "Settle down," "Watch out," "Behave yourself," and "Straighten up" because the child can easily misinterpret the behaviors expected. Parents are asked to suppose that their child, "Josh", is climbing on top of the book case and they respond with a vague, "Be careful, Josh". What is Josh likely to do? Often children will say, "I am being careful, Dad." A better instruction would have conveyed to Josh exactly what behavior was desired: "Josh, please get down." leaving little room for misunderstanding. A common vague command is the use of the child's name without additional information. For example, Kevin is banging on the table with a plastic hammer and his parent says, "Kevin!" Parents should be encouraged to add the specific instruction to the child's name (e.g., "Kevin, please play quietly with the hammer").

Give Commands in a Neutral Tone of Voice. Yelling is a trap that many parents get into with young children who do not seem to listen to them. Once parents begin to use yelling as the signal that they mean business, oppositional children realize that they can get away with ignoring instructions given in a neutral tone of voice. Parents may find themselves always having to yell to get their child's attention. A goal of PDI is for children to learn to respond to directions issued in a normal conversational tone. Neutral tone implies a firm, matter-of-fact approach that contains no trace of yelling or pleading.

> Most children worth their salt train their parents to give them a series of cues about just how serious they are. And, I don't know about you, but those cues may have to do with your tone of voice, how loud you are speaking, your facial expressions, and even physical proximity (therapist demonstrates by invading parent's space). These cues let your child know just how close to a punishment he is. When you tell your child to do something in a calm, pleasant tone of voice, he probably knows that he doesn't have to do it. He may choose to do it if he is in a cooperative mood, but he knows he doesn't have to because you haven't raised your voice, moved closer to him, and put a stern look on your face. In PDI, we want to retrain his ears to perk up and pay attention when you tell him to do something using a neutral tone of voice. We're going to do that by removing all of those extra cues and requiring him to comply when told nicely to do something.

Be Polite and Respectful. A good habit for parents to get into is to start most instructions with the word, "Please". Not only is this respectful and models good manners, but it serves as a discriminative signal to children that an important instruction is going to follow and they should listen carefully. For parents who have a particularly difficult time stating commands directly, the "please" has an added benefit. It is more difficult to turn an instruction into an indirect suggestion when it begins with "Please" (i.e., Whereas it is awkward to say, "Please would you put the blocks away?" it feels quite natural to say, "Please put the blocks away."). We find that many parents equate indirect commands with being "polite" and direct commands with being "mean." By encouraging them to start almost every direct command with the word "please," these parents learn that it is possible to be firm and polite at the same time.

Be Sure Commands Are Developmentally Appropriate. When teaching a child to comply, it is important that both the parent and therapist agree that the child is physically and cognitively capable of following the instruction. For example, suppose an oppositional child is given the instruction, "Please draw a house for Mommy." The child responds by saying, "I don't know how. You do it for me." This can be either an oppositional ploy or a valid reaction to being asked to do something that is too difficult. To avoid this common problem and to teach parents about reasonable developmental expectations, the only instructions used for practicing compliance are those that are well within the child's developmental capabilities. Children may be guided in more developmentally challenging activities by breaking the complex task down into smaller, simpler units. For example, the command "Please draw me a rabbit" should be delivered through simpler instructions such as, "Please draw a circle here," "Please draw two small circles for eyes," "Now, please give him some lines for whiskers," ... To ensure that the child receives enough encouragement, compliance with each small command should be followed by a labeled praise.

Use Gestures. Parents are advised to use gestures when giving instructions. Because many of the young children referred for PCIT have auditory processing problems, receptive language delays, or attentional deficits, gestures are used to enhance comprehension. When the child does not comply immediately, the parent points so as to clarify the objects or places involved. Gestures are more effective than repeated commands (i.e., "nagging") because they involve much less negative attention and preserve the positive tone of the interaction

Use Direct Commands Only When Really Necessary. To help parents maintain consistency, direct commands should be reserved for times when it is important that the child obey (e.g., during compliance exercises, when the child has left toys on the kitchen floor, when getting ready for school, when needing to stay with a parent in a public place, when engaging in potentially dangerous behaviors, and when needing to accomplish tasks of daily living like brushing teeth and dressing). If the parent is not invested in having the child obey a certain instruction, indirect or "question" commands can be used to suggest a possible course of action (e.g., "Would you like to give your Aunt a hug?" "Please hand me that magazine, okay?"). Compliance with indirect instructions (i.e., suggestions) is optional, but consistent consequences will be provided when the child defies direct commands. The therapist can use this

rule to help parents prioritize the importance of various instructions. In many cases, a goal of PDI is to greatly reduce the total number of commands given to these children. In helping parents understand the proper usage of direct versus indirect commands, we tell parents:

> I think that there is a place for both direct commands and indirect commands in your parenting. I just want you to be a clear communicator with your child. When it is important to you that your child do what you're telling him to do and do it right away, that should be a direct command. For example, you would want to use a direct command when telling your child to put on his shoes. You should save indirect commands for times when you just want to make a suggestion. An example of this might be, "Could you pass the salt please?" I respect you as a parent and I don't want to impose my own parenting values on you. But, I do want you to have a tool for getting your child to listen. I might choose to use a direct command for tasks of daily living that need to be accomplished like getting ready for school in the morning, doing chores, completing homework, coming to the dinner table, getting ready to go out the door, cleaning up after oneself, and getting ready for bed. On the other hand, I would use indirect commands when I want my child to do a favor for me, like bring me a tissue, bring me my purse, answer the phone, or hold open the door. Another time when I might use an indirect command is when my child seems bored and needs something to do. Then I might use an indirect command like, "How about building something with your Legos," or "Why don't you call up a friend?" Giving rapid-fire direct commands can make you sound like a drill sergeant, and I know you want home to be a calm, relaxing place for both you and your child. So if you are at the dinner table and your child is sitting on his knees or blowing bubbles in his milk, I hope you will ask yourself, "Is it critical or essential that I give a command to correct this behavior?" If the answer is "no," then it would be better to use an indirect command or a Child-Directed Interaction skill such as ignore and distract.

Incorporate Choices When Appropriate. Preschoolers often comply more readily when given choices. From a developmental perspective, choices help young children to become autonomous and learn decision-making skills. Yet, giving choices to preschoolers is only effective when the choices are very simple and issued at a developmentally appropriate level. When giving "choice instructions", a good rule of thumb is for parents to try to limit the choices to two equally acceptable behaviors. Examples include (1) "It's time to get dressed. You can put on either your blue sweatsuit or your Batman sweatsuit" and (2) "Your skates need to be put away. You can either do it now or when the cartoon is over." Oppositional children often refuse both choices, and it is better to stick with the original choices than to reinforce the oppositionality by providing additional options.

Provide a Carefully Timed Explanation. Sometimes (not always) it is appropriate for children to be given explanations for why they should do a requested behavior. These explanations can be important teaching tools for young children, helping them to understand the motives of others and the reasons why things are done in particular ways. To help parents understand the importance of using explanations with young children, we explain the following:

> One time that is especially important to use an explanation is when you are asking your child to put away what she is doing to come and do what is on your agenda. If you think about it, we expect this of young children many, many times every day. The picture that she is coloring is just as important to her as getting to the grocery store is to you. However, we expect her to always drop what she's doing to conform to the schedules of the adults

around her. Let me ask you something, Mrs. Divalectable. When you are cooking dinner and your husband comes and asks you to hold the end of the tape measure, do you feel like immediately drop what you are doing to immediately assist him? Or, do you usually say, "I'll come help you in a few minutes." Imagine what it would feel like to be a young child to be asked to always drop what you are doing to go along with others. To help your daughter feel less frustrated and be able to comply more readily, it is a good idea to use an explanation when asking her to switch from her activity to yours.

The key to "reasoning" with young children is to provide a carefully timed, brief explanation, without getting enticed into an argument or lengthy discussion. "Carefully timed" means that the reason should either precede the instruction, or be provided after the child has complied. Ill-timed and better-timed examples of the use of reasoning are as follows:

Ill-timed	
Parent:	"Please put the crayons back in the box." (direct command)
Child:	"Why?"
Parent:	"Because our special time is almost over." (ill-timed reason)
Child:	"It's not time for it to be over yet."
Parent:	"Yes, it is time." (argue) "Now put the crayons away." (repeated command/nagging)
Child:	"Why can't we just finish our coloring?"
Parent:	"Because it's time to go!" (argue)
Better-timed	
Parent:	"Our special time is almost over." (reason precedes instruction) "Please put the crayons back in the box." (direct command)
Child:	"Why?"
Parent:	(gesture: points to crayons and box); explanation already given
Child:	(puts crayons in box) (comply)
Parent:	"Thanks for doing what I asked you to. As I said before, we have to clean up because our special time is almost over." (reason provided after compliance)

When a reason is given between the instruction and compliance, it is a setup for an argument. As is apparent in the first example, the oppositional child has a talent for sidetracking the parent away from the central issue, and ill-timed reasoning is often at the root of negative attention-seeking cycles. See Table 6.2 for examples of explanations and their associated commands.

Practicing How to Give Effective Instructions

Once all of the rules for giving effective commands are presented, we have the parents practice using the skills. One option is to use the exercise from Dr. Eyberg's (1999) manual called "Changing Ineffective Commands to Effective Commands." In this exercise the parent is given a number of poorly stated instructions and must use the rules for effective commands to rephrase each instruction as an effective

Table 6.2 Sample explanations and commands

Explanation	Command
It's time to practice following instructions	Please hand me that stop sign (points and holds out hand to make it easy)
I could sure use some help	Please put these two pieces together for me
I'd like to see how good you are at puzzles	Please try to put this piece in the puzzles
Ooops. A Lego fell on the floor	Please pick it up
We're going to practice listening again	Please write your name at the top of the page
It's time to work on letters. This is a "B."	Please try to make a "B" just like mine
Now we're going to play with a different toy	Please put the cars over here (points to back of the table)
Our play time is almost over	Please put the crayons back in the box
I'm worried you might choke on that block	Please take it out of your mouth
We need to work on letters at the table	Please sit in this chair next to me
It's almost time to go	Please put one handful of Tinkertoys in the box
You might fall	Please get off of the table
I want to see how well you can follow instructions	Please make me a circle right here on the paper

command. A second option is to use a popular children's book by David Shannon entitled "No, David!" (1998) to help parents learn to quickly identify problematic commands and convert them into more effective instructions. In this book, David misbehaves on almost every page. For example, he colors on the walls, opens his mouth while eating, plays with his food, jumps on his bed, picks his nose, tracks mud into the house, breaks a vase, and runs naked down the street. David's frustrated mother responds by breaking many of the command rules. She provides negatively stated commands (e.g., "No, David!"), vague commands (e.g., "Settle down, David!"), commands given in a raised voice ("That's enough, David!"), commands that are too large ("Clean up this room, David!"), etc. The humorous pictures and dialogue in this book make the exercise fun for both the parents and the therapist. And, the book provides numerous opportunities for parents to learn to quickly restate commands using more effective language. Parents also learn to evaluate whether a command is needed in a particular situation or whether a CDI skill could be used instead (e.g., ignoring and redirecting).

Determining Compliance

Even when commands are well stated, it may be difficult to determine whether a child has obeyed. Suppose that the parent points to the red block and then her own hand while saying, "Please put the red block in my hand." The parent is asked to list all of the possible ways the child could respond to this instruction. Each response provided by the parent is then categorized as either a "comply" or a "noncomply." In addition to the parent's examples, the following "tough calls" should be discussed:

Doing Something Slightly Different from Parent's Request. It is common for oppositional children to test the limits by providing a response that it slightly different from what was requested. For example, the child may put the green block, not the red block, in the parent's hand. It must be assumed that the child knows which block the parent is referring to for two reasons: (1) only developmentally appropriate instructions are included in compliance exercises and (2) the parent pointed to the block to eliminate any ambiguity in the instruction. Therefore, the child's response is considered noncompliance. Other examples include pushing the red block toward the parent's hand, putting it on top of the parent's head, and tossing it at the parent.

Dawdling. Dawdling occurs when a child is slow to obey. For example, a boy would be dawdling if he was given a command to hand the parent the red block and then nudged it slowly toward the parent's hand. He also would be dawdling if he made the block into a helicopter and told the parent to wait until the helicopter landed in her hand, proceeding to fly it all over the room. Dawdling is handled with the 5-s rule. The parent will count silently, "one-thousand-one, one-thousand-two, one-thousand-three, one-thousand-four, one-thousand-five." If the child has not made an attempt to comply by the count of five, it is noncompliance. The 5-s rule is used because inattentive young children often forget an instruction if they do not respond to it immediately. Additionally, we tell parents that psychologists have researched nearly every part of this procedure and found that the odds of getting compliance drops dramatically 5-s after the command is given.

"Playing Deaf". When a young child ignores a parental request, it is tempting for the parent to repeat the instruction, assuming that the child has not heard it. Parents also are tempted to say the child's name repeatedly, hoping for eye contact, or to even physically prompt eye contact by touching the child's chin. However, repeating commands and prompting eye contact provides negative attention to the child and teaches the child that consequences can be delayed or avoided through the use of stalling tactics. Unless there is reason to believe that the child indeed has a hearing problem, it is best to consider "playing deaf" to be a form of noncompliance. In our experience, children quickly learn to attend to instructions if consequences are provided for ignoring parental requests.

Partially Complying. Partial compliance occurs when a child angrily pushes the red block toward the parent without actually placing it in the parent's hand. This is another way that children test the limits. If the parent accepts this as a comply, the child will view the parent's rules as being elastic. The likely result is that the child will push the limits a little further the next time. The best response is to have the parent silently point to the block and point to his or her hand to clarify the instruction. If the child does not respond to the visual cue by placing the block in the parent's hand, it is considered noncompliance.

Complying with a Bad Attitude. Imagine that the child slams the red block into the parent's hand and yells, "Here's your stupid block! Now shut up!" We remind parents that we are beginning PDI with compliance training (i.e., getting children TO DO what we want them TO DO). Only later in PDI, after compliance is well established, will we begin to work on the "STOP" behaviors. Because the child put the block in the parent's hand, this must be considered compliance. After all, the

parent did not specify that the child had to put it in the hand gently. Parents are instructed to praise the compliance and ignore the bad attitude. Because the bad attitude is not rewarded with parental attention, we find it rapidly diminishes. If complying with a bad attitude continues, we coach parents to follow immediately with a second instruction that is focused on complying "nicely" (e.g., "Now, please put the green block in my hand gently").

Undoing. "Undoing" occurs when a child initially obeys and then behaves in a way that negates the obedience. For example, a child may tentatively place the red block in the parent's hand and then quickly take it back again. In the original instruction, the parent said to put the block in his or her hand, not to put the block in the hand and leave it there. Although the child is clearly testing the limits, this is considered compliance. If "undoing" continues, the parent can be coached to follow immediately with a second instruction that is more clearly stated such as "Please put the block back in my hand and leave it there." Interestingly, many children also can be observed "overdoing" commands. When a parent asks for a red block, the child may hand the parent all of the red blocks. We often see this behavior in children who are particularly eager to please their parents and avoid time-out. "Overdoing" counts as compliance, as the child actually does hand the parent the red block.

Praising Compliance

Using the toys, the therapist can role-play possible scenarios for what might happen during the following week's compliance exercises. We start by focusing on what the parent should do when their child complies. To illustrate, a sample instruction is chosen such as: "Jason, it's almost time for us to leave. Please put Mr. Potato Head back in the box (point to Mr. Potato Head and point to the box)." The therapist can ask the parents to imagine that their child surprised them and quickly put Mr. Potato Head away. How should they respond? By this point in treatment most parents will answer that they should praise their child. What they may not realize is the specificity of the praise that should be provided. Because compliance is the target behavior, the best labeled praises are "Nice job of doing that right away" or "Thanks for minding" or "I like it when you do what I ask" or "Good following instructions." When enthusiastic labeled praises are given for listening, children begin to view compliance in a more positive light. In addition to the praise for compliance, the parent should mention that he or she is happy that the child did not have to go to time-out. The parent can be coached to say something like "Good listening! You did what Mommy (Daddy) asked you to do and you don't have to go to time-out! I'm very proud of you." This is particularly important early in treatment when young preschoolers have not yet learned the relationship between noncompliance and time-out in the chair. By praising a child for making a good choice and avoiding time-out, parents can also send a strong message that they are on the child's team and are genuinely happy that the child has been successful. Once children clearly understand the relationship between noncompliance and time-out, the labeled praise

for not needing a time-out may be discontinued. When practicing command giving during compliance exercises, parents are taught to return to CDI after the child has been praised for compliance.

Because we ask parents not to take compliance for granted and to try to praise every time their child does what they ask, it is easy to fall into a pattern of repeating the same labeled praise again and again. Repetition is problematic because the praises sound mechanical, low energy, and lacking warmth and genuineness. Robotic sounding praises lose their reinforcing value. Therefore, we work with parents to generate a list of different ways to say "thank you for following directions." Table 6.3 provides a list of compliance praises that can be used as a handout for parents.

Table 6.3 Labeled praise for compliance

You have great listening ears
Great first time listening
You did a beautiful job of minding
You are doing great at paying attention
I really like it when you listen and that gives us more time to play
You did a wonderful job of cooperating
Thanks for doing that right away
Good job of doing what I asked you to do
Thank you for following directions
I like it when you listen to instructions
I'm proud of you for being a helper
I really like it when we work together to get the toys cleaned up
Nice job of doing that so quickly
It makes me happy when you follow directions the first time I ask
Terrific job of listening with a good attitude
You're an awesome helper
I love it when you're so cooperative

Rationale for Disciplining Children with Time-Out in a Chair

Parents referred for PCIT are highly skeptical about the effectiveness of time-out because they have tried it in various forms and it has failed. It is important for therapists to be aware of the resistance they are likely to encounter regarding time-out. Because parents are so skeptical about time-out, we risk losing them if we mention too early that our discipline program is based on time-out. In fact, we NEVER mention the words "time-out in a chair" until this point in the PDI teaching session. Before presenting time-out, we need to have established rapport and credibility, and we need enough time to "sell" the entire time-out procedure to parents.

Once parents have learned to give effective commands and praise compliance, we introduce the rationales for using time-out in a chair as the primary consequence for noncompliance. Even when we have strong rapport with parents, we still should be prepared for major resistance when suggesting that time-out can be an effective

technique. We have to keep in mind that almost every parent who enters PCIT will have had numerous failure experiences with time-out. A therapeutic strategy that helps decrease resistance is to "read parents' minds". Before parents can tell you all of the reasons that time-out will not work for their child, say something like the following:

> I know what you're probably thinking. You're thinking that I must be crazy if I think Jason is going to go to time-out without a fight. You're also probably thinking that there's no way that Jason will stay in a time-out chair. And, you're thinking that time-out seems like an awfully naive solution to all of Jason's problems. Before you write this off, though, I would like it if you would just hear me out. I've worked with a lot of children with problems just like Jason's, and time-out has been extremely helpful. But, I know that there are at least 100 things that can go wrong with a time-out procedure. Children can lie down flat and refuse to go to the chair. They can hit their parents on the way to time-out. They can knock over the chair, or throw it. If a parent is able to get them to time-out, they can scream obscenities. While in time-out, they can pull their pants down and urinate on the floor. They can take their shoes off and throw them at passersby. They can try to make themselves throw up. Yes, there are many things that have to be worked out. But, if we can get all of the bugs worked out, I believe that time-out is the single most effective consequence for Jason.

Some of the reasons for choosing time-out over other types of consequences can be discussed with the parents: (1) acting-out children are motivated to avoid time-out because it keeps them from stimulating activities, including getting attention from others, (2) few consequences are more aversive to a young children than complete boredom, (3) unlike some other consequences (e.g., restriction of privileges), time-out can occur within seconds of the inappropriate behavior, (4) unlike spanking, short time-outs can be safely administered numerous times per day, thereby allowing the parent to be more consistent in following through with consequences, (5) unlike spanking, time-out does not cause some children to become more aggressive because the parent does not serve as a model for hitting, and (6) time-out is a commonly used discipline strategy in classrooms; use at home will promote greater cross-setting consistency and enhance the child's behavioral adjustment at school as well as at home.

At this point, the therapist can process with the parents how they feel about using time-out. If the parents still are not convinced that the technique has merit, the therapist always can use this strategy:

> I understand your doubts. Jason's behavior can be quite difficult. But, remember that I'm not asking you to go home and try this on your own. Instead, I'll be there coaching you through that first time-out. It will become immediately apparent to both of us whether this approach can help Jason. Given that it has worked with so many other children with problems like his, I have confidence. How about if we just proceed for now with the time-out program? If after next week you still have concerns, we'll reassess. How does that sound?"

It is often helpful to reassure parents that the child will be taught all of the rules about time-out and compliance exercises before any coaching will be conducted.

The Time-Out Warning

To explain how the warning works, the therapist should redirect the parent's attention to the role-play example: "It's almost time to go (reason given before command). Please put Mr. Potato Head back in the box (points to Mr. Potato Head and then to box)." The parents are asked to suppose that the child says, "No, you put Mr. Potato Head away!" Is that response a "comply" or a "noncomply"? Clearly, the child has not followed the instruction. At this point, the parent must NOT repeat the command. Instead, the parent will simply give the warning. The parent says in a neutral tone of voice, "If you don't put Mr. Potato Head back in the box, you are going to have to sit on the chair" (Eyberg, 1999, p. 84). If a child complies after only the first or second word of the warning (e.g., Parent: "If you don't. . ." Child: "Okay. Here."), the parent should continue saying the entire warning. We find that children will comply after the first word or two in an attempt to terminate the warning, as it is boring and aversive. But, the parent should follow through consistently, finishing the warning verbatim and then praising the child for compliance. Providing the entire warning allows the parent to follow through with a robotic and predictable consequence for initial noncompliance (i.e., a full warning statement).

The Time-Out Warning: A Promise, Not a Threat. The time-out warning must not be taken lightly. The success or failure of the discipline program rests on the consistent follow through on this warning. Whereas parents may occasionally give instructions that they do not follow through on, it is critical that they *never* provide a warning without being prepared to follow through with time-out. Parents are told to regard the warning as a serious promise, not an idle threat. To reinforce the importance of consistent follow through on the warning, parents are told to imagine how a child learns not to touch fire. The first time Emma touches fire, she gets burned. She touches fire again and she gets burned. Soon Emma learns not to touch the fire because it is 100% certain that she will get burned. The time-out warning must have that level of consistency. The first time Emma disobeys the warning, she goes to time-out. The second time she disobeys a warning, she goes to time-out. Over time, Emma will stop testing the warning because it is 100% certain that she will have time-out. With the warning, the parent is making a promise to the child that a time-out will definitely be forthcoming if the child does not comply. After numerous trials during which the parent follows through with 100% consistency, few children continue to doubt the parent's resolve. Children learn to accept that when a warning is given, the parent is prepared to follow through with the consequence.

Once the child stops testing the limits, the parents have a powerful new discipline tool at their disposal! Rather than having to yell or chase the child to gain compliance, they can provide the kinder and gentler signal of a verbal warning that is provided in a conversational tone of voice. The child will accept that the parent "means what he (or she) says and says what he (or she) means." Within a couple of weeks of beginning the discipline program, most children choose to follow directions rather than receiving the predictable time-out consequence.

Once the warning is given, parents are taught to watch closely to determine whether the child has or has not complied. If the child complies, an enthusiastic

labeled praise should be given (e.g., "Good listening! I'm glad you followed instructions so you don't have to go to time-out. Now we can play what you want to play"). If the child chooses not to obey, the parent should proceed with time-out.

Logistical Issues Associated with Time-Out

Placement of the Time-Out Chair. Most parents believe that time-out needs to be done with the child's nose in a corner or with the child near a wall. One reason to avoid time-out in a corner is its long history of use as punishment through "humiliation." However, there are other reasons to avoid this practice. It is helpful for the therapist to put a chair in a corner and role-play for the parent what likely will happen. When an active, defiant child is placed within kicking distance of a wall, it is a safe bet that his or her feet will end up on the wall. If the child is placed within reach of magazines, cupboards, wallpaper, etc., it is very likely that the child's hands will be on everything within grasp. To avoid these common pitfalls, parents should place the time-out chair so that it is in the "middle of nothing." A good strategy is to sit in the time-out chair and reach out in all directions. If nothing can be touched within that radius, the location is appropriate for time-out. Effort should also be made to minimize extraneous entertainment during time-out. The child should not be in view of the television and should not be placed in a high traffic area where siblings will be unduly tempted to interact with the child in time-out. Additionally, parents should choose a location in which the child can be easily observed while the parent goes about their business (e.g., kitchen, living room).

Choosing the Time-Out Chair. A common pitfall of time-out is choosing an inappropriate time-out chair. Children's anger can reach high levels during time-out, and the chair needs to be sturdy enough to withstand destructive behavior. One misconception is that children should have time-out in a child-sized chair. An adult-sized chair is usually more effective for several reasons: it is harder to throw, it is more difficult to fall out of, it is less likely to tip over, and it discourages impulsive young children from hopping out because their feet do not touch the floor. Some children will bite, scratch, and poke holes in the time-out chair, so expensive chairs should be avoided. Heavily cushioned chairs, rocking chairs, and chairs that have rollers are less effective because they can be fun and relaxing. The best all around choice for a time-out chair is a solid, wooden kitchen chair which can be pulled into the middle of a room as needed. For coaching time-out in the clinic, it is best to avoid light plastic chairs because they tip over easily and children tend to slide off of them. A wooden or heavy metal chair with a fabric or vinyl-covered seat is a good choice.

Getting the Child to Time-Out

Reviewing the Sequence. To help parents follow the sequence of events, the therapist can repeat earlier lessons by returning to the original role-play as follows: "Jason,

it's almost time to go (reason given before command). Please put Mr. Potato Head back in the box (direct command)." Jason responds, "No. You put Mr. Potato Head away!" The parent is then asked what happens next in the sequence. The correct answer is that the parent says, "If you don't put Mr. Potato Head back in the box, you're going to have to sit on the chair." Suppose Jason says, "No! I'm busy!" The parent is asked whether this is a "comply" or "noncomply." Because it is a "noncomply," the child must be sent to time-out as promised.

Problem Behaviors That Can Occur on the Way to Time-Out. Parents are asked what will happen when they try to get "Jason" from this seat at the table to the time-out chair across the room. To interject some humor, parents can be asked, "Will Jason walk over there like a little gentleman when you ask him to?" Parents usually respond with a series of anticipated problems (e.g., child grabs hold of seat, dives under the table, runs out the door, goes limp, lies flat on the floor, hits the parent). Parents often overestimate the amount of resistance their children will show. We do not consider this to be a problem because it enables us to problem-solve concerning worst-case scenarios. The fact that we take this information in stride reinforces our credibility with parents. We find that role-playing is the best method for teaching parents how to get their children to time-out. We often use a stuffed animal or large doll to demonstrate each step in the time-out sequence.

Escorting a Cooperative Child to Time-Out. The therapist should demonstrate (e.g., with stuffed animal) the best way to escort a cooperative child to time-out. If "Jason" is willing to be escorted, the parent should stand up, gently take him by the hand, and walk him to time-out while saying the following: "You didn't do what I told you to do so you have to sit on the chair" (Eyberg, 1999, p. 85). Once Jason is placed on the chair, the parent says, "Stay on the chair until I tell you that you can get off" (Eyberg, 1999, p. 85) The parent then walks away quickly. It is explained that children are less likely to resist going to time-out if the parent moves quickly and confidently. They are instructed to limit their speech to the words noted above and to use all of their self-control to maintain a neutral facial expression and voice tone.

Using the "Barrel Carry" with Resistive Children. After having completed the Child-Directed Interaction component of PCIT, most young children surprise their parents with how cooperative they are when instructed to go to time-out. However, realizing that most highly aggressive children are uncooperative regarding time-out, the therapist should next demonstrate the technique for getting a defiant young child to time-out. When the child will not walk to time-out on his or her own, the parent must carry the child. The safest carry is the "barrel carry," in which the parent wraps his or her arms around the child (under the child's arms and across the chest) as if holding onto a barrel. Given that a face-to-face carry would be potentially dangerous to the parent and to the child (e.g., the child can hit and kick harder from that position and can butt his or her own head into the parent's), the child's back should be against the parent's chest. To secure the carry, the parent can hold onto his or her own right wrist with the other hand. Parents are explicitly instructed that dragging or pulling children by the arms and/or legs is dangerous and should never be done.

Managing Aggressive Behavior on the Way to Time-Out. In the barrel carry, the child's arms and legs remain free. For that reason, children are capable of hitting, kicking, pinching, and hair pulling on the way to the time-out chair. To reduce the likelihood of the child physically attacking the parent, the time-out chair is positioned nearby. Also, the parent is instructed to move quickly and confidently when taking the child to time-out. However, the possibility always exists that the child could strike the parent on the way to time-out.

Employing a doll, role-playing can be used to demonstrate how the child could hit or kick from the barrel hold. Parents are asked about the possible ways they could respond to this behavior. It is then illustrated to the parent that any response in this situation will only serve to escalate the child's aggression. For example, if the parent says, "Don't you hit me!," the child will be reinforced by the fact that the angry attempt to get negative attention was successful. Thus, the parent is instructed to ignore all strikes and to continue moving the child to time-out as quickly as possible. If hitting is completely ignored, it rarely continues past the first one or two time-out episodes. The importance of limiting negative attention during the time-out process is explained to parents as follows:

> Once you have decided that Jason is not complying with the time-out warning, your job is to get him to the time-out chair as quickly as possible, providing the least amount of attention possible. If you think about it, on the way to time-out Jason is on center stage for misbehaving with a great big spotlight on him. And, we want to take him off center stage just as quickly as we can by getting him to time-out where his misbehavior can be ignored. The only words he needs to hear are "You didn't do what I told you to do so you have to sit on the chair." Please don't say anything extra on the way to the time-out chair. If he goes limp like a wet noodle, don't say, "Come on, Jason. Get up. You can go to time-out. You know how to walk there." If he starts to run away, don't say, "Come back here young man!" If he pulls your hair, please don't say, "Ouch, that hurt!" Any extra words you say are rewarding him for his misbehavior through negative attention and will make it much harder to teach him to walk appropriately to time-out.

What If the Child Agrees to Comply on the Way to Time-Out?

A common "tough call" occurs when the child begins complying after the time-out process has been initiated. For example, the parent has given the child the time-out warning, but the child has ignored the parent. Then, the parent stands up, takes the child by the hand, and begins to escort the child to time-out. Once the oppositional child realizes that the parent intends to follow through on the consequence, Mr. Potato Head is desperately thrown into the box in a last- second attempt to avoid time-out!

While this may seem like a minor technicality, it actually can be a critical point in the discipline program. When children learn that they can wait until their parent stands up before compliance is required, they seldom will follow instructions when their parent is seated or at a distance. This problem can be avoided if the parent takes the child to time-out the first several times this limit testing occurs. Thus, the parent would stand up and take the child by the hand. The child would try to comply

even though the time has expired. The parent continues to take the child to time-out while using a slight modification of the original words: "You didn't do what I told you to do quickly enough, so you have to sit on the chair. Stay on the chair until I tell you that you can get off."

What if the Child Takes a Toy to Time-Out?

Occasionally, children will try to take toys or objects with them to time-out. Because time-out is a restriction of the privilege to have stimulation and attention, it is important that children not be permitted to play during this time. The best parental response is to quickly take the toy from the child's hand. The parent should avoid saying anything such as "Give me that toy." The child is highly unlikely to follow this instruction, and will be rewarded by the negative attention.

What if the Child Puts Himself in Time-Out?

We sometimes encounter the following scenario during PDI. The parent gives the child a command, such as "Please put the lid on the Play-Doh." Instead of putting the lid on the Play-Doh, the oppositional child (who wants to control the situation and make his parents think that he doesn't mind going to time-out) may simply put himself in time-out before the parent has a chance to give the warning. It is important that the therapist help the parent to understand that this behavior does not mean that the child likes time-out. What tells us whether or not time-out works is whether the child's compliance improves over time. It is important that the manipulative behavior of placing oneself in time-out does not work for the child by altering the parent's use of the procedure. Parents are taught to ignore the fact that the child has placed himself in time-out and to follow through with the time-out warning and verbal script without interruption or alteration. The parent should walk over to the chair and say, "If you don't put the lid on the Play-Doh, you're going to have to sit on the chair." When the child continues to sit on the time-out chair without complying, the parent should say, "You didn't do what I told you to do so you have to sit on the chair. Stay on the chair until I tell you that you can get off." We find that the time-out immediately becomes less "fun" for the child once the parent takes control over the time-out process. When the child learns that placing himself in time-out will not derail the procedure, this behavior will extinguish.

Length of Time-Out

Why 3 Min? Once the child is placed in time-out, the parent should start timing. The time-out period in PCIT is 3 min. With clinic-referred children, we do not use the often-repeated rule of thumb, "1 min for each year of age." We agree that this is a good guideline for children who do not have severe behavior problems. However, for

an extremely active and disorganized 5-year-old, 5 min would likely be too long, and thereby set the child up to fail. Instead, 3 min was chosen because it is the shortest time-out period that is effective.

The "5 Seconds of Silence" Rule. The actual length of time-out in PCIT is 3 min plus 5 s of quiet. Before the parent asks the child if (s)he is ready to comply, the child must be silent for 5 s. The purpose of the silence is to prevent superstitious learning. Suppose the child had just yelled at the parent, "I hate you! You're so mean!," and because the 3 min happened to be up the parent walked over to ask if the child was ready to comply. The child could superstitiously learn that hateful remarks are a way of controlling time-out. Instead, once the time reaches 3 min, the parent should begin to slowly and silently count to 5. If the child talks, cries, screams, or pounds on the chair during that period, the parent will begin the silent count to five again. The 3 min does *not* begin again just because the child is making noise. Only the 5-s count starts over. Once the child is quiet for 5 s, the parent should hurry over to the chair, stand out of the reach of the child, and say, "You are sitting quietly in the chair. Are you ready to come back and put Mr. Potato Head in the box now?" (Eyberg, 1999, p. 86). The "you are sitting quietly in the chair" phrase teaches the child that it is the quiet that encourages the parent to end time-out, not the crying or yelling.

Common Misbehaviors in Time-Out that Should Be Ignored

Returning to the role-play, suppose that Jason refused to put Mr. Potato Head away when given the time-out warning and has been taken to time-out. The parents should now be asked about behaviors that Jason is likely to exhibit while in time-out. Inevitably, parents point out that their child will not stay in time-out and they try to get the therapist to explain immediately what to do when the child escapes. We typically tell parents that they have asked a very important question because few of the children seen in PCIT will stay in time-out without a foolproof plan. The parent is reassured that they will not leave the session without knowing that plan, but it takes a long time to explain and it will make more sense to talk about it later in the session. For now, the parents are asked to pretend that their child has been "super-glued" to the chair and cannot escape, and they are invited to list all of the behaviors the child might display.

Parents typically anticipate that their child will cry, scream, talk, whine, call them names, and ask questions like "Can I get up now?" The parent is instructed to ignore *all* verbalizations. Role-playing is often helpful to demonstrate proper ignoring. No direct eye contact should be made with the child, though the parent is expected to surreptitiously watch the child. The parent should not show disgust, amusement, or irritation. Instead, the parent's face should be as neutral and expressionless as a robot's.

> When your child is in the time-out chair, he will probably go through his whole repertoire of things he thinks will push your buttons. He may say, "I hate you! You're mean! I love Daddy more than you." Or, he may say, "I'm ready to do it now. I'm sorry. I'll do it." Or, he may even say something funny that causes you to feel like smirking, such as "I hate you

> and I hate Santa Claus" or "I'm going to tell Grandma on you." It is really important that you show no reaction whatsoever to anything he says or does while he is sitting in the time-out chair. Don't make eye contact. If he says something funny and you're having trouble controlling that smirk, turn your back before you grin. When your child says mean things to you in time-out, you really need to understand that those words, whatever they are, really mean "I'm very mad that I have to sit here." Any hateful things that the child says truly mean that he's very, very angry. Please don't over-interpret the specific words that your child says. More often that not, he doesn't mean those exact words. He only means that he's angry. He's trying to find words that will help you know just how angry he is. If you do a really good job ignoring, he will get good at sitting quietly in time-out much faster. If you react, even a little bit now and then, to the things he says, that will be enough attention to keep it going. The words that he's saying in time-out are only being said to get a reaction from you. If you withhold your reaction, they'll no longer serve any purpose and he will stop.

One situation that we always try to discuss with parents ahead of time is how to handle when the child says he or she has to go to the bathroom. This is a common ploy to avoid time-out. It is explained to parents that most children can "hold it" for 3 min and that their pleas to go to the bathroom are usually an attempt to get out of time-out. Parents are asked what would happen in future time-outs if they allow their child to go to the bathroom during the first time-out experiences. Recognizing the precedent that can be set, most parents indicate that they feel comfortable ignoring the request. However, some children participating in PCIT are either going through toilet training or have just mastered this developmental milestone. Their parents may not be comfortable denying their requests to go to the bathroom. To prevent this problem, we encourage parents to take their children to the bathroom before the beginning of clinic sessions and home practice sessions. Parents are instructed that if bathroom requests become habitual during time-out, it is a clear indicator that they are a delay tactic that should be ignored.

Time-Out Does Not End Until the Original Instruction Is Obeyed

Following through with the original instruction after the time-out is critical to the success of this program and is a common flaw in the disciplinary approaches being used in many daycares and homes. Learning to comply does not occur during time-out or because of time-out. It occurs when the child has an opportunity to "replay" the original situation with a different ending. Rather than receiving a negative consequence the second time, the child is able to experience the rewards associated with being cooperative (i.e., parental praise, continuing to play). The message to the child is simple: "You can either obey your parents, or you can go to time-out and then obey your parents. In any case, this will not end until you show that you can listen."

Returning to the role-play, assume that the child is indeed "superglued" to the time-out chair. The parent has ignored all verbalizations from Jason during the time-out. At 3 min, Jason's parent begins to count silently to determine when he achieves 5 s of silence. Once Jason has been silent for 5 s, his parent hurries over to the

time-out chair. Standing at arm's distance from Jason to avoid being grabbed (or hit or kicked), his mother holds out her hand and says "You are sitting quietly in the chair. Are you ready to come back and put Mr. Potato Head in the box?" The therapist should role-play with the parents all of the possible responses to this question, as a quick judgment must be made regarding whether the child is ready to comply.

Child Says "No" to the "Are You Ready" Prompt. One possible situation is for the child to completely ignore the parent when the "Are you ready to. . ." question is asked. The parent should count silently to 3. If the child has not made an effort to take the parent's hand, the child is considered to be "not ready" to follow instructions. Also, if the child shouts out a defiant "No!" and refuses to take the parent's hand, he or she is not ready to get out of time-out. For situations in which the child says "No" to the "Are you ready" prompt, the parent should say in a neutral tone of voice, "Okay, stay on the chair until I tell you that you can get off," and walk away. Sometimes a child's verbal and physical responses to the "Are you ready" question do not match up. For example, a child may say "no" while running over to the table and quickly putting Mr. Potato Head in the box. In this case behavior supersedes the verbal response.

Child says "Yes" to the "Are You Ready" Prompt. The child does not have to say the word "yes" to indicate agreement with the "Are you ready" prompt. If Jason nods his head or makes any attempt to return to the table when asked about readiness to comply, he is considered ready to comply. This is the case even when a child does so with a negative attitude. Once back at the table, the parent may point to clarify the instruction. However, the original instruction usually is not given again because it was just repeated when the child was asked if he or she was ready to comply. Sometimes a child will refuse, argue, or ignore the parent at this point. The parent then should matter-of-factly begin the chair procedure again saying, "You didn't do what I told you to do, so you have to sit on the chair. Stay on the chair until I tell you that you can get off."

Use of a Second Instruction to Over-Teach Compliance

Suppose the child returns to the table and complies with the original command. Contrary to what the parent might expect, it is best for the parent to avoid praising the child at this point. After all, a time-out was required to obtain compliance with the simple instruction. Instead, the parent can simply acknowledge the child's compliance using words such as "alright," "thank you," or "okay." Immediately thereafter, the child is given a second command that is very similar to the one that resulted in time-out (e.g., "Now, please put the car back in the box"). When the child complies with the second instruction (which nearly all children do right after having had a time-out), enthusiastic labeled praises should be provided. Here's an example: "Thanks for following instructions so well! I'm proud of you for learning to listen. When you choose to mind, you don't have to go to time-out. Now we can play what you want to play."

The enthusiastic praise should sharply contrast with the acknowledgment given for the child's first compliance. Through this process of making the contingencies for compliance and noncompliance crystal clear, the child learns to view compliance in a more positive light. After all, compliance leads to enthusiastic praise and a continuance of play. Noncompliance leads to a time-out, eventual compliance, and an unenthusiastic acknowledgment. With practice, compliance begins to replace noncompliance as the more rewarding behavior and oppositionality diminishes. Here's how this process of overteaching can be explained to parents:

> Most parents shy away from giving another command right after their child has come out of time-out because they don't want to go through all of that again. But, if you do that, you miss out on a really important opportunity. Right after your child has complied with that command after coming out of time-out, you have a teachable moment. About ninety percent of children are going to comply with the next command you give right after coming out of time-out. If you give a second command and they comply, that's your chance to do back hand springs and high fives. What you want to do is to maximize the contrast between how you respond when he complies right away versus what happens when he goes to time-out and then complies.

Use of Play Therapy to Decrease the Child's Anger Level

Oppositional children become angry when learning to follow instructions. In the beginning it is difficult for them to lose some of the control that they have had over their parents. Child-Directed Interaction skills serve an important role not only in bringing that anger level down, but also in helping children view compliance in a more positive light. A major goal of PCIT is to develop some give-and-take in the parent-child relationship. During play therapy, the parent allows the child to lead the play and is respectful of the child's desires. When an instruction is given, it is the parent's time to lead the play and the child learns to reciprocate by showing respect for the parent's desires. Through this process, the child comes to view following directions as a routine courtesy which leads to family harmony, parental approval, and positive attention. This allows the child to develop skills both as a leader and a follower and forms the basis of the early social skill of turn-taking. Therefore, during clinic coaching, at least 20 s of play therapy follows each instance of compliance. As much as 5–10 min may be needed following a time-out sequence to reduce the child's anger and deal with any distance that might have occurred in the parent-child relationship.

Three Time-Out Behaviors That Cannot Be Ignored

Time-Out Escape. If an oppositional child realizes that the parent is unable to enforce time-out, time-out will not work. A common time-out escape is the child jumping out of the chair immediately after being placed there. Other children are able to sit for a minute or so and then become so agitated that they impulsively

get out of time-out. Sometimes there are tough calls regarding whether a child has escaped or not. For example, many children become gymnasts in time-out, spinning, and lying across the chair. During the course of this activity, they often "accidentally" fall off and look up to the parent to determine how this will be handled. It is important for this behavior to *not* be ignored as the child will test the limits further if the original test is successful. Similarly, children can be observed to progressively slide their bodies further and further out of the chair until only their shoulder blades are on the chair or in some cases they have only a hand remaining in time-out. For these tough calls, parents are given a "50% of the body weight" rule. Once 51% of the child's body weight is off of the chair, the child is considered to have gotten out of time-out.

We explain to parents that we do not expect children to sit like "little statues" in the time-out chair. Because of the boredom inherent in time-out, children often engage in self-stimulating behaviors like wiggling, playing with their shoe laces, changing positions, and sitting on their knees. We teach parents to ignore all of these behaviors. It is acceptable for the child to turn around in the chair and look at the parent as well as fidget, as long as at least 50% of his body weight remains in the chair.

Scooting or Vigorous Rocking of the Time-Out Chair. Although scooting or rocking the chair can initially seem rather innocuous, it quickly becomes a major problem when ignored. The child can scoot the chair over to toys, to the mother's purse, to breakable artwork, and so forth. Scooting or rocking is stimulating and can be a source of reinforcement to the child. As such, children need to be informed that scooting and rocking the time-out chair are not permissible and that it will lead to a negative consequence.

Standing on the Time-Out Chair. This problem is most frequent with 2- and 3-year-olds. When placed in time-out, these children often turn around on their knees and hold onto the back of the chair in order to look at the parent (an acceptable behavior). After being ignored, they may actually stand on the chair. This is a dangerous behavior regardless of the age of the child. To protect the child, potentially dangerous behavior must be handled assertively, using back-up contingencies to be discussed later.

Using the Time-Out Room as the Back-Up for Time-Out Chair Behaviors that Cannot Be Ignored

Clinic-Based Time-Out Rooms. A time-out room will be used as a back-up punishment for children who escape from, stand on, or scoot/rock the time-out chair. The ideal time-out room in the clinic setting is attached to both the playroom and the observation room. The best size for a time-out room is approximately 5 feet by 5 feet. These dimensions allow enough space for a child to comfortably move around without providing sufficient space for gross motor activities (e.g., cartwheels, running, tumbling) that might be dangerous or stimulating. There should

be an unbreakable glass window in each door that allows the parent and the therapist to simultaneously monitor the child. It is helpful if the time-out room has padded walls and floor with extra sound proofing and contains no furniture or decorations. It must be well ventilated and lighted, with no electrical outlets or light switches inside the room. Because of fire-code and other regulations, locks are not usually used on time-out rooms. Instead, parents are coached to hold the door shut as needed. To avoid the potential negative attention associated with a "tug-of-war" at the door, it may be possible to put a childproof grip over a round, conventional door knob. As a precaution to keep children from getting their fingers pinched in the door, a "finger-less" door has been used at some sites (e.g., West Virginia University). This door is built with an extension over the edge. If the child tries to grab the edge of the door to prevent it from closing, he or she will only be able to grab the extension which has a protective space between it and the door jamb or wall. This extension may be built out of wood or a thick foam pad.

We recognize that many agencies are unable to build a time-out room specifically for the PCIT program. In such cases, an existing room must be adapted for time-out use. The room that works the best as a time-out room is the one with the fewest potential hazards. The following features are particularly hazardous and should not be in a time-out room: a window that could allow for escape, a working sink, any appliances, desks containing scissors, letter openers or staplers, chemicals, hot radiators, hanging cords, and shelves or heavy furniture that can be tipped over. Any valuable furniture or equipment and entertaining toys or activities (e.g., white board with markers) would need to be removed from the time-out room. Only rooms with visual access (e.g., windows or surveillance cameras) are appropriate for time-out so that child safety can be assured. In our experience, it is sometimes better to use the PCIT playroom as the time-out room and use the less ideal space as the playroom for PDI coaching. This is often a good choice because the PCIT playroom is usually the room with the best childproofing and visual access. A similar option is to use a technique called "swoop and go." In this technique, escape from the time-out chair results in the parent swooping all of the toys into a basket and standing outside the room while holding the door shut. With swoop and go, the PCIT room then essentially becomes a time-out room. Please see Chapter 13, Child Physical Abuse, for a more complete description of the swoop and go technique. Also see Appendix 13 for a diagram depicting the sequence and words of the swoop and go procedure.

Some agencies and therapists, particularly those working with children who have a history of abuse or neglect, prefer (or are mandated) not to use seclusion as the back-up for time-out chair escape. In such cases, it may be possible to construct a time-out back-up area in the family room (or nearby) that is not completely closed off. This time-out area usually is created as a small room (about 5 feet by 5 feet) that is accessible through a half door or "Dutch" door. In this way, the child's movement can be limited without seclusion or restraint. The child can see the parent over the top of the half door, and the parent can easily monitor the child. The half door provides a barrier that discourages the child's escape. Granted, many of our agile young clients can scale a half door. But, parents can position themselves near the door and stand in the way of the child's attempts to run out of the area.

Home-Based Time-Out Rooms. The therapist must work with parents to identify the most suitable room in their homes to use for the time-out chair back-up. The time-out room should be at least 5 feet by 5 feet and should be well lit and ventilated. It is critical to childproof the time-out room to prevent the child from being injured and to prevent damage to property. As discussed above, the following items must be removed: medicines, poisons, hot water access, breakables, valuables, heavy furniture that can be tipped over, and so forth. If the parent is concerned that the child may go into the time-out room and play with a particularly desirable item (e.g. Legos, video games), those can be removed. We discourage parents from using any room that contains window or door access out of the house or breakable glass.

In our experience, most parents choose the child's bedroom as the back-up time-out room. Parents may rule out most other rooms for a variety of reasons. Kitchens, living rooms, and family rooms generally do not work because they cannot be closed off. Siblings and parents rooms may not work because of fears that the disruptive child will damage or destroy others' belongings. It also seems unfair to the siblings and the parents to have to remove valued items from their own personal space. Bathrooms can be particularly hazardous because children may flood the room, slip on wet tile (and hurt themselves on hard surfaces), burn themselves with hot water, overflow toilets, or play in the bathtub. Closets are generally unsuitable for time-out because they can be frightening to a child. Most closets do not meet the criteria of being well lit, well ventilated, and having sufficient space to move around. Many parents have been successful at making a laundry room suitable for time-out with the removal of hazardous chemicals. Given an analysis of all of the available rooms in their home, most parents select the child's bedroom as the time-out back-up room. We encourage parents to be certain that they have key access to any room being used for time-out.

Parents should begin childproofing the child's bedroom by removing dangerous, valuable, stimulating, and potentially destructive/messy items. These would include glass items that could cut a child if broken (e.g., lamps, framed photos), heavy furniture that is not secured to the wall and can be tipped over (e.g., bookcases, tall dressers), sharp objects (e.g., scissors, pocket knives), expensive electronics (e.g., televisions, computers, telephones), collectibles and heirlooms, videogames and other particularly engaging toys, and art supplies (e.g., markers, paints, glue, clay). It is important that bedroom windows be secured to prevent escape or injury. Parents who are worried about the physical struggle of trying to hold the door closed during a time-out may ask the therapist about the appropriateness of simply reversing the lock or putting a lock on the outside of the door. We discourage parents from using a lock on the time-out door because of our concerns about the possibility of abuse or neglect (leaving the child isolated and unmonitored for excessive periods of time) and fire safety. Finally, if the bedroom is shared with a sibling, the parent should take particular care to safeguard the sibling's belongings.

Addressing Parental Resistance to Time-Out Rooms. When the time-out room is first presented, many parents are skeptical about its effectiveness. Some express concern that the child would rather go to the time-out room and play than stay in the time-out chair and comply. We have parents imagine the scenario in which their

child has defiantly jumped out of the time-out chair and is carried using the barrel technique to his bedroom and put inside with the door closed. We ask them what the child is likely to do. Almost all of the parents recognize that it is unlikely that an angry child is going to suddenly calm down and start playing. Instead, they report that their child is likely to yell, scream, and pull hard on the door. We remind parents that young children live for parental attention. Being placed in a back-up time-out room with the door closed is very aversive to the child. Some parents do not want to use a time-out room as the back-up for time-out chair escape because they are concerned that the child will be too destructive in the room. They express concern that the child will kick holes in the door and dry wall, throw everything out of the drawers and closet, and break objects. Most damage to doors and walls occurs when children kick them. Removal of shoes prior to putting the child in the time-out room may prevent costly damage. Sometimes we have children wear soft shoes or flip flops for their first week or two of PDI. We explain to parents that extremely oppositional and aggressive behavior declines rapidly after the first few weeks of compliance training. Once a child has learned to sit well in the time-out chair, the back-up time-out room is needed on very few occasions. But for the first few weeks, we must prepare for the possibility of destructive behavior in the time-out room. We ask parents to make a commitment to childproof the room for the first few weeks to minimize the potential for damage. Occasionally, parents tell us that they are worried that their child's bedroom will become an aversive place to be because of its association with time-out. Again, we remind them that the use of the time-out diminishes significantly after the first few weeks of PDI. Additionally, we ask them whether their parents ever sent them to their bedrooms for misbehavior when they were children. Nearly all say, "yes." We then get them to think back about whether they hated their bedrooms as a result, which is seldom the case. We acknowledge that the negative associations with the bedroom could become a problem if it is over-used for time-out. We assure them that PDI will be introduced gradually to prevent the scenario in which children are in time-out too many times each day. And, parents can be encouraged to balance PDI by also engaging in positive activities in the child's bedroom, such as CDI practice or reading to the child.

Implementing the Time-Out Room Back-Up. The first time that a child ever escapes from the time-out chair (this could be in the clinic or in the home) the child is brought back to the chair and a time-out room warning is given. This time-out room warning is provided only once in the child's life. The words are as follows: "You got off the chair before I said you could. If you get off the chair again, you will have to go to the time-out room" (Eyberg, 1999, pg. 87). As always, before leaving the chair the parent should say "Stay here until I say you can get off" (Eyberg, 1999, p. 87), and the 3-min timing begins all over again. After the warning has been given once, it will never be issued again. Instead, for future time-out chair escapes, the child will be taken to the time-out room immediately without a warning. For future time-out escapes, the parent is taught to say "You got off the chair before I said you could, so you have to go to the time-out room" (Eyberg, 1999, pg. 87). These words are said by the parent while quickly and calmly taking the child to the time-out room. We suggest that the parent carry the child into the room using the barrel

carry and set the child down on the floor (on his or her bottom) facing away from the door. This makes it easier for the parent to get out of the room and close the door (without catching the child's fingers in the door). The procedure allows the parent more exit time because the child is slowed by having to stand up and turn around to run out of the room. After the door is closed, the parent should time for 1 min plus 5 s of quiet. For children who are having trouble staying quiet in the time-out room, the 1-min time-out is expanded until they are able to be quiet for 5 s. When the time is up, the parent takes the child back to the time-out chair. After placing the child on the time-out chair, the parent should step back to avoid being hit by the child and say "Stay on the chair until I tell you that you can get off." The 3-min timing begins again, and this procedure is repeated until the child is able to stay seated in the time-out chair for the full 3 min plus 5 s of quiet. Once the child has sat for the 3 min and 5 s, the parent returns to the time-out chair and follows the procedure outlined above for getting the child to comply with the original command. Again, parents are encouraged to just acknowledge compliance with the original command and then to follow it up with a second instruction.

Role-Playing and Wrap-Up

Once the therapist explains the time-out room back-up, the entire time-out procedure is reviewed using role-playing. Incorporating humor, the parents can role-play taking the therapist or stuffed animal to time-out. Suggested role-plays include the following:

(1) Giving a well-stated, direct command (reason first).
(2) Child complies (follow with labeled praise).
(3) Child fails to comply (follow with time-out warning).
(4) Child defies time-out warning (escort child to time-out).
(5) Child screams in time-out (ignore all verbalizations).
(6) Child stays full 3 min and achieves 5 s of silence (ask if child is ready to comply).
(7) Child refuses to comply when asked if ready (repeat time-out).
(8) Child agrees to comply when asked if ready (escort child back to table and gesture to indicate original instruction).
(9) Child complies with original instruction (acknowledge and provide second, very similar instruction).
(10) Child complies with second instruction (provide enthusiastic labeled praise, return to play therapy to decrease anger).
(11) Child refuses to sit in time-out (provide time-out room warning the first time ever; if it happens a second time follow through with the time-out room).

Prior to the next session, parents should review the three PDI diagrams (see Appendices 7–9) and attempt to memorize the dialogue. For an integrated diagram showing all PDI procedures as well as a parent handout regarding how to use a

time-out room in the home, see Eyberg (1999). The importance of NOT using the time-out skills before the next session is stressed. The first time-out sets a precedent for all that follows. If the parents attempt it at home and something goes wrong, it will be very difficult to backtrack and re-teach the child. If, however, the first time-out occurs in the clinic, the parents will have the therapist to coach them through it. This will ensure that the first time-out will be successful, thereby setting the stage for successful time-outs in the future. The parents are asked to promise the therapist that they will not try any of the time-out techniques taught in this session until they have had a chance to be coached first. Parents are told to bring the child to the next session and to schedule extra time because the session will not end until the child has complied with the last command given. Homework this week includes reading over the handouts, continuing with daily CDI practice, thinking about where to place the time-out chair in the home, and selecting and preparing a room at home to be used as the time-out chair back-up.

References

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April 2, 2008, from www.pcit.org.

Shannon, D. (1998). *No, David!* New York, NY: Scholastic, Inc.

Chapter 7
Coaching Parent-Directed Interaction

What to Bring. . .
(1) ECBI
(2) DPICS – III Coding Sheets
(3) CDI Homework Sheet
(4) PDI Homework Sheet
(5) PCIT Progress Sheet
(6) Parent Handouts (Depending upon which session)
(7) Sheila Eyberg's Treatment Integrity Checklists/Manual

Overview of a Typical PDI Coaching Session

Table 7.1 presents the steps involved in typical PDI coaching sessions for families in which one or both parents are participating. As always, upon arrival to each PCIT session, parents complete the ECBI Intensity Scale in the waiting area. The therapist picks up the ECBI and homework sheets prior to the beginning of the session and records the ECBI score on the PCIT Progress Sheet. As in CDI, PDI sessions begin with a review of the homework. After problem-solving issues that arise with the homework and inquiring about other familial stressors, we observe and code the parent in CDI. If the parent's CDI skills have regressed and no longer meet mastery, the therapist should take about 10 min to coach CDI. If mastery criteria were met during the coding, then the therapist provides feedback on CDI skills and moves on to code 5 min of PDI. The 5 min of PDI can be coded in one of two ways: (1) use the PDI Coding Sheet available at www.pcit.org (Eyberg, 1999) or (2) write a transcript of the parent's exact words and behaviors during the PDI sequence (see Appendix 10). When choosing the transcript method, the therapist codes only command sequences (not PRIDE skills). A command sequence consists of the reason given for the command, the command, whether the child obeyed or disobeyed, praise for compliance, the time-out warning, and all parental verbalizations during PDI (including parental

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Table 7.1 Steps for conducting a Parent-Directed Interaction coaching session

One parent participating		
Step 1	Check-in and review of homework	10 min
Step 2	Coding of CDI skills	5 min
Step 3	Coding of PDI skills	5 min
Step 4	Coaching PDI skills	30 min
Step 5	Feedback on progress and homework assignment	10 min
Two parents participating		
Step 1	Check-in and review of homework	10 min
Step 2	Coding of first parent's CDI skills	5 min
Step 3	Coding of first parent's PDI skills	5 min
Step 4	Coaching of first parent's PDI skills	10 min
Step 5	Coding of second parent's CDI skills	5 min
Step 6	Coding of second parent's PDI skills	5 min
Step 7	Coaching of second parent's PDI skills	10 min
Step 8	Feedback on progress and homework assignment	10 min

mistakes such as repeating commands, indirect commands, arguing, incorrect phrasing of the warning). After coding PDI, the parents are given a "constructive feedback sandwich" (via the bug-in-the-ear) in which they are told what they have done well, are given suggestions for improvement, and are re-oriented to their strengths. Then parents are coached in PDI skills, with intermittent coaching of CDI skills. The session ends with the therapist joining the parents in the playroom to provide feedback on the session and to assign homework for the week.

Preparing for PDI Coaching Sessions

Therapists should memorize the discipline diagrams (see Appendices 7, 8, and 9) before entering the session. Because coaching decisions must be made quickly, complete knowledge of the standardized dialogue and sequence of the discipline program is critical. The playroom furniture should consist of a table, two chairs at the table for the interaction, and a sturdy time-out chair. Toys are chosen carefully. To enhance coaching, the toy selection should include ones that are both desirable and undesirable to the particular child. The "less desirable" activities can be used to teach children to comply with more challenging instructions. We avoid heavy toys that can break the mirror or become dangerous projectiles when thrown. For children who we expect might dump the toys off of the table, we avoid toys with many small pieces. To be prepared, we often keep a second bug-in-the-ear handy in case there is a technical problem during coaching.

Throughout the PDI portion of this book, we make the assumption that therapists will conduct their coaching from an observation room via the bug-in-the-ear device. We prefer this method over in-room coaching. We are highly directive in our coaching of PDI, and we find that the flow of parent-child communication is less disrupted when we make our remarks privately to the parent over the bug-in-the-ear. We also

believe it is important for children to perceive that it is the parent who is giving commands and is "in charge." When the child hears the therapist telling the parent which words to use, the parent's authority may be compromised in the eyes of the child. Coaching via bug-in-the-ear allows the therapist to direct the parent in a fast and non-intrusive fashion.

Check-In and Homework Review

At the beginning of the session, the child plays while the therapist and parents review the week. Parents are asked about the play therapy homework and any issues that arose. We encourage them to place an even higher priority on the play therapy practice as the discipline program progresses. The therapist reiterates that CDI is important for off-setting the anger and attitude problems that often arise when limits are suddenly enforced. PDI homework is also reviewed. Specific attention is paid to any time-outs that were given during the week. Parents are asked very specific questions about how they implemented time-out procedures at home. For example, if a parent says that the child "threw a fit" at bedtime and had to have a time-out, the therapist would conduct a detailed debriefing of the incident, such as the following:

Therapist: What do you mean she had a fit?
Parent: I was trying to get her to brush her teeth and she freaked out.
Therapist: So what was the original command?
Parent: Please go brush your teeth.
Therapist: Great command. It was direct, specific, and positively stated. What happened then?
Parent: She freaked out so I put her in time-out.
Therapist: Did you remember to give her a time-out warning?
Parent: Oh, yeah, I warned her.
Therapist: I'm glad to hear that you remembered the warning, because as you know, we do not put children in time-out for "freaking out." We only use time-out when they disobey the direct command and the warning. What were the exact words of your warning?
Parent: If you don't go brush your teeth, you're going to have to sit on the chair.
Therapist: I'm impressed! You memorized the words exactly and it sounds like you provided the warning in a neutral tone of voice without any negative attention. What happened next?
Parent: She just kept freaking out so I told her to go to time-out and she wouldn't go, so I carried her to the chair.
Therapist: Now you just said a lot of important things. Let me back you up just a little bit. Do you remember what words you used when you told her to go to the chair?
Parent: I don't remember.

Therapist: If you remember back to your diagram, it is important for you to say "You didn't do what I told you to do so you have to sit on the chair. Stay on the chair until I tell you that you can get off."
Parent: Actually, I think I did say that. I was shocked that she actually stayed in the chair.
Therapist: That tells me that you have been doing a great job of being consistent with meaning what you say and saying what you mean. What happened when you asked her if she was ready to go brush her teeth?
Parent: She said, "Okay" and brushed her teeth. It wasn't as long as I would have liked but at least she did it.
Therapist: What did you do?
Parent: I told her "thank you" and then I told her to put her toothbrush away, which she did.
Therapist: Great job of acknowledging her for the first command and giving her a second easy command. And what did you do when she put the toothbrush away?
Parent: I praised her. I told her that I was proud of her for doing what she needed to do.
Therapist: You did a great job with that time-out procedure. If you keep following these steps, her testing of your limits will go way down.

By asking parents very specific questions about what occurred during time-outs at home, the therapist can reinforce what the parent is doing correctly using labeled praise, educate the parent about points of confusion, and correct mistakes.

Observing and Recording Parent-Directed Interaction Skills

Prior to most PDI coaching sessions, each parent is observed and coded in 5 min of CDI and 5 min of PDI. After the CDI coding, parents are given specific feedback on the frequency of CDI skills (e.g., number of labeled praises) and how well their skills conform to the mastery criteria. If the parents fall short of the mastery criteria, approximately 10 min of the session is devoted to improving their CDI skills. If the parents are maintaining performance at the mastery level, the therapist praises and moves on immediately to PDI coding. The directions given to parents before the PDI coding vary in specificity across the sessions (see Table 8.1 for the specific instructions). The PDI interaction can be coded categorically using Eyberg's (1999) PDI Coding Sheet. Categories on this sheet include the following: Direct versus Indirect Command, No Opportunity, Obey versus Disobey of original command, Labeled Praise versus Unlabeled Praise, Chair Warning, Obey versus Disobey of the chair warning, Time-out Chair? and Time-out Room? A second option for coding the 5 min of PDI is to do a running narrative of each command sequence (see Appendix 10 for a PDI Transcript Coding Sheet). This narrative provides the therapist with a sequential analysis of the parent's use of PDI. It should include the specific words of the command (including reason if provided) and praise. If a chair warning or other

time-out phrase is stated incorrectly, it also should be written out. An examination of the exact words will give the therapist important information about whether the parent is using a variety of commands and labeled praises. It is not uncommon for the transcript coding form to reveal that the parent's commands consisted only of "hand me" instructions and that all of the labeled praises started with "Thank you for. . ." Parents need to learn to use a variety of commands and praises to prevent PDI from becoming monotonous, which can interfere with generalization. Below is a sample transcript:

Command Sequence #1 P: Hand me the camel. C: Which one? P: (Does not wait 5 s.) That camel. C: Obey. P: Thank you. That's nice.

Command Sequence #2 P: This room is really trashed. We better clean up. Why don't you put the Legos in the bucket? C: But I'm not done building (disobey). P: Get them put away now. C: Obey. P: Thanks for being my helper.

Command Sequence #3 P: Now it's time to put the trucks away. Please put the red truck in the toy box. C: Disobey. P: (waits 5 s and gives correct warning) C: Disobey. P: You're not listening to me – so go to time-out. C: Stays on chair. P: (goes to chair at 2 min 10 s) Do you want to clean up now? C: Obey P: Good cleaning up (back to CDI – no 2nd command)

After coding PDI, feedback about their progress toward meeting the PDI mastery criteria is provided to parents via the bug-in-the-ear while the child plays nearby. It is important to give a quick, "constructive feedback sandwich" and then begin coaching. For example, the therapist might say "You did a great job of using a direct command to get him to hand you the camel. We need to work on using the exact words from the diagram during the time-out procedure. I like how you used labeled praises for helping and cleaning up. I'll coach you a little bit now." If more detailed feedback needs to be provided to correct numerous mistakes, this can be accomplished by reviewing the sequence with the parents in the playroom during the check-out. (See the check-out section later in this chapter for an example of a more detailed debriefing of the command sequences above).

Criteria for Mastery of Parent-Directed Interaction Skills

As with CDI, specific mastery criteria have been established by Sheila Eyberg for the PDI portion of PCIT. These PDI mastery criteria are evaluated during the 5-min PDI coding that occurs prior to each PDI coaching session. The first requirement is that the parent provides at least four commands during coding. Seventy-five percent of the commands must qualify as being "effective," meaning that the command conforms to the rules for giving good directions (see Giving Good Directions parent handout in Appendix 6). The second PDI mastery criterion is that the parent must

demonstrate at least 75% correct follow-through with the command sequence procedure. Specifically, the parent must provide a labeled praise each time the child complies with an effective command and a correctly stated time-out warning after each incidence of noncompliance. Additionally, the parent must provide a labeled praise for compliance with the time-out warning. The third PDI mastery criterion is that the parent must demonstrate the successful use of the PDI time-out procedure if the child disobeys a time-out warning during the 5-min time-out coding period. For families that do not have the opportunity to demonstrate the time-out sequence during any of the coding periods, we recommend that they be required to demonstrate mastery of the time-out sequence in a role-play situation. Dr. Eyberg's PDI mastery criteria are presented in Table 7.2. To determine mastery, therapists should mark each command sequence as "pass" or "fail." A pass requires an effective command and completely effective follow through. If 75% of the parent's command sequences are correct, the parent meets the skills component of the PDI mastery criteria.

Table 7.2 Parent-Directed Interaction mastery criteria

During the 5-min coding at the beginning of the session, parents must

- Give at least four commands, of which at least 75% must be "effective" (i.e., direct, positively stated, single commands that provide an opportunity for the child to comply or noncomply)
- Show at least 75% correct follow-through after effective commands (labeled praise after obey and warning after disobey)
- If the child requires a time out that begins during the observation, the parent must successfully follow-through with the PDI procedure (i.e., the interaction must end with an acknowledgment for compliance with the original command and a labeled praise for compliance with the follow-up command)

Eyberg (1999, p. 113).

General Guidelines for Coaching PDI

In learning to coach the discipline skills, it is helpful for therapists to understand how the parent feels during these sessions. Nervousness is common in the first PDI sessions. Parents may be concerned that they will do or say something wrong, that the child may become aggressive, that the program may not work for their child, or that they may not have the psychological strength to succeed. To provide consistent and controlled discipline procedures in stressful circumstances, parents need a calm, confident, and decisive therapist.

As the therapist, you may not feel very calm, confident, and decisive. Even though we have treated thousands of families, we continue to feel some anxiety when taking the microphone for the first discipline coaching session. This anxiety is normal and natural. In many ways, a moderate level of anxiety is beneficial in that it helps therapists to prepare for the worst and react quickly to the inevitable dilemmas that occur during PDI coaching. Nevertheless, while it is normal to feel nervous, the therapist still has a responsibility to the family to project competence and control.

The most common mistake of novice coaches is to allow the parents too much latitude. Unlike the client-centered coaching provided in CDI, the discipline coaching is extremely directive (Eyberg, 2005). In the beginning, the therapist should guide nearly every word the parent says. Otherwise, opportunities arise for parents to fall back into old habits, such as giving repeated instructions; using negatively stated instructions; using suggestions instead of direct commands, arguing, or pleading with the child; and responding too slowly. A good PDI coach will actively direct the parents regarding when to talk, when to be quiet, when to look the child in the eye, when to ignore the child, when to walk, when to move quickly, and when to carry the child. Therapists are so directive in PDI coaching that they often interrupt and correct parental mistakes to get parents immediately back on the right track. For example, parents often begin commands indirectly with the words "could you" or "would you." As soon as the therapist hears that a command is being stated as a suggestion, he or she should interrupt the phrase and have the parent restate it as a direct command (e.g., Parent: "Could you put. . ." Therapist: "Say 'please put. . .'"). Another common parental mistake is terminating the time-out warning when the child complies in the middle of the warning. For example, the father says "Please hand me the tractor." The child disobeys. The father says "If you don't. . ." The child quickly hands him the tractor before the father has finished the warning. It is natural for a parent to provide a labeled praise at this moment. However, the therapist should interrupt the parent and say "Go ahead and finish the entire warning." When the parent completes the warning and praises the child, the therapist should provide an explanation such as: "I know it feels silly to finish the warning when he has already done what you told him to do, but you need to remain consistent and predictable by using the same words every time. The reason that he complies after you say 'If you don't. . .' is because he does not want to hear the boring words of the warning. He needs to learn that the way to avoid the warning is to comply right away." Although therapists are active and directive in PDI, a general rule is that they should reduce their level of control as PDI progresses. The ultimate goal of PDI is for parents to be able to conduct the discipline skills independently by the end of treatment.

In order to be active and directive in coaching, the therapist will provide numerous instructions to parents. A good rule of thumb for therapist-coaches is to incorporate the guidelines provided in the "Giving Good Directions" handout (see Appendix 6). The therapist should be giving instructions to parents in much the same way that the parents are giving instructions to the children. In general, coaching should be directive, concise, clear, specific, positive, and respectful. Guidelines for coaching PDI skills are presented in Table 7.3.

Give One Instruction at a Time. Like the parent, the coach should give only one instruction at a time. This helps parents to clearly understand what is being taught. A lengthy string of instructions such as the following would inevitably lead to parental mistakes: "Go ahead and get two blocks off of the table. Maybe the red and green one and then tell him that you need some help and that he needs to put the two blocks together for you." When given these instructions, the parent is likely to either leave out a step or insert a bad habit such as using an indirect command. A better approach

Table 7.3 Therapist guidelines for PDI coaching

Give only one instruction at a time
Tell the parents what TO DO (avoid "no," "don't," and "stop")
Coach nonverbals as well as verbals
Use ample praise, particularly when parents follow instructions
Provide constant reassurance
Include relaxation techniques such as deep breathing
Be active and directive
When appropriate, incorporate humor to defuse tension
Project confidence and decisiveness
Use a "running commentary" or "constant talking" approach to distract parents during conflictual situations
When parents become agitated, use a coaching voice that is softer and more monotone, with a very even rate of speech
Make quick decisions when questionable circumstances arise

is to break the instruction into smaller parts: "I'd like for you to prepare for the next instruction. Get the red and green blocks off of the table. Good job of getting ready. Now say, 'I need some help.' You gave a good reason there. Now say, 'Please put these blocks together.' Nice direct command."

Use Positively Stated Instructions. Also like the parent, the therapist should avoid negatively stated instructions. When a parent makes a mistake, such as getting enticed into an argument, the therapist should avoid saying things like "Don't argue" or "No talking." These negative instructions come across as critical and can damage rapport. In addition, negative instructions are limited in their effectiveness because the parent learns only what "not to do" rather than what "to do." Here is an alternative response to the parent who is arguing with the child: "Try to stay quiet right now. That's it. Just ignore her attempts to argue. Good job of ignoring. By staying quiet, you are letting her know that you will not give negative attention in the form of an argument."

Coach Both Verbal and Non-verbal Communication. The coach should keep in mind that he or she is coaching nonverbal as well as verbal communication. The coach not only is offering parents specific words to repeat, but also is instructing them on movement, carries, physical proximity, touches, and timing. The coach is also responsible for cueing parents on when to stay quiet and when to ignore. In disciplining a child, facial expression, voice tone, and body language are at least as important as the words that are used. The coach can assist parents in giving enthusiastic attention to positive behavior (e.g., "You must be so proud of him! How about giving him a big labeled praise for minding?"). When inappropriate behavior occurs, the coach should encourage a confident and robotic approach (e.g., "Just ignore the bad attitude. Act like it doesn't bother you in the least. Now, say in a neutral tone of voice, 'If you don't pick up the crayons, you're going to have to sit on the chair'"). See Table 7.4 for sample coaching statements addressing both verbal and nonverbal communication.

Praise Parental Compliance. During discipline coaching, the therapist will give numerous instructions to the parents. We try to give parents a labeled praise each

Table 7.4 Sample coaching statements addressing both verbal and nonverbal communication

Nice job of staying calm
I like that neutral tone of voice
Good job of getting her to time-out like a robot . . . no yelling, no extra words, no begging. You got her there quickly and in a boring and routine fashion
Nice firm warning
Stay quiet, stay quiet, just point. Go ahead and give the warning. Good job of giving him a chance
Go ahead and take a couple of deep breaths. You deserve a break right now
It was difficult getting her to time-out. But, you did a great job of staying in control
I like how quickly you moved. That gives a message to him that you feel confident and in control, even if you don't exactly feel that way right this minute (said with humor)
That's just the way we like to see children taken to time-out . . . no extra attention. I think you've really got the hang of this
Good job of pointing to make it clear which block you mean
He's trying to get your attention. Just look away. Keep ignoring
I like the way you carried her quickly but gently to the chair
Great idea to give her a high five with your praise when she listened to that second command
I like the way you made sure her hands were clear before closing the time-out room door
Terrific ignoring. I know it's hard not to laugh when he says funny things like that in time-out
He disobeyed. Take him by the hand. Stand up. Pick him up from behind. Carry him quickly to time-out. Say "You didn't do what I told you to so you have to sit on the chair." That's it
Put him on the chair. Step back. Say "Stay on the chair until I tell you that you can get off." Great, now walk back to the table and sit down. Let's start timing
It's time for another command. Think of what you want him to do. Give him your reason first and then the command. Go ahead

time they comply with the direction or prompt, even when all they do is to repeat our exact words. For example, the coach says, "Go ahead and give the time-out warning," and the parent complies. We typically follow through by saying something like "Good, firm warning." The praises reinforce parents for complying with therapist directions and serve a teaching function by providing feedback on skills. Finally, they set a positive tone for the coaching. Parents feel good about themselves and the therapist when they are receiving a great deal of positive feedback. Examples of commonly used labeled praises include good pointing, nice enthusiastic labeled praise, good job of restating that command, nice job of staying quiet, good idea to give a little hug just then, good timing on the warning, I like that ignoring, and great job of staying calm.

Offer Support and Reassurance. Another major aspect of PDI coaching is reassuring and calming parents. As mentioned previously, parents experience a range of powerful emotions during discipline sessions. These emotions include fear (that they will lose control or their child will not respond), anxiety (that they will not perform well under pressure), anger (that their child's misbehavior is causing them so much stress), and guilt (that perhaps they are being overly punitive).

There are a number of components involved in reassuring and calming parents. First, it is important to remind parents frequently that the discipline procedures they are using are in the best interests of their child. It is natural for parents to experience doubts about whether they are doing the right thing when their child is crying,

screaming, or saying "I hate you" while in time-out. A calming reassurance from the therapist, such as the following, can give the parent the strength needed to follow through during difficult moments:

> I know it is difficult to just ignore his cries. But, remember, you are doing the right thing. If he does not learn to accept limits and consequences now, he will have an even harder time when he enters school next fall. The first time-outs are always the most stressful. Soon he will be able to go to time-out calmly. He just needs to learn how. You are doing a beautiful job of helping him to learn to follow instructions. This will help him in school, with babysitters, with friends, and with relatives. He will be a much happier child because you had the strength to do what you're doing now.

Use Relaxation Training Strategies. As in the above example, often reassurances take the form of a running commentary. Not only does this distract the parents from anxious feelings and thoughts of quitting, but it helps to keep them focused on the goals. We have found that this technique of "constant talking" during stressful periods also has a very calming effect on the parents. In fact, we tend to adopt the soft, monotone voice styles used on relaxation tapes. When the parent's voice rises and he or she is escalating to an angry level, the therapist needs to assume an even quieter and more even rate of speech. In this way, the therapist's gentle coaching will help to balance out the parent's increasing agitation, helping both the therapist and parent to remain calm. Sometimes, we use a more active relaxation intervention such as prompting parents to take deep breaths and coaching them through progressive muscle relaxation.

> Nice job of putting him back into the time-out room. He is very upset right now. We need to give him some time to calm down in the time-out room. This gives us an opportunity to talk about you for a minute. I know this must be stressful for you, having to take him back to the time-pout room several times. And, I know it was hard for you to stay calm when he slapped your face. Go ahead and take a deep breath and hold it. Now let it out slowly. Go ahead and take a few more deep breaths. Can you feel the tension leaving your shoulders and your body? This is what you'll need to do at home when you are disciplining Luke. I noticed when he jumped out of the chair this last time that your voice started to get a little loud when you said, "You got off the chair before I said you could, so you have to go to the time-out room." I understand that it's frustrating. To help you avoid giving negative attention, I'd like for you to pretend like you're an actor in a play when you are putting him in time-out. The words from the diagram are your script. I want you to say those words pretending that you are calm and unaffected by his tantrum, even though you may not feel that way inside. I have been very impressed by your ability to stick with this time-out. He is calming down now. We are waiting for 5 s of quiet. Go ahead and take another deep breath and get into actor mode. Okay, you can open the door now.

Make Use of Humor. Humor is another coaching technique that can help reduce parental anxiety and tension. Often during a particularly stressful situation (e.g., ignoring a child who is throwing tantrums on the floor), the therapist can defuse some of the tension by including a humorous comment in the midst of the running commentary. A smile or laugh shared between the coach and the parent can often help everyone to relax a bit. Here's an example:

> I know it's hard to ignore her when she's screaming on the floor like that. But, she is safe. I can see her just fine and she is not hurting herself. You can take a look out of the corner

of your eye if you like. See, she is fine. She is used to people giving in to her when she throws one of these fits. Wonder what the people in the waiting room are thinking that we are doing to her! What they don't realize is what *she* is doing to *us*! Just joking. Glad you can still smile. You're really doing a great job of not losing your temper and not giving in. We will be able to distract her back to playing with you soon. Just keep ignoring and playing enthusiastically with the toys. By the way, I really like that unicorn that you just drew. I can tell you have a little girl who is into 'My Little Ponies.' Okay, she's starting to calm down some now.

Make Coaching Decisions with Confidence. Many "iffy" situations arise that call for a coaching decision to be made quickly. For example, it is sometimes unclear whether a child has obeyed. The child may dawdle, act confused, or comply with only a portion of the command. A rule of thumb for coaching is that it is more important to always make swift, confident decisions than to try to ensure that each decision is absolutely correct. In fact, in many cases there is no "correct" decision. It simply involves a judgment call. One such "iffy" situation is when the parent blurts out an inappropriate instruction or time-out warning. Sometimes it is best to go ahead and follow through with the time-out sequence in order to teach the child that the parent will be consistent. At other times, it is in the child's best interest to not follow through on an inappropriate instruction. In such cases, the parent can be instructed to provide a more appropriate instruction (e.g., "I'm worried that he may not be able to write his name. Instead, tell him to draw a line on the paper.") Again, the important thing is to act quickly and decisively. A long pause can cause everyone to become confused and provide an opportunity for the parent to make further errors.

Combining Play Therapy and Discipline Skills. After the child has received praise for obeying, parents are instructed to return to play therapy and to avoid giving further instructions for at least 20 s (usually about a minute). This play therapy serves to reinforce the child for compliance, decreases any anger resulting from being required to mind, and helps the parent remain calm. Every minute or so, another instruction is provided. In the beginning, the therapist tells the parent exactly what words to say. The parent's only responsibility is to repeat what the therapist suggests. Here's an example of how the therapist alternates between coaching the play therapy and discipline skills:

Therapist: Good describing. You're helping him to stay focused.
Child: My Potato Head has glasses.
Parent: Yes, he has green glasses.
Therapist: Nice reflection. That let's him know that you're really interested in what he has to say.
Parent: I like the way you shared the glasses with me. If you share like that at school, you'll have lots of friends.
Therapist: Excellent idea for that labeled praise. That's going to have a good impact on his social skills. Okay, I think we're ready to move onto another instruction. Give him the reason first. Say, "I can't see the picture on the box very well."
Parent: I can't see the picture on the box very well.

Therapist: Good reason. Now say, "Please put the box over here so I can see it"
Parent: Please put the box over here so I can see it.
Therapist: Now, stay quiet. Just point. Give him time to listen. Good job of waiting without repeating the command.
Child: Here's the box.
Therapist: Say, "Good listening! When you mind, you don't have to go to time-out. I'm so proud of you for learning to follow instructions."
Parent: (repeats labeled praise)
Therapist: Go ahead and let him play what he wants to play and just follow behind with your play therapy skills. Good job of putting him back in the lead.

Set Up Situations That Increase Opportunities for Coaching Time-Outs. According to the PCIT model, parents will learn skills more readily if they are able to practice the skills while receiving feedback from a coach. During initial PDI coaching sessions, the ideal situation is for the family to have successful time-outs under the therapist's guidance. Otherwise, the parents are left to their own devices for time-outs at home. When unsupervised, parents can easily make critical errors during time-out that can seriously interfere with the progress of the discipline program.

In most cases, a time-out is achieved in the first discipline coaching session. However, sometimes children will be on their best behavior at the clinic and will be 100% compliant with time-out warnings. Again, this decreases the therapist's opportunity to coach parents in key time-out skills. Examples of situations that tend to elicit noncompliance include the following:

1. Switching from a more preferred to a less preferred activity
2. Giving clean-up commands
3. Using "real-life" instructions or naturally occurring events (e.g., a child who throws a toy on the floor is expected to pick it up; a child who leaves the table is instructed to return; a child who is sitting on knees in chair is instructed to sit on bottom; a child who bangs a toy roughly is asked to play gently with the toy; a child who has trouble sharing is instructed to share)
4. Leaving the door to the coaching room open so that the child may attempt to exit without parental permission
5. Moving to the playground, a conference room, or a more stimulating play room to set the stage for more "real-life" instructions (e.g., putting toys away when finished playing with them, parking tricycles, leaving equipment alone)
6. Walking around the building to simulate a more "real-life" situation (commands include taking parent's hand, walking instead of running)
7. Increasing the pace of the instructions (less CDI in between)
8. Including a sibling in the session
9. Setting up developmentally appropriate tasks of daily living (e.g., bringing in food and practicing table manners, practicing brushing teeth, putting on socks or coat, applying sunscreen, washing hands and face, brushing hair)

Although it is important to have the opportunity to coach time-outs during PDI, we do not recommend that therapists push children to unreasonable limits to try to obtain a time-out. The nine situations described above that tend to elicit noncompliance in oppositional young children are fair and reasonable for PDI coaching because they involve behaviors that are expected of all children (e.g., taking a parent's hand on a walk). In contrast, it would be unfair to require any child to play with only one block while his mother has access to the rest of the set. Other examples of unfair situations include: making a child sort Legos by color over and over, coaching the parent to throw a block on the floor so that the child can retrieve it, requiring a child to leave his favorite blanket in the waiting room, requiring a timid child to take a note to the receptionist, telling a parent to dump out a bucket of toys for the sole purpose of having the child immediately pick them up, or forcing a child to try a new food. All commands must be fair, developmentally appropriate, and respectful. Therapists should not coach parents to purposefully antagonize children to provoke frustration and tantrums. This would obviously be counter-productive for PCIT which is designed to improve the parent-child relationship. If a time-out does not occur in the clinic, time-out homework still can be given to most parents. For those less skilled parents who are unlikely to be successful at home without guided practice, homework can be postponed until further practice occurs in the clinic setting.

Coaching a Time-Out. Acting-out young children can engage in many unexpected behaviors when disciplined. The therapist must react quickly to novel situations, giving brief and understandable instructions to the parent. Here is a common coaching sequence:

Therapist:	She disobeyed. Go ahead and say, "If you don't hand me the block you're going to have to sit on the chair."
Parent:	If you don't hand me the block you're going to have to sit on the chair.
Therapist:	Hold out your hand to make it easy for her. Point. That's it. One thousand one, one thousand two, one thousand three, one thousand four, one thousand five. She has not responded. Go ahead and stand up quickly. Take her by the hand. Start walking to time-out.
Child:	(stubbornly sits on the floor)
Therapist:	She's not walking. Pick her up from behind in the barrel carry. Say, "You didn't do what I told you to do so you have to sit on the chair."
Parent:	(while carrying child to time-out) You didn't do what I told you to do so you have to sit on the chair.
Therapist:	Put her on the chair quickly. Good. Step out of reach and say, "Stay on the chair until I tell you that you can get off."
Parent:	Stay on the chair until I tell you that you can get off.
Therapist:	Now quickly walk away. Have a seat. Just ignore the crying. She's okay. Go ahead and take a couple of big breaths. You did a beautiful job of getting her to time-out quickly without giving any extra attention. Thirty seconds has already passed. Just two and a half minutes left to go. Good ignoring.

While sitting back at the table, the parent is instructed to organize the toys to make it easy for the child to comply. In the above example, the child was told to hand the parent a particular block. To set the child up for success, the parent can use the time-out interval to move all of the toys out of the way except for the one block. With fewer distractions, the child's potential for complying immediately following the time-out is increased. See Table 7.5 for examples of coaching statements used during time-out.

Give Parents Greater Responsibility as the Session Advances. As the session progresses, the therapist should allow the parent to become more independent in generating the PDI statements and determining the next step. For skills to generalize across settings, situations, and over time, parents need to learn to handle situations by themselves. Thus, too much dependency on the therapist becomes counter-productive. An example of how parents can be prompted rather than coached in the use of specific dialogue is as follows:

Table 7.5 Sample coaching statements during time-out

Just ignore that. He's trying to get your attention. Good job of showing no expression on your face
Try to watch him out of the corner of your eye. That's it. Now you can see him without getting any eye contact
I like how quickly you moved. You made a quick decision and got him to time-out before he had a chance to resist
I'm watching him very closely. It's okay if he scoots down off of the chair a little. If it looks like he's off the chair, I'll have you walk over and give him a time-out room warning
I know it's hard to ignore the crying. But you're doing the right thing for him. Just hang in there. Once this is all over you'll be surprised how quickly the anger goes down and the close feelings return
You can shake your head yes or no. Are you doing alright? I know it was hard to ignore when he kicked you. But you did just the right thing. You didn't let him know that it bothered you and you kept moving him to time-out. Wonderful job of handling a tough situation
That's it. Just play with the toys, and watch her out of the corner of your eye. Good ignoring.
Try and keep a "robot" face. I know some of the things he is saying are cute. But this is very serious. You have to be careful not to laugh because he will view this as a silly joke. Good ignoring
I'm timing. Looks like 1 min is down and we still have 2 more to go
We're looking for 5 continuous seconds of silence. With all the screaming, it's going to be tough to get all 5 s. So, when we get close to 5, get ready to move quickly to the chair. One thousand one (child screams). One thousand one, one thousand two, one thousand three, get ready, and go quickly. Say, "You are sitting quietly in the chair. Are you ready to come back and pick up the crayons?" Hold your hand out to see if he'll take it
He's scooting the chair. Walk over quickly. Say, "You're scooting the chair. If you scoot the chair again, you will have to go to the time-out room." Push the chair back to where it was. Now say, "Stay on the chair until I tell you that you can get off "
She's off the chair again. Pick her up and say, "You got off the chair before I said you could, so you have to go to the time-out room." Place her on her bottom facing the wall. Come out quickly. Watch for fingers when you close the door. I started the timing. She needs to stay in there for 1 min plus 5 s of quiet. Good job of getting her there quickly and safely. I like the way you stayed calm and matter-of-fact

Therapist: I think he's ready for another command. Go ahead and think of a reason and a command that you can give him.
Parent: My car needs wheels. Would you please find me. . .
Therapist: (interrupts) Please find me. . .
Parent: Please find me some wheels.
Therapist: Good direct command. Try to be quiet here. Give him a chance. Point to the wheels and point to your hand. Good waiting. He's dawdling go ahead with the time-out warning.
Parent: If you don't find me some wheels, you're going to have to sit on the chair.
Therapist: Now just wait. That was a good warning. Good neutral tone of voice. Looks like he's going to give them to you. How about a specific praise?
Parent: Good listening.
Therapist: (prompts) And when you listen you. . .
Parent: And when you listen you don't have to go to time-out.
Therapist: Good job of praising listening. You also helped him to learn that from now on, time-out and disobedience are linked. Okay, let's let him lead for awhile."

The Option of Coaching in the Room During a Time-Out. There are times during PDI when therapists may choose to enter the room themselves. One purpose of having the therapist enter the room during a time-out is to teach the child some of the time-out expectations while they are actually in that situation. It is inappropriate to look directly at the child during time-out and say things like "Time-out won't end until you're quiet," "Don't you dare get out of that chair," or "I don't appreciate that kind of language." Anytime the child is talked to during time-out, PDI loses some of its effectiveness because attention was given to the child. An alternative strategy is to go into the room to talk to the parent, not the child. The child then can learn about time-out from what is being said to the parent, without the child receiving any direct attention. Yet another option for teaching children while they are sitting in time-out (without providing attention) is to have parents pretend to call someone on their cell phone. In this way, coaches can feed lines to the parent without having to enter the room.

Topics discussed in the room with the parent while the child is sitting in time-out may include the following: requirement for quiet; time-out continues for 3 min; child must agree to obey before time-out can end; child is not allowed to escape from time-out; child will go to time-out room if he or she gets out of the chair; and how well the child is sitting in time-out. At no time is the parent or therapist to look at or talk directly to the child.

This technique is based on the principle that children learn not only from being given the rules ahead of time, but also by going through the process. In our experience, children listen to the adults' conversation and learn many of the rules vicariously without actually having to test them. The conversation between the adults also helps reduce impulsive behaviors that are most likely to occur during the first few time-outs. A child who is about to jump out of the time-out chair will

think twice on hearing the adults discuss the back-up time-out room consequence for getting out of the chair. Similarly, a screaming child often can be distracted into silence when the therapist enters the room.

A goal of in-room coaching is to set impulsive and aggressive children up for success. If they can remain in time-out the first time or two, they learn that they are able to handle time-out. They also can learn that when they are able to sit for the entire 3 min, parents will follow through with the promise of giving them another chance to comply. Successful time-outs can then build on each other. The following is an example of how a therapist can go into the room to review the rules while the child listens from time-out (again, no attention is given directly to the child):

Therapist: What's going on with Allen?
Parent: We were practicing listening and he did not erase the board quickly enough. So, he had to go to time-out.
Therapist: How long will he have to stay there?
Parent: Only 3 min. But, I can't let him out until he is quiet like a mouse. That's the rule.
Therapist: So, you're waiting for Allen to get quiet so he can come out of time-out?
Parent: That's right. He has to be quiet. Also, Allen is not allowed to get out of the time-out chair. If he gets up, he will have to go to the time-out room. He won't like that.
Therapist: It is good that Allen is staying in the time-out chair so that he doesn't have to go to the time-out room. The time-out room is no fun.

For safety purposes, there are other situations that may call for the therapist to enter the room. These include: (1) when a child repeatedly refuses to stay in time-out and must go to the time-out room many times; (2) when a parent appears to be losing emotional control or is close to giving in to the child; (3) when a child's behavior is completely out of control and the parent needs help in calming the child; and (4) when a child has become so aggressive that the parent cannot safely handle the behavior alone. In all of these situations, the therapist can provide a calming influence. On rare occasions, therapists who are certified in physical restraint procedures may choose to assist physically, to reduce potential danger to both the parent and the child.

Debriefing Parents Following the Session

The last 10 min of the coaching session is spent debriefing. Whether or not a time-out was needed, parents experienced some degree of stress during the session and may need to talk about feelings and concerns. The therapist can take this opportunity to praise parents for their perseverance and determination. Parents also can be specifically praised for skills that they implemented well (e.g., ignoring foul language, moving quickly and confidently, controlling their tempers). Through the

positive feedback, the parents can begin to see themselves as having the ability to be effective limit setters for their children.

During debriefing, particular emphasis is placed on the "learning curve." Parents are given examples of how the child learned as a result of the explanations, modeling, role-playing, and consequences. For instance, almost all children learn that the time-out warning is a firm limit, not an idle threat. Their increased compliance to the time-out warning can be pointed out to parents who may not have noticed.

For parents who had a difficult session, the therapist should reassure them that time-outs will become much easier in the future. In fact, once the child begins to accept that the parent will be consistent in following through on the time-out warning, relatively few time-outs will be necessary. The disruptive time-out behaviors, such as screaming, crying, and escaping, will improve as the child gains more time-out experience. For families who have easy PDI coaching sessions requiring no time-outs, therapists should remind them that all sessions may not go as smoothly. Therefore, they need to continue looking over the PDI handout and rehearsing their time-out skills so that they can be prepared when their child eventually does test the limits. For families who have successive sessions without a time-out, the therapist should have the parents role-play (with a stuffed animal or doll) how they would implement a time-out if it were to occur.

It is important to ask parents about their thoughts and feelings associated with the time-out. Some parents have strong negative feelings about the session. They may feel embarrassed by the intensity of their child's reactions. They may be concerned that this is not the right approach for their child and may make their child worse. We have had parents tell us that the time-out consequence was too severe for the specific instance of noncompliance (e.g., putting the lid on the bucket), and they felt like we made them treat their child unfairly. When parents discuss these feelings, the therapist has the opportunity to address the concerns. Without proper debriefing, these parents may drop out of treatment. We need to help parents see that time-out episodes are about changing the big behavior of "first time listening," rather than the much smaller issue of putting a lid on a bucket. We want to make sure that parents leave PDI sessions feeling comfortable with the procedures, confident in the therapist, and hopeful regarding their progress.

Parents benefit from being reminded that being a consistent and fair disciplinarian does not cause harm to the parent-child relationship. Examples can be provided regarding how the child's anger was reduced by the play therapy or how the child quickly became engaged with the parent again after time-out. It is important for parents to realize that limit setting does not have an adverse effect on children. In fact, it makes children and parents even closer. Children feel safe and comforted by parents who are fair and predictable. It is not uncommon during PDI coaching sessions to hear children proudly say things like, "I was a good helper. I didn't have to go to time-out!" These statements are reviewed with parents as indicators that the child appreciates the structure and is developing a more positive self-image.

In addition to debriefing regarding parents' thoughts and feelings about the session, we use this time to give very specific feedback regarding the PDI skills observed during the session. Frequently this involves going over the PDI Transcript

Coding Sheet, analyzing each of the command sequences observed during the 5-min PDI coding period. To illustrate, we will return to the sample command sequences described in the coding section earlier in this chapter. We would discuss the transcript with parents as follows:

Command Sequence #1 P:	Hand me the camel. C: Which one? P: (Does not wait 5 s) That camel. C: Obey. P: Thank you. That's nice.
Therapist:	So, this was your first command, "Hand me the camel." That's a great direct command. Then Gus asked you "Which one?" I notice that you answered him by saying "That camel." Do you remember that we want to give only the command and the warning? Is there a way that you could have indicated the camel without using any words? Good, yes, you could point. I liked that you remembered to praise. You said "Thank you. That's nice." Thinking about it now, which is always easier than when you are in the situation, can you think of an even better praise that you could give? You're right, that would be better because that is a labeled praise that encourages cooperation.
Command Sequence #2 P:	This room is really trashed. We better clean up. Why don't you put the Legos in the bucket? C: But I'm not done building (disobey). P: Get them put away now. C: Obey. P: Thanks for being my helper.
Therapist:	On the second command, you provided a nice reason that was well-timed before the command. But, listen to this command, "Why don't you put the Legos in the bucket?" Can you hear the question in the command? During the coaching, I noticed that you had a tendency to start your commands with the words "could you." These indirect commands imply that he has a choice in whether to listen or not. It would not be fair to put him in time-out when the command was presented to him as though he could choose to listen or not. Can you make this command into a direct command for me? Great job. When he disobeyed you about the Legos, it seems like you wanted to repeat the command. Remember that we always give a command and then a warning with no extra words. Do you remember the warning? That's close. It goes like this "If you don't put the Legos in the bucket, then you're going to have to sit on the chair." You ended this sequence with a great labeled praise for helping.

Command Sequence #3 P:	Now it's time to put the trucks away. Please put the red truck in the toy box. C: Disobey. P: (waits 5 s and gives correct warning) C: Disobey. P: You're not listening to me – so go to time-out. C: Stays on chair. P: (goes to chair at 2 min 10 s) Do you want to clean up now?
C: Obey P:	Good cleaning up (back to CDI – no 2nd command)
Therapist:	On the last command, he went to time-out. You did a great job of getting him to the chair quickly and ignoring while he was in time-out. The only thing we need to work on there is memorizing the time-out words. It is important that we say the same words every time-out so that you provide him with no extra attention. Let me get Mr. Bear here and we can practice the words. . .

Therapists may choose to debrief with the child at the end of the session either individually or with the parent present. Positive behaviors should be reviewed with the child (e.g., staying in time-out without escape, being quiet in time-out, complying with commands, agreeing to mind after time-out). The homework assignment should be explained to the child. Sometimes role-plays are used to assist the child in learning rules and time-out expectations. Therapists may be tempted to give children prizes for being "good listeners" during the PDI coaching session. PCIT does not usually include prizes for a couple of reasons: (1) prizes decrease the probability of a time-out, thereby decreasing important coaching opportunities, and (2) prizes can undermine parental confidence in the power of social reinforcement for modifying children's behavior. When therapists use prizes, parents often comment that the child only complies at the clinic because of the "treasure box." We know that prizes are not necessary to get young children to behave. The philosophy of PCIT is that young children can be motivated to make good choices through social contingencies alone. We avoid tangible rewards because we want parents to have confidence in the power of their own parenting.

Homework

Throughout the PDI stage of treatment, daily home CDI practice continues. Parents are expected to bring in completed CDI homework sheets to each of the PDI sessions. Additionally, PDI homework is assigned at the end of each coaching session and involves a separate homework sheet (see Appendix 11). PDI homework sheets allow the parent to record behaviors such as whether they practiced commands during clean-up, number of time-outs, and number of escapes from time-out (see Eyberg, 1999). Daily home practice in PDI is designed to set the parent and child up for success, as failed practice could derail the therapy by breaking the cardinal

rules of PDI: consistency, predictability, and follow through. PDI homework assignments are constructed in a graduated fashion so that the family can obtain mastery of each step along the way. For example, PDI begins with using time-out only during 10-min compliance exercises at home. Later, PDI includes several real-life commands each day, and is then expanded to include the use of time-out for defiance to all direct commands. The goal of PDI homework is to facilitate generalization across settings by encouraging parents to over-practice skills in the home environment.

References

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April 2, 2008, from www.pcit.org

Eyberg, S. M. (2005). *Parent-child interaction therapy: Basic coaching guidelines introduction*. Power point presentation retrieved April 2, 2008, from www.pcit.org

Chapter 8
Progressing Through the Parent-Directed Interaction Sessions

Helping families progress from the first PDI coaching session to the end of the treatment program involves the successive mastery of skills. Table 8.1 presents a session-by-session chronology of how PDI unfolds. Most families progress through PDI fluidly, with one week between sessions averaging about 7–8 PDI sessions. Some families progress faster than average while others require additional time. Both child and parental factors contribute to the amount of time needed to progress through the program. For example, extremely defiant children may need more than a week for compliance exercises, while children who are very active and disorganized may require extra work on house rules (i.e., rules for disruptive behavior). Parents who do not do their homework or who are inconsistent regarding the program will require additional sessions to master the skills. Other parental factors influencing the pace of the program include intelligence, mental health, and the quality of parental role models. Parents with intellectual limitations, psychological problems (e.g., substance abuse, depression), and those who were raised by inconsistent, negativistic, or abusive parents tend to have more difficulty assimilating the skills. Thus, whereas most families spend a week on each of the PDI sessions, this time line is reduced or extended to fit the needs of particular families.

Over the course of the discipline program, coaching becomes progressively less directive. As parents become more skilled, we recognize and reinforce their competency by giving them greater autonomy. A problem-solving approach is employed in which parents develop their own behavioral programs, evaluate the effectiveness of interventions, and make modifications as needed. In this way, we avoid fostering dependency. Our goal is for parents to have the confidence

to apply their skills to new situations and problems by the end of treatment. This approach maximizes cross-setting generalization and maintenance of treatment improvements.

With children between the ages of five and seven, the therapist may choose to spend some individual time at the end of each of the PDI sessions. This is helpful for rapport-building, discussion of the child's thoughts and feelings regarding PDI, and preparation for the following week's homework. A goal of the individual time is to enlist the child's input and assistance. Children are less resistant when they feel included in the decision-making process.

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Table 8.1 Progression of the PDI sessions

PDI session #	Clinic procedures	Homework assignments
PDI teach	Teach parents all of the steps and rationales of PDI Role-play PDI with parents	Continue daily CDI (5 min) Read over handouts Memorize PDI diagrams Decide where to put time-out chair at home Select & prepare time-out back-up room Do NOT use PDI at home
1st PDI coach	Explain time-out procedure to child No CDI or PDI coding Coach PDI in a play situation	Continue daily CDI (5 min) Practice PDI in daily 5–10-min play situation at home, following CDI Call immediately if any problem with PDI at home
2nd PDI coach	Coach CDI (but no CDI coding) PDI coding Coach PDI Describe PDI mastery criteria	Continue daily CDI (5 min) Practice PDI in a daily 10-min clean-up situation Practice PDI for two to four carefully selected direct commands each day
3rd PDI coach	Use PDI for any direct commands given in the clinic or waiting area Ask parents to estimate % of all commands given that still require warnings. Predict that this will drop over the next few sessions. Code CDI Code PDI (with clean-up directions) Coach CDI (focus on skills that are low) Coach PDI (10-min play and 5-min clean-up)	Continue daily CDI (5 min) Practice PDI in a clean-up situation after each CDI session Practice PDI as needed for all positively stated direct commands throughout the day. Tell parents to use direct commands only for important tasks (otherwise use indirect commands) On back of homework sheet, list problem behaviors not easily handled with a direct command

Table 8.1 (continued)

PDI session #	Clinic procedures	Homework assignments
4th PDI coach	Review PCIT progress sheet and progress toward PDI mastery No CDI or PDI coding Coach CDI Coach PDI in play and clean-up Review remaining problems and discuss house rules procedure	Continue daily CDI (5 min) Practice PDI in a clean-up situation after each CDI session Use PDI as necessary for running commands throughout the day Write in the new house rule on the homework sheet
5th PDI coach	Code CDI Coach CDI (if skills are low) Code and Coach PDI (include clean-up directions) Review PCIT progress sheet and consider whether family is ready for graduation (i.e., are PCIT mastery criteria met?) Review first house rule and add a second house rule if needed Introduce public behavior	Continue daily CDI (5 min) Use PDI as necessary for running commands throughout the day Use PDI for house rules
6th PDI coach	Code CDI Coach CDI (if skills are low) Code PDI Coach 5-min clean-up (if PDI skills are low) Determine whether any new house rules are needed (no more than two active rules at a time) Review public behavior procedure Coach each parent on an in-vivo public behavior outing	Continue daily CDI (5 min) Assign three public behavior practice outings Use PDI as necessary for running commands throughout the day Use PDI for house rules

Table 8.1 (continued)

PDI session #	Clinic procedures	Homework assignments
7th PDI coach and beyond	If in-session skills are not at criterion, code and coach CDI and PDI as needed If in-session skills are at criterion but ECBI not within normal limits, skip coaching and discuss application of CDI and PDI to presenting problems If primary remaining problems are sibling issues, include sibling age 2–8 in session and coach a combination of CDI and PDI with both children together	Continue daily CDI (5 min) Use PDI for running commands, House Rules, and public behavior as needed Do two practice sessions of play with the two siblings together (use CDI unless there is a need to direct play with PDI due to uncooperative behavior)
Graduation session	Code CDI Code PDI (clean-up situation) If family is not at mastery for CDI and/or PDI, return to regular PDI coaching session If family is at mastery on CDI and PDI coding, congratulate the family and conduct graduation session Review discipline skills, other than time-out, that can be used in the future Give child a blue ribbon for good behavior Give parents a certificate of completion Stress importance of continuing PCIT skills Convey positive expectations for the future Schedule a booster session Have parent call if problems arise	Continue daily CDI (5 min) Use PDI for running commands, house rules, and public behavior as needed

First PDI Coaching Session

What to bring. . .
(1) ECBI
(2) Stopwatch
(3) CDI Homework Sheets
(4) PDI Homework Sheets
(5) PCIT Progress Sheet
(6) Stuffed Animal or Large Doll for Role-plays (optional)
(7) Sheila Eyberg's Treatment Integrity Checklists/Manual

Preparing for the Session. Two hours should be set aside for the first PDI coaching session. While 75 min may be adequate, there must be sufficient time for handling time-outs that occur toward the end of the session. The session cannot end until the child has complied and the parent and child have had an opportunity to work through any upsetting feelings using play therapy. For this first session, as well as for all of the PDI sessions, the coaching time is divided between the two caregivers in two-parent families. As this is the session that is most likely to elicit aggressive behavior from the child, we take particular caution in childproofing the room. To prevent power struggles over keeping children in the room, the therapist may tell the parent to slide the table in front of the door at the beginning of the coaching period.

Beginning the Session. The child plays at the table while the therapist and parent(s) review the week and the PDI procedure. Parents are asked about their CDI homework. We encourage them to place an even higher priority on the play therapy practice as the discipline program gets underway. The therapist reiterates that play therapy is important for off-setting the anger and attitude problems that may arise when limits are suddenly enforced. The parents are then asked whether they had an opportunity to study the discipline diagram. A review of the diagram takes place by briefly rehearsing the entire command and time-out sequence.

At the end of the review, we routinely ask parents whether they are physically and emotionally ready to "go the distance" with the time-out procedure. The therapist should not accept "I think so" as an answer. When parents exhibit any hesitation, they are told that a 100% commitment is needed before proceeding. We explain that the worst scenario during the first discipline coaching session would be for them to "give up" in the middle of a stressful time-out. The child would receive the message that "if I just cry, fight, scream, and run away, my mom (or dad) will let me have my way." So, to begin the first PDI coaching session, a firm commitment is needed from the parents ensuring that they are willing to follow the discipline sequence through to completion. If a parent appears depressed, tired, irritable, or hesitant, the therapist should encourage the family to delay the beginning of the discipline program and coach CDI instead.

Rehearsing Time-Out with the Child. Fairness dictates that children be informed of new rules and consequences before they are implemented. Whereas parents

commonly wait until the "heat of the battle" to explain the upcoming consequences, we believe that children are most receptive to learning new rules when they are calm and cooperative. We have experimented with various ways of educating young children in advance about the expectations for compliance exercises and the time-out procedure. Even very young children have cognitive resources that can be tapped to help the discipline program be implemented more smoothly. They adapt to the new discipline program more readily when the therapist is proactive in preparing for PDI.

There are three primary ways to prepare children for the first PDI coaching session: a quick explanation, experiential practice (with the child), and observational learning (with Mr. Bear). When providing the quick explanation approach, the parent is coached to explain the rules to the child using words such as the following: "Today our special playtime is going to be a little different. Today we are going to practice listening. I will give you lots of little things to do, like 'hand me the cat' or 'put the farmer in the barn.' When I tell you to do something, you need to listen. If you listen, I'll be very happy with you, and we can keep playing. But, if you don't listen, you'll have to go over there to the time-out chair. When you are in time-out, I will not look at you or talk to you. And, to get out of time-out, you need to be quiet like a mouse. The most important rule about time-out is that you need to stay in the time-out chair. If you get out of the chair, you'll have to go over here to the time-out room. There are no toys in the time-out room. That's no fun. Thanks for listening to the rules. Now, we can play what you want to play."

When conducting experiential practice with the child, the parent is coached to provide "pretend" commands, warnings, praises, and time-outs. When conducting the observational learning procedure with Mr. Bear, the therapist, parent, and child take turns giving Mr. Bear commands, warnings, praises, and time-outs (Eyberg, 1999 describes procedure developed by PCIT team at UC Davis Medical Center). As behavior therapists, we prefer experiential practice over observational learning because research has demonstrated that experiential procedures lead to greater or more rapid behavioral change than is achieved through modeling alone. Therefore, we prefer the experiential procedure which involves the child actually practicing compliance, walking to time-out, and sitting appropriately in the time-out chair. Yet there are times when the modeling procedure may be a better choice: (1) when the child is not developmentally capable of distinguishing between what is pretend and real (e.g., 2–3-year-olds), and (2) when the child's defiance and aggression are so extreme that they cannot cooperate with the experiential practice of time-out, even when incentives are offered. Regardless of the method chosen, it is critical that the child's rehearsal of the PDI procedure be limited to 10 min. There are two pitfalls to lengthy rehearsals. First, overtraining the child in compliance during role-play situations may greatly reduce the likelihood of the child disobeying and receiving a time-out during coaching sessions. While preventing time-out in sessions may seem like a desirable outcome, it robs families of important practice opportunities. One of the most important components of PCIT is that the parent receives direct coaching during actual time-out episodes. No amount of role-playing in the clinic will prevent a child with disruptive behavior problems from disobeying and throwing tantrums in

frustrating real-life situations. Therefore, direct coaching is needed to provide families with the skills for implementing PDI procedures calmly during defiant outbursts at home and in public places. Second, if role-playing and modeling procedures last longer than 10 min, it reduces valuable coaching time. As therapists, we are often tempted to allow role-playing to run over the allotted 10 min because it is enjoyable for all parties. We would much rather spend time laughing and playing with the family than coaching parents through a volatile time-out episode. However, the coaching time is precious and powerful, and we must ensure that the majority of the session is spent in the most therapeutic way possible.

Practicing PDI with the child. There are a number of time-out skills that children with behavioral disorders must learn. They need to learn to walk to time-out by themselves, to sit in time-out without major disruptions, and to stay in time-out for the allotted time. If time-out behavior is viewed in the same light as behaviors such as writing one's name or riding a bike, it makes sense to use an experiential learning approach. In other words, children can learn these skills through practice and repetition. Positive practice in a "pretend" situation can enhance the child's ability to have successful time-outs during the coaching and at home.

We always have the parents review the discipline program with the children before the coaching session begins. This is done by carefully coaching the parents through the rehearsal. Because most preschoolers have very short attention spans, the process must move quickly (i.e., take no more than 10 min). We sometimes use stickers or other small prizes to encourage the child to cooperate. If a therapist is worried that a child may be too cooperative to have a time-out during the first PDI coaching session, it is best to have the parent explain the rules (rather than the therapist). Children are more likely to test the limits when the parent explains the rules, as the parent has a history of being inconsistent in following through with consequences. The therapist provides the words to the parent over the bug-in-the-ear device, such that the parent quickly explains compliance exercises, the time-out chair, and the time-out room. For children who are highly defiant and likely to go to time-out no matter who explains the rules to them, the time-out explanation could involve the therapist as follows:

Therapist: (to child) We're going to do something really fun today. And, you're going to get a chance to earn some prizes. You're going to get a chance to be an actor, and I'm going to be your acting coach while we do some pretending about time-out. You're not going to have a real time-out. This is all for pretend. Your grandma is going to tell you some things to do. Some of the time I'm going to tell you to be a really good listener and do what she says right away. But, some of the time I'm going to tell you to pretend like you're being naughty and don't listen. . . don't do what she says (therapist put hands over ears and acts defiant). Then we're going to listen to what your grandma says. Remember this is all pretend. Are you ready to get started? (dumps out toys) I'm going to make a little mess.

Therapist: (to grandma) Can you think of a simple, direct command? Maybe something like, "Please put a red block in the bucket."

Parent: Please put a red block in the bucket.

Therapist: (to parent) Good direct command. (to child) Okay, go ahead and do it right away. Be a good listener! (child puts block in bucket) (to parent) Can you think of a specific labeled praise?

Parent: Thanks for doing that right away.

Therapist: (to parent) Nice labeled praise. (to child) Great job of following your acting coach's directions. You get to choose a sticker. Would you like this one or this one? Now, this time, when your grandma tells you to do it, I want you to pretend not to listen. (to grandma) Think of another simple direct command.

Grandma: Please put this stick in the box.

Therapist: (to grandma) Good direct command. (to child) Remember to be naughty. . .don't listen. (to grandma) Now it's time for the warning. Say, "If you don't put this stick in the box, you're going to have to sit on the chair."

Grandma: If you don't put this stick in the box, you're going to have to sit on the chair.

Therapist: (to grandma) Good warning. (to child) Okay, go ahead and put it in, be a good listener. (child puts stick in box) Good job following your acting coach's directions. Which of these two stickers do you want? Now this time when your grandma tells you to do it I don't want you to listen at all. We're going to do some practice with how you would walk to time-out. Now, remember, this is all for pretend. You're not having a real time-out. That's the time-out chair over there (to grandma). See if you can think of another direct command.

Grandma: Put the box on the shelf.

Therapist: (to grandma) Good direct command. (to child) Remember you're pretending not to listen at all.

Grandma: If you don't put the box on the shelf, you're going to have to sit on the chair.

Therapist: (to grandma) Good warning. (to child) Remember not to listen. (to grandma) He's choosing not to listen. So, say "You didn't do what I told you to do so you have to sit on the chair." (grandma repeats) Good job using the right words. Now walk him to time-out. Say "Stay on the chair until I tell you that you can get off." (grandma repeats) I like the way you used the exact words from the diagram. (to child) Awesome job of walking to the chair without making any fuss! You walked all on your own. You didn't argue or cry. You did a beautiful job walking on your own to the chair. Let me see you do that again (child walks quickly to the chair). There are some important things for you to know about time-out. First, when you are sitting in time-out, you need to be quiet like a mouse (therapist holds fingers to lips). You can't make any noise in time-out or your time-out can't be over. Another thing you need to know is that when you are in time-out no one is allowed to talk to you. If you are thirsty in time-out and ask your grandma for a drink of water, what do you think she will say?

Child: No, you can't have one.

Therapist: (to child) Actually she won't even answer you because she is not allowed to talk to you when you're in time-out. Time-out is a very boring place where no one is allowed to talk to you. Another important thing you need to know about time-out is that you have to keep your bottom in the chair. There is no getting out of time-out before your grandma says that you can. If you get out of the chair before your grandma says that you can, then she will have to take you to the time-out room. That will make your time-out last longer, and that's no fun. So, remember when you sit in time-out you need to be very quiet and keep your bottom in the chair. Excellent listening. You've earned a prize. Would you like this one or this one. (to grandma) Let's pretend like he's done an excellent job of sitting in time-out. So his time-out is short. You're going to go to him and say "You are sitting quietly in the chair. Are you ready to come back and put the box on the shelf? (to child) Go ahead and do it. (child puts box on shelf) (to grandma) Just acknowledge it with a fine or a thanks.

Grandma: Thank you.

Therapist: Now give him another command right away.

Grandma: Please put this stick in this hole.

Therapist: (child complies) (to grandma) Look how he did that right away! Give him a big labeled praise.

Grandma: High five for you! You're being a great helper today!

Practicing PDI with Mr. Bear. The "Mr. Bear" procedure for explaining time-out to children was developed by the PCIT team at UC Davis Medical Center. See Eyberg (1999) at www.pcit.org for a complete description of the procedure. This procedure is particularly helpful with young children who have short attention spans, as they find Mr. Bear entertaining. When using Mr. Bear, the therapist follows the sequence described above having Mr. Bear (1) comply with the original command, (2) disobey the original command but comply with warning, and (3) disobey original command and warning and go to time-out. First the therapist models Mr. Bear going through this sequence, followed by the parent and then the child. Finally, the parent and child practice alone with Mr. Bear while the therapist coaches from behind the mirror via the bug-in-the-ear. In all cases, it is Mr. Bear, not the child, who is obeying or disobeying and going to time-out. The child learns the rules of time-out vicariously.

Coaching. Once the time-out rules have been rehearsed with the parent and child, the coaching portion of the session begins. There is no CDI or PDI coding in this session. The PDI coding is omitted because the parent is not ready to do PDI without intensive coaching from the therapist. The CDI coding is omitted to allow enough coaching time to handle the child's first time-out. The therapist coaches the parent to briefly engage in CDI. The CDI is conducted to get the session off to a good start. The parent may feel anxious, and the CDI often serves to calm the parent. After the

play therapy has succeeded in setting a positive tone and calming everyone down (including the therapist), it is time for the first instruction.

According to the learning principles we are employing, it is best to start with small goals. This process allows the child to experience mastery before demands are gradually increased. A good initial step is to choose an instruction that the child is most likely to obey. If, for example, the child is already putting the pieces on Mr. Potato Head, the instruction should go like this: "Now it is my turn to choose the game (reason). Please put this ear on Mr. Potato Head (direct command)." Similarly, if the child is working a puzzle, the next piece can be given to him or her with the instruction: "It is my turn to choose the game (reason). Please try to make this piece fit (direct command)." The use of the phrase "try to" helps when giving an instruction that might present a developmental challenge. It lets the parent and child know that our goal is not perfect execution, but effort. Other first instructions that are likely to lead to success include telling the child to hand the parent a toy or to put two pieces together. For example, the parent should begin with the reason: "It is my turn to choose the game" (reason). This can then be followed immediately by a directly stated "hand me" instruction such as "Please put the dog in my hand." Gestures will accompany the instruction to decrease ambiguity and help the child attend.

In most cases, children obey the first command. Then, the parent is coached to provide an enthusiastic labeled praise such as "Terrific job of listening! You did what I asked you to do, so you don't have to go to time-out. We get to keep on playing." This labeled praise serves several purposes: (1) it encourages children to be proud of themselves for complying, (2) it increases the probability of future compliance, and (3) it reminds the child that new consequences are now in place for listening (praise, playtime) and not listening (time-out).

The commands for the first PDI coaching generally are limited to instructions regarding the manipulation of toys and play, rather than clean up and other "real-life" commands. The purpose of beginning with "play commands" is that they are easier for the child and allow the parent to become proficient at the command–comply–praise sequence before implementing the first time-out. Ideally, after the child has complied with several simple commands, the therapist prompts the parent to choose somewhat more challenging instructions so that the parent can practice giving time-out warnings and time-out procedures. Examples of the types of play commands that are more challenging for children include (1) ones that require children to give parents a toy that the children are currently playing with, (2) ones that require children to change activities, and (3) ones that require children to do small tasks that interrupt the flow of their play (e.g., picking up something that fell, bringing a toy or object to the parent). If after 20 min of coaching play commands the child has not needed a time-out, the therapist may choose to move to clean up or more real-life commands. We increase the difficulty of the commands at this time for two reasons. First, it is best that the child's first time-out occur in the clinic where therapists can guide parents through the procedure. Second, it is important that the time-out occur early enough in the session to allow sufficient time to coach through the entire episode. We avoid giving challenging commands near the end of

the session because we find that by that point parents and children are too fatigued to be at their best. Also, therapists become stressed when sessions run over their allotted time and may not provide their best coaching. The ideal first PDI coaching session allows the parent and child to experience early success with commands and compliance, followed by coaching through a time-out episode mid-way through the session, and ending with several successful command-compliance sequences. Then, there should be sufficient time remaining to fully debrief the family and assign homework.

Debriefing and Assigning Homework. Parents need a great deal of emotional support and reassurance following the first PDI coaching session, particularly if a time-out occurred. As discussed in Chapter 6, we encourage parents to talk about thoughts and feelings regarding the session, which range from skepticism, guilt, and embarrassment to excitement and enthusiasm. For parents whose children demonstrated explosive behavior in the session, it helps for the therapist to let them know that the therapist is not shocked by the misbehavior and has "seen it all before." Parents may be concerned that their child's behavior is too severe for PCIT. It is important for the therapist to convey that PCIT is exactly the right intervention for children with explosive behavior problems and that they have come to the right place. Parents need reassurance that the child will not always resist time-out and that a learning curve will occur. Rapport can be particularly affected in this session. Sometimes children are angry at the shift in emphasis from play therapy to discipline. They may tell their parents that they do not want to return to the clinic. If we do not adequately support and encourage families, there is a chance that they may drop out after this session. This first PDI debriefing is a therapeutic challenge because numerous sensitive topics need to be addressed with the parents, yet the child is often irritable and tired at the end of such a long session. Therapists may need to employ special strategies to help the child play independently while the debriefing occurs with the parent. We suggest bringing in novel toys, changing the venue, having a co-therapist play with the child, or allowing the child to watch a movie or play a video game. It is especially important to keep the child entertained to prevent misbehavior that might inspire the parent to give a poorly timed direct command, possibly leading to another time-out. In fact, therapists should tell parents not to give direct commands during the debriefing.

Many parents, who see the power of PDI in the session, leave this first discipline coaching experience feeling exhilarated and eager to begin using their new PDI skills at home. We often find ourselves needing to reign in these enthusiastic parents to prevent them from trying to do too much, too fast. As PDI needs to be implemented in a graduated fashion, therapists should educate parents about the importance of adhering to the prescribed homework assignment.

The homework assignment after the first coaching session usually involves conducting 5 min of CDI followed immediately by 5–10 min of PDI each day. Thus, the first 5 min should consist exclusively of play therapy. The next 5–10 min should involve the type of alternation conducted during the session: CDI, command, CDI, command, CDI (for a parent handout describing this homework assignment, see Eyberg, 1999, p. 104). In accordance with the mastery criteria, parents should

attempt to provide at least four commands in 5 min. Just as in the clinic, the PDI rules and consequences should be explained, modeled, or practiced at home prior to the compliance exercises. Parents are told to do the PDI practice when they are not in a hurry. If the child goes to time-out, the 5–10 min could easily turn into a 20-min commitment. Parents are given CDI and PDI homework sheets to record their practice.

Not all parents should be given this discipline homework assignment. However, those families who are not yet ready to begin PDI procedures at home will continue with the homework assignment of providing 5 min of daily CDI. There are three general guidelines for determining whether PDI homework should be given. First, if a "clean," uncomplicated time-out occurred in the clinic setting and the parent appears competent to employ the skills at home (e.g., no apparent anger-management problems), PDI homework should be given. In contrast, if the child was extremely resistant or aggressive during coaching or the parent had difficulty maintaining emotional control, a second time-out under therapist supervision is advisable before sending the parent home to carry out the program independently. Second, if the parent expresses reservations about beginning PDI at home (e.g., relatives are visiting, the taxes are due, parent lacks confidence), PDI homework should not be given. And third, if no time-out occurred during coaching, but the parent has good discipline skills and the child demonstrated a learning curve during the session, a PDI homework assignment can be given.

In preparing parents for the homework assignment, we anticipate how the child may respond to compliance exercises. Some children quickly comprehend and accept what they perceive as the "listening game." They seldom require a time-out during PDI practice. Yet, they still have significant compliance and attitude problems outside of the 10-min homework period. If the therapist does not prepare the parents for this response, they may perceive that the program is not working. Optimally, parents should be told ahead of time that the goal for this week is to teach the child to comply at a high rate during compliance exercises only. Compliance improvements outside of the 10 min are not yet expected. Nevertheless, the following benefits of successful compliance exercises should not be overlooked: (1) the child begins to perceive following directions as fun and rewarding, (2) the child's habit of disobeying all instructions is being reversed, (3) the child's self-image is changing to that of a well-behaved child who likes to be helpful, and (4) the child learns that the parent will be fair and consistent if following through with time-out for noncompliance. Anticipating that parents will become impatient with compliance exercises, the therapist should obtain a firm commitment that they will not endanger the success of the program by using the time-out chair outside of the 10-min homework period. For the rest of the day, parents are encouraged to use any safe discipline strategy of their choosing, except for time-out in a chair.

A second possible response to compliance exercises is resistance. Some children will accept the rules and limits within the structured clinic setting, but then defiantly test the parents when the therapist is not present. Parents should be advised to stop

the homework assignment and contact the therapist if any complications occur during compliance exercises. Potential complications include refusal to comply with the original instruction even after a lengthy time-out, refusal to stay in time-out, destructive behavior in the time-out room, or aggression during compliance exercises. When the parent telephones, the therapist should obtain a detailed description of events. If the parent used good skills and the child demonstrated a learning curve, the therapist may choose to have the family resume the homework. If, however, the parent seems unable to competently execute the PDI skills without therapist supervision, homework should be postponed until the family can receive additional clinic coaching.

Second PDI Coaching Session

What to Bring. . .
(1) ECBI
(2) Stopwatch
(3) PDI Skills Transcript Sheet
(4) PCIT Progress Sheet
(5) CDI Homework Sheets
(6) PDI Homework Sheets
(7) Sheila Eyberg's Treatment Integrity Checklists/Manual

After checking in with parents and discussing CDI and PDI homework, the therapist begins the coaching portion of the session with approximately 10 min of CDI coaching. CDI coding is not conducted in order to allow more time for PDI coaching. Then, PDI is coded for 5 min using the following directions:

> We want to switch to PDI in a second. We're going to code it today for 5 minutes before we coach PDI. You can tell [child's name] that now it's your turn to choose the game. Then begin with a simple command. Okay, we're starting to code PDI now. (Eyberg, 1999, p. 111).

For single-caregiver families, PDI is coached for about 20 min, whereas each caregiver receives approximately 10 min of PDI coaching in dual-caregiver families. PDI is coached in a play situation.

During debriefing, parents are shown the PCIT Progress Sheet and the PDI Skills Transcript Sheet. The mastery criteria for PDI are presented. Parents are given a homework assignment to continue daily 5-min CDI sessions. After each CDI session, parents should practice PDI in a 10-min clean-up situation. They also should use their PDI skills for 2–4 carefully selected direct commands each day. "Carefully selected" means that the parent thought about the command in advance, took care

to phrase it properly, and the parent has the time and the energy to see the potential conflict to its ultimate conclusion. These commands should not be given when the child is overly tired, the parent is overly tired, the family is on the way out the door, the parent is on the telephone, the family is outside of the home, or guests are over. To help alert children to the importance of the 2–4 commands each day, parents may begin these instructions with the following familiar cue: "We're going to practice listening now." Giving only 2–4 direct commands prevents parents from overusing time-out. If asked at this point to use the procedure for all instructions, all day long, parents are likely to become either inconsistent or overbearing. This homework assignment helps to ensure that there will be reasonable expectations for the child and that the child will not be sent to time-out too many times in one day. As always, parents are instructed to stop using the procedure and to call the therapist if a problem develops (e.g., aggressive outbursts, refusing to stay in time-out). Before sending parents home with this assignment, the therapist and parent should generate a list of good instructions that may be used at home. Sample instructions for this week include the following: "Please put your shoes away," "Please pick up the clothes you dropped on the floor," "Please turn off the television," "Please brush your teeth," "Please put your coat on," "Please put your glass in the sink," "Please help me put the spread on your bed," and "Please put the dolls in your room." These instructions can be written on the top of the PDI homework sheet as a reminder to parents. A CDI homework sheet is also sent home. Parents are told that beginning in the next session, any time they give a direct command in the clinic or waiting room, they will be expected to follow through with the PDI procedures.

Third PDI Coaching Session

What to Bring. . .
(1) ECBI
(2) Stopwatch
(3) DPICS – III Coding Sheets (for CDI coding)
(4) PDI Skills Transcript Sheet
(5) PCIT Progress Sheet
(6) CDI Homework Sheets
(7) PDI Homework Sheets
(8) Sheila Eyberg's Treatment Integrity Checklists/Manual

After checking in with parents and discussing CDI and PDI homework, parents are asked to estimate what percentage of the time their child is complying with the first command given without needing a warning. Parents then are taught how to use labeled praise to increase first-time compliance. Examples of labeled praises include "Thanks for doing that the first time told," "I like it when you do what I tell you so fast," "It's wonderful to see you minding quick as a bunny," "Awesome

first-time listening," and "Thank you for helping right away." Parents first are coded in 5 min of CDI, then 5 min of PDI. The PDI coding uses the following clean-up directions:

> Now we are going to switch to using PDI in a clean-up situation. Tell [child's name] that it is time to clean up the toys. Get him to put all the toys in their containers and to put all the containers in the toy box. (Eyberg, 1999, p. 126)

After coding PDI, the parent is coached in CDI for approximately 15 min, focusing on any skills that were weak. Next, the parent is coached in 10 min of PDI in a play situation, followed by 5 min of PDI in a clean-up situation. The therapist should add some "real-life" commands to the play situation to promote generalization outside the clinic setting (see Table 8.2).

Table 8.2 Real-life commands for promoting cross-setting generalization

I need to talk to you for a minute. Please come over here
I'm worried you might fall. Please get down from that shelf
Running is not allowed in this room. Please go back and walk this time
I like it when you shut doors quietly. Please go back and shut the door you just slammed, doing it gently this time
We're trying to talk. Please choose a quieter toy to play with
You need to stay in the room. Please come back inside
I'm worried that you're going spill my purse. Please leave it alone
Your shoe lace is untied. Please come here so that I can tie it for you
We need to keep the room neat. Please put the puzzle away before you choose another toy
A Lego just fell on the floor. Please pick it up
There are too many toys on this table. Please put the box of Lincoln Logs on the floor
Your nose is messy. Please go get a tissue
There are people trying to work next door. Please hammer the roof quietly

At this point in therapy, parents may try to move ahead in the program prematurely. They often ask the therapist to suggest management plans for behaviors that are easier to deal with later in treatment. Examples include school problems, not getting along well with other children, public misbehavior, profanity, stealing, and not sleeping in one's own bed. It should be explained to the parents that it is difficult to address these problems until the child is complying at an acceptable rate. Parents at this stage have their hands full with compliance training alone and would find it extremely difficult to be consistent with additional behavioral programs. Parents can be assured that if they persevere with the program and be patient, their concerns will be addressed in two or three weeks. We remind parents that it took years for these problems to develop and it takes time for children to change.

After coaching, parents are debriefed on their progress toward mastery of PDI skills using the PDI Skills Transcript Sheet. Parents are given a homework assignment to continue practicing CDI for 5 min each day, followed by a PDI clean-up session. Additionally, parents practice PDI as necessary for all positively stated direct commands throughout the day. Parents are given a CDI and PDI homework

sheet. On the back of the PDI homework sheet, parents are asked to note any disruptive behaviors that seemed hard to handle using a direct command. This list will be used in the next session to formulate a house rule. Given that the family will be using PDI throughout the day, the therapist should review with the family appropriate times for using direct versus indirect commands.

At this stage of treatment, we recommend that parents avoid the use of direct commands during transitional periods, such as when they are trying to get the child ready to go somewhere and cannot be late. The reason for this is that these transitional periods are high-risk times for disobedience. Because the children may have not yet learned to comply at a high rate, the parents will often find themselves in the difficult position of either giving in to the child or being late for appointments. Instead of risking a confrontation, we ask parents to phrase their instructions as suggestions, which will not be enforced with a time-out consequence if the child disobeys. Alternatively, the parent may choose to do the task for the child to eliminate the need for a command. For example, suppose the family is late for church and Bridget has not yet begun to put on her shoes and socks. Rather than giving her a direct command, the parents may choose to either phrase the instruction indirectly ("Would you please put your shoes on quickly?"), or put her shoes and socks on for her. Parents often react to these recommendations with disappointment since most are eager to learn ways to help their children listen when they are in a hurry. Parents can be reassured that later in the discipline program their children will have overlearned compliance to such a point that direct commands can and should be given with confidence during transitional periods.

Parents must promise that they will not use time-out for other than disobedience of positively stated, direct commands. The discipline program will be seriously compromised if the parents begin to place the child in time-out for "being bad." The key to success in this stage is to use time-out only for noncompliance (i.e., refusing to do what one is told to do). Disruptive behaviors (e.g., hurting, profanity, attitude problems) will be handled later. To teach parents which situations time-out is appropriate for during the week, we often use this example:

> Suppose that on Sunday you wake up and discover that Brian has been up for quite a while. He has gotten into the refrigerator. He pulled out all the eggs and cracked them open, one by one on the kitchen floor. He also poured a jar of grape jelly into the middle of the scrambled eggs. When you come into the kitchen, Brian is sitting in the middle of the mess, finger painting with the mixture. Do you put him in the time-out chair? The answer is "no." You cannot use the time-out chair for this behavior because you have not given him a positively stated, direct command. You also have not given him a time-out warning. For this week, you must promise me that you will not put him in the time-out chair without giving him the time-out warning first. Now, if you can figure out a way to turn this into a compliance issue, you can use time-out. What could you tell Brian "to do" that would make this a compliance issue? That's right, you could tell him to take a rag and help you clean it up. Then if he refuses to help, you can give him a time-out warning. Can you see the behavior we are targeting this week? We can't send him to time-out every time he misbehaves this week because he would be in time-out too often. We have to start with one problem, just getting him to listen. Once he is following your instructions we will deal with all of the other problems. But, it is important that we do this only one step at a time.

Fourth PDI Coaching Session

What to Bring...
(1) ECBI
(2) Stopwatch
(3) PCIT Progress Sheet
(4) CDI Homework Sheets
(5) PDI Homework Sheets
(6) Sheila Eyberg's Treatment Integrity Checklists/Manual

We check in with parents, discuss CDI and PDI homework, and review changes on the ECBI. Some rapidly improving families could be ready for treatment termination as early as this session. Therefore, we take a couple of minutes to review the criteria for treatment graduation. These PCIT termination criteria are presented in Table 8.3. To maximize the time available for coaching and to allow sufficient time for teaching house rules, CDI and PDI coding are omitted in this session.

Table 8.3 PCIT termination/graduation criteria

ECBI Intensity scale raw score 114
Parental confidence in managing child behavior independently
All caregivers must achieve mastery criteria for CDI
All caregivers must achieve mastery criteria for PDI
Family has learned and practiced house rules and public behavior procedures (if needed)

Eyberg (1999, pp. 197–198).

Parents are coached for about 20 min in either CDI or PDI, depending on which phase presents the most challenge for the parents.

House Rules. A primary goal of the debriefing part of the session is to teach parents to establish appropriate house rules. As a review, parents are reminded that children's behavior problems can be divided into two categories: failure TO DO what they are told to do (i.e., disobeying positively stated instructions) and doing things they are told NOT to do (i.e., breaking house rules). It is common for parents to enter this session saying, "yes, he cooperates when I provide a time-out warning, but..." indicating that a number of problems still exist. Examples of continuing problems include hurting others, running through the house, jumping on the furniture, throwing, destructiveness, arguing with siblings, cleaning up toys by slamming them into the box, profanity, spitting, getting into off-limits areas (e.g., mother's purse, parent's bedroom, refrigerator, pantry), and leaving the yard. Like noncompliance, the disruptive behaviors must be handled in a gradual fashion.

When a behavior problem is not amenable to improvement through the process of using positively stated commands for incompatible behaviors, the use of a house rule may be considered. For the first house rule, it is best to select a disruptive behavior that occurs with high frequency so that there will be many learning opportunities throughout the week. For example, some children jump on bed. Positively stated directives may be only partially effective in eliminating this behavior. A child may immediately comply when told to get off of the bed. A few minutes later, however, the misbehavior may be repeated. In such a case, a "standing" rule called "no jumping on the bed" may be more effective than repeated "running" commands. Parents are asked to explain each new house rule to the child in advance, choosing a time when the parent is calm and the child is displaying appropriate behavior. A definition of the rule is provided at the child's developmental level. It is explained to the child that jumping on the bed is dangerous, can damage the bedding, and will not be allowed. From now on, any time the child jumps on the bed there will be an immediate time-out and no warning will be given. Parents are instructed to use a 3-min time-out and then to give a reminder (e.g., "You can get off of the chair now"). Unlike time-outs for noncompliance, there is no requirement that the child comply with the original command because no command was given. As soon as possible after the time-out, the child should receive a labeled praise for the opposite behavior (i.e., I like the way that you are sitting calmly on the bed). These labeled praises for behaviors that are incompatible with the house rule serve two purposes: (1) they are positive reminders to the child about the new rule, and (2) they increase the incompatible pro-social behavior, causing the problem behavior to decrease.

House rules should be kept to a minimum, no more than two at a time. One reason for limiting the number of rules is to help ensure that time-out is not overused. Large numbers of house rules are associated with more frequent time-outs and increased frustration in children. Also, house rules should be enforced with 100% consistency. When parents develop many rules, their ability to consistently enforce them decreases. So, the therapist needs to work with the parent on determining which disruptive behaviors warrant house rules.

When deciding whether to employ a house rule, the first issue to consider is whether the problem could be handled effectively using a less restrictive strategy. We reserve house rules as a last resort. Strategies that should be attempted before implementing a house rule include the following: (1) selective ignoring, (2) strategic praise, and (3) using positively stated commands to perform incompatible behaviors. The second issue to consider is whether it would be possible to provide a consistent consequence immediately following each incidence of the misbehavior. House rules are only effective when they are enforced consistently. If the parent is unwilling or unable to place the child in time-out for nearly every infraction of the rule, the behavior should not be handled with a house rule. A third issue to consider is whether the misbehavior can be defined so clearly that the mother, father, and children can all agree about whether a rule has been broken. For example, a "no mean talk" house rule would have to be defined so clearly that everyone agrees on the exact words that are not permissible.

To illustrate the decision-making process, we will consider the common preschool problem of whining. The first consideration is whether whining can be handled with more positive strategies. One effective strategy is to offer a prompt such as "I can only understand you when you talk like a big boy," followed by ignoring of any whining. Strategic attention also can be used by taking special care to provide enthusiastic labeled praises when the child speaks clearly. Therapists may also review the "when. . .then" technique with the parents. This technique can be applied to whining as follows: "When you ask me like a big girl (boy), then I will give you the juice." The second issue to consider is whether it is appropriate or desirable to place the child in time-out each time a whine occurs. Given that whining is a developmentally normative behavior for very young children, many parents feel uncomfortable using time-out consistently as a consequence. Third, definitional issues should be considered. A careful definition of whining would be necessary to avoid confusion regarding whether a verbalization constituted immature speech, an expression of fatigue, or a whine. One option for defining the behavior would be for parents to label it (e.g., "That's a whine") for a short period prior to beginning enforcement of the "no whining" rule.

We reserve house rules for only a handful of disruptive behaviors. For aggressive children, a "no hurting" rule is usually necessary. We prefer the word "hurting" because it is easily defined and encompasses a range of aggressive behavior (e.g., hitting, kicking, biting, pinching, hair pulling). Profanity is another problem that may be appropriately addressed using a house rule. Although mildly offensive language such as "dummy," "I hate you," and "pencil-necked geek" can be managed through the use of selective ignoring and strategic attention, extremely offensive language may require a stronger consequence. In defining the "no bad words" rule, parents should carefully select a short list of profane words that no one in the family (parents included) is allowed to say. "Off-limits" house rules are particularly helpful for very active and impulsive children. Examples include "no getting into the refrigerator without permission," "no touching the computer," "no getting into mom's cosmetics and jewelry," and "no leaving the yard (house) without permission." Before resorting to an off-limits house rule, environmental manipulations should be tried such as placing cosmetics in a high cabinet. Other disruptive behaviors that may be appropriate for house rules include spitting, lying, stealing, and climbing on furniture.

The steps for implementing a house rule are as follows. To begin, the parent should explain the rule to the child using examples and a label that is developmentally appropriate before beginning the time-out procedure. If the parent is unsure as to whether the child understands the rule, the parent should label each occurrence for two to three days saying something like "That's hurting. Soon that will get you an automatic time-out, no warnings." After the house rule is established, the child is taken to time-out for every incidence of breaking the rule. The parent is instructed to say "You [house rule broken], so you have to sit on the time-out chair. Stay on the chair until I say that you can get off." Once 3 min plus 5 s of quiet is over, the parent says "You can get off the chair now." As soon as possible after the time-out, the parent should provide a labeled praise for a behavior that is incompatible with

the broken house rule. See Eyberg (1999, p. 141) for a parent handout on setting up house rules.

Homework. After house rules have been explained to parents, homework is assigned. As always, parents are asked to continue daily 5-min CDI (and record it on the provided homework sheet) as well as PDI clean-up sessions after CDI. Parents should use PDI as necessary for all positively stated direct commands throughout the day. If a new house rule was established, it should be noted on the PDI homework sheet and enforced throughout the week.

Fifth PDI Coaching Session

What to Bring. . .
(1) ECBI
(2) Stopwatch
(3) PCIT Progress Sheet
(4) DPICS – III Coding Sheets
(5) PDI Skills Transcript Sheet
(6) CDI Homework Sheets
(7) PDI Homework Sheets
(8) Sheila Eyberg's Treatment Integrity Checklists/Manual

Instead of checking in and reviewing homework, the session begins with coding and coaching. The parent is coded in 5 min of CDI. And, if mastery criteria are not met, the parent is coached for 10 min in CDI. Then PDI is coded for 5 min using these instructions: "Now we're going to code PDI for the next 5 min. Do the best job that you can." If mastery criteria are not met, PDI is coached for 10 min using clean-up directions. Also during this session, the therapist may choose to establish and enforce a "clinic rule." Helpful clinic rules for highly aggressive children would include "no throwing," "no hurting," and "no leaving the room without permission." Parents are coached to explain the clinic rule and time-out consequence, praise the child for complying with the rule, and quickly provide a time-out consequence if the rule is broken. At this point in treatment, all directly stated commands in the clinic (including the hall and waiting room) and house/clinic rules require follow through with praise for compliance and the warning/time-out sequence for noncompliance.

In the debriefing, the therapist reviews with parents the coding sheet data regarding their progress toward mastery criteria for CDI and PDI. ECBI improvements are also examined, with problem-solving about individual behaviors that remain problematic. CDI and PDI homework sheets are collected. The child's response to the first house rule is reviewed. If there has been progress on the first house rule, a second house rule may be implemented if needed. House rules are recorded on the PDI homework sheet.

Public Behavior. A major goal of the 5th PDI coaching session is to teach parents how to use PDI skills in public settings. It is helpful to begin by discussing the thoughts and feelings that parents experience when their children misbehave in public. Many parents tell us that they feel intense embarrassment because they believe others regard them as incompetent parents when their children are disruptive. Some believe that their children are misbehaving so as to cause parental embarrassment. We find it helpful to confront these maladaptive cognitions by asking parents what they think when they notice someone else's child misbehaving. They typically respond by saying they feel empathy for the parent and that the child is probably misbehaving because of fatigue or hunger. At this point in treatment, responsibility for problem-solving should be shifting away from the therapist and toward the parent. We want them to take increasing responsibility for generating ideas for how to apply their PCIT skills to the issue at hand. An example of the therapist–parent interchange in which the therapist leads the parent to assume greater responsibility in developing a public behavior plan is described below:

Therapist: When coming up with a plan for a new behavior problem, the first thing that you should think about is whether positive skills can be used to help the problem. As you know, we like to reserve time-out as a last resort because it is stressful for everyone. What positive approaches can you think of that could help his behavior in public?
Parent: Praise?
Therapist: That would be a great start. What kind of praise are you thinking about?
Parent: Well, I could praise him for being good at the restaurant.
Therapist: Exactly. What behaviors would you like to see more of at the restaurant?
Parent: Not getting under the table, not bothering other people.
Therapist: Good ideas. Now what's the opposite of getting under the table?
Parent: Staying in your seat.
Therapist: How about the opposite of bothering others?
Parent: Being calm and quiet.
Therapist: Okay, what would be a couple of good labeled praises then that you could use in public?
Parent: Thanks for staying in your seat. I like it when you use an inside voice so that the others won't hear you.
Therapist: Great praises, very specific. As you know, any behaviors that we praise will increase. So, that's bound to help a bit. But, there's still the chance that he will get pretty disruptive in public. So, let's look at some other ideas.

Before discussing how PDI can be used in public, we review tips for setting children up for success during public outings (see Table 8.4). Parents are taught to apply the PDI strategies that they have already learned to public behavior problems. For example, both noncompliance and breaking house rules can receive consequences

Table 8.4 Tips to help children behave well in public

Avoid taking tired child out in public
Bring along snacks and beverages
Intersperse errands with fun activities
Explain rules and expectations in advance
Be prepared to cut outings short if child needs a break
Bring along a backpack full of small toys, books, and other entertainment
Offer incentives for good behavior

Eyberg, (1999, pp. 152–153).

in public settings. To help children learn that "time-out can travel," we recommend that parents bring along a visual reminder that time-out is beingused outside of the home. Parents can carry a time-out towel or newspaper which can be rolled up and placed in a purse or shopping cart. Children are told that if they refuse to follow the rules in public, the time-out cloth will be used in an out-of-the-way spot and they will have to sit there for 3 min. To reduce the number of time-outs needed, parents should carefully prepare their children by explaining the rules and consequences before entering the public place (e.g., keep one hand on the shopping cart, use an inside voice, there will be no toys bought today, you may have one candy at the check-out line). Using a problem-solving approach, parents are encouraged to generate ideas for out-of-the-way places that may be appropriate for time-outs. Good options include dressing rooms, benches outside of stores, public restrooms, church hallways, and empty sections of stores. If the car is parked nearby, it can serve as a more private place for time-out, decreasing parental embarrassment. Parents need to use good judgment about using the car for time-out in extreme weather conditions. See Eyberg (1999, pp. 152–153) for a parent handout regarding public behavior.

During the didactic session, misbehavior in the car should also be addressed. Common behavior problems while riding in the car include taking off seat belts, kicking the back of the seat, yelling, and opening the car door. Safety permitting, pulling the car over for 3 min can be an effective time-out option. Children dislike the lack of stimulation involved in sitting in a still car. If other children are in the car, the parent can explain that one of the children is in time-out and should be ignored. To prevent boredom and associated behavior problems in the siblings, the parent can talk, sing, and play games with the others until the time-out is over. If the parent is close to home, a warning can be given such as "If you don't keep your feet to yourself, you will go immediately to time-out when we get home."

Homework. Parents are asked to continue daily 5-min CDI sessions. PDI is to be used for all commands given throughout the day, and house rules are to be consistently enforced. There is no public behavior homework assignment this week because parents have not yet been coached in handling behavior in public settings.

Sixth PDI Coaching Session

What to Bring. . .
(1) ECBI
(2) Stopwatch
(3) PCIT Progress Sheet
(4) DPICS – III Coding Sheets
(5) PDI Skills Transcript Sheet
(6) CDI Homework Sheets
(7) PDI Homework Sheets
(8) Sheila Eyberg's Treatment Integrity Checklists/Manual

Therapists begin the session with coding and coaching, and the check-in is postponed until the end of the session. Parents are coded in 5 min of CDI and then coached for an additional 5 min if their skills drop below mastery level. Parents are coded during 5 min of PDI using the following instructions: "OK, now we're going to code PDI for the next 5 min. Tell [child's name] that it is your turn to choose the game. You may choose any activity. Keep him/her playing with you according to your rules." If the PDI skills are not at mastery level, then the parent is coached in a clean-up situation for 5 min.

Public Behavior Coaching. In this session, PDI skills will be directly coached for approximately 30 min in a public setting. The particular public setting selected for the coaching will vary depending on the physical environment and the needs of the individual family. Settings in which public behavior may be coached include the waiting room, the hallways of a public building, a hospital cafeteria, the parking lot where the family's car is parked, a nearby park, fast-food restaurants, department stores, shopping malls, and grocery stores. During these outings, parents are coached to state behavioral expectations and consequences clearly before entering the building or other setting. Parents are coached to tell the child what good behaviors they are looking for (e.g., listening, staying close, using big kid voice) and what good things will happen if the child displays these behaviors (e.g., praise, call grandma, choose a cookie in the bakery area, small toy, drink). Parents are coached to tell the child that if he or she (1) disobeys or (2) breaks a house rule or "shopping rule" (a specific rule for that outing – such as "no begging for a toy," "no hiding under clothes racks," or "no running ahead") the child will receive a timeout. Once inside the public setting, the therapist-coach prompts the parents to use positively stated commands to manage child behavior. Examples of commonly used direct commands in public settings include "Please take my hand," "Please put your hands in your pockets," "Use an inside voice, please," "Please put your hand on the shopping cart," and "Please stay in your seat." Parents may be coached to establish a standing rule for public behavior such as "no taking things off of the shelves." Running away is a common public behavior problem that is both dangerous and

frightening to parents. Common strategies to eliminate this problem include overcorrection (i.e., requiring that the parent and child backtrack several steps then walk together hand-in-hand), strategic praise for staying close to the parent, and giving positively stated incompatible instructions (e.g., "Please stand next to me"). Should the therapist need to coach a time-out, consideration must be given to parental feelings of embarrassment and strategies for handling onlookers who provide attention to the child. Although many parents feel considerable anticipatory anxiety about this session, by the end of the in-vivo coaching most express surprise and pleasure about how few time-outs were needed in public.

Homework. After the outing, the therapist and family return to the playroom for debriefing. They are given homework sheets to record their daily 5 min CDI home sessions and their use of PDI for all commands throughout the day and house rule enforcement. Additionally, three public behavior practice sessions are assigned for the parent to complete before the next session. The parent is encouraged to make the first un-coached public behavior outing as easy as possible by selecting a setting like a walk around the neighborhood or a visit to a friend or family member's home. To maximize the chances of correct parent follow through, any outings made to public places this week should be done with the sole purpose of working on child behavior, rather than accomplishing an errand. It is also wise to consider the timing of the outing so as to avoid peak shopping hours and child nap time. Parents often get discouraged by their false belief that they will have to conduct numerous public time-outs. It is helpful to review with them the learning curve phenomenon. Implementing time-out consistently in easy public behavior exercises teaches children that "time-out can travel." Once the children believe that the parent will indeed use time-out everywhere, the time-out warning becomes just as powerful in public as at home.

Seventh PDI Coaching Session and Beyond

What to Bring. . .
(1) ECBI
(2) Stopwatch
(3) PCIT Progress Sheet
(4) DPICS – III Coding Sheets
(5) PDI Skills Transcript Sheet
(6) CDI Homework Sheets
(7) PDI Homework Sheets
(8) Sheila Eyberg's Treatment Integrity Checklists/Manual

In the seventh PDI coaching session and those that follow, the focus of the session will vary based on the family's remaining concerns. There are three possible reasons that the family has not been able to move on to the graduation session: (1)

PDI and/or CDI skills are not at mastery, (2) skills are at mastery, but the ECBI Intensity score is greater than 114, indicating that there are still remaining problems, or (3) remaining problems are primarily related to the interaction between the target child and siblings. Procedures for sessions seven and beyond will be tailored depending on the family's status with regard to treatment termination criteria (Table 8.3). If families fall into the first category (CDI and/or PDI skills below mastery), skills will be coded using the following instructions: "OK, now we're going to code PDI for the next 5 min. Tell [child's name] that it is your turn to choose the game. You may choose any activity. Keep him/her playing with you according to your rules." The majority of the session is spent in coaching that is specifically directed at deficits. These parents also role-play skills that are not at criterion with the therapist. Attention is given to frequency of home practice as a possible contributor to slow skill acquisition. If families fall into the second category (solid skills but high ECBI score), the session begins with discussion and problem-solving regarding how to apply PCIT skills to remaining problems determined by the ECBI. After approximately 40 min of problem-solving, the therapist codes CDI and PDI and may coach the family in a 5-min clean-up situation. For families who fall in the third category (remaining problems are related to sibling interactions), the family is invited to bring in one of the target child's 2–8-year-old siblings. The therapist coaches the parent to explain the rules of CDI and PDI to the sibling. Then, the therapist coaches the parent while the parent does CDI with both children in the playroom. The parent is coached to use his or her PDI skills to direct the behavior of the children in order to maintain sibling cooperation. Examples of issues that can be addressed when a sibling is present are provided in Table 8.5. For more intensive discussion of sibling concerns, see Chapter 11 of this text.

Table 8.5 Issues to be addressed during sibling sessions

Turn-taking
Sharing
Getting along well with others
Alternatives to tattling
Recognizing positive qualities of siblings
Asking before taking toys
Using polite manners
The "no hurting" rule
Problem-solving
Keeping hands and feet to oneself

Families at the seventh session and beyond are given homework to practice CDI for 5 min each day and continue the use of PDI for running commands, house rules, and public behavior. Additionally, families addressing sibling concerns are asked to have two practice sessions of play with the two children as practiced in the treatment session.

Graduation Session

What to Bring. . .
(1) ECBI
(2) Stopwatch
(3) PCIT Progress Sheet
(4) DPICS – III Coding Sheets
(5) PDI Skills Transcript Sheet
(6) Blue ribbon for child (or other award such as a small stuffed graduation bear)
(7) Graduation certificate for parent
(8) Sheila Eyberg's Treatment Integrity Checklists/Manual

The session begins with CDI and PDI coding to ensure that the family meets criteria for the graduation session. Any additional assessment measures that were given at the time of the intake should be repeated to evaluate treatment outcome (e.g., Child Behavior Checklist). If the ECBI is 114 or above the parents do not achieve criteria on CDI or PDI, the procedures of the seventh PDI coaching session should be repeated. If they meet PCIT mastery criteria (Table 8.3), then they are congratulated on graduating from the PCIT program. Awards may be given to the child (blue ribbon) and parents (certificates of completion).

By the time PCIT is completed, children's behavior is greatly improved and parents are much less stressed. In fact, some parents have difficulty remembering how distressed they were and how much difficulty they had coping with their child's out-of-control behavior at the time of the intake. Thus, major therapeutic goals for the graduation session are to (1) help parents recognize the magnitude of progress made, (2) clearly link this progress to parents' consistent use of CDI and PDI skills, and (3) bolster the parent's sense of competence in dealing with problems that will arise after treatment has concluded. All of these goals help to promote long-term maintenance of parenting skills and improvements in child behavior.

Reviewing Treatment Changes. While the child plays independently nearby, the therapist reviews with parents the initial presenting problems. The therapist then asks the caregivers to summarize their perceptions of the major changes that have been accomplished in PCIT. For each of the improvements noted, parents are prompted by the therapist to identify the reasons why these changes have occurred. Some parents have persistent difficulty associated their child's behavioral improvement with changes in their parenting strategies. For example, when asked to generate possible reasons for a shift from outside normal limits to within normal limits on oppositional defiant behavior at home, a parent may tell the therapist that it could have been the result of (1) changes in the parent's work schedule, (2) a change in baby-sitters, or (3) enrolment in karate lessons. Although we acknowledge that

young children's behavior is multiply determined, it is important that parents not discount the value of treatment. For parents to be sufficiently motivated to continue using their new skills over an extended period of time, they need to make the connection between consistent use of CDI and PDI and corresponding improvements in child adjustment. As an additional method of reinforcing the changes observed by the parent, the therapist reviews pre- to post-treatment changes on the ECBI and the DPICS. Throughout this discussion, parents are encouraged to turn to the child and provide enthusiastic and developmentally appropriate praise for behavioral improvements.

Reinforcing Parental Competence to Solve Future Problems. For PCIT to have a long-lasting impact, parents must acquire the problem-solving skills to apply their new parenting strategies to a variety of problems that may come up as the child continues to develop. As parents progressed through PCIT, they were given increasing responsibility for identifying problems, planning interventions, evaluating the effectiveness of their interventions, and making modifications in the interventions as needed. At this point in the feedback session, parents are asked to identify any remaining concerns, however minor, and to apply their newly acquired knowledge to forming a play for addressing at least one of these concerns. Although the therapist should facilitate this process by asking strategic questions, the goal is for the parent to be the architect of the plan. The therapist should then acknowledge the parent's expertise, expressing confidence in his or her ability to manage new problems as they arise. The following is an example of the way in which the "Socratic method" of asking strategic questions can be used to assist parents in problem-solving:

Therapist:	What concerns do you still have about Johnny's behavior?
Parent:	Well, he does what I ask him to do, but he has started giving me a lot of back talk while he does it.
Therapist:	Boy, I can see why you would be concerned about that. Can you give me an example?
Parent:	Last night, I asked him to put his dish I the sink. He did it, but all the way to the sink he griped about how unfair I was being because his 2-year-old sister didn't have to do it. For 15 min afterward, that's all he would talk about.
Therapist:	What strategies did you try to take care of the problem?
Parent:	I tried to explain to him that his sister isn't big enough to clean up her dishes. He yelled at me, "That's not fair! You're mean to me and not her!"
Therapist:	So you tried to use reasoning. How well did it work for you?
Parent:	Not so great I guess.
Therapist:	What's your best guess about why reasoning didn't work?
Parent:	I think in a way he liked the attention he was getting from me.
Therapist:	Bingo! I think you hit the nail on the head. He probably enjoyed your attention even though it was negative, and he probably continued arguing longer because of it.
Parent:	Well, what do you think I should have done?

Therapist: I think you know. I have confidence in your ability to figure out a very good solution to this problem. I know it's a lot easier to look back and think of solutions when you're not in the middle of a conflict. But I think it can be helpful to think about other ways to handle problems so that they will be easier to deal with the next time they come up. Looking back now, what other ideas do you have?
Parent: Well, I guess I could have just ignored it.
Therapist: That's a good idea. Exactly how could you have ignored?
Parent: I could have just walked away.
Therapist: How would you decide if ignoring worked?
Parent: If he quit arguing it worked.
Therapist: What if he didn't quit arguing?
Parent: I guess I would have to do something else.
Therapist: Is it possible that some good could come from ignoring that you might not be able to recognize right away?
Parent: (thinking) Maybe it would give him the message that I'm not going to pay attention to his arguing anymore so that he will eventually stop arguing with me.
Therapist: You really have a good understanding of how to use ignoring! I remember how hard ignoring was for you when you first started treatment. It's true that when you first begin to ignore a behavior, it gets worse. But if you stick with it over time, the negative attention-seeking behavior will stop. What would you do if he surprised you one night and took his dish away without arguing?
Parent: I would praise him.
Therapist: What exactly would you say?
Parent: Thanks for putting your dish away with a good attitude.
Therapist: Terrific problem-solving. I know you could figure out a good solution.

One pitfall that can cause poor maintenance of treatment effects is parental overuse of time-out. This occurs because parents have found a strong tool that produces rapid change. However, using time-out many times a day for weeks on end will result in inconsistent skill use and problems in the parent-child relationship. Parents need to have a range of tools in their kit, particularly as children continue to develop. A portion of the graduation session is spent discussing alternatives to time-out (see Appendix 12 for "Handling Future Behavior Problems" handout or Eyberg, 1999 "Other Discipline Tools" handout). Examples of the alternatives include praising the opposite of the problem behavior, tactically ignoring the disruptive behavior, distracting the child from the problematic behavior, using overcorrection, and setting up a token system. We use an exercise to demonstrate to parents how to apply these alternatives to new situations. We have parents select problem behaviors one at a time out of a bowl. See Table 8.6 for a sample of problem behaviors that can be used for this exercise. Once the behavior is drawn, the parents' task is to select any of the alternatives to time-out from the handout and describe how they would apply that strategy to address the challenging behavior. For example, if the parent

selected "making artificial fart noises at the dinner table," the parent might describe how to use ignoring and distracting to redirect the behavior. To ensure that parents understand how to use an array of behavioral strategies, ignoring and distracting is then removed from the list of options. Depending on how much time is available in the session, we typically can work through 4–5 problem behaviors, allowing us ample opportunity to praise parents for their expertise in behavior management.

Table 8.6 Sample problem behaviors for alternatives to time-out exercise

Calling sister a "fatso"
Riding tricycle out of the driveway
Opening the car door before the car stops
Interrupting while parent is on the telephone
Bed-wetting
Stealing a tootsie-pop from the convenience store
Screaming at the television while playing video games
Refusing to try new food
Easily irritated when told to do something
Invading parent's personal space (clinging)

Scheduling a Booster Session. Ordinarily, a booster session is scheduled for three months after treatment is concluded. However, this session can be scheduled sooner if the therapist anticipates problems with maintenance. Situations in which an earlier booster session could be warranted include: imminent birth of a new sibling, beginning pharmacotherapy, starting school, caregiver returning to work, going through a divorce, and other major life stressors. Parents are reminded that they can telephone the therapist if problems arise prior to the scheduled booster session.

Conclusion

This concludes Part One: Fundamentals of Parent-Child Interaction Therapy. We hope we have succeeded in providing a practical step-by-step clinical description of how to implement PCIT. To provide the purest version of Dr. Eyberg's PCIT, we recommend that clinicians and researchers adhere as closely as possible to the procedures detailed in Chapters Three through Eight. Additionally, to provide the intervention with the highest treatment integrity, we recommend utilizing the treatment integrity checklists in Dr. Eyberg's (1999) manual available online at www.pcit.org. The treatment outcome studies described in Chapter Two are based on evaluations of unmodified PCIT. In most of these studies, PCIT was conducted according to the standard model, with nothing added, adapted, or omitted. Since PCIT has become widely disseminated, there are many modifications to the protocol that have not been evaluated. Evidence for the effectiveness of modified versions of PCIT is limited. In Part Two of this text, we present new directions for Parent-Child Interaction Therapy. We describe adaptations of PCIT for children outside of the typical age range, for special child populations, for special parent populations, and for integrating PCIT into applied settings. We want to emphasize that for the

most part these modifications of PCIT do not have the strong empirical support of Dr. Eyberg's standard protocol as described in Part One of this text. So, when possible, we advise clinicians and researchers to do the version of PCIT that we know works (i.e., Eyberg, 1999). When doing more experimental versions, it is important not to portray the intervention as equivalent to Dr. Eyberg's evidence-based model. Nevertheless, we are excited about the new therapeutic doors that have been opened by PCIT since we wrote the first edition of this book in 1995. We hope that innovative PCIT researchers and clinicians will approach new horizons in PCIT much like us, with a mixture of starry-eyed enthusiasm and healthy skepticism, always striving to carefully evaluate the effectiveness of new applications.

Reference

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April 2, 2008, from www.pcit.org

Part II
Adaptations of Parent-Child Interaction Therapy

Chapter 9
Younger Children

Increasingly, mental health resources are being targeted toward prevention and early intervention programs. For example, in the United States the Head Start initiative has grown from being a program primarily for 4-year-olds to providing services to high-risk families with children in the 0–3-year-old age range. Additionally, numerous programs are available throughout the UnitedStates and abroad that target the development of parenting skills in pregnant and high-risk adolescent mothers. Some high schools even provide on-site nurseries and parenting classes to teenagers. With the emphasis on teaching positive parenting to parents of infants and toddlers, there has been an increased demand for provision of PCIT services to children from birth to 24 months.

Infants and toddlers may be referred for PCIT through several channels. We have had children referred by home visitation professionals who encountered parents struggling with their aggressive and defiant toddlers. Sometimes pediatricians refer these young children for PCIT when they have exhausted their own resources for offering advice to parents. In addition, it is not unusual in clinical practice to see disruptive behaviors such as throwing tantrums and biting in the younger siblings of children referred for a range of psychological services.

In our experience, many families with aggressive children under the age of 2 have been told to be patient while their children outgrow this challenging phase. Although some children clearly do outgrow early oppositionality, that typically is not the case for toddlers with severe behavior problems. Even for those children who may outgrow their acting-out behavior, their parents are still stressed at the time of referral and need immediate support. If effective strategies are not provided to these parents, many negative outcomes may occur. Without intervention, extremely strong-willed toddlers have a greater likelihood of progressing to more serious behavior problems and parent-child relationships are likely to suffer. This "wait and see" policy is risky in that it also places the stressed family at a higher risk for child maltreatment.

In response to the demand for services with young children, some clinicians have been using a modified version of PCIT with toddlers (aged 12–30 months) who have a history of maltreatment. One of these modified programs is called Parent-Child Attunement Therapy or "PCAT." Dombrowski, Timmer, Blacker, and Urquiza (2005) described the use of PCAT with one 23-month-old child with a

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history of maltreatment and his biological mother. Using standard PCIT measures, the researchers demonstrated that PCIT was effective with this family, improving the relationship between caregiver and child. In this chapter, we describe our own adaptations of PCIT with infants and toddlers, which is similar in many ways to the PCAT approach.

"Meaningful Differences in the Everyday Experience of Young American Children"

Several years ago, Todd Risley sent us a book summarizing a longitudinal study of children's language development (Hart & Risley, 1995). After having read our 1995 PCIT book, he was inspired by the theoretical and practical connections between our research programs. In his book inscription, dated August 1998, the late Todd Risley wrote, "To Cheryl Bodiford McNeil, co-author of *Parent-Child Interaction Therapy* – a masterpiece of brevity, clarity, and usefulness about the right approach to helping parents talk to their children." After having read Hart and Risley's research, we also are inspired by the potential of PCIT to enhance children's language and intellectual development. To understand the connection between PCIT and early cognitive development, we first must describe the benchmark research presented in Hart and Risley's book entitled, "Meaningful Differences in the Everyday Experience of Young American Children."

The research of Hart and Risley began decades ago in response to findings that Head Start failed to raise IQ scores in children from impoverished backgrounds. These researchers sought to understand the discrepancies in children's language development that occurred even before children arrived in Head Start programs. The original study involved 42 families who fell into three categories: professional, working class, and welfare. Researchers went into the homes and recorded family interactions 1 h per month from the time the children spoke their first words until they were about 3 years old. After analyzing 1,318-h-long transcripts, they found that by age 3 there were huge differences in the vocabulary development of children from professional and welfare backgrounds. In fact, the child with the lowest vocabulary development in the professional group had a significantly greater vocabulary than the highest child in the welfare group. As you can see in Fig. 9.1, the discrepancy in vocabulary growth between the groups increased on a monthly basis. At the age of 3 years, children in the professional group had a cumulative vocabulary of about 1,100, as compared to 750 words for the working class families and about 500 words for the welfare families.

After recognizing the striking discrepancies in vocabulary development as early as age 3, the researchers went back to the data to try to understand why the children from impoverished environments had lower language development than those from more advantaged backgrounds. They found the answer by examining the amount and quality of language spoken by the parents to the children. Whereas children of professional families heard about 2,153 words per hour, children of working class

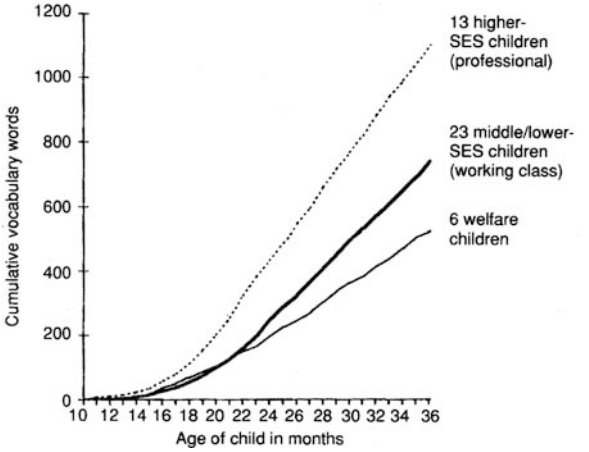

Fig. 9.1 Vocabulary differences from 10 to 36 months (Hart & Risley, 1995, p. 234, Reprinted by permission of Paul H. Brookes Publishing Company)

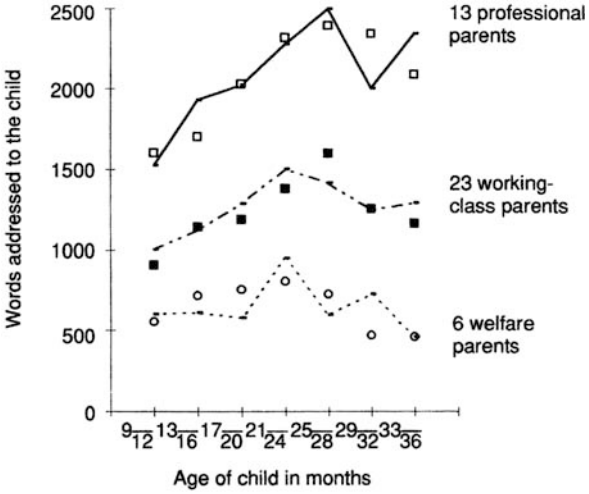

Fig. 9.2 SES differences in number of words spoken to children by parents (Hart & Risley, 1995, p. 239, Reprinted by permission of Paul H. Brookes Publishing Company)

families heard 1,251 words, and the children from welfare backgrounds heard only 616 words per hour (see Fig. 9.2). An analogy that hits home for us in understanding these findings involves how children learn to skate. If one 3-year-old has skated for 2,000 min and another for 600 min, who would we expect to be more competent at skating? When one adds up the words addressed to children over time, the differences are staggering. By the age of 4, children of professionals have heard approximately 50 million words as compared to the children from a welfare background who have heard only 10 million words (see Fig. 9.3). Hart and Risley used similar social learning concepts to explain the monumental differences in vocabulary that occur in advantaged and disadvantaged populations prior to preschool.

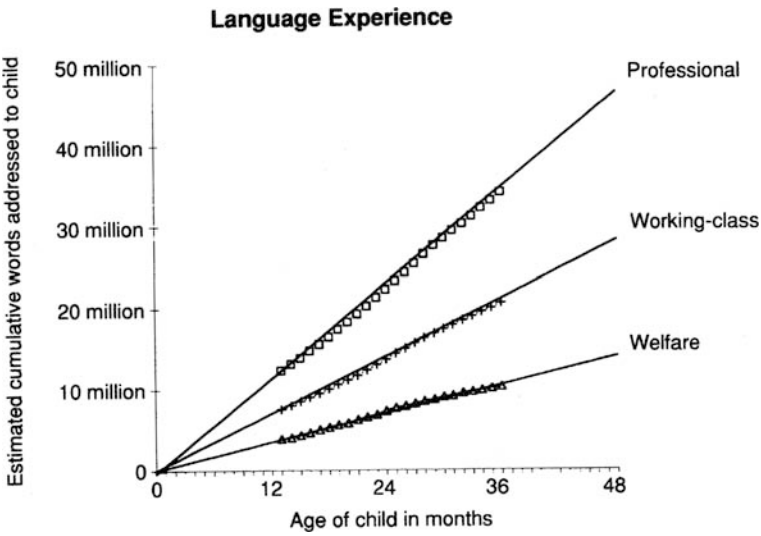

Fig. 9.3 Total words addressed to children in three SES groups by the age of 4 years (Hart & Risley, 1995, p. 252, Reprinted by permission of Paul H. Brookes Publishing Company)

In addition to examining the quantity of words spoken to the children, Hart and Risley took a close look at the quality of the language that the children experienced (see Fig. 9.4). Not only did the impoverished children experience much less language than the other two groups, they also received far more discouragements or prohibitions ("stop. . .," "bad"). The ratio of prohibitions to total talk was seven times higher in the welfare group than in professional families. Additionally, children from a welfare background received far fewer encouragements from parents, including reflections and praise. Thus, the overall language experience of children in the welfare group was one in which they were talked to infrequently. When they were spoken to, it was likely to be a negative or critical statement with only occasional words of encouragement.

After analyzing hundreds of hours of family observations, Hart and Risley identified several key features of positive verbal interaction (see Fig. 9.5). Regardless of group assignment, parents of children with high vocabularies were described as having done the following: (1) "they just talked," (2) "they tried to be nice," (3) "they told children about things," (4) "they gave children choices," and (5) "they listened" (Hart & Risley, 1995, p. 149). The researchers formed a parenting composite based on how often parents displayed these five behaviors with their children, beginning when the children spoke their first words and ending when the children were 3 years old. Then they re-evaluated the children's language development at the age of 9 years. Their findings were remarkable. Hart and Risley found a correlation of 0.77 between the parenting composite score (obtained when the children were toddlers) and the children's IQ test scores at age 3. Interestingly, the correlation between SES and the age 3 IQ test scores was only 0.54, indicating that the parenting

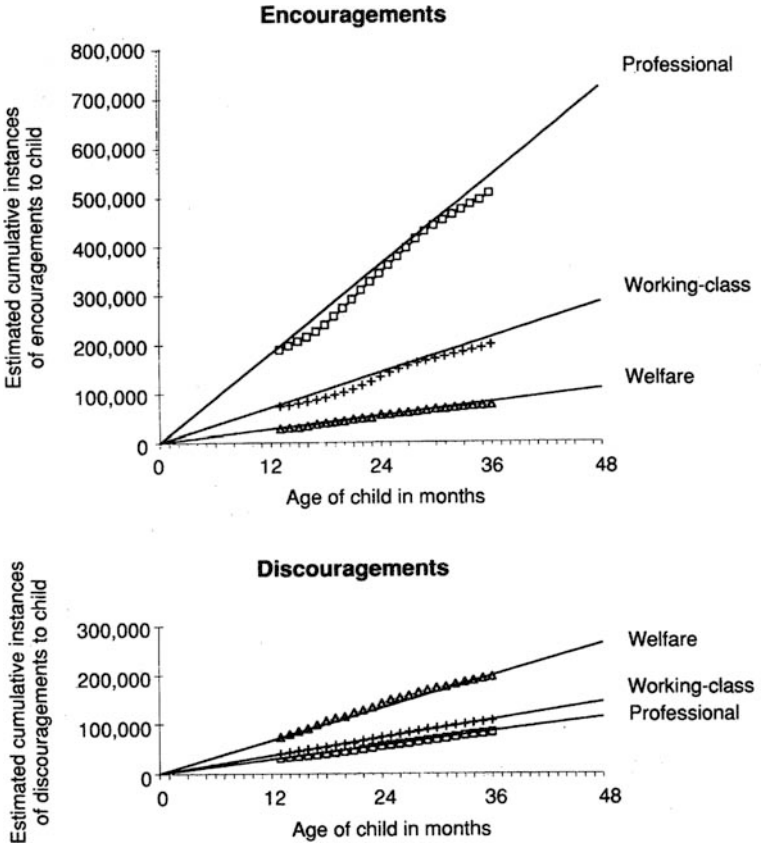

Fig. 9.4 Total number of encouragements and discouragements addressed to children in three SES groups (Hart & Risley, 1995, p. 253, Reprinted by permission of Paul H. Brookes Publishing Company)

composite was more highly related to outcome than was poverty. Similarly, correlations of 0.78 were found between the parenting composite and Peabody Picture Vocabulary Test and Test Of Language Development Scores at age 9 (see Fig. 9.6). These findings are particularly remarkable given that parenting scores collected when these children were babies correlated extremely highly with language outcomes over 6 years later! Whereas SES accounted for only 30% of the variance in children's language development at age 9, the parenting accounted for over 60% of the variance. Interestingly, the child with the highest language ability came from the working class group, and that child also had the highest parenting composite score.

Upon reading our first book, Todd Risley immediately recognized how well the CDI and PDI skills mapped onto the five parenting characteristics that formed the parenting composite. He was impressed by the potential of PCIT for training parents

Impressions of parent behaviors described in examples	Sets of quality features coded in data variables	Categories of significant family experience exemplified in derived variables
They just talked	Vocabulary: all words, all different words (nouns, modifiers, verbs, functors)	Language Diversity: sum of different nouns plus different modifiers used per hour
They tried to be nice	Valence: approvals, repetitions, prohibitions	Feedback Tone: affirmatives (approval plus repetition) divided by affirmatives plus prohibitions per hour
They told children about things	Sentences: clauses, verb tenses (past, present, future)	Symbolic Emphasis: sum of nouns, modifiers, past-tense verbs per hour divided by utterances per hour
They gave children choices	Discourse functions: declaratives, imperatives, interrogatives (wh-questions, yes/no questions, auxiliary-fronted yes/no questions)	Guidance Style: Auxiliary-fronted yes/no questions divided by auxiliary-fronted yes/no questions plus imperatives per hour
They listened	Adjacency conditions: initiations, responses, floorholding	Responsiveness: responses minus initiations divided by responses per hour

Fig. 9.5 Hart and Risley's (1995, p. 149) Positive parenting composite (Reprinted by permission of Paul H. Brookes Publishing Company)

from less advantaged backgrounds to interact with their children in a more stimulating fashion. He saw that PCIT provides a way to operationalize the five parenting characteristics into simple skills that can easily be taught to parents. For the categories of "they just talked" and "they told children about things," we coach parents to talk at a high rate using many descriptions of children's behavior and their environment. For "they tried to be nice," we encourage parents to provide high rates of labeled praise and to interact with enthusiasm. With respect to "they gave children choices," we teach parents to let their children take the lead and to imitate their children's play. For "they listened," we coach parents to reflect almost all of their children's verbalizations. In this respect, PCIT can be viewed as a general model for positive parenting.

Hart and Risley's groundbreaking research has remarkable implications for the potential of PCIT to improve the cognitive development of infants and toddlers.

	Vocabulary growth at age 3		Vocabulary use at age 3		IQ test score at age 3		PPVT score at age 9		TOLD score at age 9	
	All SES[a]	Working class	All SES	Working class	All SES	Working class	All SES	Working class	All SES	Working class
n[b] =	41	22	42	23	42	23	29	19	29	19
SES	.65**	.46	.63**	.31	.54**	.24	.55*	.19	.49*	.15
Parenting[c]	.78**	.74**	.78**	.80**	.77**	.76**	.78**	.82**	.78**	.75**

*$p < .01$ **$p < .001$

[a]All SES = professional, welfare, and working class.

[b]See text for explanation of differences in the number of children included in each analysis. Data for individual children and families are shown in Table 3. The outlier, Child 36, was not included in the analyses of vocabulary growth; see this chapter, endnote 4.

[c]Parenting = all five categories of significant family experience combined.

Fig. 9.6 Correlations between SES, parenting composite, and child outcomes (Hart & Risley, 1995, p. 168, Reprinted by permission of Paul H. Brookes Publishing Company)

In our first book, we presented PCIT primarily as a treatment to address disruptive behavior. Yet in more recent years we have come to appreciate its broader applications. By teaching parents to use PCIT skills from the time of the child's birth, we believe that we not only can prevent many behavioral problems, but also may be able to enhance children's cognitive and language development.

Using Child-Directed Interaction with Infants

The Child-Directed Interaction portion of PCIT may be used to develop strong bonding and communication between parents and infants (0–12 months). From birth, parents need to talk a lot to their babies. While most parents have heard that it is good to talk to babies, many do not understand the purpose. Still others feel silly talking to a baby who cannot answer or comprehend. One way that we work with high-risk mothers is to describe Hart and Risley's research in terms that they can understand. We often draw a graph for them showing the relationship between number of words spoken to children and vocabulary development while explaining to them that their children's ability to talk is based on how much talking they hear. The skating example presented earlier is a nice way to illustrate that practice increases skills.

After explaining the rationale for talking to babies, we teach parents to describe their babies' actions and feelings, their own actions and feelings, and nearly every aspect of the environment. For example, when a baby is eating in a highchair, the parent can say, "You're picking up the apple. Chew, chew, chew. Yummy apple. Oh, now you have the spoon. In the cereal it goes. Oh, you're taking a bite. In your mouth it goes." As the mother is carrying the child up the stairs for a nap, she can describe,

"Up the stairs we go. One, two, three, four steps. Up, up, up we go. Bouncy, bouncy bounce." While playing on the floor with the baby, the parent can say, "You have a book. You're opening the book. I see a cow. Moo, moo says the cow. Oh, I see a chicken. Cluck, cluck, cluck."

With infants, reflection, imitation, and praise are also key to cognitive and social development. At this age, reflection often takes the form of repeating sounds made by the baby. Examples might include repeating sounds like "baba," "coo," and "eee." Later, as the baby begins to approximate words, the parent will reflect back the word with correct pronunciation. So if the baby says, "joo," the parent will reflect the word, "juice." Babies find imitation particularly fun. When an infant hides her face, the father would then cover his face as well. When a baby shakes a rattle, the parent can pick one up and shake it too. There are many opportunities to praise babies. Expressions of love and approval are important at every age. Baby praises include, "I love you thisssss much!", "Look at the pretty baby!", "Good eating!", "I like your smile!", and "Hooray! (clap, clap, clap)". PRIDE skills engage babies at their level of development and involve activities that already hold their interest. When descriptions, reflections, imitation, and praise are provided with enthusiasm, they lead to smiles and laughter which strengthen the parent-child bond.

One CDI skill that is seldom appropriate for use with infants is ignoring. Secure attachments develop over the first several months of life as a result of babies "feeling felt." This process occurs when parents consistently recognize and respond to their babies' needs, returning distressed infants to a state of calm. To ignore a young baby's cries can undermine the development of a secure attachment. Instead of ignoring distressed babies, parents are coached to read their babies' needs and respond appropriately. At times this may involve taking care of the baby's basic physical needs such as feeding, burping, diapering, and providing a pacifier. Other times, babies need to be soothed by holding them securely, rocking, reducing stimulation, and patting their backs. Parents of difficult babies often describe screaming fits in which the baby arches her back and seems inconsolable. We recommend that these parents consult a physician about the possibility of a medical basis for the baby's distress. When medical causes have been ruled out, we coach parents to use distraction to interrupt the episode. For example, parents might be told to bring a crying baby to another room or outside. Sometimes a change of scenery or temperature can distract the child and calm her. Or a parent could be coached to bring out new toys, provide a snack, describe interesting sights with enthusiasm, take the baby on a drive, or place the baby's car seat on top of the warm, vibrating dryer. Once the baby calms, the parent can return to use of the PRIDE skills.

Adapting Child-Directed Interaction and Parent-Directed Interaction for Toddlers

The Child-Directed Interaction phase of PCIT can be conducted with toddlers aged 12–24 months with only a few minor modifications. Parents still play on the floor

with their children using age-appropriate toys. Again the overriding rule is to allow the child to lead the play, avoiding questions, commands, and criticism. All of the PRIDE skills, including ignoring of negative attention-seeking behaviors, are appropriate to use with this age range. Yet, with these very young children who are just developing their receptive language skills, we encourage parents to exaggerate their facial expressions and voice intonations. For example, when praising toddlers, parents may need to put on giant grins and enthusiastically say "good sitting!" We also encourage parents to include a great deal of affectionate touch paired with verbal praise. These touches can include hugs, kisses, high fives, tickles, clapping, and raspberries on the cheek. Without parents' exaggerated expression and gestures, the toddler may miss the positive message.

Another way to help toddlers understand the verbal messages of CDI is to shorten the sentences. Instead of "I like the way you are putting the blocks in the bucket," the parent could say, "Good cleaning!" Other labeled praises could include, "Great talking!", "Nice eating!", "I like hugs!", and "Good job walking!" With older children our imitation and reflections often extend or elaborate on their play and conversation. For example, if a 5-year-old child is driving a train and saying, "into the tunnel," the parent would be encouraged to reflect by paraphrasing, "Your engine is driving into a dark tunnel." The parent might be coached to imitate by driving another train around the track. However, we find that toddlers prefer and learn more from exact imitation and reflection. Therefore, the toddler's parent would be coached to also drive their train into the tunnel right behind the child's and to reflect the exact words, "into the tunnel!"

Parent-Directed Interaction offers many helpful strategies to parents of toddlers. Teaching effective commands helps maximize early acquisition of compliance skills.

As with praise in the CDI portion of PCIT, commands need to be shortened, simplified, and accompanied by gestures. For example, if a parent wants the toddler to come, we would coach the parent to say, "Come here, Danny," while holding out arms and beckoning. When the floor is covered with blocks and it is time to clean up, we coach parents to give many small, specific commands, such as, "Put this block in" or "Block in." While giving a command, the parent is coached to model picking a block up and placing it in the bucket. Then, the parent is told to put the block back on the floor for the child to put away. Subsequent commands are then paired with gestures like pointing from the block to the bucket to help toddlers understand what is expected of them. After each small, simple command, the parent is coached to determine whether the child complied and to provide a labeled praise for compliance. As in the CDI portion, labeled praises should be short, enthusiastic, and often accompanied by an affectionate touch.

When non-compliance occurs, we recommend a different PDI procedure than that used for children 2–7 years. The consequences in PDI need to be adapted for the toddler's developmental level. Standard PDI assumes that children have the capacity to understand the "if–then" basis for the command, warning, timeout, and compliance sequence. This usually occurs around 24–30 months of age. In adapting PCIT to younger children, we need to be sensitive to the child's developmental level. Most

18-month-olds would not understand "if you don't put the block in the bucket you're going to have to sit on the chair." We also need to be sensitive to the fact that toddlers are just learning to comply with directions. Our approach needs to be more educative and less punitive in this early stage of learning. Therefore, we do not recommend using time-out for *non-compliance* with toddlers less than 24 months. Due to wide variability in normal child development, we recommend that clinicians decide on a case-by-case basis whether a child in the 2–3-year-old range has the developmental capacity to benefit from standard PDI.

In our modified PDI procedure, we coach parents to give a command two times before moving to a hand-over-hand prompt. So, when a toddler does not comply with the first command, the parent is coached to repeat the command once using exactly the same words and neutral affect. If the toddler complies, an enthusiastic praise is provided. If the toddler does not comply, we encourage parents to use a hand-over-hand prompting method. To extend our earlier example, consider Danny who has been told, "Put block in." When he does not comply, the mother is coached to calmly repeat the command saying, "Put block in," while pointing to the block and bucket. When Danny still does not comply, the mother is told to place her hand on top of Danny's and guide his hand to pick up the block and drop it in the bucket saying, "I'll help you." After this assisted compliance, Danny's mother is coached to enthusiastically praise him for complying. She might say something like, "Good job putting the block in!" The purpose of saying "I'll help you" when doing hand-over-hand prompting is to emphasize that this is a teaching procedure rather than a punishment.

In standard PDI, compliance training is followed by the establishment of standing house rules. In our modified toddler version, house rules are usually not needed. Most incidents of toddler aggression are simply corrected with a firm, "No hitting," followed by redirection to a more constructive activity. An exception would be for the toddler who displays serious and repeated aggression such as biting that does not respond to verbal correction. Severe physical aggression can present a significant safety concern for the child, siblings, and peers and must be corrected quickly and effectively. We recommend that parents use a brief time-out for aggressive behavior. The time-out can be done in a playpen, an area with a baby gate, or a high chair. The parent is coached to firmly say "No biting" and to immediately pick the child up from behind, underneath the armpits, and quickly place the toddler in the time-out area. No extra words, touches, or other attention should be given. The time-out should last 1 min, which is long enough to interrupt the aggressive act, yet short enough that toddlers will associate the time-out with the problematic behavior.

One of the most frequently reported concerns in toddlers is temper tantrums. In this age range, tantrums are a normal developmental response to fatigue, hunger, and illness. It is not an appropriate goal to eliminate all tantrums. However, we do teach parents to decrease the likelihood of tantrums by being sensitive to their children's physical needs. For example, when a toddler is late going down for a nap, we counsel parents to lessen demands and increase nurturing behaviors. Other tantrums are developmental responses to frustration and limit setting. A developmental issue

that contributes to these tantrums is that toddlers often do not have sufficient language development to quickly find the words to communicate their needs. We often see tantrums when an early speaker does not get what he wants or becomes frustrated by his inability to make something happen (e.g., get out of the car seat) or solve a problem (e.g., make a toy work). We coach parents to attempt to head off tantrums by recognizing early signs, prompting children to use their words, and attempting to meet the child's need before escalation occurs. For example, suppose that Patrick, a 20-month-old, is trying to feed himself with a spoon and keeps dropping the rice on his plate. He whines, scowls, and hits the high chair tray with his fist. We might coach his mother to respond, "Say please help me." If he complies, his mother would be coached to praise him for using his words. If he does not comply, Patrick's behavior likely will escalate into a tantrum. Once a tantrum begins, parents are coached to monitor the child (surreptitiously) to ensure his safety while offering no verbal or non-verbal attention. Parent then can use distraction by enthusiastically describing their own activities or something they see in the environment, as though they are talking to themselves. To illustrate, while Patrick is screaming in the highchair, his mother could turn on music and start singing and dancing. As soon as Patrick becomes distracted and calms, the mother would return her attention to him and offer to assist with the rice.

In addition to non-compliance, aggression, and temper tantrums, toddlers present with many common developmental challenges that have to be addressed throughout PCIT. Typical developmental issues include toilet training, transitioning from the crib to the toddler bed, getting the child to sleep well, weaning off the bottle and pacifier, and eating a variety of healthy foods. For defiant toddlers, it is often necessary to first reduce non-compliance and throwing tantrums before addressing these developmental challenges. In this way, children are best prepared to cooperate with strategies parents employ. It is beyond the scope of this chapter to review clinical interventions for toileting, sleep, and feeding problems. For more information on these topics, we refer the interested reader to Lyman and Hembree-Kigin's (1994) book, "Mental Health Interventions with Preschool Children."

Case Illustration

Background Information. Sherry and Darnell are the unmarried, 18-year-old parents of Jarod, who is 18 months old. They have lived together with Jarod in an apartment for approximately 4 months. Prior to that time, both Sherry and Darnell lived separately with their parents. Sherry was enrolled in a state-wide, federally funded grant project to assist teenage mothers. From early in her pregnancy, she received home visits from a nursing assistant who provided information regarding nutrition during pregnancy, child birth options, and the advantages of breast feeding. After Jarod was born, the focus shifted to education regarding basic infant care such as preparation of formula, diapering, bathing, and recognizing signs of illness. After Sherry and Darnell moved in together, the nursing assistant recognized signs of language

delay and separation anxiety in Jarod, as well as parenting deficits and increasing parental stress. At 18 months, Jarod had spoken only three single words. The nursing assistant referred the family to a PCIT home-based counselor.

Baseline Observation. DPICS observations were conducted in the home with each parent. Sherry and Darnell demonstrated very similar parenting styles during the three structured situations. In CDI, the parents tended to passively watch Jarod play, while occasionally asking questions that he did not answer. No praise, reflection, imitation, or behavioral descriptions were used by either parent during the first 5-min situation. In PDI, they continued to allow Jarod to play on his own, providing occasional commands with which he did not comply or understand (e.g., "Could you put the giraffe over here behind the fence?"). In the clean-up situation, Sherry relied heavily on lengthy, indirect commands like, "Show Mommy what a good boy you are and clean up all of the toys, OK?" After a few minutes, she seemed to give up and just put the toys away herself. Darnell was equally ineffective in getting Jarod to clean up. Darnell gave few commands, laughed nervously, and commented, "He's too little to clean up, isn't he?" Across the three situations, Jarod's rate of compliance was only 12%. The nursing assistant who referred the family expressed concern about Jarod's clinginess to Sherry and his distress when she left him with his father. To assess the separation distress, another observation was conducted in which Sherry was asked to hand Jarod to Darnell and then leave the room. Jarod responded by crying, reaching toward his mother, and kicking his feet. Darnell held Jarod and talked to him saying, "It's OK, your mother is just going to be gone for a few minutes, then she will come back and see you little dude." Jarod did not calm and Darnell put him down on the floor saying to the observer, "Hey, what am I going to do, man? He just wants his mama. It's always like this at home. I don't think he likes me."

Parental Interview. Both Sherry and Darnell commented that their baby was not talking as much as their parents said they talked at this age. Neither of them had been around toddlers very much and they were unsure whether they should be concerned about his language. Sherry reported that she felt overwhelmed by the demands of mothering Jarod. She complained that he clings to her, does not want to go to his father, and will not just sit and play on his own. Darnell repeated to the counselor that he would like to help more with Jarod, but that Jarod wants only his mother. He said he felt it was unfair for Sherry to criticize him because he was doing the best anyone could do.

Child-Directed Interaction. In CDI, Sherry and Darnell were presented with information regarding the association between children's language learning and their exposure to a language-rich environment. They were taught didactically and through coaching to implement the PRIDE skills with Jarod. They were directed to have several sit down playtimes with Jarod each day in which they focused on using their newly acquired parent-child communication skills. In addition, they were encouraged to use their PRIDE skills throughout the day, every day, to provide the most stimulating environment and to enhance their bonding. In sessions four and five, Darnell was coached to use his PRIDE skills during times when Jarod needed to separate from Sherry. After Sherry was asked to leave the room, Darnell was

coached to become very enthusiastic, speak at a high rate, and describe exciting play activities. While Jarod did initially cry during the coaching, it only took a minute or two for him to become distracted and join his father in play.

After six home visits, the change in parent–toddler interactions was remarkable. Sherry displayed the strongest CDI skills, reaching mastery after only three sessions. Although the skills did not come easily for Darnell, he did reach mastery by session six. Darnell's behavioral descriptions increased from 0 to 13, he reflected all of Jarod's sounds, and he provided 11 labeled praises. Darnell reported with pride that Jarod loves his special playtime and comes running to him when he returns home at the end of the day. Sherry said that they now have fun family times in which the two of them play on the floor with Jarod. They both noted that Jarod had learned to say many new words and seemed eager to talk. Darnell reported feeling confident in his use of CDI skills to reduce Jarod's separation anxiety. Sherry expressed relief that she was able to get a break to go shopping without worrying about Jarod and Darnell. However, both parents agreed that they still had a difficult time getting Jarod to follow directions and that they wished he would have fewer temper tantrums.

Parent-Directed Interaction. During a 1-h didactic session, Sherry and Darnell were taught the rules of effective commands. The rules that were most challenging for them were making the commands direct (i.e., telling rather than asking) and simplifying the instructions. The parents were taught to praise Jarod when he followed instructions. For non-compliance, they were taught to repeat the command, and if he still did not comply, they were told to use the hand-over-hand prompting procedure. The didactic session ended with various role-plays of the PDI procedures.

During the first coaching session, nearly every command required a hand-over-hand prompt to get compliance from Jarod. Sherry and Darnell both needed frequent reminders to make their commands direct and short. The counselor needed to do a great deal of modeling and active coaching to help the parents issue more effective, developmentally appropriate commands. In the second session, Jarod required physical guidance for the first three commands, but began to comply without assistance early in the coaching session. Darnell and Sherry were very excited when Jarod complied on his own and provided genuine and enthusiastic praise. Jarod enjoyed all the attention and seemed increasingly eager to comply with instructions as the session progressed.

The next two sessions required only minimal counselor coaching, as the parents became increasingly confident and competent. On coding, Darnell reached mastery in the fourth PDI session, whereas Sherry reached mastery in the fifth. In sessions three and four, Jarod's rates of compliance were 65 and 75%, respectively. At the end of session four, Jarod seemed cranky and required two hand-over-hand prompts in a row. Sherry commented, "I wonder if he's feeling tired because I had to cut short his nap to get to the grocery store." The counselor reminded Sherry and Darnell that children of this age often show fatigue through fussy behavior and that the developmentally sensitive response is to decrease demands and increase nurturance. The counselor and parents agreed that it would be best to wind down the session with

CDI only and continue with compliance training the following week. In the fifth and sixth PDI sessions, all PDI mastery criteria were satisfied. The parents demonstrated the use of effective commands and praise for compliance, while Jarod's compliance rate remained high. In the sixth session, post-treatment DPICS observations confirmed the mastery of both CDI and PDI skills.

At the time of Jarod's treatment, we suspected that PCIT increased his rate of talking and vocabulary, as indicated by anecdotal reports by the parents and behavioral observations in sessions. However, we had only indirect ways of evaluating his language development (e.g., Peabody Picture Vocabulary Test). We recently have become intrigued by a program called LENA (Languages ENvironment Analysis: www.lenababy.com/Research.aspx). LENA is a published electronic apparatus that captures the number of words that a parent and child speak to each other, as well as conversational turn-taking (i.e., times when a parent speaks to the child and the child responds or vice versa). The system is based on Hart and Risley's (1995) research demonstrating that the quantity of talk experienced by a child is directly related to language and IQ outcomes. Marketers of LENA suggest that parents strive to speak 30,000 words per day to their children to optimize language development. With this program, parents are given a small audio processor that is placed inside the child's clothing. After one day, the parent (or clinician or researcher) can plug LENA into a PC to compare the number of words spoken to the child throughout the day to LENA norms from other parents. Additionally, a particular family could be assessed before and after PCIT and receive feedback on changes. For researchers and clinicians conducting PCIT as a prevention approach, the LENA system may provide a helpful way to monitor the quantity of parental and child verbalizations outside of clinic sessions.

Parent-Child Interaction Therapy and Prevention

With each PCIT case, like Jarod's family, we find ourselves wondering about how outcomes might be different if all parents had access to PCIT training *before* problems arose. As parents ourselves, we feel blessed to have had the good fortune to learn PCIT from Sheila Eyberg before starting our own families. From the time our oldest children were born, we have used PCIT skills to communicate and bond with them. PCIT has provided us with a compass for navigating the myriad of parenting crossroads that we encounter everyday. Although we make plenty of mistakes, we generally recognize them and can right our course with PCIT principles. We wish all parents had access to PCIT to assist them in the countless, quick decisions that have to be made in the course of parenting.

Imagine with us how Sherry and Darnell's parenting experience would have been different if they were required to master PCIT skills in high school. From the time of Jarod's birth, both parents would have provided him with a language-rich environment full of descriptions, reflections, and praise. His sense of security would have been strengthened through the consistent and responsive parenting provided

by both his mother and his father. Instead of spending his early development in a home fraught with stress and parenting confusion, Jarod could have thrived in a loving, nurturing, consistent environment. Sherry and Darnell would have "talked" to Jarod, would have "tried to be nice" to him, would have "told him about things," would have "given him choices," and would have "listened" to Jarod. Hart and Risley's research clearly tells us that Jarod's language and cognitive development would have been enhanced by a more stimulating environment, despite his family's economic disadvantage. Again, imagine with us the potential for PCIT to erase the gap in development between children in Hart and Risley's welfare, working class, and professional groups. We think all children deserve the chance to get the best possible start in life, and as Hart and Risley have so eloquently shown us, early parenting makes all the difference.

References

Dombrowski, S. C., Timmer, S. G., Blacker, D. M., & Urquiza, A. J. (2005). A positive behavioural intervention for toddlers: Parent-child attunement therapy. *Child Abuse Review*, *14*(2), 132–151.

Hart, B., & Risley, R. T. (1995). *Meaningful differences in the everyday experience of young American children*. Baltimore: Paul H. Brookes.

Lyman, R.D., & Hembree-Kigin, T. L. (1994). *Mental health interventions with preschool children*. New York: Kluwer.

Chapter 10
Older Children

Standard PCIT was developed and validated with children between the ages of 2 and 6 years. In this chapter, we present adaptations for PCIT that make it suitable for use with older children, aged 7–10. We encourage PCIT therapists to use their clinical judgment in determining the degree of adaptation necessary for 7-year-olds. Some smaller and less mature 7-year-olds can benefit from PCIT in its standard form. These children are still small enough to be carried to a time-out chair and find Child-Directed Interaction (CDI) enjoyable. Other 7-year-olds might be too large and aggressive to safely use hands-on strategies for discipline. Still others are too cognitively sophisticated for the communication skills of CDI that are geared toward preschoolers. In this chapter, we illustrate how to conduct PCIT in a developmentally sensitive way with this older population.

In the last 10 years, PCIT programs have become more widely available. The effectiveness of these programs with younger children has generated interest in the potential for PCIT to help older children with behavior problems. Currently, there is a paucity of evidence-based programs for treating disruptive behavior problems in elementary school-aged children. Since most of these families have long-standing parent-child relationship problems, it seems like a logical next step in service delivery to adapt CDI to bring these parents and children closer together. The literature clearly shows that if parents are not able to intervene with their children's early behavior problems, the children are likely to progress to more serious conduct-disordered behaviors in their teenage years (e.g., Farrington, 1995; Lahey et al., 1995). We believe that the Parent-Directed Interaction (PDI) portion of PCIT holds a lot of promise for assisting these parents in gaining more behavioral control over their defiant school-aged children.

Developmental Issues

There are several elements of PCIT that are not developmentally appropriate for older children. In CDI with younger children, parents are coached to provide a high rate of verbalization that older children find intrusive. The constant talking that helps younger children stay focused actually interrupts the attention and concentration of older children. Additionally, most older children have outgrown their interest in

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playing with many of the toys and activities recommended in CDI (e.g., blocks, crayons). Because older children have longer attention spans and enjoy more complex activities, the 5-min play session typically does not provide adequate time for a relaxed, warm interaction. PDI with younger children is very hands-on, with parents coached to carry resistant children to time-out. For the safety of our older children and their parents, we must employ less physical and confrontational strategies.

University of Oklahoma Health Sciences Center Adaptations for Older Children

In response to the demand for PCIT with these older children, a number of clinics have begun to offer adapted versions of the program. Yet, research regarding the efficacy of PCIT in this adapted form is largely unavailable. One notable exception is the work of Chaffin et al. (2004) at the University of Oklahoma Health Sciences Center.

These researchers conducted a randomized control trial of 110 physically abusive parents and their children up to the age of 12. Unlike most studies of PCIT, the children did not have to have significant behavioral concerns to be included in the research. The researchers were evaluating the potential of PCIT to prevent recidivism in abusive parents.

For the purposes of this chapter, we examine the Chaffin et al. (2004) study and the associated clinical procedures because they include several interesting recommendations for adapting PCIT to older children. First, recognizing the need to decrease the overall rate of parent verbalizations in CDI, these researchers recommended using modified mastery criteria. They specifically suggested reducing the number of behavioral descriptions, reflections, and labeled praises required. Second, to insure the over-learning of CDI skills, they did therapist–parent drills during sessions. These drills involved having parents reflect everything that the therapist said, as well as describing and praising the therapist's play at the high rate expected in CDI with younger children. Yet, when they coached the parent-child interactions, these researchers encouraged parents to use the CDI skills at a lower rate to make the playtime more enjoyable and relaxed for older children. Third, this research group recommended use of more developmentally appropriate toys for older children such as putting together models, painting fingernails, and making jewelry. And fourth, they recommended using hands-off discipline techniques such as restriction of privileges for enhancing compliance.

Concerns Raised by the SAMHSA Study Regarding PCIT with Older Children

The work conducted by the Oklahoma Health Sciences research group has provided valuable insights into how to adjust PCIT to be more developmentally appropriate for older children. These ideas dovetail with our own clinical observations and

adaptations in using PCIT with our school-age referrals. In addition to our clinical experience we have learned a great deal from two PCIT effectiveness studies nearing completion (Franco, Soler, & McBride, 2005) This project funded by the Substance Abuse and Mental Health Services Administration involved two randomized controlled trials, one in Kentucky and one in Oregon. Approximately 200 children aged 5–10 years who were referred to community or school mental health clinics with a diagnosis of ADHD, ODD, or Conduct Disorder were randomly assigned to either Systems-of-Care (treatment as usual) or Systems-of-Care plus PCIT. In developing the treatment integrity manuals for the study, no age-related modifications were made to the CDI protocol. During supervision with the therapists, major concerns arose regarding the appropriateness of standard CDI for the older children, particularly the 8–10-year-olds. Some children did not want to do daily CDI with their parents because they did not enjoy the traditional CDI activities. They told their parents that they would rather keep playing video or computer games or watch TV than play with toys and draw with their parents. Therapists reported that many of the older children did not like the effusiveness of praise, the intrusiveness of the parents' constant talking, and the condescending tone of concrete reflections. Some older children responded by rolling their eyes, telling the parents to "shut up," sarcastically mocking parents' praise in a sing-song voice, covering their ears, or turning away. Rather than bringing these parents and children closer together, CDI sometimes became an annoying task for both the parent and child. Another issue raised by the therapists was that the older children often responded to the therapist in an antagonistic, hostile fashion. It appeared that the children viewed the therapist and parents as "ganging up" on them. Therapists had a harder time maintaining a positive relationship with these older children.

In the SAMHSA treatment effectiveness study, adaptations were made to the PDI portion of PCIT to make it more appropriate for children as old as 10. The first change involved adding a session in which parents were coached in effective command giving prior to the time-out teaching session. Recognizing that it is not uncommon for younger children to become aggressive in the first time-out coaching session, we wished to minimize this in older children because of safety concerns. We felt that older children would be less likely to become aggressive in the first time-out coaching session if they had a prior successful experience with compliance training. Therefore, after a didactic session in which parents were taught to give effective instructions, the family was coached to give commands and praise compliance. When non-compliance occurred, the parents were coached to provide a "big ignore" by turning away for 45 s. In addition, parents were instructed to use effective commands and to praise compliance at home during the 2 weeks preceding the time-out coaching session. In this way, we felt that older children would enter the first time-out coaching session with a higher rate of compliance and positive expectations. The second change made to the standard PDI protocol for the SAMHSA project was use of a hands-off time-out procedure. Rather than carrying the resistant child to time-out, parents of older children were instructed to use a warning followed by restriction of a privilege.

By trying both standard and adapted PDI procedures with older children in the SAMHSA study and in our practices, we have identified several age-related concerns. First, older children are more independent than younger children, and do not require the same high rate of command giving to accomplish tasks of daily living. In our experience, younger children quickly begin to enjoy pleasing their parents in PDI sessions by complying with the rapid-fire pace of at least one command per minute. But, older children find the frequent commands to be irritating and artificial. Second, older children are more capable of complying readily with complex and multi-step commands because of longer attention spans. The simplified nature of typical PDI commands, such as "Put the red crayon in the box," seems condescending to older children. Third, we have noticed that older children are puzzled and sometimes offended by the arbitrary nature of "play" commands. For example, they may have a hard time accepting that it is okay for their parents to dictate what colors they should include in their pictures. Or, they find it irritating and manipulative when their parents interrupt their creative play to require them to put a block in a particular spot for no apparent purpose. Fourth, we have also found that the older children are good at detecting praise that is not genuine. Repetitive labeled praises for compliance can come across as mechanical and disingenuous to more sophisticated children. When these children detect that praises are being provided in a robotic and forced way, the praise loses its reinforcing value. And, for some children, the frequent praises for listening and helping actually become aversive, such that they begin to ignore and/or mock the parents' kind words. Finally, as mentioned earlier, older children are bigger and stronger. Therefore, the physical confrontations that are used when younger children do not cooperate with time-out are more dangerous when used with older children.

Adapting CDI to Older Children

The rationales for devoting time to a daily child-directed play session are the same with older and younger children (e.g., improving the parent-child relationship, enhancing self-esteem). Additionally, parents of older children are taught the same Do (PRIDE) and Avoid (question, command, criticism) skills as well as the use of ignoring for negative attention-seeking behaviors. Parents also are encouraged to do CDI at home on a daily basis. However, there are several important adaptations that make CDI more developmentally appropriate for older children.

Reducing the Frequency of PRIDE Skills. To conduct CDI in a developmentally sensitive way with older children, we have to decrease the overall frequency of parent talk. We recommend a different set of mastery criteria that allows for more silences and mental processing. We reduced the standard CDI mastery criteria of 10 labeled praises, 10 reflections, and 10 behavioral descriptions to 7 in each category (see Table 10.1). For the avoid skills, we continue to require parents of older children to display three or fewer questions plus commands plus criticism. By lessening the overall rate of parent talk in this adapted CDI, we feel that the parent-child interactions appear more reciprocal and relaxed.

Table 10.1 Mastery criteria for CDI with older children

Skill	Mastery
Praise (Labeled plus unlabeled)	7 (at least 4 labeled)
Reflection	7
Description (Behavioral plus information)	7 (at least 4 behavioral)
Commands + Questions + Criticism	3 or less

Adapting Each of the PRIDE Skills. Although we continue to teach all of the PRIDE skills, we do make adaptations to make them more appropriate for use with our older children. We continue to teach parents to praise their children's positive behaviors. However, we have reduced the number of required labeled praises (at least four) while accepting unlabeled praises as counting toward the mastery criterion. We have given more importance to unlabeled praise with older children because we feel that they have enough sophistication to recognize what behavior is being praised without having to spell it out for them. In our work with older children we have found them to be more accepting of a combination of labeled and unlabeled praise because they do not feel that we are talking down to them. In addition, we encourage parents to express approval using such non-verbal praises as: a gentle pat, thumbs up, a quick celebratory dance, bumping knuckles with the child, or a wink of the eye. By combining labeled, unlabeled, and non-verbal praise, the older child experiences a rich variety of approval messages that seem more genuine and interesting.

Even with the adaptations described above, it is common for older children to reject parental praise. For example, consider the parent who praises her 10-year-old son for being a good artist. He may very well dismiss her praise, saying "I am not." Many parents and therapists feel that they should avoid praising these children because it seems to make them uncomfortable. For these parents we explain:

> Imagine that you wore a new outfit to work and your co-worker said, "Hey, you look great in that new jacket!" You may very well reply, "No I don't. You're just trying to make me feel good." But, just a minute later when you're walking down the hallway, you think to yourself, "Yeah, I do look good today." So even though you outwardly dismissed the praise, it still worked. You still ended up feeling better about yourself. When you praise your child, he may act like he disagrees, when on the inside he still reaps the rewards. So even though he almost punishes you for praising him, it is important that you keep doing it.

With reflection, we teach parents to use more summarizing and paraphrasing rather than directly repeating the child's statements. For example, if the older child says, "I'm making a bridge," and the parent reflects with, "You're building a bridge," the child is likely to respond sarcastically with comments like, "Duhhhh," and "I just said that!" We tell parents to paraphrase "I'm making a bridge," with a comment like, "Your bridge will make it so that the knights can get across the moat." Another way to make reflection more developmentally appropriate is for the parent to allow the child to make several comments and then to summarize their meaning. Here is an illustration:

Molly: I'm thinking about making two matching friendship bracelets. I could give one to Andrea. But, I'm not sure if I have enough purple. Maybe they don't need to match exactly.

Mom: Yeah, sometimes friendship bracelets match. But, you're thinking ahead and making a plan in case there aren't enough beads for that.

With standard reflection, each of Molly's statements would have been repeated. The "ping-pong" reflections would probably have interfered with her flow of thought and disrupted her problem-solving. We think of reflection with older children as a form of active listening and teach parents to use non-verbal signs of interest (e.g., leaning in, making eye contact, nodding) to accompany their verbal reflections.

Parents of older children also are encouraged to avoid direct imitation in favor of engagement in a similar activity. In other words, we teach parents to show interest and approval of the child's activities by joining in. However, we ask them to avoid directly copying or mimicking what the child is doing. For example, if Molly was doing a red, blue, purple bead pattern in her friendship bracelet and the parent copied the same pattern, Molly might find it patronizing or annoying because she knows that the parent could come up with her own good ideas. Molly would enjoy the imitation more if the parent came up with her own bead pattern. This makes the play more spontaneous and interesting for more mature children. Although we want parents to display some creativity when imitating, we do not advocate that they "out do" their child by showing much greater mastery. It would be counterproductive for self-esteem enhancement to have parents creating masterpieces next to their children's age-appropriate crafts. Our general recommendation is that parents participate in the same activity as the child, showing approval and interest by making similar, but not exact, products.

We teach parents to add complexity and variety to their running commentary by using both behavioral and informational descriptions. In this way, they can alternate between describing the child's play and their own thoughts and activities. The interaction can feel somewhat unidimensional and boring when the parent only describes what the child's hands are doing. Older children appreciate hearing about the parent's problem-solving, opinions, and interests during play. Younger children enjoy the intense focus associated with high-frequency behavioral descriptions in CDI. But the older child, who is less egocentric, can feel uncomfortable having every tiny behavior described, and may perceive the parent as overbearing and intrusive. By alternating behavioral and informational descriptions, the parent can give attention to the child's activities in a reciprocal, non-intrusive fashion. Here's an example of standard CDI with a strong focus on behavioral descriptions versus the older child's adapted version of describing:

Dad Using Behavioral Descriptions: "You're sorting the Legos into piles. You put the yellow ones together. You put the big blue ones over here. You're putting all of the heads together. Now, you are putting all the bodies together."

Dad Alternating Between Behavioral and Informational Descriptions: "You're sorting the Legos into piles. I'll help you look for yellow ones. You put the big blue ones over here. The blue ones are my favorite. You're putting all of the heads together. I think I might need one of those heads in a minute.

The descriptions in the second example are less mechanical and more interesting for the older child who appreciates more variety in the interaction.

While we do want parents to play with their older children in an enthusiastic way, we ask them to avoid coming across as effusive and fake. Younger children will believe that highly animated parents are really that excited about their play. But, older children are better at reading the feelings of others and can discern when a parent's enthusiasm is not genuine. Rather than using an overly playful and sing-song voice, we encourage parents to show enthusiasm with more subtle changes in inflection. As long as the parent is having fun and displaying genuine emotion, the older child will enjoy the interaction.

Using More Developmentally Appropriate Activities. To do effective CDI with older children, parents must select toys and activities that interest school-age children. Toys like Mr. Potato Head, Barbies, farm sets, kitchens, and coloring with crayons are unlikely to engage 8–10-year-olds. Rather than crayons, we have greater success with more sophisticated art supplies like charcoal pencils and sketch pads, gel pens, scissors, hole punches, glitter glue, and paints. Crafts such as modeling clay, bead sets, picture frame kits, popsicle sticks, pipe cleaners, spin art, weaving looms, and card making may be used. Other CDI activities may revolve around hobbies such as constructing train villages, scrap booking, and making model cars. Older girls might enjoy painting fingernails with their mothers. Advanced constructional toys like Legos, K'nex, and Magnetix remain popular with older children. We have also had success using CDI to enable parents to join with children during non-violent and non-competitive video games. In addition, there are many creative computer activities that hold the attention of school-age children such as card making, art, theme-park construction, and educational programs. With some families, it may even be possible to use CDI skills effectively while parents and children search the Internet together. The underlying principle is that we choose non-violent, non-competitive activities that involve conversation and interaction, and can hold the interest of both the parent and elementary school-aged child.

Increasing the Length of Special Playtime at Home. When you consider the toys and activities that are appropriate for CDI with older children, it becomes apparent that 5 min is not long enough for a satisfying play session. It is likely to be frustrating for both the child and the parent to begin a craft like a paper mache mask with only 5 min to complete the activity. School-age children have longer attention spans and the standard length of special playtime would seem to fly by. Therefore, we recommend extending the CDI play session to 10 min. Again, we discourage parents from using a timer so that they can make small adjustments in the time to allow for the completion of an activity. Just as in standard CDI, the child may be allowed to wind down the activity on her own. If the activity has been completed or it is important to move on to something else, it is the job of the parent

to begin cleaning up and to use expressions of approval when the child voluntarily assists. It is important that CDI end positively, without a power struggle over clean-up.

Individual Therapy Time. As children get older, they are increasingly capable of sabotaging behavioral interventions. They look for loopholes in token economies, they secretly add stickers to charts, they hide school to home notes, and they figure out ways to play videogames while in time-out in their rooms. PCIT is also vulnerable to the sabotage of older children. For example, because of the older child's longer attention span, he can dig in his heels and make a time-out last for well over an hour, wearing down his parent's resolve to follow through. Therefore, in conducting PCIT with older children, it is especially important to maintain a strong therapist–child rapport. Given that therapists spend a lot of time talking to parents about skills and coaching them in sessions, it is easy for the older child to feel that the therapist and parents are allied against him. For these reasons, we recommend devoting 10 min of each coaching session to individual therapy with the child.

The individual time is usually spent doing CDI while adding in occasional questions to prompt children to talk about their CDI experience. The therapist asks questions like the following: "How are you liking special playtime at home?" "Are there some toys or activities that I could have for you here that would make these sessions even more fun?" "How often are you getting to have special playtime at home?" "How is it for you when I'm coaching your mom to play with you? Does it seem weird or are you okay with the whole bug-in-the-ear thing?" and "What sorts of activities do you like during special playtime at home?" Yet, most of the time is spent following the child's lead and providing supportive remarks such as, "I really want you to enjoy coming here. Let me know if there is ever anything I can do to make this more fun." We want children to feel liked, respected, and part of the therapy team.

Whereas we recommend adapting some aspects of CDI, we keep the basic teaching sequence. In other words, we begin with a didactic session with the parents alone followed by CDI coaching sessions that continue until mastery is reached. Each coaching session involves check-in with the parents, individual time with the child, coding, coaching, and assigning homework.

Adapting PDI to Older Children

The PDI portion of PCIT can be conceptually divided into three modules. The first consists of Command Training (CT) in which parents are taught to provide effective commands followed by praise for compliance. In this module, they are coached to use an intermediate step as a consequence for non-compliance, the "big ignore." In the second module, Time-out with Incentive Chart (TIC), parents are instructed in the use of time-out procedures with a back-up incentive system to encourage older children to cooperate with the time-out protocol. The third module is Time-out with Suspension of Privileges (TSP), in which parents are taught a procedure for restricting children's privileges when they do not cooperate with going to or staying

in time-out. The use of house rules is introduced in the TIC module and public behavior is addressed in the TSP module. See Table 10.2 for a session-by-session summary of clinical procedures and homework assignments in the PDI portion of PCIT.

Table 10.2 The three modules of the PDI program for older children

	Clinic procedures	Homework
Module 1 – Command Training (CT)		
Session one (parents only)	Teach effective commands, praise for compliance, warning for initial non-compliance, and "big ignore" for continued non-compliance	10-min CDI Use CT techniques throughout day
Session two (parents and child)	Coach CT skills	10-min CDI Use CT techniques throughout day
Module 2 – Time-out with Incentive Chart (TIC)		
Session three (parents only)	Teach time-out with incentive chart as back-up for refusal to go to or stay in chair	10-min CDI Use CT techniques throughout day Do not use TIC this week
Session four (parents and child)	Coach TIC skills	10-min CDI Use TIC skills throughout day
Session five (parents and child)	Coach TIC skills Explain house rules	10-min CDI Use TIC skills throughout day for non-compliance and one house rule
Module 3 – Time-out with Suspension of Privileges (TSP)		
Session six (parents and child)	Coach TSP skills	10-min CDI Use TSP skills throughout day for non-compliance and house rules
Sessions seven and beyond (parent and child)	Coach TSP skills Explain public behavior	10-min CDI Use TSP skills throughout day for non-compliance, house rules, and public behavior

Command Training (CT) Module

Session One of PDI. In the standard PDI protocol, command giving and time-out are all taught in the same session. But, for older children we slow down the discipline program, adding new demands more gradually, to increase children's cooperation with PDI (see Table 10.2). In Session One, a didactic session that the parents attend without their child, we teach parents how to give effective commands, but time-out

is not taught in this session. By dividing the didactic information into two parts, greater attention is given to the importance of effective commands and praising compliance. Additionally, parents get an opportunity to see how much better their children comply by simply giving better instructions and praising their children for listening. Parents are taught the same basic rules of giving commands that are used in standard PDI, with one exception. Whereas we encourage parents of younger children to "make commands single and small, not compound," we teach parents of older children to include some more complex and multi-step commands that are age-appropriate. For example, a common command issued to a younger child would be, "Please put your shoes in the closet." For an older child, a parent could say, "Please hang up your coat and put your shoes in the closet." In addition to being more respectful of children's developing cognitive abilities and attentional capacities, these more complex commands help to prepare older children for the multi-step directions common in elementary school classrooms (e.g., "Everyone put your backpacks away, turn in your homework packets, mark your lunch preference, and start your seatwork."). Children who hear only one-step commands at home are at a disadvantage in most second through fourth grade classrooms.

Just as in standard PDI, parents are taught to praise children for every act of compliance. With older children, it is particularly important for the praise to sound genuine. If a parent is overly effusive and enthusiastic, the praise can be perceived by the child as fake. If the parent repeats the same labeled praises again and again (e.g., "Thank you for listening"), it comes across as mechanical and insincere. We teach parents to provide a wide variety of praises for compliance, incorporating both labeled and unlabeled praise (see Table 10.3 for ways to praise compliance in older children). We allow parents to use some unlabeled and non-verbal praise with older children as they have the cognitive capacity to identify which behavior is being praised (e.g., "Awesome, dude!", parent gives a high five). Additionally, broadening the variety of praise words and actions makes the exchange appear more natural, interesting, and sincere.

When children do not comply with a direct command, parents are taught in this session to provide a warning: "If you don't. . ., I will turn and ignore." This "big ignore" is different from the ignoring procedure used in CDI. If the child does not comply with the warning, the parent turns away for 45 s. Attention is not returned earlier, even if the child complies after dawdling or displays positive behavior (e.g., says "I'm sorry, I'll do it now."). In this way, the "big ignore" is essentially a "mini time-out" in which the child receives no parental attention for 45 s. After the "big ignore," the parent is told to proceed with CDI prior to issuing the next command. A limitation of this ignoring procedure is that the child is not required to comply with the original command. Instead, after the "big ignore" and some CDI, the parent issues a different instruction.

Ignoring is used as a consequence for non-compliance, only in the first and second PDI sessions, because the parents have not yet learned how to do time-out. We recognize that ignoring does not work as a long-term consequence because it allows the child to escape the demand. Therefore, in the third PDI session, parents are taught the time-out procedure, and it is used as their consequence for

Table 10.3 Praising compliance with older children

Great first time listening
Awesome job!
You did a beautiful job of minding
Thanks a bunch
Nice work, Dude!
You are doing great at paying attention
You go girl!
I really like it when you listen and that gives us more time to play
Way to go, buddy!
You did a wonderful job of cooperating
Thanks for doing that right away
Good job of doing what I asked you to do
Thank you for following directions
You're on it!
I like it when you listen to instructions
I appreciate your help
I really like it when we work together to get the toys cleaned up
Nice job of doing that so quickly
You're my "go to" guy
You're being "G-A-G" ("Good as gold!")
It makes me happy when you follow directions the first time I ask
Right on
Terrific job of listening with a good attitude
Look at you go
You're an awesome helper
That's amazing that you got that done already. Wow!
I love it when you're so cooperative

non-compliance from that point forward. As an intermediate step, ignoring is used as a non-confrontational method of providing a consequence for disobedience. By teaching the parents effective commands, praise, and ignoring in a separate session, children's compliance rates increase and they become more comfortable with the transition from child-directed to parent-directed play prior to the introduction of time-out. Slowing down the pace of PDI gives the older child time to adjust to the new demands and decreases the likelihood of an explosive, and potentially dangerous, temper outburst during the first time-out coaching session.

To help parents better understand the value of ignoring, a role-play often is conducted in this session. In the role-play, the "parent" (played by the therapist) tells the "child" (played by the parent) to sit down in a chair. The "child" refuses and argues. In the first scenario, the "parent" responds to the child's refusal by arguing, threatening, yelling, and cajoling. At the end of the role-play, the parent is asked to describe how it felt to be a defiant child. Most respond that it was "fun" and that they liked the feeling of power. In the second scenario, the "child" behaves the same while the "parent" behaves very differently. This time, the "parent" uses the command–warning–ignore sequence described earlier. It goes something like this:

Parent (Therapist): (in a neutral tone of voice) Please sit in the chair (points to the chair).
Child (Parent): (angrily) No way!
Parent: (continues to point to the chair and stays quiet, counting silently to 5, one Mississippi. . .)
Child: (escalating) You can't make me. I hate you! I'll do whatever I !@#ing want to do!
Parent: (in a neutral voice) If you don't sit in the chair, I will turn and ignore.
Child: Shut up!!
Parent: (counts to five Mississippi, then turns away and ignores for 45 s)
Child: (during "big ignore") See? (sing song voice) You can't make me! You can't make me!

After this scenario, the parent is asked how it felt to be the child this time. Most reply that it was less fun and harder to keep up the oppositionality because the parent stayed so calm and would not argue back. The therapist then teaches the parent that they can choose how to respond to their child's defiance. They can drop down to the child's level and argue with him, thus escalating the conflict and reinforcing the child with exciting attention. Alternatively, they can remain at the adult level, controlling their emotional responses and withholding negative attention. Through this role-play, most parents recognize how ineffective it is to yell and argue with a defiant child.

At the end of Session One of PDI, parents are instructed to continue their daily CDI sessions at home. In addition, they are encouraged to use their effective commands throughout the day at home. They are told to praise every act of compliance and to give the warning and the "big ignore" for non-compliance. In cases when it is crucial that the child complies, the parent is instructed to handle the problem in their usual fashion after the "big ignore." We forecast for parents that while this procedure is likely to increase their child's compliance somewhat, we are only at the beginning of the discipline phase. We explain to parents that ignoring non-compliance will not work as a permanent solution. We assure parents that more effective strategies will be presented in upcoming sessions. Parents are sent home with two homework sheets, one for CDI and one for command giving.

Session Two of PDI. In this session we coach parents with their children in the command–warning–ignore sequence. To make the commands seem more relevant to older children, we modify the types of activities used in PDI sessions. Rather than the non-directive construction toys used in standard PCIT, we recommend activities that call for parental guidance. We want to set up situations in which it seems natural for the parent to give directions to the child. We select activities in which there is a right and wrong way to complete the task. For example, we often use crafts that must be constructed in a step-by-step fashion using written directions interpreted by the parent (e.g., foam kits to make door signs, popsicle-stick houses, beaded key chains, paper airplanes, origami). We also include tasks that simulate children's homework and classwork experiences. Children might be asked to bring in actual homework or workbooks. We keep work sheets in the clinic for basic math facts and lined paper to

practice penmanship. In addition, we use construction-oriented toys such as Legos and Lincoln Logs with illustrated step-by-step instructions. Beginning in this first PDI coaching session, we use these toys and activities to set the stage for parents to provide frequent, natural commands to their children for the purpose of compliance training.

We start this session with a brief check-in time with both the parent and child to discuss how the week went, particularly the homework assignment. We review the homework sheet, discuss what went well, and work out solutions for problems. If parents are discouraged, we remind them that it is early in the discipline program and they will be given more strategies in the near future. Next, we spend about 10 min of individual time with the child. We explain to the child that this session will be different from the special playtime sessions. We explain that we are going to start working on listening skills to help the child follow directions better at home and at school. We tell the child about the fun, new activities that will be included in the upcoming sessions, emphasizing that we will use them to help the child learn to follow directions. When working with older children, we feel it is important to be direct and honest about the goals of treatment. Children need to know that their parents are learning nice, respectful ways to give directions. Their parents also are learning to notice and appreciate those times when the child does listen. We describe this session's PDI sequence to the child. In other words, the child is told that the parent will give many directions, say and do nice things when the child obeys, and will turn and ignore if the child disobeys. By explaining the procedures in advance, the older child is more likely to cooperate during the coaching because she feels like she is part of the therapy team.

Next, we bring the parent and child together for coding and coaching. For the first 5 min, the parent is told to do her very best job of CDI while the therapist codes the interaction. After the CDI coding, feedback is provided to the parent via the bug-in-the-ear, and the PDI coaching begins.

We first coach the parent to explain to the child what will be happening in this session. We spend approximately 25 min coaching the parent in effective command giving, praising compliance, giving a warning for initial non-compliance, and using the "big ignore" for non-compliance with the warning. The process of alternating between the coaching of CDI skills and command giving throughout the session is basically the same as with younger children. However, older children are given fewer commands. Whereas, we coach parents of young children to give approximately one command per minute, we would reduce that rate with older children to approximately one command every 2 min. We coach parents to use explanations before their commands whenever possible. Understanding the rationale behind the request helps to enlist the older child's cooperation. We also incorporate many two-step commands into the coaching to assist older children in following more complex instructions both at home and at school. For example, when working on homework the parent might say, "Part of your letter 'S' fell below the line. Please erase the letter and write it again."

We conclude the session by debriefing with the parents and child. We use labeled praise to emphasize what they did well. Here is an example:

> Wow! I was really impressed with how well the two of you worked together to get that homework done in here today. Maxine, you did a great job of giving clear, specific directions to Bobby. And Bobby, you followed directions really well and you kept a positive attitude during the tough parts. Maxine, I liked the way that you noticed that Bobby was trying hard and let him know that you appreciated it. Bobby, do you realize that you got all of your writing assignment done in only 12 minutes? And you both got the work done without anybody getting mad. Imagine what it would be like if the two of you used these skills to get along better at home. To get the ball rolling, I've got an assignment for you guys. . .

In this example, you can see that we are treating the parent and older child as a team working together to solve their problems.

At the end of this session, a homework assignment is given to the family. As always, they are asked to continue their 10-min special playtime. In addition, parents are told to continue to use their CT skills throughout the day. In particular, we ask parents to anticipate times during the day when commands are most often needed (e.g., getting ready for school, homework, chores, bedtime routines). We then ask parents to generate effective commands for each of these activities. Examples of commands include, "Please brush your teeth," "Gather up your homework and put it in your backpack," and "Please empty your lunchbox and put it in the kitchen."

Time-out with Incentive Chart (TIC) Module

Session Three of PDI. To learn the time-out procedures, parents attend this session without their children. Parents are told that a time-out procedure will now replace the ignoring that they have been doing in response to non-compliance. We briefly review the command, praise, and warning sequence. It is the same procedure that is used in standard PDI with younger children. The warning is: "If you don't . . . (repeat command), you will have to go to the time-out chair." If the child complies with the warning, the parent provides praise. If the child does not start to comply within 5 s, the parent is instructed to stand up, approach the child and say, "You didn't do what I told you to do, so you have to go to the chair." The parent then is told to walk with the child to the time-out chair. Once the child is seated, the parent is to say, "Stay here until I say you can get off." The child is required to sit on the chair for 3 min plus 5 s of silence. At the end of the time period, the parent walks to the chair and asks, "You are sitting quietly in the chair. Are you ready to come back and . . . (original command)?" If the child says no, the parent is to respond, "All right, then stay on the chair until I say you can get off." On the other hand, if the child does indicate readiness to comply, the parent then guides the child back to the original activity and points to remind the child of the original command. For non-compliance, the child receives another time-out. For compliance, the parent is to acknowledge with a simple "okay." Then the parent gives a second command. If the child complies, a labeled praise is provided.

The only major change in the PDI procedure for older children is the parent's response when children either refuse to go to time-out on their own or escape from the time-out chair. Rather than attempt to carry a resistant older child to the

time-out chair or physically move the child to a back-up room for time-out escape, we recommend using a hands-off back-up procedure. In this session, we teach an incentive-based procedure in which children are given rewards for both complying so well that time-out is not necessary and cooperating with the time-out procedure. Parents are presented with a rationale for using rewards to encourage children to cooperate with time-out. To many parents, it seems contradictory to give children a prize for going to time-out. We explain that we are not rewarding children for having a time-out. Instead, we are rewarding them for either not needing a time-out or not resisting time-out. We tell parents:

> For school-age children, time-out is the best consequence for disruptive behavior because it is immediate, kids don't like it, and it interrupts the misbehavior. Time-out allows you and your child to be apart for a few minutes, helping both of you to calm down and make good choices. The big challenge in using time-out with Will now that he is 8 years old is getting him to actually go to time-out and stay there. He's too big and strong for you to carry him, and you can't insure everyone's safety if you try to physically make him stay in time-out. So we need to motivate Will to cooperate with time-out. Once he is able to walk to time-out on his own and stay in time-out, you'll have a powerful tool for dealing with his behavior problems at home. To motivate Will, we are going to give him a reward each day for cooperating with time-out. It may seem weird to you to give him something special for going to time-out. It kind of sounds like paying him for misbehaving. But actually, we are rewarding him for learning a very difficult new behavior. If you think about it, we often reward children for doing chores. Yet, accepting time-out is much harder for Will than doing a chore. For children that have an oppositional streak, it takes a lot for them to control their tempers and accept consequences. But, it is an extremely important skill for them to learn. So I feel that Will does deserve a reward while he's learning the new skill of cooperating with time-out.

At this point, we show the parents a sample time-out incentive chart (See Fig. 10.1). On this chart, parents will put a sticker or draw a star for each day that their child does one of two things: (1) receives no time-out, or (2) cooperates with each time-out that is given (i.e., walks to time-out, stays in time-out). For weekend days, the parent has the option of breaking the day into segments such that the child may earn a sticker and reward for each time period (i.e., morning, afternoon, evening). Parents also will list on this chart a range of daily rewards that will be given at the end of each sticker day. Common daily rewards include: getting a piece of candy, having extra computer time, choosing from a grab bag, getting an extra story at bedtime, staying up 15 min later, having extra videogame time, parent playing game with the child, watching a TV show with the child, having a special snack, and getting an extra 10 min of special playtime. The chart also includes a section for larger, weekly rewards. The number of stickers required to earn the weekly reward is individualized for each child. Examples of weekly rewards include going to a movie, going to a favorite restaurant, having a friend over, going on a picnic, getting fingernails done, going on a family bike ride, selecting a movie or videogame to rent, or money (for children who are only cash-motivated). In this session, we ask parents to generate a pool of ideas for possible daily and weekly rewards that can be discussed with their child in the next session.

TIME-OUT STICKER CHART

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Your child receives one sticker for each half-day that they do the following:

1) Receive no time-outs
2) Accept time-out (e.g., walk to time-out, stay in time-out)

Each day that your child receives 2 stickers, reward with one of the following:

1) Piece of candy
2) Small mystery toy
3) Special time with you (e.g., you will play a video game with your child, take your child for a special walk, watch a tv program with your child, play "go fish" with your child, or provide 5 extra minutes of special playtime)
4) _____
5) _____

Each week, add up the stickers. If your child receives _____ stickers, you will give your child one of these larger rewards (e.g., $5, movie, restaurant, McDonald's playground, sleepover):

1) _____
2) _____
3) _____

_____

Fig. 10.1 Time-out sticker chart

Next, parents are taught how to use the chart in the command–non-compliance–time-out sequence. For example, the child may be told, "It's time to go to the store. Please put on your coat and shoes." When the child does not comply, the parent says, "If you don't put on your coat and shoes, you will have to go to the time-out chair." Of course, if the child complies with the warning, the parent provides praise. If the child does not comply with the warning, the parent is to stand up and say, "You didn't do what I told you to do, so you have to go to the chair." If the child

resists walking with the parent to time-out, the parent is to give a warning about the need to walk on his own: "If you don't walk to the chair, you won't get your sticker." If the child refuses to walk to the chair, the parent says, "You didn't walk to the chair so you won't get your sticker." Or, suppose that the child does agree to walk to the chair. Then, the parent walks with the child to the chair and says, "Stay here until I say you can get off." Suppose that after 1 min the child gets up from the chair and walks over to the toys. Then the child receives an escape warning, "If you don't stay on the chair, you won't get your sticker." If the child does not return to the chair within 5 s, the parent says, "You didn't stay on the chair so you won't get your sticker." Following the loss of a sticker, the parent is told to do the "big ignore." The purpose of the 45 s of ignoring is to provide the child with a "mini time-out" from parental attention and to prevent the parent from engaging in a coercive exchange with the angry child.

Before concluding the didactic session, we role-play various PDI scenarios with the parents (e.g., child cooperates with the whole time-out procedure, child refuses to walk to time-out, child escapes from the time-out chair). We encourage parents to memorize the sequence and words of TIC before the next session. We end the session by telling parents to continue the same homework assignment as the previous week (i.e., 10 min of CDI and CT throughout the day). Parents are specifically instructed *not* to use the TIC procedures at home until they have been coached with their child. The therapist keeps the incentive chart so that it can be finalized with the child in the next session.

Session Four of PDI. This is the session in which parents are first coached to use time-out for non-compliance with the incentive chart as the back-up for resisting time-out. The session begins with a brief check-in with both the parent and child regarding homework from the previous week. Then we spend approximately 10 min working individually with the child to explain the new consequence for non-compliance. The TIC procedures are explained to the child in a positive way:

> Today, you and your dad are going to be using a new approach that will help you follow directions better and help him be nicer when he's disciplining you. I think you're going to like this because you get to earn cool rewards. You can get little rewards every day and big rewards each week. All you have to do to get these rewards is to cooperate with how your dad tells you to do time-out. The good thing about the time-out is that your dad is going to start using a warning before punishing you. So, whether or not you get a time-out is completely up to you. The warning that your dad will give you is, "If you don't do such and such, you will have to go to the time-out chair." When you hear those words, if you make a good choice, you won't have to go to time-out. If you don't have any time-outs all day, you'll get a sticker or a star on a chart like this. In a few minutes, we'll talk together with your dad about what you will get for that sticker.
>
> No one expects kids to be perfect and to never have a time-out. So there's another way that you can earn stickers. If during a day you have to have some time-outs, you'll still get a sticker that day if you cooperate with each time-out. That means that you have to walk to the chair by yourself and stay for the whole 3 min. Let me show you how long 3 min is (therapist lets child hold a stop watch or egg timer). So, what do you think? Is it worth it to sit still for just 3 min to get some cool rewards? We're going to practice this today and give you a chance to earn a prize at the end of the session. Ready to give it a try?

The parent and child, with the therapist's help, decide on the daily and weekly rewards using the draft of the incentive chart developed in the previous session. The therapist explains to the family that if the child either receives no time-outs or cooperates with the time-outs during today's coaching, he or she will be given a reward at the end of the session. First, the therapist codes 5 min of CDI and 5 min of PDI. After giving feedback on the coding, the therapist coaches the parent to alternate between CDI and PDI for approximately 20 min.

The focus of the PDI coaching is for the parent and child to create together a final copy of the time-out incentive chart. Some families may choose to use the provided chart (see Fig. 10.1), filling in the blanks, decorating, and signing it. Others may wish to make their own chart from scratch. Types of commands used to create the chart include the following: "Put the ruler here and draw a line across the page," "Write 'McDonalds' on this line," "Choose a color for the border," and "Sign your name right here." In general, parents are coached to use their effective command-giving skills, time-out warnings as needed, and follow through with the time-out procedure if necessary. The coach particularly focuses on helping parents to remain calm, to not add extra words to the CT and TIC protocols, and to provide genuine and developmentally appropriate praise for compliance. If children are not cooperative with time-out, parents are coached through the "walk to the chair" and "escape" warnings, as well as the restriction of the sticker if needed. Because some children become quite angry and defiant when resisting time-out and losing a sticker, the coach has to be very directive in talking parents through the "big ignore" and helping parents redirect their child using CDI skills. If the incentive chart is completed before the coaching time has expired, the therapist coaches the parent to transition to another parent-directed activity such as folding paper airplanes or handwriting practice. At the end of the coaching, if the child has cooperated and has earned a sticker for the session, the parent is coached to praise and remind the child how his good behavior earned him a reward. For homework, parents are told to continue their 10 min of daily CDI and use their effective commands and TIC skills throughout the day. Parents are taught to prioritize commands, using direct commands only when they are willing and able to follow through with the time-out procedure. For other times during the day, parents are encouraged to use skills such as (1) ignore and redirect, (2) "when-then" statements, (3) indirect commands, and (4) avoidance of a command entirely (e.g., parents pick up the shoes themselves, parents allow the child's bed to go unmade).

Session Five of PDI. This session is structured much like the fourth session (e.g., individual time with the child, sticker and reward for cooperation with time-out). During the child's individual time, we present a method for accepting time-out as a consequence. Children are taught that the ability to accept a consequence such as time-out is a social skill that can be broken down into steps, practiced, and mastered. We use a series of steps presented in the book, "Skill-Streaming the Elementary School Child," by McGinnis and Goldstein (1997). The steps for accepting time-out are as follows: (1) Stop and say to yourself, "I need to stay calm," (2) Accept that you did something wrong, (3) Walk to time-out, (4) Take 3 deep breaths, (5) Think about how you can make things better by accepting time-out, (6) Tell

yourself encouraging things like, "Time-out isn't very long. I can do it," and (7) After time-out, say, "I'm sorry for not listening." Together with the child, we role-play three time-out situations in which they can use the seven-step procedure. In the first situation the child is told to use the seven steps exactly as written with assistance from the therapist. In the second situation, just for fun, we tell the child to do the opposite of what is written in each step (e.g., instead of "walk to time-out," run the opposite way). In the third situation, the child is instructed to use the seven steps correctly again with only minimal assistance from the therapist. We typically use tokens, tickets, or a sticker chart to motivate children to cooperate with role-plays.

After working individually with the child, families who had a successful week with the TIC homework are taught to use house rules (see Chapter 8). For families who struggle with the initial TIC assignment, we continue to focus on compliance and cooperation with time-out before adding new rules. The coaching this week typically involves having the family develop a new time-out incentive chart as well as working on various parent-directed crafts and academic tasks. Families who are progressing well with TIC may be asked to bring their child's actual homework to this session. Coding and coaching procedures are the same as in the fourth session. With respect to homework, families who are progressing well are assigned another week of TIC for non-compliance with the addition of using TIC for one house rule, usually "no hurting." As always, all families are to continue daily CDI practice.

Time-Out with Suspension of Privilege (TSP) Module

Session Six of PDI. For children who are not overly aggressive and who are progressing well in the program, the Time-out with Suspension of Privilege (TSP) module is introduced (see next section for children who are aggressive and resistant to PDI). The incentive chart is replaced with suspension of all privileges as a back-up for refusing to walk to time-out and time-out escape. This session begins with the parent and child together to discuss the rationale and procedures of TSP. Here is an example of how we might explain TSP to children and parents:

> Mom, over the past two weeks, you have learned a lot about being clear about what you expect of Sean. I've noticed that you are much more calm and respectful when disciplining him. You have become very good at telling him how much you appreciate his cooperation, and you have learned the importance of giving him special rewards when he does something that is hard for him.
>
> Sean, I have been impressed with how well you have been following your mom's directions. You also have become more respectful during discipline situations. And you've done a great job of accepting time-out. Because of all your progress, I don't think you need a chart anymore to help you be successful with discipline. Our goal now is for you, Mom, just to remember on your own to praise and reward Sean for his good behavior. And Sean, our goal for you is to be a good listener and to cooperate with time-out without needing stickers.
>
> So here's what we're going to do today. We're going to continue with Mom leading the play and giving directions. But now, when Sean needs a time-out he is expected to just walk there by himself and to stay. Sean, if you choose to fight the time-out, then your mom is going to suspend all of your privileges until you agree to do your time-out the right way.

> That means that in this session, you will not have any toys to play with, activities to do, or attention from your mom while you are refusing time-out. At home, your mom will put on hold all of your fun activities like TV, videogames, and outside play until you complete your time-out. Mom, this does not mean that you stop meeting his basic needs. You wouldn't withhold food, the bathroom, or his bed. You would simply suspend entertaining activities in the here and now, until he completes his time-out. When I say here and now, I mean that you can't threaten to take away future activities like the upcoming sleepover or watching his favorite Saturday morning cartoons. But you will prevent him from watching TV, using the computer, riding his bike, playing videogames, and playing with his brother or friends until he completes his time-out correctly. Remember Sean, you will not need to have any of your privileges suspended as long as you do a good job of cooperating with time-out. Sean, even though you do not have a chart this week, I am expecting your mom to continue to give you special rewards now and then for being a good listener and cooperating with discipline. Do you agree with that Mom?

After describing the TSP procedures, the parent is coded in CDI and PDI skills. Then the parent is coached in parent-directed play and academic activities. When the child defies a direction and resists time-out, the parent is coached to use the TSP procedures. In particular, the parent is told to gather all the toys in a provided box or laundry basket and remove them from the room. The parent withdraws positive attention from the child, sometimes reading a handout or magazine. The few children who will defy their parents at this point in the program tend to be extremely stubborn and volatile during this part of coaching. To prevent the child and the parent from escalating even further, the parent may offer a supportive phrase reminding the child how he can get his privileges back. In a genuine and caring tone of voice, the parent says, "I would love for you to have your privileges back. Remember, all you need to do is finish your time-out." This phrase typically is repeated like a broken record whenever the child tries to negotiate with or challenge the parent. The phrase sends the message that the parent is on the child's side and really wants the child to be successful. Yet, it should be clear to the child that the parent will follow through on the promised consequence.

Of course, parents will follow the typical PDI procedure if the child chooses to complete his time-out before the end of the session. If the child still has not returned to time-out when the session time is over, the parent is instructed to continue suspending privileges at home until the time-out is completed at home. In these severe cases, it is advisable for the therapist to provide a follow-up phone call to the parent later that day. Another session may be scheduled the same week to provide additional problem-solving and coaching.

With respect to homework, parents continue with CDI and use TSP skills throughout the day for non-compliance and breaking the house rule (e.g., hurting). During suspension of privileges at home, parents and children should continue with tasks of daily living. Because suspension of privileges may last an hour or longer, parents are certainly allowed to talk to their children during this time. After all, they may need to have the child finish homework or take a shower while waiting for the child to complete the time-out. In response to any questions or challenges from the child about the TSP, the parent is instructed to stick to the provided phrase: "I would love for you to have your privileges back. Remember, all you need to do is

finish your time-out." It is very important that parents not argue or reason with their children about the TSP consequence. Parents are sent home with a homework sheet.

Sessions Seven of PDI and Beyond. These sessions begin with a check-in with the parent and child to review homework and problem-solve. The public behavior protocol is presented (see Chapter 8) with TSP as the back-up for time-out resistance. For example, if a child resists a time-out provided at the mall, she will have her privileges suspended until she is ready to complete her time-out. In other words, she may not be allowed to buy anything, to have any treats, or play at the arcade. If the time-out is not completed at the mall, the privileges continue to be suspended at home. In the seventh session and beyond, the therapist continues to spend about 10 min of individual time with the child to maintain rapport and to discuss the child's perspective of how CDI and PDI are going at home. School-age children can provide us with valuable information about whether parents are consistently providing special playtime and rewards. Parents continue to be coded in each session and coached in the use of TSP skills. Treatment continues until families have met both the revised CDI (see Table 10.1) and standard PDI mastery criteria (see Chapter 7). They must also meet the additional termination criteria outlined in Chapter 8 (e.g., ECBI scores within normal limits).

Alternatives to the TSP Module for Children Who Are Extremely Aggressive and Defiant

Some extremely aggressive and defiant older children may not be ready for the TSP module as outlined above. These children may be so aggressive and defiant that parents are unable to successfully follow through on withholding privileges. For example, a large 9-year-old could become combative when suspended from the privilege of television and video games. He may even run out of the house to play with a friend. When thwarted, an explosive child may punch holes in the wall, smash dishes, destroy expensive electronics, or hurt a sibling. We would not advocate for parents to engage in a physical confrontation to enforce the suspension of the privilege. With older aggressive children, there are serious safety concerns when trying to physically manage them. Instead, we recommend a less confrontive procedure in which we continue with the Time-out Incentive Chart with some modifications. Children continue to receive stickers and rewards for cooperating with or not needing time-outs during specified time intervals. Yet, the program is an extension of the TIC module in that it also includes a time-delayed restriction of privilege for each time the child loses a sticker (e.g., refusal to accept time-out leads to loss of computer time before bed).

The therapist works with the parent to identify privileges that the parent can fully control. This list might include video games, a portable DVD player, computer time, cell phone, stereo, Ipod, skateboard, and a portable television in the child's room. Privileges that parents might not be able to follow through on include watching the family television, going outside, riding a bike, using the house phone, and jumping

on the trampoline. With these privileges, there is no small object that can be removed or hidden to prevent the defiant child from access. With the second list of privileges, parents would have to get in a physical confrontation to prevent an aggressive and defiant older child from gaining access. For example, older children could push their way past parents to get to a bicycle or trampoline. Restriction of privilege in this program is different than the suspension of all privileges in the standard program because the restriction is circumscribed and delayed. Providing a consequence in the moment can exacerbate an escalating coercive interaction. Instead, the consequence is delivered after the parent and child have calmed down, decreasing the chance of an aggressive outburst. The delayed restriction of a single privilege is less potent than the immediate suspension of all privileges in TSP. Therefore, we recommend that this adaptation be made only for older children at risk for dangerous behavioral escalations.

For 7–10-year-olds who are highly aggressive and defiant, PCIT often is not the best choice of intervention. PCIT is a high-risk therapy with this population, as it involves direct coaching of potentially volatile situations with a child who is strong enough to hurt an adult and parents who typically have anger management problems. Therapists should consider all options with these families. Other evidence-based approaches that should be considered with older children include Multisystemic Therapy (e.g., Henggeler, Schoenwald, Rowland, & Cunningham, 2002), Functional Family Therapy (e.g., Sexton & Alexander, 1999), Parent Management Training (e.g., Feldman & Kazdin, 1995), and Parent Management Training – the Oregon Model (e.g., Forgatch & Patterson, 2005). All of these models involve evidence-based, behavioral approaches to working with families.

Conclusion

We conceptualize our method of using PCIT with 7–10-year-old children as being like a set of five Russian nesting dolls. At the beginning of treatment, the children display their highest level of behavior problems, which we picture as the largest Russian nesting doll. Then, the relationship improvement that occurs in the Child-Directed Interaction phase reduces the level of behavior problems to the size of the second nesting doll. When the parents learn to give effective commands, praise compliance, and avoid coercive interactions in the Command Training module, a big jump in behavioral improvement occurs, bringing problems down to the size of the third nesting doll. The frequency and intensity of behavior problems is reduced again when parents learn to use time-out and implement rewards in the Time-out Incentive Chart module, bringing problems down to the size of the fourth nesting doll. By the time we reach the phase of treatment in which we must use the most intense and aversive consequences (Time-out with Suspension of Privileges module), few children have behavior problems severe enough to require more than occasional use of these confrontive strategies. The last module of PDI is designed to address these residual behavior problems that have not been eliminated with more

reinforcement-based approaches. After parents learn to use suspension of privileges in Time-out with Suspension of Privileges and children have learned to better accept consequences, we are down to the smallest Russian nesting doll. The tiny nesting doll that remains does not generally overwhelm the resources of our families. By this point in treatment, the goal is for families to be able to use the PCIT skills consistently, such that treatment gains can be maintained.

References

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*(3), 500–510.

Farrington, D. P. (1995). The development of offending and antisocial behavior from childhood: Key findings from the Cambridge study in delinquent development. *Journal of Child Psychology and Psychiatry*, *36*, 929–964.

Feldman, J., & Kazdin, A. E. (1995). Parent management training for oppositional and conduct problem children. *The Clinical Psychologist*, *48*(4), 3–5.

Forgatch, M. S., & Patterson, G. R. (2005). *Parents and adolescents living together: Family problem solving* (2nd ed., Vol. II). Champaign, IL: Research Press.

Franco, E., Soler, R. E., & McBride, M. (2005). Introducing and evaluating parent-child interaction therapy in a system of care. *Child and Adolescent Psychiatric Clinics of North American*, *14*, 351–366.

Henggeler, S. W., Schoenwald, S. K., Rowland, M. D., & Cunningham, P. B. (2002). *Serious emotional disturbance in children and adolescents: Multisystemic therapy*. New York: Guilford.

Lahey, B. B., Loeber, R., Hart, E. L., Frick, P. J., Applegate, B., Zhang, Q., et al. (1995). Four-year longitudinal study of conduct disorder in boys: Patterns and predictors of persistence. *Journal of Abnormal Psychology*, *104*, 83–93.

McGinnis, E., & Goldstein, A. (1997). *Skillstreaming the elementary school child: New strategies and perspectives for teaching prosocial skills*. Champagne, IL: Research Press.

Sexton, T. L., & Alexander, J. F. (1999). *Functional family therapy: Principles of clinical intervention, assessment, and implementation*. Henderson, NV: RCH Enterprises.

Chapter 11
Siblings

PCIT is most often conceptualized as an intervention directed toward addressing the behavior problems presented in one identified child. Yet, the standard protocol involves siblings in two ways. First, parents are encouraged to provide special playtime at home to all children within the age range. This helps to promote positive relationships between all parents and children in the family. When CDI is provided to only one child, a sibling close in age is likely to feel jealous, causing additional conflict in the family. By having parents practice CDI with more than one child, their skills progress faster and become automatic sooner. Second, during the latter sessions of PDI (usually after the "no-hurting" house rule has been put into place), parents are given the option of including siblings in the coaching sessions. Inclusion of siblings in PDI sessions strengthens treatment in several ways. When siblings attend, many opportunities for command giving arise as parents manage multiple children and their potential conflicts. Having siblings in these sessions teaches parents to apply rules consistently across the children. When only one child is receiving time-out for noncompliance, feelings of favoritism and resentment can arise. Perhaps the most important benefit of including siblings in sessions is that parents learn to use PDI skills in real-life situations. During single-child coaching sessions, parents are able to work on giving consequences for noncompliance, but few opportunities arise for coaching disruptive behaviors. With siblings present, there is a wealth of clinical material to address including hair pulling, name calling, grabbing, pushing, bossiness, tattling, and whining. Because a "no hurting" house rule is in place at the time of the sibling PDI session, we coach parents to put children in time-out for sibling aggression. If both siblings break the "no hurting" rule by fighting with each other (regardless of who starts it), the parent is coached to put both children in separate time-out chairs. The reality is that most parents have to be able to manage the behavior of multiple children simultaneously and effectively cope with their interactions. Thus, including siblings in sessions promotes generalization to the real world.

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Including Siblings with Disruptive Behavior Problems

When sibling issues are prominent, PCIT may be adapted to include siblings in a variety of ways. We find it helpful to include siblings when there is another child in the family in the age range who also displays disruptive behavior. For example, we obviously would share treatment sessions in cases involving twins with the same types of behavior problems. Similarly, when a case is referred with a preschooler and a kindergartener, both with some acting-out behavior problems, we try to include both children in treatment. This can be accomplished in several ways. We can alternate coaching sessions such that the children take turns coming. Or, we can split each coaching session in half, allowing the parent to be coached with each child each session.

Another option for working with siblings could be to occasionally coach the parent with the two children together. We typically find ourselves doing this type of session when child care falls through and parents unexpectedly bring siblings. It can be unsafe to allow young siblings to sit in a waiting area unattended, and they can either be included in the session or it may be canceled. These sessions provide a nice opportunity to teach parents to use selective attention (i.e., focusing on the child displaying appropriate behavior) and to use CDI techniques to help children play nicely with one another, share toys, wait their turn, ask politely, use nice words, allow siblings to add their ideas, and to keep hands and feet to themselves. Yet, we do not advocate for routinely including siblings in CDI sessions because it detracts from the fundamental goal of PCIT which is to enhance the parent-child relationship. While it may be convenient to include siblings in a session, the best way to promote bonding between a parent and child still lies in coaching one-on-one play therapy. Additionally, coaching parents with more than one child can send a confusing message to parents that group special playtime could substitute for one-on-one play therapy at home.

Including Siblings Without Behavior Problems

Sometimes we include siblings without behavior problems in PCIT. Because CDI is so reinforcing, the child without behavior problems may become jealous when the identified child brags about the fun that happens at the clinic. In such cases, we may devote a small amount of time during a couple of the CDI coaching sessions to the non-referred sibling. Some of our parents are sensitive to the issue of scapegoating or stigmatizing one child as the "problem child" and request that sessions be spoken of as family therapy and include all of the children. In such cases, we sporadically provide coaching of one-on-one parent–sibling interactions, but spend the majority of therapy time working with the identified client.

Another time that we include siblings who do not display behavior problems is in the rare case when the identified child's behavior is so disruptive that the parent is having a difficult time learning the CDI skills. For example, we had a case of a

low-functioning parent with two children aged 3 and 6. The 3-year-old had behavior that was totally out of control. During CDI sessions, the 3-year-old would knock all of the toys off the table, run out of the room, throw toys, tip over chairs, and hit the mother. The mother was overwhelmed and had no opportunity to begin developing PRIDE skills in the midst of the chaos. So we coached her with her much better behaved 6-year-old. Once she developed some competency with the PRIDE skills and ignoring, we taught her to apply those skills in coaching sessions with the 3-year-old. We have also found it helpful to incorporate well-behaved siblings during the first PDI coaching session. The identified client may benefit from watching the sibling cooperate with the time-out role-plays and listening exercises before doing the role-plays and exercises himself.

Coaching Older Siblings as Babysitters

There are times when we actually coach children during CDI sessions, particularly when there is an older sibling who serves as a babysitter in the home. In one case, we worked with a single mother who had four children between the ages of 2 and 12. The 2-year-old, Cody, was a terror. He harassed the older children, particularly the 12-year-old, by jumping on them, spitting on them, grabbing their things and running, biting, messing up their rooms, and scribbling on their homework. When the mother was home alone with Cody during the day, she experienced minimal problems. But as soon as the siblings came home from school, the household erupted, as Cody demanded attention from his brothers. While the mother was trying to work with one child on homework and start dinner, the two other siblings would be screaming and complaining about Cody's bad behavior. In addition to coaching the mother with Cody, we devoted part of each session to training the 12-year-old brother, Matthew, in special playtime skills. Just as we find it important to train other major caregivers such as grandparents in PCIT skills, we embrace opportunities to improve the skills of older siblings who frequently babysit as part of their expected responsibilities in the home. In Cody's case, his older brother enjoyed learning the CDI skills and actually met mastery. As a result, the mother asked Matthew to do special playtime with Cody for about 30 min immediately when walking in each day after school. This provided Cody with the attention that he craved, prevented the chaotic escalation of disruptive behavior, and allowed the mother some time to get the other boys going on their homework. Matthew was compensated for going "above and beyond" with his younger brother and received extra allowance.

Direct Coaching of Children to Decrease Sibling Conflict

Sibling relationships generally improve with PCIT even when siblings are included only in the final stages of PDI. However, with severe sibling problems that do not respond to standard PCIT (e.g., continued fighting and jealousy) or are at a crisis level (e.g., one sibling is in danger or has been harmed), we may choose to intensify

and speed up our intervention. Early in treatment, we may bring in siblings and directly coach both children in pro-social interactions. One child and the parent are given ear pieces. The child is coached in targeted social skills while the parent is coached to use CDI skills to support the child's efforts (e.g., describing sharing, giving labeled praises for working as a team). At the half-way point, the other child is given the earpiece and coached. Examples of skills we might coach include sharing, asking nicely for toys, waiting for a turn, accepting no from a sibling, complimenting, accepting compliments, offering to help, and ignoring (see Table 11.1). There are three components to coaching a child during a sibling interaction: (1) praising the spontaneous use of social skills, (2) prompting the child to exhibit a skill, and (3) providing private observations to the child about the positive effect that the

Table 11.1 Target skills during sibling coaching sessions

Sharing
Asking nicely for toys
Waiting for a turn
Accepting "no" from a sibling
Complimenting
Accepting compliments
Offering to help
Ignoring
Joining in
Working as a team to solve a problem
Using supportive statements
Using polite manners

skills are having on the sibling and the relationship. Examples of private observations include: "your brother really thinks you're funny," "your nice words meant a lot to him," "she's copying your drawing because she looks up to you," "brothers can become best friends. . .looks like you're on your way," and "since you've been complimenting her, she's using nice words back." It is important that these observations be made privately over an earpiece because it prevents the sibling from disagreeing with your interpretation or "spin" to save face or to get negative attention. Even though the parent wears an earpiece during this coaching, he or she is not directly coached. The advantage of the earpiece is that it allows parents to learn through the therapist's modeling how to prompt and reinforce positive sibling interactions outside of the clinic.

Direct Coaching of Children to Improve Social Skills (e.g., Asperger's)

We sometimes coach a child in interactions with a sibling when one of the children presents with severe social skill deficits such as those seen in Asperger's disorder. Social skills that can be coached with these children include eye contact, answering questions, and initiating a conversation (see Table 11.2 for additional social skills to

Table 11.2 Direct coaching of children with severe social skills problems (e.g., Asperger's disorder, pervasive developmental disorders)

Eye contact
Answering questions
Initiating a conversation
Asking questions
Reading facial expressions and body language
Pausing to allow others a chance to speak
Ending conversations
Correct use of pronouns
Using descriptions for small talk
Using more typical intonation and cadence of speech

coach). In these cases, coaching statements might include (1) go ahead and answer that question, (2) show interest in his play by asking what he is making, (3) you need to look her right in the eye or she will think you aren't paying attention, (4) she's looking bored. . .can you change the topic? (5) stay quiet a moment. . .it's his turn to talk, (6) remember, he talks, you talk, he talks, you talk, and (7) say it like this (therapist models using inflection).

Using the Cooperation Game

Rationale for the Game. For families who have a primary presenting complaint of poor relationships among their children, we sometimes recommend incorporating the "Cooperation Game" into PCIT. The game is most helpful for sibling pairs in the 4–12-year-old range. The game can be introduced at any point during CDI or PDI. Playing the Cooperation Game has several purposes. First, parents are taught that they are not just passive observers of how their children's relationships develop. Instead, parents can have a profound impact on the feelings children have toward each other. Second, the Cooperation Game identifies the skills that are key to maintaining a positive relationship as well as behaviors that tear relationships apart. Through the Cooperation Game, parents can teach children social skills and motivate them to practice the skills at a high rate. The Cooperation Game provides a way to address sibling problems in a fun, engaging fashion that brings families closer.

Explaining the Game to Children. The game is introduced to children with the following explanation:

> In every healthy family there are two strong teams. Do you know who's on these teams? That's right, there's the parent team and the kid team. What do you think the job of the parent team is? It's to take care of you by feeding you, clothing you, giving you a home, teaching you, disciplining you, loving you, having fun with you, and raising you up to someday be a happy healthy independent adult. Parents do this by cooperating together and working as a team. They don't always agree with each other, but when they don't, they work out solutions so they can be a strong team. How do you think your parents are doing as a team?

> Now, who do you think is on the other team? Right. What is the job of the kid team? Well, the job of the kid team is to cooperate with each other, support each other, stick up for each other, be loyal to each other, learn from each other, and love and protect each other. What kind of a team are you guys? Well, I want to help you to become the strongest kid team possible. The longest relationship you are ever going to have in your lives is this one. Some brothers/sisters are the best of friends, and I would love for you to have that kind of relationship with each other. I have a really cool game that you guys are going to be able to play that I think will help you to become a stronger team. It's called the Cooperation Game. This game is great because it gives you a chance to earn some cool prizes. Here's how it works.

Children are taught that there are specific behaviors that will strengthen them as a team and certain behaviors that will weaken them.

Moving on the Game Board. Using a game board (see Fig. 11.1), children can earn a turn rolling a die by engaging in any of a set of reciprocal relationship-building skills.

Fig. 11.1 The Cooperation Game. Photo Credit: Daniel Wilson McNeil, Ph.D.

These skills are reciprocal in that each child on the team is required to perform a part of the skill in order for the team to move forward on the board. To illustrate, the skill of exchanging favors will earn the team a roll of the die only if each child does her part. One example of exchanging favors would be if the brother brought his sister a drink when he got up to get one for himself. To reciprocate on the favor, the sister could later bring the brother some popcorn when she gets a bowl for herself.

Parents often report that jealousy is a big obstacle to a positive sibling relationship. Jealousy often presents itself in the form of one child criticizing or minimizing the other child's success or valued possession. For example, when one child receives a soccer trophy, the other child might say, "Well, that's a dinky trophy and you were just a sub anyway." When a friend gives one child a friendship bracelet at recess, the jealous sibling might say, "only sissies wear those." For families experiencing a lot of sibling jealousy, an important target skill is "celebrating your sibling's success." Parents are taught to anticipate situations that may lead to sibling jealousy such as birthday gifts, school awards, sports awards, and special opportunities with friends (e.g., sleepovers, going to the zoo). In these situations, the parent should have a private discussion with the sibling about positive ways to think about their sibling's good fortune. Rather than viewing their sibling's success as somewhat detracting from their own worth, they should be encouraged to remember that the sibling is their teammate and their teammate's success is also their own. Parents can role-play with the sibling how to respond when faced with their sibling's success. Examples of positive responses would include saying something nice about the gift, congratulating your sister on her award, and showing interest when they describe special activities. In addition to celebrating a sibling's success, other common reciprocal behaviors that would earn the children a turn at the game are presented in Table 11.3.

Table 11.3 How children move forward in the Cooperation Game

(1)	Playing together for 20 min without arguing or fighting
(2)	Pitching in together to do a chore
(3)	Giving a genuine compliment and the other one accepting it nicely
(4)	Sticking up for a sibling and the sibling saying "thanks"
(5)	Comforting a sibling who is sad or injured and sibling accepting comfort
(6)	Sharing and other sibling thanking nicely
(7)	Compromising
(8)	Including each other in play when friends are over
(9)	Exchanging favors
(10)	Celebrating sibling's victory and sibling showing appreciation

Sibling teams also can move backward on the game board when they engage in behaviors that hurt the relationship. Here's one way to explain this part of the program:

> There are things that you guys probably already do that weaken you as a team. The first is hurting. Think about what it would be like if you were on a basketball team. Would you whack and kick your teammate? If the team was hitting and kicking each other, would that make you stronger or weaker as a team? The second problem is name-calling. What are some of the names you call each other? I think that it's fine for you guys to disagree sometimes. All brothers and sisters do. But it is not okay to use hurtful words. That clearly weakens you as a team. You also should not be using mean talk. It's not okay to say things like, "I hate you," "You suck," or "Shut up." Yelling at each other in anger will also make you weak as a team. You also are not allowed to go into each other's rooms without permission. Strong teams are respectful of each other's space and property. What you can do is to

knock on the door, even if it is open, and wait to be invited in. Good teams do invite each other in a lot. But, everyone has a right to have time alone and can sometimes say "no."

The last thing I want you to avoid doing is tattling over non-safety issues. What I mean by that is that you are being a good brother to tell your parents when your sister is doing something unsafe like playing with matches or riding without her bicycle helmet. It is your job to help keep her safe. But, it is not your job to tell on her when she breaks other rules at home. For example, if she is getting a popsicle without permission before dinner, it's okay to quietly remind her once about the rule about snacks. If she chooses to listen to your advice, great. But if not, you need to let it go. Let's remember our basketball team example. How would it be if you went and told the referee that your teammate double dribbled? Would that make you a strong team or a weak team? When your parents see you doing any of these things, they will send you back a square on the game board.

In addition to the rules described above, Table 11.4 presents behaviors that result in weakening of the sibling relationship. For example, taunting includes bragging about something. Provoking or antagonizing encompasses a wide-range of behaviors designed to irritate or "get a rise" out of the sibling. Ways children may provoke or antagonize a sibling include stepping on brother's foot under the dinner table, singing the same phrase over and over after being asked to stop, holding up the sister's stuffed animal and threatening to fart on it, stealing the chair the sister was sitting on, changing the channel in the middle of a show, kicking the back of the brother's seat, and throwing a used tissue at the brother. Parents are told to limit backward movement on the board to one square at a time. Although it is tempting to take away a lot of squares for big fights, the Cooperation Game is more effective when children consistently move forward on the game board.

Table 11.4 How children move backward in the Cooperation Game

(1)	Name calling
(2)	Mean talk
(3)	Going in each other's rooms without permission
(4)	Tattling over non-safety issues
(5)	Yelling at each other
(6)	Displaying jealousy
(7)	Physical hurting
(8)	Taunting
(9)	Provoking or antagonizing

Constructing the Game Board. We coach families to construct their own large format game board during a session. Entertaining themes can be incorporated such as a frog hopping along lily pads, a mouse walking along a snake body, a train moving along a track, a pirate searching for treasure, a race car on a test track, a ghost flying through a haunted house, and a superhero climbing up a tall building. Materials that work well for the game board are poster paper, poster board, and laminated paper that can be tacked to a wall, or a sheet of paper that can be attached to the refrigerator with magnets. We sometimes borrow the die and game piece from another board game such as Candy Land or Sorry! Families are provided with markers, stickers, rulers, and crayons to make the board in session because the program will likely not get off the ground if the parents are responsible for designing

the board at home. The game piece can be secured to the board using sticky-tack, double-sided tape, a magnet, clay, or a push-pin. The game board should include approximately 20–25 squares between reward spaces. For most families, this spacing will allow children to reach a reward space every 1 to 2 weeks. A typical game board will include approximately four reward spaces. See Figure 11.1 for a picture of a sample game board. It usually takes about 4 to 6 weeks to finish one game. At that time, the family starts back at the beginning with a new set of rewards.

Rolling the Die. When the game is begun, it is played continuously throughout the days and weeks. Anytime the sibling team does one of the cooperation skills (e.g., compromising), labeled praise is provided, and they get a turn at the Cooperation Game. They go together to the game board and one child rolls the die and moves the game piece. To avoid conflict over whose turn it is to roll, each child places his initial in the corner of the board after rolling. Whenever the children engage in one of the behaviors that weaken them as a team, their game piece is moved back one square.

Rewards. When they reach a reward space or go beyond it, the reward has been earned. Rewards *cannot* be lost when the game piece is moved backward. The siblings are just that much farther away from the next reward. Rewards also cannot be earned a second time when the game piece (that had just gone backward) passes the reward space again. The types of rewards that work best are ones that involve shared family activities with all family members included. Examples of rewards may be found in Table 11.5.

Table 11.5 Cooperation Game rewards

Putt-putt golf
Bowling
Going to a favorite restaurant
Ice skating
Family bike ride
Going to the movies
Going to the zoo
Going to a skate board park
Going to a video arcade
Swimming
Playing laser tag
Going to a museum
Going on a picnic
Going fishing
Going camping
Making homemade ice cream
Family game night
Family movie night
Going to a theme park
Painting pottery
Getting manicures
Camping out in the backyard

Challenge Squares. To enhance the game, the family can add special "challenge squares" prompting children to practice one of their cooperation skills. When the sibling team lands on a special square, they are given the opportunity to move forward an extra square if they are successful at performing the cooperation skill during a brief interaction. Examples of activities they might be prompted to perform include (1) playing rock, paper, scissors; (2) taking turns walking each other like a wheel barrow; (3) playing tic, tac, toe; (4) doing a three-legged walk; (5) thumb wrestling; (6) seeing who can stand on one foot the longest; (7) singing a duet; (8) playing leapfrog; (9) giving each other sincere compliments; and (10) working together on a quick, simple chore (e.g., putting some toys away, putting plates on the table). Parents are welcome to create their own challenges as long as they keep the activity short, approximately 1 min.

Prompting Cooperation Skills. How quickly children progress through the game depends partly on the children's motivation to earn the rewards. But it is at least equally dependent on the parents' willingness to set their children up for success by prompting the cooperation skills, particularly in the beginning. Early on, it is the parent's job to point out opportunities to use the cooperation skills and progress in the game. For example, when the older brother brings home a good grade on a spelling test, the parent could prompt the younger brother to give him a compliment. Another coaching opportunity would be when the two children are disagreeing over the choice of restaurant. The parent could cue, "Here's an opportunity to compromise and get closer to going to Skate Land." Some children have trouble progressing on the board because they go backward so much for one child's impulsive and antagonistic behavior toward the sibling. In these cases, parents can implement a warning (e.g., holding up their index finger) to help the child make better choices. The child is taught that if he stops the behavior when the signal is given, the team will not be penalized a square. Also, for those cases in which a sibling team is not making good progress on the board, the therapist should assess whether the family is misusing the board to penalize children for general misbehavior. The board is to be used only for the specified sibling interactions.

Determining When to Discontinue the Game. One concern that parents might have about the Cooperation Game is that siblings are only working together to get the prize. In response, parents are told that in the beginning this is true. The only reason that the children are trying so hard to get along is to earn rewards. They worry that sometimes the children appear to be "just faking it" to get a turn at the Cooperation Game. We explain to parents that it is acceptable for children to fake the behaviors, particularly in the beginning in that it provides them with an opportunity to practice pro-social skills. But, over time, a positive snowball effect occurs. With a lot of practice, children's interaction habits improve and the positive cooperation skills come more naturally to them. As children treat each other better, they begin to like each other more. After all, we all like people who like us.

Some parents will ask us "How long do I have to do this before they just get along?" Challenging questions such as this send a message to therapists that parents may unrealistically expect their children to just get along without much effort on the part of the parent. Some parents tell us that their children's personalities are like "oil

and water" implying that it is a foregone conclusion that they will never get along. A part of our intervention is to educate parents that sibling interactions are behaviors and behaviors can be modified, but it takes work on the part of the parent. Parents are told that the Cooperation Game should continue to be played until the skills become automatic and seem genuine (e.g., compliments are exchanged outside of the parent's presence without the expectation of reward). We forecast for parents that sibling conflict may resurge after the Cooperation Game has been over for a few months (e.g., with all the togetherness of summer break). If this occurs, another round of the game can be played.

Conclusion

In PCIT we teach parents the skills that they need to improve their relationships with their children and the strategies that they need to provide effective discipline. Although a healthy parent-child relationship is key to family stability, it is not the only element to harmony within the home. Even when very positive relationships exist between parents and children, sibling conflict can be destabilizing to the family unit. We believe that it is imperative for parents to understand that they bear responsibility for shaping the interactions of their children. We want parents to feel empowered to use strategies that will enhance the relationships among their children. When parents are effective in using these strategies, they have less child misbehavior to redirect, longer periods of peaceful play between siblings, and generally less stress and chaos at home.

Chapter 12
Autism Spectrum Disorders

Joshua Masse

Although PCIT was devised for families of children with externalizing behaviors, several investigations have examined its usefulness in reducing behavioral problems in more specialized populations. For example, Bagner and Eyberg (2007) conducted a randomized controlled study examining the efficacy of PCIT in reducing disruptive behaviors in children with mental retardation. Study results showed that children in the PCIT group demonstrated significantly higher compliance rates than children yet to receive treatment. In addition, findings demonstrated that mothers who received PCIT reported fewer disruptive behaviors (as rated by the Eyberg Child Behavior Inventory) and exhibited greater use of the PRIDE (e.g., praise, reflection) skills as compared to mothers in the waitlist control group. Implications of this study suggest that PCIT may be an efficacious treatment for children with more pervasive difficulties who also demonstrate co-occurring behavior problems. Although traditionally used with typically developing children, this study prompted researchers to consider whether PCIT could be extended to other groups of children with specialized and chronic disorders such as high-functioning autism, pervasive developmental disorder, or Asperger's disorder. This chapter provides an overview of how PCIT may be an effective treatment in reducing disruptive behaviors in children on the higher end of the autism spectrum while maintaining the core components of the intervention.

Historically, cases of autism spectrum disorders (ASD) have been excluded from participation in PCIT as it was assumed that the treatment would not be successful given PCIT's reliance on social contingencies (e.g., verbal reinforcement, ignoring, time-out). Yet, many behaviors of children with ASD who are in the high-functioning range are reinforced by social attention. Moreover, some research has demonstrated that most children who fall on the autism spectrum present to clinics with externalizing behavior as the primary focus of treatment (Mandell, Walrath, Manteuffel, Sgro, & Pinto-Martin, 2005), and many parents desire to initially treat their child's non-compliance and aggression before treating other atypical behaviors. Therefore, we have seen an increase in referrals for children with ASD which has raised the question of whether PCIT may be an effective gateway therapy to enhance children's readiness for more comprehensive treatments that

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target behavioral concerns specifically associated with autism (e.g., social skills, speech/language therapy).

Clinically, we have seen that PCIT has been a successful first-line treatment in that children with ASD become more compliant and less aggressive. Our experience demonstrates that parents tend to be more optimistic about undertaking additional services once their child's behavior is under better control. However, in terms of research, only a paucity of studies examining PCIT and ASD exists, though preliminary data from studies currently being conducted are promising. For instance, Masse and McNeil (in preparation) have examined the efficacy of PCIT with high-functioning autism using a single-subject design ($N = 3$) and found a drastic increase across participants in child compliance and positive parenting behaviors while parent-reported behavioral problems decreased to below clinically significant levels. Other research groups also have provided preliminary studies of PCIT and found similar results (e.g., Jonathan Campbell & Sarah Vess at the University of Georgia; Solomon, Ono, Timmer, & Goodlin-Jones at the University of California, Davis, 2008). Though initial findings suggest PCIT could be an efficacious treatment in reducing externalizing behaviors with children on the autism spectrum, much more research is needed with this population. Therefore, until further research is conducted, it is recommended that the primary treatment for children with autism be an empirically supported treatment (EST) for this population (see Table 12.1). However, as treatments for autism are specialized and availability depends on geographic region, it is possible that PCIT may be the best option for a family in a particular area. In this case, PCIT may be a viable alternative for families with children on the higher end of the autism spectrum. It is worth noting that although PCIT is showing success with the high-functioning autism/Asperger's population, not all children with ASD are expected to benefit from PCIT. For example, children with poor receptive language skills (< 24 months) who do not understand simple instructions likely would not benefit from PCIT. Also, because PCIT is based on social reinforcement, children with extreme social withdrawal may not benefit from PCIT. Therefore, PCIT may only be indicated for children who would be described as falling on the higher functioning end of the autism spectrum.

Table 12.1 Empirically supported treatments for children with autism spectrum disorders

Treatment	Overview	Selected readings
Applied behavior analysis	• Emphasis on functional assessment and building skills • Increase socially appropriate repertoires while decreasing challenging behaviors • Develop skills that will allow access to the widest possible range of reinforcers	Green, 1996
UCLA young autism project	• Intensive and comprehensive treatment employed at home, school, and the community • Improve desirable behavior (e.g., language, social behavior) and reduce disruptive behavior (e.g., aggression, tantrums)	Cohen, Amerine-Dickens, & Smith, 2006 Lovaas, 1987 Lovaas & Smith, 2003 Sallows & Graupner, 2005 Smith, Groen, & Wynn, 2000

Table 12.1 (continued)

Treatment	Overview	Selected readings
	• Use of discrete trial training (DTT) and incidental learning to teach goals of therapy	
Pivotal response training	• Based on applied behavioral analytic principles and used to treat language, social, behavioral, and play deficits • Improve broad areas of functioning that will generalize to many other domains • Improve independence and self-education through intervening in the key pivotal areas of motivation and self-initiation	Koegel, Bimbela, & Schreibman, 1996 Koegel, Koegel, Harrower, & Carter, 1999 Koegel, Koegel, & Brookman, 2003 Koegel, O'Dell, & Koegel, 1987
Positive behavior support	• Assist in creating lifestyle that will lead to improved quality of life • Decrease undesirable behavior by helping to achieve goals in a more socially acceptable and desirable manner • Basic steps include conducting a functional assessment, developing hypotheses, designing an appropriate plan, and implementing a maintainable plan	Carr et al., 2002 Dunlap and Fox, 1999 Durand and Carr, 1992 Horner, Carr, Strain, Todd, & Reed, 2002
TEACCH method	• Emphasize structure in teaching new behaviors, targeting specific skills, and defining conditions and consequences of behaviors through shaping • Focus on tolerance, compromise, acceptance, and personal enhancement rather than normalization or inclusion	Mesibov, 1994 Ozonoff and Cathcart, 1998 Schopler, 1994 Schopler, Mesibov, & Baker, 1982
DIR/Floortime	• Focus on attending to child needs and creating mutually enjoyable, shared experiences between child and caregiver • Components include observing the child's actions, acknowledging the child's emotional tone and gestures, and extending and expanding play through supportive comments	Greenspan & Wieder, 1999 Greenspan & Wieder, 2006 Wieder & Greenspan, 2006

Theoretical Similarities of PCIT and Empirically Supported Treatments for ASD

PCIT is unique in that it contains a blend of therapeutic techniques seen in a number of therapies devised for children with ASD. For example, PCIT, like Floortime and TEACCH, recognizes the importance of consistent, one-on-one parent-child interaction and stresses that the quality of a parent-child bond is important to demonstrate acceptance and support for the child's behaviors and verbalizations. In addition, PCIT is similar to Pivotal Response Training in that it emphasizes the importance of using familiar play objects in an environment that is comfortable for the child in an effort to promote generalization. Indeed, families in PCIT are instructed to

use their parenting skills at home on a consistent basis with familiar activities and stimuli that encourage parent-child interaction. A common theme inherent within many interventions for children with ASD is to take a comprehensive approach by allowing parents to play an integral part in therapy. By increasing parental involvement, skills learned within a clinic are then generalized to other settings such as the home and public environments. Likewise, PCIT views the parent as the agent of change in a child's life and therefore trains parents to a mastery level in each component of treatment. In having stringent mastery criteria, requiring consistent practice, and providing ample live feedback to parents, PCIT places a great deal of emphasis on treatment fidelity, generalization across environments, and maintenance over time. Lastly, PCIT not only stresses the importance of relationship-building through enriching and rewarding parent-child interactions, but also contains an intensive compliance training component (i.e., command–consequence sequence) similar to the discrete trials seen in ABA protocols.

Overall, due to its overlap with current specialized treatments, PCIT presents a number of components that may prove to be helpful for children with ASD. More specifically, PCIT may serve to prepare a child for more intensive therapy by serving as a necessary primer that enhances the parent-child relationship and increases child compliance, thereby setting the stage for greater success across a variety of treatment modalities (e.g. social skills training, academic tutoring).

Child-Directed Interaction

Similar to the theoretical implications of Floortime, child-directed play in PCIT improves the parent-child relationship by allowing the child to lead the play situation, in turn, conveying a message that the child's verbal and behavioral expressions are not only accepted but also encouraged and rewarded through social reinforcement. Children choose the play activities, while parents express approval and interest by following the child's lead through the use of skills like imitation and reflection. As the parent-child relationship improves and the bond is strengthened, it creates a situation in which the child views playtime as a rewarding experience and seeks to increase time spent with the parent and constructive play behaviors develop.

In addition to increasing the value of one-on-one time, CDI is also effective in building language and conversational skills. Reflective statements are useful in that they provide immediate attention for any verbal expression increasing the likelihood the child will talk more often during special playtime. For example, a child with ASD in our clinic initially presented with limited verbalizations providing few words during the first several sessions. However, as his mother began to reflect the child's utterances and words on a regular basis, the number of vocalizations increased. After a number of therapy appointments, the child was consistently verbalizing throughout the entire session.

In addition to increasing the number of expressed verbalizations and words, CDI also helps motivate a child to use language in order to obtain desired snacks or objects. For example, in our clinic, one child with language capability often pointed, screamed, or physically guided his parent when he desired a particular object. We taught the parent to ignore the child's inappropriate attempts to acquire particular objects, to prompt his use of words (e.g., "When you say 'dog,' then I will give you the doggie"), and then to praise the child for using words. If parents reward inappropriate, yet efficient methods of getting demands met (e.g., yelling, pulling parent toward object), the children will not be motivated to use language, as this requires more effort and concentration. The less the child uses appropriate communication, the more delayed the language functioning is likely to become. As an adapted homework assignment, parents are told to withhold desirable objects and treats at home until the child uses a developmentally appropriate language request (e.g., "When you say 'juice,' then I will give you the juice," "When you say 'Help please,' then I will help you take off your shirt," and "When you say 'I want to play computer,' then I will set up the computer for you").

Next, the use of CDI skills increases a child's attention span and ability to remain seated and focused on the task at hand. To accomplish this, parents employ behavioral descriptions (a running commentary of the child's behaviors) which allow a child to focus on an activity for longer periods of time, thereby diminishing the likelihood of off-task behaviors (e.g., repetitive, stereotyped behaviors). Theoretically, the social reinforcement resulting from the parent's focus on the child's play increases time spent on that particular activity. In one case of ASD seen in our clinic, CDI skills greatly increased the child's time spent engaged in appropriate play. This, in turn, expanded his play repertoire as he obtained more exposure to objects such as crayons and toys, while spending less time engaging in repetitive, self-stimulatory behaviors (e.g., twirling, opening and closing doors). Overall, CDI establishes a situation for making parent-child interactions more reinforcing to both the parent and child by teaching the parent to follow the child's lead and demonstrate interest and acceptance of the child's activities. An improved parent-child relationship sets the stage for success during the compliance training phase of treatment (i.e., PDI).

Working with Stereotyped, Repetitive Behavior During CDI

When conducting CDI with children with ASD in our clinic, we have had to address an important theoretical issue with respect to repetitive behaviors. CDI involves two parallel objectives: (1) to improve the parent-child relationship by following the child's lead and (2) to modify behavior through selective attention (i.e., ignoring inappropriate behavior, redirecting the child's inappropriate activities, and providing attention to incompatible pro-social behaviors). If repetitive, self-stimulatory activities (e.g., frequently reciting the pledge of allegiance, lining up toys) are categorized as "inappropriate," these activities should be ignored and redirected during

CDI. However, during functional assessments in our clinic, we have found that many of these behaviors serve a self-stimulatory function and are not maintained by parental attention. Therefore, when we coached the parent to ignore and distract, the behaviors were extremely resistant to redirection. Additionally, in some cases, the children had few if any behaviors that were "appropriate," such that ignoring repetitive behavior equated ignoring most of the child's behavioral repertoire. Thus, when we defined repetitive behaviors as "inappropriate," a great deal of CDI was spent ignoring rather than joining with the child. Attempts to modify the repetitive behaviors clearly interfered with the equally important goal of improving the parent-child relationship. Therefore, we decided to define self-stimulatory behaviors as "appropriate" during CDI as long as they were not dangerous or destructive. For example, one parent in our clinic was coached to imitate, describe, and praise her child's repetitive pen-spinning behavior. In addition, she was coached to reflect her child's echolalic comments in order to keep him in the lead. Although this seemed somewhat contradictory to the parent, she was reassured that upon mastery of CDI skills she would then lead the play and be able to redirect her son's ritualistic behavior and encourage more age-appropriate tasks and behaviors. By teaching parents skills to keep their children in the lead, it allows children with ASD to engage in familiar and soothing behaviors and to experience parental acceptance in the form of parental imitation, praise, and description of the children's preferred activities.

Parent-Directed Interaction

PDI presents a number of benefits for children with ASD in that it targets non-compliance and allows parents to redirect idiosyncratic play to more developmentally appropriate activities. In this phase of treatment, parents are instructed to give short, simple commands and then subsequently follow-through with appropriate consequences. For compliance, a parent gives verbal praise and then allows the child to lead the play for a brief time period. For non-compliance a structured time-out sequence takes place that ends with compliance to the original command (i.e., no escape). Many mental health professionals believe that time-out cannot be an effective consequence for children with ASD because time-out from social attention may be reinforcing rather than aversive. However, we have found that time-out can be used successfully with children on the high end of the autism spectrum as long as the children are always required to return from time-out and immediately complete the task. In this way, time-out cannot function as an escape from tasks and social demands. In many ways, the command–reward or command–time-out sequence is comparable to the applied behavior analysis approach. It parallels the one-step directions employed in discrete trial training such that a basic command is given ("Look at me" or "Please hand me the block") followed by a consequence. In contrast to applied behavioral analysis (ABA), PCIT does not typically employ tangible or edible reinforcers but instead uses social rewards in the form of labeled praise and

CDI. Also, in contrast to the hand-over-hand prompting used in many ABA programs, PCIT employs the time-out sequence. In PDI, compliance is over-trained to the point where it becomes a well-rehearsed habit. Compliance training begins with the use of simple "play" commands (e.g., "Please put the man in the house") and progresses to real-life instructions (e.g., "Please sit at the table"). Children overlearn compliance by practicing to comply at very high rates in both the clinic and in the home. During "listening exercises," children are given a command almost every minute for the 40-min weekly clinic coaching and for the 5-min daily home practices.

In our clinical experience, PDI has proven to be helpful in not only reducing a number of oppositional and aggressive behaviors commonly associated with high-functioning autism, but also in targeting self-stimulatory behaviors. By administering a simple command while a child is engaging in a self-stimulatory behavior, a parent can redirect the self-stimulation and expand the child's behavioral repertoire. For example, a child with ASD in our clinic would repeatedly write a series of phone numbers and would spend most of the CDI coaching sessions (and much of the day at preschool) writing the numbers over and over. In CDI, his mother would give him positive attention by using the PRIDE skills: describing his behavior ("Now you are writing a 6"), imitating his writing, enthusiastically praising ("You write your numbers so well!"), and reflecting all verbalizations. However, during PDI the child's mother was coached to direct her son away from his self-stimulatory behavior to another task (e.g., "Please draw me a tree"). By learning the compliance sequence and not allowing her son to escape from original commands, the parent was not only able to reduce oppositional and self-stimulatory behaviors, but was also able to teach the child different tasks and activities that would never have been possible before (e.g., drawing age-appropriate pictures, playing cards, participating in sports). By redirecting self-stimulatory behavior and managing behavioral difficulties, the parent taught her child skills that increased his capacity to learn and be successful in structured classroom environments. If PDI was not used to disrupt the self-stimulatory behavior, the child may have never expanded his behavioral repertoire and may have fallen even further behind his peers developmentally.

Overall, the blend of PDI and CDI skills is advantageous to the child in that it establishes a rhythm or expectation that the child and parent will alternate leading and following during their daily practice sessions. By establishing that the child does not lead the entire play session, an element of flexibility is established for the child. In this way, the child learns that there are times when listening and complying are necessary. Also, the combination of PDI and CDI allows for children with ASD to take a break from demands and again lead the play as they wish. These breaks seem to be important for children with ASD as their anxiety and frustration decrease when they have opportunities to engage in their preferred activities while receiving attention and acceptance from their parents. Alternating between the parent's lead and the child's lead also makes the parent-child interactions more reinforcing and compliance less aversive. Ultimately, the rhythm established during PCIT sessions (i.e., 1 min of CDI–20 seconds of PDI–1 min of CDI, etc.) may generalize to

additional settings, establishing an expectation that a balance is to be struck between behaviors that the child finds comfortable and demands given to the child. As compliance becomes more consistent, greater demands can be placed on the child in turn expanding the behavioral repertoire and improving school-readiness.

Time-Out Concerns

For over 40 years, researchers have debated the appropriateness of the use of aversive procedures in children with developmental disabilities creating a division within the ASD research community. This debate has generated a number of arguments including the definition of aversive: a term that could potentially have a number of meanings ranging from physical pain to temporary mild irritation. In an effort to develop a more precise definition of the term, Turnbull (1986), while delivering his presidential address at the American Association on Mental Deficiency (AAMD), stated that "not every intervention that is unwelcomed by the client or that may cause unpleasant consequences should be regarded as presumptively questionable. To take that approach would be to exclude, for example, time-out, seclusion, medications, or modest repetitions of skill building tasks" (p. 266). Currently, many researchers argue that some use of punishment may be necessary for childhood learning and development (Newsom & Kroeger, 2005). Going further, some researchers propose that a solely positive approach may not be as effective as one that employs a combination of positive methods and punishment, recognizing that punishment is a necessary first step in establishing an environment where positive consequences can become reinforcing (Sidman, 1989).

Employing a time-out procedure for difficult behaviors is a technique that is widely accepted and used in behavioral parent training programs. In order to insure a safe and accurate implementation of the time-out procedure, PCIT requires clinicians to dedicate a session solely to teaching and practicing the time-out sequence with parents. In addition, parents receive in vivo coaching during the first time-out sequence in the clinic and are coached to a mastery level (see Chapters 6 and 7).

Based on Baumrind's (1971) research, it has long been recognized that an authoritative parenting style (one that is characterized not only by warmth and praise, but also consistent limit setting) enhances the likelihood of more positive child outcomes. Further, as aversive contingencies (e.g., restricted privileges) are commonly used to modify behavior in the natural environment (e.g. workplace, classroom), a solely positive approach may not be comprehensive enough for helping children with high-functioning autism cope with societal demands (Newsom & Kroeger, 2005).

To summarize, PCIT incorporates both positive parenting skills and limit setting and it has been successful in reducing difficult behaviors with typically developing children. PCIT has been shown to have clinical efficacy with a high degree of caregiver acceptability. Yet, in families of children with high-functioning ASD, there exists a need for further empirical research to examine if this treatment is a

beneficial gateway intervention. It is possible that PCIT opens the gateway for children to be better able to benefit from more comprehensive and multi-component treatments. In other words, PCIT is expected to improve compliance and social responsiveness, two fundamental skills that provide a gateway for treatment that addresses a variety of adaptive behaviors (e.g., social skills training, occupational therapy for sensory integration, speech therapy). If children with ASD do not learn at an early age to attend and comply, they remain distracted by stereotypical interests and behaviors that prevent them from progressing with treatments addressing higher order concerns such as identifying the feelings of others and social reciprocity.

Clinical Limitations

Client Characteristics. As PCIT is a specialized treatment that targets specific behaviors, it is important to clarify that it is not an appropriate intervention for all children on the autism spectrum. Instead, our experience has demonstrated PCIT to be an effective treatment for children with a particular clinical presentation. For instance, PCIT has shown to have preliminary success with high-functioning autism and/or Asperger's disorder. As the delivery of PCIT requires parent-child communication, success of the intervention is dependent on a child's language capability. For example, a child must be able to understand simple instructions and sentences for PCIT to be effective. Children with receptive language capabilities below a 24-month-old level may not be appropriate candidates for PCIT.

Therapist Characteristics. As children with ASD present with a variety of complex behaviors, it is recommended that only experienced PCIT clinicians attempt to treat children with ASD. Although definitive conclusions have not yet been reached regarding the minimum training requirements for a PCIT therapist, most members of the PCIT National Advisory Board advocate that PCIT trainees obtain at least 40 h of initial training, as well as an advanced training component and/or supervision after completion of approximately 4–8 cases (Eyberg & Brestan, 2006). Due to the complexities of the disorder, it is suggested that clinicians with limited PCIT experience refer ASD cases to a more experienced PCIT therapist or to a local agency specializing in treatment of ASD. If future research supports the use of PCIT with ASD, then specialized training programs should be developed to assist advanced PCIT therapists in adapting the program to meet the needs of this population.

Social Reinforcement. One issue that needs to be thoroughly assessed in considering the appropriateness of PCIT for children with autism is whether social attention is reinforcing. As PCIT utilizes social approval (e.g., labeled praise) as a reinforcer, it is important to consider the effect this has on a child's behavior prior to starting therapy. In other words, a functional assessment should be conducted to determine whether behaviors increase when followed by social attention and approval. Some children with autism may find social praise slightly aversive and may seek to avoid or escape parental attention.

As a byproduct of social reinforcement, clinicians must also assess the effectiveness of selective attention and time-out. One advantage of PCIT is that each session is essentially a continuous functional assessment as therapists are coaching parents through systematic manipulations of antecedents and consequences and monitoring the changes in the child's behavior (Greco, Sorrell, & McNeil, 2001). In our experience, systematically ignoring (e.g., the parent turning his back to the child after she engages in undesired behavior) during CDI sometimes does not result in behavior change in children with ASD. In some cases, children did not seek attention when parents turned their backs, but instead used the "break" in play to engage in self-stimulatory behavior. For example, one child with a limited behavioral repertoire would engage in self-stimulatory behavior for a considerable portion of a CDI session. When the child's behavior was ignored, he did not seek to regain his mother's attention but continued with self-stimulatory behavior. In addition, as some children with autism may find time-out to be a place of retreat and one not requiring social demands, it may be counter-intuitive to employ this particular technique. For instance, a child does not comply with a command to hand his mother a red block and is given a warning that he must comply or go to time-out. Upon non-compliance, the child receives a time-out where he can "escape" the command for a certain time period and engage in other behaviors such as rocking or flapping. Although the child eventually needs to comply with the command, the time-out chair may serve as a relief from playtime with his mother. In this way, child non-compliance is negatively reinforced as it results in escape from social demands.

Although time-out may not be effective with some children with ASD, our clinical experience has shown that it typically serves as a more powerful consequence than ignoring. Therefore, it may be necessary for a clinician to begin therapy with the PDI portion first and then progress to CDI (see Eisenstadt [Hembree-Kigin], Eyberg, McNeil, Newcomb, & Funderburk, 1993). In our experience, the most robust behavioral changes with children on the autism spectrum have taken place during PDI (i.e., compliance training). As PDI establishes a play situation in which a child can only escape the social interaction through a time-out (as opposed to self-stimulation), more opportunity to experience social attention is granted in this phase of therapy. Also, in cases when oppositional behavior is destructive or extreme, compliance training may be indicated as an initial part of treatment to make it possible for the child to participate safely in therapy. For example, one child with ASD would refuse to engage in any behavior and would place his hands over his ears and yell at his mother for a majority of the session. As his refusal was so extreme, PDI needed to initially be implemented in order to increase his receptiveness to parental attention and constructive play activities. Alternatively, we also have had success providing a short course in CDI (didactic plus one or two coaching sessions), followed by a complete course of PDI, and then returning to a full course of CDI. This provides the advantage of being able to enter PDI with a parent who is trained to be socially reinforcing using CDI skills. This allows the parent to better alternate following and leading the play. After children have expanded their behavioral repertoires in PDI, later CDI sessions are characterized by much richer parent-child interactions.

Adapting PCIT: Communication and Social Skills Component

One adjunctive component to PCIT that seems important for increasing and/or enhancing communicative repertoires in children with ASD is social skills training. In fact, we advocate adding a social skills and communication training module after successful completion of CDI and PDI. In this module, parents are coached in different ways to prompt their child to answer questions, ask questions, use eye contact, and initiate/maintain conversations. By administering social skills training toward the end of PCIT, it allows the parent to teach these critical skills after a child has become more receptive to social interactions and also more likely to comply when prompted to speak. In addition, teaching parents to provide the social skills training is useful in that the parent then serves as co-therapist and can prompt the child to use the skills in a more generalized fashion. For example, after successfully mastering CDI and PDI, a parent can be coached in a variety of methods for motivating their child to improve their social competency and can help the child to be exposed to situations in which he/she can use the skills (e.g., restaurant, bowling alley).

In the context of communication and social skills training, it is important to consider the possible distinction between verbal delays and non-compliant behavior. In other words, some children with ASD may not have the capability to use more advanced language and failing to initiate (e.g., saying hello to a teacher or friend) or maintain social communication may not be a refusal behavior. As verbal behavior cannot be physically guided and refusing to engage in a social activity is typically not an act of defiance in children on the high end of the autism spectrum, administering a time-out is seldom warranted when coaching parents to use social and communication skills training with their children. PCIT, then, is only appropriate for children who demonstrate both receptive and expressive language abilities equivalent to or above 24 months.

Answering Questions. One of the first communication skills taught in the social skills component of PCIT adapted for ASD is answering questions. It is important for parents to not allow their children an opportunity to escape from responding. Answering questions could be aversive to a child with ASD for several reasons. First, it may require the child to suspend a self-stimulatory behavior and attend to the social interaction. Second, the pragmatic language skills of children with autism spectrum disorders are usually different than typically developing children, thus requiring greater effort to understand a question and respond. Lastly, answering a question often results in additional social demands that may be uncomfortable for the child. Thus, it is typical for a child with ASD to ignore the parent in order to escape the demands of answering the question. If a parent fails to repeat the question, then the child's ignoring behavior is negatively reinforced such that the child becomes increasingly unresponsive to conversational demands.

As answering questions is a difficult endeavor for children with ASD, parents are taught to ask questions strategically. As in standard PCIT, parents are coached to recognize and eliminate all questions during CDI and PDI coaching sessions. Later, in the social skills/communication module, parents are coached to add in strategic and

constructive questions. They are taught to ask questions sparingly, which requires eliminating "rapid-fire" and "rhetorical" questions, as well as tag and voice inflection questions. Rapid-fire questions are those that do not provide the child with a full 5 s to respond ("What are you making? Is it a farm? Are those horses?"). Rhetorical questions are those that parents are not desiring or expecting the child to answer ("Are you turning the page?" "Where did they find these silly toys?" and "What am I going to cook for dinner tonight?"). Questions tags are phrases attached to the end of statements that turn them into questions (e.g., "You're building a bridge, aren't you?" and "That's big, huh?"). Inflection questions are ones in which the parent's voice intonation is raised at the end, turning a statement into a question ("You're drawing a cow?"). By eliminating undesirable questions and strategically adding in constructive questions, the value of questions and the motivation to answer are increased. Constructive questions are ones that are developmentally appropriate, begin with a question word (e.g., "who, what when, where, or why"), and provide the child with 5 s to respond. For children on the autism spectrum, the question, "What did you do at school this morning?" may be inappropriate as many of these children have difficulty understanding the concept of time (e.g., past or future). Also, questions concerning perceptions or attitudes should be avoided in the early stages of social skills training as it may be difficult for the child to convey ideas about these abstract concepts. Instead, parents are coached to begin with questions that are more concrete and easily comprehended (e.g., "What color is this block?"). When the child answers the question, reinforcement is provided in the form of praise that is paired with a break (i.e., the child is able to lead the play and be temporarily free from another question).

In addition to asking developmentally appropriate questions, parents are also taught a broken record method in which the same question is asked repeatedly (with a 5 s pause in between questions) until an answer is received. If the question is not answered after the third delivery, the child is prevented from engaging in the preferred activity until the child provides an answer. For example, if the child is drawing, the parent would remove the crayon from the child's hand or hold the child's hand until the child answers. Similarly, if a child is running his/her hand back and forth across a table, the parent would pull the chair away from the table and continue to ask the question until the child verbally answers. By repeating the question, it becomes aversive to the child to avoid answering and the lack of response is not negatively reinforced by the parent disregarding the question. Our clinical experience has shown us that the broken record has been effective in obtaining verbal responses. For example, one child's rate of answering questions increased from 10% prior to teaching parents the broken record technique to 90% following implementation of the technique.

It is worth noting that occasionally a child may not respond to the broken record. Another technique parents are taught and coached to use are "when–then" statements. A "when–then" statement suspends preferred activity until the requested behavior is performed. For example, one child in our clinic oftentimes sought to play with toys in the laboratory's attached room. Following a question, he would sometimes attempt to escape the play situation to engage in his preferred activity,

playing in the attached room. In this situation, the parent was coached to tell the child, "When you answer my question, then you may play in the other room." If the child answered the question, he was verbally praised. If the child would not answer the question, he was unable to engage in his desired activity until he complied with the original request.

Some children will not answer questions even after trying the broken record and the "when–then" strategies. As a last resort for situations such as these, where the question was clearly one that the child was capable of answering, time-out may be considered. The parent could provide a direct command, such as "Say red." If the child does not comply, the parent would provide a time-out warning followed by the time-out procedure as needed. We use time-out as a last resort for communication training, as the parent is unable to physically guide the child to answer the question, making it impossible to guarantee that the sequence will end with a comply.

Asking Questions. Parents are also coached to use suspension of privileges to teach their children to ask questions. As with answering questions, parents are coached to teach their children the particular words necessary to ask the question. For instance, when a child reaches to get an object without permission, a parent is coached to say, "When you say 'can I please have the block?', then you may play with it." By having the child use ask a question each time he or she wants an object, asking questions becomes a greater part of the child's verbal repertoire and begins to generalize to a variety of environments (e.g., school, home).

Initiation of Social Interaction. Another social skill we want to increase through the use of suspension of privilege combined with social reinforcement is "initiation of social interaction." Children with high-functioning autism oftentimes have difficulty with a number of behaviors required to initiate social interaction such as making eye contact and appropriately beginning or ending conversations (i.e., saying "hello" or "good-bye"). By coaching parents to have their children make eye contact and say "hello" and "good-bye" at every opportunity for social interaction, social skills are over-trained and are likely to generalize to other contexts without the need for prompts or requests. Typically, parents are trained and coached to teach these behaviors gradually so that only saying "hello" is required for each social initiation with the social requirements expanded as the child begins to show mastery of the skill. For instance, after a child is saying "hello" on a consistent basis, a parent is coached to have the child make eye contact while saying "hello." Eventually, the child learns more advanced communication skills that help begin a conversation (e.g., "Do you want to see my picture?").

Pronoun Reversal. Pronoun reversal is commonly seen in preschoolers with high-functioning autism. By withholding preferred activities until desired behavior was performed and verbally prompting the child with the correct word (e.g., "I want to get a drink" as opposed to "You want to get a drink"), pronoun reversals were shown to decrease over time with one child in our clinic. Similar to other social and communication skills described, prompting and "when–then" statements are decreased over time as children independently produce more correctly stated pronouns. In addition to "when–then" statements, non-verbal prompting has demonstrated success in reducing pronoun reversal. For example, parents can be coached to extend

their index finger as a cue for the use of an "I" statement and then to praise their child for saying "I" in response to the visual cue.

Summary. Overall, both the broken record technique and "when–then" statements have led to clinical success when teaching social and communication skills in this adapted version of PCIT. In many instances, these techniques can be used in conjunction with one another. For example, a parent may administer a "when–then" statement in a broken record fashion by waiting for 5 s between statements and then repeating the "when–then" statement for three consecutive trials. In using these techniques, parents are equipped with a method by which they are able to decrease their child's social and communication avoidance (i.e., by providing a more immediate negative consequence in the form of suspending preferred activities until the behavior is performed). Over hundreds of trials in the clinic and at home, the child learns to respond quickly and consistently to social demands.

Case Study

Charles is a 5-year-old Caucasian male who presented to our clinic with a diagnosis of Asperger's disorder with co-occurring non-compliant, aggressive, and risk-taking behaviors. His mother reported that he would often place himself in harm's way by running into street traffic or climbing to unsafe heights. She stated that he would become physically aggressive with her including hitting, kicking, or biting her whenever he heard the word "no." She said that his behavior had gotten so out of control that his preschool teacher threatened to remove him as he had become a danger to the other students. Charles also had difficulty making friends and became ostracized in the classroom. The children at school identified Charles as "weird." He became fixated on mechanical objects such as calculators or staplers and did not show much interest in age-appropriate toys or activities. He would rarely make eye contact with others and his content of speech was typically not congruent with the conversation topic and consisted mainly of immediate and delayed echolalia (e.g., reciting the television news verbatim). He often wandered around the classroom especially during "circle time" or other structured activities. Charles would frequently demonstrate self-stimulatory behavior precluding his ability to take part in the school curriculum. Overall, Charles' behavior became so impairing that it began to impact the relationships with most individuals in his life.

Charles's mother was desperate for services when she presented to the clinic. She said she had tried everything to control his behavior but nothing seemed to work. As there was not a clinic specializing in treating children on the autism spectrum in the region, it was possible that Charles would not receive services anywhere else for his behavioral issues. To decide whether PCIT would be effective with Charles, a functional assessment was conducted to measure whether social attention was reinforcing to him. As Charles was reinforced by his mother's presentation and withdrawal of attention, it was decided by the clinical staff and Charles's mother that PCIT would be an appropriate treatment option. The primary goals of

PCIT were reducing Charles's oppositional, aggressive, and non-compliant behavior across contexts and improving the parent-child relationship. Secondary goals consisted of improving on-task behaviors or time spent sitting in seat, teaching appropriate use of toys, improving social skills (e.g., eye contact), and transitioning better.

Although the standard PCIT protocol was employed, several modifications were needed in order to better suit Charles's needs. In particular, since Charles demonstrated a reading ability well beyond his age and developmental level, written signs, prompts, and stories were used as a way for Charles to better understand expectations. For example, several "no hurting" signs were posted around the lab to serve as a reminder. In addition, Charles's self-stimulatory behavior was reinforced by his mother during CDI and then targeted for reduction during PDI with incompatible commands. If Charles would walk across the room and engage in self-stimulatory behavior, his mother would give him the command to sit at the table. Given Charles's social deficits, his mother was taught to look for pro-social behaviors (e.g., eye contact, starting conversations, answering questions) and immediately praise them as they occurred. In order to increase symbolic play, Charles's mother would often describe herself playing appropriately with a toy (e.g., flying an airplane through the air while Charles spun the wheels of the airplane). As the parent-child relationship improved, Charles would often engage in similar play as his mother and then receive praise for the appropriate use of the toy. Through the course of therapy, the core features of PCIT were not modified but rather the focus shifted at times to improving social and communication skills.

Following adapted PCIT (with a social skills and communication component after CDI and PDI), Charles demonstrated less disruptive behavior at both home and school with compliance increasing from 15 to 75%. In addition, he was able to remain seated for longer periods of time (30 s–1 min at pre-treatment, 15–20 min at post-treatment) while engaging in less self-stimulatory behavior. By being able to engage in on-task behaviors for longer periods of time, Charles developed more interest in appropriate toys and games. Also, as pro-social behaviors were continuously reinforced through the use of PRIDE skills, Charles exhibited more verbal behavior with peers and adults and became more approachable to children in his school.

In terms of formalized assessments, the Childhood Autism Rating Scale (CARS) was completed by three independent raters before and after treatment (e.g., Schopler, Reichler, & Renner, 1986). This measure showed a reduction in mean score from 45 (severely autistic range) at pre-treatment to a mean score of 31 (mild–moderate autistic range) at post-treatment. In addition, assessment revealed that Charles's behavioral improvement generalized to the classroom setting. The Child Behavior Checklist-Teacher Report Form (CBCL-TRF; e.g., Achenbach, 1991) scores decreased on a number of domains including withdrawn, pervasive developmental disorders, externalizing behaviors, and total problems. Lastly, Charles's performance changed on the Peabody Picture Vocabulary Test-Revised (PPVT; e.g., Dunn & Dunn, 1981) with Charles's standard score increasing from 95 to 102.

After treatment, Charles' behavioral improvement allowed him to obtain additional services targeting core components of autism. For example, he was able to return to speech therapy (after being asked to leave prior to PCIT), and was able to participate fully in the intervention. In addition, his academic performance increased, while his improved social and communication skills allowed him to develop more meaningful friendships with same-aged peers.

Conclusion

Overall, PCIT strives to increase school-readiness skills by using techniques designed to enhance the parent-child relationship, improve language and social skill capabilities, increase attention span, expand play repertoire with age-appropriate tasks (as opposed to self-stimulatory behaviors), increase compliance rate, and decrease oppositional and aggressive behaviors. As externalizing behaviors are a common component of the clinical presentation of autism spectrum disorders and are typically the initial focus of treatment for children within this population, it is feasible that PCIT might be an effective gateway treatment for preschoolers with high-functioning autism who demonstrate co-occurring aggressive and non-compliant behavior. Yet, the appropriateness of using PCIT with this population is only speculative at this time as information is based on uncontrolled clinical case studies. Research is greatly needed in this area to assist clinicians in determining the appropriateness of PCIT as a component of an intensive, multifaceted treatment protocol with children on the autism spectrum.

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References

Achenbach, T. M. (1991). *Integrative guide to the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington, VT: University of Vermont, Department of Psychology.

Bagner, D. M., & Eyberg, S. M. (2007). Parent-child interaction therapy for disruptive behavior in children with mental retardation: a randomized controlled trial. *Journal of Clinical Child and Adolescent Psychology*, *36*, 418–429.

Baumrind, D. (1971). Current patterns of parental authority. *Development Psychology Monographs*, *4*(1, Pt. 2), 1–103.

Carr, E. G., Dunlap, G., Horner, R. H., Koegel, R. L., Turnbull, A. P., Sailor, W., et al. (2002). Positive behavior support: Evolution of an applied science. *Journal of Positive Behavior Interventions*, *4*, 4–16.

Cohen, H., Amerine-Dickens, M., & Smith, T. (2006). Early intensive behavioral treatment: Replication of the UCLA model in a community setting. *Journal of Developmental Behavioral Pediatrics*, *27*, S145–S155.

Dunlap, G., & Fox, L. (1999). A demonstration of behavioral support for young children with autism. *Journal of Positive Behavior Support*, *1*, 77–87.

Dunn, L. M., & Dunn, L. M. (1981). *Peabody Picture vocabulary test – revised*. Circle Pines, MN: American Guidance Service, Inc.

Durand, V. M., & Carr, E. G. (1992). An analysis of maintenance following functional communication training. *Journal of Applied Behavior Analysis*, *25*, 777–794.

Eisenstadt, T. H., Eyberg, S. M., McNeil, C. B., Newcomb, K., & Funderburk, B. (1993). Parent-child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome. *Journal of Clinical Child Psychology*, *22*, 42–51.

Eyberg, S. M., & Brestan, E. V. (2006, January). *Advisory board review*. Paper presented at the 6th annual meeting of the Parent-Child Interaction Therapy Conference, Gainesville, Fl.

Greco, L. A., Sorrell, J. T., & McNeil, C. B. (2001). Understanding manual-based behavior therapy: Some theoretical foundations of parent-child interaction therapy. *Child & Family Behavior Therapy*, *23*, 21–36.

Green, G. (1996). Early behavioral intervention for Autism: What does the research tell us?. In C. Maurice, G. Green, & S. C. Luce (Eds.), *Behavioral intervention for young children with autism* (pp. 29–44). Austin, TX: PRO-ED.

Greenspan, S. I., & Wieder, S. (1999). A functional developmental approach to autism spectrum disorders. *Journal of the Association for Persons with Severe Handicaps*, *24*, 147–161.

Greenspan, S. I., & Wieder, S. (2006). *Engaging autism: Using the floortime approach to help children relate, communicate, and think*. Cambridge, MA: DaCapo Press.

Horner, R. H., Carr, E. G., Strain, P. S., Todd, A. W., & Reed, H. K. (2002). Problem behavior interventions for young children with autism: A research synthesis. *Journal of Autism and Developmental Disorders*, *32*, 423–446.

Koegel, R. L., Bimbela, A., & Schreibman, L. (1996). Collateral effects of parent on family interaction. *Journal of Autism and Developmental Disorders*, *23*, 347–359.

Koegel, R. L., Koegel, L. K., & Brookman, L. I. (2003) Empirically supported pivotal response interventions for children with autism. In A. E. Kazdin & J. R. Weisz (Eds), *Evidence-based psychotherapies for children and adolescents* (pp. 341–357). New York: Guilford Press.

Koegel, L. K., Koegel, R. L., Harrower, J. K., & Carter, C. M. (1999). Pivotal response intervention I: Overview of approach. *Journal of the Association for Persons with Severe Handicaps*, *24*, 174–185.

Koegel, R. L., O'Dell, M. C., & Koegel, L. K. (1987). A natural language teaching paradigm for nonverbal autistic children. *Journal of Autism and Developmental Disorders*, *17*, 187–200.

Lovaas, O. L. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, *55*, 3–9.

Lovaas, O. L., & Smith, T. (2003) Early and intensive behavioral intervention in autism. In A. E. Kazdin & J. R. Weisz, (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 325–340). New York: Guilford Press.

Mandell, D. S., Walrath, C. M., Manteuffel, B., Sgro, G., & Pinto-Martin, J. (2005). Characteristics of children with autistic spectrum disorders served in comprehensive community-based mental health settings. *Journal of Autism and Developmental Disorders*, *35*, 313–321.

Masse, J. J., & McNeil, C. B. (in preparation). *An empirical examination of parent-child interaction therapy for children with high-functioning autism.*

Masse, J.J., McNeil, C.B., Wagner, S.M., & Chorney, D.B. (2008). Parent-child interaction therapy and high-functioning autism: A conceptual overview. *Journal of Early and Intensive Behavior Intervention*, *4*(4), 714–735.

Mesibov, G. B. (1994). A comprehensive program for serving people with autism and their families: The TEACCH model. In J. L. Matson (Ed.), *Autism in children and adults: Etiology, assessment, and intervention*. Belmont, CA: Brooks/Cole.

Newsom, C., & Kroeger, K. A. (2005) Nonaversive treatment. In J. W. Jacobson, R. M. Foxx, & J. A. Mulick (Eds.), *Controversial therapies for developmental disabilities: Fad, fashion, and science in professional practice* (pp. 405–422). Mahwah, NJ: Erlbaum.

Ozonoff, S., & Cathcart, K. (1998). Effectiveness of a home program intervention for young children with autism. *Journal of Autism and Developmental Disorders*, *28*, 25–32.

Sallows, G. O., & Graupner, T. D. (2005). Intensive behavioral treatment for children with autism: Four-year outcome and predictors. *American Journal on Mental Retardation*, *110*, 417–438.

Schopler, E. (1994). A statewide program for the treatment and education of autistic and related communication handicapped children (TEACCH). *Psychoses and Pervasive Developmental Disorders*, *3*, 91–103.

Schopler, E., Mesibov, G. B., & Baker, A. (1982). Evaluation of treatment for autistic children and their parents. *Journal of the American Academy of Child Psychiatry*, *21*, 262–267.

Schopler, E., Reichler, R. J., & Renner, B. R. (1986). *The childhood autism rating scale (CARS) for diagnostic screening and classification of autism*. New York: Irvington.

Sidman, M. (1989). *Coercion and its fallout*. Boston: Authors Cooperative.

Smith, T., Groen, A., & Wynn, J. W. (2000). Randomized trial of intensive early intervention for children with pervasive developmental disorder. *American Journal on Mental Retardation*, *102*, 228–237.

Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B. (2008-Epub). A pilot study of the effectiveness of Parent Child Interaction Therapy (PCIT) for children on the autism spectrum. *Journal of Autism and Developmental Disorders*, 38(9), 1767–1776.

Turnbull, H. (1986). Presidential address 1986: Public policy and professional behavior. *Mental Retardation*, *24*, 265–275.

Wieder, S., & Greenspan, S. I. (2006) Infant and early childhood mental health: The DIR model. In G. M. Foley & J. D. Hochman (Eds.), *Mental health in early intervention: Achieving unity in principles and practice* (pp. 175–189). Baltimore, MD: Paul H. Brookes.

Chapter 13
Child Physical Abuse

Lisa M. Ware and Amy D. Herschell

This book highlights the dynamic nature of Parent-Child Interaction Therapy (PCIT) and the robust findings demonstrating its effectiveness in enhancing the quality of parent-child relationships and reducing child behavior problems. These qualities have led clinicians and researchers to consider the use of PCIT with other clinical populations including families with a history of child physical abuse (CPA). Looking back, we can see how the focus on the parent-child relationship and the direct coaching of skills in vivo make PCIT a logical fit for use with families with a history of CPA; however, it took the vision of a pioneer in the field of child maltreatment (Barbara Bonner) and an eager post-doctoral student with solid training in PCIT (Cheryl McNeil) to make it all come together.

The application of PCIT to families with a history of CPA first began at the University of Oklahoma Health Sciences Center. Dr. Cheryl McNeil received her graduate training at the University of Florida with Dr. Sheila Eyberg, creator of PCIT, as her mentor. After completing her internship at the University of Oklahoma Health Sciences Center, Dr. McNeil was hired to begin a PCIT program at the Child Study Center in Oklahoma City. At that time, she received her post-doctoral supervision for licensure from Barbara Bonner, Ph.D. Dr. Bonner immediately saw the potential in implementing PCIT with families who have a history of CPA. In the mid-1990s, Drs. Bonner and McNeil gave several professional talks at conferences such as the American Professional Society on the Abuse of Children (APSAC) on PCIT and CPA. The early talks on PCIT and child abuse attracted the attention of Child Abuse Recovery, a child abuse agency in Santa Rosa. Drs. Bonner and McNeil provided PCIT training to Child Abuse Recovery in 1992 followed by training of the University of California Davis Child Protection Center (now the UC Davis CAARE Center). Soon after, Dr. McNeil began collaborating with Dr. Anthony Urquiza of the UC Davis Child Protection Center on an NIMH R21 grant to study the effectiveness of PCIT with physically abusive families.

As a result of their collaboration, Urquiza and McNeil composed a conceptual article in which they articulated the rationale for use of PCIT with families with a history of CPA (Urquiza & McNeil, 1996). Using a social learning framework

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largely based on Patterson's "coercion hypothesis" (p. 136), Urquiza and McNeil explain that while there may be many etiologies for the development of CPA, many cases of CPA occur when caregivers have instituted physical discipline as a method of gaining child compliance or reducing child disruptive behavior (e.g., whining).

Almost 10 years later, the first randomized controlled trial of PCIT with CPA was completed examining the efficacy and sufficiency of PCIT in preventing re-reports of CPA. Chaffin and colleagues (2004) randomly assigned 110 parent-child dyads to one of three treatment groups: (a) PCIT, (b) PCIT + wraparound, or (c) a standard community parenting group. Compared to a standard community parenting group, PCIT resulted in clinically and statistically significant reductions in re-abuse rates. After approximately 850 days (over 2 years), reports of re-abuse were 19% for the PCIT group compared to 49% for the standard community parenting group. Given these results demonstrating the ability of PCIT to reduce child maltreatment recurrence, PCIT has been chosen as a model for widespread dissemination by groups including the Kaufman Best Practices Project (Chadwick Center, 2004) and the National Child Traumatic Stress Network (www.NCTSNet.org). In addition, PCIT was identified as a *supported and acceptable* treatment by the National Crime Victims Research and Treatment Center and the Center for Sexual Assault and Traumatic Stress in their review of current interventions for child victims of maltreatment and their families (Saunders, Berliner, & Hanson, 2004).

This chapter highlights some of the rewards and challenges in implementing PCIT with families with a history of CPA. We begin by describing this population including typical referral concerns, family patterns and dynamics, and problems that often co-occur in families with a history of CPA (i.e., substance abuse, domestic violence, poverty, and mental health concerns). Next, we discuss adaptations to PCIT based on the unique treatment needs of these families such as determining appropriate cases, remaining sensitive to co-occurring problems, and engaging families. We then provide specific information on the assessment and treatment of families with CPA. Finally, we present a case illustration in order to demonstrate specifically how PCIT may be adapted for a family with a history of CPA in a manner that is consistent with the original treatment protocol.

Understanding the Population

Who Are These Families? As a society, when we think about parents who physically abuse their children, these parents seldom receive much compassion. Instead, abusive parents are often seen as villains at worst, and sociopaths at best. This may be due, in part, to the cases we see the most often, the extreme cases portrayed in the media – the case of a father placing his 3-year-old son and 2-year-old daughter in a hot dryer (Hutchinson, Kansas, 12/15/06), or a mother and step-father beating a 7-year-old girl to death (Brooklyn, NY, 1/14/06), or a neighbor throwing a 2-year-old boy over an overpass to his death (Honolulu, Hawaii, 1/18/08). While these cases catch our attention and are quite disturbing, in reality, the problem of CPA is often much more subtle and complicated than what the media portrays.

Children of all ages are abused; however, those under age 7 years have higher victimization rates, suffer the most severe injuries, and are the most likely to experience a recurrence of maltreatment (U.S. Department of Health & Human Services, 2007). Physical abuse occurs across socioeconomic, gender, ethnic, and cultural groups. More often, it is boys of varying ages who are physically abused. Physically abused children are seldom removed from their homes (only about 9% are removed).

The most common physical abuse scenario is the mother who physically abuses her own child (U.S. Department of Health & Human Services, 2007). This is likely because mothers are usually the primary caregivers for their children. These mothers generally have few social supports or good interpersonal relationships. They are often poor and have multiple children and stressors. It was once thought that the majority of parents who abused children were abused themselves as children. Instead, it is now thought that only about a third of parents who abuse their children have been abused themselves (Belsky, 1993). It has been our experience that physical abuse by these mothers is rarely premeditated. Instead, it is discipline gone awry – the over-reaction of a stressed parent when a child misbehaves. For example, in one typical case, a mother beat her son with a belt after he hit his younger sister. The mother was so upset that he had hurt his younger sister, that she kept beating the boy until there were welts on his buttocks and legs.

Like most things, discipline occurs on a continuum, which ranges from light correction (e.g., redirection, gentle reminders to stop a behavior) to physical discipline (e.g., spanking) to overly harsh physical responses (e.g., beating, burning). It is sometimes difficult to determine when a parent's response has escalated from physical discipline to physical abuse. Even the legal definition of physical abuse varies slightly in each state, though in all states physical discipline is permitted and in some social groups, even encouraged. Therefore, for treatment purposes, we treat all families on the high end of the discipline continuum similarly, regardless of state criteria or abuse classification status. In this chapter, we will use the term "physical abuse" to mean families who have a substantiated case of child physical abuse in the child welfare system as well as those families who use overly harsh and aggressive strategies to manage their child's behavior. In other words, in this chapter we refer to the families who use harsh words, criticism, rejection, hostility, and physical means to control and discipline their children.

Typical Referral Concerns

Children with a Physical Abuse History. It was once thought that children who were physically abused would be the children who afterward became fearful and inhibited. While this may sometimes be the case, it is more often the exception to the rule. Instead, children who have been physically abused often exhibit aggressive and defiant behavior (Kolko, 1992). Physically abused children tend to have poor social skills and are described by their teachers and peers as bullies. Essentially, they are displaying the behavior they have learned through modeling – aggression, control, and domination.

In recent years, we have noticed an increase in the number of children involved in the child welfare system who are being referred for PCIT services with a diagnosis of Reactive Attachment Disorder (RAD). RAD is a diagnosis of early childhood and infancy with symptoms including impaired social interactions presumably due to a history of pathogenic care, such as institutionalization or severe maltreatment (APA, 2000). Associated features, such as manipulation of caregivers and lack of cause and effect thinking, have been used anecdotally to describe RAD (Hanson & Spratt, 2000). Impaired social interactions are considered: (1) inhibited, characterized by "persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions" (DSM-IV-TR; APA, 2000, p. 116) or (2) disinhibited, typified by "the failure/inability to discriminate in their social interactions (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)" (DSM-IV-TR; APA, 2000, p. 116). While children with CPA histories meet the criteria for pathogenic care, it is not clear if their behaviors are best represented by RAD or other diagnoses (e.g., disruptive behavior disorders, posttraumatic stress disorder, anxiety disorders), thereby raising questions about the validity of the RAD diagnosis (Hanson & Spratt, 2000).

In addition to concerns regarding diagnostic validity, there are significant concerns related to the interventions being used to treat children diagnosed with RAD. Specifically, the use of controversial attachment treatments gained media attention after the death of 10-year-old Candace Newmaker during a "rebirthing" procedure (Cannon, 2000), a technique in which restraints are used to simulate a rebirthing process. In response to this controversy, the American Professional Society on the Abuse of Children (APSAC) assembled a task force, which published a report outlining current controversies on attachment therapy, reactive attachment disorder, and attachment problems and provided recommendations for clinicians (Chaffin et al., 2006). Among their recommendations for treatment and intervention, the Task Force suggests that

> State-of-the-art, goal-directed, evidence-based approaches that fit the main presenting problem should be considered when selecting a first-line treatment. Where no evidence-based option exists or where evidence-based treatment options have been exhausted, alternative treatments with sound theory foundations and broad clinical acceptance are appropriate (p. 87).

In addition, it is recommended that "First-line services for children described as having attachment problems should be founded on the core principles suggested by attachment theory, including caregiver and environmental stability, child safety, patience, sensitivity, consistency, and nurturance" (p. 87). Given the dyadic nature of PCIT and its roots in attachment theory, and the recommendation made by the APSAC task force, we feel that PCIT is an appropriate intervention for use with children with a diagnosis of RAD.

Caregivers with a Physical Abuse History. In comparison to non-maltreating parents, abusive parents generally tend to be less positive and affectionate when interacting with their children (Bousha & Twentyman, 1984; Kavanaugh, Youngblade, Reid, & Fagot, 1988). For example, they are less supportive and use fewer positive

or encouraging words (e.g., praise). They also display fewer appropriate care giving behaviors and seem to lack empathy when responding to their children's cues (e.g., will not comfort a child after a fall). In fact, they even respond less often to their children in comparison to non-abusive parents (Kavanaugh et al., 1988). Many abusive parents also have difficulty with impulse control and managing negative affect (e.g., anger, anxiety, depression); they seem to display a lot of negative emotions and volatility themselves, but do not understand emotional issues, in general. Abusive parents also often have difficulty with problem-solving and other cognitive skills, which is particularly apparent with regard to their expectations for their children's behavior. Abusive parents often have strong (even rigid) ideas about discipline and unrealistic expectations for child development.

Family Patterns and Dynamics. The relationship between abusive parents and their children is complex. It seems that CPA and child behavior problems are bi-directional with parental violence encouraging child behavior problems and child behavior problems increasing a child's risk for being physically abused, perhaps due to increased parent stress. Patterson's "coercion hypothesis" (Patterson, 1976; 2002) provides a conceptualization of this dynamic. His social learning perspective emphasizes the importance of the parent-child relationship in escalating behavior. Patterson suggests that many challenging child behaviors are part of typical child development (e.g., the "terrible twos" are characterized by noncompliance). Because they are a part of development, specific behaviors (e.g., noncompliance) typically are temporary and vary in severity by child. Patterson (1976) argues that specific conditions (e.g., a parent's failure to reinforce pro-social skills and instead respond to the child's inappropriate behavior) may ensure that some children continue to engage in specific behaviors, like noncompliance, even when it is no longer developmentally appropriate.

In terms of parent-child interactions between abusive parents and their children, abusive relative to non-abusive parents engage in more negative interactions (both verbal and nonverbal) and inconsistent discipline strategies with their children (e.g., Reid, Taplin, & Lorber, 1981). Verbal interactions are characterized by parent verbal aggression such as whining, yelling, criticizing, threatening, and screaming (Lahey, Conger, Atkeson, & Treiber, 1984). Similarly, abusive mothers were more likely to engage in physically aggressive (e.g., biting, grabbing, kicking) behaviors with their children when compared to both neglectful and non-abusive mothers, and to seldom use rational guidance (e.g., reasoning with the child in response to misbehavior; Bousha & Twentyman, 1984). In support of Patterson's coercion hypothesis, researchers (Lorber, Felton, & Reid, 1984) have found that abusive mother–child dyads maintained a pattern of behavior in which they reinforced each other's aversive behaviors. In other words, mothers were likely to reinforce their child's negative behavior and children were likely to reinforce their mother's negative behavior.

Consider the following example. A mother asks her child to put on his shoes because they need to get ready to leave the house, and he screams "No, I'm playing!" She ignores him, begins getting things ready to go, and the child continues to play. Once she is ready, she again asks the child to put his shoes on. He again screams "No!" They begin to argue, which culminates in the mother dragging the child by

the arm to his shoes and physically shoving them on to his feet as he cries. The shoes are put on and they can go. In this example, the child's noncompliance is reinforced by his mother avoiding him – at least initially. So, while she ignores his initial screaming and saying no, he gets to continue to play. On the other hand, the mother's aggression is reinforced because that is ultimately what met her needs of getting his shoes on.

Often Co-occurring Problems. Specific problems often co-occur with CPA including (most often) substance abuse, domestic violence, poverty, and behavioral health difficulties, including trauma symptoms (for more information, see Chapter 18 regarding parents with major life stressors). While PCIT does not directly address these problems, they must be assessed by the clinician, accounted for in the clinical conceptualization of the case, and treated, oftentimes in another treatment format (e.g., individual therapy). Particular attention is paid to the assessment of these issues in the intake assessment. If needed, additional intervention strategies are incorporated within the PCIT framework. If PCIT cannot be appropriately adapted to successfully target these problems, referrals are made to other service providers. Typically, the issues of substance abuse, domestic violence, and active behavioral health problems (e.g., severe depression, unregulated bipolar disorder, psychotic symptoms) have to be stabilized before PCIT can be helpful to the family.

Substance Abuse. Between one-third and two-thirds of child maltreatment cases involve substance abuse (U.S. Department of Health and Human Services, 1999). The outcomes for maltreated children with substance-abusing parents are worse than maltreated children without substance-abusing parents (U.S. Department of Health and Human Services, 1999). For example, maltreated children with substance-abusing parents are more likely to be placed in foster care and to remain there longer; to have poorer physical, intellectual, social, and emotional outcomes; and to be at greater risk for developing substance abuse problems relative to children without substance-abusing parents (U.S. Department of Health and Human Services, 1999).

Domestic Violence. About 40% of CPA cases also involve domestic violence (Appel & Holden, 1998). Multiple forms of violence within the family seem to indicate a systemic problem; however, the abuse of women and the maltreatment of their children typically are treated as separate phenomenon (Schechter & Edleson, 1995). Aggression, like child abuse and domestic violence, alters family roles and interaction patterns. After living in a violent home, disruptive behavior on the child's part can actually serve as a reminder of the mother's own trauma and may elicit trauma symptoms. For example, a child screaming and hitting might trigger behavior from the mother such as withdrawal, which would inadvertently reinforce the child's behavior. Conversely, that same child behavior (i.e., screaming and hitting) might elicit an aggressive response from the mother, which could result in repeated physical abuse.

Poverty. Child maltreatment occurs across socioeconomic lines; however, it occurs at significantly higher rates among families living in poverty, which likely is due, in part, to the extreme stress that these families experience (cf. McGuinness & Schneider, 2007). Research consistently indicates that poverty and economic hardship have negative consequences in and of themselves (e.g., poor school

performance, peer rejection, behavioral and emotional difficulties) for children that persist into adulthood (Eamon, 2001; Sobolewski & Amato, 2005).

Additional Behavioral Health Concerns. In addition to substance abuse, abusive parents relative to non-abusive parents evidence higher rates of behavioral health concerns including depression (Whipple & Webster-Stratton, 1991), mood disturbance, and personality disorder (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994). Similarly, maltreated children experience higher rates of behavioral health difficulties in comparison to their non-abused peers with approximately a third of physically abused children experiencing post-traumatic stress disorder (Famularo et al., 1994).

Adaptations and the Unique Treatment Needs of Families with a History of CPA

This is an exciting time in the field of PCIT as the treatment is being adapted for various cultural and clinical populations and dissemination continues to expand (Herschell, Calzada, Eyberg, & McNeil, 2002). Dr. Sheila Eyberg, treatment developer of PCIT, has distinguished between *tailoring, adaptation,* and *modification* of empirically supported treatments (Eyberg, 2005). When tailoring a treatment, the clinician may change the focus or delivery style of particular PCIT components in order to address the specific needs of the family. This is done in *all* PCIT cases. If the clinician makes changes in the structure or content of PCIT, this is considered a treatment *adaptation.* Similarly, adaptation has been defined as a process in which the treatment model is changed for use with a given population (e.g., separation anxiety disorder) or situation (e.g., home-based PCIT) while faithfully and competently delivering the model (Funderburk, Ware, Althsuler, & Chaffin, 2008). It has further been suggested that adaptation is usually undertaken by someone who already has achieved mastery of the treatment model and its underlying theory base. In contrast, *drift* occurs when a therapist commits technical errors or abandons the critical components of the model (Funderburk, Ware, Althsuler, & Chaffin, 2008) and is related to loss of effectiveness (Schoenwald, Sheidow, & Letourneau, 2004; Elliott & Mihalic, 2004). Great care must be taken to ensure that any adaptations are made with fidelity to the PCIT model. Our recommendation is that adaptations be made to the original protocol *only* when necessary or when components from the original protocol would be contraindicated. Any modification is a potential threat to the integrity of the treatment. Any gains made by potential modifications are attenuated by the risk of reducing the effectiveness of the program.

When making any type of adaptation it is important to do so carefully. Guidelines have been provided for the type of clinical reasoning that therapists should use when considering such adaptations (Funderburk, 2007), and recent reviews have suggested that there are crucial components to programs that enhance their effectiveness (Kaminski, Valle, Filene, & Boyle, 2008). Funderburk suggested that decisions about potential adaptations be examined to determine if there is any conflict with the

core principles of PCIT. One example of a core principle is the focus on live coaching of the interaction between the parent and child. Therefore, if a clinician develops an adaptation that contradicts this core principle, the adaptation is problematic. But perhaps even more significant than whether or not the adaptation is in line with the core principles of PCIT (which are based on underlying theoretical principles), clinicians should ask themselves the "bigger picture" question of whether or not the adaptation will help the client toward reaching their treatment goals, attaining skills criteria, and/or increasing parental competence. We would add, not only does the adaptation help, but could the same results be achieved without the adaptation? In other words, is it a *necessary* adaptation?

In addition to utilizing the guidelines established by Funderburk (2007), we strongly recommend that clinicians consult with their PCIT colleagues on a regular basis, especially when considering an adaptation to the protocol. This can be accomplished through a variety of means. Hopefully, if you are a PCIT provider, there are other PCIT providers at your workplace with whom you could consult. If there is not another provider at your agency, there is a list-serve dedicated to facilitating discussion of PCIT-related topics. Subscribers are able to post their questions via email, which are then read by many PCIT providers who can respond with their expertise. For more information on subscribing to the list-serve, please visit www.pcit.tv. Finally, there is an annual PCIT conference dedicated exclusively to research and clinical issues related to PCIT. This is a great opportunity to network with other PCIT providers and establish working relationships.

Our review of the caveats in making adaptations to PCIT are not intended to scare clinicians away from providing PCIT to families with a history of CPA or inhibit clinical creativity. Our intention is only to remind clinicians that any adaptation should be made mindfully. In the next section we discuss some examples of how PCIT can be tailored and adapted for work with families with a history of CPA. Specifically, we review general therapeutic issues including how to determine appropriate cases, remain sensitive to co-occurring concerns, and increase parent engagement. We also discuss using additional assessment measures, incorporating additional coaching targets, and tailoring the Parent-Directed Interaction phase of treatment to families with a history of CPA.

General Therapeutic Issues

The most notable adaptation of PCIT for CPA populations is an increased focus on the parent. Families are selected for participation in treatment if the *parents* have demonstrated aggressive or abusive behavior toward one or more of their children. Instead of being conceptualized as a *caregiver-mediated* treatment for child behavior problems, we view our work with CPA families as a *parent-treatment* for their abusive behavior.

As a result of this unique conceptualization, child behavior problems, or a lack thereof, are not important in the selection of treatment. If child behavior problems

are present, they become treatment targets, but are not conceptualized as "difficult" or "problematic." Many children enrolled in PCIT with abusive parents do not have clinically significant behavior problems.

Determining Appropriate Cases. Not all cases in which there has been physical abuse are appropriate for PCIT. Different types of maltreatment often co-occur. For example, neglect and physical abuse are often experienced together. If the primary concern is chronic child neglect, referral to another program such as Lutzker's Project SafeCare (Lutzker & Bigelow, 2002) may be warranted prior to participation in PCIT. Sometimes physical and sexual abuse co-occur. For children who have experienced both physical and sexual abuse, care should be taken in determining the role of caregivers in the sexual abuse. Caregivers who committed a sexual offense or who helped to support an offender of child sexual abuse usually should *not* be included in PCIT.

Also, care should be taken in determining when to begin and who to include in PCIT for children who have been removed from their biological home. If it is unclear if a child will be returned to his or her biological parent, the biological parent should *not* be included in PCIT with the child. The first phase of PCIT focuses on relationship enhancement. It likely would be harmful for a child to spend time in treatment with his/her biological parent building their relationship only to ultimately be removed from that parent if the parent's rights are terminated. On the other hand, if it is likely that the child will return to the biological parent and the child and parent have a reasonable amount of weekly contact (e.g., at least 1-h weekly visits), PCIT could help build their relationship and increase the parent's skills before the child's return home.

PCIT has been found to be helpful with foster parents (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005). Children with CPA histories are sometimes placed in foster care with foster parents who feel unprepared to manage the level of disruptive behavior exhibited by these children. PCIT can be initiated at any point in the foster placement.

Remaining Sensitive to Co-occurring Concerns. As previously mentioned, care is taken to assess difficulties that commonly co-occur with CPA in the pre-treatment assessment session so that these issues can be considered in the full case conceptualization, ensuring that treatment decisions are well-informed. Substance abuse, domestic violence, and extreme parent behavioral health concerns (e.g., untreated depression, bi-polar disorder, personality disorders) should be stabilized prior to beginning PCIT. Once PCIT is initiated, attempts are made to support previously achieved treatment successes. Referrals are made if there are relapse difficulties or if it is learned that a parent's problems are too substantial or detract from the focus of PCIT. It is preferable that additional services are completed sequentially, rather than simultaneously, so that multiple, and sometimes inconsistent, services do not overwhelm an already stressed family.

Given that families with a history of CPA often present to clinicians with a variety of additional concerns outside of the scope of PCIT, the clinician is at risk for becoming involved in a cycle in which more time is spent dealing with the "crisis of the week" than on the essential components of PCIT (e.g., coding, coaching).

While clinicians have found benefit in engaging caregivers in conversation on topics apart from their child's behavior or the parent-child relationship, it is important that these conversations do not overtake the session. A minimum of 30 min per session should always be devoted to direct coaching of PCIT skills in order to ensure progress toward treatment goals.

Engaging Families. One of the first challenges to providing PCIT services to families with a history of CPA is to get them engaged in the treatment process. In our experience, caregivers with a history of CPA typically come into the mental health system involuntarily; they have been told to participate by their caseworkers or mandated by the court as part of their family service plan. These families are also likely to experience additional stressors which compromise their ability to participate in an intensive program such as PCIT on a regular basis (McNeil & Herschell, 1998). Given the difficulty in engaging families with a history of CPA, PCIT clinicians and researchers have recognized this challenge and have developed some creative strategies to increase session attendance and participation as well as homework completion.

Enhancing Parents' Motivation. One of the most significant advances in this area has been the incorporation of a motivation enhancement protocol to the standard PCIT program. The University of Oklahoma's Center on Child Abuse and Neglect has incorporated the use of a Self-Motivation group in their work with abusive families (Silovsky et al., 2005). This program was designed for use with families with known histories of harsh discipline or physical abuse. Based on the principles of Motivational Interviewing (Rollnick & Miller, 1995) and the Transtheoretical Model of Stages of Change (Prochaska, DiClemente, & Norcross, 1992), the goal of the Self-Motivation group is to overcome the barrier of low motivation by increasing motivation to change parenting behavior, eliciting motivation to overcome external barriers (e.g., transportation, babysitting), increasing beliefs in ability to implement new parenting strategies, and developing commitment to program completion and parent-child relationship enhancement. Early in this program, clinicians address the issue of mandated participation. They acknowledge and empathize with caregivers' concerns, while simultaneously asking caregivers to try and get the most out of the services that are being offered.

Group leaders use a variety of exercises throughout the six-session program designed to resolve the parent's ambivalence about changing their parenting. For example, during the first session, caregivers complete a decisional balance exercise in which they are asked to consider the pros and cons of using different discipline strategies (including forceful discipline). The goal at this stage is not to change the caregiver's mind about using forceful discipline. Instead, the goal is to encourage thought and reflection about parenting practices. A randomized clinical trial is currently underway to examine the effectiveness of the Self-Motivation group in PCIT. Preliminary data suggest that caregivers who participated in the Self-Motivation group had higher retention rates than those in the standard orientation group (Chaffin, Funderburk, Bard, & McCoy, 2008).

McKay and colleagues (2004) have described interventions for initial contacts designed to increase the engagement of families in their children's mental health

services. A telephone engagement strategy has been utilized to clarify the need for services and identify potential barriers to obtaining treatment (e.g., poor previous experiences with mental or behavioral health providers, logistic concerns such as transportation or daycare). This strategy alone resulted in a 30% increase in initial appointment attendance. Another engagement strategy has targeted the first interview and is aimed at clarifying roles, establishing a foundation for a positive working relationship, identifying issues that can be addressed immediately, and identifying solutions for potential barriers to treatment participation.

In addition to implementing a structured intervention aimed at enhancing motivation such as those mentioned above, there are several clinical tools that PCIT clinicians can implement throughout treatment in order to enhance motivation. Table 13.1 outlines some of the tools that we have found helpful in working with families with a history of CPA. These tools address how to build a working alliance with families, get families to regularly attend sessions, increase participation within the session, and improve homework completion.

Assessment

In addition to the standardized, parent-report measures such as the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999), Parenting Stress Index (Abidin, 1995), and Brief Symptom Inventory (Derogatis, 1975; 1993) that are routinely collected at the PCIT pre-treatment assessment, families with a history of CPA are asked to complete to the Child Abuse

Potential Inventory (CAPI; Milner, 1980; Ondersma, Chaffin, Mullins, & LeBreton, 2005) prior to beginning treatment. Together, these assessment tools help the clinician to understand the clinical significance of the child's behavior as well as parents' stress, behavioral health concerns, and parenting practices. Similarly, the intake interview is expanded to include detailed questions about physical discipline methods used, domestic violence, substance abuse, the parent's behavioral health symptoms, and other safety concerns (e.g., neighborhood violence). Standard, structured behavioral observations also are completed and coded using the Dyadic Parent-Child Interaction Coding System – III (DPICS – III; Eyberg, Nelson, Duke & Boggs, 2005). On this assessment, care is taken to understand the number of verbalizations a parent directs toward their child (physically abusive parents often have fewer comments than non-abusive parents) as well as the type of verbalizations (e.g., increased attention to criticisms and direct commands). If the child is cared for outside of the home (e.g., school, Head Start, daycare), other caregivers are asked to complete standardized behavioral measures such as the Sutter-Eyberg Child Behavior Inventory (SESBI; Eyberg & Pincus, 1999). Information from additional sources (e.g., teacher, social worker, another caregiver, another behavioral health provider) provides another important perspective given that physically abusive parents often tend to over-report child behavior problems.

Table 13.1 Engagement challenges and solutions

Challenge	Clinical solution	Example and rationale
Building a working alliance with the family	Clarify roles	Be straightforward with families regarding your role. Parents typically assume that the PCIT provider works for or with child protective services. It will be important to clarify this misconception
	Clarify goals	Have families identify goals early in treatment. This will help the family find value in therapy. These goals may be related to their own parenting behavior, their child's behavior, or the parent-child relationship. In some cases where parents are particularly resistant to treatment, the main motivation may be to finish their family service plan and no longer be involved with child protective services
	Make the implicit explicit – define treatment expectations, structure, process, and content in the first session	Often times, we assume that parents will know what to expect from treatment; however, this is seldom the case. Make sure that parents have a good understanding about the structure and process of treatment as well as what they can (and cannot) expect from you and from treatment. For example, if you will be providing progress reports to social workers throughout treatment, let the parents know. Perhaps you could even show them a sample report template and explain the information you will be providing
	Listen to the parent	Non-judgmentally listening to the parent and hearing their struggles can be very powerful. Parents with a history of CPA often have been frequently criticized and judged. If they feel as if you are listening and offering solutions, they will be more willing to work with you
	Provide visual reminders of your clinic	Some agencies have used magnets or pens with the agency name and logo to provide to clients
Getting families to attend sessions regularly	Troubleshoot potential barriers early in treatment in order to prevent this from becoming a problem	Problems with transportation, child care resources, and multiple appointments can make getting to PCIT sessions difficult for families. Identifying and solving these barriers early in treatment will help eliminate unnecessary obstacles
	Provide families with regularly scheduled appointments that do not vary	Not only will this ensure consistency, it will help the family incorporate sessions as part of the family's routine

Table 13.1 (continued)

Challenge	Clinical solution	Example and rationale
	Work with family to identify the best way to remember their appointment	Simple strategies may help increase attendance such as having the parent post a reminder in a conspicuous place or send a voicemail to him-/herself with a reminder of the appointment. You could also send a text message to the family as a reminder
	Create accountability	Find naturally occurring opportunities to create accountability. For example, if you will be providing progress reports to social workers throughout treatment, let the parents know what exactly will be contained in the report and how they can positively impact the report (e.g., attendance and participation in sessions). Regularly show parents their progress in treatment through weekly review of behavior observation data charts
	Be helpful within the first session	The old saying "You'll never have a second chance to make a first impression" is applicable for PCIT intake sessions. The first session sets the tone for treatment. It will be important to set a helpful, non-judgmental tone in the first session and to offer the family a practical solution to an identified treatment barrier (e.g., bus tickets if they have transportation problems.)
Increasing session participation	Use drills to work on skills deficits	For parents who are having difficulty with a particular skill, have them do a drill devoted to that skill. For example, if the parent has trouble with labeled praises, you might tell them to try and give as many labeled praises as they can in 1 min (without your help!)
	Provide concrete examples	For many parents, abstract reasoning will not be beneficial. Instead, tying the behavioral skills to issues from their "real life" may help. For example, if the parent has reported problems with aggression, point out that praising the opposite behavior (i.e., being gentle) will increase the likelihood of gentle behavior Parent: I like how you are being so gentle with the toys Therapist: Great labeled praise! You mentioned that hitting has been a problem for Joey, like when he hit his sister this morning at breakfast. By praising gentle behavior he is more likely to be gentle (rather than aggressive) in the future

Table 13.1 (continued)

Challenge	Clinical solution	Example and rationale
	Point out parent progress in treatment	There are several ways to demonstrate progress throughout treatment. Using graphs to display changes in parent use of DPICS skills and changes in ECBI scores can provide a visual depiction of progress in treatment. Another powerful way to point out progress is during coaching. When you notice changes in the parent's behavior, the child's behavior, or the quality of the parent-child relationship, point it out to the parent. They may have missed it! Parent: You are doing a great job using your inside voice today. (Gives child a small hug and kiss on forehead. Child smiles) Therapist: Wow! That is really neat to see. You are giving Tameka praise for doing the right thing and she just loves those hugs and kisses. Did you see her face light up? She loves it and she loves spending time with you
	Be genuine	While we aim to find as many opportunities to praise parents as possible, it is critical that this praise is genuine. If the therapist doles out "saccharine-sweet" praise that is insincere, the parents will know and the therapist will lose credibility
	Avoid getting pulled down by negative affect	There may be situations where the parent is having a particularly difficult day or has been resistant to treatment from the beginning. In these cases, it is hard not to get "dragged down" by the negativity. Clinicians should try to maintain the pace of the session, set a positive tone, and be encouraging. The therapist should praise any bit of enthusiasm from the parent. It may help to address the parent's tone directly Therapist: I know you've had a rough week and can probably think of other things you'd rather be doing right now, but I also know that you have been working hard at this and I would hate to see you lose momentum!
Increasing home work completion	Change the name of homework	Some parents have not had a great experience with school and the thought of having "homework" may be a big turnoff. Instead the therapist may use another name such as "daily practice" or "daily special time"
	Troubleshoot barriers to complete homework	Develop a homework strategy with the parents that is as concrete as possible. Where will special time take place? What toys will be used? What time of day will work best on a day-to-day basis? This is important for all parents in PCIT, but especially for high-risk families with multiple stressors

Table 13.1 (continued)

Challenge	Clinical solution	Example and rationale
	Complete homework sheet at beginning of session if not completed at home	If parents forget their homework sheet, be sure to have blank copies on hand to complete the form with the parents at the beginning of the session
	If the child is not living at home with the parent, get creative in ways for parents to practice the skills	This is a difficult situation. If the parents have other children at home, they can certainly practice their skills with them. If there are no children in the home, parents can practice with significant others or other children in the extended family. We've even had parents practice on a family pet (good for practicing behavioral descriptions, not so good for practicing reflections!). In addition, you may assign other types of homework such as a "Praise the Opposite" worksheet where parents have to generate a labeled praise for the opposite of a problem behavior

Treatment

Incorporating Additional Coaching Targets

Child Emotion Regulation. An important aspect of psychosocial development for preschool children is the ability to regulate their emotions (Campos, Frankel, & Camras, 2004); however, development of these skills is disrupted by the maltreatment process (Cicchetti & Lynch, 1993). Infant temperament, maternal mood, affective quality of the mother–child relationship, and the predominant pattern of emotional expression in the family (Endriga, Jordan, & Speltz, 2003) each strongly influence the development of emotion regulation. The entire first phase of PCIT is dedicated to improving the parent-child relationship. Caregivers may be coached to label their child's feelings (so long as attention is not being provided for misbehavior). For example, if a child successfully builds a castle and looks at their caregiver with a smile, the caregiver may be coached to say, "Wow, you look really happy and proud that you built the castle by yourself. I'm proud of you, too, for sticking with it." Coaching the caregiver to identify and label their child's emotions is an intervention for the child and the caregiver. The child is learning appropriate emotion labels that coincide with internal states, while the caregiver is learning to be attuned to their child's emotional state. Other strategies are incorporated to improve parent's expression of affect as well as to generalize appropriate expression of emotion from clinic to home settings.

Reasoning – Talk More to the Child. While providing PCIT to caregivers of children with disruptive behavior problems, one of the challenges can be getting caregivers to reduce their use of rationale and reasoning with their children. Often times, these caregivers have difficulty giving a direction or a consequence for misbehavior without having a lengthy "discussion" about the child's behavior (e.g., why it was wrong). In contrast, we find that in working with physically abusive caregivers, there is a tendency to have less overall interaction, which translates into less "discussion" about the cause and effect nature of the world around them. When done on a consistent basis, this can lead to confusion for the child.

For parents who appear to have difficulty engaging with their children and providing them with general information about the world around them, we address this during coaching. Information descriptions are a great way for caregivers to describe the child's world. For example, when a caregiver gives their child a warning that there are 5 min left of special playtime, this may help the child prepare for a transition. While these types of descriptions do not move caregivers any closer to meeting mastery criteria, we feel that they are an important skill for caregivers. Parents are also taught to provide a context for commands from the beginning of PDI. With all parents, we teach them to give a rationale before their command. This can be especially helpful for parents with a history of CPA. By teaching them to provide a rationale first, they are giving their child additional information about their world. For example, instead of saying, "Go get your jacket on" we might coach a parent to say, "It is really cold out there today and I want to make sure you're warm – please go put your jacket on."

Developmental Expectations. We often find that parents with a history of CPA have inappropriate developmental expectations of their children. These expectations may be too high or too low. For caregivers with high developmental expectations, this can easily lead to frustration and excessive discipline because the children are not behaving as the parents expect them to behave. One example of this is during potty training when caregivers may be expecting their children to be potty trained before they are developmentally ready.

This can be addressed in subtle ways throughout CDI. During CDI coaching, the therapist may be looking for examples to point out to the caregiver. For example, if the toys are positioned on the table such that the child cannot reach them adequately without standing up in the chair, we will coach the parent to move the toys closer to the child or push the child's chair in so that he or she is better able to access the toys. Another way that the therapist can help teach parents about their child's developmental level is by talking about the developmental appropriateness of the toys being used during session. We might put out a toy that is at the upper limit of what we think the child's developmental level is and then observe their use of the toy and point it out to the parent by saying something like, "Oh, it looks like those blocks are a little too small for James to be able to put together with his little fingers. The box next to that has some larger blocks. Let's try taking some of those out to see if he likes those better." Another way to teach developmental appropriateness is by pointing out to caregivers what is typical behavior. For example, when using Play-Doh®, some caregivers have great difficulty with the colors being mixed together (if this is a problem, Play-Doh® should not be used during CDI). Caregivers may try to stop their children from mixing the Play-Doh® during CDI. The therapist can point out, "Lots of children Eduardo's age mix the colors together. It's alright. Let's see what he comes up with."

Education and child development can also be addressed more directly during PDI. We teach all parents about the importance of giving developmentally appropriate commands. It is critical that parents give commands that are developmentally appropriate to ensure that their child is able to comply before following through with the consistent discipline program. Depending on the specific needs of the family, this discussion may be extended during the PDI didactic by providing the parents with psycho-education about developmentally appropriate expectations for children.

Child Language Development. Another important aspect of psychosocial development for preschool children, which interacts with emotion regulation, is language development (Bloom, 1993). Unfortunately, children with a history of physical abuse typically score lower on language tests relative to children with no physical abuse history (e.g., Coster, Gersten, Beeghly, & Cicchetti, 1989). To improve language for these children, CDI coaching focuses on encouraging the parent to increase the number of words said to their children as well as the use of rationales, generally, and for commands, specifically. Parents are coached to increase descriptive comments. They also are taught to use reflections as a gentle way to correct language errors.

Negative Attributions About the Child. One common challenge in working with caregivers with a history of physical abuse is that the caregiver's view of the child

may be inherently negative. For example, if her daughter has a temper tantrum after missing her nap that day, the mother may attribute the temper tantrum to the "difficult" nature of the child instead of considering the fact that the girl may be tired. To address some of these concerns it is important for the therapist to be aware of the family's schedule. This way, the therapist can gently provide alternative explanations for the child's behavior that are more developmentally appropriate.

Tailoring and Adaptations Specific to PDI

Anger Management. Discipline is often an emotionally charged subject for families with a history of CPA. Often, it is an incident of discipline that has escalated out of control which led the family to be referred for PCIT. Bousha and Twentyman (1984) determined that not only were abusive mothers more likely to engage in physically aggressive behaviors (i.e., biting, grabbing, kicking, punching, slapping, spitting on, or hitting another person), but they were also more likely to engage in verbally aggressive behaviors (i.e., threatening, swearing, yelling, criticizing, name calling, or screaming at another person) with their children than both neglectful and non-abusive mothers. Caregivers participating in PCIT are somewhat inoculated to the stress associated with parenting during the CDI phase of treatment. During CDI, caregivers were introduced to ignoring as a behavior modification skill. To ignore successfully requires a great deal of control from the caregiver and typically requires help from the therapist (at least initially). Once the caregiver meets mastery criteria, they have learned to use ignoring which necessarily means they have been able to manage their anger about their child's behavior to some degree.

During PDI, we up the ante by putting the caregiver and the child in more realistic discipline situations in the form of command→compliance sequences. In order for PDI to be successful, emotion and excitement have to be removed from the procedure. To help caregivers accomplish this goal, therapists may role-play a time-out situation with the caregiver several times before the "real thing." During these role-plays, the therapist may introduce brief relaxation techniques and provide the caregiver with praise any time they are able to implement the procedure with neutral affect.

Back-Ups to Time-Out. Perhaps one of the biggest adaptations to PCIT for use with families with a history of CPA occurs in the implementation of the time-out procedure. In the Florida protocol, the back-up to time-out is a 1-min period in a time-out room. Using a time-out room necessarily has a physical, hands-on component. Specifically, if children refuse to go to the time-out room, the caregivers need to physically get them there. History of CPA alone may not be sufficient reason for deviating from the original protocol; however, there are several situations in which an alternative back-up may be warranted. First, if the child's abuse history involved any type of containment in a small room or closet, use of a time-out room may be contraindicated. The time-out room is meant to be aversive to the child, but not to be a fearful experience and certainly not to re-traumatize a child. For this reason,

it would be important to have a complete abuse history. Another situation in which a time-out room may not be used is when agency regulations or state laws prohibit confining a child in a room alone. Our experience is that this is a common situation in many community mental health settings across the United States. Finally, there are situations where a time-out room is simply unavailable and clinicians need additional options.

Due to these concerns, "hands-off" alternatives to the time-out room have been developed and implemented, although they have not yet been empirically studied. One back-up alternative is implementing the use of a "Dutch door" on the time-out room in which the top and bottom of the door open independently of one another. In this case, when the bottom of the door is closed and the top portion is open, the child can see out of the room very easily and the concerns regarding isolation may be satisfied. However, there are other situations in which a completely "hands off" procedure may be warranted. In these cases, the clinician's options become more limited.

One creative solution to the lack of a time-out room and need for a hands-off procedure has been termed the "Swoop and Go" technique. See Appendix 13 for a diagram describing the words and procedures used in swoop and go. With this procedure, the therapy room serves as the time-out room. If the child refuses to sit in the time-out chair, the parent provides the following once in a lifetime warning: "You got off the chair before I said you could. If you get off the chair again, I will take the toys and wait outside. Stay on the chair until I tell you that you can get off." If the child jumps off of the chair again after the warning about toy removal, the parent is coached to *swoop* all of the toys into a large bin (already in the room) and *go* out into the hall. While gathering the toys, the parent says, "You got off the chair before I said you could, so I will take the toys and wait outside." At this point, the child is essentially in a time-out room. The removal of the toys and the caregiver makes the room less rewarding and leaves fewer objects in the room that could be harmful to the child or that the child could destroy. The other aspects of the time-out procedure remain the same. The therapist continues to have visual contact with the child through the one-way mirror in order to monitor the child's behavior and continues coaching the parent via the bug-in-the-ear device. The parent waits for 1 min plus 5 s of silence before giving the child an opportunity to complete time-out in the chair (and later comply with the original and follow-up commands). For most children, the parent returns to the room after 1 min plus 5 s of silence and puts the child back on the chair saying only, "Stay on the chair until I tell you that you can get off." For children who are highly defiant and/or aggressive during swoop and go, however, we recommend that the parent avoid returning full attention to the child until there is a high probability of success in getting the child to complete time-out in the chair. Thus, at 1 min plus 5 s of silence, the parent can open the door up halfway and ask, "Are you ready to sit in the time-out chair now?" If the child is not cooperative, the parent should close the door and wait another minute. Finally, for children whose behavior escalates during swoop and go (to the point that safety is a concern), it may be necessary for the therapist to go into the room and further childproof the area (e.g., remove a table that the child stood on) or monitor the child from a closer distance.

Another alternative is to utilize behavioral techniques to increase the chances of the child sitting in the time-out chair. For example, some clinicians have used the character, Mr. Bear (a medium to large sized teddy bear), to introduce the time-out procedure. In our experience, children who have seen repeated role-plays of Mr. Bear going to time-out and refusing to sit in time-out are less likely to go to the time-out chair at all. It appears as though through modeling, children are less likely to go to time-out (and hence need a back-up to time-out). One serious drawback to this back-up method is that caregivers may have less opportunity to practice time-out in the clinic with the aid of a PCIT therapist. This is especially concerning when working with caregivers with a history of CPA as you want to ensure that they can implement the procedure appropriately while managing their anger.

Another behavioral intervention includes using a sticker chart for accepting time-out "like a big boy or girl." If children accept their time-out, they can earn a sticker. Stickers can then be redeemed for rewards at the end of the session. If stickers are given for accepting time-out, then stickers must also be given for not having to go to time-out at all during session. The time-out sticker chart can be used both in the clinic and at home. Similarly, restriction of privilege approaches can be used such that children lose a privilege (e.g., a favorite television show, video games) for refusing to accept a time-out. Major drawbacks of using a sticker chart or restriction of privileges include: (1) the loss of privilege is not immediate, (2) the child never complies with the original command, and (3) younger children are too impulsive to make good choices about delayed consequences.

Case Illustration

Background Information. Elias is a 4-year-old Hispanic male who currently resides with his biological mother, Carolina, her paramour (Frank), a 2-year-old sister (Bella), and 1-year-old brother (Xavier). Elias's father is currently incarcerated and has not had contact with the family since Elias was 2 years old. Frank is the father of Bella and Xavier. Carolina works part-time and Frank works intermittently. Frank has a drinking problem which negatively affects his ability to hold a job as well as his relationship with Carolina. The couple often argues about finances and Frank's drinking. The family was referred by their DHS caseworker, Sally Givens, after a daycare provider discovered bruises on Elias's back. During a DHS interview, Carolina explained that she had only "swatted" Elias a few times with a belt when he "just wouldn't listen." The family has little social support. Carolina's family lives in another state and many of Frank's family members also experience substance abuse difficulties.

Baseline Observations. Two separate behavior observation assessments were conducted using the Dyadic Parent-Child Interaction Coding System (DPICS): one with Carolina and Elias, and the second with Frank and Elias. During the Child-Directed Interaction (CDI) portion of the observation Carolina interacted very little

with Elias. She did not use any labeled praises, reflections, or behavior descriptions. She used 13 commands and 12 critical statements. Elias switched between the toys often and did not appear able to maintain attention to one toy for very long. Carolina occasionally interjected critical statements about Elias's play (e.g., "You're messing up the Play-Doh! Don't mix the colors or they won't let you come back and play with their toys!"). During the Parent–Directed Interaction (PDI) portion of the observation, Carolina switched activities abruptly and told Elias sternly, "It is my turn to pick the game. I don't want to play with Play-Doh® anymore." Carolina was attempting to get Elias to draw shapes with crayons on the paper. When Elias continued to try and play with the Play-Doh®, Carolina said loudly, "We're done with that now! My rules now! It's time for my game!" Carolina used many indirect commands and had difficulty engaging Elias in her new activity. When given the instructions for clean-up, Carolina looked exasperated and said to the therapist through the mirror, "He's not gonna do it." Carolina gave Elias the instructions for clean-up and he refused. He pleaded with his mother to help and became increasingly distressed when she refused. Elias became aggressive with the toys, throwing them across the room and at Carolina to which she responded by either chuckling or yelling at him to stop. He then sat in the corner of the room and cried until the end of the 5 min. Carolina became increasingly irritated and her affect escalated throughout the 5 min. She became frustrated and yelled for the therapist to come back in the room.

During the CDI portion of Frank's DPICS assessment with Elias, Frank did not use any labeled praises, reflections, or behavior descriptions. He gave 34 commands (mostly indirect) and 14 critical statements. Frank "took over" the play and became self-involved in building his own high tower. Frank built the tower so high that Elias was unable to add pieces without standing up in his chair. When Elias attempted to stand up to help with the tower, Frank told him to sit down. During the PDI portion of the observation, Frank tried to get Elias to play with a farm set. Frank divided the farm animals between the two of them. Whenever, Elias tried to use some of Frank's farm animals, Frank refused. During clean-up, Frank gave Elias the instructions and when Elias refused to clean up, Frank began to plead with him saying, "C'mon man, pick 'em up. Clean up. Help me out. C'mon." When Elias did not respond, Frank began to clean up the toys for Elias.

Parent Interview. During an intake interview with the caregivers, Carolina and Frank stated that they were participating in the PCIT program because their caseworker told them they had to be there. When asked about the incident that led to their referral, the caregivers stated that the situation has been "blown out of proportion" and the daycare provider did not like them because they were occasionally late in paying their bill; however, they admitted to swatting him. They denied any problems managing Elias's behavior stating that he can be difficult at times, but that they could handle his behavior. Carolina and Frank reported that when he does not get his way, Elias becomes aggressive with his younger siblings. The caregivers did not view this behavior as problematic. Carolina and Frank agreed to hear about other methods of discipline, but were not optimistic that the new methods would be helpful.

Child-Directed Interaction. During the CDI phase of treatment, the most significant challenge for Carolina was learning to engage in play with Elias. She reported to the therapist that she did not play often as a child as she had many household responsibilities from an early age. She stated that she was uncomfortable playing because she felt that she was being "fake." This concern was addressed with Carolina during the didactic portions of the session as well as during coaching. The therapist made a concerted effort to give labeled praises to Carolina in response to her use of the skills, noting to Carolina when her statements sounded particularly genuine, and, most importantly, pointing out Elias's positive responses to Carolina's use of the skills. Once Carolina became more comfortable in her use of the PRIDE skills, she dramatically increased her use of the techniques.

Frank also initially seemed uncomfortable playing with Elias and specifically, in letting Elias lead the play. Most of the work in the first sessions involved coaching Frank to take a step back and follow Elias's lead. The therapist accomplished this through coaching Frank to use skills incompatible with leading the play (e.g., behavior descriptions and reflections). In order to give good behavior descriptions and reflections, the caregiver has to pay close attention to what the child is doing. It is virtually impossible for a caregiver to use behavior descriptions and reflections AND lead the play. Frank would offer suggestions for play (indirect commands) or use critical statements (e.g., "That's not how the train goes together – here, let me show you how it goes"). The therapist responded to this behavior with gentle corrections (e.g., "Let's see what Elias comes up with. He has such great ideas.") or coaching of incompatible behavior (e.g., behavior descriptions). Once Frank was able to follow Elias's lead, he acquired the CDI skills within eight sessions.

Another challenge for Carolina and Frank during CDI was the use of ignoring for inappropriate behavior. Initially, both expressed concerns about ignoring. Specifically, they felt that ignoring the behavior was "letting Elias get away with it." After some discussion, they were willing to try it, but had difficulty mastering the skill. Specifically, Carolina became irritated by Elias's misbehavior and her initial reaction was to confront Elias and reprimand him. Similarly, Frank's initial reaction to misbehavior was to plead with Elias to "be a good boy." The therapist took care to incorporate relaxation exercises during ignoring and after a few weeks of coaching, Carolina and Frank drastically improved their ignoring skills.

Parent-Directed Interaction. Even though CDI was a struggle for Carolina and Frank, they persevered and met mastery criteria. PDI, however, proved to be even more of a challenge. Carolina and Frank had a history of inconsistent parenting. For example, when Elias was aggressive with his siblings they would sometimes respond by punishing him with a swat on the bottom. Other times, aggression would be encouraged if Elias was "punishing" one of his siblings for doing something wrong. Other times the behavior would be ignored. These behaviors were addressed during the PDI didactic and as many "real-life" examples from the family's daily life were incorporated into the discussion as possible.

Once PDI began, Carolina again had difficulty, feeling as though the commands seemed "fake." Specifically, she had difficulty giving play commands. She

commented to the therapist that it seemed silly to give play commands because "who cares if he hands me the crayons?" Time was spent with Carolina acknowledging her feelings that the initial PDI commands seemed silly, but it was explained that the commands are necessarily small at the beginning of PDI because Elias is learning a new skill – compliance. The therapist used concrete examples to illustrate the point. For example, when children learn to write their names, they start with one letter at a time and they work up to writing their whole names. Similarly, in order for Elias to learn how to comply with the "big, real-world" commands like "Please come take my hand" when he is running off in the department store, they needed to start with smaller commands and work their way up. Once Carolina understood the rationale behind the progression of the PDI program, she did well with giving direct commands.

Another challenge for Carolina was staying neutral and calm during the time-out procedure. When Elias refused time-out, he became loud and angry. Carolina initially responded by escalating along with Elias. She raised her voice, repeated her commands, and made additional comments to Elias beyond the PCIT protocol (e.g., "Stay in the chair until I tell you to get up. Stay there. If you sit quietly then you can get out."). This required quick, direct intervention from the coach. Here's an example of the therapist's coaching technique with Carolina during a command→compliance sequence:

Therapist:	Alright, let's try a command. Say, "I want the giraffe to come play with my rhino. Please hand me the giraffe."
Carolina:	I want the giraffe to come play with my rhino. Please hand me the giraffe.
Therapist:	Great direct command. Counting silently. . . Hold out your hand . . .2. . .3. . .
Carolina:	Elias. [Carolina looks at Elias with glaring eyes]
Therapist:	Stay quiet. Let's see if he does it. 4. . .
Carolina:	That one right there [Carolina points to giraffe and voice is starting to rise]
Therapist [says quickly]:	Okay. I can hear that you're getting frustrated. In a calm, neutral voice say, "If you don't hand me the giraffe, you are going to have to sit on the chair."
Carolina: [says calmly]:	If you don't hand me the giraffe, you will have to go to time-out.
Therapist:	Perfect warning. You are calm and neutral and he knows you mean business. We're counting in our heads. . .2. . .3. . .
Elias:	No! I'm playing with it!
Carolina:	Elias! I said hand it –

Therapist [interrupts]:	Stay calm, stand up quickly, and say, "You didn't do what I told you to do so you have to sit on the chair."
Carolina:	[stands up and grabs Elias by the shoulder]
Therapist:	Gentle, gentle – take him by the hand gently.
Carolina [takes Elias by the hand]:	You didn't do what I told you to do so you have to sit on the chair.
Therapist:	Great job staying calm, Carolina! You're cool and calm. Tell him, "Stay on the chair until I tell you that you can get off."
Carolina [says calmly]:	Stay on the chair until I tell you that you can get off.
Therapist:	Perfect! Walk away quickly. You are a neutral time-out robot. You are taking all the fun out of discipline. Great work.
Carolina:	[walks back to table and sits down]
Elias:	[screaming and crying in time-out, but staying in the chair]
Therapist:	You are doing a terrific job ignoring his crying. I know it's hard for you. Take a deep breath. Let's work on those relaxation skills. This is a lot of work but he's learning an important lesson here. He's learning that you say what you mean and you mean what you say. Take another deep breath [3 min elapses plus 5 s of silence].
Therapist:	Okay, it's been 3 min and he's stayed in the chair the whole time. This is a *big* change from last week. He's quiet now. Go see if he's ready to hand you the giraffe.
Carolina:	You are sitting quietly in the chair. Are you ready to come back and hand me the giraffe?
Elias:	[nods sullenly]
Therapist:	Perfect, Carolina! You sound very calm, very neutral.
Carolina:	Okay. [leads Elias back to the table and gestures to the giraffe and to her hand]
Elias:	[hands Carolina the giraffe]
Therapist:	Okay, he complied. Say, "okay."
Carolina:	Okay.
Therapist:	Are you ready for a follow up command?
Carolina:	[nods head]
Therapist:	Okay, take a deep breath and give it a shot.
Carolina:	I want the alligator to come play with the rhino, too. Please hand me the alligator.

Therapist:	Great follow up command. Good rationale.
Elias:	[hands Carolina the alligator]
Carolina:	[smiling, says enthusiastically]: Thank you for listening! When you listen we get to keep playing.
Therapist:	Great labeled praise and I love that enthusiasm! You are really getting the hang of it. You got Elias to comply by staying calm and neutral and following through with what you said. Go right back into your PRIDE skills. That will help to calm Elias.

During PDI, Frank had difficulty with giving direct commands and following through with consequences. Frank reported to the therapist that he often felt guilty disciplining Elias because he wasn't around much. Because Frank avoided discipline, Elias's behavior would escalate. Frank would then become frustrated with Elias's behavior, and would give him a swat. To help with Frank's use of direct commands, the therapist had Frank do practice drills aimed at turning indirect commands into direct commands. The therapist empathized with Frank's concern that he did not want his limited time with Elias spent on discipline. The therapist then reframed the concept of discipline into providing structure that children want and need. Frank appeared to respond to this idea stating that he remembered being frustrated as a child growing up in a home that was chaotic due to his family's substance abuse issues.

Frank's initial difficulty using direct commands and following through with commands required immediate feedback from the therapist. Here is an example of coaching Frank through a time-out procedure:

Therapist:	Great job with your PRIDE skills, Frank. Now, we're going to move into giving some play commands. Are you ready?
Frank:	[nods head]
Therapist:	Great. Tell Elias, "I want to use lots of colors on my car, please hand me the yellow block."
Frank:	I want my car to have lots of colors. Could you hand –
Therapist [interrupts]:	Please hand me. . .
Frank:	Please hand me the yellow block.
Therapist:	Great direct command. Let's see if he does it. Stay quiet. . .3. . .4. . .5. . .Say, "If you don't hand me the yellow block, you will have to go to time-out."
Frank:	If you don't hand me the yellow block, you are going to have to sit on the chair.
Therapist:	Perfect. Now stay quiet. 2. . .3. . .4. . .5. . .
Frank:	Elias, hand me the yellow block and you won't have to go to time-out.

Therapist [interrupting]:	He already had a warning. Stand up quickly and say, "You didn't do what I told you to do so you have to sit on the chair."
Elias:	[hands Frank the yellow block]
Frank:	[looks to the mirror for guidance from the therapist]
Therapist:	Too late. Say, "You didn't do what I told you to do so you have to sit on the chair."
Frank:	You didn't do what I told you to do so you have to sit on the chair.
Elias:	I gave it to you, I gave it to you. No fair!
Therapist:	Ignore that. Good job, Frank. Way to follow through. Take him by the hand to the time-out chair.
Frank:	[takes Elias to the time-out chair and sits him down calmly]
Therapist:	Good job staying calm. Now say, "Stay on the chair until I tell you that you can get off."
Frank:	Stay on the chair until I tell you that you can get off.
Elias:	Not fair. You're mean!! I gave it to you!!
Frank:	I know you did, but –
Therapist [interrupting]:	Ignore that, Frank. Walk away quickly [3-min time-out begins].
Frank [walks back to table, looks to one-way mirror]:	I don't think he gets it. He doesn't understand.
Therapist:	I know it's hard, but he's trying to push limits. If you let him get away with complying after the 5 s, he's going to keep trying to push his limits. Remember what we talked about? We're teaching Elias that you mean what you say.
Frank:	Does he get it though?
Therapist:	I think you need to give Elias some credit. He's a bright boy and he's learning. It might be a tough lesson, but you're teaching him that when you tell him to do something, he needs to listen right away. I know you said that dawdling is a big problem for Elias, and by remaining consistent and only allowing him 5 s to comply, you're teaching him to comply quickly. The more you're consistent, the more he'll get it.
Frank:	Alright.
Therapist:	Okay. Our 3 min is up and Elias is being quiet. Go over to Elias and ask him, "You are sitting quietly in the chair. Are you ready to come back and hand me the yellow block?"
Frank:	You are sitting quietly in the chair. Are you ready to come back and hand me the yellow block?
Elias:	[nods head]

Frank:	Okay [leads Elias back to the table]
Elias:	[hands Frank the yellow block]
Frank:	Okay.
Therapist:	Great job. Now a follow-up command.
Frank:	I need more colors, can you hand –
Therapist [interrupting]:	Please hand me. . .
Frank:	Please hand me a red block.
Therapist:	Perfect direct command. You told him exactly what you needed rather than asking him or using words like "can you or could you."
Elias:	[hands Frank a red block]
Therapist:	Say, "Thank you for listening *so quickly.* When you listen, you don't have to go to time-out."
Frank:	Thank you for listening *so quickly*. When you listen, you don't have to go to time-out.
Therapist:	Great labeled praise. By praising him for minding quickly, we're praising the opposite of dawdling and we increase the chance that he will mind the first time you give a command.
Frank:	[nods head in agreement]
Therapist:	Great work, Frank! Your consistency and follow through are helping Elias learn how to listen. That is really going to help him once he starts kindergarten. Alright, go right back into your PRIDE skills.

Conclusion

PCIT is an evidence-based intervention that has demonstrated reductions in future child physical abuse rates. As clinicians and researchers who work in the field of child maltreatment, we have long recognized the need for effective interventions in the treatment of families with a history of CPA. We are excited about the continued growth of PCIT including its dissemination out of the university laboratory and into community mental health settings where there is greater potential to reach more families in need. Our excitement is only matched by our sincere hope that as dissemination of PCIT continues, clinicians and researchers take prudence in adhering to the original treatment model.

Working with families with a history of CPA can be challenging for even the most seasoned clinicians. Multiple stressors can impede a family's ability to participate in treatment or even make it to their first intake session. Even if clinicians are successful in getting families into treatment, families initially may be resistant or even hostile. In spite of the challenges, working with families in the child welfare system can be rewarding. By treating these families with respect and providing them

with skills to enhance the quality of the parent-child relationship and effective, non-physical parenting strategies, we can make a significant difference in the lives of children with a history of CPA and their families.

References

Abidin, R. (1995). *Parenting stress index: Professional manual* (3rd ed.). Lutz, FL: Psychological Assessment Resources, Inc.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed, text revision). Washington, DC: Author.

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology*, *12*(4), 578–599.

Belsky, J. (1993). Etiology of child maltreatment: A developmental-ecological analysis. *Psychological Bulletin*, *114*, 413–434.

Bloom, L. (1993). *The transition from infancy to language: Acquiring the power of expression*. New York, NY: Cambridge University Press.

Bousha, D. M., & Twentyman, C. T. (1984). Mother-child interactional style in abuse, neglect, and control groups: Naturalistic observations in the home. *Journal of Abnormal Psychology*, *93*, 106–114.

Campos, J. J., Frankel, C. B., & Camras, L. (2004). On the nature of emotion regulation. *Child Development*, *75*, 377–394.

Cannon, A. (2000, September 18). From mumbo jumbo to a child's death. *U.S. News & World Report*, *129*, 36.

Chadwick Center for Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA: Author.

Chaffin, M., Funderburk, B., & Bard, D., & McCoy (2008, June). *New research on motivational enhancement and PCIT*. Paper presented at the PCIT Washington Membership Meeting, Seattle, Washington.

Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., et al. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, *11*, 76–89.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*(3), 500–510.

Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment. *Psychiatry*, *56*, 96–118.

Coster, W. J., Gersten, M. S., Beeghly, M., & Cicchetti, D. (1989). Communicative functioning in maltreated toddlers. *Developmental Psychology*, *25*, 1020–1029.

Derogatis, L. R. (1975). *Brief symptom inventory*. Baltimore, MD: Clinical Psychometric Research.

Derogatis, L. R. (1993). *BSI brief symptom inventory: Administration, scoring, and procedures manual* (4th ed.). Minneapolis, MN: National Computer Systems.

Eamon, M. K. (2001). The effects of poverty on children's socioemotional development: An ecological systems analysis. *Social Work*, *46*(3), 256–266.

Elliott, D. S., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science*, *5*, 47–53.

Endriga, M. C., Jordan, J. R., & Speltz, M. L. (2003). Emotion self-regulation in preschool-aged children with and without orofacial clefts. *Journal of Development and Behavioral Pediatrics*, *24*, 336–344.

Eyberg, S. M. (2005). Tailoring and adapting parent-child interaction therapy for new populations. *Education and Treatment of Children*, *28*, 197–201.

Eyberg, S. M., Nelson, M. M., Duke, M., & Boggs, S. R. (2005). *Manual for the dyadic parent-child interaction coding system* (3rd ed.). Unpublished manuscript, Gainesville, FL: University of Florida.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory and Sutter-Eyberg behavior inventory-revised professional manual*. Odessa, FL: Psychological Assessment Resources, Inc.

Famularo, R., Fenton, T., Kinscherff, R., Ayoub, C., & Barnum, R. (1994). Maternal and child posttraumatic stress disorder in cases of child maltreatment. *Child Abuse & Neglect*, *18*, 27–36.

Funderburk, B. W. (2007, September). *PCIT: Back to Basics*. Paper presented at the Parent-Child Interaction Therapy Conference, Oklahoma City, OK.

Funderburk, B., Ware, L., Altshuler, E., & Chaffin, M. (2008). Use and feasibility of telemedicine technology in the dissemination of parent-child interaction therapy. *Child Maltreatment*, *13*, 377–382.

Hanson, R. F., & Spratt, E. G. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. *Child Maltreatment*, *5*, 137–145.

Herschell, A., Calzada, E., Eyberg, S. M., & McNeil, C. B. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice*, *9*, 9–16.

Kaminski, J. E., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, *36*, 567–589.

Kavanaugh, K. A., Youngblade, L., Reid, J. B., & Fagot, B. L. (1988). Interactions between children and abusive versus control parents. *Journal of Clinical Child Psychology*, *17*, 137–142.

Kolko, D. J. (1992). Characteristics of child victims of physical violence. *Journal of Interpersonal Violence*, *7*, 244–276.

Lahey, B. B., Conger, R. D., Atkeson, B. M., & Treiber, F. A. (1984). Parenting behavior and emotional status of physically abusive mothers. *Journal of Consulting and Clinical Psychology*, *52*, 1062–1071.

Lorber, R., Felton, D. K., & Reid, J. B. (1984). A social learning approach to the reduction of coercive processes in child abusive families: A molecular analysis. *Advances of Behavior Research and Therapy*, *6*, 29–45.

Lutzker, J. R., & Bigelow, K. M. (2002). *Reducing child maltreatment: A guidebook for parent services*. New York, NY: Guilford.

McGuinness, T. M., & Schneider, K. (2007). Poverty, child maltreatment, and foster care. *Journal of American Psychiatric Nurses Association*, *13*(5), 296–303.

McKay, M. M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., et al. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention*, *4*, 177–186.

McNeil, C. B., & Herschell, A. D. (1998). Treating multi-problem, high-stress families: Suggested strategies for practitioners. *Family Relations: Interdisciplinary Journal of Applied Family Studies*, *47*, 259–262.

McNeil, C. B., Herschell, A. D., Gurwitch, R. H., & Clemens-Mowrer, L. (2005). Training foster parents in parent-child interaction therapy. *Education and Treatment of Children*, *28*(2), 182–196.

Milner, J. S. (1980). *The child abuse potential inventory: manual*. Webster, NC: Psytec.

Ondersma, S. J., Chaffin, M. J., Mullins, S. M., & LeBreton, J. M. (2005). A brief form of the child abuse potential inventory: Development and validation. *Journal of Clinical Child and Adolescent Psychology*, *34*, 301–311.

Patterson, G. R. (1976). The aggressive child: Victim and architect of a coercive system. In E. J. Mash, L. A. Hamerlynck, & L. C. Handy (Eds.), *Behavior modification and families* (pp. 267–316). New York: Brunner/Mazel.

Patterson, G. R. (2002). The early development of coercive family process. In J. B. Reid, G. R. Patterson, & J. Snyder (Eds.), *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention* (pp. 25–44). Washington, DC: American Psychological Association.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. (1992). In search of how people change. *American Psychologist*, *47*, 1102–1114.

Reid, J. B., Taplin, P. S., & Lorber, R. (1981). A social interactional approach to the treatment of abusive families. In R. B. Stuart (Ed.), *Violent behavior social learning approaches to proneness, management, and treatment*. New York: Brunner/Mazel.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*, 325–334.

Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.

Schechter, S., & Edleson, J. L. (1995). In the best interest of women and children: A call for collaboration between child welfare and domestic violence constituencies. *Protecting Children*, *11*(3), 6–11.

Schoenwald, S., Sheidow, A., & Letourneau, E. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child and Adolescent Psychology*, *33*(1), 94–104.

Silovsky, S., Swisher, L., Kees, M., Valle, L. A., Chaffin, M., McCoy, C., et al. (2005). *The self-motivation group manual*. Unpublished manuscript, Oklahoma: University of Oklahoma Health Sciences Center.

Sobolewski, J. M., & Amato, P. R. (2005). Economic hardship in the family of origin and children's psychological well-being in adulthood. *Journal of Marriage and Family*, *67*, 141–156.

U.S. Department of Health and Human Services (1999). *Blending perspectives and building common ground: A report to congress on substance abuse and child protection*. Washington, DC: U. S. Government Printing Office.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families (2007). *Child maltreatment 2005*. Washington, DC: U.S. Government Printing Office.

Urquiza, A. J., & McNeil, C. B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment*, *1*, 134–144.

Whipple, E. E., & Webster-Stratton, C. (1991). The role of parental stress in physically abusive families. *Child Abuse & Neglect*, *15*, 279–291.

Chapter 14
Anxiety Disorders

Although PCIT was originally developed to assist families with young children displaying oppositional behavior, there has recently been increased interest in using PCIT as an early intervention approach for preschoolers experiencing anxiety. There are several reasons why clinicians and researchers have been exploring the use of PCIT with anxiety disorders. First, PCIT is one of the few evidence-based and developmentally appropriate mental health interventions for children between the ages of 2 and 7. Most treatments for anxiety have relied on cognitive-behavior interventions that require meta-cognition and well-developed verbal abilities, making them impractical for use with preschoolers. PCIT is appealing for working with this population because it is behaviorally based and uses parents as the agents of change. Second, children with anxiety disorders often present with a symptom picture including a mix of anxious and oppositional conduct. Parents need strategies for how to respond to the controlling behaviors that are often associated with anxious avoidance. For example, many young children referred for treatment of anxiety disorders often display extreme resistance and tantrums when directed to enter a fear-evoking situation such as separating at daycare or joining in with a new group of children. Third, parents of children with anxiety are often anxious themselves and need a great deal of parenting support. PCIT provides these families with a clear and comprehensive parenting plan that increases parents' confidence and improves the parent-child relationship.

Separation Anxiety Disorder

As clinicians working with preschool-age children, we get many referrals in which the primary complaint or part of the symptom picture is difficulty separating from caregivers. Young children may experience persistent distress upon separation from parents at the beginning of preschool, kindergarten, and first grade. The severity of distress may range from mild protest and clinging to prolonged, sobbing episodes. Although it is common for young children to feel mild separation distress in novel situations, for some children the distress does not diminish over time and begins to interfere with their daily functioning and development. Children may miss out

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on important educational opportunities when their parents withdraw them from preschool in an effort to avoid separation distress. These children may be unable to comfortably participate in social enrichment activities such as dance classes, sports, swim lessons, play dates, and birthday parties. The separation anxiety also interferes with family functioning because these children cry and tantrum when left with babysitters, placed in church nurseries, or required to sleep in their own beds. Parents become overwhelmed and exhausted by the constant neediness of their anxious children. When the separation anxiety causes high levels of distress for both the child and the parents, they are often referred to an early intervention specialist for treatment.

Donna Pincus, Molly Choate, and David Barlow at the Center for Anxiety and Related Disorders at Boston University have collaborated with Sheila Eyberg to adapt Parent-Child Interaction Therapy for very young children with Separation Anxiety Disorder (SAD). This research group is currently conducting a randomized clinical trial of an adapted version of PCIT with 4–8-year-old children diagnosed with SAD. In this section we describe the rationale for using PCIT with SAD and summarize the innovative work presented in Choate, Pincus, Eyberg, and Barlow (2005), Pincus, Eyberg, and Choate (2005), and Pincus, Santucci, Ehrenreich, and Eyberg (2008).

In reviewing the literature, Pincus and colleagues have concluded that parent-child interactions play a significant role in the maintenance of separation distress. First, parents of anxious children have been described as modeling fear and avoidance behaviors. For example, parents of children with SAD have been observed to inadvertently encourage their children's fear during an intake appointment by predicting a problematic separation before it occurs. While trying to be supportive, these parents might go overboard in their reassurance by saying, "Don't worry, Honey. I'll be right in the other room. You can come and get me if you need me. Do you think you'll be okay?" These types of statements send a message to children that there really might be something to be worried about. A second related issue is that these parents tend to be overprotective of their children, preventing their children from experiencing autonomy and independence. They may give very frequent prompts to stay close, over-focus on stranger-danger education, and discourage their children from engaging in age-appropriate activities like climbing trees, riding fast on scooters, or going down tall slides. A third pattern noted by Pincus and colleagues is a tendency for parents of children with SAD to become critical when their children are crying and resisting separation. An overriding concern is that parents of anxious children inadvertently reinforce separation distress by providing attention to fearful behaviors, either in the form of reassurance or criticism.

Pincus and colleagues recognized the potential for PCIT to alter the dysfunctional parent-child interactions maintaining anxiety. Specifically, they noted that the CDI portion of treatment includes a number of skills that could be used to teach parents to promote independence and autonomy in their children. For example, parents can be taught to provide labeled praises when their children engage in "brave" behaviors such as going upstairs alone, playing in a separate room, sitting at the children's table, and staying with a grandparent while the parent goes shopping. Parents also

can be taught to ignore clingy, fearful behavior while separating quickly from a child. In CDI, parents become skillful at using distraction to redirect their child toward more positive behavior. Consider the situation of a child who whines and cries whenever his mother leaves him at home with his father. After the mother says good-bye and quickly departs, the father can use his CDI skills to enthusiastically describe the airplane passing overhead, birds in the trees, or hot air balloon. If the child continues to cry, the father can ignore the separation distress and get out some toys and enthusiastically describe his play. Once the child becomes engaged, the father can praise the child's appropriate behaviors.

CARD Protocol for Adapting PCIT for Treatment of SAD

At the Center for Anxiety and Related Disorders (CARD), Pincus and colleagues developed a treatment protocol for use of PCIT with 4–8-year-olds presenting with separation anxiety (see Table 14.1). The primary modification in the standard protocol for PCIT is the addition of a third treatment phase entitled "Bravery-Directed Interaction" (BDI). The BDI phase was designed to provide parents and children with education about anxiety including factors maintaining fearful behaviors and the importance of gradual exposure for alleviating anxiety symptoms. The adapted treatment protocol begins with an enhanced pre-treatment assessment that includes measures of anxiety. Then standard CDI is provided, followed by the anxiety-focused BDI module, and concluding with the standard PDI protocol and a post-treatment assessment.

Intake Assessment. As in standard PCIT, all families complete a set of measures evaluating the child's behavior and parenting issues. These measures include the Child Behavior Checklist (CBCL: Achenbach, 1991), Parenting Stress Index (PSI: Abidin, 1997), the Eyberg Child Behavior Inventory (ECBI: Eyberg & Pincus, 1999), and the Parental Locus of Control Scale (PLOC: Campis, Lyman, & Prentice-Dunn, 1986). Additionally, the families are observed and coded using the Dyadic Parent-Child Interaction Coding System–II (DPICS–II: Eyberg, Bessmer, Newcomb, Edwards, and Robinson, 1994). For the purpose of this SAD assessment, a fourth situation was added to the DPICS during which the therapist calls the parent out of the room while a co-therapist enters the room and plays with the child. Parents and children are coded for 5 min using a modified DPICS that includes separation-specific behaviors (e.g., clinging, refusing to separate, reassuring child). In this modified DPICS, families are observed in CDI, PDI, separation, and clean-up, in that order. Other anxiety-specific measures include the Anxiety Disorders Interview Schedule–IV (Child and Parent Version) (ADIS-IV-C/P: Silverman & Albano, 1996), the Multidimensional Anxiety Scale for Children (MASC: March, Parker, Sullivan, & Stallings, 1997), fear hierarchies using a "fear thermometer," and the Weekly Record of Anxiety at Separation (WRAS: Choate & Pincus, 2001).

CDI. The standard protocol is used for both teaching and coaching CDI. According to Pincus and colleagues, most families reach the mastery criteria after

Table 14.1 PCIT adapted for treatment of SAD (Center for Anxiety and Related Disorders, Boston University)

Session 1 – Intake assessment	Standard PCIT pre-treatment measures Modified DPICS (add 5-min separation situation) SAD measures ADIS-IV C/P MASC Fear thermometer WRAS
Session 2 – CDI didactic Sessions 3–5 – CDI coaching	Standard CDI teaching session, parents only Standard CDI coaching sessions, parents & child Number of CDI sessions depends on mastery
Session 6 – BDI didactic	Anxiety education for parents Factors maintaining anxiety Applying CDI skills to separation situations Importance of exposure (practicing separation) Use of exposure in small steps (hierarchy)
Session 7 – First BDI coaching	Explain Bravery-Directed Interaction skills Explain and construct bravery ladder w/child Parents use CDI skills during bravery ladder Plan five rewards for using bravery ladder Child chooses bravery homework
Session 8 – Second BDI coaching	Review homework Discuss responses to separation during week Coach parents in CDI and BDI Apply stickers to the bravery ladder Select new homework assignment
Session 9 – PDI didactic	Standard PDI teaching session, parents only PDI is NOT used during separation situations Review CDI and BDI homework Remind parents to reward ladder success
Sessions 10–12 – PDI coaching	Standard PDI coaching, parents and child Review CDI and BDI homework Remind parents not to use PDI during separation
Session 13 – Post assessment	Repeat intake measures Give TAI to parents

Choate et al. (2005) and Pincus et al. (2005).

three to four sessions, which is shorter than is typical of families with oppositional children. They noted several recurring themes when coaching parents of anxious children. Parents had difficulty following their children's lead in play (e.g., not allowing the child to solve problems), were anxious themselves and self-critical of CDI mistakes, and had trouble being playful and relaxed during CDI. Therefore, these therapists found it helpful to focus the coaching on (1) allowing the child to

choose the toy and solve problems, (2) encouraging parents to go "easy on themselves," and (3) prompting warmer and more playful interaction (e.g., animated "play talk"). Finally, therapists at the Center for Anxiety and Related Disorders emphasized the importance of building children's feelings vocabulary by coaching parents to label and reflect emotions during play (Pincus et al., 2005).

BDI. The purpose of Bravery-Directed Interaction is to provide families with a structure for understanding anxiety and to set the stage for practicing separation. In the BDI teaching session, parents are given information about the nature of anxiety, how attending to anxious behavior perpetuates anxious responses, and how avoiding situations in which the child has to separate actually causes separation distress to continue and sometimes worsen over time. Parents are taught to use CDI skills during separation situations and to practice separation in small steps. During BDI Coaching sessions, the importance of exposure is explained to children in developmentally appropriate language. Children are encouraged to assist in constructing the bravery ladders (e.g., ladders for separating for play dates, school, church, etc.). Children also help to generate rewards for working their way up the bravery ladders. To motivate children to cooperate with exposure exercises, they are given control over selecting which ladder will be worked on as homework. During exercises in the clinic and at home, parents are instructed to use their CDI skills of description, praise, reflection, and imitation for providing positive attention as the child works on a step on the ladder. For clingy or fearful behaviors, parents use ignoring and distraction. If children struggle to master a step on the ladder, families are instructed to practice the previous step longer and then try again. For ladder success, the child places a sticker next to the mastered rung. When all steps are mastered, the child may select a reward from the list of special parent-child activities.

Using Pincus and colleagues' BDI protocol, we could construct a bravery ladder for a young child experiencing extreme separation anxiety when dropped off at preschool. The ladder would consist of a series of exposure experiences sequenced from the least stressful to the most stressful (see Table 14.2).

PDI and Post-assessment. Most children with SAD comply well with parental instructions, but PDI skills are still included in the protocol to help parents deal with

Table 14.2 Sample fear ladder for separation to attend preschool

(1) Read a picture book about a child going to school
(2) At home, role-play a school drop off in which the child separates for 1 min
(3) At home, role-play a school drop off in which the child separates for 5 min
(4) Child stands with parent in front of the school without clingy behavior
(5) Child walks with parent to classroom door without clingy behavior
(6) Child separates from parent at classroom door and parent leaves the area, returning 1 min after the child displays calm behavior
(7) Child separates from parent at classroom door and parent leaves the area, returning 5 min after the child displays calm behavior
(8) Mother walks child to classroom, says a short and warm good-bye, and Mom leaves, returning at the end of class

age-appropriate behavior problems. The standard PDI protocol is followed for children with SAD. However parents are cautioned not to use PDI skills in separation situations associated with anxiety, relying instead on positive approaches presented in CDI and BDI. Researchers at CARD note that the PDI phase usually lasts only three to four sessions with children referred for SAD. Measures administered at intake are re-administered in a post-treatment assessment session. In addition, parents are asked to complete the Therapy Attitude Inventory (TAI: Eyberg, 1993), a measure of how satisfied the parents were with treatment.

Treatment Outcome Research

Research examining the use of PCIT with children who display SAD is in its infancy. To date, there have been two evaluations, both conducted by researchers at the Center for Anxiety and Related Disorders at Boston University. In a multiple baseline design across three families, Choate et al. (2005) evaluated standard PCIT (without the Bravery-Directed Interaction component) with children who had a principal diagnosis of SAD. After treatment, none of the three participants met criteria for a diagnosis of SAD as measured by the Anxiety Disorders Interview Schedule for DSM-IV, Child and Parent Versions (Silverman & Albano, 1996). Significant improvements were also obtained on both the children's and parents' ratings of fear and avoidance (FAH: Heard, Dadds, & Conrad, 1992), and both internalizing and externalizing behaviors on the CBCL (Achenbach, 1991) decreased after treatment. Most of the decrease in separation anxiety appeared to occur during the CDI phase of treatment. During the PDI phase, separation incidents decreased to nearly zero for all three children. All treatment improvements were maintained at 3–6-month follow-up. Researchers identified four potential mechanisms through which PCIT may have decreased children's separation distress: (1) increasing child control, (2) providing positive attention for brave behavior, and (3) improving the security of the parent-child relationship (making parents less anxious about separating from their children) (Choate et al., 2005).

The second evaluation of PCIT with SAD involves a randomized clinical trial of 58 children with a principal diagnosis of SAD assigned to waitlist control and treatment conditions (Pincus et al., 2005). As in the Choate et al. (2005) study, the first 10 families received standard PCIT. The researchers evaluated these families and obtained extensive feedback from the parents. Although these families reported many improvements as a result of PCIT, the researchers noted that several concerns remained. For example, parents continued to avoid placing their children in new situations in which separation might be required. The parents seemed overly reassuring at times of separation, as if they were worried that they would be "bad" parents if they allowed their children to experience distress. They behaved as though they felt that anxiety would be harmful to their children. The researchers were concerned that parents did not have a sufficient understanding of the mechanisms of anxiety, particularly the benefits of exposure, to allow generalization over time and across separation situations. Hence, families could leave treatment having mastered

separation in one or two presenting situations, yet be no better prepared to handle future separation and other anxiety-provoking situations. As a result, the researchers decided to add the Bravery-Directed Interaction Phase for the remainder of the study participants. At the time of this writing, no outcome data are yet available. Qualitative observations reported by the researchers suggest that this adapted PCIT is producing favorable results (Pincus et al., 2005).

Generalized Anxiety

In our clinical practices, we have many children who present with diffuse anxiety and specific fears, some of whom will receive a diagnosis of obsessive compulsive disorder at some point in their development. These children are generally slow to warm up, inflexible, irritable, poor at self-soothing, overly sensitive emotionally, easily frustrated, and intolerant of certain sensory stimuli (e.g., loud noises, feel of clothing, textures of food). Young children with generalized anxiety are most comfortable with rigid routines and predictability. When faced with novel situations, they tend to become anxious, avoidant, and often oppositional. Temper tantrums are common when things do not go as expected or they do not have immediate success at a task. Children who are forced into anxiety-provoking situations often exhibit extreme reactions that include sobbing, screaming, begging, flailing, self-injurious behaviors, biting, and kicking. Preschoolers with this temperament often present with a variety of fears including fears of dogs, toilets flushing, bugs, storms, escalators, sirens, fire alarms, and the dark. Resistance to toilet training is common, with the child often developing a pattern of withholding bowel movements resulting in constipation and encopresis. These children are generally shy, have trouble providing friendly greetings, and sometimes develop selective mutism. The avoidance of new situations can become so extreme that children are unable to participate in age-appropriate activities such as preschool, karate, and school field trips. The parents of these children learn to "walk on egg shells" to avoid provoking anxious reactions. Their extreme attempts to accommodate these children lead to restricted family activities, frustration, stress, embarrassment, and fatigue. Parents can never successfully anticipate all of the triggers for their children's outbursts and report feeling like they are living with a "time bomb."

Enhancing PCIT for Young Children with Generalized Anxiety

When providing PCIT to children with generalized anxiety, we use the standard PCIT protocol with several enhancements integrated throughout treatment. From the beginning of treatment we provide families with anxiety education, emphasizing the necessity of exposure. Parents are taught about the genetic predisposition toward anxiety, chronic course, biology of the fear response, and how avoidance maintains anxiety. Parents are taught that they need to encourage their children to

face fears, support them during exposure, and reward their successes. These themes are revisited in nearly every session over the course of treatment. After teaching and coaching CDI skills, anxiety specific target behaviors are identified and parents are coached to attend to the incompatible pro-social behavior. For example, for children who look down when greeted, parents can be coached to describe and praise the opposite behavior which might be "looking the person in the eye." For more examples of anxious behaviors and corresponding pro-social targets for coaching, see Table 14.3.

Table 14.3 CDI coaching of anxious children

Problem behavior	Pro-social target	CDI statement
Mumbling	Speaking up	Good job using your big voice!
Clinging	Walking by yourself	I like how you're walking on your own
Whining	Using big boy voice	You're sounding so grown up
Pouting	Smiling	You've got a great smile
Giving up	Trying when it's hard	That's great the way you keep trying even though it's hard
Being rigid	Being flexible	I like how you tried it a different way this time
Perfectionism	Tolerating mistakes	Great job of finishing the picture even though it didn't turn out just how you wanted

Another way in which we enhance PCIT to fit the needs of anxious children is by teaching a set of developmentally appropriate social skills that the child does not consistently display. Parents are taught to prompt and reinforce children for use of skills such as greeting others, joining in, using brave talk, accepting no, trying when it is hard, being a good host, and being a good guest. A good source for schematics that provides operational definitions for skills such as these may be found in McGinnis and Goldstein's (2003) *Skillstreaming in Early Childhood.*

Throughout treatment, parents are encouraged to expose their children to feared situations. To help young children tolerate the frequent, aversive experience of exposure, parents are taught strategies to use during the exposure exercises. For example, children can tolerate exposure longer when they are distracted by their parents (e.g., singing a funny song) or parents help to elicit an emotion that is incompatible with anxiety (e.g., tickling to elicit happiness, sweet treat to elicit pleasure). Even employing these strategies, exposure exercises are aversive to children and often result in extreme tantrums. We coach parents to use ignoring and distraction to de-escalate these tantrums. These outbursts can be highly stressful and embarrassing for parents. As a result parents need a great deal of support for doing their exposure homework. With all of the anxiety education, focus on coaching non-anxious behaviors, and exposure exercises, the course of treatment is typically longer than in standard PCIT with children with only acting-out behavior problems. PCIT with anxious children typically requires a minimum of 14 sessions.

The Case of Alexander H

Alexander is a 5-year-old Caucasian male who was referred for PCIT by his pediatrician due to parental concerns that he would be too anxious to attend kindergarten. Most recently, he was unable to separate from his mother for the kindergarten readiness test. The test was administered with Alexander on his mother's lap and he was unable to respond audibly to the teacher's questions. Alexander lives with his mother, father, and 10-year-old sister. Genetic history is positive for maternal panic disorder.

As a baby, Alexander was reportedly colicky, poor at self-soothing, and an irregular sleeper. He met all developmental milestones on time except for toilet training. Potty training was attempted at age 2½, with no success and attempted again at age 3½. At that time, Alexander insisted that his mother sit in the bathroom with him, and he would only urinate in the toilet. When diapers were discontinued, he withheld his bowel movements because the toilet seat shifted once and he was afraid he might fall into the toilet. He developed constipation, requiring maintenance on an oral laxative. Within the last 6 months, he has consistently produced bowel movements in the toilet. However, he requires a particular padded ring that the parents must carry with them everywhere. Alexander began preschool at age 3, with significant separation distress. Mrs. H. reported that he would take off his seat belt in the car so that she would have to pull over, thereby delaying arrival at preschool. Mrs. H. admitted that she sometimes resorted to "tricking" Alexander by telling him that they were going to the store, instead of preschool. Alexander's teacher described him as withdrawn, irritable, and overly sensitive. He insisted on carrying his stuffed monkey and would cry and tantrum if any of the children looked as though they might touch it. After several weeks, the teacher was able to get Alexander to join in circle time, but only if he was allowed to sit on his own special carpet square. He seldom participated in songs, finger plays, show and tell, and group games, preferring to stand away from the group and watch. The teacher noted that there were certain stations that were particularly problematic for Alexander. He resisted finger painting, Play-Doh, water and sand table, and writing numbers and letters in shaving cream. There was nearly always a tantrum on water day because Alexander would refuse to allow the teachers to put sunscreen on him. No early academic concerns were noted.

At intake, Mr. and Mrs. H described a number of anxiety-related problems at home. There were many power struggles over clothing because Alexander seemed overly sensitive to certain textures. For example, all the tags had to be cut out of his clothing and they had to order seamless socks over the Internet. Alexander had no tolerance for being sticky or wet, requiring multiple clothing changes each day. He found only one style of shoes comfortable and his parents bought them in multiple sizes as he grew. He insisted on wearing only loose fitting sweat pants and shorts, and would have screaming fits if forced to put on dress clothes for church. Mr. and Mrs. H. described Alexander as a picky eater, refusing to branch out beyond approximately ten preferred foods. He was sensitive to food textures and smells, gagging easily when exposed to novel foods. When eating, he did not want his foods

to touch each other and insisted on separate utensils for each item. Mrs. H. described an event that occurred the previous night. She served Alexander a dinner in which one of his pieces of diced chicken touched the apple sauce. Alexander cried and begged her to give him a different plate of food. She responded by throwing away the one piece of chicken that had apple sauce on it. But, Alexander continued to cry, screaming that he was hungry and could not eat that "yucky" food. After about 15 min, while Alexander was still crying, Mrs. H. said that she felt sorry for him and brought out a new plate of food.

Mr. H. complained that Alexander insists that only his mother can help him with daily tasks like bathing, brushing his teeth, and getting him ready for bed. When the father tries to help out by fixing a drink for his son, Alexander refuses to accept it, crossing his arms and pouting. They said that he becomes anxious if his bed is not arranged with his stuffed animals in a particular order, and he is unable to sleep unless his mother reads "Good Night Moon." The parents described Alexander as rigid, controlling, and inflexible, having particular problems with transitions and changes in routine. To cope with his inflexibility, they have gotten into the habit of providing multiple transitional warnings before he needs to change activities and by preparing him at least a day in advance for any change in routine (e.g., Dad taking him to school). At intake, Mrs. H. described a frustrating day in which it took her nearly 5 h to persuade Alexander to get in the car to go to the grocery store. At first he resisted going because she had not told him in advance about the errand. As she was trying to get him dressed, he refused to put on the pair of pants she selected insisting that she wash his favorite sweat pants. When the pants were washed, gray clouds drifted in and he was afraid that they would be caught in a thunderstorm. When she convinced him that a storm was not imminent, he was unable to find a pair of socks that felt right inside his shoes.

The parents reported several specific fears including storms, the dark, loud noises like sirens and fire alarms, lit candles, bees, and hair cuts. Because of his extreme reactions to these feared stimuli, his parents go to great lengths to avoid exposing him to these triggers. When he does encounter a feared stimulus, he panics, trying to get away. If he cannot escape, he trembles, shrieks, sobs, and covers his ears or eyes. Mr. and Mrs. H. described him as appearing terrified and having difficulty catching his breath and calming down. After one of these episodes, Alexander often complains of tummy aches, headaches, and fatigue. Because there are so many triggers for Alexander's fear reactions, the parents have resorted to taking two cars on many outings. In that way, one parent can remove Alexander if necessary while the other parent stays with his older sister.

Alexander's Feedback, Anxiety Education, and CDI Teaching Session. Following a standard PCIT pre-treatment assessment that was supplemented with measures of anxiety and depression, we met with the parents alone for a 2-h session that included feedback regarding the assessment results, anxiety education, and a CDI didactic. The results of assessment indicated that Alexander was displaying clinically significant levels of anxiety in both the home and school setting. Acting-out behavior problems were strongly endorsed by the parents but were not reported by the teacher. There was no evidence of depression or developmental disorders.

A large part of the session was devoted to educating Mr. and Mrs. H. regarding the etiology and nature of anxiety and setting the stage for treatment. In this session, we explained to the parents that anxiety has a genetic base:

> Most young children like Alexander who present with anxiety so early in life come into this world with a genetic predisposition toward being anxious. If you think back to his infancy, we can see red flags even at that early age. He had an anxious disposition, inability to self-soothe, oversensitivity to sensory stimuli, irregularity in sleeping patterns, and irritability. As a toddler, Alexander was clingy and slow to warm up. He cried excessively when separating from you. And, the terrible twos never seemed to resolve. The vast majority of children like Alexander have a biological relative who has struggled with anxiety. And, in this case, there clearly is a genetic link with Mom's history of Panic Disorder. Given what we know about Alexander, it is very likely that he has inherited a biological predisposition to be anxious. So, even if Alexander had been adopted at birth and raised by another family with no anxiety issues, it is likely that he still would be presenting with similar anxiety problems.

Providing this genetic explanation helps parents put aside feelings of guilt and blame which get in the way of focusing on our intervention.

To help Alexander's parents understand the rationale for the treatment plan, we next addressed the biology of the fear response. We tried to explain the "fight or flight response" in words that the parents could understand:

> When a child is fearful, a predictable sequence occurs. First, the child perceives a threat. It could be that he might be embarrassed or that he might be separated from his parent or that he might get struck by lightning. This thought of threat triggers the worry center in the brain to release adrenaline. Adrenaline travels through the body and causes a number of physical symptoms of anxiety or fear, like heart racing, blushing, sweating, butterflies in the stomach, shortness of breath, and even dizziness. When this happens, we are all biologically wired to react to this flow of adrenaline by what we call the "fight or flight" reaction, either fighting back against the perceived threat or running away. So, when Alexander sees dark clouds in the sky, he thinks, "Oh no, a big storm is coming and I might get struck by lightning!" His worry center releases adrenaline, causing very uncomfortable feelings, like nausea, a racing heart, and difficulty breathing. His first reaction will be to try to get away from the storm. But, if you don't see the storm as a threat, and you force him to go outside, the "fight" reaction will be triggered, causing him to tantrum and physically resist.
>
> Because of Alexander's genetic predisposition to be anxious, he has an overactive worry center in the brain, causing him to perceive threat more readily than other children and to perceive threat even when no real threat exists. He also has a genetic predisposition to have a quicker and more intense biological response to threat. And, based on how sensitive he is to sensory input like sounds and the tags in his clothing, you know that he is going to be especially tuned in to bodily sensations, like the heart racing and the butterflies in the stomach. He will perceive these normal reactions to a potential threat as more aversive and uncomfortable than another child might experience them. Because Alexander is biologically wired this way, he will have to deal with this overactive "fight or flight" system his whole life. He always will have this predisposition to have an automatic and extreme physiological reaction to a large range of perceived threats.

This biological explanation of the fear response helped Mr. and Mrs. H. make sense out of what previously seemed like unpredictable and unprovoked behavior problems.

Our next goal in the session was to educate Mr. and Mrs. H. about the role of avoidance in maintaining anxiety responses. We wanted them to understand that

their tendency to help him avoid stressful situations was actually counter-productive, increasing rather than decreasing anxiety problems.

> When Alexander is feeling anxious and the adrenaline is flowing, he tries to get away from what is scary to escape the awful bodily sensations of shortness of breath, queasy stomach, etc. And, it works. When he covers his ears, screams "help me," and hides under the desk during a planned fire drill at school, the adrenaline decreases and he feels better because he is able to escape the noise. But, the message that he gets is a dysfunctional one. That message is that the fire alarm really might hurt him and it was important that he got away from it. This is dysfunctional because it reinforced for him that the way to handle things you're scared of is to run away. That would be fine if he is scared of only real threats but he is not. So, the next time he experiences a perceived threat, something that is not really harmful, such as a hair cut, he will react by trying to escape the situation because that is what has worked in the past. We need to send him a new message. We need for him to face his fears and learn that if he stays in the situation nothing bad will happen to him. What we know about biology is that adrenaline cannot stay in the system very long. It always dissipates. So, if we can get him to simply stay in the barber chair long enough, the adrenaline will diminish and the bad physiological feelings will go away. He then will get the message that he is safe after all and that haircuts cannot hurt him. So, whether it is haircuts, dark clouds, fireworks, or candles, the way to treat his fears is by repeatedly exposing him to the feared situations and allowing the anxiety to subside.

The purpose of this explanation about how avoidance maintains anxiety was to get Mr. and Mrs. H. prepared to be receptive to the exposure-based treatment plan. We wanted to make sure that later in treatment, when we ask Mr. and Mrs. H. to stand outside with Alexander looking at dark clouds on the horizon, that the parents would feel confident that what they were doing would help him, not hurt him. It is important that parents of anxious children, who tend to be overprotective and to have some anxiety issues themselves, be fully "on board" with the treatment plan so that they do not have second thoughts that lead to guilt and noncompliance with the exposure exercises.

After the anxiety education, our next task was to provide a rationale to the H. family for using PCIT to decrease Alexander's anxiety and behavior problems. Mr. and Mrs. H. were told the following about PCIT:

> Parenting a child with an anxious temperament is extremely challenging. The parenting strategies that work with most children, will not work with Alexander. You essentially are going to need to become "Super Parents" with specialized skills for helping an anxious child cope with daily fears and stresses. And, the two of you need to be on the same page with a clear plan for how to respond to his tantrums, clinging, rigidity, and avoidance. Parent-Child Interaction Therapy will be very helpful to Alexander in several ways. First, in the play therapy phase, you will be working on increasing his sense of security, improving his self-esteem, and helping to make your relationship with him as strong as it can be. We also will be giving you homework each week in which you will be gradually exposing Alexander to feared stimuli, like lit candles and bees. In the play therapy half of treatment, you will learn strategies to use during these exposure exercises to encourage his success and deal with his resistance. In the second half of treatment, we will implement a very structured discipline program that will allow the two of you to respond to behavioral concerns in a consistent way. This discipline program is designed to provide the structure and predictability on which an anxious child thrives.

The remainder of this 2-h feedback and didactic session was spent providing the parents with the standard CDI teaching. We highlighted the importance of using the PRIDE skills anytime that Alexander engaged in behaviors that are the opposite of anxious responding. For example, we encouraged the parents to enthusiastically praise and describe independence, trying new things, altering routines, facing small fears, and being brave in new situations. In terms of dealing with Alexander's anxiety-related outbursts, the parents were told to avoid excessive reassurance, ignore disruptive behaviors, and use enthusiastic description of an interesting aspect of the environment as a distracter (e.g., point out children playing at a park when Alexander begins to be worried about dark clouds).

Alexander's CDI Coaching. During the early CDI coaching sessions, Alexander entered the room hiding behind his mother with a scowl on his face. As we checked in on good things happening during the previous week, Alexander refused to participate in the discussion and bristled when his parents praised his successes. His parents were reluctant to comment on good things that he had done because it nearly always elicited a denial or angry response. We talked with the parents about Alexander's difficulty accepting praise:

> Children like Alexander who are anxious and shy often feel uncomfortable when they are praised because they feel like there is a big spotlight of attention shining on them. They usually respond in ways that make people less likely to praise them in the future. This is a problem for Alexander because he is setting up an environment in which he receives less praise than the average child when in fact he is a child who, with all of his challenges, especially needs that support to feel good about himself. Without healthy doses of praise, Alexander is likely to have low self-esteem. We believe that Alexander's discomfort with praise is similar to his discomfort with new situations. If we expose him to lots of praise, he will become more comfortable with it over time and the praise can do its job.

Therefore, at the beginning of our CDI coaching sessions, we encouraged the parents to continue to list positive things that Alexander had done throughout the week, even though he resisted the praise. As therapists, we also provided Alexander with lots of praise and ignored when he grunted or rolled his eyes.

In CDI, Alexander rigidly insisted on his mother being coached first. To demonstrate the best way to address his rigidity, we had the parents begin by teaching Alexander a new word, "flexibility." We coached the parents to say, "It is good to do things differently now and then. That is called flexibility. We will be helping you to become more flexible. So, today, we're going to start with Dad." We then coached the parents to describe and praise as quickly as possible all neutral and cooperative behaviors displayed by Alexander when Mr. H. entered the room to be coached. But, in the first session, Alexander escalated to a tantrum almost immediately. So, Mr. H. was coached to ignore the tantrum and to describe the new Lego set on the table. It took almost 15 min for Alexander to calm down and begin to play with the toys. During the ignoring, Mr. H. needed a great deal of support from the therapist. To help him deal with his fear that he was being "mean," Mr. H. was reminded about the importance of exposure. He also was reminded that if Alexander stays in the feared situation long enough his anxiety will go down and he will learn that

nothing bad happens when you change a routine. During other CDI coaching sessions, we addressed Alexander's rigidity by sometimes having the parents put toys together incorrectly. For example, the mother once was coached to put a monkey head on a giraffe body. As she was putting the head on the giraffe (before Alexander could become distressed), we coached her to say, "Great job of letting me put the monkey head on the giraffe body. I know that this isn't the way that it goes. But, it's fun to be creative. Thanks for staying so calm and letting me try something new. I'm proud of you for being flexible."

At first, the parents were resistant to the exposure exercises. They reported feeling like we were making Alexander upset for no reason. They talked about how mean it seemed to purposefully change the arrangement of the stuffed animals on his bed, knowing that it would upset him. They wondered why they should not just let him relax and leave the bed the way that he likes it. We provided the parents with analogies to help them understand why it is important to prompt Alexander to face situations that make him anxious:

> Imagine a child who is terrified of the water. What if we just let that child relax and never insisted that she make small steps toward facing her fear? To get better, she really needs to begin by putting her toes in the water and then take small steps toward getting into the water. Without her parents requiring her to face her fear, she could avoid the water her entire life, never putting her toes in the water and never learning to swim. It is easy to feel like you are being mean when you purposefully expose your child to his fears. And, it can make you feel guilty and sad to see your child in such distress. But, in real life, we all experience anxiety and stress. Alexander needs to learn to tolerate those feelings and not let them interfere in his day-to-day life. In Alexander's case, his challenge is anxiety. But, imagine a child who is challenged by dyslexia and becomes extremely frustrated when trying to read. Would it make sense for that child's parents to always read aloud to that child because they do not want him to feel upset? Obviously, if they always read for the child, he will not have an opportunity to develop his reading skills and they will be handicapping him for life. With Alexander, he has many fears, such as thunderstorms and hair cuts. If you do not make him face those fears, he will not put his toes in the water and he will not learn to read. He has to experience some frustration to grow, and he will need for you to be brave and to make it happen.

For homework, we often had the family work on changing routines and praising Alexander for doing things differently. Homework assignments included changing the position of the stuffed animals on Alexander's bed, reading the night time books in a different order, and driving to the preschool via a different route. The parents were encouraged to notice all incidences of flexibility in Alexander and to give him a great deal of positive attention when he was changing routines.

Alexander's PDI Coaching. The PDI teaching session and the first two PDI coaching sessions were conducted according to the standard PDI protocol, with an emphasis on giving effective commands and getting Alexander to comply with simple instructions. Starting with the third PDI coaching session, we began to add exposure exercises in to the PDI coaching. For example, we coached the parents to tell Alexander to put on a pair of "scratchy" socks. Mrs. H. began the PDI sequence with a rationale: "Today we are going to practice being flexible about

the socks you wear. You will be able to take them off right away. But, it is important that you listen." She then gave a simple, direct command: "Please put on these socks." Alexander cried and whined, but he put on the socks. She ignored his crying and praised the compliance by saying, "Great job of being flexible about your socks. Now you may take them off if you want." In this PDI session, we continued to work on the sock exposure exercise by having him wear the socks for 10 s, then 20 s, and then 1 min. Other exposure exercises included putting on a shirt with a tag, playing with Play-Doh, touching shaving cream, sitting in the room with a bee in a jar, stepping outside on a cloudy day, and having his dad comb his hair.

Ending Treatment with Alexander. As in all PCIT, treatment was completed when the family met all of the mastery criteria. The pre-treatment assessment was repeated. Alexander's externalizing behavior problems improved to within normal limits. Although he was not within the clinical range, Alexander continued to have sub-clinical elevations on measures of general anxiety. Most of his specific phobias were alleviated, but Alexander continued to have high levels of distress during actual thunder storms. During this post-treatment feedback session, Mr. and Mrs. H. were reminded that they would need to stick with a life-long parenting style in which they encourage Alexander to face his fears, embrace new situations, and be flexible about routines. As Alexander will always have a tendency to see threat in neutral situations, we recommended that Mr. and Mrs. H. bring Alexander back for some additional cognitive-behavioral work on anxiety management when he is older (e.g., 9–11).

References

Abidin, R. R. (1997). Parenting stress index: A measure of the parent-child system. In C. P. Zalaquett & R. J. Wood (Eds.), *Evaluating stress: A book of resources* (pp. 277–291). Lanham, MD: Scarecrow Press, Inc.

Achenbach, T. M. (1991). *Manual for the child behavior checklist/4–18 and 1991 profile*. Burlington, VT: Department of Psychiatry, University of Vermont.

Campis, L. K., Lyman, R. D., & Prentice-Dunn, S. (1986). The parental locus of control scale: Development and validation. *Journal of Clinical Child Psychology*, *15*, 260–267.

Choate, M. L., & Pincus, D. B. (2001). The weekly record of anxiety at separation: A home monitoring measure for parents, (unpublished measure).

Choate, M. L., Pincus, D. B., Eyberg, S. M., & Barlow, D. H. (2005). Treatment of young children with separation anxiety disorder using parent-child interaction therapy. *Cognitive and Behavioral Practice*, *12*, 126–135.

Eyberg, S. M. (1993). Consumer satisfaction measures for assessing parent training programs. In L. VandeCreek, S. Knapp, et al. (Eds.), *Innovations in clinical practice: A source book* (Vol. 12, pp. 377–382). Sarasota, FL: Professional Resource Press/Professional Resource Exchange, Inc.

Eyberg, S. K. 4, Bessmer, J., Newcomb, K., Edwards, D., & Robinson, E. (1994). Dyadic parent-child interaction coding system II: A manual. Social & behavioral sciences documents. San Rafael, CA: Select Press.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory and Sutter-Eyberg student behavior inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources.

Heard, P. M., Dadds, M. R., & Conrad, P. (1992). Assessment and treatment of simple phobias in children: Effects on family and marital relationships. *Behaviour Change*, *9*, 73–82.

March, J. S., Parker, J. D. A., Sullivan, K., & Stallings, P. (1997). The multidimensional anxiety scale for children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 554–565.

McGinnis, E., & Goldstein, A. (2003). *Skillstreaming in early childhood: New strategies and perspectives for teaching prosocial skills*. Champagne, IL: Research Press.

Pincus, D. B., Eyberg, S. M., & Choate, M. L. (2005). Adapting parent-child interaction therapy for young children with separation anxiety disorder. *Education and Treatment of Children*, *28*, 163–181.

Pincus, D. B., Santucci, L. C., Ehrenreich, J. T., & Eyberg, S. M. (2008). The implementation of modified parent-child interaction therapy for youth with separation anxiety disorder. *Cognitive and Behavioral Practice*, *15*, 118–125.

Silverman, W. K., & Albano, A. M. (1996). *Anxiety disorders interview schedule for DSM-IV, child & parent versions*. San Antonio, TX: Psychological Corporations.

Chapter 15
Attention Deficit Hyperactivity Disorder

Back in 1974 when PCIT was first being developed by Sheila Eyberg at Oregon Health Sciences University, the treatment was used primarily with children with disruptive behavior and/or developmental disabilities from families experiencing multiple stressors. Research studies evaluating PCIT over the next three decades described the young participants as having "conduct problems." Over time, PCIT has become known as an effective intervention specifically for preschoolers with a diagnosis of oppositional defiant disorder. Little attention has been paid to the fact that these participants with "conduct problems" generally included children with co-morbid diagnoses including ADHD. In a literature review of PCIT with ADHD, Wagner and McNeil (2008) reported that across 14 outcome studies of PCIT, an average of 69% of participants were described as showing features suggestive of ADHD (range = 41–100%). Although these studies emphasized the use of PCIT with oppositional problems in young children, the reality is that PCIT has been used for many years to treat young children with ADHD.

Many of the outcome studies included pre- and post-treatment measures of ADHD symptoms and reported statistically significant improvement on these measures. In particular, many of these studies included a structured DSM interview with the parents at pre- and post-treatment. The number of children diagnosed with ADHD in this manner decreased significantly across all studies. However, this method of diagnosing ADHD likely over-identified ADHD in the samples. The diagnosis was based solely on the report of parents, usually highly stressed mothers. And, the studies often used only one measure evaluating ADHD behaviors in only one setting. A valid diagnosis of ADHD is much more likely to be obtained using multiple informants and multiple modes of measurement (e.g., direct observation, rating scales, continuous performance tests), examining both the home and school settings. Because of methodological problems with the assessment of ADHD in the PCIT studies, we cannot currently conclude that PCIT is an effective intervention for ameliorating problems with distractibility, impulsivity, disorganization, and hyperactivity. However, evidence suggests that it is a promising early intervention approach for ADHD, and data demonstrate that PCIT is effective for treating co-morbid oppositional behaviors that are common in this population (Wagner & McNeil, 2008).

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To address the need for research evaluating the efficacy of PCIT for treating young children with ADHD, Drs. Sheila Eyberg, Stephen Boggs, and Regina Bussing are currently conducting an NIMH-funded grant entitled Project Shape. For this grant, 128 families with a young child between the ages of 4 and 6 diagnosed with ADHD (half with ADHD alone and half with ADHD co-morbid with ODD or CD) will be randomized to either individual or group PCIT. The researchers are using multiple informants and multiple methods of measurement to assess ADHD behavior problems both at home and at school. Follow-up assessments will be conducted at 12 and 24 months after treatment. This study is expected to provide information about whether children with ADHD alone may be treated successfully using a more economic group PCIT intervention. Children with co-morbid behavior disorder diagnoses are expected to require individualized PCIT. It also is expected that this study will identify predictors of treatment outcome and test models of mechanism for change (Project Shape at www.pcit.org).

Conducting PCIT with Children Diagnosed with ADHD

The balance of this chapter is spent describing our own clinical adaptation of PCIT with children with ADHD. We focus heavily on parent education about the disorder, highlighting explanations that we provide to parents using lay language. We also describe ways that we adapt PCIT to make the intervention more targeted toward the key issues associated with ADHD. As is always the case, we begin our intervention with a thorough pre-treatment assessment.

Pre-treatment Assessment. All of the measures standardly used in the pre-treatment assessment are included when we assess young children with ADHD. Additionally, we incorporate ADHD-specific measures such as the Conners Rating Scales (parent and teacher versions: Conners, 2000a), the Early Childhood Inventory-4 (parent and teacher DSM-IV checklists; Gadow & Sprafkin, 1997, 2000), the Barkley Structured Intake Interview (Barkley, 2006), and a continuous performance test (e.g., Test of Variables of Attention, Greenberg, 1988–1999; Integrated Visual and Auditory Continuous Performance Test, Sandford & Turner, 1995, 1994–1999; Conners' Continuous Performance Test-II, Conners, 2000b; Conners' Kiddie Continuous Performance Test, Conners, 2001; Gordon Diagnostic System, Gordon, 1983). In addition, we typically conduct standard classroom observations using the Revised Edition of the School Observation Coding System (Jacobs et al., 2000). For these observations, we have the teacher identify a child of the same gender in the classroom who displays "average" behavior. We then do a time-sampling procedure to code three behaviors: on-task/off-task, appropriate/inappropriate, and compliance/noncompliance. Inclusion of a typical peer allows us to compare our client to classroom-specific norms.

Education About ADHD. Following the pre-treatment assessment, we set up a 2-h appointment with the parents (no child) to provide feedback regarding the evaluation, education about ADHD, and a CDI didactic. The purpose of the feedback is

threefold: (1) to share findings about the nature and severity of the problem behaviors, (2) to demonstrate to parents that we have a good understanding of their child and the family's concerns, and (3) to motivate the parents to follow through with treatment recommendations. When a child has a diagnosis of ADHD, we commend the parents for catching the problem early and seeking treatment. We emphasize that this is not "boys will be boys" behavior, but that it is a disorder that requires intervention. We emphasize how important it is to intervene early because the problems will multiply over time. With regard to ADHD education, we cover the following topics: etiology, biological processes and symptom presentation, course, role of pharmacotherapy, myths about ADHD, classroom accommodation plans, and the need for specialized parenting. It is important for parents to understand the biological nature of ADHD in order to help them to be more understanding, accepting of, and patient with their children. These parents receive a great deal of criticism from teachers, relatives, and friends about their inability to control their children's behavior. Once parents understand the genetic nature of the disorder, they can let go of guilt feelings associated with perceived parenting deficits. Educational information provided in this chapter represents our attempt to translate complex physiological and theoretical information into language parents can understand. For the scientific and research underpinnings, please see Barkley (2006) *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment (3rd Ed),* Barkley (2005), *ADHD and the Nature of Self-Control,* and Zentall's (2005) article in *Psychology in the Schools.* Another useful reference is the International Consensus Statement on ADHD (2002) which reviews the latest scientific evidence refuting arguments that ADHD is not a true disorder.

Etiology. We explain to parents that in the vast majority of cases ADHD is an inherited condition. Some researchers suggest that they can identify the particular place on the particular gene where heritability occurs. For a minority of children with ADHD, the cause can be traced to some sort of prenatal insult to the brain, birth trauma, or acquired head injury. We emphasize that there is nothing that they could have done in their parenting to cause their child to have ADHD, nor could they have done anything to prevent it from occurring. We also discuss with parents and dispel common myths about the etiology of ADHD such as too much sugar in the diet and allergies to food dyes and additives.

Education About Frontal Lobe Functioning. We feel that it is important for parents to understand the role of the frontal lobes in ADHD. We convey that through the following explanation:

> I think that it is important for you to understand what is going on in the brain of a child who has ADHD. The area of the brain that is implicated is the frontal lobes, the area right behind your forehead. The frontal lobes have four functions. First, they act as a filter allowing us to focus in on what we want to attend to. It is what allows you to focus on my voice and let the rest fade to background, like the loud ticking of the clock, road noises outside, and shadows of people walking by in the hallway. For a child with ADHD, that filter is not working properly, and all stimuli take on equal salience. That is why when your child with ADHD is sitting at the table doing homework and he sees something out the window, his attention is pulled away so easily. Think of all the visual and auditory stimuli present in the classroom. Other children can focus on their work in the midst of people coming in and out the door,

friends rummaging in their backpacks, and classmates talking with the teacher. For a child with ADHD, all of these stimuli are equally likely to capture his attention, causing him to become easily distracted and off-task.

The second function of the frontal lobes is impulse control. The frontal lobes are the parts of the brain that give you a latency period between thinking something and acting on it or saying it. It gives us a pause to consider whether it is a good idea for us to comment on someone's ugly shirt or how fat they are. For children with ADHD, thoughts pop into their heads and come out of their mouths or are acted upon, with no chance to consider the outcomes. One of the things that is often said of children with ADHD is that they do not seem to learn from consequences. They actually do learn from consequences. But, what they learn is that we disapprove of their behavior. Unfortunately, that does not make it any less likely to occur the next time because they do not have the chance to stop and think. For example, a little girl with ADHD might talk to the girl next to her and get a red card from the teacher. She has learned that it is not okay to talk when the teacher is talking. But, it will happen again the next day because she does not get a chance to stop and think that yesterday she got in trouble for talking so she better not do that again today. Instead, she impulsively talks again, the teacher catches her eye, and she claps her hand over her mouth saying, "Oops I forgot. I'm sorry. I won't do it again." But we and her teacher know that she will.

The third function of the frontal lobes is to control activity level. Your frontal lobes are what allow you to sit so still while we are talking. The frontal lobes are an inhibitory brain structure. Other parts of the brain are excitatory in function, meaning that when cells fire we do things, we perform actions, we think thoughts, or we feel sensations. But, when the cells in the frontal lobes fire, we do less. We pay attention to fewer stimuli. We're less likely to blurt things out. And, we hold our bodies still. Children with ADHD often struggle with staying in their seats and keeping their hands and feet to themselves.

The fourth function of the frontal lobes is planning and organization. This is the part of the brain that allows you to break projects down into manageable components, to accurately perceive how long it should take to do projects, and to keep track of belongings. Children with ADHD are often described as disorganized, messy, and lazy. Their bedrooms and backpacks are typically disasters and teachers complain about the trail of belongings scattered around their desks. Individuals with ADHD also have a different perception of the passage of time than the rest of us. If a teacher gives an assignment at 8:00 a.m. that is due at 10:00 a.m., most children recognize that the deadline is approaching early enough to complete good quality work. In contrast, children with ADHD perceive 10:00 as being far away, with plenty of time to entertain themselves in other ways before needing to get to work. Most people with ADHD are described as procrastinators.

PET scans of glucose metabolism in the frontal lobe area of the brain demonstrate that most people with ADHD have a slower rate of functioning in their frontal lobes. Rate of function in the frontal lobes is not stable over time; it increases and decreases based on both internal and external factors. For all of us, we concentrate less well and are more likely to blurt out something we should not say when we are fatigued. Frontal lobes also work more slowly when people are ill. Frontal lobes tend to speed up when we are doing something we find very interesting. Most children with ADHD are able to concentrate just fine when they are watching television, playing video games, playing on the computer, watching movies, or doing activities that they are very interested in. Many parents think that if he can concentrate for 30 min on his Nintendo, he ought to be able to concentrate for 30 min of homework. But, that is not true. Frontal lobes slow down when we are engaged in tasks that we do not find particularly interesting. And, unfortunately, homework often falls in that category.

Think back to a time when you were in school and you were in an interesting class with a dynamic teacher. It was probably easy for you to pay attention to instruction, and the time probably seemed to fly by. Now think back to a time when you were in a boring class in which the teacher spoke in a monotone. The class probably seemed to take forever.

> While you were seated, you probably moved much more, fidgeting and doodling, and you probably had your mind on other things, like what you were going to do after school. In the interesting class, your frontal lobes sped up and you were able to concentrate well. In the boring class, your frontal lobes slowed way down. It is the same for your child. To give you an example, I observed a child with ADHD in his gifted classroom. When I first arrived, it was whole-group instruction. The teacher was joking, working the room, sitting on kids' desktops, and very animated. My client with ADHD looked no different from the rest. All of the kids were very tuned in to the lecture. Then, it was time for independent seat work. The children had 20 min to write an essay. While other children filled line after line on their papers, my client with ADHD found a paper clip that he poked into an eraser, twirled it in the air, crawled around the floor to find it, made spit wads, and talked to his neighbor. In the same period of time, he was able to produce only two sentences. The writing task was boring for him and his already-compromised frontal lobes slowed down so far that he could not perform. Then the children lined up to go to the library. We were met at the library door by a little old man in a sweater vest and horn-rimmed glasses. He sat the children down on the carpet, in front of a flip chart of the Dewey Decimal System. In a nasal monotone, he proceeded to go from the beginning of the alphabet to the end of the alphabet, showing children the types of books that would be found under each abbreviation on the spine. All of the children were bored. They fidgeted, they squirmed, and they stared into space. However, my ADHD client was unable to remain seated and appropriate. He did a crab walk across the floor, pulled books off the shelf, played in the hair of the girl in front of him, and pulled the shoe lace out of his shoe. Again, his already slow frontal lobes had slowed down to a snail's pace, and he was unable to provide even minimal attention to the speaker.

To summarize, education about the role of frontal lobes in ADHD involves covering the four functions of frontal lobes: (1) attention/concentration, (2) impulse control, (3) modulating activity level, and (4) organization/planning. Presenting this information using lay terminology with lots of examples helps parents to make sense of their own children's behavior patterns. They often leave the session with more empathy for their child and his challenges.

Education About Arousal. To help parents have a greater understanding of their ADHD child's experience, we also find it helpful to educate them about the role of neurological arousal. We describe it to parents this way:

> Based on our brain chemistry, we all have an optimal level of arousal. It differs from person to person. Some of us have a very low need for arousal. Our perfect vacation might be sitting on the beach in a lounge chair reading a good book. For others, there is a great need for stimulation. A perfect vacation for a stimulation seeker might be to ride jet skis and parasail at the beach. Based on our own optimum level of arousal, there are times throughout the day when we become either over-aroused or under-aroused. Over-arousal often presents itself as stress. We can become over-aroused when our alarm does not go off, we get stuck in traffic, everyone needs something from us at once, and there is no time to eat or go to the bathroom. When you are over-aroused, what do you feel like doing at the end of the day? Most of us want to decrease stimulation to get back to our optimum level of arousal. The opposite is also true. We can become under-aroused at various times during the day. Under-arousal also is not a pleasant state. To understand under-arousal, think back again to that really boring class at school. Imagine that you are wide awake and not sleepy at all. How does it feel to sit and listen to a monotone, slow, and pedantic teacher? You feel frustrated and impatient. You are below your optimum level of arousal. So you find yourself fidgeting, playing with your shoe laces, talking to your neighbor . . . essentially looking like a child with ADHD. According to the research about arousal, children with ADHD have very high needs for arousal. As a result, these children are constantly dipping into a state

of under-arousal. They feel like we feel in that boring class, but they feel like that much of the day. It's extremely frustrating and aversive. Optimal arousal is a biological need. I think of under-arousal like being thirsty or hungry. When you are thirsty, you seek out a drink. When you are hungry, you seek out food. And when you are under-aroused, you seek out stimulation at almost any cost.

Imagine that a child with ADHD is sitting next to a classmate and they are watching a movie. At the beginning of the movie both children are optimally aroused and able to sit still and pay attention. However, the child with ADHD soon becomes bored with the "talky" part of the movie. He reaches over and sticks his dirty feet in the face of his classmate. What is the purpose of his behavior? Is he trying to make a friend or impress his classmate? No. He is under-aroused and has a biological need for a "tall glass of stimulation." When the classmate screams and hits, the child with ADHD smiles because it feels good to get back up to his optimal level of arousal.

Because of the fact that these children are neurologically under-aroused, they have to be parented differently than children with lower needs for stimulation. Let me give you an example. Suppose a child with ADHD and a classmate are both eating pudding and become silly. They make pudding mustaches and pudding earrings. You respond like most parents by saying, "That's disgusting. You're supposed to eat pudding, not play in it." How will the calmer classmate feel? He will probably feel sorry that he disappointed you, and he will immediately wipe the pudding off of his face. Yet, when you use exactly the same parenting strategy with the child who has ADHD, what happens? He laughs, makes a pudding beard on his face, and throws his pudding at you. So for the average child, criticism is a very effective deterrent. That child will probably never put pudding on his face in your house again. But, for the child with ADHD, the criticism is like the tall glass of water for a thirsty person. He was under-aroused and the criticism provided the stimulation he needed to feel better. Rather than being a deterrent, the criticism was actually a reward. So, we have to parent children with ADHD very differently than we parent other children. Fortunately, there is an intervention that we can do here called Parent-Child Interaction Therapy that was specifically designed for children who do not respond to typical discipline.

Pharmacotherapy. Once parents have been educated about the biological bases of ADHD, we find it helpful to discuss medication issues. Parents need to understand how medications work in the system, including the expected benefits and potential side-effects. We address common myths about stimulant medication that have been perpetuated in the media. Finally, we discuss the pros and cons of using stimulant medication with very young children. When discussing medication for ADHD, we are always careful to remind parents that we are not prescribing physicians and they should consult with a medical doctor concerning the advisability of using medications with their children. A discussion of medication issues might sound like the following:

The class of medication that has been most commonly used with ADHD is stimulant medication. That includes ones that you have probably heard of like Ritalin and Adderall. It may sound strange to be giving stimulant medications to a child who is already overactive. But, now that you understand about under-arousal and how the frontal lobes work, it should make more sense. Providing stimulation to the brain helps children to maintain their high optimal level of arousal, meaning that they will not need to be as active to get enough stimulation to the brain. And, the stimulant medication works by increasing the rate of function in the frontal lobes. The right medicine at the right dose should speed up the frontal lobes so that they are working at about the same rate as in other children of the same age and gender. Remember that the frontal lobes are an inhibitory brain structure. When you speed them up, they become better at shutting down behavior. This essentially levels the playing

field for the child with ADHD, giving him a better opportunity to pay attention and focus. Unfortunately, we are not pharmacologically sophisticated enough to send the stimulant only to the frontal lobes, and it does affect other brain structures. That is why we get side effects.

The most common side effects are appetite suppression and sleep difficulty. However, both of these are dose related and depend on the timing of the dose. Stimulant medications are very short acting, and they are in and out of the body in a matter of hours. They do not need weeks to build up in the system like antidepressants and anti-anxiety medications. So, when children with ADHD wake up in the morning, they have essentially no medications in their systems and can generally eat a substantial breakfast. After the medication is in their systems and working, they may have appetite suppression for lunch and they may be ready for dinner later than you would generally serve it. For most kids with ADHD, there is a rebound in their appetite that happens at the end of the day in which they may be ravenously hungry and want to eat throughout the evening. Difficulty with sleep onset is usually related to the timing of the medication. For some children with ADHD, one morning dose is sufficient for the day. And, by bedtime, the medication is largely out of their systems. For other children, a mid-afternoon dose is needed to help them with homework and extracurricular activities. Those children may experience some difficulties with sleep onset with medication administered late in the day. Stimulant medication comes in both immediate-acting and sustained-release versions. Depending on which medication it is and the child's rate of metabolism, the immediate acting will usually work for 4 to 6 h. Sustained-release versions provide 8–12 h of symptom relief. For a very small percentage of children who take stimulant medications, a motor tic will develop. Generally, these are children who have a genetic familial history of motor tic disorders, and some pediatricians believe that the stimulant is uncovering an underlying tic disorder. If you notice anything that causes you to suspect a tic, it is important to notify the prescribing physician immediately, and it might be necessary to discontinue the medication.

Some parents worry that ADHD medication will turn their child into a "zombie," changing his personality. But, remember that this is a stimulant medication rather than a "tranquilizer." The reality is that the right dose of the right medication should take away the impulsivity and distractibility without altering your child's personality. If this dose is too high, we can see social withdrawal or a blunting of his emotions. If that happened, the physician would likely lower the dose and the side effects may go away. Other parents worry that their children may become addicted to the medication or get so used to "popping pills" that they are at risk for drug and alcohol addiction as teenagers. The truth is that stimulant medication is so short acting that the body generally does not develop tolerance to it, and it is not physiologically addictive. Children do need increased doses as they grow, but that is because of increases in body weight, not because they have become dependent on the medication. Longitudinal research has shown that all children with ADHD, because they tend to be stimulation-seekers, are at greater risk for drug and alcohol use than the general population. But, the children who have been treated successfully with pharmacotherapy are far less likely to use drugs and alcohol than their ADHD peers who did not receive this treatment. A third concern raised by parents is that they would feel guilty giving their child medication just to make life easier for themselves and teachers. But, we need to keep in mind just how painful ADHD is for the child. These children are being constantly redirected, often rejected by their peers, having difficulty with school work, and dealing with excruciating boredom. The medication can produce a light-switch kind of difference in most children with ADHD. Instead of hearing criticism all day, they begin to get praised. They begin to work to their potential and are able to complete homework in far less time. Because they are not disrupting the classroom and acting in impulsive, irritating ways, they are better able to make friends. They become proud of their accomplishments and feel so much better about themselves. We use medication to improve the quality of life of children with ADHD. If

parents and teachers are less stressed because the child is on stimulant medication, well, that's just a pleasant added bonus, but not our goal.

Although stimulants are the most common class of medication used to treat ADHD, there are non-stimulants that have been shown to be helpful. One medication in particular, Strattera, has shown promise as a medication that can provide 24-h symptom relief for ADHD. It often is used for children with co-morbid anxiety or motor tic disorder. This is a much longer acting medication that needs several weeks to build up to a therapeutic level in the bloodstream and has a different mechanism of interaction in the brain. Like stimulants, Strattera can suppress appetite. It also can produce stomach upset and should be given before bed or with a meal. As with all medications, you should work with your physician to figure out the right treatment for your child.

When we think about the possibility of using medication, we also have to take age issues into account. It is important for you to understand that frontal lobes mature over time. When babies are born, their frontal lobes are doing almost nothing. They have very, very short attention spans. As they grow, their frontal lobes continue to develop over the preschool years, and their ability to concentrate grows. There is a big spurt in maturation in the frontal lobes between the ages of 5 and 7, increasing their ability to stay seated and pay attention to whole-group instruction in school. Another spurt in frontal lobe function occurs with the onset of puberty. The hormones that are released affect frontal lobe functioning, making early adolescents capable of the high degree of organization needed to transition between class periods and keep track of multiple assignments and deadlines from several teachers. Because your child is still growing, we expect some of these symptoms to change or lessen with maturity.

With very young preschoolers (ages 2–4), we are conservative about medication referrals. With preschoolers, it is harder to accurately diagnose ADHD because the criteria are not developmentally sensitive. The research on ADHD medication with preschoolers is very limited and we still do not know the long-term effects of introducing a chemical into the brain during such a critical period of rapid neurological development. Additionally, with preschoolers, noncompliance and tantrums can cause a child to appear impulsive, disorganized, and active. We prefer to defer the ADHD diagnosis and medication considerations until PDI has been implemented and the oppositional behavior reduced. Even when it is clear after PDI that a preschool child has ADHD, it is often possible to delay the use of medication until kindergarten or first grade because very young children may not need to sustain focus in the home and daycare environments. In other words, we think it is important to give maturation and PCIT a chance to work before considering medication with preschoolers. For school-aged children who may benefit from stimulant medication, we encourage parents to think of a medication trial as more information gathering. It is a way to find out how their child might benefit from the medication, but does not commit them to that course of treatment. If they find that the stimulant medication is ineffective or the side effects are unacceptable, the medication can be promptly discontinued and will be out of their systems in less than a day.

Classroom Interventions. Also in this feedback and education session, we educate parents regarding a range of interventions that may be conducted in the classroom setting. We advise them that their child is likely to have academic and behavioral problems in the classroom and that it is important for them to be strong advocates for their children. They need to be aware that children whose ADHD is interfering with their academic performance may have a right to protection under

Section 504 of the Civil Rights Act. Under Section 504, children with disabilities, including those with a diagnosis of ADHD, may be provided reasonable accommodations to allow them to function in a regular education classroom. Common Section 504 accommodations include preferential seating near the area of instruction, more frequent redirection to tasks, behavior management plans, and homework reduction. Some children with ADHD will have co-morbid learning problems qualifying them for special education services under the Individuals with Disabilities Education Act. In our practices, we consult with the teachers to develop a behavior management plan and enhance school to home communication for children receiving PCIT. One tool that we have found helpful in working with teachers is the Tough Class Discipline Kit (McNeil, 2001), a whole-classroom token economy that motivates children with ADHD and their peers to follow rules and complete work. For more information on school consultation, please see Chapter 22 of this text.

Rationale for PCIT. For most children with ADHD, there are three avenues of intervention: pharmacotherapy, classroom interventions, and behavior therapy. It is important that they not leave this session believing that medication will be a panacea without need for other services. To make the case for conducting PCIT, we tell parents the following:

> Because your child has ADHD, he has a nervous system that prompts him to be very active. This nervous system places him at risk for other problems that are more behavioral in nature. Because of his high activity level, you have to give him many more commands and set many more limits than you would have to do with a calmer child. A calm child might need only 10 instructions per hour to stay safe and do what he is supposed to do. But a child with ADHD might need 50 instructions in that same hour. His nervous system is guiding him to obtain as much stimulation as possible. You as a parent are guiding him to calm down and focus. Over time, the child with ADHD gets angry and frustrated by all of the commands to calm down and do what does not come naturally. And the natural course for children with ADHD is that they begin to defy their parents and other adults. With 50 commands an hour, parents tend to get worn down and become inconsistent in following through with the request. The ADHD child quickly learns that if he simply tunes you out and waits long enough, the request will go away and he can continue to obtain the high levels of stimulation that he needs. So, two problems go hand in hand. On the one hand, there is the neurologically based ADHD that causes over-activity, inattention, and impulsivity. On the other hand, there is the learned behavior problem that we call oppositionality.
>
> Although medications may help your child to focus better, a state-of-the-art behavior plan is needed to get your child to follow rules and respect you as an authority figure. Even if your child is placed on medication and becomes calmer, most medications do not work 24 h a day. You will need a specialized parenting approach that will teach your child to follow directions even when the medication is out of his system. In PCIT, you will learn exactly what to say and what to do to manage all of the oppositional behaviors that go along with ADHD.
>
> Imagine how your life would be different if your son listened to everything you told him to do the first time you told him to do it. So, you tell him to put the sword away and he says, "Okay, Mom." And you tell him to pick up the Legos and he does it right away. With PCIT, you can expect your son to learn to listen at an extremely high rate. Because of his nervous system, he will still be more active and need more direction than the average kid. PCIT does not change the basic biological nature of ADHD, but it gives you the tools you need to manage the learned oppositional behaviors that go along with ADHD.

In addition to discussing the deficits associated with ADHD, we recount some of the positive things that are often said about people with ADHD. They may be described as the "life of the party" because they are often quick witted and charismatic. Many individuals with ADHD are very bright and talented. They often learn to channel their energy in positive ways and can be very high achieving. After educating parents about ADHD and its treatment, we recommend that they continue learning about ADHD through resources such as the Children and Adults with Attention Deficit Disorder (ChADD) website, Russell Barkley's website (http://www.russellbarkley.org) and Barkley's (2005) book, *Taking Charge of ADHD: The Complete Authoritative Guide for Parents (Revised).* We often provide parents with a print out of Dr. Barkley's Fact Sheet, "About ADHD," which can be downloaded from his website.

CDI Didactic. In addition to providing feedback to parents regarding test results and educating the parents about ADHD and its treatment, we begin PCIT in this session by teaching the parents CDI. The didactic session follows the standard protocol, emphasizing the way in which each skill is helpful for children with ADHD. In particular, we help parents to understand the importance of behavioral descriptions in helping children with ADHD to sustain attention. Behavioral descriptions serve several key functions with ADHD. First, descriptions provide a lot of stimulation for on-task behavior. When parents enthusiastically describe their ADHD child's productive play, the task becomes more stimulating to the child and he is able to stick with one activity for longer periods of time. Staying with a task longer is beneficial because children are more likely to do their best, to finish a project, and to feel proud of their accomplishments. Figure 15.1 shows a picture of a Christmas Tree drawn by a child with ADHD with an adult observing silently. Figure 15.2 shows how much more detailed the second drawing became several minutes later when the adult provided behavioral descriptions during the task. A second reason behavioral descriptions are beneficial for children with ADHD is that they help children to organize their thoughts. When parents describe behavior in a step-by-step fashion, they are helping their children to think in a step-by-step, linear way. Without descriptions, a young child might pour out the Lincoln Logs, put two together, and then open a can of Play-Doh, in rapid succession. With descriptions, the child is more likely to slow down and think about what she is doing with her hands and may actually build a structure with the Lincoln Logs. The third benefit of behavioral descriptions is that they prompt children to develop self-talk. After many home sessions of CDI in which the parent provides a running commentary of almost everything the child is doing, the child begins to imitate descriptive language. First she may talk out loud when playing alone, describing her own play (e.g., "I'm putting the man in the tractor. He's going to feed the animals."). Over time, these descriptions become internalized and she can silently talk her way through tasks. This self-talk increases the attention span of children with ADHD when they are engaging in independent play.

CDI Coaching. The structure of the CDI coaching sessions follows the standard CDI protocol. However, there are certain issues that we have noticed across ADHD cases. For example, parents of ADHD children often tell us that labeled praise does not work. In fact, some say that it makes their children worse. We have noticed that

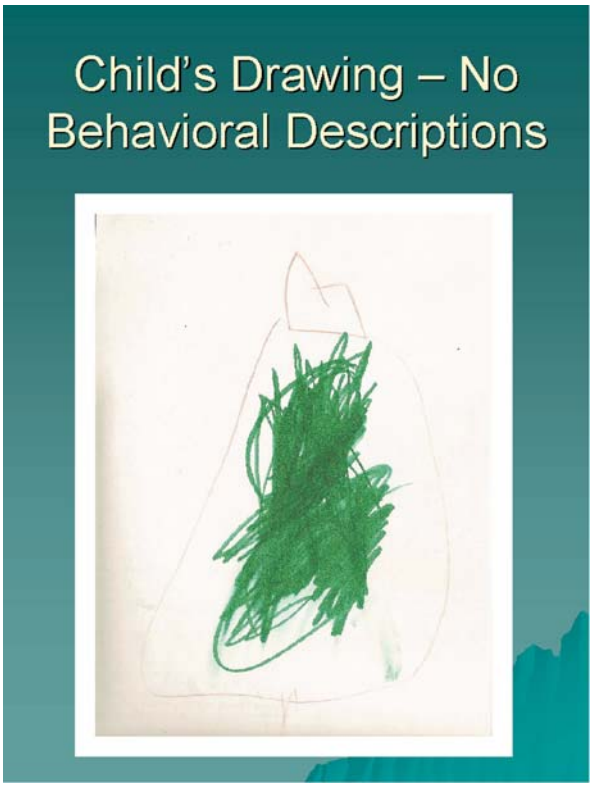

Fig. 15.1 Christmas tree drawn without behavioral descriptions (thanks to Kimberly Foley for sharing the pictures in Figures 1 and 2)

early in treatment it is common for children with ADHD to immediately engage in an opposite behavior when praised. For example, we coached a parent to say, "I like how you are sitting so still in your chair." The little girl with ADHD got a big grin on her face, looked right at her mom and started bouncing up and down in her seat. The mom then looked at us is exasperation. It certainly seemed as though the labeled praise backfired. Here is how we explain this phenomenon to parents:

> Parents with active children like your daughter often tell me that labeled praise does not work with their child. And, they are partly right. If they say to their child, "That's pretty the way you're coloring inside the lines," the child with ADHD may very well do the opposite and look right at the mother and scribble all over the paper. Then, the frustrated parent will probably say something critical like, "Now why did you have to go and ruin it?!!" Now what do you think was the purpose of scribbling on the paper? The fact that she was looking right at her mother when she did it tells me she was looking for a reaction. Remember that children with ADHD are under-aroused. When parents give them a low-key praise, it's only mildly stimulating, like a small glass of water for a thirsty nervous system. But, when the parent raised her voice and criticized her daughter, she gave her a nice tall glass of stimulation, and the child responded with pleasure. The criticism was more stimulating and therefore more reinforcing than the praise.

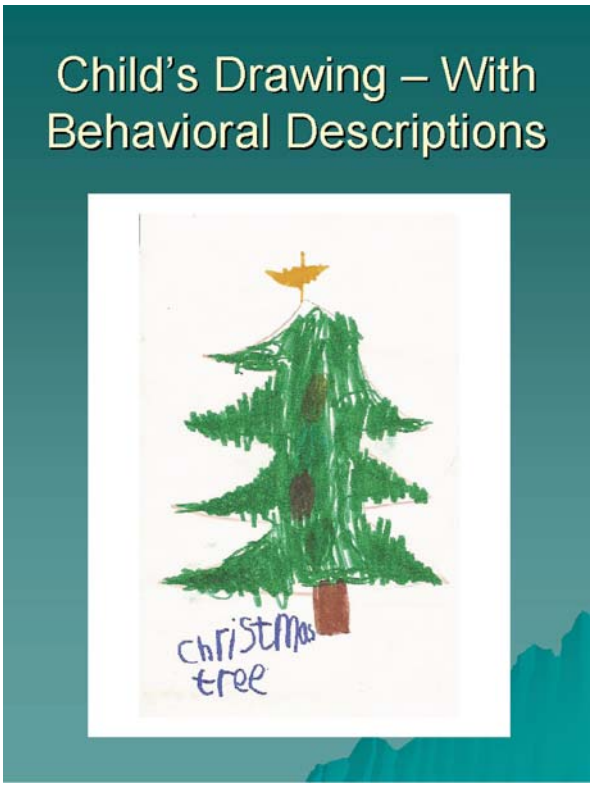

Fig. 15.2 Christmas tree drawn with behavioral descriptions

> In order for labeled praise to work with your daughter, you are going to have to ignore those times when she does the opposite behavior. If the choice is between a labeled praise which is only a little stimulating and an animated criticism which is extremely stimulating, your child will always choose to do the opposite and get the negative attention. But if the choice is between an enthusiastic labeled praise and nothing (you ignore), the labeled praise will begin to work. So here's what we're going to do. You say, "That's pretty the way you're coloring inside the lines." Then your child scribbles and laughs. You should turn around and ignore. When your child realizes that she has lost your attention, she will be motivated to work for the praise. While you are ignoring, she may very well say, "I'm coloring in the lines now. I'm coloring in the lines." When the choice is between praise and nothing, praise will begin to work.

By teaching parents to ignore children's negative reactions to labeled praise, we have had great success using labeled praise with children with ADHD. For examples of common labeled praises used with children with ADHD, see Table 15.1. Additionally, there is a nice handout in Eyberg's (1999) PCIT manual entitled, *Differential Social Attention for ADHD: Good Ways to Respond to Positive and Negative Behaviors in the Child-Directed Interaction.* We recommend that therapists provide this handout to parents of children with ADHD.

Table 15.1 Labeled praise for children with ADHD

Problem behavior	Pro-social target	Labeled praise
Rocking in chair	Sitting still	Good job of sitting still!
Impulsivity	Thinking before acting	I like the way you thought out a plan before you started!
Easily frustrated	Trying when its hard	I think it's great the way you keep trying even though it broke apart!
Short attention span	Sticking with it	I'm proud of you for finishing that whole puzzle!
Loud	Playing quietly	It's nice to play with you when you're so calm and quiet!
Overreacting	Staying calm	You've gotten so good at staying calm when things don't go your way!
Frenetic play	Slowing down	Thank you for slowing down so I can keep up with you!

Whereas in CDI we usually coach parents to play with their children on the floor, this can lead to problems in families with highly active children. Children may crawl rapidly around the floor, run around the room, switch activities rapidly, engage in gymnastics, and get so stimulated that they become destructive with toys and try to rough house with the parent. For these children, it is stressful for parents to follow the child's lead and keep up with their rate of activity. To encourage a calm, controlled interaction, we have these families do CDI at a table. Sitting in a chair at a table provides needed structure to the child with ADHD, preventing him from becoming over-stimulated with motor activity, and encouraging calm and productive play. It is hard for parents to focus on the CDI skills and to enjoy their children when they are chasing them about the room. A benefit of restricting CDI to the tabletop is that it provides numerous opportunities to practice ignoring and redirecting inappropriate behavior, skills that are vitally important when parenting children with ADHD. We coach parents to ignore when children leave the table, describe their own play enthusiastically and provide attention and praise when the child returns to the table. Another benefit of using a table for CDI is that it teaches children to remain seated, an important skill for classroom success. We begin the first two CDI coaching sessions by asking parents to provide the following explanation of CDI rules to their children:

> Today we get to have special playtime. It's going to be very fun. There are just two rules. You have to stay at the table and you have to play nicely with the toys. If you get up and run around or play roughly with the toys, I'll turn around like this (demonstrates turning away) and play all by myself. Then, when you sit back down or play nicely with the toys, I'll turn back again and play with you. I like the way you're playing at the table right now! We can play anything you would like to play.

In our practice, we have noticed that we get many referrals of families of children with ADHD with a mother who is low in energy and presents with a sad or flat affect. There is a clear mismatch in the demeanor and needs of the mother and her child. These children need stimulating environments with energetic parents, whereas these

mothers need a reduction in stress and demands. As therapists, we try to meet the needs of both the parents and the children. With these mothers, we help them to identify ways to reduce their stress. For example, we encourage them to take better care of themselves through exercise, increased respite from parenting, getting better sleep, paying attention to their own nutrition, and seeking support from friends and family. We tell them that the better they do at taking care of themselves, the more resources they will have for parenting these demanding children. We educate them about the need to get their children into active extracurricular activities. This allows children with ADHD to work off some energy and gives parents a break. With respect to the children's needs, we teach these mothers the importance of providing a highly stimulating environment. When these mothers speak in a monotonic, dull tone of voice, they are less likely to engage their children's attention and often provoke disruptive behavior in their stimulation-seeking children. Much of our coaching focuses on increasing the mother's enthusiasm, animation, inflection, and playfulness.

Because ADHD is largely a genetic disorder, we often see parents with ADHD symptoms. These parents are disorganized, often forgetting appointment times and homework. They often jump from topic to topic and have difficulty focusing during the lengthy didactic sessions. In their interactions with their children, they can be over-stimulating, working children up rather than calming them down. The parent's wild and high-rate play interactions can lead to chaotic and frenetic behavior in children. Reflections may be low as these parents often talk too much during CDI, never pausing to allow their children to speak. When coaching we might say:

> I would like for you to try something for me. Try to stay quiet for just a little bit here and let's see if we can get your daughter to talk a little more... That's it... Just stay quiet for a second... (child speaks) Good! Now you gave her a chance to talk. Go ahead and reflect that. Good job slowing down so she could lead the conversation.

While stimulation and animation are helpful for children with ADHD, some parents go over the top, providing too much stimulation and leading the play. During coaching, we encourage them to lower their voices and slow their overall rate of speech. We often have to use a very calm and slow tone of voice when coaching to model for these parents a moderate energy level. Some of our parents have undiagnosed and untreated ADHD that is causing functional impairment and interfering in their ability to follow through with PCIT. These parents may benefit from a referral to a specialist in the assessment of ADHD in adults.

Because parents of children with ADHD receive a great deal of negative feedback about their children, we make a special effort in these cases to frequently point out the child's positive attributes during CDI coaching sessions. For example, these children often have a delightful sense of humor. In coaching, we might say to the parent something like, "Julie really is funny. She cracks me up." For a specific child, we might point out positive traits like physical attractiveness, intelligence, affectionate and loving disposition, and helpfulness. We sometimes forecast for the parents that we could envision their child growing up to be an engineer, runner on Wall Street,

architect, choreographer, artist, or comedian. These positive observations help parents to put current challenges in perspective and to be optimistic about their child's future.

Explaining ADHD Medications to Children. Parents of children with ADHD often inquire about what they should tell their children regarding medication. We tell them that it is important for their child to have a basic understanding of what the medicine can and cannot do. We feel that it is important for children to understand that the medication cannot clean their room, do their homework, treat their friends nicely, or take their spelling test. They need to understand that the purpose of the medication is to slow them down so that they have the same chance to make good choices as other children their age. It is important that children take ownership for their successes rather than attributing them to the pill. We want children with ADHD to feel proud when they behave well, concentrate on their work, and keep their hands and feet to themselves. By the same token, we do not want children with ADHD to blame their failures on lack of medication. Instead, we need them to try their best to use self-control and concentrate regardless of medication status. We suggest that the parents not tell young, impulsive children the name of the medication they are taking because the child cannot be counted upon to use good judgment to keep that information private. With the abundant misinformation regarding both ADHD and stimulant medication, we do not want families set up for additional stress by having to justify their choice to try pharmacotherapy. To assist parents in explaining ADHD and medication to their very young children, two picture books are recommended: *Shelley the Hyperactive Turtle* (Moss, 1989) and *Otto Learns About His Medicine* (Galvin, 1995).

PDI with Children with ADHD. Few adaptations of the standard PDI protocol are needed for children with ADHD. In coaching, we make a special effort to keep parents from giving rapid-fire commands without allowing their children the opportunity to comply. Over the years, young children with ADHD train their parents to repeat commands and expect noncompliance. As therapists, we break this habit by coaching parents to stay quiet for 5 s after issuing a command. The coaching sequence would sound like this:

Parent:	Please hand me the block. Hand me. . ..
Therapist (interrupts parent):	Hold on. Stay quiet. Give him time. Just point to the block and point to your hand.
Child:	(hands parent the block).
Therapist:	Go ahead and praise.
Parent:	Nice job of doing what I asked you to do!.
Therapist:	Good job of staying quiet and giving him a chance to listen.

Parents are frequently reminded to "bite their tongues" after giving a command in order to give their children five full seconds to understand the command and initiate a response.

Toward the end of PDI, we focus the coaching on situations that are more challenging for children with ADHD such as academic tasks (e.g., writing letters),

staying close to parents while walking down hallways and in parking lots, and keeping hands and feet to themselves while interacting with their siblings. An issue that often arises with enforcing the "no hurting" house rule is that these impulsive children often hurt siblings and friends by accident. They are rowdy, rambunctious, and physical which often results in somebody getting hurt. Parents often ask us whether it is appropriate to put them in time-out when they hurt someone by accident. When the hurting occurs as a result of inappropriate, overly aggressive behavior (e.g., Kung Fu kicking, sword fighting with sticks), we recommend that the parent use time-out to provide the children with an opportunity to calm down and to encourage them to use better judgment in the future. In contrast, we do not recommend use of a time-out consequence for incidental hurting that occurs during appropriate play (e.g., stepping on another child's toe). In those situations, we encourage children to express appropriate remorse and to comfort the injured party.

Post-treatment Assessment and Follow-Up. As always, we conclude PCIT by conducting a post-treatment assessment. In the case of ADHD, we often find that the oppositional behaviors have improved to within normal limits. On the other hand, for young children who are not on medication, the ADHD behaviors (hyperactivity, inattention, impulsivity) improve somewhat, but typically do not decrease to within normal limits (McNeil, Eyberg, Eisenstadt (Hembree-Kigin), Newcomb, & Funderburk, 1991). It is not uncommon for families to contact us again reporting additional problems 1 or 2 years after PCIT has concluded. We used to find this discouraging and worried that PCIT may not be effective with this population. But we have come to understand that the reason that the parents contact us again is that they are dealing with a chronic disorder and know that PCIT has been helpful to them in the past. These families may require additional services during transition times such as when the child's academic demands increase, his school or teacher situation changes, his medications are being adjusted, or a stressful life event occurs (e.g., divorce, death of a loved one). Later, as the child enters puberty, we typically hear from these parents again because parents need new discipline strategies and their children need assistance with organizational skills (especially related to the new demands of changing classes in junior high school).

We have come to believe that the recurrent treatment of these families would best be delivered via a "dental model" (Kazdin, 1997) in which periodic checkups would occur over the course of development, with new interventions employed as the need arises. We think that PCIT is an effective intervention for preschoolers with ADHD, but we know that it is not a cure. We may very well work with a child with ADHD whose behavior comes to within normal limits at the age of 4, but we do not expect that this child will be problem-free for the rest of his development. ADHD is a chronic condition requiring multi-modal interventions that change based on the child's developmental level and presenting problems. In contrast to conducting PCIT with children who have oppositional behavior that is fully addressed with only one episode of treatment, we should expect that children with ADHD will require periodic tune-ups and additional services as they develop.

References

Barkley, R. A. (2005). *Taking charge of ADHD: The complete authoritative guide for parents* (Revised ed.). New York: Guilford.

Barkley, R. A. (2006). *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment* (3rd ed.). New York: Guilford.

Conners, C. K. (2000a). *Conners′ rating scales-revised technical manual*. North Tonawanda, NY: Multi Health System.

Conners, C. K. (2000b). *Conners′ continuous performance test II: Technical guide*. Toronto, Canada: Multi-Health Systems.

Conners, C. K. (2001). *Conners' kiddie continuous performance test*. Toronto, ON: Multi-Health Systems.

Eyberg, S. M. (1999). *Parent-child interaction therapy: Integrity checklists and session materials*. Retrieved April, 2, 2008, available online at www.pcit.org

Gadow, K. D., & Sprafkin, J. (1997). *Early childhood inventory: Norms manual*. Stony Brook, NY: Checkmate Plus.

Gadow, K. D., & Sprafkin, J. (2000). *Early childhood inventory – 4: Screening manual*. Stony Brook, NY: Checkmate Plus.

Galvin, M. (1995). *Otto learns about his medicine*. Washington, DC: Magination Press.

Gordon, M. (1983). *The Gordon Diagnostic System*. DeWitt, NY: Gordon Systems.

Greenberg, L. M. (1988–1999). *The test of variables of attention (TOVA)*. Los Alamitos, CA: Universal Attention Disorders.

International Consensus Statement on ADHD. (2002). *Clinical Child and Family Psychology Review*, *5*(2), 89–111.

Jacobs, J. R., Boggs, S. R., Eyberg, S. M., Edwards, D., Durning, P., Querido, J. G., et al. (2000). Psychometric properties and reference point data for the revised edition of the school observation coding system. *Behavior Therapy*, *3*, 695–712.

Kazdin, A. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology*, *26*(2), 114–129.

McNeil, C. B. (2001). *Tough class discipline kit*. Longmont, Co: Sopris West.

McNeil, C. B., Eyberg, S. M., Eisenstadt (Hembree-Kigin), T. H., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology*, *20*, 140–151.

Moss, D. M. (1989). *Shelley the hyperactive turtle*. Bethesda, MD: Woodbine House, Inc.

Project Shape (2008). Retrieved April 4, 2008, from http://www.pcit.org

Sandford, J. A., & Turner, A. (1994–1999). *Integrated visual and auditory (IVA) continuous performance test*. Richmond, VA: BrainTrain.

Sandford, J. A., & Turner, A. (1995). *Manual for the integrated visual and auditory (IVA) continuous performance test*. Richmond, VA: BrainTrain.

Wagner, S., & McNeil, C. B. (2008). Parent-child interaction therapy for ADHD: A conceptual overview and critical literature review. *Child and Family Behavior Therapy*, *30*, 231–256.

Zentall, S. S. (2005). Theory- and evidence-based strategies for children with attentional problems. *Psychology in the Schools*, *42*, 821–836.

Chapter 16
Extremely Aggressive and Explosive Children

Nearly all children referred for PCIT present with clinical levels of disruptive behavior including aggression, noncompliance, and tantrums. In this chapter, we consider children who are extreme outliers displaying highly aggressive, disruptive, and explosive behavior. All PCIT therapists will encounter children from time to time who challenge the boundaries of their expertise in behavioral management. These children often have been expelled from multiple daycare settings and sometimes require therapeutic preschools, day treatment programs, or inpatient stays. They may have histories significant for prenatal exposure to drugs and alcohol and come from homes with domestic violence and child maltreatment. A common scenario is one in which the child lives with a mother who is unassertive and acts victimized by her young child's aggression. Often she is in a relationship with a man with a history of extreme anger control problems evidenced by punching his fist through walls or serving prison time for assault. Many of these children have been removed from the biological parents because of child maltreatment and have experienced many lost foster care placements, resulting in being bounced around from home to home. Attachment problems are paramount. These children may present with extreme levels of hyperactivity, very low tolerance for frustration, high irritability, a quick temper, and even self-injurious behavior (e.g., scratching face until it bleeds, banging head on hard surfaces, punching self, biting self). Some of these children will have a clinical diagnosis of bipolar disorder and may be receiving pharmacotherapy under the care of a psychiatrist.

The Case of Mario

To illustrate the challenges these children present, we describe the case of Mario. Mario was the 4-year-old son of a single mother who was a recovering alcoholic. He had diagnoses of fetal alcohol syndrome and ADHD and had been expelled from Head Start. It was extremely difficult to obtain his medical and social history during the intake session, as he frequently screamed at his mother, played very roughly with toys, and was in constant motion. At one point, the mother answered intake

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questions while repeatedly flipping the boy in mid-air over her shoulder. His behavior escalated to the point of slapping his mother, and she asked if we could give him a short break on our playground. As the therapist relaxed by leaning against a ride-on lion, Mario rushed at her yelling, "Get off my damn lion!" The therapist was so taken aback that she nearly complied, until realizing that relinquishing the lion would only reinforce his aggressive behavior.

The first CDI coaching session was a total disaster. The problems began when Mario tried to grab the mother's cigarette lighter out of her purse. She told him, "no," and then he pulled the purse out of her hands, dumping everything on the floor. They wrestled over the cigarette lighter. She was able to place it in her pocket, but not before he bit her forearm so hard that it left indentations. At that point, he kicked the contents of her purse and spotted a previously confiscated bouncy ball. He proceeded to throw the ball with all his might onto one of the walls, making it ricochet wildly throughout the room. All of this occurred within 3 min of entering the playroom, providing the mother with no opportunity to follow his lead. The therapist coached the mother to ignore the rough play with the bouncy ball and play enthusiastically with toys, but the mother's attempts to redirect Mario were not nearly exciting enough to distract him from his frenetic play. At this point, the therapist decided to send them on break to give her a chance to form a new game plan.

CDI Pitfalls with Explosive Children

It is extremely challenging to initiate CDI with children like Mario. In the first CDI coaching session, we can expect misbehaviors that are so intense, so frequent, and so dangerous that they cannot be ignored. We have had chaotic and disastrous sessions in which children have entered the playroom and quickly tipped over the table full of toys, picked up and threw large toys like doll houses, attacked the parents, banged with full force on our observation windows, urinated on our playroom floor, and struggled with the parent to escape the playroom. When these behaviors occur in the first few sessions of CDI, it is particularly problematic because the parent has not yet developed the necessary CDI skills to use contingent attention to interrupt the escalation. Nor does the parent have the necessary PDI skills to use commands to redirect aggressive behavior. When these children begin therapy, many of them have few constructive play skills and often do not find toys very reinforcing. As a result, the children become easily bored when playing with toys and seem to prefer the more stimulating activities of throwing and kicking toys around the playroom. Additionally, the parent-child relationship is often so poor that the child does not even want to play with the parent.

With extremely disruptive behavior in the first few sessions, ignoring may not be appropriate or effective. The rule of ignoring is that we ignore "annoying and obnoxious" behaviors, but not dangerous or significantly destructive behaviors. However, with explosive children, they can quickly escalate from producing

obnoxious but ignorable misbehavior toward displaying aggressive and destructive behaviors, which cannot be ignored. For example, we had a first CDI coaching session in which we encouraged a parent to ignore for more than 20 min while her son dumped out every single toy in the playroom, spat on the mirror, used profanity, and kicked the potato head around the room like a soccer ball. Technically, these behaviors could be ignored because he was not hurting anyone or breaking toys. By ignoring, however, a precedent was set for the child that the PCIT clinic was a place where he could "get away with murder" and no one would say or do anything to stop him. At the next session, the child came into the room and immediately began to once again dump out all of the toys because it was very stimulating and he knew he could get away with it.

Asking a parent to ignore such intense misbehavior leaves the therapist with a credibility problem. While ignoring, the parent may feel frustrated, embarrassed, scared, and skeptical about our ability to deal with their child. Drop-out potential is high because the parent does not want to return to treatment for "round two," armed only with turning away and allowing the child to escalate. With children displaying lower intensity behaviors, we can use ignoring successfully because the acting-out behavior does not escalate to the same level of severity. And, these children can be enticed back into play much more readily since they usually enjoy the toys. For cases in which a great portion of the first session or two is spent trying to manage high levels of disruptive behavior, we recommend modifying CDI to better meet the needs of these families. If we do not do something differently, the parent will never have an opportunity to learn the PRIDE skills well enough to be able to engage the child. Possible poor outcomes of doing CDI "as usual" are that the child could escalate to the point of destroying property or hurting someone, or the parent could lose hope and drop out of treatment.

CDI Adaptations for Explosive Children

Preparing the PCIT Room in Advance. With respect to preparing the environment, it is important to prevent as many dangerous and destructive behaviors as possible by setting the room up for success. The therapist should scrupulously childproof the playroom. Furniture that could be tipped over when climbed on (e.g., toy shelves) should be removed or bolted to the wall. Examples of items that should be removed include framed pictures, mother's purse, cords on blinds, clocks on the wall, trash cans, lamps, plants, and end tables. Electrical outlets should be covered and windows should be sealed. Careful consideration should be given to the furniture that will be used in the session. For some of these cases, we remove all chairs and tables so that children cannot jump from them or throw them. Similarly, therapists should carefully select the toys that are placed in the room. We avoid heavy toys such as wooden doll houses that could be dangerous if thrown at a parent or a window. We also avoid toys with lots of little pieces that can create chaos in the room when dumped out. Markers and crayons probably should be avoided unless the therapist

is prepared to wash or paint the walls. Safe toys are ones that are light or soft, with few pieces such as rubber, cardboard, or foam blocks, a small box of construction straws, a small box of Legos, a magna-doodle drawing toy, small chalkboard and chalk, hot wheel track with two small cars, and farm figurines. We recommend including about four toys at a time in the playroom. As escape attempts are common, it is important to block the playroom door so children are contained. Since fire-codes may not allow the use of a sliding lock outside the child's reach, we have the parent either sit in front of the door or move the table in front of the door to block the child's exit.

Explaining the CDI Rules in Advance. With highly aggressive children, we recommend explaining the CDI rules at the beginning of the first CDI coaching session. The therapist asks the parent to repeat these rules word for word to the child. The rules might sound like this:

> Today we are going to have special playtime. You can play with any of these toys, and I will play with you. It will be a lot of fun. There are just a couple of rules. You have to play calmly and gently with the toys. And, you have to play nicely with me. If you play roughly with the toys or use mean words with me, I will turn around like this and play all by myself. Then, when you play nicely again, I will turn around and play with you. You're playing calmly now, so I can play with you.

By explaining the rules in advance, children quickly recognize that when the parent turns away, he or she is following through with the planned ignoring. This prevents escalations that occur when a child is confused by the parent's "weird" reaction. Although explaining the rules in advance does not prevent acting-out behaviors that are displayed in defiance to the ignoring consequence, the explanation does help aggressive children adjust to the ignoring rule of CDI more quickly, thereby decreasing the overall rate of extreme behaviors during CDI coaching..

Entering the Room for Destructive and Aggressive Behavior. Even with our best foresight, sessions can get out of control. If a child sweeps all of the toys off the table or throws toys around the room creating a chaotic environment, we need to stop the session so that we can have the chance to clean up the room and remove problematic toys. Yet, we do not want to reinforce disruptive behavior and let the child "win" by sending him for a drink at the height of a temper tantrum. Instead, we look for a pause in the disruptive behavior and quickly enter the room saying something like, "I like how you've calmed down. This is a good time for you and your mom to take a break." While the parent and child are gone, the therapist childproofs the room as a way to set the child up for success during the rest of the coaching session.

Sometimes we cannot wait for appropriate behavior before entering the room because the child is engaging in dangerous (e.g., climbing onto a high window sill and jumping down), aggressive (e.g., punching or biting the parent), or highly destructive behavior (e.g., trying to throw a heavy toy at the one-way mirror). When safety is an issue, we always go in the room. We want to interrupt the misbehavior as quickly as possible by drawing the attention to ourselves. We open the door with a flourish, and enter with an air of authority. We might say in a louder than normal voice something like, "Excuse me. You are in my playroom and we have rules here. Everyone must stay safe. You are not allowed to hurt anyone." At that

point, the child is usually surprised and therefore stops the aggression. We quickly provide a labeled praise such as, "I like the way you've calmed down. I'm going to bring in my new Lego police car. I think you'll like it. Thank you for playing gently with your mom." A new toy is quickly brought in, and the therapist coaches in the room until the CDI is back on track. For families in which the child does not appear to enjoy playing with the parent (usually flat, monotone parent), it may be necessary for the coach to stay in the room for a while to calm the child down. While in the room, the therapist should join the parent in using PRIDE skills with the child. Having two adults playing with the one child often provides enough extra attention and stimulation to engage the child in play, and it provides an opportunity for the therapist to model the CDI skills for the novice parent. The therapist should avoid "taking over" the CDI, choosing instead to use PRIDE skills in combination with the parent, constantly encouraging the parent to use the skills as well.

For children who engage in repeated episodes of dangerous and destructive behavior, we recommend having the parent leave the room so that the therapist can firmly review the playroom rules with the child. We ask the parent to leave the room for three reasons. First, the aggressive and destructive behavior is usually being done to get parental attention. So, asking the parent to leave interrupts the disruptive behavior by removing its target. Second, children are less comfortable acting out when alone with an unfamiliar adult. And, third, explosive children are more likely to accept limits set by the therapist who has greater credibility in their eyes than the parent. When possible, a warning is first provided to the child. For example, after the child throws the Lego bucket across the room, the coach has the parent say "If you throw another toy, I will have to leave the room." Then, when the child throws the next toy, the therapist should quickly enter the room and the parent should exit the playroom for a brief period of time (e.g., 30 s). Depending on the clinic setup, the parent may be able to observe the interaction from behind the one-way mirror. The therapist says to the child "There is no throwing in my playroom. Every time you throw a toy, your mom will leave." Then the therapist picks up the room and says, "That's great that you are following the playroom rules now. I'll bring your mother back in." This procedure is used each time the child throws toys or attempts to hurt the parent.

Building Up Parents' CDI Skills in Advance. The second way that we can adapt CDI to work with children displaying extreme levels of disruptive behavior is to build up parents' use of PRIDE skills in advance. Parents will be more successful in a CDI coaching session if their skills are near mastery before they are coached again with the aggressive child. There are several models for improving PRIDE skills without needing to have the referred child present. First, a less disruptive sibling can be recruited so that the parent can be coached in PRIDE skills. Second, we may be able to get a parent's skills near mastery simply through role-plays with the therapist. Third, therapists may join with parents (or "double team" the child) in conducting CDI, alternating between modeling PRIDE skills and coaching the parent. It is helpful for the therapist to build the parent up in the child's eyes by providing praises such as "Your dad has great ideas about playing" or "Your dad is having a great time playing with you." As the child becomes receptive to the

parent's verbalizations and the parent's skills improve, the therapist can phase out of the CDI, allowing the parent greater independence.

Breaking Up the Coaching Sessions. A third way that we can adapt CDI to set highly aggressive children up for success is to break up the coaching sessions. As mentioned before, many of these children are extremely hyperactive with very short attention spans for constructive play. For these children, boredom is often the trigger for an explosive outburst. Our standard 40-min coaching time may simply be too demanding for them. One way to address this is to have the family come to the clinic for two 30-min PCIT sessions rather than one 1-h session each week. A second option is to provide one or more breaks during coaching. Because some children cannot transition back into the playroom well following a stimulating break, another alternative is to frequently rotate toys in and out of the playroom.

Setting Up a Reward Program. A fourth way that we can adapt CDI is to put in place a simple star chart to motivate children to comply with one or two simple rules like "no hurting" and/or "no throwing." The star chart divides the session into three segments of 10 min each. The child is awarded a star at the end of each time interval if she has not broken the rule(s). At the end of the session, each star earns the child a small prize from the prize box. To increase the likelihood of quick success, the therapist explains the star chart to the child at the very beginning of the session. We prefer that the therapist, rather than the parent, introduces the star chart so that we can ensure that it is explained clearly and with enthusiasm. Star charts are used only in the first few sessions and are phased out as soon as the parent has sufficient skill development and the child is responsive to CDI. It is important to phase out the star chart because parents can erroneously conclude that behavioral improvements were due to the prize rather than mastery of the PRIDE skills.

Conducting PDI Before CDI. As an absolute last resort for highly aggressive children, we may recommend that therapists conduct PDI before CDI, but only if they have access to a nearby, well-constructed time-out back-up room. A potential advantage of doing PDI first is that parents can be taught how to deal with dangerous and destructive behavior assertively and confrontively. In this way, parents, who might otherwise drop out because they are opposed to the idea of "simply ignoring" highly disruptive behavior, may be motivated to continue treatment. Back in the late 1980s, we conducted a study with Sheila Eyberg in which half of the families received PDI before CDI (Eisenstadt (Hembree-Kigin), Eyberg, McNeil, Newcomb, & Funderburk, 1993). Although the outcome data appeared positive, as clinicians we observed many disadvantages of reversing stage sequence. Without the strong foundation of a positive parent-child relationship addressed in CDI, the first PDI coaching sessions were among the most conflictual and physical we have seen. Children required many more time-outs, were much more likely to escape from time-out, and took much longer to let go of their anger after a time-out when PDI was conducted before CDI. When they did comply, children often did it with a surly attitude. The data from the study suggested that families who received PDI first were less likely to maintain their treatment gains at long-term follow-up than families who received CDI first. Interestingly, the two of us have treated over 1,000 families with PCIT since conducting the stage sequence study about 20 years ago.

Of those 1,000 cases, we have only switched the stage order four times. Because of the many potential drawbacks of conducting PDI before CDI, we truly view this as an absolute last resort approach to be used only when all other options have failed.

Preparing for Behavior Problems at the End of the Session. Children are often at their worst at the end of the session, when they are bored with the room and the toys and must entertain themselves while the adults debrief. It is important that the session end on a positive note so that parents leave feeling successful and optimistic about continued success. It is unfortunate to have a session end in chaos because there is no opportunity to debrief the session, assign new homework, and reinforce parental competency. In university settings, we have the luxury of co-therapists who can occupy the child during the check-out. However, most PCIT therapists will need to find other solutions. For example, a snack can be provided at the beginning of the check-out time to keep the child busy. Alternatively, we sometimes are able to move the child and parents to a novel playroom, so that the child can enjoy a new set of toys. We also may choose to conduct an informal check-out with the parent, as we walk with them to the car. Finally, a therapist may wish to omit the check-out altogether to insure that the session ends on a positive note. Debriefing would then happen in a phone call home. For those inevitable times when a session does end badly, we recommend that therapists provide a supportive mid-week telephone contact, reminding parents that we have many more strategies to use and forecasting that the child's behavior will get much better as we get further into PCIT.

PDI Adaptations

Surprisingly, few adaptations to PDI are needed when working with very aggressive and explosive children, as long as the therapist has a well-constructed time-out back-up room. After all, the PDI techniques were specifically designed to handle these types of behaviors. One adaptation that we have sometimes found helpful is to enter the room when a child becomes aggressive while the parent is attempting to place him in time-out. Entering the room offers several advantages. First, we are able to see the parent-child interaction more clearly and can better determine whether the parent is following through on procedures safely. And, second, while coaching the time-out in the room, we can manipulate the environment to remove obstacles and help the parent calmly follow through with the time-out procedures. In the room, the therapist is able to move toys away from the time-out chair, accompany coaching words with gestures, steady the time-out chair, move a table out of the way, and gain eye contact with the stressed parent who may need face-to-face support. When we enter the room, we do *not* physically touch the child. For example, we do not put children in time-out ourselves, nor do we assist parents in carrying children to time-out. We want children to know that their parents can handle their behavior. And, we do not want to undermine parental confidence by "taking over" the time-out procedure. Furthermore, being hands-on with children, particularly in the middle of an aggressive episode, raises liability issues.

The second adaptation that we make for children with extreme levels of disruptive behavior is to add an "Are you ready to sit in the time-out chair now?" prompt prior to allowing them to leave the time-out back-up room. We have found that 1 min plus 5 s of silence in the back-up room is rarely sufficient to motivate these children to sit in the time-out chair. In our experience, these children usually need at least 5 min in the back-up room to demonstrate a willingness to cooperate with the time-out chair. When these children are not ready to sit in the chair, they frequently respond to the "Are you ready. . .?" prompt by defiantly refusing to leave the back-up room. The prompt, then, is helpful in that it reduces the likelihood of releasing these children from the time-out back-up room too soon, thereby preventing the possibility of another physical confrontation (i.e., the parent carrying the child back to the room).

A third adaptation to PDI for highly aggressive children is to use physical guidance for compliance as a last resort contingency when time-out behavior has escalated to extreme levels. Granted, many time-out situations with children referred to PCIT are stressful and involve high rates of disruptive behavior. With this adaptation, we are referring only to the most extreme situations (e.g., 1 out of 500 PCIT cases), in which time-out must be ended for reasons such as the following: (1) the time-out has proceeded too long (e.g., well over an hour) and other responsibilities must be met, (2) the child has reached a point in which learning from the time-out procedure is almost impossible (e.g., vomiting, falling asleep), (3) the parent cannot control his or her temper and could hurt the child, and (4) the child is engaging in severe self-injurious behavior (i.e., resulting in possible tissue damage). As is always the case in PCIT, the time-out procedure must end in compliance. If the child was to learn that he or she could escape a PDI command by escalating to extreme levels, it would be quite difficult (if not impossible) to make PCIT successful. As a last resort contingency in these extreme cases, the therapist may choose to coach the parent through hand-over-hand prompting, also called physical guidance. In this procedure, the parent goes to the time-out chair or back-up room and says to the child, "Now, you *will* put the crayons back in the box (original command)." The parent leads the child back to the play area, which contains only the crayons and the box. The parent then guides the child's hand to put the crayons back in the box. Once the child has "complied," the parent provides a labeled praise and returns to CDI. The session is ended without the follow-up command or additional commands. This procedure is a "last resort" because it is not as effective as requiring the child to comply independently. It is analogous to a stalemate in chess (a "draw"). The parent did not come out on top, but neither did the child. It simply postpones the learning until the next session, allowing the parent, child, and therapist a rest period to garner resources for "Round 2" of the first PDI coaching session. PDI cannot progress until the child is able to independently comply with the original and follow-up commands. The hand-over-hand prompt is positive because it allows the therapist to end a session that has gotten out of control without losing much ground. But, the procedure is used rarely and only as a last resort because it results in a "lost" session, postponing the child's learning process and prolonging treatment.

Conclusion

It seems like the referrals for extremely explosive behavior in very young children are increasing over time. Unfortunately, the most common scenario in many communities is to label these young preschoolers with bipolar disorder and to refer them to a child psychiatrist for mood stabilizers without adjunctive behavior modification. Yet, we have great success using PCIT for this population. Because we are concerned about the possible negative effects of placing 3-, 4-, and 5-year-old children on anti-psychotic medication, our approach is to begin with PCIT whenever possible, giving PCIT a chance to work before making a medication referral. Clinically, we have found that most cases are successful if we can motivate families to continue through the initial difficult sessions. Clearly, however, research is needed to examine the effectiveness of PCIT with children who have clear diagnoses of bipolar disorder.

Reference

Eisenstadt (Hembree-Kigin), T., Eyberg, S. M., McNeil, C. B., Newcomb, K., & Funderburk, B. (1993). Parent-child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome. *Journal of Clinical Child Psychology*, *22*, 42–51.

Chapter 17
Marital Conflict

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With every new family referral comes the possibility of co-morbid marital issues. While the presenting complaint typically involves child disruptive behavior, conflict between parental figures may also be present and could hinder a successful treatment outcome. Marital problems pose persistent obstacles in PCIT given the need for consistency across parents and the general focus of working together to monitor and manage child behavior. Adding to the difficulty of addressing these issues is the reluctance of parents to mention marital conflict during intake and early treatment sessions. It takes couples, on average, 6 years after determining serious problems within the marriage to attend marital therapy (Notarius & Buongiorno, 1992, as cited in Gottman & Gottman, 1999). As most parents are typically at their best behavior when attending PCIT sessions, therapists are often unaware of conflict within the home and thus have an inaccurate initial case conceptualization. In this chapter, we first set out to elaborate on how to effectively assess for potential marital conflict. We then illustrate how a PCIT clinician can address marital problems and effectively integrate treatment within the framework of PCIT. Before we begin, we clarify that PCIT is not a stand-alone treatment for marital issues, nor was it designed to be one. When marital conflict is based primarily on disagreements regarding child rearing, PCIT may be a potent intervention for couples. However, when the marital problems are more complex, perhaps involving infidelity, communication problems, and disagreements over finances, PCIT alone is not sufficient. Rather, with some minor additions, PCIT can act as a stopgap and help keep marital problems at bay while the child's maladaptive behaviors are addressed. As the standard PCIT protocol is not likely to improve severe marital problems without a more direct intervention, we present various techniques, which when incorporated into PCIT may improve parental interactions and act as a catalyst to treatment. This chapter is designed to present strategies for helping parents who are experiencing marital conflict. It is not intended for families in which child abuse and/or intimate partner violence are present. Strategies for working with families who are experiencing violence in the home are presented in Chapter 13 (Child Physical Abuse) and Chapter 18 (Parents with Major Life Stressors).

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Encouraging Both Parents to Attend Treatment

At the time we schedule an intake appointment for PCIT, we tell the parent who contacts us that it is important for both parents to attend. Such a request is with good reason. Studies have demonstrated that PCIT with an involved mother and a father increases the treatment's effectiveness and improves child behavior compared to treatment with single-parent families (Bagner & Eyberg, 2003). Furthermore, clinical experience suggests that consistency across caregivers aids in various aspects of treatment outcome. Yet, oftentimes only one parent presents at intake. That parent, typically the mother, tells us that the father could not make it because he was unable to get off work, has a demanding travel schedule, does not see any problems in the child, does not believe in "shrinks," or feels that it is the mother's job to parent the child. Dealing with such an initial resistance to treatment is difficult. Even if the father agrees that a problem is present, he may be resistant to the idea of spending relatively large amounts of time, resources, and energy on a treatment which, in his eyes, is not worthwhile. As it benefits treatment, we work very hard to encourage reluctant spouses to attend all PCIT sessions. Beyond being flexible in scheduling to accommodate work and travel responsibilities, if only one parent attends the first session, we say:

> Since your husband does not share the same concerns that you have about your daughter's behavior, that makes it all the more important that I hear his input. Children can behave very differently across situations and caregivers. I assume that your husband has valid input to share with me. While I would encourage him to participate in our sessions, at the very least, I need to have his input on these assessment measures *(hand mother rating scales to be completed by the father)*. After these are completed, he can participate in the feedback session we have already scheduled, or we can arrange a separate, brief session at his convenience. We could even put him on the speaker phone during our longer feedback session. Please talk to him about these options.

We find that it is easier to get a reluctant spouse to come to the clinic if we try for just one short (e.g., 15 min) session at first, rather than demanding a commitment to attend all treatment sessions. Once we get the spouse in the door, we can provide a great deal of support and education that may change his opinions about PCIT and motivate him to be involved in therapy sessions. Additionally, he may see firsthand how changes in his parenting techniques can lead to improvement in his child's behavior. In some cases, the spouse vehemently refuses to meet the therapist, regardless of the supportive interventions. As such a strong reaction to treatment may be indicative of a more serious problem in the home, it is all the more reason to assess marital discord and, potentially, domestic violence and child abuse. If physical violence is present in the home, family safety becomes the first priority (see Chapter 13 and Chapter 18 for more information).

Assessment Techniques

When we are successful at getting two parents to attend the intake session, we always provide a basic screen for marital problems. As this is a sensitive area

to broach, we offer numerous recommendations which vary in their level of confrontation; however, it is imperative that PCIT therapists inquire about marital quality given its effect on the child's behavior. During our intake interview, we incorporate questions designed to elicit information about the marital relationship, each listed in Table 17.1. We find that inquiring about the marriage within the context of the child's experiences is most effective in eliciting honest responses without the parents feeling that judgment is being cast on the state of their marriage. Another less direct method to elicit marital information is by asking parents to tell us which of a number of stressful life events (e.g., financial problems, death in the family, major accident or illness, change in employment) have occurred during the last year, with marital difficulties embedded in the list. This can serve as a springboard to discussing what conflict may be present in the home and the extent of the child's exposure to such conflict (e.g., raised voices, profanity). Sometimes we find that parents have a healthy respect for one another's decision making and are able to resolve disagreements in front of children in a calm and appropriate fashion. In other cases, parents model behaviors that are similar to the behavior problems exhibited by the child. Most frequently, parents allude to the occurrence of heated arguments in front of their children or that there has been talk amongst themselves of separation. Through modeling, children may acquire their parents' negative interaction patterns and learn maladaptive ways to express their anger.

Table 17.1 Interview questions evaluating the marital relationship

How consistent are the two of you in your disciplining?
Do you two ever disagree over methods of discipline?
How do the two of you handle disagreements?
How good are the two of you at supporting each other when it has been a tough parenting day?
How often are you, as a couple, able to get alone time away from the kids?
What sorts of things do the two of you do together for fun?
What kind of stressors have you experienced recently (e.g., loss of job, death in the family, marital conflict)?
Has your child been exposed to any marital conflict (e.g., arguments)?
Are there any concerns about the quality of your marriage?

Assessing marital problems is not a process which should occur only during the intake session. Rather, given the close interactions among parents over the course of PCIT, therapists should be on the alert for certain warning signs. The most noticeable signs are arguments and criticisms between parents. Outside of a blow-up during a session, spouses may take verbal "stabs" at each other. For instance, while observing their spouse practicing the CDI or PDI skills with their child in session, one parent may tease or insult the other. Even if these put-downs seem innocuous, they may be indicative of more serious negative interactions outside of treatment. We have also observed parents engaging in an unhealthy competition of who can be a "better" PCIT parent. The two parents may focus on outdoing one another instead of learning skills for the betterment of the child. Non-verbal cues, such as the persistent angling of chairs away from one another or absence of humor, can also be an indicator of marital distress. Furthermore, children's behaviors possess a great

deal of information about their parents' marriage. Observing children's interactions with each parent in-session may provide further insight to conflict which may occur in the home. The marital therapy literature suggests that couples experiencing marital discord often display the following interaction patterns, colloquially referred to as the "Four Horsemen of the Apocalypse" (Gottman, 1994). Table 17.2 lists and explains each of the telltale signs.

Table 17.2 The four horsemen of the apocalypse

Criticism	Attacking partner's personality or character, with the intent of making someone right and someone wrong	All or none generalizations; "you always. . ." or "you never. . ."
Contempt	Attacking partner's sense of self with the intention to insult or psychologically abuse	Insults, name calling, hostile humor, mockery, body language, tone of voice, or sneering
Defensiveness	Seeing self as the victim, warding off a perceived attack	Making excuses, meeting partner's complaint with a different complaint, disagreeing and then complaining, agreeing but later disagreeing
Stonewalling	Withdrawing from the relationship as a way to avoid conflict	Changing the subject, removing yourself physically, silent treatment

Note: Adapted from *What predicts divorce: The relationship between marital processes and marital outcomes* (Gottman, 1994).

If there are indications of marital distress, we recommend formally evaluating the marital relationship through well-established marital satisfaction rating scales, such as the Locke–Wallace Marital Adjustment Test (Locke & Wallace, 1959; for further detail on administration of this measurement, see Fischer, 2007), publicly available online at http://www.familynow1.com/reviews/lockewallace.htm. Parents are sometimes better able to report on a written questionnaire what they may feel uncomfortable reporting in person. The Locke–Wallace Marital Adjustment Test has a cut-off score of 85 to which lesser scores are indicative of significant marital conflict. While the Locke–Wallace Marital Adjustment Test is practical in the sense that it is brief (15 items) and requires about 10 min of the couple's time, there are other available measures which can be used as an adjunct if additional information is desired. The Marital Satisfaction Inventory (Snyder, 1997), for instance, provides rich data on the specific nature of the marital conflict, although it is more time consuming at 150 true/false questions. In addition to evaluating 13 marital domains, the Marital Satisfaction Inventory also evaluates indices of overly positive responses and inconsistency. The use of a validated assessment of marital conflict provides another method of examining the problem at hand as well as tracking the couple's improvement.

In families in which marital issues serve as a barrier to treatment, it is necessary to discuss this information in a sensitive manner with the parents. These families often desperately need clinicians who are able to remain non-judgmental, address issues sensitively, and genuinely empathize with their stressors. After discussing the

presence of marital problems, we typically provide a referral to a marriage therapist; however, our prior experience with parents suggests that marital referrals will often be thrown to the wayside and never utilized. If this occurs and the parents refuse marital therapy, we offer a wide array of potential treatment options within the PCIT framework. Often we find that parents will refuse a referral to a marriage therapist, but they may be willing to take steps to work on these issues if it is incorporated in their child's treatment. This approach may feel less threatening to them, as the child's well-being remains the focus of treatment. In these situations it is important to educate parents in how marital issues may undermine treatment, add additional conflict, weaken treatment adherence, or limit potential for improvement. We may say:

> Each time a child is brought into our clinic we must take a look at why children may be acting out. We often find out that children are reacting to stressors such as problems at school, family issues, or major life changes. As we went through the intake interview and as you completed the rating scales, my goal was to better understand all of the factors affecting your child's behavior. One of the rating scales you completed asked about your marital relationship. As I'm sure you realize, how happy you are in your marriage and how well the two of you communicate affects your children. Based on the information you provided to me, it seems that problems in your marriage may be affecting your child's behavior.
>
> I understand that you may not feel that your marital issues are a primary concern. It is completely understandable for you to want to first focus on your child's behavior. But, our experience tells us that many parents benefit from the help of a marital therapist. Families often benefit from setting aside some time to work with an experienced therapist who helps couples work out problems. We find that parents who address problems in their own relationship either before starting PCIT or while going through PCIT generally have better outcomes.
>
> I think that it is important that I provide you with treatment options that will offer the best outcome for your family. I would like to hear your thoughts about how you wish for treatment to proceed. One possibility is that I could refer you to a marital therapist, and the two of you could work out some problems in your relationship before we begin PCIT. Another option is that we could start PCIT now, but have you see a marital therapist at the same time. If you prefer not to see a marital therapist at this time, a third direction we could take is to continue PCIT and add into treatment some exercises for the two of you to help improve your communication and problem-solving skills. How do you feel about these options? Which of these options might work best?

In conducting PCIT in the context of marital discord, we elaborate on six potential components, as seen in Table 17.3. Each may be incorporated into the standard treatment protocol by itself as a potentially effective option or may be incorporated as part of a series of techniques emphasizing marital issues.

Integrating Marital Therapy Within PCIT

Once it has been determined that significant marital problems are present, we work even harder than usual at building rapport with both parents, as we will be handling very difficult and personal issues with them. With couples characterized as having negative interactions, a goal within PCIT is to begin replacing the family atmosphere

Table 17.3 Marital conflict components within PCIT

Parent education regarding relationship between marital conflict and child behavior problems
Parents as models for their children's behavior
Use of CDI skills in the marital relationship
Teaching parents to be positive during coaching
Use of PDI skills in the marital relationship
In-session practice and marital homework assignments

of criticism with an atmosphere of appreciation. When learning the effective use of the PRIDE skills, parents are taught ways to apply the positive principles not only with their child, but also their spouse.

Parent Education. We often begin with parent education regarding the impact of marital conflict and arguing in front of children. Older children and adolescents may devise methods to escape or avoid their parents' arguments (e.g., turning up the volume on the television, listening to an iPod, going over to a friend's house, spending a great deal of time in their bedrooms). But, preschoolers cannot use these coping strategies and are often a captive audience for marital conflict. We suggest scheduling a separate session with parents to introduce these issues, similar to the CDI or PDI didactic. During this session, we spend a great deal of time talking directly to parents about the role marital discord plays in child behavior and its effect on treatment outcomes. We might have parents reflect back on a time when their parents fought. We may discuss how old they were, how that made them feel, or how they responded.

An essential part of this discussion is to introduce parents to the documented effects of marital discord on child behavior problems. Many parents are unaware that research has consistently found exposure to inter-adult anger to be associated with angry and physically aggressive child behaviors (e.g., Cummings, 1987). Other findings suggest that the strategies that couples use when resolving marital disputes may contribute to the presence of externalizing and internalizing behavior patterns in children (e.g., Grych & Fincham, 1990; Jenkins & Smith, 1990; Sanders, Nicholson, & Floyd, 1997). For example, a mutually hostile marital communication style is correlated with externalizing behavior patterns, whereas marital relations in which only the father is angry and withdrawn from the marital relationship tends to lead to child internalizing behavior. The frequency and intensity of marital conflict have been shown to be strongly related to externalizing behaviors in children. More frequent and intense conflict results in greater stress for children (e.g., Jenkins & Smith, 1990; Johnston, Gonzalez, & Campbell, 1987). We may also discuss ways to minimize the negative effects of marital conflict on the child such as not arguing in front of the child and not confiding in the child when discussing issues of conflict. Facilitation of this open dialogue allows us to further assess the extent of the marital discord and suggest a direction or approach to treatment.

Parents as Models. All parents have disagreements from time to time; however it is important that parents do not model behaviors that they would find unacceptable to witness in their children. With this said, we do not instruct parents to never

disagree with one another, but we do suggest that parents act in ways that demonstrate composure and respect for others. When children observe appropriate resolutions to occasional minor disagreements, they are taught that problems can be solved without arguing, name calling, or aggression. In the absence of appropriate models, children have great difficulty learning the skills required to resolve conflict and deal with frustration. Additionally, the instability brought on by such parental turmoil may, in turn, lead the child to exhibit the presenting problem behaviors. We may tell parents:

> Young children are a captive audience. Children may sometimes find themselves directly involved in the parental conflicts, but more commonly they watch and listen from the staircase, the hallway, through the door, or tucked away in bed. Children have the remarkable ability to recall a parent's every move and every spoken word, which many parents wish wasn't true. Children are typically much more aware and intuitive about their parents' relationship than most parents think and it is this awareness which can have a strong positive or negative effect on a child's development. Think of each time that you've said something inappropriate, cursed, or called your spouse a bad name. If your child did that, you would punish him/her! As the greatest role models in your child's life, you have the power to teach your child how to behave by the way *you* behave. Each time you lose your temper, think carefully about your actions and words and how you would want your child to act in this situation.

Another important role of the marital relationship is modeling appropriate affection toward one's spouse. In two-parent households, the relationship parents hold with one another has a considerable influence on the way children learn to establish bonds with others. "Yuck!" is a common response when children witness parental affection such as holding hands or kissing, but regardless of the squeals, such displays of affection affirm the stability and security of the child's environment and demonstrate what a healthy, intimate relationship should resemble.

Use of CDI Skills. Over the course of PCIT, parents with marital problems may criticize, disagree, or cut each other's skills down during session. In these situations, it is important to encourage spouses to use the CDI skills in their interactions with each other. When working on the marriage within the context of PCIT, we educate parents that the CDI skills are not only positive parenting skills, but they are positive communication tools that can also be used to enhance interactions with their partner. We discuss the benefit of many of the CDI tools in the context of their marriage as well, such as being tuned in and attentive, using active listening and support (e.g., reflections and labeled praise), and a willingness to ignore insignificant minor misbehaviors.

Although it is difficult for parents to learn to begin using these skills with their children, it is often more difficult for parents with a long history of marital discord to begin this type of constructive communication with their spouse. Building the marital friendship is the basis of effective repair. It is helpful to provide parents with a method of tracking the PCIT skills in relation to marital interactions, like the standard CDI homework sheet. During sessions, we may instruct parents to use labeled praise while the other is interacting with the child, recognizing and articulating the parenting strengths and positive skills of their spouse. Furthermore, it may be necessary to practice marital reflection in session. To operate as a parental unit,

it is helpful for couples to listen attentively, respond with enthusiasm, affection, and genuineness, and support the other's problem-solving efforts. The introduction to marital reflection might sound something like this:

> This week I would like to see an increase in reflective statements. During your time together each day this week, talk about something stressful that happened to you; your spouse is going to practice reflecting back without offering advice. This is reflective listening. During this conversation, try to practice the other CDI skills that we have discussed such as avoiding questions, commands, and criticisms. Let's give it a try right now.

Teaching Parents to Be Positive During Coaching. During in-session PCIT coaching, parents often observe behind the mirror as their spouse interacts with the child. It is not uncommon for the observing parent to criticize their spouse's parenting, limit setting, or discipline strategies. We see this as an opportunity to help the observing parent see their spouse more favorably. For instance, we may ask a critical spouse to name five strengths that their partner exhibits when engaged with their child. This is not only helpful in adjusting one's perspective from focusing on the positive (instead of the negative), but it can be used as labeled praise if the strengths are then relayed from one spouse to another. In utilizing a scaffolding technique when coaching parents, we are able to assist couples in behavior change through the gradual application of learned skills. We may begin by having the spouse listen to our coaching and positive support of their partner. In this way, we are able to model a calm tone of voice and the gentle support needed to build confidence in their partner during difficult parenting situations. As couples become comfortable with the coaching process we may involve spouses in coding their partner's skills and providing positive feedback about what was seen. With further refinement and in-depth exposure to positive coaching by the therapist, we may even have spouses take hold of the microphone and begin dialogue and identification of positive parenting skills displayed by their partner. As clinicians, this is often seen as a balancing act. While our primary goal is always to enhance each parent's skills during CDI and PDI in order to improve their child's behavior, it is possible to incorporate these methods of marital therapy without it coming at the expense of the child's treatment.

PDI Skills. Throughout the CDI phase of treatment, parents have begun a foundation of positive interaction and communication with one another. Now, during PDI, parents will be asked to advance these skills by addressing larger issues of communication and problem-solving. As conflicts arise, it is necessary for parents to use the PRIDE skills of CDI (e.g., discussing without criticizing, using positive statements, reflective listening) to communicate not only with their child but also their spouse. Toning down negativity rather than allowing immediate escalation will permit spouses to communicate concerns in a respectful manner.

When working on problem-solving conflicts we find it helpful to educate parents about ways to "put the brakes" on disagreements that are getting out of hand because of criticism, defensiveness, or contempt. Using *repair attempts* (Gottman, 1979) offers a new way of communicating during disagreements and may prevent

escalations from occurring. Repair attempts are often reflections, praise, or description of another's behavior or the current conflict situation (see Table 17.4).

Table 17.4 Repair attempts while problem-solving within the context of PCIT

This is not your problem—this is our problem
I really like how you are. . .
My reactions were too extreme. Sorry
Let's compromise here
Let's find our common ground
I know this isn't your fault

Much of what is taught about the value of commands during PCIT can be further extended to marital communications. A notable exception is the use of direct versus indirect commands. Although it is appropriate for parents to use direct commands with their children, it is not advisable for them to do so with one another. The parent-child relationship is a hierarchy, whereas the marriage is a partnership between peers. Other aspects of command giving taught in PCIT do apply more directly to marital communication. For example, it is important to make indirect commands positively stated, suggesting what a spouse should do rather than not do. Negatively stated commands sound critical and do not elicit cooperation from a spouse. Table 17.5 compares negatively stated and positively stated commands, demonstrating how the tone of the command changes when focusing on what you want the spouse to do. Just as children comply at a higher rate when explanations precede commands, it is helpful for spouses to provide reasons for their requests. A partner might not respond favorably to being told, "Come here," but might be more responsive to the following sequence: "It's going to take another set of hands to hold this shelf in place while I put up the bracket. Could you please give me a hand?" Similarly, transitional warnings help spouses to respectfully communicate their desires for a task to be done, without making it sound as though they expect the other to drop everything immediately and "hop to it."

Table 17.5 Commands within the context of PCIT

Negative commands	Positive commands
You never listen to my feelings	I would like for you to listen to what I have to say
You never back me up	It would be nice if you could support me in front of our daughter
Quit coming home so later from work	It would be great for our family if you could leave work a little earlier to be with us
Don't just sit there on the couch doing nothing while I do all the work	Could you please take the garbage out?
Stop yelling at me	Let's discuss this calmly

As parents recognize that children comply better when expectations are made clear using specific rather than vague commands, we can help them see that they can get more out of their partners by being clear. For example, a husband might not know what his wife wants when she says, "Didn't you hear me? I said we've got people coming over." It would be more effective for the wife to be clear and specific and say, "We've got people coming over. Could you replace the burned out light in the bathroom?"

In-Session Practice and Marital Homework Assignments. PCIT is predicated on the principle that behavior change is based on practice and feedback, rather than didactic discussion alone. Thus, it is important that therapists coach couples as they interact in the clinic prior to sending them home to practice new skills. Typically, the therapist will discuss with parents how to apply a PCIT principle within their relationship, coach them in an analog exercise, provide them feedback on their performance, and design a couples-based homework assignment related to that skill.

A common issue with our families is that the parents do not spend enough quality time together. For example, many of our parents joke that with the birth of their first child, date night disappeared. We may assign these parents homework that involves spending quality time together using the PRIDE skills, having a date, or going on a short vacation without children. Suspending the stress of parenting for even brief periods helps couples remember what attracted them to each other. Marital homework check-in is conducted at the start of session along with the daily CDI homework check-in or after coaching at the close of the session. We find that within the busy and demanding lifestyle of most parents, couples afford much of their time and efforts toward daily demands and little or no time toward enriching the marital relationship. We find homework should be a natural extension of what happens within the session (e.g., practicing communication) and can add further direction and communication to move parents from marital gridlock by providing avenues for change (e.g., use of PRIDE skills).

Like in CDI, the goal of marital homework assignments during PDI is to further extend in-session activities (e.g., avoiding the four horsemen, identifying repair attempts, compromising on issues of conflict) and guide parents toward successful problem-solving regarding child behavior. We especially focus on child behavior problems which are straining the marital relationship, such as getting the kids to bed on time or a child sleeping with their parents, both of which prevent intimate time alone. One homework assignment could be for parents to practice, identify, and record their repair attempts made during a daily problem-solving time. We find that a willingness to compromise is necessary before problem-solving issues of conflict. It is often helpful to have parents identify an issue of conflict (e.g., child bedtime, financial disagreements) and to have parents further distinguish details of this issue that they are willing to compromise and those that they are not willing to compromise. During these problem-solving exercises, parents may be coached to make a list of all of the potential ways to solve a specific conflict. Then they may be coached to use their foundation of positive communication to compromise and agree upon a single solution. As parents demonstrate effective problem-solving in session, they are given homework assignments to problem-solve other specific disagreements.

Termination of Treatment

When adding a marital component to PCIT, there are three separate termination scenarios. In the first, marital discord could have been so great during sessions that it was not possible for the parents to work as a team and master the PCIT skills. In this scenario, feedback is provided to parents regarding the necessity of seeing a marital therapist and working on their issues prior to a continuation of PCIT. In the second scenario, the marital component is strong enough to help parents to work together to successfully reduce child behavior problems. However, it is apparent to the therapist that significant marital problems persist, generally unrelated to parenting issues, that need to be resolved in couples therapy. We advise parents that failure to follow through on a couples' intervention could cause their children to lose many of their gains. This is a time to reintroduce the family's treatment options following termination of the PCIT treatment. We might say:

> At the start of our treatment sessions we had two major goals: improving your relationship with your child and reducing your child's behavior problems. During our sessions we have monitored the progression of these goals by your report on the homework sheets, on various assessment measures, and through our in-session observations. When we first met, you wanted assistance in managing your child's problem behaviors. Both you and your child have worked hard and have come a very long way since our first session. You have increased the positive interactions that you and your child share, and your child now listens to you and has maintained these behaviors over the course of the past several weeks. You have demonstrated that you have met your initial goals and that you are capable of maintaining your child's behavior on your own.
>
> However, marital conflict issues were also something that we addressed throughout our sessions. Although it is clear that you have made gains in your communication with one another, our goal was only to patch this treatment barrier as we addressed your child's problem behaviors. In order to maintain the marital relationship gains that the two of you have made this far, these issues need to be addressed further and in more depth than I can provide in the context of PCIT. In an earlier session we discussed the option of meeting with another clinician who specializes in marital therapy. I hope that you will see the positive effects that your work here has had on your relationship with your child and take this into consideration as you reconsider addressing the difficulties in your relationship with each other. I would like to provide you with a few referrals of well-respected therapists who are very effective in their work. If this is something that you are interested in now, I would be glad to arrange your first meeting.

If parents are receptive to seeing a marital therapist following treatment, it is often a good idea to arrange this first appointment. This arrangement will ensure that the appointment is made quickly and that parents do not have time to fall out of their routine of attending weekly treatment. Furthermore, by making trusted referrals, therapists are able to suggest other clinicians who might best be suited for the clients, given their concerns and impairment. With the rapport built throughout the duration of their PCIT treatment, clients may be more inclined to value their therapist's suggestion for further services at the conclusion of PCIT treatment.

In the third and last scenario, parents enter treatment with marital conflicts focused primarily on disagreements regarding child rearing. Through PCIT and applying its principles within the marriage, the couples' partnership is strengthened

and most of the conflict resolved. For these families, the behavioral gains in PCIT are likely to maintain well with no need for additional marital therapy interventions. By learning PCIT and the application of PCIT skills to marital relationships, parents may learn to become a strong, united parenting team. These couples develop positive communication skills that may enhance all of their relationships, including those with co-workers, friends, in-laws, and neighbors.

References

Bagner, D., & Eyberg, S. M. (2003). Father involvement in parent training: When does it matter? *Journal of Clinical Child and Adolescent Psychology*, *32*, 599–605.

Cummings, E. M. (1987). Coping with background anger in early childhood. *Child Development*, *58*, 976–984.

Fischer, J. (2007). *Measures for clinical practice and research: A sourcebook*. Oxford, NY: Oxford University Press.

Grych, J. H., & Fincham, F. D. (1990). Marital conflict and children's adjustment: A cognitive-contextual framework. *Psychological Bulletin*, *108*, 267–290.

Gottman, J. M. (1979). *Marital interaction: Experimental investigations*. New York: Academic Press.

Gottman, J. M. (1994). *What predicts divorce: The relationship between marital processes and marital outcomes*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Gottman, J. M., & Gottman, J. S. (1999). The marriage survival kit. In R. Berger & M. T. Hannah (Eds.), *Preventive approaches in couples therapy* (pp. 304–330). Philadelphia, PA: Brunner/Mazel.

Jenkins, J. M., & Smith, M. A. (1990). Factors protecting children living in disharmonious homes: Maternal reports. *Journal of the American of Child and Adolescent Psychiatry*, *29*, 60–69.

Johnston, J. R., Gonzàlez, R., & Campbell, L. E. (1987). Ongoing postdivorce conflict and child disturbance. *Journal of Abnormal Child Psychology, 15*, 493–509.

Locke, H. L., & Wallace, K. M. (1959). Short marital-adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, *21*, 251–255.

Sanders, M. R., Nicholson, J. M., & Floyd, F. J. (1997). Couples' relationships and children. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 225–253). Hoboken, NJ: John Wiley & Sons, Inc.

Snyder, D. K. (1997). *Marital satisfaction inventory* (Revised). Lutz, FL: Western Psychological Services.

Chapter 18
Parents with Major Life Stressors

Kimberly P. Foley

Working with families who are experiencing major life stressors can be particularly challenging – to the therapist! How many times have you developed a fabulous treatment plan after an intake session, only to never see the family again? How many times have you stayed late at the office to see an emergency client who did not show up to his or her session? How many times have you worked tirelessly with a family who did not seem committed themselves? All therapists have wanted to throw up their hands at one point and call it a day. But the truth is that PCIT therapists truly love their work and most are in the profession to help those with the greatest needs. These are the clients you dreamed about helping when you were in college and have nightmares about now that you are in the real world. Working with families who have major life stressors such as divorce, substance use/abuse, intimate partner violence, and low social economic status can be both challenging and rewarding for the same reasons. The reward for a PCIT therapist comes from helping these families overcome their challenges and lead more successful lives.

One of the challenges of working with families who have major life stressors is that therapists try to understand their clients' lives, but really cannot possibly know the daily challenges these families face. Numerous consultations with colleagues and supervisors will still leave you perplexed when working with parents who are in the midst of an acrimonious divorce. Even with the best preparation, you will still be stumped when working with one or more parents with a long history of substance use/abuse. Years of experience assisting parents who experience intimate partner violence will still leave you in awe of the challenges these families endure. All of the reading you did as a student will not prepare you for the first time you step into a government housing project in your brand new suit, look around you, and suddenly realize that you actually have no idea what you are doing. To complicate matters more, rarely do families undergo only one life stressor. More often, families will present with multiple, unique combinations of life stressors that will complicate treatment and require extensive support services. For example, substance abuse may lead to intimate partner violence which may lead to divorce. Or a parent may be thrust into poverty due to a recent divorce. While life is challenging for families with

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one major life stressor, it is overwhelming for families with multiple stressors. It is the PCIT therapist's responsibility to assess families for these major life stressors, sensitively address these issues, and incorporate/modify components that address these stressors to maximize PCIT treatment success.

Our experience working with parents with major life stressors has demonstrated that these parents are generally open to discussing their current life circumstances. Most parents will readily discuss this information candidly, but only if the therapist first broaches the topic. Many therapists do not ask pertinent questions because the *therapist* feels uncomfortable, not because the *client* feels uncomfortable. PCIT therapists should feel comfortable asking personal questions about topics that may have a serious impact on a family's treatment.

There are some basic guidelines that we have found helpful when working with multi-problem families. Before beginning an intake session, we ask parents to provide us with documentation regarding child custody. Custody agreements vary with regard to who is allowed to provide informed consent for treatment. In some cases, treatment may be provided with the consent of only one parent, whereas in others, consent from both parents is mandated. After establishing that the presenting parent(s) is authorized to provide consent for services, the intake interview can begin.

We are honest with our clients and try to minimize any anxiety parents and children may be experiencing about being at the clinic for the first time. We begin by telling the parents that the sessions will be confidential (unless they are court-referred and the therapist has to file reports or they reveal information that therapists are mandated to report such as child abuse, etc.); so parents can feel free to express concerns in session. We tell them that we have worked with numerous families over the years and they all have shared challenging life experiences with us. So, we reassure parents that they do not have to be embarrassed to share personal information. We also make sure that we talk directly with children. Most parents tell their children that they are "going to see the doctor," which in child language translates into "get a shot." We tell children that we are not the kind of doctors that gives shots; we are the kind of doctors that talk to children and moms and dads and we try to help them work together well as a family.

We sometimes conduct portions of the intake interviews with members of a family separately. This can sometimes be managed by interviewing one parent while you have the other parent complete paperwork in the waiting room. Once the intake interview is complete with one parent, they can switch positions. Interviewing parents separately allows the therapist to build rapport with each parent while also allowing the parent privacy to discuss matters they may not want to discuss in front of their partner. For example, we once conducted an intake with a family who had a 9-year-old son with moderate ADHD. This family was picture-perfect and the only thing they reported was that their son was a bit "hyper." Imagine our surprise when 6 weeks later the mother revealed that she and her husband had separated approximately 12 weeks ago due to physical violence that had left her hospitalized with cuts, bruises, and a broken rib. We would never have had this information if the father was able to attend that day's session. We conducted the intake interview with both parents present, and the mother had not revealed this important piece of information due to her fear of future violence at the hands of her soon-to-be ex-husband.

We also often conduct intake interviews with parents separately from their children. We are often amazed by the types of things parents will say about their children and each other while their children are present. We once had a father state, in front of his daughter, that he did not want to come to treatment, that he had given up on her, that he thought she should be placed with another family, and that he would prefer to be home playing Nintendo because that was the only time he "got any peace and quiet." The little girl was devastated and a huge family argument ensued in the clinic between the mother, father, daughter, and son. This argument would have been avoided (or at least more manageable) if we had interviewed the adults separate from the children. Interviewing parents without their children allows you to discuss sensitive information, while also providing an opportunity for psychosocial education regarding the psychological harm that can occur when speaking negatively about children in their presence.

In order to minimize therapist and client embarrassment regarding topics such as divorce, substance use/abuse, intimate partner violence, and low social economic status, we have invested a great deal of time developing the wording of sensitive questions. Before beginning an intake session, we may actually show our clients the intake form and say:

We have a standard set of questions that we ask of all the families we work with here at the clinic. There are all sorts of questions about your child, your child's behaviors, and your family. So, just because we ask you a question does not mean that we think it may be true for your family – we just ask all families. Some of these questions may be really true for your family and some of them will not be true at all. Please feel free to be honest with me though because the information that we gather here today will help all of us in treatment for the next few weeks.

Showing parents your intake form communicates to them that you are not "hiding" anything from them and do not have a secret agenda. Remember, many of these families have been involved with other services before and did not have good experiences. Their first instinct may be to be distrustful; they may even view you as the enemy! Once parents begin to relax with you and feel comfortable discussing personal aspects of their life, you will be able to design and tailor a treatment plan to meet that family's particular needs.

Besides establishing rapport and gathering information about the family's background, the intake session often reveals a great deal about how these families live their lives. All parents have stress, but some parents experience extreme levels of stress on a daily basis. Parents who are experiencing divorce, substance use/abuse, intimate partner violence, and low social economic status face struggles that are difficult to comprehend unless you develop strong rapport and ask the right questions.

Strategies for Working with Multi-stressed Families in PCIT

McNeil and Herschell (1998) collaborated to delineate several strategies for PCIT therapists who are working with families with major life stressors. These strategies are simple and cost-effective and may improve families' adherence to treatment and homework, as well as increase their acquisition of pertinent PCIT skills.

Briefly, McNeil and Herschell suggest increasing the structure of sessions, requiring attendance contracts, conducting brief assessments, developing realistic treatment goals, referring out for issues outside of PCIT treatment, and increasing the value of PCIT therapy for the family.

Increasing the Structure of Sessions. The authors recommend providing the clients with a written document that details the date, time, and location of the scheduled appointment and assisting the client to brainstorm several transportation options. It is also suggested that appointments be made for the same time and day of the week in order to help the client develop a routine for therapy. It also is helpful to telephone the clients the day prior to session to remind them about their appointment.

Developing an Attendance Contract. McNeil and Herschell also recommend developing an attendance contract with clients. This is a great opportunity to educate clients about the benefits of therapy when attended regularly and how non-attendance is detrimental for treatment. It also allows the client to understand the value the therapist places on treatment; hopefully they will too.

Begin Services Quickly. Assessments should be kept brief (one or two sessions) so that treatment can begin as quickly as possible. Having a long interval between the referral and the therapy services increases the chances that these multi-problem families will drop out of services due to a new crisis that requires their attention. Interventions, rather than evaluation, should comprise the bulk of each subsequent session. The briefer assessment stage allows therapists to more quickly attend to the family's urgent needs.

Develop Realistic Treatment Goals and Refer Client for Treatment of Ancillary Issues. Therapists should also avoid trying to tackle all of the family's difficulties. These are families with many challenges and a therapist could easily spend the entire session trying to manage the latest crisis. This might help the family for the moment, but they would never manage to complete PCIT. Instead, it may be more beneficial for PCIT therapists to refer clients with additional stressors to other mental health professionals who are able to target and reduce these other needs.

Increase the Value of PCIT for the Family. Lastly, McNeil and Herschell advocate that PCIT therapist instill a sense of value to their clients. This can be accomplished by ensuring that the family's PCIT experience is positive and upbeat. At our clinic we instruct PCIT therapists to use the PCIT skills with parents. We ask them to provide the parents with labeled praises for their accomplishments and to illustrate for the parents what they are doing right and how this will help their child's behaviors. These are parents who do not often hear positive things about themselves from other people in their lives. Increasing the parents' confidence and self-esteem in their ability to parent will make them more likely to attend sessions and to feel better about themselves.

Divorce

Background Information on Divorce. The Center for Disease Control's National Center for Health Statistics (2007) reported that in 2005 the marriage rate in the

United States was 7.6 per every 1,000 people, while the divorce rate was 3.6 per every 1,000 people. This means that approximately 50% of marriages end in divorce and suggests that therapists must be prepared to work with children and families affected by this common outcome. Parents who are separated, in the process of divorcing, or divorced, have great challenges dealing with adjustments to their new life circumstances. Adults find this time difficult, but they usually are capable of expressing their emotional and psychological needs. Young children also experience adjustments to their lives following divorce, but they usually do not have the same level of coping kills as adults. These children may express their needs and frustrations in other ways, namely by acting out at home, school, daycare, and in the community. Children whose parents are experiencing divorce may demonstrate such behaviors as anger, shock, sadness, anxiety, depression, confusion, and blame/responsibility.

Even more difficult than the initial divorce may be the possible remarriage of one or both parents. Remarriage following divorce obviously results in step-parents, but also step-siblings, half-siblings, and the redefining of each family member's role within those extended families. Suddenly, a young girl who was the "baby" of her family for the last few years now has new siblings from her parents' remarriages. This child now has to renegotiate her role within both of these families. Several years ago, our clinic received a referral for Kathryn, a 5-year-old girl who recently began demonstrating aggressive temper tantrums at both her mother's and father's homes. Kathryn was the younger of two children and had always received a great deal of attention from her mother, father, and older sister. Her parents separated 2 years ago, divorced 1 year later, and remarried within 2 months of each other. To complicate matters, both parents had baby boys within 1 week of each other a few months prior to entering PCIT treatment. Kathryn went from being the "baby" of both households to having a new baby in each household. These new babies received a great deal of attention and Kathryn began acting aggressively toward these new half-siblings. For Kathryn, her parents' divorce, remarriages, and two new children in such a short time-frame were too many new changes in her life. These parents and step-parents had to work diligently to ensure they were spending quality time with all of their children and to acknowledge Kathryn's new role as a "big sister."

Possible Divorce Questions. As therapists, we have conducted interviews with couples who initially were kind, cordial, even funny and affectionate toward each other, at intake. Later, we were surprised when these great, "easy" families informed us that they were having marital problems or that they had separated. Did these parents actually lie to us? No. Did they withhold information regarding their relationship? Possibly. Did we not ask questions about their relationship or ask the wrong questions based on our assumptions? More than likely. Because of experiences such as these, we have found it important to ask all parents, regardless of how "easy" they appear in session, questions about their previous, current, and future relationships with each other and their children.

Below (see Table 18.1) are a few questions that PCIT therapists may ask parents about their current marital status and the quality of their relationship during the

initial intake interview. As you will see in future sections, we always start off the intake interview with the same opening statement because it puts parents at ease (i.e., exploratory rather than accusatory).

Table 18.1 Possible divorce questions

I have a standard set of questions that I ask of all the families I work with here at the clinic (show them the list of questions). There are all sorts of questions about your child, your child's behaviors, and your family. So, just because I ask you a question does not mean that I think it may be true for your family – I just ask all families. Some of these questions may be really true for your family and some of them will not be true at all. Please feel free to be honest with me though because the information that I gather here today will help all of us in treatment for the next few weeks.
Children are affected by their parents' relationship with each other. Even when we think that our children are unaware of challenges in our relationships, they often pick up on them. How would you describe the quality of your relationship with each other?
All parents have disagreements with each other from time to time. Do you have verbal disagreements in front of your children? If yes, how often?
Are you living together, married, separated, in the process of divorcing, or divorced? How long were you married? How long ago did you divorce? How old were your children at that time?
Are either of you remarried? If yes, what is the new configuration of family members?
What is your legal custody arrangement with your children? What is your actual parenting arrangement? How do your children split time between parents? Do they alternate weeks, weekends, school holidays, summers?
What is the quality of the child's relationship toward each parent? Is one parent the "fun" parent while the other is the "strict" parent?
What would be your ideal relationship with your child? What do you think would be your child's ideal relationship with you?
Well, I know I asked a lot of questions today. Both of you were patient and helpful and shared a great deal of information that will help us work with your family. Before you leave, I want to double check and see if there is anything else I need to know about your child or your family situation.

Possible Divorce Assessment Measures. Many therapists have conducted thorough intake interviews in which they asked all of the right questions, only to find out later that the answers were not truthful! In order to eliminate these inconsistencies in reporting and also to track changes over the course of treatment, we recommend using one or more assessment measures to gauge the parents' relationship. The assessments listed in Table 18.2 are only options and each therapist may want to consider other assessment measures that work best for their clinic and the populations they serve. The information gathered from these assessments may also be helpful in educating parents about how their relationship with each other impacts their children.

Considerations for Using PCIT with Families Affected by Divorce. Subsequent to a thorough intake interview complete with objective assessment measures, therapists should possess enough information to develop a well-designed treatment plan. For families affected by divorce, we often provide psychosocial education regarding

Table 18.2 Possible divorce assessment measures

Marital Satisfaction Inventory – Revised (MSI – R). The MSI – R was developed by Snyder (1997) in order to assess conflict within relationships. It consists of 150 questions (true/false) and can be administered and scored within 25 min. This assessment measure provides information regarding affective communication, role orientation, problem-solving communication, aggression, dissatisfaction with children, disagreement about finances, conflict over child rearing, sexual dissatisfaction, family history of distress, time together, and total marital distress.
Parenting Alliance Measure (PAM). The PAM was developed by Abidin and Konold (1999) to assess how parents co-parent their children. It consists of 20 questions and can be administered and scored within 15 min. This assessment measure provides information regarding parents' communication, cooperation, and mutual respect toward the other parent regarding parenting tasks
Dyadic Parent-Child Interaction Coding System – Third Edition (DPICS – III). The DPICS – III has most recently been revised by Eyberg, McDiarmid Nelson, Duke, and Boggs (2004) and is part of the standard intake process for every new PCIT family. This assessment consists of three 5-min components and can be administered and scored within 15 min for one parent or 30 min for two parents. This behavioral observation coding system is able to provide two different types of information for families affected by divorce: (a) how each parent-child dyad interacts, and (b) how the parents are similar or different in their parenting styles

divorce issues such as guilt, consistency between parents, limit setting with children, communication between caregivers, and the involvement of step-parents in treatment. It is important to remember that each family is different and will need varying levels of support.

Many parents experience significant feelings of guilt following a divorce. This guilt may manifest in expensive or frequent gifts or permissive parenting styles in which rules are not enforced in one or both households. One child client, Robin, had parents who felt extremely guilty following their divorce. Both her mother and father purchased her expensive electronic equipment, took her on extravagant vacations, purchased her costly clothing, and there were no rules in either household. Each of Robin's parents wanted to be her "favorite parent" and the situation quickly got out of control. Robin had developed into a whiney and spoiled child who was disrespectful at home, often threw temper tantrums, and would not follow rules at school. Robin's parents needed to learn to set boundaries with their child. We had to teach them that gifts will not buy affection and that over-indulging their child was leading to the development of multiple behavior problems. We worked extensively with these parents to develop a list of affordable activities they could do with Robin that would increase the quality of their time together. Robin's parents learned that they did not need to indulge her every whim in order for her to love them. PCIT also taught these parents multiple techniques for handling Robin's inappropriate behaviors and how to praise her good behaviors.

Parents undergoing divorce need education about the importance of consistency across households with respect to acceptable and unacceptable behaviors. Children quickly detect inconsistency and learn how to play adults off each other. They know which parent is going to say "yes" to cookies for dinner and staying up all

night. With PCIT, parents in both households learn to ignore negative attention-seeking behaviors, prioritize compliance, and establish the same set of house rules. Sometimes it is helpful for both parents to meet together in a PCIT session to confirm for the child that they will be on the same page and that the same rules and time-out consequence will apply in both homes.

Lastly, it is important to consider which parents will be involved in treatment. If neither parent is remarried then PCIT may be straight forwarded and include only the mother and father. However, if one or both parents are remarried, then it is important for the family to decide who is going to be involved in treatment. The child may only spend every other weekend with one parent, so that parent may not get to practice PCIT skills as often with his/her child. If this is the case, therapists may ask that parent to practice PCIT skills with other children in the home (or nieces and nephews). This allows parents to keep their PCIT skills current and be prepared to utilize these skills when their child is spending time with them. Furthermore, parents may also return to their parents' (child's grandparents) home following a divorce. We have worked with several grandparents who had assumed a significant caregiving role in their grandchild's life following a divorce. These grandparents were excited to be spending so much time with their grandchild but reported feeling "lost." Time-out was not popular when these grandparents were raising their children. PCIT can help these grandparents learn how to raise a child in today's society. Regardless of the family configuration, it is important that the PCIT therapist work together with the family to determine who will be involved in treatment in the clinic and at home in order to maximize positive results.

Community Resources for Families of Divorce. Parents affected by divorce may find support groups at their respective places of worship, the YMCA/YWCA, or local community centers. For example, Parents Without Partners is an organization located in 36 states and Canada that provides support for single parents with children. This organization provides parents with a support system for dealing with the emotional conflicts of divorce. Parents Without Partners also provides discussions, professional speakers, and social activities for families affected by divorce in order to ensure the well-being of children affected by divorce. Alternatively, with the ease and access of computers, families also have the opportunity to join online support groups. Lastly, some parents may wish to seek individual counseling with a therapist in order to address any remaining issues subsequent to divorce.

Substance Abuse

Background Information on Substance Abuse. Roughly 60% of 26- to 39-year-old Americans reported consuming alcohol in 2006 (SAMHSA, 2007). Most of these individuals reported the occasional consumption of alcoholic beverages (a glass of wine with dinner, a beer while watching football, etc.). Others reported episodes of binge drinking patterns (five or more alcoholic beverages during one time-frame at least 1 day in the previous month) or heavy drinking patterns (five or more alcoholic

beverages during one time frame at least 5 days in the previous month). Most parents on occasion consume alcohol; however, excessive consumption of alcohol can have deleterious impact on the individual and the family system.

Alcohol is the most commonly used, legal substance in the United States. However, it is not the only substance that PCIT clients will consume that may have serious implications regarding treatment. In 2006, the National Survey on Drug Use and Health was conducted and revealed that substance use in America was rampant. Of Americans 12 years of age and older, 25 million used marijuana, 16.2 million used prescription drugs for non-prescribed purposes, 6 million used cocaine, and 1.9 million used methamphetamines at least one time within the year (NIDA, 2008). These are only a few of the more commonly used substances; millions of Americans also use other substances that are not listed here. As these statistics are for individuals 12 years and older, we know that older siblings in the home may be using substances as well. Therefore, it is important to not only assess parents, but to ask parents about substance use by other family members.

Children with parents or other family members who use legal or illegal substances may demonstrate externalizing behaviors in the home, academic, or daycare environment. These behaviors may include disobedience, aggression, control problems, unstable sleep patterns, low self-esteem, and decreased attachment to parents and other family members. Often, parents of these children may not realize that they have substance use issues or may be in denial of the impact of their substance use upon family members. They may be hesitant to disclose their substance use to a therapist. Some signs of substance use a therapist should look for include "drunken" behavior, memory loss, slurred speech, disorientation, sweating, tremors, hyper- or hypothermia, loss of appetite, insomnia, difficulties in the workplace, and/or legal ramifications.

Possible Substance Abuse Questions. When working with families who are experiencing substance use issues, it is important to remember that these members may be in fear of having their children taken away from them or facing fines and prison sentences if they are found to be abusing substances. Parents may not feel comfortable discussing their substance use for good reasons. Hence, it is important to develop good rapport with the family prior to discussing substance use issues. Table 18.3 presents a list of possible questions that can assist therapists in determining the role of substance abuse in family problems.

Considerations When Doing PCIT with Substance-Abusing Families. Substance use is prevalent in our culture and PCIT therapists must be prepared to work with families who are faced with this particular challenge. The use of alcohol or drugs by families who are seeking treatment may have serious implications for treatment success. An additional challenge is that parents who are using substances may not fully understand the impact of their substance use upon their children. After the initial intake interview, we sit down with parents and a blank calendar of the past week. We divide the calendar in half, ask the parents when they used substances in the past week, and then fill in the calendar. We then ask parents when their child had behavior problems and fill in that portion of the calendar. We review this information with the parents and they are usually surprised to find that the times they are engaging

Table 18.3 Possible substance use questions

I have a standard set of questions that I ask of all the families I work with here at the clinic (show the list of questions). There are all sorts of questions about your child, your child's behaviors, and your family. So, just because I ask you a question does not mean that I think it may be true for your family – I just ask all families. Some of these questions may be really true for your family and some of them will not be true at all. Please feel free to be honest with me though because the information that I gather here today will help all of us in treatment for the next few weeks.
Does anyone in your household currently drink alcohol? If yes, who drinks alcohol? What type of alcohol? How many times per week do they drink alcohol? How much do they drink?
Did anyone in your household previously drink alcohol? If yes, who did drink alcohol? What type of alcohol? How many times per week did they drink alcohol? When was the last time they consumed alcohol?
Does anyone in your household currently use drugs (give examples: pot, cocaine, crack, etc.)? If yes, who uses drugs and what drugs do they use? How many times per week do they use each drug? How much do they use?
Did anyone in your household previously use drugs (give examples)? If yes, who used drugs and what type of drugs did they use? How many times per week did they use each drug? When was the last time they used each drug?
Does anyone in your household currently (or in the past) have any legal issues related to alcohol or drug use? If yes, what are the legal issues?
How has your child been affected by alcohol or drug use in your household?
Well, I know I asked a lot of questions today. Both of you were patient and helpful and shared a great deal of information that will help us work with your family. Is there anything I forgot to ask you that you think would help me to understand your family better?

in substance use usually coincide with the times their children are demonstrating inappropriate behaviors. We then provide psychosocial education regarding how parents' behaviors toward their children are altered when they are under the influence of substances. For example, parents tend to have decreased patience, yell more frequently, ignore the child, and may become aggressive toward their child.

The Case of Avery. Avery was a 7-year-old girl whose father had full custody of her. For the past 2 years, she had been anxious and had refused to speak to her father for the previous 3 weeks. Her father presented as a devoted, but stressed-out parent. He had a full-time job and was overwhelmed with being a single parent. He reported that he drank on the weekends after Avery went to sleep. Avery reported a much different story to the therapist. She was hesitant at first because she did not want to get in trouble with her father. After reassuring her that we would do everything we could to keep her safe, she told her story. About a month prior, she woke up from a nightmare crying and had gone in search of her father. She walked down the stairs and found her father, drunk in the living room. He became enraged when he saw that she was crying hysterically, and told her "shut up or I'll give you something to cry about!" Avery was terrified by her drunken father. She ran upstairs and hid in the bathroom. Avery stayed up all night listening for him. She had not spoken to him since because she feared he would hit her if she did. Her father did

not even remember this incident. He had no idea how much he was drinking on the weekends and how he acted toward his daughter when he was drunk. PCIT was able to help him repair his relationship with his daughter and to develop a trusting bond with her again. However, he also had to seriously evaluate his alcohol consumption. He decided to limit the amount of alcohol he kept in the house to a six-pack at a time. That way he was less likely to consume enough alcohol to become verbally violent toward his daughter. If we had not asked about his substance use, this cycle may have continued to repeat and we would not have been successful with this family.

Families affected by substance abuse face numerous challenges during the course of treatment. They are less likely to attend scheduled sessions, participate during sessions, practice PCIT homework, and meet CDI and PDI mastery criteria. The parents are likely to pay less attention to their child and to become easily frustrated or apathetic if they or their child does not quickly and easily master PCIT. PCIT therapists will have to provide extra support for these families and develop methods that are tailored to address these families' individual needs. Some examples can include confirmation telephone calls for appointments, arranging taxis to sessions, longer session times, allowing more sessions in order to obtain mastery, and lots of patience and support.

Community Resources for Families Affected by Substance Abuse. There are several local and national programs that have been developed to assist individuals dealing with different types of substance abuse. These include Alcoholics Anonymous, Narcotics Anonymous, in- or outpatient treatment programs, and local support groups in the community. In order to facilitate this process, we usually contact these groups prior to discussing these options with the family. That way we are able to provide the family with information regarding meeting times and places, cost of treatment, and confidentiality. We may even offer to escort the family to their first meeting and will follow up with them the next week regarding how their meetings are going and progress made toward goals (Table 18.4).

Possible Substance Abuse Assessment Measures. The assessments listed below are only options and therapists may want to consider other assessment measures that work best for their clinic and the populations they serve. The information gathered from these assessments may also be helpful in demonstrating to parents how their substance use impacts themselves, their children, and their family. Parents may not realize how much and how often they are using substances (Table 18.5).

Intimate Partner Violence

Background Information on Intimate Partner Violence. In the United States, women experience 4.8 million episodes of intimate partner violence (IPV) each year (Tjaden & Tiioennes, 2002). It is reported that 1 in 4 women have experienced some form of IPV over the course of their lifetime. While both sexes experience IPV, it is more commonly female partners who are the victims of abuse and suffer the most severe consequences (AMA, 1992; APA, 2001; Fergusson & Horwood, 1998). IPV

Table 18.4 Community resources for families dealing with substance abuse

Alcoholics Anonymous (AA). AA is a support group that was founded in 1935 in order to support men and women in their attempts to obtain sobriety. There are over 2 million members that attend approximately 110,000 support groups in 180 countries. The only requirement to attend these meetings is the aspiration to cease drinking. This service is completely free. There are no dues associated with joining these groups. There are no files kept on members, and confidentiality is highly regarded.
Narcotics Anonymous (NA). NA is a support group that was founded in the 1950s in order to support men and women in their attempts to recover from drug addiction. There are over 25,000 support groups in 127 countries that offer their services free of charge to their members. This group is run similarly to AA and does not keep records on their members, and confidentiality of members is respected.
In- and Outpatient Treatment. More intensive services may be required for some individuals dealing with substance abuse issues. Outpatient treatment tends to involve the implementation of multi-disciplinary services at a single location (hospital or otherwise) for extensive periods of time each weekday. The patient arrives at treatment in the morning and returns home in the evening. In-patient treatment is similar but offers additional support services. Patients reside at their treatment facility and are under constant supervision by physicians and staff.

Table 18.5 Possible substance abuse assessment measures

Alcohol Use Inventory (AUI). The AUI was developed by Horn, Wanberg, and Foster (2003) to assess a number of components associated with the consumption of alcohol. The measure can be completed in 35–60 min and consists of 228 questions. Norms are available for individuals 16 years of age and older. There are four primary scales: benefits, styles, consequences, and concerns and acknowledgments, and one broad-band total score.
Substance Abuse Subtle Screening Inventory (SASSI-3). The SASSI-3 was developed by Miller, Roberts, Brooks, and Lazowski (1997) to screen for individuals 18 years of age and older who may have substance abuse disorder. The measure can be administered and scored within 15 min. The SASSI-3 assists in the identification of individuals, with 97% accuracy (Lazowski, Miller, Boyce, & Miller, 1998) who are likely to have a substance dependence disorder.

may manifest in many forms, the most common being physical or sexual violence, but may also include emotional and psychological violence. Furthermore, IPV is rarely a one-time event, but rather occurs continuously throughout a relationship. IPV incidents usually begin as small, isolated, non-physical events and gradually develop into more severe and frequent forms of physical violence. IPV is a serious issue that affects all members of a family, including children.

An estimated 3.3 (Carlson, 1984) to 10 million (Straus, 1992) children are exposed to IPV per year. A child does not necessarily have to visually witness IPV to experience its impact. Many children accurately report violence that they have overheard between their parents and display symptoms similar to experiencing violence themselves. PCIT therapists should also be aware that IPV and child abuse and neglect (CAN) have a 40% co-morbidity rate (Appel & Holden, 1998), so many families experience more than one type of violence. PCIT therapists will need to work closely with parents to provide education on how exposure to violence affects their children. Children who are exposed to IPV are more likely to

display conduct disorder, posttraumatic stress disorder, anger, learning and socialization difficulties, anxiety disorder, major depressive disorder, withdrawal, somatic complaints, substances abuse, and criminal activity.

Working with families who have or are currently experiencing IPV is particularly challenging. There is no standard IPV case and each family affected by IPV will respond in a different manner. Typically, mothers who have experienced IPV are likely to be depressed and passive, while fathers tend to be verbally abusive and physically intimidating. Children who have experienced IPV tend to swear and be physically violent, especially toward their mothers. Some of these behaviors may also be seen in typical PCIT families. Therefore, a thorough assessment is necessary to determine the origins of these behaviors.

The Case of Christopher. In the last 2 years, we have treated several families with a history of intimate partner violence. One child, Christopher, was 4 years old and living at home with both of his parents. His father had been verbally and physically violent toward his mother for the past 7 years. Several weeks prior to treatment, the neighbors had telephoned the police to report on a domestic dispute that was occurring at the couple's home. The police arrested Christopher's father and he spent the night in jail. He was released the next day and immediately drove home, barricaded himself, his wife, and Christopher in the home, and stated that he would kill all three of them if his wife tried to leave him. The police were again called and a stand-off ensued for the next several hours until Christopher's father could be persuaded to leave the house. He was then incarcerated but continued to harass his wife verbally during visitations at the prison and through telephone calls. Christopher became withdrawn and had severe anxiety when asked to separate from his mother. He also displayed extremely aggressive behavior at his daycare center and at home. He misinterpreted other children's actions as intentionally hostile toward him and had been expelled from his daycare program for biting both teachers and students. Christopher was extremely protective of his mother and would threaten to kill anyone who came too close to her. His mother sought treatment when he "head-butted" his aunt and called her a "stupid bitch" when she had tried to hug his mother. He thought that she was going to hurt her and could no longer tell the difference between appropriate and inappropriate physical contact.

Possible Intimate Partner Violence Questions. Working with families who have experienced IPV can be extremely challenging. Usually these families are coming into therapy due to a recent, traumatic event or when a child's behavior is so extreme neither parent is able to cope with the behavioral outbursts any longer. Discussing violence with parents in not an easy topic to broach; it requires a therapist to be kind, sensitive, supportive, non-judgmental, and informed. PCIT therapists should be prepared for an emotional session (have plenty of tissues on hand) and should extend session time if IPV is expected. It is important that PCIT therapists interview parents separately as they may not discuss the violence in front of their partner for fear of reprisal. Lastly, some parents will not acknowledge IPV during the intake process. We once treated a family affected by IPV and they did not reveal the violence until 10 weeks into treatment! It is important to continuously ask these questions

during treatment as a stronger rapport will likely result in more truthful responses (Table 18.6).

Table 18.6 Possible intimate partner violence questions

I have a standard set of questions that I ask of all the families I work with here at the clinic. (Show them the list of questions!) They are all sorts of questions about your child, your child's behaviors, and your family. So, just because I ask you a question does not mean that I think it may be true for your family – I just ask all families. Some of these questions may be really true for your family and some of them will not be true at all. Please feel free to be honest with me though because the information that I gather here today will help all of us in treatment for the next few weeks.
I know that these events can be difficult and embarrassing to discuss with others. Please know that you are not the only person who has experienced these types of events. I often work with families who have violence in their homes. In order for me to better understand this violence, it is important for me to understand exactly how these events occur, from beginning, middle, to end. That way I will know what you and your family experience, because every family is unique. Could you please describe a typical violent event in your home from the beginning to the end? How do you, your partner, your children, and others who may be in your home respond during these episodes?"
There are many forms of violence (physical, sexual, emotional, financial, psychological, etc.). Many people have experienced various forms of violence. Has your partner ever been violent like this toward you? Have you ever been violent like this toward your partner?
What types of violence have you experienced? How often does the violence occur? How severe is the violence?
Does the violence occur in front of the children? If yes, how often does the violence occur in front of the children? Are the children aware of the violence?
How do you think your children are affected by being exposed to this type of violence – both physically and psychologically?
Well, I know I asked a lot of questions today. You were patient and helpful and shared a great deal of information that will help us work with your family. Before you leave, I wanted to double check and see if there is anything I forgot to ask you that you think would be important for me to know.

Possible Intimate Partner Violence Assessment Measures. As a clinician, it is important to assess IPV for a variety of reasons. Assessment allows both the clinician and family to determine the specific types of violence present in the home and to understand the duration, severity, and frequency of this violence. This information can also be a useful starting point with clients who are in denial. Allow them to complete assessment measures, present them with the data, and then ask them about violence in their relationship. This is especially true of families that are referred for child abuse and neglect as the co-morbidity of these two forms of violence is high. The assessments listed below are only options and therapists may want to consider other assessment measures that work best for their clinic and the populations they serve. The information gathered from these assessments may also be helpful in demonstrating to parents how violence in their relationship impacts their children (Table 18.7).

Table 18.7 Possible intimate partner violence assessment measures

The Aggression Questionnaire (AQ). The AQ was developed by Buss and Perry (1992) to assess individuals' aggressive responding to environmental stimuli. It consists of 29 questions and can be administered within 10 min. This assessment measure provides information regarding physical aggression, verbal aggression, anger, hostility, indirect aggression, and total aggression. Norms are provided for individuals as young as 9 years of age, which means that both children and adults can complete this form to assess their levels of aggression (Buss & Warren, 1992).
Conflict Tactics Scale-Revised (CTS-2). The CTS-2 was developed by Straus et al. (1996) in order to assess the amount and severity of intimate partner violence over the previous year. It consists of 78 questions and can be administered and scored within 20 min. This assessment provides information regarding negotiation, physical assault, injury, psychological aggression, and sexual coercion. Approximately half of the questions refer to the respondent's behaviors and half refer to the partner's behaviors. While this measure will assess for the amount and severity of IPV, it does not assess for the frequency or overall duration of IPV.
O'Leary–Porter Scale (OPS). The OPS was developed by Porter and O'Leary (1980) in order to assess child exposure to multiple forms of intimate partner violence. It consists of 10 questions and can be administered and scored within 5 min. This assessment provides information regarding financial discussions, child manipulation of parents, child discipline disagreements, gender roles of family members, partner affection, and overall intimate partner violence.

Considerations for Intimate Partner Violence Treatment. One of the first things we do during therapy with parents who have a history of IPV is provide psychosocial education regarding the effects of IPV upon children and explain to them the concept of modeling. We teach them that children learn how to act by watching how their parents act. For example, if children hear their parents say "please" and "thank you," then children are more likely to say "please" and "thank you." If children see their parents turn off the lights when they leave a room, then children are more likely to turn off the lights when they leave a room. Children are essentially little copy cats of their parents and they do what they see their parents do. To really drive this point home, you can easily find video footage of Albert Bandura's "Bobo the Doll" study online. Show the parents this video and point out that the children in the video who saw violence used violence. In contrast, the children in the video that did not see violence did not use violence. After showing this video, we ask parents how they think violence in the home is affecting their child and review the types of behaviors their child is exhibiting. This is usually either met with complete denial, fear, embarrassment, or crying. After coping with the initial emotional reaction, we then ask parents how they would like their children to act and later follow up with questions regarding what behaviors they are modeling for their children. This is a great opportunity to teach parents that they are their children's first teachers. If children see parents being violent, then they will learn to be violent. It is important that parents model good behaviors for their child!

There are several adaptations to treatment that can be made during PCIT to help these families. These include allowing a greater number of sessions for the family to learn and master the PCIT skills, avoiding lecturing the family, and possibly referring the parents to couples therapy. It is important that PCIT therapists

remember that for some of these families this is the first time they have discussed their experiences with IPV. For others, they have already received numerous lectures and admonishments from family and friends. Instead of another speech from a therapist, they need support and encouragement.

PCIT therapists may need to have more CDI sessions (7 or 8 sessions compared to 6 sessions) in order to allow the parent-child to develop a secure and loving relationship. Remember, these children have seen their parents being violent. They may be fearful of their parents and may need more time to allow their relationship to develop into a positive one. PCIT therapists may also need to allow for more PDI sessions (7 or 8 sessions compared to 6 sessions) in order to allow parents more time to learn, practice, and master the non-violent discipline skills taught during this phase. Since the PDI phase involves implementing discipline practices, it is a good idea to have the parents practice using these new skills on the therapist who is role-playing the part of the child. This allows the therapist to display severe temper outbursts and for the parents to practice using these skills prior to using these skills with their own child. This extra practice will help parents with anger control problems to be safer with their children during the first PDI coaching sessions.

During standard PCIT sessions, therapists tend to sit behind the one-way glass and utilize the bug-in-the-ear device to communicate with parents. When working with parents with a history of IPV, this may need to be altered. Therapists may need to stay in the room to ensure that the interactions stay safe. Children who have witnessed violence tend to use violence. We have seen children from violent homes hit, punch, bite, and scratch their mothers hard enough to draw blood while swearing and verbally degrading them. These are behaviors a therapist obviously cannot ignore. If these behaviors are present, the PCIT therapist should enter the room and state: "There is no hurting. If you continue to hurt your mother, then she will have to leave the room." If the child continues to be violent toward the parent, then the PCIT therapist should return to the room. The parent is asked to leave the room while the PCIT therapist stays with the child. This break also allows both the parent and child time to calm down before returning to PDI coaching.

Similar to families of divorce, when working with families with a history of IPV it is important to consider who will be involved in treatment. Are both parents active in the child's life? How often does the child see the parents? Is the child fearful of one or both parents? Could it put family members at additional risk to have both parents involved? Should both parents be required to attend couples counseling prior to attending PCIT? Therapists should review these questions with the families with whom they are working. The answers to these questions will be different for each family, so there is no fixed format to follow when working with families affected by IPV. Rather, therapists will have to work diligently to incorporate all of their knowledge into developing the best possible program based upon the strengths and weaknesses of each family.

Therapists should be prepared for the fact that some mothers will deny that IPV exists in their home. They may do this out of fear of future violence. They may worry that revealing IPV could result in reprisal from their partners, embarrassment about living with violence, or fear that their children may be removed from their

custody. Many men and women in violent relationships do not realize that violence is never an acceptable part of any relationship. Education may be necessary to help these couples become aware of the characteristics of appropriate relationships.

Community Resources for Families with Intimate Partner Violence. Each community will offer different resources for families experiencing IPV. Most offer at least a support group that meets weekly or bi-weekly. Others offer everything from emergency shelters to financial assistance. PCIT therapists should be familiar with resources not only in their immediate community but in surrounding communities as these families may be able to access these services as well (Table 18.8).

Table 18.8 Community resources for families with intimate partner violence

Local Emergency Housing. Most areas have emergency housing available for women and children who are living with intimate partner violence. Unfortunately, there are few housing options for men and children living with intimate partner violence and these families may have to access homeless shelters. Therapists should be aware that the locations of these shelters are kept strictly confidential in order to ensure the women's safety. Therapists probably will not be able to tour these facilities, but could arrange to meet with shelter workers at a local café to discuss their resources. It is important to ask about the ages and genders of children permitted in a particular residence. Some shelters will not allow older male children into the residences and therapists may need to find several shelter options for families depending upon the gender and ages of their children.
Develop a Safety Plan. Therapists should also work with parents, or refer them to another therapist, to develop a safety plan for the family. This plan should include a list of people whom the parent can turn to for support (parents, siblings, friends, neighbors). The safety plan should include a mental checklist of all the important things in the home they may need to remove in an emergency, such as medications, identification, birth certificates, and special pictures or other items. Parents should know the names and telephone numbers of local emergency shelters in the area or have a way to contact the police in case of an emergency.
National Domestic Violence Hotline. 1-800-799-SAFE, 1-800-787-3224, www.ndvh.org
National Coalition Against Domestic Violence. www.ncadv.org

Low-Income Families

Background Information on Low-Income Families. According to the US Census Bureau (2007), 36.5 million men, women, and children lived below the poverty line in 2006. Furthermore, 17.6% (12.8 million) children under 18 years of age lived below the poverty line, which means that approximately 1 in 6 children in the United States live in poverty. In 2008, the poverty line in the United States for a family of four was $21,200 (United States Department of Health and Human Services, 2008). Poverty impacts all components of a person's life. Low-income families are forced to live in neighborhoods with lower rents, which have schools that often do not meet high standards of academic success. These families live in substandard housing, which can have serious health and safety implications for themselves and their children. They have to make difficult decisions regarding how to allocate their

financial resources; should they pay their electric bill, purchase groceries, or buy medications? These families experience extreme stress on a daily basis. As a therapist, it can be easy to forget that clients have real concerns regarding their lives that are more pressing to them than therapy. Although we may want these families to be 100% dedicated to therapy, it may not be realistic when they are struggling to survive.

Possible Socioeconomic Status Questions. Asking questions about a family's financial status can be particularly challenging. Most of us were taught that it is rude to discuss finances with anyone, much less a total stranger. The families you may work with that live close to, or below, the poverty line may be hard-working people who are doing the best that they can to provide for their families. They may have lost their jobs or experienced medical emergencies that have depleted their financial resources. These are difficult times for families who may also be struggling with the shame and embarrassment of living in poverty. It is important for a PCIT therapist to be understanding and non-judgmental when working with these families. It is also vital that the therapist accurately assess the family's current financial status. This information will be useful in evaluating the previous and current living standards of the family and to assist in securing additional resources should the family qualify. Below are a few questions that PCIT therapists should ask parents about their current financial situation during the initial intake interview (Table 18.9).

Table 18.9 Possible socioeconomic status questions

I have a standard set of questions that I ask of all the families I work with here at the clinic. (Show them the list of questions!) They are all sorts of questions about your child, your child's behaviors, and your family. So, just because I ask you a question does not mean that I think it may be true for your family – I just ask all families. Some of these questions may be really true for your family and some of them will not be true at all. Please feel free to be honest with me though because the information that I gather here today will help all of us in treatment for the next few weeks.
Answering questions about finances can be difficult, but it will allow me to understand more about the different stressors in your life. How much is your weekly (bi-weekly, monthly) income? How much of that goes toward rent, bills, food, gas, savings, etc? How much does that leave you at the end of the week (every other week, month)?
Do you receive assistance from outside resources (your parents, family members, social services, etc.)?
What are some of the stressors that you face due to your income? How do these stressors affect your ability to care for your child?
Well, I know I asked a lot of questions today. Both of you were patient and helpful and shared a great deal of information that will help us work with your family. Before you leave, I want to double check and see if there is anything I forgot to ask you that you think would be important for me to know.

Possible Socioeconomic Status Assessment Instruments. Assessing poverty may be done by asking a few simple questions about the number of family members in the home and the total income of the home. The assessments listed below are only options and therapists may want to consider other assessment measures that

work best for their clinic and the populations they serve. The information gathered from these assessments may also be helpful in determining if families meet the requirements to qualify for numerous types of financial assistance (e.g., Head Start) (Table 18.10).

Table 18.10 Possible socioeconomic status assessment instruments

Total Household Income and Number of People in the Family. Information regarding poverty line can be gathered and determined using figures developed by the US Census Bureau
Four-Factor Index of Social Status. Hollingshead (1975) developed a method of calculating a family's socioeconomic status (SES) utilizing education, occupation, gender, and relationship status. This measure has received criticism as being outdated but is still commonly used to determine SES. This measure can be included as part of the standard intake and can be completed in under 5 min

Considerations for Families of Low Socioeconomic Status. Our clinic is located in a small city in West Virginia. There are not many clinics in the area and because we are a training facility we are able to offer services for little or no payment. As such, we often see clients who are living in poverty. Recently, we treated a client who had moved to the United States several years ago from Mexico. The father had been a migrant worker who traveled to different regions of the country picking apples. He had met a local woman and settled down in the area. They had three children and had no income during the winter months as the father was no longer traveling to pick apples. As the father was not a legal US resident he was unable to find employment and did not qualify for benefits. The mother of the children had severe psychopathology and was also unemployed. She would experience severe depressive episodes that left her incapable of caring for her children. The father was often left with three children, no money, and in a culture with which he was not familiar. Social Services had intervened when a report was filed that the children were being physically abused and neglected. If the parents did not attend PCIT, the children would be removed from the home.

This was a difficult case. The family did not have money for treatment, a telephone to contact them for appointments, transportation, and childcare for additional siblings. There were also language and cultural barriers and psychopathology present in the maternal caregiver. In order to work with this family we had to make several adjustments to our typical session. First, we had to arrange for transportation for this family to and from sessions. Social services sent a cab for them that was often late picking them up for sessions and early to bring them back home. This severely cut into the time we were able to spend with the family. We had to streamline sessions to cover the topics that were the most important. It was impossible to call and confirm appointments. It also was hard for the family to contact us to let us know that their transportation was late, so we often sat around the clinic wondering if this family was going to show up. The family did not have the money to purchase toys to use for at home for CDI. So we found some extra toys in the clinic and sent them home with the family for practice. Because all three children came to sessions, we had to arrange for some fabulous undergraduates to provide childcare while we

worked with the eldest sibling. This family also had no income to pay for PCIT services, so we arranged for their services to be pro-bono. In addition to all of this, the father had some concerns regarding treatment. Specifically, he thought that providing praise was spoiling his child according to his culture – so we ended up reframing the praise to be more culturally acceptable. The father was quite happy to have any form of support. He called the clinic regularly from payphones when he was in town to provide progress reports between sessions. These "update" calls sometimes allowed us to confirm appointments a few days in advance. We extended PCIT by a few months due to a lack of transportation and decreased time in-session, but this family eventually made significant progress and was able to remain intact. We recognize that most agencies would not have the resources to make all of the accommodations that we were able to make for this family. However, this case illustrates the types of resources and flexibility needed to be successful with impoverished families.

Community Resources for Low-Income Families. In our clinic we see two types of low-income families; those that have accessed a great deal of services and those that have accessed none. Families that are service savvy usually require less intensive support. However, others need help learning how to access support services in their area. Being a PCIT therapist with low-income families usually requires more than providing parent training. Clinicians should know possible referral sites in their respective communities. We have gone through the telephone book several times and have made contacts at many local agencies. When a client comes in who needs additional services, we know right where to send them and who to refer them too. This is great for two reasons: (1) it gets the client services, and (2) it builds wonderful rapport. Our suggestion would be to conduct an extensive review of services in your area, type up a list of these organizations complete with specific program information and contact personnel, and have this list on hand should clients qualify for any of the programs. It is important to thoroughly research these services prior to providing information to your clients (Table 18.11).

After providing families with this list of services, allow them to contact the organizations on their own. This allots them the opportunity to assume responsibility for themselves and learn to navigate these systems independently. However, be sure to follow up with the families the following week to ensure that they have called to set up appointments.

Parting Words

Working with families with major life stressors can be as trying as it is rewarding. These are families who are truly in crisis by the time they are referred to PCIT clinics for services. It is easy for therapists to burn out. We are faced daily with the challenges of working with families in the most dire of circumstances. These are families who cannot afford to buy food for their families or pay their rent, parents who may have substance abuse issues, or families that may experience violence on a

Table 18.11 Community resources for low-income families

Head Start. Head Start is a federal program for preschool children from low-income families. The Head Start program is operated by local non-profit organizations in almost every county in the country. Children who attend Head Start participate in a variety of educational activities. They also receive free medical and dental care, have healthy meals and snacks, and enjoy playing indoors and outdoors in a safe setting. Head Start helps all children succeed. Services are offered to meet the special needs of children with disabilities. Most children in Head Start are between the ages of 3 and 5 years. Services are also available to infants and toddlers in selected sites (US Department of Health and Human Services website).
Department of Social Services. The Department of Social Services (DSS) offers different services dependent upon the state and county in which the family resides. Typically, DSS provides families with respite care, childcare assistance, food stamps, clothing vouchers, and transportation. If DSS is not able to fulfill a client's needs, they will more than likely have referrals for additional services in your community that may be more appropriate.
Women, Infants, and Children. Women, Infants, and Children (WIC) provides services to pregnant women, postpartum women, and children up to 5 years of age. WIC provides services such as food stamps, healthcare referrals, and educational programs.
Salvation Army and Rescue Mission. Both the Salvation Army (SA) and Rescue Mission (RM) offer extensive services to the community. These organizations provide services such as drug and alcohol counseling, affordable clothing purchases, affordable furniture and household items, employment opportunities, employment counseling, emergency housing options (may be gender specific), free meals, and drop-in centers for emergency purposes.
Local Resources. There are numerous organizations in your community that may be willing to help with the families you serve. Many communities have organizations that are specific to that community and provide resources such as educational programs, food and clothing assistance, affordable counseling services, and temporary housing.

regular basis. PCIT therapists must understand that these parents love their children and want to commit to therapy, but treatment is not a top priority for those struggling to make ends meet. Therapists should try not to judge these families, but rather try to understand their life circumstances. Most families do the best that they are able to do. As a therapist, it is your responsibility to help your clients get the most out of treatment. This may include understanding the extent of their current stressors, adapting treatment to enhance its effectiveness, and providing additional support services.

References

Abidin, R. R., & Konold, T. R. (1999). *Parenting alliance measure*. Lutz, FL: Psychological Assessment Resources, Inc.

American Medical Association. (1992). Diagnostic and treatment guidelines on domestic violence. *Archives of Family Medicine*, *1*, 39–47.

American Psychological Association (2001). *Intimate partner abuse and relationship violence*. Retrieved January 6, 2006, from http://www.apa.org/pi/parv.pdf

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology*, *12*(4), 578–599.

Buss, A.H., & Perry, M. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology, 63*, 452–459.

Buss, A. H., & Warren, W. L. (1992). *The aggression questionnaire*. Lutz, FL: Western Psychological Services.

Carlson, B. (1984). Children's observations of interparental violence. In A. Roberts (Ed.), *Battered women and their families*. New York: Springer, 147–167.

Center for Disease Control. National Center for Health Statistics. (2007). *Marriage and divorce*. Retrieved March 26, 2008, from http://www.cdc.gov.nchs.fastats/divorce.htm

Eyberg, S. M., McDiarmid Nelson, M., Duke, M., & Boggs, S. R. (2004). *Manual for the dyadic parent-child interaction therapy coding system, Third Edition*. Unpublished manuscript, University of Florida.

Fergusson, D. M., & Horwood, L. J. (1998). Exposure to interparental violence in childhood and psychological adjustment in young adulthood. *Child Abuse & Neglect*, *22*(5), 339–357.

Hollingshead, A. (1975). *Four factor index of social status*. Unpublished manuscript. New Haven, CT: Yale University.

Horn, J., Wanberg, K. W., & Foster, M. (2003). *Alcohol use inventory*. Minneapolis, MN: Pearson Inc.

Lazowski, L. E., Miller, F. G., Boye, M. W., & Miller, G. A. (1998). Efficacy of the substance abuse subtle screening inventory-3 (SASSI-3) in identifying substance dependence disorders in clinical settings. *Journal of Personality Assessment*, *71*(1), 114–128.

McNeil, C. B., & Herschell, A. D. (1998). Treating multi-problem, high stress families: Suggested strategies for practitioners. *Family Relations*, *47*(3), 259–262.

Miller, F. G., Roberts, J., Brooks, M. K., & Lazowski, L. E. (1997). *SASSI-3: Substance abuse subtle screening inventory*. Lutz, FL: Psychological Assessment Resources, Inc.

National Institute on Drug Abuse. (2008). *Drugs of abuse information*. Retrieved April 2, 2008, from http://www.nida.nih.gov/drugpages.html

Porter, B., & O'Leary, R. E. (1980). Marital discord and childhood behavioral problems. *Journal of Abnormal Child Psychology*, *8*, 287–295.

Snyder, D. K. (1997). *Marital satisfaction inventory, Revised*. Lutz, FL: Western Psychological Services.

Straus, M. (1992). Children as witnesses to marital violence: A risk factor for lifelong problem among a nationally representative sample of American men and women. In D. Schwartz (Ed.), *Children and violence: Report on the 23rd Ross Roundtable on critical approaches to common pediatric problems* (pp. 98–104). Columbus, OH: Ross Laboratories.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., Sugarman, D. B., Finkelhor, D., Moore, D. W., & Runyan, D. K. (1996). *Revised conflict tactics scales*. Lutz, FL: Western Psychological Services.

Substance Abuse & Mental Health Services Administration. (2007). *Results from the 2006 national survey on drug use and health: National findings*. Retrieved April 2, 2008, from http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.pdf

Tjaden, P., & Tiioennes, N. (2002). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey*. Washington, DC: Department of Justice.

United States Census Bureau. (2007). *Housing and household economic statistics division*. Retrieved March 26, 2008, from http:www.census.gov.hhes/www/poverty/poverty06/pov06hi.html

United States Department of Health and Human Services. (2008). The 2008 HHS poverty guidelines. *Federal Register*, *73*(15), 3971–3972.

Chapter 19
Ethnic Minority Children and Families

Karla Anhalt and Joaquin Borrego

This chapter focuses on issues to consider when implementing Parent-Child Interaction Therapy (PCIT) with ethnic minority children and families in the United States. Cultural sensitivity and competence have become increasingly important aspects of assessment and treatment of children's mental health issues. In the United States, one third of all school-age children belong to non-White ethnic minority groups (Santrock, 2005). By 2025, it is estimated that about 40% of adults and 48% of children living in the United States will be from racial and ethnic minority groups (US Census Bureau, 2001). Mental health professionals who are implementing PCIT need to be aware of the unique needs of ethnic minority children and families.

Parent Training, PCIT, and Application to Ethnic Minorities

The research literature on behavioral parent training (BPT) has identified significant gaps with regard to documentation of treatment outcome and specific needs of ethnic minority families (e.g., Forehand & Kotchick, 1996; Butler & Eyberg, 2006). Many studies evaluating BPT have not included information about participants' socioeconomic status, racial identity, or ethnic group affiliation (Brestan & Eyberg, 1998). The generalizability of many parent training programs to US ethnic minorities has been questioned, as their development and evaluation has primarily included Caucasian, middle-class parents and families as participants (Coard, Wallace, Stevenson, & Brotman, 2004; Forehand & Kotchick, 1996). Limited attention has been paid to including race- or ethnicity-specific components that may enhance BPT's efficacy with minority populations (Coard et al., 2004).

Despite these gaps in the research literature, a limited number of articles have described unique aspects of implementing PCIT with ethnic minority groups. In the last decade, studies have explored topics ranging from treatment acceptability, adaptation of PCIT for specific minority groups, and evaluation of the effectiveness of PCIT without modifications for minority families. In this chapter we provide a

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brief review of this literature, as well as recommendations for practice. The literature review focuses on PCIT with Hispanics/Latinos, Native Americans, and African-Americans, as these are the groups that have received the most attention. We also discuss strategies to asses the social validity of PCIT as a process for practitioners to examine the cultural fit between PCIT and family expectations and satisfaction with treatment.

PCIT with Hispanics

Before we discuss the applicability of PCIT to Hispanic populations, it is important to first highlight some general demographic information about this group. In no way is this brief section meant to be a detailed review of demographic information. Instead, the information highlighted is meant to increase awareness in the reader and, in turn, to encourage readers to pursue further information.

To start, the term *Hispanic* is a pan-ethnic term that is used as an umbrella to include people from Mexico, different countries from Central and South America (e.g., Guatemala, Bolivia, Colombia), and other countries in the Caribbean region such as Puerto Rico, Cuba, and Dominican Republic. In all, there are over 20 countries that represent people who qualify for the term Hispanic. In addition, *Latino/a* is at times used interchangeably with the term Hispanic. There are regional differences with regard to preference for which term is used. As an example, the term Latino/a is at times preferred in west coast states such as California and the term Hispanic is often used in southwestern states such as Texas. In addition, although Spanish is the shared common language, it is important to know that regional differences dictate the use of different terms for the same object, etc.

Hispanics are now the largest ethnic minority population in the United States (US Census Bureau, 2004). In addition to being the largest ethnic group, the Hispanic population continues to increase at a rapid rate. However, Hispanic parents and children are heterogeneous with regard to language use and preference, immigration status, years of education level, acculturation level, and socioeconomic status. Given all the different countries and regions represented, there is at times more within-group than between-group heterogeneity. As an example, a second-generation, acculturated Mexican-American family may have more in common and share more family characteristics with a Caucasian family than with a recently immigrated family from Mexico who does not speak any English. Just as there is great variability with regard to country of origin and acculturation level, there is also great variability among Hispanics with regard to parenting and discipline practices.

The following sections describe the applicability of PCIT with different Hispanic subgroups. The two subgroups that are discussed are Mexicans and Puerto Ricans. Our discussion is limited to these two groups because there have been no other writings about PCIT with other Hispanic subgroups. We first discuss work by Borrego, Anhalt, Terao, Vargas, and Urquiza (2006) in which the authors used a single-case design to document the effectiveness of PCIT with a Spanish-speaking mother of Mexican descent. Next, the work by McCabe, Yeh, Garland, Lau, and Chavez

(2005) is discussed by highlighting the process she went through to adapt PCIT with Mexican-Americans in southern California. McCabe referred this program as GANA, which stands for *Guiando a Niños Activos* or Guiding Active Children. Although outcome data is not currently available from McCabe et al., the process by which they made adaptations is highlighted as it provides useful and relevant information regarding working with Mexican-Americans. Finally, the work by Matos, Yeh, Garland, Lau, and Chavez (2006) is discussed as they adapted PCIT for Puerto Ricans living on the island. After this work is discussed, general recommendations will be made on issues clinicians should address when working with Hispanic populations in the context of PCIT.

Single-Case Study. Using a single-case design, Borrego et al. (2006) were able to demonstrate the effectiveness of PCIT with a Spanish-speaking, Mexican-descent foster care mother. The foster mother had long-term guardianship of a 3-year-old multi-ethnic, bilingual child who presented with disruptive behavior problems (e.g., temper tantrums, physical aggression, and noncompliance). Borrego et al. (2006) noted that the most significant adaptation made was providing services that matched the mother's preferred and dominant language: Spanish. This meant that assessment instruments (e.g., ECBI, PSI) and forms given to the parent (e.g., CDI & PDI didactic and homework sheets) were made available in Spanish, in addition to PCIT being delivered in the mother's preferred language. Beyond this needed adaptation, PCIT's structure and content were followed in standard format. A number of characteristics of PCIT were hypothesized to be culturally appropriate, including PCIT's emphasis on the parent-child relationship, direct coaching, and an action-oriented treatment. In addition, the PCIT therapist was a bilingual, bicultural Mexican-American therapist. Although not formally assessed, the therapist was aware of certain cultural values such as *respeto* (respect) that were used throughout treatment. As an example, the therapist never addressed the mother by the first name. Instead, he referred to her by her last name (e.g., Sra. Gutierrez/Mrs. Gutierrez). Another cultural value that may be emphasized in treatment is *personalismo,* which means developing a relationship that is characterized by being warm. Incorporating the value of *personalismo* may mean spending more one-on-one time with the parent than is typically done in PCIT.

Observational data collected throughout treatment documented acquisition of PCIT skills. At pre-treatment, the mother exhibited numerous questions and commands when interacting with her child. A low number of descriptions and verbal praises were observed at pre-treatment. This type of behavioral profile (low number of positive verbalizations and high number of negative verbalizations) is common for parents who seek PCIT services to address child behavior problems. As treatment progressed, the mother's positive verbalizations increased while the frequency of negative verbalizations decreased (Borrego et al., 2006).

Parent-report measures also were completed by the child's mother as part of this case study. At pre-treatment, the mother reported clinically significant behavior problems (as evidenced by elevated Eyberg Child Behavior Inventory and Child Behavior Checklist scores) and stress related to parenting the child (as evidenced by an elevated Parenting Stress Index profile). The results of the intervention suggest

that PCIT was effective in reducing the child's behavior problems and the parent's level of stress. At post-treatment and at a 1-year follow-up, clinically significant improvements were found on the ECBI intensity, PSI parent domain and total stress, and CBCL externalizing scores. In summary, the data presented on this parent-child dyad is promising in highlighting the efficacy of PCIT in Spanish.

The GANA Program. McCabe et al. (2005) took PCIT in its original form and went beyond simply translating PCIT into Spanish. The authors went through a thorough analysis of the cultural appropriateness of PCIT with Mexican-Americans in southern California. McCabe and her colleagues tailored standard PCIT and came up with a program called *Guiando a Niños Activos* (GANA, Guiding Active Children). As with standard PCIT, this program was developed for working with Mexican-descent parents with young children with conduct behavior problems.

The clinical research team went through a detailed process of tailoring PCIT for Mexican-American parents. Initially, the authors relied on extensive literature reviews related to parent training, mental health services, and Mexican populations and also used interviews and focus groups to collect data from therapists and parents. The information collected led to an initial adaptation of PCIT for use with Mexican-descent parents. After this initial adaptation, the tailored treatment was evaluated by an expert panel and clinical researchers for further feedback and refinement.

In addition to the program and relevant literature being made available in Spanish, a notable change in the program included not using the term PCIT (which has *therapy* as part of the title and the stigma that is sometimes attached to this term). The terms therapy and treatment were de-emphasized throughout the program as the authors were aware that among Mexican-Americans there may be considerable stigma attached to people who seek treatment or are in therapy. Instead, by using GANA, the authors were able to focus on skill-building goals. Other noted adaptations included phone calls to parents beyond therapy sessions and spending sufficient time orienting parents to the conceptualization of disruptive behavior problems and skills that could be acquired through the GANA program (McCabe et al., 2005).

McCabe et al. (2005) also incorporated cultural values into GANA. An example of this was the addition of a component that included other family members in treatment. By doing this, the authors were addressing the cultural value of *familism*. McCabe and colleagues were also cautious about having these adaptations be erroneously applied to *all* parents of Mexican origin. To address this in treatment, culturally related variables such as perceived barriers to treatment were included as part of the assessment process with each family (McCabe et al.).

PCIT in Puerto Rico. Matos et al. (2006) followed a similar process in tailoring standard PCIT to be culturally appropriate for a Puerto Rican sample. This adaptation was for Puerto Ricans living on the island. Another difference was that Matos and her colleagues were interested in targeting parents who had children with both externalizing behavior problems and hyperactivity. Matos et al. (2006) followed a four-step process in adapting PCIT in Spanish for use in Puerto Rico. The first step involved translating PCIT into Spanish, using terms appropriate for Spanish as

spoken on the island. The second step involved conducting a pilot study with nine families about the feasibility, efficacy, and acceptability of the culturally adapted PCIT version. The tailored intervention was implemented by staff born and raised in Puerto Rico. The third step included further revising the PCIT program in Spanish and the fourth step was gathering information about the process and outcome of PCIT from therapists and parents involved.

Through the fourth step of soliciting feedback from therapists and parents, Matos et al. (2006) obtained valuable information about the perception of specific PCIT components. For example, parents felt that the CDI portion of PCIT gave children too much control and they felt that the time-out portion of PDI was too demanding for parents (Matos et al.). The Puerto Rican adaptation also included a component that focused on educating parents regarding child behavior problems and orienting them to treatment. Matos and colleagues also incorporated cultural values such as working with a number of family members when possible (familism) and placing an even greater emphasis on the therapeutic relationship (Matos et al.).

The data collected from this pilot study suggests that a Puerto Rican Spanish version of PCIT was efficacious with families. Parents in the study reported that the children's behavior problems and parental stress decreased by the end of treatment. In addition, parents also reported that they used more effective means of disciplining their children. Data related to treatment acceptability suggests that parents were satisfied with both the process and outcome of the PCIT program in Spanish.

In summary, the culturally adapted version by Matos and colleagues suggests that PCIT is efficacious with Puerto Rican families living on the island. The data reported about the efficacy of PCIT in Puerto Rico is based on parent report measures. Unfortunately, observational data that would give us more information about changes in parent-child interactions were not reported.

Summary and General Recommendations for Working with Hispanic Families. The above section was meant as a brief introduction to the Hispanic population. Given the great heterogeneity, clinicians should not assume a "one size fits all" approach. The limited information available about PCIT with Hispanics (Borrego et al., 2006; Matos et al., 2006) suggests promising results. These two studies indicate that PCIT can be efficacious when delivered in Spanish. PCIT with this population is still in its infancy, but the structure (e.g., being action-oriented) and some of the content (e.g., focusing on the parent-child relationship) seem to be culturally appropriate.

The following are general recommendations for clinicians when working with different Hispanic subgroups. First, clinicians should determine the country of origin. Knowing the country of origin may help clinicians determine if certain words or terms have different meanings in different contexts. Next, clinicians should determine level of acculturation. Knowing the level of acculturation can help clinicians determine to what degree adaptations need to be made. For example, no or minimal adaptations may be needed if working with a third-generation Cuban-American family. In contrast, adaptations may be required for a first-generation Cuban family. Once acculturation level is assessed, clinicians should *determine language use and preference*. Clinicians should assess along the following five descriptors:

monolingual Spanish, bilingual but Spanish dominant, bilingual and equally dominant in both languages, bilingual but English dominant and monolingual English. Assessing language preference will allow clinicians to determine to what extent Spanish will need to be used.

Case Example with a Hispanic Family. This is a vignette of a Hispanic parent-child dyad that presented for PCIT services. The case example highlights some of the points discussed in this section. Pedro and his mother presented for PCIT services at a psychology clinic. Pedro is a 7-year-old Mexican-American male who was born in Mexico but has lived in the United States most of his life. Pedro is bilingual but tends to use more English. This is a product of being in a first grade classroom in which English is spoken. The mother, Sra. Herrera, is in her late twenties, does not have any family in the United States, works, and is monolingual in Spanish. This information allowed us to determine that the child was more acculturated than the mother.

The pre-treatment data were collected in Spanish. The DPICS instructions were given in Spanish and the instruments (e.g., ECBI & PSI) were administered in Spanish also. Before the CDI didactic was introduced, the mother was given a detailed vignette that described the CDI phase and was asked to rate the acceptability of this procedure. After this information was collected, the CDI didactic was conducted and this was followed by a post-CDI didactic assessment in which we gauged treatment acceptability again. This allowed the clinicians to determine initial level of treatment acceptability.

Although the treatment was mainly administered in Spanish to the mother, English terms were also introduced. This was done because the mother expressed an interest in wanting to learn English so that she could communicate more with her son in his preferred language. The cultural values of *respeto* (respect) and *personalismo* (developing a relationship that is characterized as being warm) were also incorporated into treatment. Examples include addressing the mother more formally by referring to her by her last name and spending more time checking in on a weekly basis.

PCIT with Native Americans

Native Americans comprise over 500 tribal groups that are federally defined as sovereign entities. In addition, 250 American Indian groups are not recognized by the US government. Therefore, when we discuss Native Americans it is important to keep in mind that we are referring to over 750 communities within the United States and most of them have their own language, customs, and culture (DHHS, 2001). There are some historical events that have affected many of these tribal groups. These include a shared history of removal from the lands where original settlement occurred and boarding school experiences in the nineteenth and twentieth centuries. Additionally, these groups have experienced forced assimilation to mainstream US culture and religion as a result of US government intolerance for

traditional religious, spiritual, and tribal practice (Bigfoot & Braden, 2007; DHHS, 2001).

With regard to boarding schools, between the 1880s and 1960s there were numerous government and church-supported boarding schools. Until the 1980s, these boarding schools were not controlled or managed by Native Americans. It was common practice for Native American children to be removed from their parents and community, taken to the boarding schools, and required to spend their formative years in these settings without access to or visitation with parents, relatives, or their Native American community. Harsh discipline was common in these settings, as was physical, emotional, and sexual abuse (DHHS, 2001). The use of Native languages and traditional customs and rituals was harshly punished. When students graduated from boarding schools, there was little effort from the school sponsors or the US government to integrate graduates into mainstream US society (DHHS, 2001). This experience across Native tribes and communities has had a negative impact on the well-being of families and has interrupted oral traditions and teachings about child rearing and other parenting issues.

Forty two percent of Native Americans today live in rural areas, compared to 23% of the general population. Current risk factors for Native American children and families include poverty, lack of availability and access to health and mental health services, and higher prevalence of alcoholism, diabetes, and suicide when compared to the general population (DHHS, 2001). Native Americans differ by geographic location, tribal affiliation, physical and mental health status, and level of acculturation. Values differ from family to family and community to community. Barriers to seeking therapy may include lack of availability, historical distrust of Western/majority culture, and the lack of culturally relevant interventions. With regard to child rearing, community elders, extended family members, and other community members often take an active role. (Ballew-Dunlap, 2005).

In the following section we review two studies that have examined parenting factors and treatment acceptability of PCIT and behavioral parent training among Native Americans. The Masse (2006) study explored whether there were differences in the responses of a group of Native American parents compared to a non-Native American parent group. Ballew-Dunlap (2005) evaluated similar variables, but her sample was only Native American. Variables of interest to Ballew-Dunlap included social support, acculturation, and acceptability of different PCIT components. After this, we briefly present clinical perspectives from the first edition of the PCIT book regarding practice with Native American families. Finally, we describe the important programs for Native American families available through the Center for Child Abuse and Neglect in Oklahoma.

Evaluating Differences Between Native and Non-Native American Parents. Masse (2006) conducted a study to compare parenting styles of Native and non-Native American parents, involvement of extended family in parenting, and acceptability of behavioral parent training (BPT), among other variables. No differences were detected between the groups with regard to acceptability of BPT as an intervention. In addition, both groups had mean ratings that reflected acceptability for BPT as an intervention for child behavior problems. With regard to extended

family, parents in the Native American group reported obtaining more support from extended family members when compared to the non-Native American parent group. Finally, parents in the Native American group reported lower scores on parental monitoring of their children's behavior. These findings may be interpreted to reflect Native American parents' greater likelihood of encouraging a higher level of independence in their children. Additionally, Native American parents commonly practice shared parenting responsibility that involves extended family and other tribe members in child supervision (Masse, 2006).

Native American Parent Views on Acceptability of PCIT Components. Ballew-Dunlap (2005) examined the relation between acculturation, parenting stress, perceived social support, and PCIT acceptability in a sample of Native American parents in Oklahoma. Fifty-one caregivers of children aged 6–12 participated in the study. No significant associations were found between acculturation and social support, between acculturation and acceptability of PCIT scenarios, or between acculturation and parenting stress. There was a significant finding for parental stress and social support, and income moderated the association between these two variables. Perceived social support was associated with decreased parenting stress when income was high but was unrelated to parenting stress when income was low (Ballew-Dunlap, 2005). Parents with high income and high levels of perceived social support had the lowest reported levels of parenting stress.

When presented with a range of scenarios describing various components of PCIT, participants indicated acceptability of the general components, including the Child-Directed and Parent-Directed Interaction didactic sessions, as well as the use of modeling and coaching as part of treatment. Ballew-Dunlap (2005) concluded that findings from her study do not support a need to modify PCIT to increase its acceptability for Native American families in Oklahoma. With regard to participants' interest in the incorporation of traditional Native American cultural activities into parent training programs, caregivers were most interested in the addition of historical walks and involvement of elders. Instead of creating a separate PCIT protocol for Native American families, Ballew-Dunlap (2005) suggested that interest in the inclusion of specific cultural components should be addressed with each individual family.

*Clinical Recommendations from Hembree-Kigin and McNeil (*1995*).* As a result of clinical work with Native American families in Oklahoma, Hembree-Kigin and McNeil (1995) noted that many parents reported feeling uncomfortable with the intensity and directness expected while providing labeled praise as part of PCIT. They also reported that labeled praise came across to family and friends as boastful. Therefore, the labeled praise expectation was adapted so that it allowed for more subtle forms of praise, such as indirect praise. Examples of indirect praise include "Your grandmother would like that drawing," "We should put this in a place of honor," "Your patience reflects well on our family," "Your play is interesting," "I look forward to playing with you again," "You are showing that you have learned a lot," and "Your brother could learn from you." To increase the acceptability of labeled praise, Native American parents were sometimes coached to whisper labeled praises to their child. This allowed them to use very specific labeled praise without

encountering social sanction or embarrassment. Similarly, Native American parents often expressed discomfort with the skill of "enthusiasm." Some did not feel natural being animated in their speech. For them, smaller differences in intonation were used to convey interest and approval, along with smiles, humor, and physical affection. Additionally, Native American parents reported that the fast-paced and high-energy nature of the coaching felt intense, pressured, and uncomfortable. The coaching was made more acceptable by slowing down the frequency of feedback, allowing for silences during playtime.

Oklahoma Health Sciences Center Work with Native Americans. The Center for Child Abuse and Neglect (CCAN) at the University of Oklahoma Health Sciences Center has offered PCIT to Native American families for over 10 years. The Center has actively sought to provide technical assistance and disseminate PCIT to Native communities throughout the state of Oklahoma (CCAN, 2008a) and the United States. As with other populations, PCIT has been used as an intervention to reduce child behavior problems and as a model to prevent child physical abuse. Under the leadership of Dr. Dolores Subia Bigfoot, Director of Native American programs offered through CCAN, PCIT has been adapted to incorporate traditional American Indian teachings and practices. This is an effort to increase the social validity and treatment acceptability of PCIT, as well as to accommodate the needs and preferences of a range of Native communities (CCAN, 2008b). Bigfoot and her colleagues have named the adaptation of PCIT for Native American families "Honoring Children, Making Relatives" (CCAN, 2008b). They focus on the clinical application of parenting techniques in a framework that incorporates traditional Native American values of honor, respect, the importance of extended family, and an emphasis on instruction, modeling, and teaching (Bigfoot & Braden, 2007).

PCIT with African-Americans

As is the case with other minority groups reviewed in this chapter, African-Americans are not a homogeneous group. The risk and protective factors within each family affect their ability to access and remain in treatment, particularly socioeconomic status (SES). Therefore, it is necessary for therapists to assess and identify the risks and protective factors within each African-American family they treat.

Family, parent, and child stressors, access to health and mental health services, and social support vary significantly depending on the resources and experiences of each family. To illustrate the heterogeneity within the African-American population, consider these two extremes: (1) an African-American family composed of a mother who is the primary (and single) caregiver, whose education level is a high school diploma, who has three children, with income below the poverty line, living in subsidized housing and dependent on state/federal support as a source of income and (2) a family composed of an African-American mother and father, who both have professional degrees, live in a neighborhood with high-quality schools and services, and have an income level placing them in the upper middle class. For the

first family, PCIT will likely require many adaptations (see Chapter 18), while the second family is likely to benefit from the standard PCIT protocol.

Compared to Hispanics and Native Americans, few articles and studies about PCIT with African-American children are available. This is surprising, as African-American children are overrepresented in the referral population for PCIT. For example, African-American children are more likely than those of other ethnic groups to enter the child welfare system. Forty-five percent of children in public foster care and more than half of children waiting to be adopted are African-American (DHHS, 2001). In addition, African-American children are overrepresented in educational settings as students identified with severe emotional and behavioral disturbance and as recipients of exclusionary and punitive consequences in school settings (Rhodes, Ochoa, & Ortiz, 2005; Skiba, Michael, Carroll Nardo, & Peterson, 2002; DHHS, 1999). Finally, African-American children are overrepresented among the poor. Thirty seven percent of African-American children are poor, compared to 20% of all children living in the United States (DHHS, 2001).

There is a dearth of research literature describing cultural issues to be considered when working with African-American children with disruptive behavior problems. McNeil, Capage, and Bennett (2002) provide an overview of the issues that mental health professionals should consider when working with this population, and we summarize the article in this section. Studies specifically evaluating PCIT with African-Americans are scarce. We found only one article (Capage, Bennett, & McNeil, 2001) that specifically evaluated differential outcome of PCIT with African-American and Caucasian families.

African-American Children with Disruptive Behavior Disorders. McNeil et al. (2002) identified factors to consider when working with African-American children with disruptive behavior disorders. These include the impact of poverty, increased levels of parenting stress, and family constellation (McNeil et al., 2002). An increased risk of disruptive behavior disorders has been identified for children living at or below the poverty level. In their review of mental health literature, McNeil et al. (2002) noted that African-American families living in poverty are more likely than their Caucasian counterparts to drop out of treatment and to experience stress. The increased incidence of single-parent, mother-headed homes in the lives of African-American children may also function as a risk factor in the development of disruptive behavior problems. Limited research has been performed to evaluate the potential impact that cultural differences in parenting and child development may have in African-American children presenting with behavior problems. The authors recommend an idiographic approach to treatment, where traditional behavioral parent training programs are adapted to meet the family's needs and values (McNeil et al., 2002).

Empirical evaluation of PCIT outcomes with African-American versus Caucasian children is limited to date. One study examined archival data of African-American and Caucasian families referred for treatment of disruptive behavior problems who received PCIT (Capage et al., 2001). Participants were matched based on gender, age, referral location, and income so that these variables would not confound the results of the study. No significant group differences were found

at pre-treatment between African-American and Caucasian children with regard to diagnosis, family constellation, parenting stress, and severity of behavior problems. In addition, there were no differences between the groups with regard to treatment variables, including the number of treatment sessions received or the timing of drop-out from treatment. The authors concluded that matching the groups based on various characteristics (including income) may have eliminated group differences at pre- and post-treatment (Capage et al., 2001).

Examining Social Validity

Assessing the social validity of PCIT with ethnic minority families is one way of determining the degree to which the intervention is perceived as culturally appropriate. This framework allows clinicians to assess the social importance of treatment goals, procedures used, and satisfaction with the process and outcomes of the intervention (Wolf, 1978; Foster & Mash, 1999). Using this framework in clinical practice allows for continuous feedback from the parent or family about the importance of the treatment goals, the acceptability of the procedures being used, and the level of satisfaction with the process and outcome of therapy.

Assessing for the social importance and acceptability of treatment goals allows the clinician to gauge the family's agreement with the goals. Given that PCIT is theoretically grounded, there are assumptions about what contributes to the development and maintenance of child behavior problems (e.g., coercive parent-child interactions). Clinicians should discuss this with ethnic minority families. PCIT will be less effective if parents hold a strong belief that they do not have an influence on their child's behavior. Parents can be asked how they view their child's behavior problems and what they believe is causing them. Once there is a level of agreement about the influence of parent-child interactions, the clinician should work with the family to develop treatment goals. Including the parent and other family members in this process can help the clinician identify treatment goals that the family finds acceptable and important to address. For example, clinicians should assess parental perspectives on which settings and contexts are most problematic. For some families, it may matter more to them that children not misbehave in front of other family members such as godparents and grandparents than that they behave better at home setting.

Once therapists and families agree on the PCIT treatment goals, the acceptability of treatment procedures should be assessed. This is probably the most important social validity component and is one that clinicians should carefully monitor. Assessing for the acceptability of the CDI and PDI procedures after they are introduced but before they are implemented is a good way for clinicians to gauge the family's initial level of treatment acceptance. Clinicians should not assume that *all* parents will find *all* treatment procedures (e.g., using differential attention, time-out) equally acceptable. As an example, recent work by Borrego, Ibanez, Spendlove, and Pemberton (2007) found that a Mexican-American parent sample did not find

differential attention to be as acceptable as other child management techniques such as response cost (i.e., restriction of privileges). Data by Matos et al. (2006) suggest that the Puerto Rican sample found *ignoring* difficult to implement effectively. Having this information can help clinicians determine how much time should be spent explaining the procedure and rationale. Similarly, McCabe et al. (2005) and Matos et al. have incorporated orientation components into PCIT. Orienting families to PCIT, the treatment procedures used, and rationales for their use may assist in increasing acceptability. Assessing for treatment acceptability can also be done on a session-by-session basis when new techniques are introduced and attempted for the first time.

Finally, assessing for the importance of the outcomes achieved in PCIT can provide valuable information for clinicians. The most common method for assessment of this third social validity component is through consumer satisfaction. Overall satisfaction with the process and outcome of PCIT can be assessed. The most common measure for assessing consumer satisfaction following PCIT is the Therapy Attitude Inventory (Eyberg, 1974). This measure is available at www.pcit.org. The Therapy Attitude Inventory (TAI) measures parental satisfaction with aspects of PCIT such as discipline techniques, child behavioral improvements, confidence in parenting, and improvements in the parent-child relationship. In addition to using the TAI, the clinician can assess for the degree to which other key family members (e.g., spouse, grandparents) were supportive of the parent implementing a new procedure at home. There is some promising data regarding satisfaction with PCIT as the Matos et al. (2006) outcome study showed that Puerto Rican families were generally satisfied with the intervention.

In summary, assessing for the social validity of PCIT with ethnic minority families can be a very useful tool for clinicians. Valuable information can be gained from families about how they view the child's behavior problems, the importance of the established treatment goals, acceptability of treatment procedures, and the degree to which parents were satisfied with PCIT services. Monitoring these components can lead to culturally relevant PCIT services.

Conclusion and Final Recommendations for Therapists

In conclusion, it is promising that there is a growing literature focusing on PCIT with specific ethnic minority groups. In the future, we hope that greater research and clinical attention is given to this topic. It would be helpful to have more empirical studies evaluating the degree of adaptation needed in order to effectively implement PCIT with various ethnic minority groups. It is still not known how the degree of adaptation of the PCIT protocol may improve treatment engagement, retention, outcomes, and satisfaction with therapy. To date, there are few studies that have investigated whether adaptations to empirically supported treatments, such as PCIT, benefit outcome and satisfaction with intervention, compared to standard empirically supported protocols (Butler & Eyberg, 2006). As we know, clinical work

always involves tailoring to the individual needs of clients, and this is certainly true for ethnic minority families and children receiving PCIT as an intervention.

Readers of this chapter who may be interested in expanding their knowledge of the issues discussed here are encouraged to begin by reviewing the references cited in the text. A wide range of resources are available that discuss clinical work and therapy with ethnic minority populations. One issue that we did not address in this chapter but is necessary to develop cultural competence is for therapists to actively seek more information about the diverse populations with whom they work. A significant ingredient to effective work with minority populations involves mental health providers being informed about the groups they are serving. Therapists also need to be open to critically examining their own biases and stereotypes of minority populations.

Mental health trainees interested in developing the skills to work with ethnic minority populations may want to pursue a structured approach, such as taking a graduate course on the topic (e.g., multicultural counseling). Workshops, symposia, and panel discussions on diversity issues are often components of conference programs. Mental health professionals can seek out these programs to actively engage in developing their cultural competence.

References

Ballew-Dunlap, M. S. (2005). *The role of cultural and social variables in parenting stress and acceptability of parent training with Native American parents*. Unpublished doctoral dissertation, Oklahoma State University, Stillwater, OK.

Bigfoot, D. S., & Braden, J. (2007, Winter). Adapting evidence-based treatments for use with American Indian and Native Alaskan children and youth. *Focal Point: Research, Policy, & Practice in Children's Mental Health*, *21*(1), 19–22.

Borrego, J., Jr., Anhalt, K., Terao, S. Y., Vargas, E. C., & Urquiza, A. J. (2006). Parent-child interaction therapy with a Spanish-speaking family. *Cognitive and Behavioral Practice*, *13*, 121–133.

Borrego, J., Jr., Ibanez, E. S., Spendlove, S. J., & Pemberton, J. R. (2007). Treatment acceptability among Mexican American parents. *Behavior Therapy*, *38*, 218–227.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatment of conduct disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology*, *27*, 180–189.

Butler, A. M., & Eyberg, S. M. (2006). Parent-child interaction therapy and ethnic minority children. *Vulnerable Children and Youth Studies*, *1*(3), 246–255.

Capage, L. C., Bennett, G. M., & McNeil, C. B. (2001). A comparison between African American and Caucasian children referred for treatment of disruptive behavior disorders. *Child & Family Behavior Therapy*, *23*(1), 1–14.

Center for Child Abuse and Neglect (2008a). *Native American programs*. Retrieved August 11, 2008, from http://devbehavpeds.ouhsc.edu/native.asp

Center for Child Abuse and Neglect (2008b). *Indian country child trauma center*. Retrieved August 11, 2008, from http://www.icctc.org/treatment.htm

Coard, S. I., Wallace, S. A., Stevenson, H. C., Jr., & Brotman, L. M. (2004). Toward culturally relevant preventive interventions: The consideration of racial socialization in parent training with African American families. *Journal of Child and Family Studies*, *13*(3), 277–293.

Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General – Executive Summary*. Rockville, MD: US Department of Health and Human Services,

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Eyberg, S. M. (1974). *Therapy attitude inventory*. Available at www.pcit.org

Forehand, R., & Kotchick, B. A. (1996). Cultural diversity: A wake-up call for parent training. *Behavior Therapy*, *27*, 187–206.

Foster, S. L., & Mash, E. J. (1999). Assessing social validity in clinical treatment research: Issues and procedures. *Journal of Consulting & Clinical Psychology*, *67*(3), 308–319.

Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-child interaction therapy*. New York: Springer.

Masse, J. J. (2006). *Comparison of parenting practices, acculturation, and the acceptability of behavioral parent training programs between a Native American and a non-Native American sample*. Unpublished Master's thesis, West Virginia University, Morgantown, WV.

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

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

McNeil, C. B., Capage, L. C., & Bennett, G. M. (2002). Cultural issues in the treatment of young African American children diagnosed with disruptive behavior disorders. *Journal of Pediatric Psychology*, *27*(4), 339–350.

Rhodes, R. L., Ochoa, S. H., & Ortiz, S. O. (2005). *Assessing culturally and linguistically diverse students: A practical guide*. New York: Guilford Press.

Santrock, J. W. (2005). *Children* (8th ed.). Boston, MA: McGraw-Hill.

Skiba, R., Michael, R. S., Carroll Nardo, A., & Peterson, R. L. (2002). The color of discipline: Sources of racial and gender disproportionality in school punishment. *The Urban Review*, *34*, 317–342.

US Census Bureau. (2001). *Census 2000 redistricting summary file*. Washington, DC: US Census Bureau.

US Census Bureau. (2004). *American community survey*. Washington, DC: US Census Bureau.

Wolf, M. (1978). Social validity: The case for subjective measurement. *Journal of Applied Behavior Analysis*, *11*, 203–214.

Chapter 20
Staff-Child Interaction Therapy

Gus Diamond

Although PCIT traditionally focuses on coaching parent-child interactions in the clinic, this chapter will discuss the adaptation and application of PCIT principles to child care settings such as shelters, group homes, after-school programs, and day treatment facilities. In such settings, the caregivers are not parents, but rather paid staff members. Thus the interactive training described in this chapter will be referred to as Staff-Child Interaction Therapy, or SCIT.

This writer has extensive experience working with children and training staff in settings spanning the continuum of child care, from inpatient hospitalization to temporary shelter placements. These diverse settings share a commonality of working with children challenged by many different characteristics, including poor emotional regulation, cognitive and executive functioning deficits, and language and social skill impairments. SCIT is a training model that effectively bridges the gap between knowledge and application, which is where traditional didactic teaching methods fall short. For example, one cannot teach the skills of tennis or golf using only handouts, overheads, and chalkboards. Similarly, it is difficult for staff to become skillful in managing behavior, teaching positive social skills, and developing healthy relationships without interaction training. Understanding behavior management and being able to apply the techniques are simply not the same.

The foundation of SCIT is based on the PCIT model, but is expanded not only to meet the needs of an individual child, but also to teach training strategies for group behavior management. The SCIT model was first piloted in 1999 in the new staff training program at the Child Crisis Center in Mesa, Arizona. The Child Crisis Center at that time was a non-profit agency providing 36 shelter beds for children between birth and 12 years. The Center also housed an 18-bed group home for children between the ages of 4 and 12. The staff included 45 full-time child care workers who provided the daily direct care, and an additional 4 full-time master-level therapists who provided individual and group counseling.

In 1999, the Child Crisis Center hired Toni L. Hembree-Kigin, Ph.D. to consult with the clinical program and to assist in the special needs of some of the more challenging clients. As Dr. Hembree-Kigin assessed the needs of the children and

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the challenges of the clinical program, the application of the PCIT model to a setting outside of the family was conceived.

Before any new training model can be implemented, the administration and directors must support the transition. Changing the norms of any established cultural milieu can be a daunting task without the full support of its leadership. PCIT was first presented to the Clinical Director of the Child Crisis Center, and then to the Executive Director, before receiving the green light. Directors and staff raised valid questions about the new regimen. While strong empirical evidence supported the benefits of PCIT, would these benefits transfer to multiple staff and groups of children? Would new staff readily learn and implement the techniques? Would the model be cost-effective? Most facilities, and the Child Crisis Center was no exception, deal with chronic funding shortages. Scarce funds must be wisely spent. An unfortunate byproduct of limited resources is a revolving door of staff turnover. Training is valuable and necessary, but is also expensive.

The Center's administration decided that SCIT would be piloted on the group home unit targeting the majority of it residents that were between the ages of 4 and 8. The group home staff was considered the veteran staff and all had additional training (50 training hours the first year and 24 thereafter) to work with the more challenging children. Most of these children were on psychotropic medication and had disrupted out of previous placements or were not considered stable enough to be transitioned into a family setting.

Initiation of SCIT began by assessing the needs of the clients as well as the staff. A baseline was established using a modified DPICS coding sheet (see Table 20.1) to allow the coding of 4 staff and 12 children. The setting chosen was the children's enclosed outdoor play area during a one-hour free play time period. Children were allowed to ride bikes, skate, or play with a variety of sport balls. Staff was encouraged to both play with the children as well as provide supervision. They were also informed that Dr. Hembree-Kigin would be outside observing. During this baseline period there were numerous time-outs, including one child's removal from the group for escalating aggression. Although the staff reported the play period as fairly typical, it was apparent after reviewing the coding sheet that there was significant room for improvement. The most surprising of these statistics was that there were zero labeled (or unlabeled) praises during this 1 h period.

This writer and one other master-level therapist were first selected to be the identified trainers of the group home staff. Since PCIT is the basis for SCIT, training began by reading Parent-Child Interaction Therapy (Hembree-Kigin & McNeil, 1995). A didactic training session by Dr. Hembree-Kigin followed, which provided an overview of PCIT. Next, video demonstrations of actual PCIT sessions were shown. Dr. Hembree-Kigin then coached the selected trainers, using a child volunteer until competency was demonstrated in the two treatment phases of Child-Directed Interaction and Staff-Directed interaction. Finally, two additional didactic sessions on coaching were followed by several booster sessions. The booster sessions included feedback and coding assistance as the trainers then coached the group home staff. DPICS sheets completed by the two trainers were additionally reviewed for coding accuracy.

Table 20.1 SCIT coding sheet

Milieu coding

Unit_____ Observer _____
Date_____ # Adults_____
Children _____ Children's age range _____
Start time_____ End Time _____

Observed behaviors	Staff #1 _____	Staff #2_____	Staff#3_____	Staff #4_____
Labeled praise				
Behavioral description				
Reflection				
Negative talk				
Questions				
Direct command Followed by. . .				
No opportunity				
Comply w/praise				
Comply no praise				
Noncomply w/ Time-out				
Noncomply w/o Time-out				
Indirect command followed by. . .				
No opportunity				
Comply w/praise				
Comply no praise				
Noncomply w/ Time-Out				
Noncomply w/o Time-out				
Child disruptive behavior followed by. . .				
Ignored				
Responded to				

Table 20.2 SCIT training checklist

I. Child-Directed Interaction
o Baseline
o Didactic video "SCIT-CDI"
o Didactic session with coach
"Child-Directed Interaction" & "Selective ignoring" handouts discussed & "SCIT Demonstration video" viewed (10 min)
Coding/Coaching sessions
o Competency reached with one child
o Competency reached with two children
II. Staff-Directed Interaction
o Didactic video – "SCIT-SDI"
o Didactic session with coach
"Giving good directions" & "Time-out protocol" handouts discussed
Coding/Coaching sessions
o Competency reached with giving directions
o Role-play time-out sequence (if no opportunity presented in session)
o Coaching session on the milieu

The next phase of implementation was to devise a training outline (see Table 20.2). The goal of this outline was to provide a training package that was both effective and cost-efficient. This outline is the 2008 version that has been successfully used since 1999 at the Child Crisis Center in Mesa, Arizona.

Baseline

All new staff members are required to begin SCIT within 30 days of their start date. Additional SCIT training is scheduled on a weekly basis until training is complete. Consistent weekly training proved to be the fastest and most effective way to train staff. During the first 30 days, new staff receives a baseline coding using the same criteria and DPICS coding sheet as used in PCIT. The clinical playroom is set up with a small table and chairs. All toys are put away with exception of three construction-oriented toys (e.g., Legos, Mr. Potato Head, and Play-Doh). The session starts by showing the staff member the playroom, one-way mirror, and communication device (a Motorola two-way radio with earpiece).

Before beginning, the three coding situations are reviewed: child-led play, staff-led play, and clean-up. Next, a child from the unit is chosen. This writer finds it beneficial to pick a child who is considered "easy to manage" for the first session. The staff member explains to the child that his caregivers are practicing how to better play with children, and he will get to play with some fun toys. Children are typically eager for the individual attention, especially the ones that have already experienced SCIT. The child is introduced to the staff member if he or she does not already know the caregiver, and the child is taken to the playroom. The child is shown the earpiece that the caregiver will be wearing and is told that voices might be audible from the

earpiece. The trainer then codes the staff member from behind the one-way mirror during the staff–child play interaction.

Over the years of training staff, the vast majority have been enthusiastic about improving their ability to work with children. This was especially true when new trainees had worked with veteran staff already trained in SCIT methods. However, some new staff exhibit extreme anxiety about being observed and coded. Often, the best way to "sugar the pill" is to explain to the new trainee that the main purpose of the baseline and coding sessions is to evaluate the *coach's* ability to teach SCIT techniques. This removes much of the performance anxiety from the trainee and directs it toward the coach.

SCIT Video on Child-Directed Play

Video presentation of SCIT was found to be the most effective use of time and money. The video allowed for great scheduling flexibility. Staff members were permitted to take the video home to watch, so as not to interfere with shift responsibilities. The video provides a brief history of the development of PCIT, the core concepts of the model, and the overall goals of SCIT. It then explains the Do (Pride) and Avoid skills of child-directed play. Staff members are encouraged to document any questions, concerns, or confusion they had while watching the video for later review.

Didactic Child-Directed Interaction Session with Trainer

This session reviews the handouts on the Do and Avoid skills of CDI and discusses the techniques of strategic attention and selective ignoring. It is also the time any questions or concerns that the staff may have from the video are reviewed. The DPICS coding sheets are reviewed for competency with emphasis placed on the coach's ability to teach the techniques. The session ends with discussion of homework. Staff members are instructed to pick one or two children each shift during a quiet time to practice their skills using appropriate toys for 5-min play periods.

Coding and Coaching of Child-Directed Interaction

The child-directed play follows the same guidelines as outlined in PCIT. The first modification to address group dynamics is added after competency is reached with one child. This begins by introducing a second child into the child-directed sessions. Coaching focuses on distributing the staff member's attention evenly between two children and addressing disruptive behavior. For example, if one child was to leave his chair, rather than focus on the inappropriate behavior, the staff would focus attention on the other child's appropriate behavior. "I really like the way you are sitting

in your chair and following directions." This is done without looking at or attending to the disruptive child. When the disruptive child returns, the staff member gives labeled praise: "Thank you for sitting in your chair; I really like it when you follow directions." The majority of staff only required two additional sessions and reported two children to be generally easier than one child. Staff consistently reported that focusing attention on the appropriately behaving child was more effective in getting the disruptive child to appropriately adjust his behavior, than when interacting with a single child alone.

SCIT Video on Staff-Directed Interaction

A Staff-Directed Interaction video was created that includes topics such as giving effective commands, using a time-out warning statement, and implementing time-out. Staff members are again allowed to take the video home.

Didactic Staff-Directed Interaction Session with Trainer

Questions and concerns about the Staff-Directed Interaction video are discussed. Handouts on giving good directions and the time-out protocol are reviewed. This session ends with a role-play of time-out to give the staff a chance to apply newly learned skills.

Coding and Coaching of Staff-Directed Interaction

The staff-directed stage remains the same as outlined in PCIT with one child. This writer would pick a child known for being "challenging" in order to give staff the opportunity to be coached through a time-out with a non-compliant child. This happens only rarely. Even the most difficult children are so responsive to the warm-up period of child-directed play that they rarely need a chair warning cue. Since children are so compliant, role-play of a time-out is commonly employed (i.e., coach pretending to be a non-compliant child) to give the trainee the opportunity to demonstrate an effective time-out.

Coaching Sessions on the Milieu (Two-Way Radio with Earpiece for Staff)

Coaching sessions on the group home unit proved to be a necessary element of SCIT. This was done to address what may be labeled the "fireman syndrome." What typically happens in settings working with children is that staff members spend little time addressing the group or individuals when there are no disruptive behaviors, like a fireman hanging out in the station waiting for a fire. This unfortunately decreases

the reinforcement of pro-social behavior (e.g., inside voice, playing cooperatively, cleaning up, etc). When there is disruptive behavior (e.g., talking loud, arguing, breaking an established rule), staff come out to douse the undesirable behavior. Although the staff may feel the intervention was successful because the undesirable behavior temporarily stopped, the attention given usually serves only to reinforce the behavior increasing the likelihood of seeing that behavior in the future. SCIT coaching on the unit focuses on continuously distributing attention across the group for pro-social behaviors or particular behavior(s) that are being targeted (e.g., polite manners, playing quietly). Staff members are coached to circulate throughout the room and to use their PRIDE skills (labeled praise, reflections, imitation, behavior descriptions, enthusiasm). They are also taught how to ignore any benign disruptive behaviors and to look for a child or children who are displaying the appropriate behavior and to praise them. For example, Billy begins talking in a loud voice during a group activity. The staff member would look for a child near Billy who is using an inside voice and say, "I really like the way you are talking quietly." This could be repeated with other children until Billy lowers his voice. The staff member would then be coached to give Billy a labeled praise like, "It's so nice when you talk quietly so that all of the kids can hear the directions."

This technique of strategic praise can be further reinforced or emphasized with other tangible rewards (e.g., hand stamps, stickers, tokens) awarded demonstratively to a child or group of children behaving appropriately. A public announcement serves to alert children about the possibility of being rewarded. For example, while putting supplies away after an art activity, Cindy and Jesse begin talking and are not contributing to the clean-up. The staff member might say, "I'm going to give stickers to everyone who is helping to clean up." The caregiver would then begin by giving stickers and praise to the children who are cleaning up closest to Cindy and Jesse. Once Cindy and Jesse start contributing the staff member could say "Thank you Cindy and Jesse for cleaning up," and award them stickers as well. If the behavior cannot be ignored or is dangerous (e.g. teasing a sensitive child, hitting), Staff-Directed Interaction skills would be immediately employed.

Working with groups of children is often like a juggling act. When one ball gets off course, immediate adjustment must be made so as not to drop the other balls. Often, staff members may not know how to meet the individual needs of a child while still being aware of the group dynamics. Leaving a group of children unattended to focus on one child for too long can escalate quickly into a much larger problem. SCIT coaching on the unit teaches staff to circulate the room using their PRIDE skills while keeping all children under their supervision. They must also be mindful of the individual needs of a child. When a brief amount of attention is simply not enough, staff must ask the following questions:

- Is this a good time to give more attention? More individual time can be given when the group is calm or engaged in an activity (e.g., movie, board game).
- Can the other staff members manage for a period without me? This should always be communicated to the other staff (e.g., "Would this be a good time for me to talk to Johnny about what is bothering him?").

- Do I need to briefly acknowledge the child's need or make an appointment to help or talk later when things are more under control? (e.g., "When dinner is over and we are having quiet play time, I will help you work on your puzzle.").

New staff members in particular have difficulty distributing their attention, but coaching on the unit has been very essential in teaching them how to effectively attend to the whole group.

Post-intervention Findings

After the group home staff had all completed SCIT training, staff members were again coded under the same conditions as described in the baseline period. The results were astonishingly different. The playground area was filled with children and staff laughing, numerous praises, zero time-outs, and very little redirections required. An interview of staff following SCIT training provided further convincing results. Staff reported less stress and higher job satisfaction, improved relations with the children, and a greater confidence to work with difficult children. Word of the pilot program spread to the shelter unit and other staff began to request SCIT training. Administration reviewed these results and decided to make this a standard requirement for the staff of both the group home and shelter units at the Center. Since the inception of SCIT in 1999, it has become a standard part of the 50 h of training required for all new employees. Each staff member is additionally re-baselined every 2 years to ensure continued mastery of child- and staff-directed play. Booster sessions are offered to those whose skill level has dropped. When monthly unit coaching is provided to the staff, booster sessions are rarely required, as the vast majority of staff is able to maintain their level of competency even years after their initial training.

Conclusion

PCIT can be effectively modified and adapted to meet the needs of young children and the staff that care for them. These adaptations, or SCIT, provide a framework for staff to receive actual clinical training and provide quality service to facilities that work with children between the ages of 3 and 8. This hands-on approach of teaching greatly outperforms models of training that rely solely on didactic training. Whether working in a group home or a day treatment facility, the benefits of SCIT make it an ideal training model.

References

Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent–child interaction therapy*. New York: Plenum Publishers.

Chapter 21
Teacher–Child Interaction Therapy for Preschool Classrooms

Jennifer Tiano

Research Underpinnings

Research has demonstrated that behavioral improvements in children following completion of PCIT have extended to the classroom setting (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991). And, recent studies have been investigating whether training teachers directly in the use of PCIT skills results in even greater gains at school. For example, McIntosh, Rizza, and Bliss (2000) examined the use of a modified PCIT called Teacher–Child Interaction Therapy (TCIT) in a single preschool classroom with a 2-year-old child. These authors found that teacher's use of positive PCIT skills (i.e., labeled praises, reflections, behavioral descriptions) increased, while number of commands decreased. In addition, the child's compliance increased and disruptive behavior decreased (McIntosh et al., 2000). Filcheck, McNeil, Greco, and Bernard (2004) found similar results in a preschool classroom of 17 children. Again, teacher use of labeled praises improved and child inappropriate behavior decreased following teacher training in PCIT skills. Similarly, Head Start teachers receiving PCIT training utilized more labeled praises in their classrooms than teachers receiving no training (Tiano & McNeil, 2006). Finally, Karen Budd and her colleagues at DePaul University have obtained similar results, suggesting that TCIT results in improvements in teacher–child interactions (e.g., Lyon et al., 2009). As a result of the promising research on TCIT, clinicians have increasingly been targeting teachers with modified versions of PCIT.

Establishing Rapport with the Teacher

When conducting TCIT, it is important to have a strong working relationship with the preschool teacher. To facilitate a team approach, we find it helpful to first meet with the teachers about their goals, difficulties, techniques that they have and have not tried, as well as the philosophy of the school or agency. Making teachers active

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participants in the planning of the training will increase both the likelihood of an alliance between the clinician and teachers and the responsiveness of the teachers to trying new strategies in their classrooms.

Format of Training

Once an alliance is formed, teacher training can begin. The didactic training sessions can be held as 1-day group workshops, several shorter group workshops (e.g., three 2-h workshops), or individual teacher training. We often conduct one workshop for CDI and a separate one for PDI skills training (in classrooms this is TDI or Teacher-Directed Interaction). The course of training typically involves a CDI workshop, CDI coaching to mastery, a TDI workshop, and TDI coaching to mastery. TCIT includes didactic lessons, group activities, role-playing, coding, coaching, and brainstorming about obstacles to implementing these skills. Most techniques used in PCIT are the same when used in the classroom, but some may require modifications to comply with school policies or address logistical concerns. Teachers should also be instructed in the behavioral principles behind PCIT skills to increase their understanding of how and why these skills are effective. The clinician can help facilitate teacher time off, classroom coverage, or compensation through the school/agency to motivate teachers.

Coaching TCIT

Teachers are trained in and practice skills first in the didactic workshop and then in their own classrooms. It is helpful for clinicians to model techniques for the teacher in his/her own classroom before the teacher uses the skills. Coaching the teacher in his/her own classroom allows for immediate feedback from the clinician in a comfortable environment for the teacher. We find it helpful to use progressive coaching to assist teachers to reach mastery criteria. More specifically, we begin coaching by pulling the teacher aside with first one student. The clinician can sit beside the teacher and coach the one-on-one interaction with the child. Once the teacher achieves mastery criteria with that student (i.e., 10 labeled praises, 10 reflections, 10 behavioral descriptions and no more than 3 total commands, criticisms, and questions), the teacher is then coached with two students to mastery level, then three students, and finally with the entire classroom.

Child-Directed Interaction in TCIT

The goals of CDI in TCIT differ somewhat from those of the CDI phase of PCIT. While a goal of CDI in PCIT is to improve the attachment between a parent and child, TCIT is more focused on relationship improvement and using contingent attention to prevent behavior problems. Teachers are coached in all of the

PRIDE skills and learn the importance of providing positive and stimulating attention for appropriate behavior. The rationales for using Praise, Reflections, Imitation, Description, and Enthusiasm are basically the same in the classroom as they are in the home. When teachers use these skills at a high rate, it sets a warm, nurturing tone in the classroom. Because teachers are motivated to use the PRIDE skills to manage disruptive behavior in the classroom, much attention in the CDI phase is focused on the use of labeled praise which typically produces an immediate and noticeable change in behavior. Other important skills for teachers in CDI are ignoring and reducing rapid-fire questions.

Labeled Praise. The TCIT therapist coaches the teacher to catch students exhibiting pro-social behaviors and provide immediate labeled praise. For example, the teacher can walk around the classroom as the students are at different stations and provide labeled praise to specific students for sharing, using inside voices, following rules, etc. (e.g., "Johnny, I love the way you are sharing your crayons with your friends."). Teachers should develop the habit of constantly scanning their classroom for behaviors to praise. We find that teachers often overestimate their use of labeled praise in the classroom. One technique to assure that the teacher is using enough labeled praise is to ask the teacher to place 10 marbles or pennies in a pocket and transfer one to another pocket each time a labeled praise is given. Our goal is for the teacher to transfer all of the marbles or pennies to the other pocket in less than an hour.

When helping teachers to increase their use of labeled praise in their classrooms, we focus on the skill of "praising the opposite." This involves having teachers do an exercise in which they list a number of problems common to their classrooms. Then, we ask teachers to name the opposite of each of the behaviors. For example, one teacher indicated that she had a problem with the children frequently banging on the fish tank. When asked about the opposite of that behavior, she responded like many teachers with a negatively stated opposite (i.e., "not banging on the fish tank"). We devote training time to helping teachers quickly define the opposite positive behavior of the problematic behavior so that a completely positive labeled praise can be developed. Rather than saying, "Thank you for not banging on the fish tank," the teacher can be coached to say "I like the way you are watching the fish with your hands in your pockets. You are being a good friend to the fish." Teachers are given a great deal of practice identifying the positive opposites of the disruptive behaviors on their lists and stating associated labeled praises.

The Ignoring Signal. Teachers are coached to use selective ignoring to remove attention for inappropriate behaviors and provide enthusiastic labeled praise to children following the rules. More specifically, if the required behavior is to sit with legs crossed during circle time, the child or children not following the rule (e.g., sitting on his/her knees, rolling around on his/her back) will be ignored, and each child sitting with his/her legs crossed will receive a labeled praise (e.g., "Suzie, you are doing such a great job of sitting with your legs crossed. Tommy is a good boy for remembering the rule."). The child not following the rule will receive the "ignoring signal." The ignoring signal is discussed with the children ahead of time so they all understand the strategy. In addition to the teacher, the children are instructed to

ignore the misbehavior of any classmate who is being shown the ignoring signal. The teacher places her thumb and fingers together (like closing a hand puppet's mouth) and directs this signal toward the student not following the rules. By using this signal, the teacher and children are removing attention from the misbehavior, and the other children in the classroom know that the teacher is addressing the behavior.

Reducing Rapid-Fire Questions. One issue that arises when training teachers in CDI skills is the elimination of questions. While it may be desirable to eliminate all questions during brief parent-child play sessions, it is not realistic or desirable to do so in a classroom. Questions are used often by teachers in instructional settings to ensure that students are understanding classroom material. They also are used to stimulate curiosity and creativity. Thus, the mastery criteria in TCIT are modified to allow for appropriate use of questions, while reducing the use of rapid-fire questions that do not allow children the opportunity to think and respond. During coaching with a single child, the clinician or therapist aids teachers in identifying the difference between rapid-fire and appropriately paced questions. Specifically, appropriately paced questions provide children with at least 5 s to formulate a response. The goal in one-on-one analog coaching is to reduce questions to less than three, heightening teachers' awareness of the common problem of overusing questions. Of course, teachers are encouraged to use appropriate questions in real-life teaching situations with the entire class.

TCIT Mastery Criteria

When coaching a teacher with a single child, the mastery criteria are the same as in PCIT. In other words, teachers must demonstrate 10 labeled praises, 10 reflections, and 10 behavioral descriptions in 5 min while also using fewer than three commands, criticisms, and questions. Teachers are coded prior to each coaching session to determine their progress toward mastery. This level of skill acquisition generally results in strong generalization to teacher communication in the whole-class environment. We do not expect teachers to keep up the high frequency of skill over an entire school day. Instead, we need to be realistic in recognizing that teachers have many goals to accomplish during the day that prevent the constant use of the PRIDE skills. Clearly, it is not desirable to try to read a book aloud to a class while providing 10 labeled praises, 10 behavioral descriptions, and 10 reflections in 5 min! By overtraining teachers in the one-on-one situation, their overall use of the skills should increase greatly and be used during appropriate times throughout the day.

Teacher-Directed Interaction Phase

The TDI training is conducted similar to that in the CDI phase. Teachers attend a workshop to learn behavior management strategies for use in the classroom (e.g., giving effective commands, time-out warning statement, time-out). During this

workshop, we find it helpful to brainstorm with the teachers and staff about the philosophy of the center. Any discrepancies with center policy should be resolved with the aid of the teachers before implementing programs in the classroom. For example, Head Start philosophy focuses on a positive approach to discipline that avoids "punishing" children for misbehavior. Thus, Head Start teachers may feel more comfortable with a more educationally based "Thinking Chair" than a more consequence-based "Time-out Chair." Children can sit in the "Thinking Chair" to think about their behavior and why it was wrong. We encourage teachers to discuss a child's misbehavior with him/her, but only after the child has completed time-out. Waiting until after the time-out prevents the child from receiving attention for, and thus reinforcing, inappropriate classroom behavior. When working with Head Start Centers and other preschools that have positive, child-centered policies it is important to reframe time-out as an opportunity to calm down and learn from misbehavior. In addition to the term "Thinking Chair" many of these centers are more comfortable with terminology such as "Solution Station," "Calm Down Chair," or "Cool Down Spot."

Teachers must decide how and where to implement the time-out procedure. Some teachers are more comfortable with the time-out chair facing the classroom as opposed to facing the wall. We work hard to respect the values and preferences of teachers and try to develop strategies for making TDI acceptable. If teachers do not agree with the skills, the program will fail. Allowing teachers to have a hands-on approach to developing classroom management by incorporating their philosophy and approach to behavior problems (while ensuring adherence to behavioral principles) will increase the utilization of these effective behavior modification strategies.

Additionally, it is helpful to brainstorm with teachers during the workshop about back-ups for children refusing to stay in time-out. We must individualize time-out back-ups for each preschool classroom. A common back-up to time-out in PCIT is the time-out room. However, this option often is not available or acceptable in most preschool settings. Instead, a back-up time-out area may be used with children who refuse to stay in time-out. These time-out areas may include the director's office, the hallway, another classroom, or the cafeteria. Thus, if children are unable to stay quietly in time-out in the classroom setting, they will be escorted to the back-up area. To enhance the acceptability of TDI, we often use time-out procedures only with identified children. For the children who need the extra assistance of time-out, a specific time-out plan can be put into writing, almost like an Individualized Education Plan (IEP). Then, it is clear to both administration and teachers that time-out will be used only as a last resort. In other words, time-out will only be used on an individual basis for particular children who are not responding well to the standard positive behavior supports already being used in the class, and time-out will only be used for extreme behaviors (e.g., defiance to a warning statement, physical aggression, running out of the area, profanity).

Once teachers and staff have completed the workshop and decided on the time-out sequence, we find it helpful to discuss and role-play the process with identified children. As with PCIT, the therapist coaches the teacher one-on-one with each child

in the class who is likely to need time-out (or who has a written time-out plan in place) During these one-on-one coaching sessions, the teacher explains the time-out rules to the child and has the child rehearse the time-out procedure in a role-play situation. Clinicians coach the teacher in describing the time-out rules including the time-out warning statement, and how to sit appropriately in the chair. The teacher is coded in TDI skills and must reach the same mastery criteria as parents do in PCIT. Mastery criteria for the TDI phase are giving at least 4 commands, 75% of which are direct commands with correct follow-through (i.e., labeled praise for compliance and warning for noncompliance). Once mastery criteria are reached with one child, the teacher is coached with all children who require the time-out plan.

When–Then Statements. Once teachers master TDI, it is important for them to develop additional discipline skills that can reduce their reliance on the time-out procedure. We find it helpful to train teachers in the use of "When–Then" statements. Teachers are taught that they have many items and activities at their disposal that they can use to encourage children to comply. For example, teachers can briefly delay privileges such as passing out crayons, turning the page in the story, or lining up for lunch until children display certain positive behaviors. The clinician and teacher together can develop a list of these privileges and use them to motivate children to follow rules. Some examples include, "When everyone is quiet, then we will go to lunch," "When everyone is sitting, then I will pass out the crayons," and "Sally, when you are quiet, then I will give you the paper." Once the child or children exhibit the requested behavior, the teacher should provide an immediate labeled praise (e.g., "You did such a great job of sitting at the table. Now I can pass out the crayons.").

Follow-Up Consultation

Upon completion of trainings, the clinician should be available for consultation. Clinicians may provide periodic booster sessions to review the skills and answer any questions or concerns the teachers may have. Clinicians also may find it helpful to periodically code trained teachers using the DPICS – III to ensure that their skills maintain at a high level. Some TCIT clinicians have developed PRIDE posters for teachers that serve as a visual reminder of the skills. Upon completion of the TCIT training, teachers can be encouraged to leave the PRIDE posters displayed on the walls to enhance maintenance of skill acquisition.

References

Filcheck, H. A., McNeil, C. B., Greco, L. A., & Bernard, R. S. (2004). Using a whole-class token economy and coaching of teacher skills in a preschool classroom to manage disruptive behavior. *Psychology in the Schools*, *41*, 351–361.

Lyon, A. R., Gershenson, R. A., Farahmand, F. K., Thaxter, P. J., Behling, S., & Budd, K. S. (2009). Effectiveness of teacher–child interaction training (TCIT) in a preschool setting. *Behavior Modification, 33*(6), 855–884.

McIntosh, D. E., Rizza, M. G., & Bliss, L. (2000). Implementing empirically supported interventions: Teacher–child interaction therapy. *Psychology in the Schools*, *37*, 453–462.

McNeil, C. B., Eyberg, S., Eisenstadt, T. H., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology*, *20*, 140–151.

Tiano, J. D., & McNeil, C. B. (2006). Training head start teachers in behavior management using parent-child interaction therapy: A preliminary investigation. *JEIBI*, *3*, 220–233.

Chapter 22
School Consultation

In our clinical experience, at least half of the children referred for PCIT would benefit from a school consultation sometime during the course of treatment. These children exhibit a range of problem behaviors in the classroom that include noncompliance with teacher directions, disrupting other students' learning, failing to complete tasks, aggression, separation problems, social skill deficits, and selective mutism. The consultation may provide needed assessment information, communication with the teacher, crisis management, education regarding special needs, and circumscribed classroom interventions. In contrast to Teacher–Child Interaction Therapy, which involves intensive teacher training and direct coaching of skills, school consultation is generally provided via one or two brief interactions with the teacher. It can take the form of a short face-to-face meeting, phone calls, emails, or exchange of written materials. Clinic-based therapists often avoid school consultation because it is time consuming, costly, logistically difficult, and takes place in an unfamiliar setting. Additionally, we often are not properly trained in classroom interventions, as most of our graduate training focuses on individual work with children. Yet it is critically important to conduct school consultation with many of our cases because classroom behavior problems can be the primary presenting concern or represent a significant area of dysfunction in the child's life.

As described in the research overview earlier in this book, the effects of PCIT have been found to generalize to the school setting. More specifically, children participating in PCIT became more compliant and less disruptive in the classrooms without school consultation (McNeil, Eyberg, Eisenstadt (Hembree-Kigin), Newcomb, & Funderburk, 1991; Funderburk et al., 1998). Therefore, it may then seem contradictory to say that school consultation is often a necessary component of PCIT. Yet, as researchers on these studies and PCIT clinicians, we know the limitations of these findings. First, generalization to the school does not occur instantaneously. We do not expect children's behavior to improve in the classroom until PDI is almost completed. Waiting for generalization to occur may not be feasible because the severity of the presenting complaint may reach crisis levels early in treatment. For example, we frequently have children in danger of losing their preschool placement because of aggressive behavior. This sends working parents into crisis mode and puts them in need of immediate intervention. Other crisis situations include school refusal, imminent placement in a self-contained classroom that

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might not truly be the child's least restrictive environment, and getting kicked off the bus. In these situations, we feel ethically obligated to provide school consultation to stabilize the child while we have time to complete the full course of treatment. Our second reason for providing direct classroom consultation is that the school generalization data are based on aggregate findings indicating that groups of children do better at school after PCIT. However, there were some children in these studies that displayed minimal or no improvements in the classroom. As clinicians, we are not able to predict which children will obtain sufficient school improvement without direct intervention. Therefore, in cases where school concerns are paramount, we offer school consultation. A third limitation of the school generalization findings is that children's behavior in the classroom did not improve in all areas. While noncompliance and disruptive behaviors were lessened, there were no improvements in the area of on-task behavior. In addition, there were a number of important classroom behaviors not assessed in the study. Thus, it is unknown whether other school concerns such as social skills deficits, separation anxiety, impulse control, and organizational skills improve with PCIT. To treat the full array of presenting problems, we often find it necessary to provide direct interventions in the classroom environment. See Erchul and Martens (2002) and Jordan (1994) for more comprehensive coverage of general techniques and conceptual issues in school consultation.

Assessment

Part of our standard PCIT intake involves obtaining teacher rating scales, such as the Child Behavior Checklist – Teacher Form (e.g., Achenbach, 1991; Achenbach & Rescorla, 2001) and the Sutter-Eyberg Student Behavior Inventory (e.g., Eyberg & Pincus, 1999), as well as parent-report of school history. We use this as a screening to determine which children will require additional classroom assessment and perhaps direct school interventions. Examples of cases that would typically require a school visit include children with a possible diagnosis of ADHD, children at risk for losing their current classroom placement, and children displaying more problems in the school than home setting. Procedurally, we always obtain a release to exchange information with school personnel at the time of the intake interview with the parents. The second logistical issue is the challenge of finding a time to talk with the teacher to set up classroom observations. Teachers have very narrow windows to make and receive phone calls, as do therapists. For this reason, we often ask parents to facilitate the first contact. We may give a list of available times to the parent and ask the parent to work out an observation period (ideally during the most problematic portion of the day). It is likely that the parent will need to sign a release with the school to allow the observation to occur. The teacher is asked to alert the school office regarding the scheduled visitation. When setting up an initial observation, we attend to issues of reactivity. Children often behave very differently when a familiar therapist comes to the classroom. To minimize reactivity, we try to schedule observations before treatment begins or ask a colleague, school psychologist, school counselor, or trainee to observe.

Observations may be conducted in either an informal or formal fashion. An informal observation can be as simple as writing a running description of the child's behavior, the ongoing activities, and the teacher's management approaches.

> Mr. Shredder's Kindergarten Classroom, 8:05am. Children are seated on the carpet for calendar. Xander – last child to sit at circle. Teacher asks for volunteer – X jumps up and down, calling out "me, me, me!" Teacher told him to sit down because she only chooses friends who are sitting criss-cross applesauce. X says, "oh, crap," and sticks out tongue. X licked his fingers and then waved them in face of boy next to him. Redirect from the teacher to keep hands in lap – played with his shoelaces – wandered away from the carpet. Received three redirects and one time out warning. Teacher style: calm, positive, unlabeled praises, labeled praises, X was the most inattentive in class – needed more redirection than others, looks impulsive.

Observations may also be conducted using a formal coding system. Several are available including the CBCL – Direct Observation Form (Achenbach & Rescorla, 2001) and the Revised Edition of the School Observation Coding Systems (RedSOCS; Jacobs et al., 2000). In these systems, the therapist codes certain target behaviors using an interval sampling procedure (e.g., every 10 s), comparing the identified child to a same-gender peer. Target behaviors might include on-task/off-task, compliance/non-compliance, and disruptive/not disruptive. It also is possible to code teacher behavior on an interval coding system (e.g., criticism, labeled praise). See Table 22.1 for definitions of the appropriate/inappropriate category of the RedSOCS and Fig. 22.1 for a sample coding sheet.

Establishing Rapport and Credibility with the Teacher

Many school consultants express frustration that they take well-conceived interventions to the classroom, but they are not followed through on by the teacher. Common pitfalls that serve as barriers to effective consultation include the consultant's failure to establish rapport, show respect for teacher's expertise, and present a plan with realistic goals and procedures. Consultation should be founded on a positive, respectful relationship with the teacher that is formed through showing empathy and promoting rapport. Consultants need to be tuned into the fact that they are outsiders in a school system that has established procedures and resources and often highly expert personnel. Accordingly, from the outset consultants should communicate respect for the training, knowledge, and experience of the teacher and the educational team. In many cases, we are brought in to assist with the development of interventions for children who have a long history of school-related problems. Many professionals may have been involved in their cases and a great deal of time and expertise may have been devoted to resolving their classroom issues. It would be naïve and insulting to come into the teacher meeting with an air of superiority, assuming that you can provide a quick fix for problems that other qualified professionals have failed to resolve. As consultants we need to realize that teachers may feel vulnerable and threatened by our presence in their classroom. They may

Table 22.1 Revised edition of the school observation coding system: sample definitions

Category: Inappropriate behavior

A. *Appropriate behavior*: The absence of inappropriate behavior for the entire 10-s interval. If unsure as to whether the behavior was appropriate or inappropriate, code Appropriate Behavior.
B. *Inappropriate behavior*: Behaviors are coded as Inappropriate Behaviors because they are annoying or disruptive to the target child, the teacher, or other children.

Definitions of Inappropriate Behaviors:

1. *Whining* – Coherent words uttered by the child in a slurring, nasal, high-pitched, voice.
2. *Crying* – Inarticulate utterances of distress (e.g., audible weeping) that may or may not be accompanied by tears.
3. *Yelling* – Loud screeching, screaming, shouting, or crying. The sound must be loud enough so that it is clearly above the intensity of normal indoor conversation. Not coded during outdoor recess observations.
4. *Destructiveness* – Behaviors during which the child damages or destroys an object or threatens to damage an object. Do not code destructiveness if it is appropriate within the context of play situation (e.g., ramming cars in a car crash).
5. *Aggressive behavior* – Examples include fighting, kicking, slapping, hitting, grabbing an object roughly from another person, or threatening to do any of the preceding.
6. *Negativism* – Verbal or non-verbal behavior expressing a negative attitude. Negativism may be scored when the child makes a neutral comment that is delivered in a tone of voice that conveys an attitude of "don't bother me." Negativism may be expressed in a derogatory, uncomplimentary, or angry manner. Also included are defeatist statements such as "I give up," contradictions of another person, and teasing or mocking behaviors or verbalizations. "Pouting" facial expressions are included in this category.
7. *Self-stimulation* – Repetitive physical movements (involving only the child's body and not other objects) that may be harmful and that interfere with a child's ability to attend or complete a task. Examples include head-banging, thumb-sucking, and masturbation.
8. *Demanding attention* – Includes inappropriate verbal or non-verbal requests for attention from the teacher or other students (e.g., "Call on me! Call on me! Call on me!). Examples include tugging on the teacher's sleeve, tapping a neighbor on the shoulder, waving arms in the air, and passing notes to another child.
9. *Disruptive behavior* – Any physically active or repetitive behavior that is or may become disruptive to others or interfere with the target child's ability to attend or complete a task. Examples include kicking a child's chair repeatedly, drumming on the table loudly, clowning, making funny noises, teasing, or spinning a pencil on the desk.
10. *Talking out of order* – Any talking, unless called on to speak, when the class has been instructed to be silent. This includes situations in which a "classroom rule" exists that silence is to be maintained (i.e., the teacher does not have to give the instruction explicitly – the expectation for silence is sufficient). Examples include whispering to a neighbor, answering a question directed to someone else, calling out to another child, and talking, singing, or humming to oneself.
11. *Being out of area* – Coded when the target child, without permission, leaves the area to which s/he is assigned. Examples include standing up when the rest of the class is seated, leaving the desk, approaching the teacher without permission, or playing with a toy that is not in the child's assigned work area. The behavior must be inappropriate for the context or classroom norms (e.g., in some classrooms children are allowed to walk to the teacher's desk to obtain help with an assignment).

For a complete description of this measure, see Jacobs et al. (2000).

Child #1: _____Teacher: _____Date: _____

Child #2: _____ Time: _____ Coder: _____

	Child #1 = Odd Numbers Child #2 = Even Numbers														
Interval	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Appropriate															
Inappropriate															
Teacher Praise															
T. Criticism															
Interval	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**2**	**27**	**28**	**29**	**30**
Appropriate															
Inappropriate															
Teacher Praise															
T. Criticism															

Response Key: L = Labeled Praise; U = Unlabled Praise

Inappropriate Behaviors: whining, crying, yelling, destructiveness, aggressive behavior, negativism, self-stimulation, demanding attention, disruptive behavior, talking out of order, being out of area

Fig. 22.1 Revised edition of the school observation coding system: sample coding sheet for appropriate/inappropriate and teacher behaviors

be concerned that the presence of a consultant could be perceived by others (e.g., parents, principal, teachers) as indicating a lack of competence. If we do not show adequate respect for the teacher's expertise and acknowledge the challenging nature of the situation, the teacher will continue to feel defensive and be less than enthusiastic about implementing our recommendations. A red flag often indicating that the teacher is feeling too defensive to accept our consultation is the use of the words, "yes, but. . ." When our ideas are met with resistance, we need to back track and spend more time showing empathy and establishing rapport. Our goal early on in the consultation is to establish a climate of mutual respect in which we join with the teacher as a teammate.

Most school consultation meetings are limited to 30–45 min while children are at specials or during planning periods. Therefore, we must be efficient in establishing rapport and providing recommendations. Below, we outline a model for classroom consultation that is designed to help alleviate common pitfalls that undermine program success (Rork & McNeil, 2008).

Begin with Chit-Chat and Rapport-Building. From the moment of introduction, it is important to present as warm, friendly, and non-judgmental. We like to start with small talk about positive impressions of the school, nice things we have heard about the teacher, how appreciative we are to have the chance to come to the school, and praise for the way the classroom is set up or decorated. These small compliments set the stage for a positively toned meeting in which we will be respectful of the teacher and school.

Ask the Teacher to Describe His/Her Concerns to You. We find it helpful to begin by encouraging the teacher to describe in detail the presenting problems. It is important for the teacher to have plenty of time to vent. They need to convey to us the full scope and intensity of their concerns before we ever offer ideas for intervention. If we jump into advice-giving before the teacher feels that we fully understand the complexity of the problem, we will encounter resistance. Allowing teachers to vent provides us with the opportunity to reflect their frustrations and empathize with their stress. We can then validate that the problem is indeed very challenging and set the stage for working as a team to provide the intervention.

Find Out What the Teacher Has Already Tried. We need to learn about prior interventions for several reasons. First, there may be a school-wide or grade-wide discipline policy in place that teachers are required to implement. By finding out the details of this required program, we may be able to offer a plan that interfaces well with the existing system. Similarly, the teacher may have developed her own plan that can be reworked to better meet the child's needs. Second, if previous programs were ineffective, we need to make sure that we provide intervention options that are different from the ones already attempted. Third and most important, finding out about the teacher's attempts to resolve the problem provides us with an excellent opportunity to provide labeled praise for the creativity and dedication of the teacher.

Briefly Describe Your Own Expertise. Once rapport has been built, we need to establish our credibility with the teacher. We do that in several ways. It helps to provide a brief description of our professional experience working with difficult children. We mention that we provide a specialty service in our clinic for children with problems similar or even more severe than in the current case. We reassure the teacher that we are working with the parents to address issues in the home that may be related or carrying over to the classroom setting. An overview of PCIT is provided emphasizing the coaching component. We instill expectations of generalization from the home to the school setting, but acknowledge that change may take some time. We emphasize to the teacher that implementing a classroom program that compliments the home program is something we commonly do to expedite behavior change. It is important for us to convey to teachers that we are experienced classroom consultants and that this is a routine part of the services we provide.

Indicate that Typical Behavior Management Could Not Be Expected to Work for This Child. We empathize with the teacher that this is a particularly challenging problem and is outside the range normally seen among typical students. We support the teacher's efforts by indicating that the programs already in place are theoretically sound and are clearly working for the majority of children in the classroom. However, teachers are told that the plan we develop will need to go to a new level and be highly specialized to suit the unique needs of the child in question.

Wait Until the Teacher Asks for Recommendations or Seems Interested in Your Input. Again, if we jump the gun and provide a solution before the teacher is receptive, it is unlikely that we will get buy-in from the teacher. Without buy-in, the teacher may be polite during the meeting, but will not act upon our suggestions after we leave. Usually, after we form a positive working alliance with the teacher, describe our expertise, and emphasize the importance of implementing a "cutting edge" behavior plan, teachers are eager for our input.

Present Practical Recommendations. When developing a behavior plan for an individual child, we must take into account the challenges of implementing it in a group setting. We frequently consult in classes where one teacher is meeting the needs of approximately 25 students. Teachers cannot devote excessive amounts of time to any one child. Teachers also have a very limited budget, often dipping into their own personal resources to fund special projects and rewards. It is not the teacher's responsibility to finance the reward systems we design. Therefore, we must develop practical programs that do not require excessive amounts of teacher time or expense. It is our goal to remove as many obstacles as possible to teacher implementation. We try to supply all of the materials necessary to put our plan into action. For example, we give teachers all of the home–school note forms that they might need as well as any stickers, charts, tokens, or classroom "bucks" called for in our plan.

Present Recommendations with Confidence. As consultants, we need to convey sound rationales for our programs and enthusiasm about their likelihood of success. Our confidence can motivate a skeptical or an overwhelmed teacher to try an innovative approach. If at this point in consultation our recommendations are still met with resistance, we may encourage teachers to consider this to be "an experiment." We ask teachers if they would be willing to try this new approach for just a short period of time (e.g., 1 week) and then assess with us its effectiveness. We acknowledge that the child may throw us an unexpected curve ball and we want to be ready to put our heads together with the teacher to problem-solve ways to adjust the plan accordingly.

Classroom Interventions

Teacher Education. In order to provide strong rationales for our classroom interventions, we generally need to provide some form of teacher education. Topics include medication issues (particularly with ADHD), nature of specific disorders (e.g., Aspergers, Selective Mutism), and behavioral constructs (e.g., antecedents, consequences). This education can be delivered in the form of discussion, handouts (e.g., Dr. Russell Barkley's fact sheet, *About ADHD),* videos, and references for

websites. Provision of these resources helps enhance motivation by strengthening their understanding of intervention rationales and bolstering our credibility.

Individualized Education Plan (IEP) and Section 504 Accommodation Meetings. Parents often invite us to attend their children's educational planning meetings. Many of the children we work with have IEPs in place to address both learning and behavioral needs. The IEP is reviewed annually with modifications made in goals and objectives. Similarly, many of our clients do not have special education needs but qualify for accommodations in their regular education setting. These accommodations are generally developed by a team during a school meeting with the parents. Parents respect our expertise and ask us to participate in these meetings to advocate for the best possible plan for their children. We use our consultation model to convey respect for the expertise of the educational professionals involved, listen fully to teacher concerns, and offer practical ideas for interventions. Public school personnel typically enter these meetings with a long checklist of accommodation options. Examples include preferential seating near the area of instruction, token economy for on-task behavior, redirection to task, extra time for tests, and homework modification. It is often our job to help teachers visualize how to put these general recommendations into action. For example, we often work with children who have social skills deficits such as those with social anxiety, Asperger's Disorder, and ADHD. These children may eat alone at lunchtime and wander the playground alone, or they may be so intrusive that they alienate peers at the lunch table and at recess. We want to teach these children that there are two rules for recess. First, because they sit at a desk much of the day, they should be expected to be physically active at recess. Second, because they are expected to stay on task and not socialize much in the classroom, they are expected to interact with other students at recess. In a 504 meeting, the team may agree on a general accommodation such as "social skills instruction." It is then our job to help develop a specific plan to encourage the client with social skills deficits to be active and interact during recess times. We may provide the playground supervisor with a schematic for the "Joining In" skill from Skillstreaming in Early Childhood (McGinnis & Goldstein, 2003), so the child may be coached to interact with peers during unstructured time.

Individual Child Interventions. Most often, we are asked by the parent to go into the classroom and develop a plan to help their child function successfully at school. Our interventions are typically designed to be applied only to our client, not implemented on a class-wide basis. However, all consultants from time to time will encounter teachers who are highly resistant to providing individual reward programs. The argument they make is that it is unfair to the rest of the class to reward the acting-out child for behavior that is simply expected of classmates. Some teachers believe that behavior problems are not a type of disability and that children should have control over their behavior. In the teacher's view, it is unfair to the classmates to divert teacher time and energy to help a child who should just choose to behave. To try to persuade teachers to be open to an individual reward program, we encourage them to consider how much of their instructional time already is being diverted to managing the behavior problems. We tell them that effective individual reward programs can end up saving time and resources as children require less redirection

and fewer negative consequences. We reframe disruptive behavior as currently being out of the child's control and resulting from a combination of biological factors and learning history. We encourage teachers to think of children with disruptive behavior as having special needs in much the same way as a child with a visual impairment. All teachers would agree that it is appropriate to make accommodations for children with visual impairments, such as giving them preferential seating in the front of the classroom. Children with behavior disorders that interfere with their academic functioning have a right to receive individual accommodations as well. Few teachers would argue that it is unfair to the rest of the class to place the visually impaired student in the front row. By the same token, it should not be argued that it is unfair to the rest of the class to have an individual incentive program for a child with a disruptive behavior problem. For teachers who remain skeptical about individual reward programs, we sometimes set up a system where the target child is allowed to work toward rewards that are given to the whole class (see Table 22.2 for sample whole-class rewards). For example, a child who blurts out could be given poker chips for waiting to be called on. Once he has obtained 50 poker chips, his parents could be responsible for bringing in popsicles for the whole class. When we use such a program, we never include a response-cost component because classmates could criticize the target child when he loses chips. With a totally positive system, the target child gets to be the "hero" who earns rewards for everyone, thus raising his peer status. With teachers who buy into the idea of individual reward programs,

Table 22.2 Group rewards for the whole class

Pizza party
Holding class outdoors
Popcorn party
Listening to music while working
Ice cream party
Popsicles at recess
Extra recess
Movie
Hot chocolate
Pajama day
Water play day
Silly hat day
Crazy hair day
Teacher dresses weird (baby, clashing, clothes inside out)
Nature walk
Talent day
Special games (Heads up 7-up, Draw and guess, Charades, Freeze dancing)
Picnic lunch on the lawn
Craft
Cookies
Teacher sings a song for the whole school over the intercom

we develop interventions that may be grouped into two categories: school–home notes and positive reinforcement systems with response-cost components.

School–Home Notes. An important goal of consultation is to promote frequent and constructive communication between parents and teachers. Busy parents and teachers often have difficulty connecting with one another to exchange information about the child in a timely fashion. This is problematic because teachers want parents to support the behavioral contingencies occurring at school. With limited time and resources, teachers may not be able to provide potent rewards and deterrents for individual children on a daily basis. Parents are in a better position to give treats, restrict television and video games, and reward good behavior with special privileges. In order for parents to be able to support the in-class behavior plans, teachers need a mechanism for providing daily feedback regarding children's targeted behaviors. School–home notes and behavior tracking sheets are simple, cost-effective vehicles for improving teacher–parent communication and strengthening classroom behavior plans.

Effective school–home notes conform to certain guidelines. They should target a small set (usually three or less) of specific behaviors. Tracking too many behaviors causes the system to become cumbersome and impractical. With 24 other children, it is difficult for teachers to accurately track many target behaviors. Children also cannot be expected to change all of their problematic behaviors simultaneously. As behaviors improve, they may be replaced with new targets. Rather than tracking problematic behaviors, we find it more helpful to rate the corresponding positive behaviors. For example, we prefer to monitor the positive behavior of "raising hand before speaking" as opposed to the more negative behavior of "blurting out." Monitoring incompatible positive behaviors promotes a focus on reinforcing and building pro-social replacements for maladaptive behavior. This is an approach that is consistent with the avoidance of negative command giving in the PDI portion of PCIT. For a listing of problematic classroom behaviors and their pro-social targets, see Table 22.3.

A simple format for constructing a school–home note is presented in Fig. 22.2. For an excellent reference on how to construct school–home notes, see Kelley's (1990) book entitled, "School–Home Notes: Promoting Children's Classroom Success."

Behavior Tracking Sheets. An alternative way to document children's classroom behavior is using a tracking sheet. A tracking sheet differs from a school–home note in that it provides ratings during specific intervals of the day. For example, a tracking sheet might divide the child's day into opening circle, story time, journal, lunch, recess, math, library, and science. The teacher rates the child's behavior immediately following each activity. In that way, children receive continuous feedback on their performance throughout the day. Whereas the more global school–home note provides an overall daily rating, the tracking sheet allows teachers, parents, and therapists to look for temporal patterns in problematic behaviors. This is particularly important when working with children who are taking short-acting medications such as stimulants. Temporal patterns also are important with children who have blood

Table 22.3 Classroom problem behaviors and pro-social targets

Problem behavior	Pro-social target
Daydreaming	Paying attention
Talking to neighbor	Working quietly
Touching others at circle time	Keeping hands and feet to self
Pushing in line	Walking with hands at sides
Not finishing work	Completing assignments
Throwing tantrums	Controlling temper
Hitting	Using gentle hands with friends
Leaving seat	Remaining seated
Name calling	Respectful talk
Leaving the area	Staying with the group
Talking out of turn	Raising hand
Making noises	Being quiet
Tipping back in chair	Keeping chair legs on the floor
Playing with toys in the desk	Staying on task
Disobeying the teacher	Following directions
Using profanity	Using appropriate language
Angry outburst when disciplined	Accepting consequences nicely
Arguing with teacher	Accepting "no" appropriately
Refusal to separate from parent	Separating quickly without distress
Bossiness	Asking peers nicely
Playing alone on playground	Joining in
Grumpy attitude	Pleasant voice and smiling face
Cutting in line	Waiting your turn
Selectively mute	Speaking aloud

Child's Name: Zachary Date: _____

Target Behavior	**Good Job**	**Okay**	**Needs Improvement**
Completed Work	_____	_____	_____
Raised Hand to Speak	_____	_____	_____
Kept Hands and Feet to Self	_____	_____	_____

Comments: _____

_____

_____

_____

Fig. 22.2 Sample school–home note

Child's Name: _____ Date: _____

Target Behavior: Following Class Rules

Activity	Good	Okay	Needs Improvement
Bell Work	____	____	____
Journal/Writing	____	____	____
Math Centers	____	____	____
Morning Recess	____	____	____
Reading Group	____	____	____
Lunch	____	____	____
Special: _____	____	____	____
Science/Social Studies	____	____	____
Language	____	____	____
Wrap Up	____	____	____

Fig. 22.3 Sample tracking sheet

sugar issues, may not be accustomed to full-day kindergarten, and display difficulties in only certain subjects or settings. Because tracking sheets are portable and carried by children to specials, they are especially helpful for children who have difficulty with transitions and exciting activities (e.g., physical education, music). Whereas the school–home note provides only one teacher's feedback, the tracking sheet provides comprehensive feedback across teachers and activities. At the end of the day, children bring their tracking sheets home to parents who are then able to provide consequences based on daily performance. For a sample tracking sheet, see Fig. 22.3.

Positive Reinforcement and Response Cost with Reinforcement Systems. A positive reinforcement system is one in which children earn rewards for positive behavior. A response-cost system is one in which children are penalized for inappropriate behavior. A response-cost system with reinforcement is one in which children receive small penalties for inappropriate behavior (e.g., losing tickets, going down a level) but are rewarded if they remain above a certain threshold (e.g., get a candy if they have three of ten tickets remaining at the end of the day). There is a universe of possible positive reinforcement and response-cost systems including star charts, token economies, levels systems, point systems, and classroom stores. It is beyond the scope of this book to review all the variations on reward systems that could be

adapted for individual children in a classroom setting. Therapists and teachers may choose from a host of reinforcement systems such as token economies in which poker chips, tickets, classroom bucks, popsicle sticks, marbles, or pinto beans can be traded in for rewards. For illustrative purposes, we will describe two systems. The first is a classroom reward system that is based on performance documented on the child's tracking sheet, and the second is a "rising star" reward system that allows the targeted child to earn rewards.

In the first system, a disruptive classroom behavior such as one listed in Table 22.3 is identified along with its pro-social target. A tracking sheet is used to allow the teacher(s) to rate the child's performance with respect to the positive behavior target over the course of the school day. A reward system is put in place in which the child is required to obtain a certain number of favorable ratings to obtain a teacher-delivered reward. As the child shows improvement, the threshold for reward delivery may be raised, never with the expectation of perfect performance.

The second system, the rising star, incorporates response cost with positive reinforcement. This system can be implemented using a cardboard star taped to a clipboard at the teacher's desk. At the beginning of the day, the star is placed at the bottom of the clipboard. Whenever the child displays the pro-social behavior (e.g., following directions), the star is raised. When the identified negative behavior (e.g., disobeying the teacher) occurs, the star is lowered. At the end of a pre-selected period of time, the child will earn a reward if the star is over the halfway point (i.e., more compliance than non-compliance). In some cases, providing the child with an opportunity to receive a reward once a day may be sufficient. In other cases, children my need to have more frequent reward opportunities such as twice a day or even once an hour.

Teachers often tell us that reward programs do not work for the identified child. What this tells us is that the reward system attempted by the teacher was probably flawed in one of two ways: either the target behavior was unrealistic, or the reward was not potent enough. We could offer a million dollars to a child with ADHD if he would sit perfectly still all day and the program would fail. Obviously, the program is flawed because the child with ADHD is incapable of sitting still for en entire day. Similarly, we could offer a penny to a child with ADHD for sitting still for 3 min and it might fail. In this case, the reward is not potent enough to motivate the child to do his best. Clearly these are extreme examples, but as effective consultants we analyze the source of the failure and make modifications accordingly. We frequently lessen the amount of time the child is expected to display the behavior (from all day or even all week, to smaller intervals), and we often define the target behavior more specifically ("being good" is operationalized as "keeping hands and feet to self"). With respect to rewards, we advise teachers to try to incorporate novel and stimulating incentives such as those that involve physical activity and break from routine. See Table 22.4 for a sample list of rewards that teachers can deliver to individual children. Because children with behavior problems satiate quickly on any single repeated reward, we advise teachers to rotate rewards frequently and incorporate mystery motivators (e.g., grab bags).

Table 22.4 Individual rewards for classroom interventions

Sit at the teacher's desk
Go to lunch with the teacher
Have lunch with a friend in a special place
Check out an extra library book
Get a dress down day (no uniform)
Computer time
Read to a younger student
Free time at desk
Listen to a book or music on tape
Extra show & tell
No homework pass
First in line for lunch or recess
Draw on the white board
Bring a stuffed animal for the day
Choose the book for story time
Child chooses where to sit for the day
Small food treat
Get first pick of play equipment
Reading the announcements on the intercom
Taking care of the class animal
Choose a movie for Fun Friday
Be a special helper (clean board, run an errand)
Get to take the class stuffed animal home for the night
Bring a toy to school for recess
Pass out snacks to class
Get a good phone call home from the teacher
Happygram (smiley face note with positive message)
Go to the principal's office for a piece of candy

Whole-Class Interventions. Although individual classroom programs are the easiest to develop and implement, there are times when a whole-class approach is more appropriate. For example, we will choose a whole-class approach when we encounter a teacher who does not buy into the rationales for individual reward programs. These teachers are very concerned about fairness and have strong feelings about providing all children in the classroom with equal access to rewards. A second situation in which we would be likely to choose a whole-class approach is when there are multiple children in the classroom with challenging behavior. In this situation, it would be unwieldy to try to be consistent with multiple individual reward programs. The fairness issue becomes even more prominent when four or five children are receiving special rewards that are not available to well-behaved children in the classroom. An advantage of whole-class programs is that all children are full participants and benefit from the added incentives. Sample rewards that can be used in whole-class systems are listed in Table 22.2.

Of course, most teachers already have some form of classroom-wide behavior management program in place. Ones we often see are based in part on Lee Canter's Assertive Discipline (Canter & Canter, 2001). Typically, teachers focus on only one or two aspects of the Assertive Discipline program, particularly some variation of

placing the child's name on the board with checks (associated with increasing severity of consequences) for each misbehavior and some variation of placing marbles in a jar for the whole class to earn a reward. In classrooms we often see stoplight systems in which all children start out on green and move to yellow and red with rule infractions. At the end of the day, consequences may be provided based on the ending color. For example, children in the green zone may receive a hand stamp or sticker. Children in the yellow zone do not receive a sticker, and children in the red zone get a note or phone call home. In another system, students begin the week with five poker chips or popsicle sticks. When classroom rules are broken, the children are required to give the teacher a token. Over time, they can save up tokens to buy things from a classroom store or purchase special privileges (e.g., getting to eat lunch with a friend may cost 25 popsicle sticks). Frequently, all of the students are working together for some type of group reward such as a classroom party. One variation of the marbles in a jar strategy is to try to fill up an apple tree on a bulletin board with stickers by earning an apple for displaying a particular target behavior. Another variation is when the teacher writes a message on the board such as, "If we follow the classroom rules, we are going to have a pizza party on Friday, April 28th." In this system, the teacher erases a letter of the message each time the class does not conform to the rules. If any letters are left on the board by the identified date, the children will be rewarded with a party.

These systems enjoy widespread use because they work for the great majority of students. However, they are not potent enough for many of the children who are referred for PCIT. Our clients may fail at these systems for several reasons. First, most of these programs are based on the system of "three strikes and you are out." For example, in a stoplight system, if a child bothers others at calendar time and then talks to a neighbor during writing time, he has ceilinged-out and already earned a note home by 9:00am. Children who have high activity levels and impulsivity, may break classroom rules 50 times per day. With a system that punishes after only two infractions, the child will either be punished every day and have no access to rewards, or the teacher will become extremely inconsistent in following through with consequences. Other reasons why typical group management systems may be ineffective for PCIT clients are that the rewards are not sufficiently potent (e.g., handstamp, bookmark, pencil), the consequences are too delayed, and the client's misbehavior prevents other students from being rewarded, thus damaging the client's peer relationships.

On a website (http://canter.net) accessed on November 8, 2007, Lee Canter described the influence of his Assertive Discipline program on classroom behavior management practice over the last several decades. He emphasized that many teachers have oversimplified Assertive Discipline, taking from it only the punishment components. According to Canter,

> Teachers who are effective year after year take the basic Assertive Discipline competencies and mold them to their individual teaching styles. They may stop using certain techniques, such as putting marbles in a jar or writing names on the board. That's fine. I don't want the legacy of Assertive Discipline to be – and I don't want teachers to believe they have to use – names and checks on the board or marbles in a jar. I want teachers to learn that they have to take charge, explain their expectations, be positive with students, and consistently employ

both positive reinforcement and negative consequences. These are the skills that form the basis of Assertive Discipline and of any effective program of classroom management.

In the section below, we present a few whole-class programs designed to help children with high rates of disruptive behavior.

A whole-group intervention designed for preschool to kindergarten classrooms is Dr. Cheryl McNeil's "Sunny Day Level System" (Filcheck, McNeil, Greco, & Bernard, 2004). This program combines positive reinforcement and response cost to motivate young children to follow classroom rules. A chart is posted in the classroom with seven color- and weather-coded levels, moving a gray, stormy sky level to a neutral white center zone, to a bright blue sunny sky zone at the top (see Fig. 22.4). Each child in the class has a unique marker (e.g., animal, shape, alphabet letter) that is placed in the neutral white zone at the beginning of each designated interval. When children display positive behavior, they are given a labeled praise and allowed to move their markers up a level (if more convenient, the teacher may move the marker). When preschoolers break a classroom rule, the teacher provides a visual and verbal warning: (holding up two fingers) "Sam, you have two choices, you can keep your hands to yourself, or you can move down a level." It is important for teachers to provide the warning in a neutral tone of voice with as little negative attention as possible. Often, it is less intrusive for teachers to simply call the child's name and provide the two choices visual signal. If the child continues to misbehave following the signal, the teacher moves the child's marker down a level. Teachers

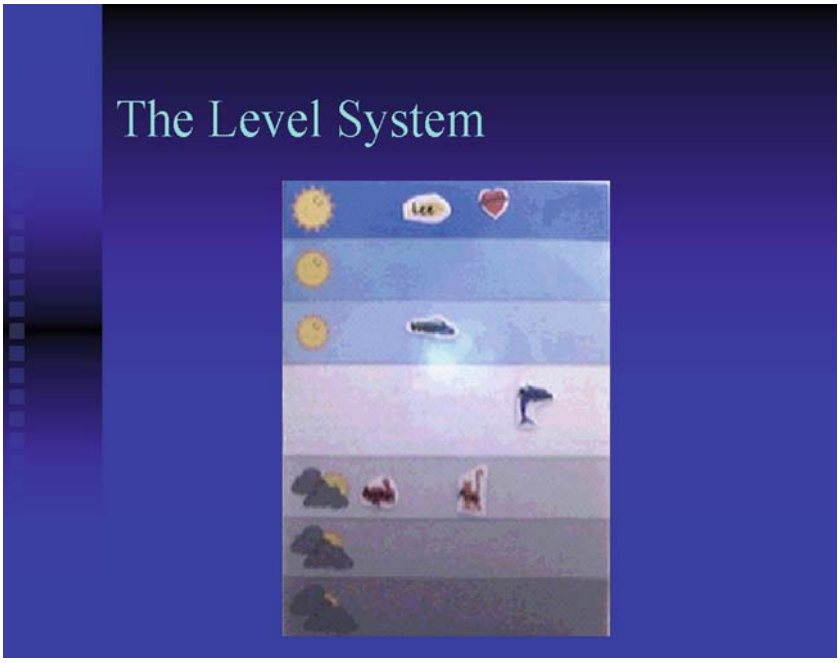

Fig. 22.4 Sunny Day Level System

are encouraged to stand by the board during each major transition, to provide preschoolers with immediate feedback on their behavior during the previous activity (e.g., story time). This also gives teachers an opportunity to give consequences during the often chaotic transition times. At the end of a particular time interval chosen by the teacher (e.g., after morning work), all children who are in the sunny zone will receive a reward. The teacher draws a reward card and all "sunny zone" children receive the same reward. Examples of rewards include short games (e.g., follow the leader, hot potato) and activities (that take less than 3 min), snacks, handstamps, and stickers. The games and activities are designed to be highly stimulating to motivate active children to work hard for the reward. Consequently, teachers are advised to use the Sunny Day Level System to regain class control after the reward is provided. Immediately after the game is finished, the markers are reset to the neutral zone and the teacher immediately begins looking for chances to move children up and to provide warnings to those needing to calm down. Many of the games for the reward cards came from a website maintained by Geof Nieboer entitled *Games Kids Play* (http://www.gameskidsplay.net). See Appendices 13 and 14 for the rules and reward cards needed to implement the Sunny Day Level System.

The Sunny Day Level System offers several advantages over standard preschool and kindergarten whole-class behavior management systems. First, the "sunny levels" provide the opportunity for positive reinforcement of newly developing prosocial skills (e.g., sharing, using your words, turn-taking). The inclusion of "cloudy levels" enhances children's motivation to follow rules by encouraging them to work to avoid negative consequences in addition to working to earn rewards. Additionally, the use of warnings prior to movement down provides young learners with the opportunity to self-correct before experiencing a negative consequence. As opposed to a "three strikes and you're out" system, the combination of many levels and warnings gives teachers numerous opportunities to provide children with feedback and small corrections for the many misbehaviors that occur throughout the day. Finally, the Sunny Day Level System has been investigated in empirical studies and has been shown to decrease disruptive behavior, increase teacher use of praise, and decrease the number of time-outs used in preschool classrooms (Bahl, McNeil, Cleavenger, Blanc, & Bennett, 2000; Filcheck et al., 2004; Filcheck, & McNeil, 2004).

Another whole-class intervention developed by Dr. Cheryl McNeil is the "Tough Class Discipline Kit" (McNeil, 2001). This program has many of the same features

Group	Happy Face	Sad Face
Leopards	lll	
Ponies	ll	l
Zombies		llll
Transformers	ll	ll
Chargers	llll	l

Fig. 22.5 Sample tally chart for the Tough Class Discipline Kit

as the Sunny Day Level System, but is designed for use in elementary school classrooms (grades K through 6). See Fig. 22.5 for a sample tally sheet that can be drawn on the whiteboard. Children in the classroom are divided into groups of approximately four to five students each. Children are encouraged to balance the groups so that children with disruptive behavior are teamed with students that are positive role models. The basic premise of the program is that groups earn both happy and sad faces based on the behavior of the group and its individual members. As in the Sunny Day Level System, the teacher provides a labeled praise when giving a happy face ("Great job Transformers of getting your books out so quickly!"). When an individual child or an entire group is breaking a class rule, the teacher holds up two fingers and provides a brief warning (e.g., "Chargers, quiet please"). If misbehavior continues following the warning, the teacher provides a sad face to the group.

All groups with more happy than sad faces get a reward. The groups do not compete with each other, and many times, the whole class will be successful and receive the reward. At the end of the teacher-selected time interval (typically just before lunch and just before dismissal), all of the groups with more happy than sad faces come to the front of the classroom and play the game. The teacher chooses someone who walked calmly and quietly to throw a Velcro ball at a target with numbers. The numbers correspond to reward cards. All children receive the reward listed on the card. As with the Sunny Day Level System, rewards include brief games and activities, treats, etc. Each group has a rotating student leader who is taught to give a behavioral warning cue (displaying a two finger warning) to group members who are not following classroom rules. Teachers are encouraged to award happy faces for instances of good leadership. Teachers also are taught to individualize expectations for children with disruptive behavior, allowing them to receive happy faces for lesser accomplishments than might be expected of other team members. In this way, children with disruptive behavior do not become a burden to their group mates which could lead to problematic peer relationships.

The Tough Class Discipline Kit has been studied and the data suggest that it decreases disruptive behavior and increases on-task behavior in the classroom. In a case study using the Kit (Anhalt, McNeil, & Bahl, 1998), results indicated an increase in appropriate behavior of almost 17% above the baseline and an increase in on-task behavior approximately 11% above baseline measures. These results were replicated and extended in a study by Bahl et al. (2000). The Tough Class Discipline Kit contains a manual, target and balls, reward cards, and a 15-min demonstration video. It is available for purchase from Sopris West Educational Services at http://store.cambiumlearning.com.

A third whole-class program that we have found useful for motivating children with behavior problems is the class auction or sale. In this program, teachers reinforce appropriate behaviors of all the children in the classroom with play money called "classroom bucks." All children in the class are given a starting weekly "allowance" of perhaps $50. The teacher keeps a ledger with all of the children's names on one side and a credit and debit column for each child. Children are awarded extra bucks for teacher-selected target behaviors such as good handwriting, helping a classmate, accepting a negative consequence, completing all of their

math problems, walking quietly in the hallways, and everyone returning their field-trip forms. The target behaviors are tailored to individual children's special needs. In this way a whole-class system can be flexible enough to motivate one of our oppositional PCIT clients to be a better listener in the classroom. Children may also be fined for unacceptable behavior such as excessive talking, defiance, pushing in line, not turning in homework, dawdling on a work assignment, name calling, etc. At the time that the child earns or loses money, the teacher alerts the child ("You just lost a buck for calling out," "Great job of staying quiet while I talked to Mr. Will. You all get a buck!") and records it on the ledger. At the end of the week, the classroom banker (could be teacher or student) distributes the amount earned to the children who keep it in envelopes in their desks. If the teacher is concerned about potential loss or theft, they can wait to distribute the money until right before the auction or sale. Typically, auctions or sales occur at least once each quarter. Parents are asked to contribute gently used books, toys, games, DVDs, or novelty items (white elephants). The teacher or parent volunteers organize the items on a table based on estimated value. In the case of an auction, children are given the opportunity to bid on items they would like to purchase. No child can purchase a second item until every child has gotten something. In the case of a sale, names are randomly selected from a hat, and children take turns coming to the table to make their purchase. They may purchase only one item per turn.

Conclusion

Most children in PCIT present with behavior problems in both the home and school settings. PCIT therapists must be effective not only at parent training but also at developing classroom management plans. Using the skills of PCIT, therapists can establish strong working alliances with teachers and other school personnel and, by using the behavioral principles of PCIT, therapists can develop effective behavior plans either for individual children or for the entire class. Although school consultation is time consuming, we find that it is worth the extra effort because it results in better outcomes for our young PCIT clients.

References

Achenbach, T. M. (1991). *Integrative guide to the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington, VT: University of Vermont, Department of Psychology.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Anhalt, K., McNeil, C. B., & Bahl, A. B. (1998). The ADHD classroom kit: A whole-classroom approach for managing disruptive behavior. *Psychology in the Schools*, *35*, 67–79.

Bahl, A. B, McNeil, C. B., Cleavenger, C. J., Blanc, H. M., & Bennett, G. M. (2000). Evaluation of a whole-classroom approach for the management of disruptive behavior. *Proven Practice*, *2*, 62–71.

Canter, L., & Canter, M. (2001). *Assertive discipline: Positive behavior management for today's classroom*. Bloomington, IN: Solution Tree.

Erchul, W. P., & Martens, B. K. (2002). *School consultation: Conceptual and empirical bases of practice*. New York, NY: Springer.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory and Sutter-Eyberg student behavior inventory – revised. Professional manual*. Odessa, FL: Psychological Assessment Resources.

Filcheck, H. A., McNeil, C. B., Greco, L. A., & Bernard, R. S. (2004). Using a whole-class token economy and coaching of teacher skills in a preschool classroom to manage disruptive behavior. *Psychology in the Schools*, *41*(13), 351–361.

Filcheck, H. A., & McNeil, C. B. (2004). The use of token economies in preschool classrooms: Practical and philosophical concerns. *Journal of Early and Intensive Behavioral Intervention*, *1*(1), 95–105.

Funderburk, B. W., Eyberg, S. M., Newcomb, K., McNeil, C. B., Hembree-Kigin, T. L., & Capage, L. (1998). Parent-child interaction therapy with behavior problem children: Maintenance of treatment effects in the school setting. *Child and Family Behavior Therapy*, *20*, 17–38.

Jacobs, J. R., Boggs, S. R., Eyberg, S. M., Edwards, D., Durning, P., Querido, J. G., McNeil, C. B., & Funderburk, B. W. (2000). Psychometric properties and reference point data for the revised edition of the school observation coding system. *Behavior Therapy*, *31*, 695–712.

Jordan, A. (1994). *Skills in collaborative classroom consultation*. Routledge, NY: Routledge Press.

Kelley, M. L. (1990). *School-home notes: Promoting children's classroom success*. New York: Guilford.

McGinnis, E., & Goldstein, A. (2003). *Skillstreaming in early childhood: New Strategies and perspectives for teaching prosocial skills*. Champagne, IL: Research Press

McNeil, C. B., Eyberg, S. M., Eisenstadt (Hembree-Kigin), T., Newcomb, K., & Funderburk, B. W. (1991). Parent-child interaction therapy with young behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology*, *20*, 140–151.

McNeil, C. B. (2001). *The Tough Class Discipline Kit*. Longmont, CO: Sopris West. (http://store.cambiumlearning.com).

Rork, K. E., & McNeil, C. B. (2008). A behavioral model of school consultation. *The Behavior Therapist*, *31*(4), 69–73.

Sopris West Educational Services at http://store.cambiumlearning.com.

http://Canter.htm. *A*ccessed on November 8, 2007

http://www.gameskidsplay.net last updated on January 28, 2007. Maintained by Geof Nieboer. Games Kids Play. Accessed on 11/8/2007.

Chapter 23
Home-Based PCIT: From the Lab to the Living Room

Joshua Masse

Just as PCIT has expanded to include a diverse set of populations and clinical disorders, it has also begun to increase its transportability to various contexts. As the field now looks toward dissemination as a vehicle to bridge the gap between the university laboratories and "real-world" settings, in-home PCIT has begun to fill the void between efficacy and effectiveness. A recent article published in *Child and Family Behavior Therapy* (Ware, McNeil, Masse, & Stevens, 2008) provides research support for the use of home-based PCIT, demonstrating child and parent changes similar to what has been found with clinic-based studies.

Although PCIT therapists lose a degree of control when attempting to deliver the intervention outside of a clinic or laboratory, the home setting is advantageous in that it grants a first-hand look at behaviors and situations as they occur in their "natural" environment. This chapter discusses the numerous advantages in-home PCIT offers in addition to providing some helpful tips about how to easily and effectively implement PCIT in the home.

Clinical Advantages

Ecological Validity. One major advantage to conducting home-based PCIT is being able to implement the therapy without needing to visualize a client's home. Conducting PCIT in the home allows a therapist to avoid the visualization and brainstorming that oftentimes takes place in a clinic setting thereby enabling a therapist to individualize the PCIT protocol based on first-hand knowledge of the family's living situation. For instance, implementing the time-out portion of PCIT at a client's home is advantageous in that it allows a therapist to survey the living arrangement and suggest ideas about how to carry out particular procedures. A therapist can show a parent the *exact* location a time-out chair can be placed, or a parent and therapist

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C.B. McNeil, T.L. Hembree-Kigin, *Parent-Child Interaction Therapy*,
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can choose an appropriate back-up room and childproof it together. By describing and demonstrating procedures while sitting in a client's home, PCIT comes to life and enhances the likelihood that implementation will be more successful. Likewise, each therapy session offers an opportunity for a therapist to troubleshoot live with a parent. In this way, in-home PCIT saves the time it takes for a parent to describe all the slight nuances and unique challenges that each family presents and allows problems to be solved on the spot.

"Real-Life" Behaviors. As every therapist knows, children often do not demonstrate the same behavioral intensity in the clinic that typically occurs in more comfortable settings. Behavioral differences may occur for a number of reasons. Perhaps going to a doctor's office is anxiety-provoking for a child, or maybe the novelty of the office or the presence of the therapist puts children on their best behavior. For whatever reason, parents oftentimes report that their child's behavior during therapy sessions is dramatically different in comparison to what is seen at home.

Some PCIT therapists have indicated that they have to wait several sessions before they can coach parents through an ignore or time-out sequence. In-home PCIT eliminates the behavior contrast dilemma by allowing therapists to observe and coach parent and child behavior as it *actually* occurs within the home setting. For example, what happens if a child escapes from a time-out chair and runs up the stairs to his bedroom? Or when a child, during a parental ignore, attempts to play on the computer in the room thereby greatly diminishing the value of the removal of parental attention? Or perhaps there is an unanticipated arrival of a sibling, spouse, neighbor, or pet? What if the telephone rings during special playtime or a time-out? Situations like these are commonplace for any family but extremely difficult to troubleshoot on the spot without a therapist's guidance. Frequently, therapists spend much of a session discussing issues like these and send parents off hoping that parents can implement the plan themselves. We have found that parents often come back the next week with the same problems. With in-home PCIT, these problems can be managed in-vivo by a therapist. Each situation that presents itself while the therapist is in the home is a new opportunity to generalize skills to alternative situations.

In addition to individual child behaviors, home-based PCIT therapists also have the benefit of observing interactions with siblings and other caregivers during different times of the day. This allows therapists to work with parents as household "chaos" unfolds. For example, a therapist could coach a parent when their children are getting ready for school, at dinnertime, homework time, or any situation in which a parent identifies as a time of high stress. It is also not uncommon to observe or coach siblings or spouses during sessions as they are more likely to be around at certain times of the day.

In order to identify and monitor difficult household behaviors, we teach parents at pre-treatment to develop a tracking sheet of the persistent behaviors they would like to see reduced or eliminated. We work to identify specific behaviors and narrow down situations in which the behaviors occur. As a great deal of time is spent in

the client's home, therapists have the benefit of observing behavior outside of special playtime. When noticing a behavior, a therapist can ask if it is a problem and, if so, add it to the tracking sheet. For instance, following each session, one child consistently acted defiant when told to put his sneakers on. After noticing this event on several occasions, the therapist asked the parent whether putting on sneakers is a behavior she would like to see increased and added to the tracking sheet. After learning the PDI skills, the therapist coached the parent through the situation on several occasions. As the child received specific praise for the behavior, he began to initiate the behavior himself. Thus, as PDI progresses, parents are coached in real time to use the skills with targeted behaviors. Another child consistently refused to get out of the car when he arrived home from school. Knowing this, a PCIT therapist arranged to be at the home when the family arrived. The therapist was then able to coach the parent through the difficult process of getting the child out of the car and into the home. There are countless situations like these that parents attempt to manage on their own. An in-home PCIT therapist benefits from being able to identify a wider range of behavioral problems than might be apparent in the clinic. Additionally, the home-based PCIT therapist can actively coach parents on how to solve these problems in the setting in which they actually occur.

Low Attrition Rates. Drop out from treatment is a problem that most therapists face on a regular basis. Conducting in-home PCIT reduces the potential for client no-shows and cancellations. More regular treatment sessions help parents to improve their skills more rapidly. In addition to skill development, home-based PCIT allows clinicians to regularly monitor homework completion and to brainstorm potential barriers that may be preventing parents from consistently practicing PCIT skills.

Clinical "Tips"

While conducting in-home sessions, we have found several modifications that make implementation of PCIT more effective and conducive to the home environment. The following is a series of clinical "tips" that one may consider when conducting in-home PCIT.

Clinical Tip #1: Choose the Coaching Room Carefully. It may be helpful to determine in advance which room is the most appropriate for coaching parent-child interactions. By assigning a specific room and location within the room, the therapist is then able to better prepare himself/herself for whatever comes up. Making a pre-treatment visit to "scout out" the various rooms in the home may be useful. We have found it helpful to do this during the pre-treatment or assessment phase of therapy.

Clinical Tip #2: Eliminate Distractions. For rooms in which coding/coaching takes place, try to eliminate distractions prior to the outset of each session. For example, if the therapy is taking place in a room with a television, computer, or video

game console, make sure all electronic equipment has been turned off or removed and the child is out of arm's reach from any items that may potentially serve as a distraction. In addition, any toys or materials in the room that are contraindicated for PCIT (e.g., toy guns, handheld video games) or that may be physically harmful (e.g., swords, sharp objects) should be removed prior to each session. As therapy progresses, however, it is recommended that distractions are phased in so that skills and situations start to generalize to more natural behaviors.

Clinical Tip #3: Define the Play Area in Advance. It may be useful to designate a particular area where playtime will occur. By specifying a play area, the parent and child are aware of the boundaries of the play and the parent is able to determine when the child has left the play area. If it is decided that a table is the most appropriate place to carry out special time, be sure the heights of the table and the chairs are at a level where the child can freely manipulate toys without major difficulty. One strategy we have found to be effective is to place a "play blanket" or a similar item on the floor. By using a blanket, the boundaries of the play are clearly delineated. Regardless of the play setting (e.g., table, blanket, mat), it is important that the child is aware of the play rules and the boundaries of the play. Therefore, prior to special playtime, the parent should describe the rules of the play to the child. The following can be used as a script introducing special playtime using a "play blanket:"

> We are going to have special playtime. You can play with any toys on the blanket, and I will play with you. There are two rules. You have to play gently with the toys and you have to stay on the blanket. If you play roughly with the toys or get off the blanket, I will turn around like this (demonstrate ignore) and play all by myself. Then, when you are playing nicely or sit back down on the blanket, I will play with you again. You're playing nicely now, so we can play with anything on the blanket that you want to play with.

Clinical Tip #4: Select and Childproof Time-Out Back-Up Room. In terms of the time-out back-up room, a good deal of time should be spent on choosing and modifying the room. It is important that it is inspected for any potentially dangerous situations or substances and that both the therapist and parent take the time to ensure that a time-out room is safe before PDI begins. This may mean removing all potentially dangerous or breakable objects (e.g., vases, medicine, tweezers, electronics, lamps, pictures) prior to PDI session. For children with extremely severe behavioral problems, it is recommended that the bathroom not be used as a back-up room as it seems to carry the highest risk of danger (e.g., hot water, chemicals, hard and slippery surfaces). We often use the child's own bedroom as the back-up room but it usually requires removing a number of toys and rewarding items (e.g., television, video games).

Clinical Tip #5: Evaluate the Door to the Back-Up Room. Our experience has shown us that many children spend much time in the back-up time-out room pulling on the doorknob and kicking the door. For these cases, the quality of the door and door handle should be assessed. Also removing a child's footwear prior to PDI coaching can help to reduce the amount of damage that can be done to a door!

Clinical Tip #6: Consider Adding a Clinic-Based Session. It may be useful for particular sessions to take place in the PCIT laboratory or clinic. For instance, the

initial PDI session could take place within a PCIT clinic so that both the child and parent can experience the entire time-out sequence in the safest and most controlled environment. After one or two time-outs in the clinic, the home-based PDI coaching can then be conducted. Similar to the clinic protocol, it is helpful to review the rules of time-out in advance by showing the child the time-out chair and back-up room that will be used in the home.

Clinical Tip #7: Determine Whether to Use Bug-in-the-Ear Equipment. When conducting in-home PCIT, therapists generally coach within the same room as the parent-child dyad. Children sometimes have a difficult time ignoring the therapist's presence and suggestions being given to the parent, particularly during the beginning of coaching sessions. Depending on the child's age, reactions to in-room coaching vary. Some children attempt to talk to the therapist, while other children view coaching as embarrassing and, in turn, act more inhibited. Another common problem is that children realize that the therapist is telling the parent how to respond, undermining parental credibility. Several options are available to alleviate these problems. First, as the bug-in-the-ear equipment is portable, it is feasible to bring the equipment to the home and use walkie talkies or baby monitors to listen to the play. By using this strategy the therapist could position her/himself across the room and be more removed from the play yet still provide immediate and continuous feedback. If this option is not available, then in-room coaching is the alternative. As mentioned, in-room coaching can initially be awkward for the parent-child dyad and the therapist. This is particularly true for older children. However, although initially uncomfortable, our experience has shown us that even older children get adjusted to the situation rather quickly. Therefore, it is common for older children not to demonstrate disruptive behaviors for the first several sessions due to the novelty of the situation and then begin to behave more naturally as therapy progresses.

In order to eliminate the potential for therapist–child interaction, we have developed the following script that we explain to children prior to coding/coaching:

> I cannot look at you or talk to you when you are playing with your mom. You should pretend that I am invisible or not in the room. I will be whispering ideas to your mom to make the play even more fun. If you try to talk to me while you are playing with your mom, I will ignore you. Once our coaching time is over, then I will talk to you and play with you again.

If a child attempts to communicate with the therapist during these times, a general ignore typically suffices to eliminate a child's future efforts to interact.

Clinical Tip #8: Use Writing for Private Communication. As compared to clinic-based coaching, children in home-based PCIT are much more aware that the therapist is telling the parent what to say and do. Our clinical experience has shown that children with high levels of oppositional behavior tend to become more defiant when their parents, as opposed to a therapist, explain the rules and provide the commands. In the home-based format, children are less likely to misbehave as they can directly hear the instructions coming from the therapist. In some cases, children begin to comply while the therapist is giving the parent instructions, thus reducing the likelihood of misbehavior during therapy sessions. One technique that can potentially be helpful is developing a system in which instructions are written down on a sheet of paper or index card and placed directly beside the parent. When it is

time for a transition to occur, the therapist then points to the notepad and the parent delivers the next set of written instructions (e.g., "Ignore that." "How about a labeled praise?" "Can you reflect that?" "Tell him to put all of the animals back in the barn.")

The therapist and parent should devise and discuss the written system prior to the coding session. It may be useful for a parent and therapist to preemptively develop a list of direct commands in an effort to reduce or eliminate verbal communication between the therapist and parent during PDI sessions. As therapy progresses, it is useful to fade out the exact written instructions and instead have index cards that only state "direct command." Then intermittently throughout the session the therapist will hold up the card or pass the card to the parent. In this way, the play becomes more natural and parents begin to feel comfortable with producing their own commands. As in vivo feedback is a critical part of PCIT, it cannot be avoided. At the beginning of therapy when parents are learning skills, frequent verbal feedback is required.

Clinical Tip #9: Minimize Disruptions. Although distractions cannot be avoided, it is helpful to remind each parent to minimize as many as possible during sessions. One small strategy that may prove to be helpful is to devise a sign or reminder that can be hung on the room door in which the session is being conducted. A spouse or other family member is then reminded of the session reducing the likelihood of interruptions. We also found it useful to have a parent sign a home visitation policy. The form is typically written in a format where the expectations (i.e., turn off the television, refrain from answering phone, schedule visitors for times after the session) are clearly stated. By having the parent/guardian sign an agreement form, he/she enters into a written contract that serves to enhance the likelihood and motivation to participate in therapy and establishes expectations of the home environment. If distractions become an issue then the therapist can remind the parent about the contract and the importance of minimizing as many distractions as possible. Remember, although distractions disrupt the flow of therapy and may be an inconvenience, it is an advantage that you are able to manage the distraction as it is actually happening. Distractions should be embraced as an opportunity to help parents manage situations as they occur.

Clinical Tip #10: Choose Appropriate Toys. Prior to beginning PCIT, the therapist should conduct an inventory of appropriate toys already present in the home. The therapist should incorporate as many of the child's own toys as possible to help with generalization. However, many families referred for PCIT do not have a wide enough range of appropriate toys to maintain the child's attention for approximately six 1-h coaching sessions. As a result, we often supplement the family's toys with a set we bring from the clinic. As one can only bring a narrow range of play activities when conducting in-home visits, it is important that special attention is given to assessing what play items are preferred by each parent-child dyad. By gaining a sense of preference, a therapist is then able to plan ahead to bring only those activities that will establish the most rewarding playtime. For example, if a mother expresses that her child has a strong dislike for Legos, it would be wise to leave those behind for that family's session.

Concluding Remarks

In-home PCIT is an exciting alternative to the clinic-based model as it allows a therapist to observe, assess, and change behavior in the natural environment. Although a degree of clinical control is lost by conducting PCIT in the home, the ability to troubleshoot "live" is an advantage to both the therapist and the family. In this way, what therapists lose in the lab (control), they gain in the home (generalization). Too often parents talk about how PCIT "is easier in the clinic" and tell the therapist "I wish I could videotape his behavior at home." In-home PCIT eliminates the artificial nature of sessions by giving parents hands-on coaching and feedback on the very behaviors that parents try to describe and therapists try to visualize. For this reason, home-based PCIT is a viable and effective alternative to the clinic-based model.

References

Ware, L. M., McNeil, C. B., Masse, J., & Stevens, S. (2008). Efficacy of in-home parent-child interaction therapy, *Child and Family Behavior Therapy*, *30*(2), 99–126.

Chapter 24
PCIT Around the World

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PCIT was originally developed as a treatment for behavior disturbances. It was developed based on behavioral strategies known to be acceptable to European-American families in the United States. With this origin, it is possible that PCIT is a culturally biased treatment and may not be well suited to other cultural groups. Some experts in multicultural issues have discussed whether it would be advantageous to make culturally specific adaptations to PCIT with the hope of providing better mental health services to groups that traditionally have been underserved. Within the United States, several systematic trials with PCIT in different subcultures have been conducted to see if the effects of PCIT differ based on cultural group. These studies have looked at whether adaptations of PCIT are necessary to be used with African-American families, Mexican-American children, Native Americans, and for families in Puerto Rico (see Chapter 19).

Just as in the United States, the demand for evidence-based treatments has also led to a rapid growth and implementation of new methods in countries all over the world. So, in addition to adaptation to new subcultures within the United States, there has been a continual implementation of PCIT into new countries outside the United States during the last 10 years (see Table 24.1). This means that the field is rapidly changing, and this list shows only the situation in January 2009.

Table 24.1 Countries outside of the United States with PCIT programs

Australia
Canada
England
Hong Kong
Germany
The Netherlands
Norway
Puerto Rico
Russia
South Korea
Taiwan

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Several of the same questions raised by the adaptations within the United States apply to adaptations to new countries. The way in which parents behave toward their children is strongly determined by culture, and socializing the child to the culture is an important element of a parent's role. Culture defines what is considered proper child-rearing practice and what is considered appropriate behavior for children. Some therapies, like PCIT, define the focus of change to be the interaction between parents and their children. This raises the question of whether it is possible to import a treatment from a culture in one country to another when what is "treated" is so culturally determined.

In the western world, over the past few decades, we have seen a gradual change from an authoritarian parenting approach toward a more democratic and permissive parenting style. The anti-authoritarian political and cultural ideas in the late 1960s and 1970s led to radical changes in views on child-rearing practices. There are great differences between countries in how these changes have affected the culture, but in the Scandinavian countries the changes had an early and profound impact. The view of the child changed from "someone who could be seen but not heard" to a person with a "right to be heard." At the same time, the number of working mothers grew, and parents' roles also changed toward more equal partners with shared responsibility as caretakers for the children

It has been speculated that this ideal of "democratic child rearing" has contributed to the seemingly growing number of children with behavior disorders. This could be because these ideals can sometimes be difficult to live up to, and many parents find it challenging to determine when and how to set limits for their children. With oppositional and defiant children, the contradicting ideas of what is best for the child (i.e., firmness versus negotiating versus letting the child decide) are confusing and contribute to inconsistency.

When we move east, the picture seems to be somewhat different. For example, even though Hong Kong has a mix of eastern and western culture, this eastern society still emphasizes the respect of elders. Child-rearing practices have traditionally valued the authority of parents. As a result, aspects of PCIT that focus on teaching children to behave respectfully to adults tend to be more acceptable to clinicians and parents in this part of the world.

Adapting PCIT for New Countries

Australia. Australia was probably one of the first countries outside the United States to implement PCIT. There are now several therapists practicing PCIT in this country. Griffith University in Queensland has a clinic that offers PCIT for training and research. A group of researchers at Griffith University recently published an article with a review and meta-analysis of studies of PCIT and Triple P (Positive Parenting Program) (Thomas & Zimmer-Gembeck, 2007). One of the best controlled studies in the research on PCIT has also been done in Australia. Nixon, Sweeney, Erickson, and Touyz (2003) compared the effect of standard PCIT to an abbreviated

version where therapists could use the telephone for consultations, along with other treatment components. It appeared that both groups gained from the treatment and this was maintained at 1–2-year follow-up (Nixon, Sweeney, Erickson, & Touyz, 2004). These studies demonstrated that an abbreviated version of PCIT can have similar treatment effects to standard treatment, and this could open up new possibilities to give better service to groups and communities in countries with a rural and remote population. Because of the research done in Australia, PCIT has received government support and multiple agencies have received funding to complete PCIT training.

Norway. Implementation of PCIT in Norway started in 1999 after a visit by Dr. Cheryl McNeil. She trained and supervised therapists working in outpatient clinics in Child and Adolescent Mental Health Care. Later, Norwegian therapists have gone to Sheila Eyberg and Cheryl McNeil for advanced training and have started training new therapists in the clinical field. PCIT is also taught at the Department of Psychology at Norwegian University of Science and Technology (NTNU) in Trondheim. Students have done studies to see if PCIT can be used to coach personnel in daycare who work with preschoolers with behavior problems (Kvarum, 2005) and with teachers in schools (Wist, 2007). Students have also studied differences in DPICS scores between clinical and non-clinical groups (Ebbesen & Stedje, 2008) and compared parents' DPICS scores with measures of their mental health and stress (Gudmundsen & Martinsen, 2008). The growing number of therapists using PCIT and sites where this treatment is delivered have also made it possible to conduct a randomized controlled trial of the effectiveness of PCIT with Norwegian children (Bjørseth, 2006). This study is currently collecting data from three sites.

The Netherlands. In contrast to Australia and Norway, where PCIT was introduced by interested therapists, a more systematic and much larger scale implementation of PCIT has started in The Netherlands. PCIT was chosen for implementation after considering several different therapies to improve the country's treatment of children with behavior difficulties. A group of therapists has been trained by Sheila Eyberg and her associates at the University of Florida. Since March 2007, PCIT has been offered in several Amsterdam area centers for early intervention called deBascule. This implementation is done in cooperation with and will be evaluated by researchers from the University of Utrecht.

Hong Kong. After having been trained by the California PCIT group at the University of California at Davis CAARE Center in 2005, and in cooperation with representatives from the University of Hong Kong and Hong Kong Institute of Education, therapists at the Tung Wa Group of Hospitals started practicing PCIT in Hong Kong with families at risk for child abuse. In 2007, they presented some of their experiences as well as a study of the effectiveness of PCIT conducted in Hong Kong at the PCIT conference in Oklahoma (Tsang et al., 2007). The study showed that PCIT had a positive effect on parents and children, but the authors pointed out the need for a larger evaluative study to promote the wider implementation of PCIT.

Taiwan. In terms of practicing PCIT in Taiwan, doctor Yi-Chuen Chen is originally from Taiwan and attended West Virginia University in 2001, receiving a

doctoral degree in Clinical Child Psychology in 2006. During her time at West Virginia University, Dr. Chen was under direct supervision of Dr. McNeil and learned to conduct PCIT. Since Dr. Chen joined the faculty at National Chung-Cheng University, Chia-Yi, Taiwan, as an Assistant Professor in August, 2006, she has successfully set up a laboratory and formed a research team for developing and conducting a Chinese version of the PCIT protocol.

International Issues with PCIT

The work we have described shows that PCIT has been successfully implemented in several countries outside of the United States. There are, however, some variations in how well the different elements of PCIT are accepted internationally. Based mainly on information from Norway, Hong Kong, and Taiwan, the cultural differences in child-rearing practices seem to influence the administration of PCIT. This seems to be of special importance in connection with limit setting and praising children.

Cultural Adaptations of CDI. According to Hong Kong researchers, CDI was the most challenging component of PCIT for parents. One of the elements of CDI that makes it difficult for these parents is the use of labeled praise. It seems that parents in Hong Kong worry that if other adults hear them praise their child, they will think of it as bragging or boasting, which is not socially approved. This difficulty also was reported by the Taiwanese research team. In Taiwan, parents spend less effort bolstering a child's self-esteem. This might be due to centuries of reliance on Confucian ideology. Parents even fear that excessive praises might cause such undesirable psychological traits as overconfidence, stubbornness, and an unwillingness to be corrected. For example, if a Taiwanese girl is learning to play piano, her mother may praise her child's work when they're alone at home together. However, if visitors are present and ask how her daughter's piano lessons are going, instead of praising her child, the mother may feel more comfortable to answer "Oh, just so-so." Thus, Taiwanese parents are much more likely to focus on what their child does wrong and prefer to use a child's mistakes to teach life lessons rather than to praise their children. Additionally, Chinese culture values emotional restraint. A pilot study conducted by the Taiwanese research team found that Taiwanese children did not verbalize on a frequent basis during play. Thus, their parents found reflections to be difficult, as there were few opportunities to reflect children's verbalizations.

To solve these problems, in addition to CDI teaching and coaching sessions, Taiwanese therapists found it helpful to devote session time to discussing with parents the various ways that they could generalize labeled praise and reflections from a play context to more real-life situations. The Hong Kong therapists also suggested that the parents could whisper the praise to the child. In this way treatment fidelity was maintained, while praising was made acceptable for the parents. It is

also possible that a whispered praise has its advantages. It could be experienced as even more genuine and deeply felt by the child, which could enhance the relationship between the parent and child. As therapists, we see this as an idea that can be useful in other situations as well. For instance, parents who are shy and find it hard to praise their child "in public" could use whispered praise.

According to popular belief in Norway, Norwegian parents are afraid that praising their children too much will spoil them. When we started PCIT in Norway, we therefore expected some problems with labeled praise. One of our doubts was whether it would be possible for Norwegian parents to do 10 labeled praises in 5 min. After discussions with Doctors Eyberg and McNeil, we were prepared to reduce the number of labeled praises needed to reach mastery in CDI. Yet, our experience so far is that this number is within reach for most of the parents we see. We have found it necessary, however, to expand the concept of labeled praise and include expressions that are seen as "positive regard" within the culture. The praise can be subdued, and apparently lack the enthusiasm that seems to come easier to American parents. This can be illustrated by the father saying to his son in a neutral tone of voice, "Now you work like a real working-man." The recognition was easily felt and made it obvious that this was a labeled praise and not a behavioral description.

What we see as common in these adaptations is that the importance of labeled praise is maintained, while the way of giving the praise is changed according to culture. PCIT continues to be PCIT, with treatment fidelity maintained. And as therapists, we see that these adaptations add to the variety of ideas we can use to tailor the treatment.

Cultural Adaptations of PDI. During PDI the parents are trained in setting limits for their children in a safe way. As far as we know, the standard procedure for PDI has been implemented without adaptations in most countries. Usually parents of children with behavior problems readily accept PDI. In fact, the standard procedure involves trying to motivate parents to get through CDI by reminding them of the great changes expected in PDI.

According to the Taiwanese research team, a similar situation occurred in Taiwan. Because Chinese culture is relationship-oriented and group needs often have higher priority than personal needs, Chinese parents tend to value self-discipline and obedience to authority. Thus, PDI appeared to be the most acceptable component of PCIT for parents in Taiwan.

In Norway, however, therapists have been reluctant to implement PDI. Many worry that what they consider a "harsh treatment" will do more harm than good. While using time-out and a time-out chair has become culturally accepted during the last several years, finding an acceptable back-up procedure for time-out escape has been very difficult in this country. The seclusive nature of using a separate back-up room has been considered by some to be too controversial both legally and ethically. The search for alternative procedures has led to different recommendations depending on the child's age and problem. For the youngest children (2–3 years), a holding chair can be used as the back-up for time-out escape. For somewhat older children

(4–5 years), a "swoop-and-go-technique," where the parents take the toys and leave the room, may be a viable alternative (see Chapter 13). For the oldest children (6 years and above), a "hands-off-procedure" with potential loss of privileges (e.g., time-out sticker chart – see Chapter 10) has been recommended.

Language Concerns. In PCIT, the dialogue between parents and children and between the therapist and the parent is crucial and needs to be based on a common language. Implementation to a non-English speaking country or culture always starts with a translation of the core concepts of PCIT. The translation from English to a new language is an extensive process, and compromises are often necessary. The challenge is to find words that give the correct associations for the parents in the country and at the same time have the correct theoretical content. For instance the word "reflection" is hard to translate into Norwegian because the direct translation is a word that is "academic" and rarely used in daily language. The word "enthusiasm" also is difficult to translate into Chinese in a play context. Another example is the use of the word "please." In English it is possible to give a direct command in a polite way by using the word please. However, in Norwegian, using the equivalent of "please" will automatically make the command indirect. The solution to these problems has been to not wait for the perfect translation, but to find new ways of expression verbally and non-verbally in cooperation with parents and other therapists.

Conclusion

This chapter shows that with some cultural adaptations PCIT continues to be PCIT, even when implemented in other countries. In our view the countries currently adopting PCIT share a tradition of having extensive contact with different cultures, which has led to an openness and willingness to be influenced by new ideas. Although located in different parts of the world, the countries where PCIT has been implemented so far do not represent much of the variation one can find between countries. In addition there are many sub-cultures and local variations in countries around the world that have not yet been exposed to PCIT. Undoubtedly additional adaptations will become necessary as PCIT is disseminated to a wider range of cultures around the world.

We have tried to highlight some cultural differences that need to be taken into consideration by implementation of PCIT to new countries. However, there are principles underlying PCIT that are more universal, including learning and attachment theory. These principles are on the one hand quite simple, but at the same time complex and sophisticated. In PCIT these principles are transferred to the parent-child dyad, and the crucial factor seems to be whether the therapist is sensitive to the needs of the actual family and is able to adapt to the cultural and language differences. We find that the elements that constitute good communication between parents and children are universal and applicable to parent-child interaction all over the world.

References

Bjørseth, Å. (2006). *Effect of parent-child interaction therapy (PCIT) in the treatment of behaviour disorders in small children*. Unpublished manuscript.

Ebbesen, N. K., & Stedje, I. (2008). *Differences in parent-child interaction in nonclinical and clinical groups using dyadic parent-child interaction coding system as the discriminative tool*. Unpublished master's thesis in Psychology, NTNU 2008.

Gudmundsen, K., & Martinsen, K. B. (2008). *Parent-child interaction in relation to family stress and parents' symptoms of anxiety and depression*. Unpublished master's thesis in Psychology. NTNU 2008.

Kvarum, I. M. (2005). *PCIT-techniques for pre-school teachers. Preventing disruptive behavior in young children: An intervention program for kindergartens*. Unpublished master's thesis in Psychology, NTNU 2005.

Nixon, R. D. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-child interaction therapy: A comparison of standard and abbreviated treatments for oppositional defiant preschoolers. *Journal of Consulting and Clinical Psychology*, *71*, 251–260.

Nixon, R. D. V, Sweeney, L., Erickson, D. B., & Touyz, S. W. (2004). Parent-child interaction therapy: One- and two-year follow-up of standard and abbreviated treatments for oppositional preschoolers. *Journal of Abnormal Child Psychology*, *32*, 263–271.

Thomas, R., & Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of parent-child interaction therapy and triple P-positive parenting program: A review and meta-analysis. *Journal of Abnormal Child Psychology*, *35*, 475–495.

Tsang, S., Leung, C., Chan, M., & Choi, T. (2007, September). *Good practices in applying parent child interaction therapy (PCIT) on Chinese families with children having serious behavior problems*. Paper presented at the 7th National Parent Child Interaction Therapy Conference, Oklahoma City, OK.

Wist, K. W. (2007). *PCIT i skolen. Implementering av prinsipper fra parent-child interaction therapy (PCIT) i skolen. Opplæring og veiledning av lærere for barn med atferdsvansker*. Unpublished. master's thesis in special education. NTNU 2007.

Chapter 25
Training Issues

Because PCIT now appears on many professional organization lists of evidence-based treatments, the demand for training has grown tremendously. PCIT is being rapidly and widely disseminated throughout the United States and the world. While it is exciting to know that many more families are gaining access to this effective program, it is also time to pause and consider the dangers of rapid dissemination. Our biggest concern is loss of treatment integrity. Just as a picture that gets photocopied and then recopied loses its clarity, there is danger that the recipient of third or later generation training will learn a fuzzy form of PCIT that does not look like the original. Each PCIT therapist brings his or her own individual interpretation to the approach. Then that therapist trains a new group of therapists with a slightly different version of Eyberg's original research-based protocol. Although each individual's departures may be relatively small, the cumulative effect of multi-generational training can be huge. The "photocopied" PCIT may not be as effective as the original, which could eventually undermine the reputation of PCIT and its status as an evidence-based intervention. A second danger of rapid dissemination is that enthusiastic therapists may jump into providing a version of PCIT based on inadequate training such as reading this text or attending a day-long workshop. If individuals claim to do PCIT when actually providing only some of its components, its effectiveness is diluted and messages are sent to third-party reimbursors, consumers, administrators, and policy-makers that PCIT does not work. Additionally, among the many people claiming to provide PCIT, it may become difficult to identify the ones actually providing a quality program. Because of the dangers inherent in large-scale dissemination, leaders in the field of PCIT have made it a priority to establish clear guidelines for training and to develop a credentialing process.

PCIT National Advisory Board

Since the first PCIT conference in Sacramento, California, in 2000, leading PCIT researchers have met annually to discuss direction and policy issues related to PCIT. Sheila Eyberg serves as the chairperson of the advisory board. One of the first tasks undertaken in advisory board meetings was to enumerate the required components

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of PCIT. This issue became important because many therapists were choosing to use only certain parts of PCIT (e.g., only CDI, no coding, little coaching), yet were referring to their services as "PCIT." Table 25.1 presents guidelines for the necessary components of PCIT. Perhaps the most salient agenda topic addressed by the advisory board has been training standards and qualifications for conducting PCIT. In advisory board meetings, we discovered that prominent individual training programs (e.g., University of Florida, University of Oklahoma Health Sciences Center, University of California at Davis CAARE Center, West Virginia University) had developed their own sets of guidelines for training PCIT therapists and PCIT trainers. Although these protocols varied regarding the intensity and length of training needed to become a PCIT therapist, there was significant agreement in the set of methods and core elements of training. The advisory board used these materials to put together a document entitled, "Training Guidelines for Parent-Child Interaction Therapy." These guidelines have been approved and are now posted on Dr. Eyberg's website (www.pcit.org). These guidelines likely will change over time. Therapists and trainers should keep abreast of changes to the guidelines and adjust their practices accordingly.

Table 25.1 Required components of PCIT

** Use of assessment to guide treatment (e.g., ECBI, DPICS – III)
** Inclusion of both CDI and PDI
** Majority of non-didactic sessions spent in coaching
** Coding of parent-child interaction almost every coaching session
** Assignment of homework between sessions

Minimum Professional Qualifications to Conduct PCIT

In early research publications describing PCIT, the program was referred to as "Parent-Child Interaction *Training*." The last word was deliberately changed to *"Therapy"* with the realization that the program required more than education and skills training. A critical component of the approach was identified to be the "art" of the therapeutic process. To deliver PCIT well, a clinician needs to be able to join with families, motivate them to do what is hard, apply sound behavioral principles in an individualized fashion, attend to family dynamics, recognize child and parent psychopathology, manage aggression in sessions, and use data to guide clinical decision making. Therefore, leaders in the field of PCIT have recommended that trainees have at least a master's degree and be licensed as mental health practitioners with child and family experience. We find it appropriate to train individuals with qualifications such as licensed social workers, professional counselors, marriage and family therapists, psychologists, and psychiatrists. In addition, we train master's program psychology and social work students and individuals who already have a master's degree and are receiving supervision for licensure. Professionals

whose backgrounds do not prepare them to be PCIT therapists include parent educators, nurses, occupational therapists, physical therapists, respite workers, guidance counselors, child-care workers, teachers, and bachelor's level residential care staff. Although they cannot be PCIT therapists, there are two ways that these individuals may benefit from PCIT in their work. First, we often train direct care staff (e.g., teachers, child-care workers) in PCIT to improve their direct interactions with children, just like we do with our parent clients (see Chapters 20 and 21). Second, we often share PCIT materials with paraprofessionals who may then distribute handouts and readings to families. Using PCIT materials in this way is different from conducting therapy because the paraprofessional provides the information only in a written or didactic format (i.e., no therapy sessions, coding/assessment, or direct coaching).

Becoming a PCIT Therapist: Minimum Training Requirements

Although training groups use different methods to teach PCIT (e.g., once per week training, week-long workshops, distance training via two-way video, co-therapy), there are basic requirements for PCIT training. To refer to one's self as a PCIT therapist, the training guidelines require that the following criteria be met:

(1) At least 40 h of face-to-face training in basic PCIT skills by a PCIT trainer
(2) PCIT case experience with supervision/consultation with a PCIT trainer
(3) Approximately 16 h of advanced PCIT skills training (after some case experience, usually 2–6 months after initial training)
(4) Mastery of PCIT skills (ECBI, DPICS – III abridged coding, CDI didactic, PRIDE skills, CDI coach, use DPICS to guide coaching session, PDI didactic, coach PDI, coach time-out sequence, explain house rules and explain public behavior)
(5) Successful completion of 2 PCIT cases
(6) Treatment review (of live or videotaped sessions) by a PCIT trainer, including CDI didactic, PDI didactic, CDI coaching, and PDI coaching

We acknowledge that there are many ways to structure PCIT training to meet these six objectives. The structure will be different based on whether the training is local or distant. When a PCIT trainer is mentoring someone in the same facility (e.g., graduate student, new therapist, interns), a strong method of training is the co-therapy model. In such cases, the 40 h of basic training criterion may be satisfied by distributing it over many weeks by providing co-therapy and supervision across a particular semester or year. For PCIT trainers who are training therapists in their local vicinity (e.g., within a three-hour drive), the strongest training model might involve 10 weekly 4-h workshops, rather than a 40 h intensive training. Strengths of the weekly training model include opportunity for reflection, avoidance of information overload, chance to do PCIT during the actual training, and the opportunity

to get feedback on cases during the training. Because only a handful of sites across the country provide training, many aspiring PCIT therapists only have access to long-distance training. One model is for trainees to travel to a major training site (e.g., WVU, UF) and participate in an intensive, week-long basic skills experience. Similarly, an agency might contract for a trainer to travel to their site for a 40 h training workshop. An innovative long-distance training method is currently being used at the University of Oklahoma Health Sciences Center in which two-way telecommunication is used to provide real-time supervision on PCIT cases being conducted in remote areas, particularly with Native Americans in Alaska and other western states (Funderburk, Ware, Altshuler, & Chaffin, 2008). All of these training modes have been effectively used to satisfy the six minimum criteria listed above for becoming a PCIT therapist.

When administrators and clinicians first hear of the heavy training requirements associated with PCIT, many are surprised that any therapy could require such a large commitment of training time. However, having conducted a great deal of training in our careers we are convinced that this is the minimum investment that will result in competent PCIT services. PCIT training is more intensive than most other evidence-based therapies because it involves live coaching of parent-child interactions. Trainees must first master the skills that are required of parents in PCIT. They also must become proficient at an elaborate coding system (the manual is over 200 pages long) that records every verbalization made by the parent as well as a number of child behaviors. Trainees must learn to coach parents, which involves practicing a new telegraphic language. PCIT training involves over-learning of skills so that therapists can make quick judgments and provide immediate feedback during contentious parent-child interactions. Because PCIT is an experiential rather than didactic or educational intervention, training involves therapist skills testing and practice until mastery. See Table 25.2 for a list of components that usually are included in the 40 h of basic skills training.

Table 25.2 PCIT basic skills components

** Overview of the theoretical foundations of PCIT
** Administering and scoring of pre- and post-treatment assessment measures (e.g., ECBI, SESBI)
** Coding of parent-child interactions using the DPICS for both pre- and post-treatment assessment, as well as at the beginning of each session
** Conducting a CDI didactic session
** Learning to use CDI skills themselves while playing with children
** Coaching CDI
** Conducting a PDI didactic session
** Learning to use PDI skills themselves with a child
** Coaching PDI
** Learning to phase-in PDI
** Teaching house rules and public behavior

In addition to the 40 h basic skills training, it is essential that trainees apply their newly acquired skills with actual cases immediately following training. Failure to solidify the new knowledge with practice and therapy experience will cause the trainees to quickly lose the skill competence gained during training. Therefore, we strongly suggest that trainees identify several potential PCIT cases prior to the workshop. At the end of the training, we give them a homework assignment to complete a CDI didactic and one CDI coaching session prior to a follow-up phone consultation (2–4 weeks after training).

After approximately 3 to 6 months, the 2 days of advanced skills training should be conducted. In this workshop, we assess the trainees for "drift" and re-ground them in PCIT essentials. We also ensure that they have maintained a high level of mastery. Most of this follow-up training addresses advanced coaching techniques, predominantly in PDI, as well as teaching therapists to better motivate parents to do their homework assignments and to complete treatment. The time-out sequence is practiced repeatedly until it becomes automatic.

There are a number of training competencies required of a PCIT therapist. Throughout both the basic and advanced trainings, we observe, code, and test therapists to determine mastery of these competencies. First, therapists must demonstrate that they can effectively teach CDI to parents. This can be assessed by observing them in an actual CDI didactic with a client, or a "mock" CDI didactic. Second, the therapist must master the CDI skills with a child. With regard to the PRIDE skills, the therapists must meet the same mastery criteria as parents and display 10 behavioral descriptions, 10 labeled praises, and 10 reflections in 5 min, while providing fewer than 3 questions plus commands plus criticisms. Third, therapists must demonstrate competence in teaching the discipline skills of PDI. Again, mastery can be assessed via observation of an actual PDI didactic with a client or a "mock" didactic session. Fourth, therapists must master the same PDI skill criteria as parents. In other words, during a 5-min coding session, they must provide at least four commands. At least 75% of these commands must be "effective," and there must be at least 75% correct follow-through after the commands. Fifth, competency in DPICS coding requires that the therapist obtain at least 80% agreement with the trainer during a live coding session. Finally, therapists must demonstrate competence in both CDI and PDI coaching. This usually is assessed through observation by the trainer and may involve coding the coaching statements.

Finally, we want PCIT therapists to be able to apply their skills to an array of presenting problems, socioeconomic groups, family dynamics, and cultural groups. By successfully completing at least two PCIT cases under the supervision of a PCIT trainer, therapists learn to apply what they have learned to the complex issues presented by real families. The two-family criterion also ensures that therapists have used the skills enough that they have become automatic and will be maintained over time.

Becoming a PCIT In-agency Trainer: Minimum Training Requirements

Just being a PCIT therapist does not qualify someone to be a PCIT trainer. The PCIT Training Guidelines (October 2008, www.pcit.org) differentiate between in-agency trainers and master trainers. In-agency trainers are qualified to teach and supervise therapists only within their own agency, while master trainers provide broad dissemination of PCIT. With regard to in-agency training, therapists who wish to train others must obtain additional experiences that prepare them to anticipate and solve the many problems that may occur in PCIT cases. Trainers also need to be very familiar with the research literature and latest developments in PCIT to provide quality training. Below are the four minimum criteria needed to be an in-agency PCIT trainer.

(1) Satisfied basic criteria to be a PCIT therapist
(2) Successful completion of at least 4 PCIT cases in consultation with a master PCIT trainer, and continued activity in PCIT service delivery
(3) Maintain a relationship with the master trainer for supervision/consultation for a minimum of 1 year and engage in continuing education regarding PCIT (e.g., remaining current with the literature, attending a PCIT conference, attending a PCIT workshop)
(4) Conduct one supervision or training session on CDI and one on PDI under the supervision of a PCIT master trainer

Becoming a PCIT Master Trainer: Minimum Training Requirements

PCIT master trainers are experts who are able to train PCIT therapists and trainers at outside agencies. They must have an extensive history of provision of PCIT. Additional requirements are listed below:

(1) Satisfied requirements to be a PCIT trainer
(2) Regularly provides advanced training in PCIT (e.g., through an academic program, training institutes)
(3) Knowledge of the most recent advancements in PCIT and ability to maintain fidelity of the model across agencies
(4) Must be approved through the review procedure developed by Sheila Eyberg, Ph.D.

Costs of Starting a PCIT Program

Starting a PCIT program is not cheap. PCIT requires special equipment and space to be conducted with integrity. Additionally, the cost of time-intensive (approximately 56 h) training is high not only in terms of payment to a trainer, but also in terms of lost billable hours while staff receive training. We have found that programs that attempt to save money by training only one therapist tend to lose money in the long

run because the PCIT program is either never properly launched or does not continue over time. Training only one staff member is a mistake for many reasons. First, because of issues like high staff turnover, pregnancy leaves, and job reassignments, there is a good chance that the trained therapist will not be in a position to provide PCIT for that agency 1 or 2 years down the road. Second, launching a new PCIT program requires a great deal of time, energy, and support. Therapists must publicize the service, educating referral sources about the specifics of the program, while also setting up the physical space. Finally, it is hard to learn and maintain PCIT skills in a vacuum. Without at least one other colleague trained in PCIT, the therapist often does not have the peer consultation needed to problem-solve issues that arise during the initial learning cases. Therefore, when establishing a PCIT program at an agency, it is recommended that at least two therapists receive the training. Depending on the existing resources of a given facility, start-up and training costs may vary greatly. In Table 25.3, we detail the resources necessary to begin a PCIT program. In Table 25.4, the agency requirements for beginning a PCIT program are listed.

Table 25.3 Start-up and training commitments needed to establish a new PCIT program

Bug-in-the-ear equipment
Audio system
Videotaping equipment
Two-way mirror
Time-out room
Toys
Trainer costs for basic training, advanced training, and follow-up consultation
Travel expenses
Lost billable hours during training time

Table 25.4 Agency requirements for beginning a PCIT program

(1)	proper equipment and space (one-way mirror, observation room, time-out back-up room) – all home-based PCIT programs should be adjunct to a clinic-based program with adequate facilities
(2)	minimum of 2 clinicians trained
(3)	agencies should support new therapists in identifying practice PCIT cases prior the 40 h basic training
(4)	at least monthly supervision is recommended until the completion of at least 2 cases

Although PCIT requires substantial start-up costs, research suggests that it is well worth the expense. In a recent examination of cost-effectiveness (Goldfine, Wagner, Branstetter, & McNeil, 2008) found that it costs approximately $1000 per client to provide PCIT services. Other treatments have been found to cost more while producing less (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004; Krivelyova, Sukumar, Stephens, & Freeman, 2007). PCIT is cost-effective in that it is a relatively short-term program that produces large magnitude improvements. The data suggest that PCIT may be potent enough to prevent the high costs associated with juvenile delinquency and adult criminal behavior that will come with failed early interventions (Goldfine et al., 2008). With respect to cost-effectiveness for an agency, PCIT

is a program that pays for itself through increased referrals and ease of obtaining grants and contracts. In our experience, the overwhelming majority of agencies that commit to PCIT training are highly satisfied with the long-term results of the investment. Please see Table 25.5 for a list of sites currently providing a great deal of PCIT training.

Table 25.5 Major sites currently providing PCIT training

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Beverly Funderburk, Ph.D.
Robin Gurwitch, Ph.D.
Melanie Nelson, Ph.D.
OUHSC PCIT Training Program
Child Study Center
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(405) 271-6824, ext. 45121
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Alissa Porter, M.S. (Anthony Urquiza, Ph.D.)
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Sacramento, CA 95820
(916) 734-6610

References

Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth*. Olympia: Washington State Institute for Public Policy.

Funderburk, B. W., Ware, L. M., Altshuler, E., & Chaffin, M. (2008). Use and feasibility of telemedicine technology in the dissemination of parent-child interaction therapy. *Child Maltreatment*, *13*, 377–382.

Goldfine, M. E., Wagner, S. M., Branstetter, S. A., & McNeil, C. B. (2008). Parent-child interaction therapy: An examination of cost-effectiveness. *Journal of Early and Intensive Behavioral Interventions*, *5*, 119–141.

Krivelyova, A., Sukumar, B., Stephens, R., & Freeman, K. (2007, March). *Treatment costs for children and families receiving parent-child interaction therapy or services as usual in a system of care setting*. Poster presented at the 20th Annual Research Conference, Tampa, FL.

Parent-Child Interaction Therapy's National Advisory Group Committee on Training (2008, October). *Parent-child interaction therapy training guidelines*. Accessed from www.pcit.org on June 23, 2009.

Appendices
Appendix 1

DPICS – III CODING SHEET - Adapted

Child _____ Date _____Caregiver _____ Session # ____
(If Intake or Post-Assessment CLP _____ PLP _____ CU _____)

CDI - Do Skills Coding

		Parent Skill Total	Coding **Mastery**
Labeled Praise			**(10)**
Reflection			**(10)**
Behavioral Description			**(10)**

Imitation	Satisfactory Needs Practice	
Enthusiasm	Satisfactory Needs Practice	
Ignoring Disruptive Behavior	Satisfactory Needs Practice	Not Applicable

**** Mastery = Satisfactory or Not Applicable for Imitation, Enthusiasm, & Ignoring**

Parent Skill	**Coding**	**Total**	**Mastery**
Neutral Talk			Not Applicable
Unlabeled Praise			Not Applicable

CDI - Avoid Skills Coding

		Parent Skill Total	**Coding**
Commands			
Questions			
Negative Talk (Criticism & Sarcasm)			

** **Mastery = no more than 3 questions + commands + criticisms.**

CHILD COMPLIANCE (Coded at Intake and Post Only in Place of Commands above)

Category	*Direct:*	*Compliance %* *	*Indirect:*	*Total*
Compliance				
Noncompliance				
No Opportunity				
TOTAL COMMANDS				

- COMPLIANCE PERCENTAGE = Total Compliance Divided By Total Commands

Adapted from Chase & Eyberg (2006). *Abridged Manual for the DPICS-III. Retrieved April 2, 2008 from* www.pcit.org.

C.B. McNeil, T.L. Hembree-Kigin, *Parent-Child Interaction Therapy*,
Issues in Clinical Child Psychology, DOI 10.1007/978-0-387-88639-8_26,

Appendix 2

CDI HOMEWORK SHEET

Name: Date:

	Did you practice play therapy for five minutes? **YES**	**NO**	**Describe the toys used and what happened.**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

MASTERY:

Labeled Praise = 10 ***Reflections = 10*** ***Behavior Descriptions = 10***

Questions + Commands + Criticism = 3 or Less

Appendix 3

Pride Skills

Child-Directed Interaction

Do Skills	Definition	Rationales	Examples
Praise – Labeled **P**	Saying specifically what you like about your child's play, accomplishments, words, appearance, or personality.	Adds warmth to the relationship Causes the behavior to increase Increases self-esteem Lets child know what you like Makes both parent and child feel good!	Parent: You are doing a great job of coloring in the lines. Parent: Terrific counting! Parent: I like the way you're playing so quietly. Parent: Thank you for asking nicely.
Reflect **R**	Repeating or paraphrasing what your child says	Allows the child to lead the conversation Shows the child that the parent is interested Demonstrates acceptance and understanding Improves child's speech Increases verbal communication	Child: The horse is going to be friends with the cow. Parent: The horse is going to be friends with the cow. Child: The camel got bumps on top. Parent: It has two humps on its back.
Imitate **I**	Doing exactly what your child does, or joining your child in play	Permits the child to lead the play Teaches the child how to play with others Shows interest and approval for your child's choice of play Increases child's imitation of you	Child: I'm making a circle. Parent: I'm going to draw a circle too – just like yours.
Describe Child's Behavior **D**	Talking about what your child is doing.	Allows child to lead Teaches concepts Models speech Holds the child's attention Organizes the child's thoughts and activities	Parent: You are driving the car into the garage. Parent: You drew a smiling face.
Be Enthusiastic **E**	Showing excitement, enthusiasm, playfulness, and interest	Keeps the child interested Helps to distract the child when ignoring	Voice has lots of inflection. Words sound playful. Speech sounds animated and excited.

Avoid Skills	Definition	Rationales	Examples
Questions	Seeming unsure and requesting information	Leads the conversation, instead of following Many are commands or require answer May seem like you aren't listening to your child May seem like you disagree with your child	Parent: What are you making? Parent: That's a blue one, right? Parent: You want to play with the wastebasket? Parent: You're having fun, aren't you?
Commands	Direct commands involve *telling* your child to do something. Indirect commands involve *asking or suggesting* that your child do something.	Takes the lead away from the child Sets up the interaction to be unpleasant	*Direct* Parent: Put the blocks in the box. Parent: Come here. *Indirect* Parent: Will you hand me that paper? Parent: Could you show me the orange square?
Criticism and Sarcasm	Comments that find fault with the child or express disapproval Often includes the words **"no," "don't," "stop," "quit," and "not"**	Often increases the criticized behavior May lower child's self-esteem Creates an unpleasant interaction	Parent: That's not how you should do that. Parent: You're being naughty today. Parent: I don't like it when you talk back. Parent: Don't scribble on the paper. Parent: No, honey, that's not right.

Final Do Skill	Definition	Rationales	Examples
Ignore inappropriate behavior (unless dangerous or destructive) a. Avoid looking at your child, speaking, smiling, frowning, etc. b. Ignore every time the behavior occurs c. Expect behavior to increase at first d. Wait until your child does something appropriate e. Enthusiastically praise or describe your child's appropriate behavior>	Taking away attention for negative attention-seeking behavior	Avoids increasing negative behavior Decreases negative attention-seeking behavior Helps child notice difference between your reactions to appropriate and inappropriate behavior	Child: (sasses parent, then picks up toy) Parent: (ignores sass; praises picking up) Child (hits parent) Parent: (GAME STOPS; can't be ignored)

Note: Modified from Eyberg, S.M., & Boggs, S.R. (1989). Parent training for oppositional-defiant preschoolers. In C.E. Schaefer & J.M. Briesmeister (Eds.), *Handbook of parent training: Parents as co-therapists for children's behavior* problems (pp. 105-132). New York: Wiley. Table Table 5.1 on pages 109-110 was adapted with permission of John Wiley & Sons, Inc.

Appendix 4

SUGGESTED TOYS FOR CHILD-DIRECTED INTERACTION
PARENT HANDOUT

Creative, constructional toys, like:

Building blocks
Legos
Duplos
Tinkertoys
Magnetic blocks
Lincoln Logs
Constructo-Straws
Mr. Potato Head
Dollhouse with miniature people
Bristle blocks
Toy garage with cars
Waffle blocks
School bus with riders
Erector set
Toy farm with animals
Chalkboard and colored chalk
Crayons and paper
Magnetic picture board

TOYS TO AVOID DURING BEHAVIORAL PLAY THERAPY

Ones that encourage rough play, like:
bats, balls, boxing gloves, punching bag.
Ones that lead to aggressive play, like:
toy guns, toy swords, toy cowboys and Indians, superhero figures.
Ones that could get out of hand and require limit-setting, like:
paints, scissors, Play-Doh.
Ones that have preset rules, like:
board games, card games.
Ones that discourage conversation, like:
books, audiotapes.
Ones that lead parent or child to pretend they are someone else, like:
puppets, costumes, toy phones.

Child's Name:

Parent's Name:

PCIT PROGRESS SHEET

Session																
Date																
																Mastery
Labeled Praise																10
Reflections																10
Behavior Descriptions																10
Questions																< 3 Q+C+C/S
Commands																< 3 Q+C+C/S
Criticism/Sarcasm																< 3 Q+C+C/S
ECBI Intensity																<114

Adapted from Eyberg (1999). *Parent-Child Interaction Therapy: Integrity Checklists and Session Materials,* p. 38. Retrieved April 2, 2008 from www.pcit.org .

Appendix 5

Appendix 6

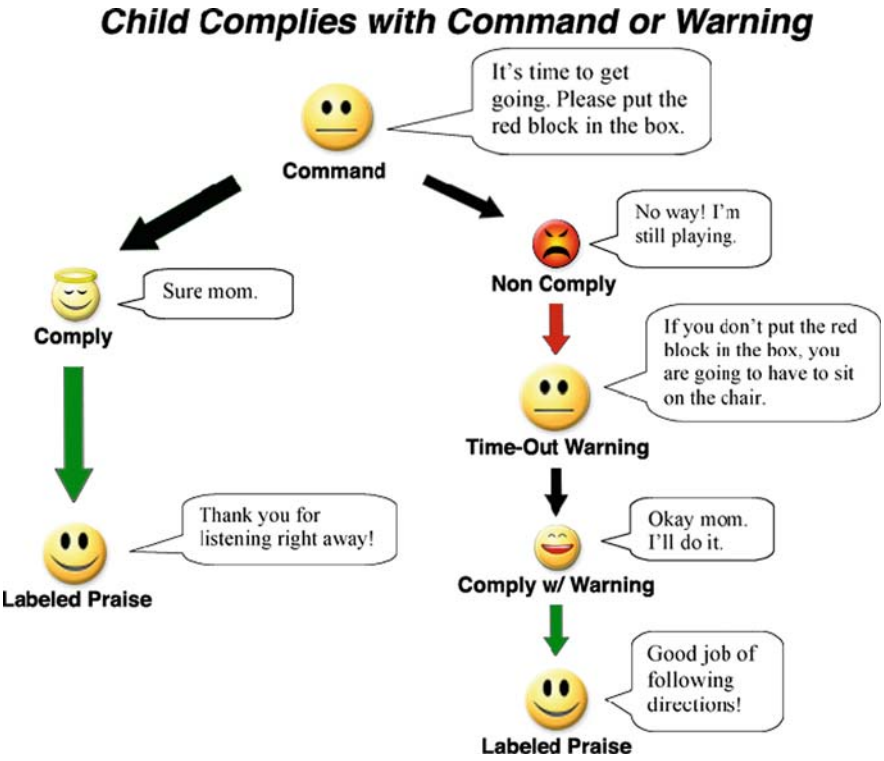
GIVING GOOD DIRECTIONS – PARENT HANDOUT

Rule	Rationale	Examples
Make commands direct, not indirect.	Eliminates any ambiguity about whether parent expects child to obey. Makes it clear the child, not parent, is to do the task.	Direct: Sit down right here. Indirect: Would you like to sit down? Direct: Pick up your toys. Indirect: Let's pick up your toys, OK?
Make commands single rather than compound.	Easier for child to obey smaller commands that are not overwhelming. Some children can't remember multiple-part commands. The child gets more opportunities for praise.	Put your shoes in the closet. (instead of . . .Clean your Room) Put on pajamas. Brush your teeth. Use the bathroom. (with a labeled praise for each compliance) (instead of . . .Get ready for bed.)
State commands positively (tell child what TO DO, instead of what NOT TO DO).	Oppositional children rebel against "stop and "don't" commands Tells child what (s)he can do instead	Child: (on kitchen counter) Parent: Get down please. (instead of. . .Don't climb on the counter!) Child: (bouncing ball indoors) Parent: Please get a book to read. (instead of. . .Stop bouncing that ball!) Child: (runs away from parent) Parent: Hold my hand. (instead of...Don't run away from me!)
Make commands specific, not vague.	Lets child know exactly what is expected Eliminates confusion Makes it easier to decide whether child has obeyed	Use your indoor voice. (instead of...Act nice!) Please walk (instead of...Behave yourself.) Wait for your turn. (Instead of...Play nicely.)
Give commands in a neutral tone of voice (instead of yelling or begging)	Children need to learn to respond to commands given in a normal, conversational voice. Makes interactions more pleasant for both child and parent	Come sit next to me. (instead of...Sit here now!! Or it would really make mommy happy if you would sit here, please?!)
Be polite and respectful.	Makes interactions more pleasant Models good social skills Less likely to cause an oppositional child to disobey	Please hand me the crayon. Sit next to me please.

GIVING GOOD DIRECTIONS – PARENT HANDOUT

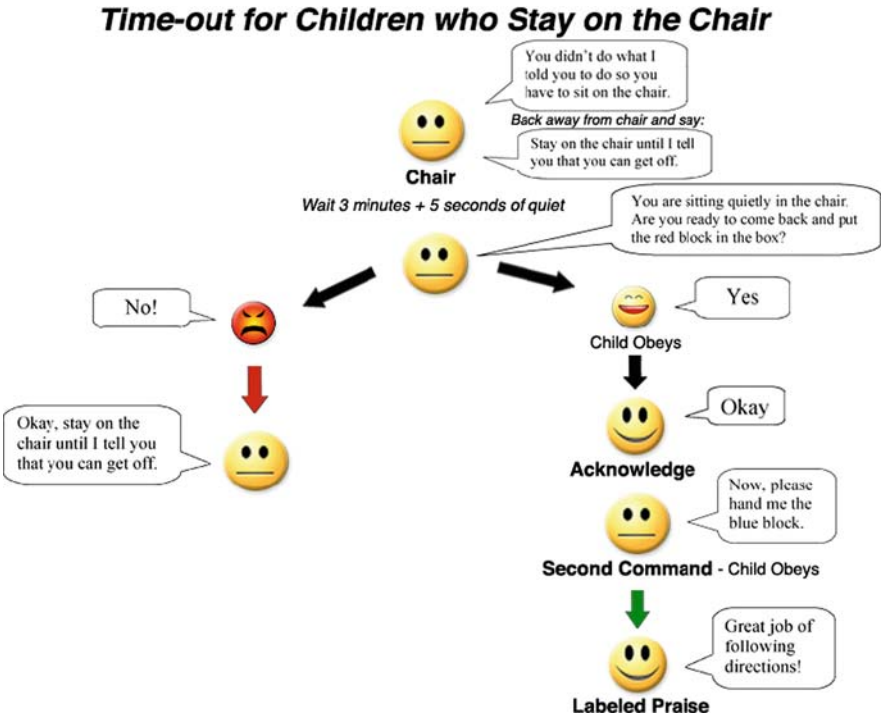
Rule	Rationale	Examples
Be sure commands are developmentally appropriate. Use gestures.	It's unfair to punish disobedience if the child was unable to obey To encourage a child to try something new, use an indirect command or suggestion, instead of a direct command Enhances comprehension. Provides less negative attention than repeated commands.	Make a picture. (instead of...Draw a stop sign) Would you like to try and sign it? (instead of...Write your name) Parent: Put the block (points at block) in the box (points at box).
Use direct commands only when really necessary.	Neither adults nor children like to be told what to do constantly If parents give many commands, it is hard to follow through with consequences each time	Child sits on knees while eating dinner. Instead of giving a command, parent chooses to ignore.
Incorporate choices when appropriate.	Encourages the development of autonomy and decision-making Doesn't take the "power" away from a child who tends to get in power struggles	Please watch TV or color quietly. Please put on your white socks or your blue socks. Use your indoor voice or play in the backyard.
Provide a carefully timed explanation.	Children who ask for explanations are usually more interested in stalling then knowing the answer Gives child the impression that he might be able to talk his way out of it If used, give explanation before the command to head off arguing.	Parent: Put the crayons away. Child: Why? Parent: Because we need to get ready to go. Child: After I finish. Parent: I said put the crayons away now!! Better... Parent: Our playtime is over and we need to get ready to go to the store. Please put your crayons away. Child: Why? Parent: (ignores delay tactics because explanation has already been given)

Appendix 7



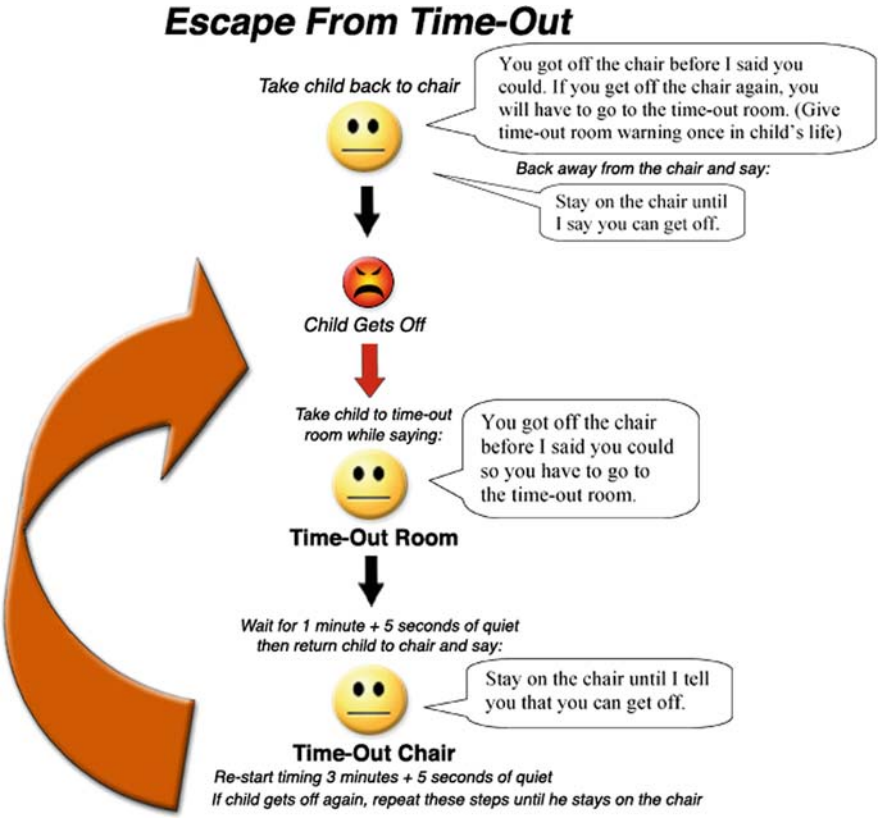
Adapted from Eyberg (1999). *Parent-Child Interaction Therapy: Integrity Checklists and Session Materials,* p. 89 (Time-Out Diagram). Retrieved April 2, 2008 from www.pcit.org.

Appendix 8



Adapted from Eyberg (1999). *Parent-Child Interaction Therapy: Integrity Checklists and Session Materials,* p. 89 (Time-Out Diagram). Available on-line at www.pcit.org

Appendix 9



Adapted from Eyberg (1999). *Parent-Child Interaction Therapy: Integrity Checklists and Session Materials,* p. 89 (Time-Out Diagram). Available on-line at www.pcit.org

PDI TRANSCRIPT CODING SHEET

Child _____ Date _____Caregiver _____ Session # _____

COMMAND (write it out)		Obey	Disobey		Praise (write it out)	Chair Warning (if incorrect, write it out)		Obey	Disobey		Praise (write it out)	Chair		Time-Out Room

PDI MASTERY CRITERIA

During the 5 -minute coding at the beginning of the session, parents must give at least 4 commands, of which at least 75% must be "effective," (i.e., direct, positively-stated, single commands that provide an opportunity for the child to comply) and parents must show at least 75% correct follow-through after effective commands (labeled praise after obey and warning after disobey). In addition, if the child requires a time out that begins during the observation, the parent must successfully follow-through with the PDI procedure (i.e., the interaction must end with a labeled praise for compliance to the follow-up command).

Appendix 11

PDI HOMEWORK Sheet

Child's Name: _____

Parent's Name: _____

Day of the Week	**YES** Practiced PDI	**NO** Did Not practice PDI	**# of Time-outs in Chair**	**# of Time-out Back Up Rooms**	**Questions?? Problems?? Concerns??**
MONDAY					
TUESDAY					
WEDNESDAY					
THURDAY					
FRIDAY					
SATURDAY					
SUNDAY					

Appendix 12

Handling Future Behavior Problems

Problem: Time-out should not be overused (more than 4 times per day). The overuse of time-out causes children to become angry and parents to become more stressed and less consistent.

Solution: Use these alternatives to time-out.

1. Praise the Opposite of the Problem. Define a behavior which is the opposite of the problem behavior. Then, provide attention, particularly in the form of labeled praise, to the opposite behavior. It is best to catch the child engaging in the opposite behavior before there is an opportunity to engage in the problem behavior.
2. Give Positively Stated Direct Commands to Do the Opposite of the Problem. Use positively-stated, incompatible commands to direct the child to a more appropriate behavior. Labeled praises for the positive behavior must always follow compliance.
3. Tactically Ignore the Disruptive Behavior. This involves calling a conference with the child at a neutral time. During the conference, the disruptive behavior is carefully defined. You should explain that every time the child engages in that behavior, the parent will either turn away or walk away. The ignoring process is role-played with the child.
4. Ignore and Distract. Briefly ignore the disruptive behavior while quickly distracting the child into a more positive behavior.
5. Use Overcorrection. This involves having the child engage in a more positive behavior, in an exaggerated or repeated manner, immediately following the disruptive behavior. Positively stated, incompatible commands are used to direct the child in the overcorrection procedure and labeled praises reinforce compliance. For example, a child who frequently slams the back door could be told to go back and shut the door gently 5 times.
6. Use a Star Chart. Set up a token system/star chart to reinforce the child for progressive improvements.
7. Develop a Written Behavioral Contract. This is done by calling a conference at a neutral time (e.g., when the child is engaging in appropriate behavior and the parent is in a calm state). The disruptive behavior is discussed with the child. The child's input is solicited regarding reasons for the problem and possible solutions. A written contract is created which details the solutions generated by you and your child. Usually the solutions involve some type of reward in exchange for the child taking charge of that behavior, as well as negative consequences for choosing to continue the problematic behavior.

8. Analyze Whether You Are Contributing to the Problem. Carefully examine what is happening before, during, and after the behavior. Consider whether you are contributing to the problem by providing negative attention, being inconsistent, backing the child into a corner, overreacting, expecting too much from the child, being vague about rules and consequences, not providing enough positive attention to the child, and/or setting the child up for failure. If you find that you are contributing, always change your approach before asking the child to change.

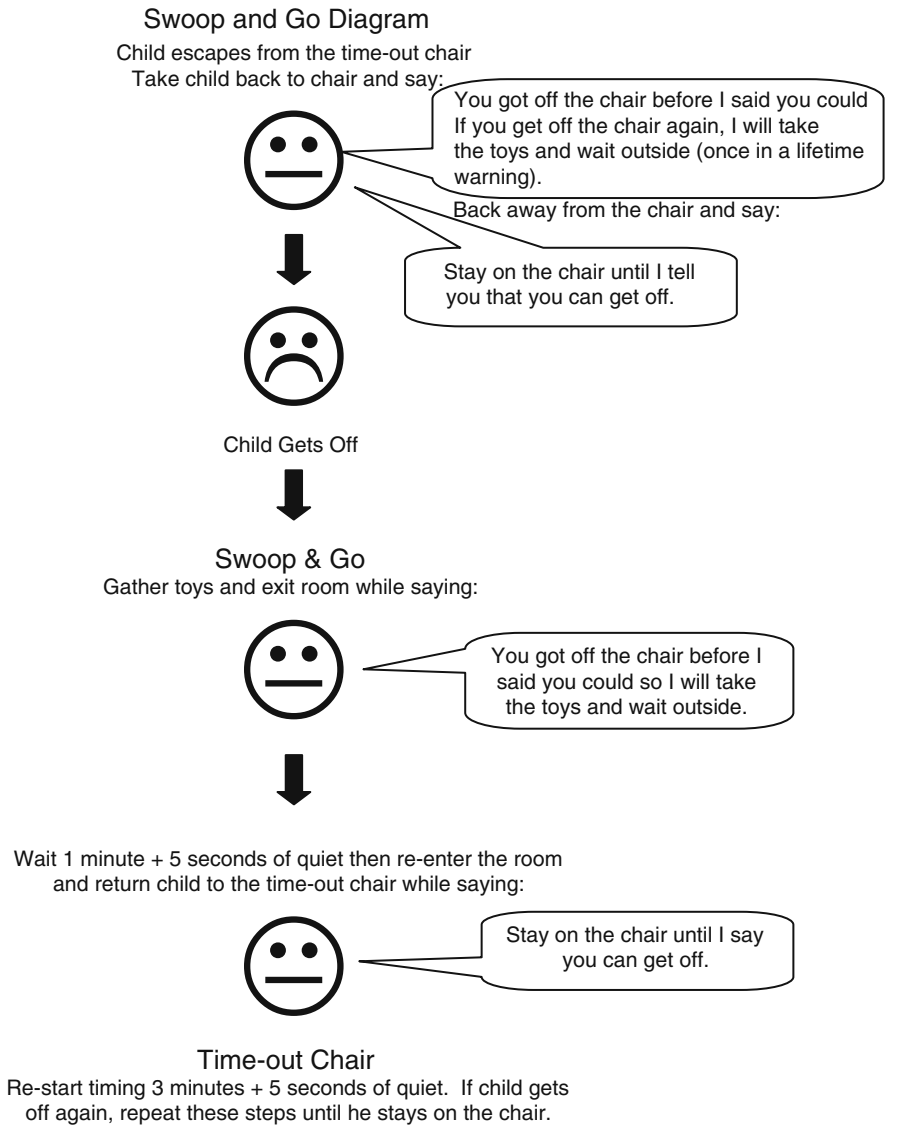
9. Review Rules with the Child Immediately Before Entering Situations That Provoke Disruptive Behavior. For problems that occur in only particular situations, use a "think aloud/think ahead" approach. This involves anticipating the problem, explaining the rules in advance, and reviewing the consequences immediately before entering the problem situation. For example, children who often tantrum when playing a particular video game could be given the rules and expectations immediately before being allowed to play (e.g., "If you scream and whine during the game, I will have to turn it off.").

10. Assess Whether the Child Is Receiving Enough Special Playtime. Are you being consistent with special playtime? Have your skills regressed? Are you making sure that your special playtime is one-on-one, without interruptions? Perhaps your child needs an extra child-directed time on challenging days. An extra playtime could decrease your child's anger and frustration, as well as add warmth to the parent-child relationship. A happy child will engage in fewer disruptive behaviors

11. Use Logical or Natural Consequences. If your child is having trouble with a particular friend or toy, consider providing a warning and then removing the problem (e.g., "If you do not play calmly with Robbie, he will have to go back to his house."). Sometimes we think of this as "timing-out the toy." Rather than using a command sequence that could end in sending your child to time-out (possibly provoking a physical confrontation), give a warning and then time-out the toy. For example, for a child who keeps pinching her brother with a Slinky, the parent could say, "If you do not play gently with the Slinky, I will have to take it away."

12. Use When–Then Statements. You can hold back privileges until your child provides behaviors that you desire. The "when" part of the sentence should always involve a positive expectation, rather than a "don't" or "stop." Examples include: (1) (child is whining for a snack) "When you ask nicely, then you can have a cookie," (2) (child is eager to play outside) "When you pick up the crayons, then you can go outside," (3) (after breakfast, child asks you to set up a computer game) "When you brush your teeth, then I will load your game onto the computer," and (4) (while driving in the car, child is kicking the back of your seat to get you to hand him the water bottle) "When you put your feet down, then I will hand you the water bottle." Parents are in control hundreds of privileges each day. Rather than giving them out for free, you can use some of them strategically to encourage desired behaviors.

Appendix 13


Swoop and Go Diagram
Child escapes from the time-out chair
Take child back to chair and say:
You got off the chair before I said you could If you get off the chair again, I will take the toys and wait outside (once in a lifetime warning).
Back away from the chair and say:
Stay on the chair until I tell you that you can get off.
Child Gets Off
Swoop & Go
Gather toys and exit room while saying:
You got off the chair before I said you could so I will take the toys and wait outside.
Wait 1 minute + 5 seconds of quiet then re-enter the room and return child to the time-out chair while saying:
Stay on the chair until I say you can get off.
Time-out Chair
Re-start timing 3 minutes + 5 seconds of quiet. If child gets off again, repeat these steps until he stays on the chair.

Appendix 14

The Sunny Day Level System

The Level System can be used as a way to provide positive attention to appropriate behavior and give a warning and a minor consequence for inappropriate behavior.

To implement Level System for the whole class.

- Each child is assigned a certain shape on the System.
- The Level System should be placed somewhere in the room so that the children are able to see where their shapes are on the System. It should remain visible during the entire class period.
- Use the Level System at times during the day when children's behavior may interfere with the classroom routine or with learning (e.g., circle time, transitions).

Moving Up

Children move up for appropriate behavior (e.g., sitting correctly, putting coat in the cubby, following class rules) and down for inappropriate behavior (i.e., annoying and obnoxious behavior, not following class rules). When children move up, they are given a labeled praise (i.e., specific praise such as "Thank you for sitting in your seat") for the appropriate behavior.

Moving Down

1. Children first are given a warning for inappropriate behavior, and then if they do not begin to behave appropriately, they move down. For example, the teacher would say, "You have two choices. You can either put the crayons in the basket, or you will move down into the cloudy area." Alternatively, for obvious behaviors (e.g., child is doing cart wheels in the reading area), the teacher can use the visual two choice warning signal without words and simply say the child's name. Then, if the child did not begin to behave appropriately, the teacher would move the child down.
2. Children are not given a warning for hurting others (e.g., hitting other children and

making them cry) or destruction of property (e.g., tearing up other children's work); they simply are moved down a level. The teacher has the option of adding a consequence (e.g., time-out) when the child is moved down for these behaviors.
3. If a child continues to misbehave after being moved down a level, give the child another warning if appropriate (i.e., not hurting or destruction). If he or she continues to misbehave after the warning, move the child's shape down a level again. If the misbehavior continues after you have moved the child's shape down 2 times, provide another consequence, such as time-out or restriction of privilege, that you would typically give to a child who engaged in that misbehavior.

Rewards

4. Near the end of the 1-h class period, the teacher should give out the rewards. All children in the sunny area of the Level System receive a reward (e.g., snack, play a game, get a special activity), and all children in the cloudy area do not receive the reward.
5. The rewards are printed on cards, and all of the children receive the same reward. The teacher should give out the rewards at least once during the morning and once during the afternoon.
6. Each reward card should be used once before any reward card is used again. Place the used reward cards in the envelope so that each teacher knows which cards have been used.
7. After the reward is given to the children, all of the children's shapes are placed back in the neutral area, and a new period begins where they can earn a reward. The children essentially are starting over for the next period.
8. All of the children in the class should have equal access to the rewards. To ensure that the children are receiving the rewards with the same frequency:
    a. Expectations must be individualized for each child, so that some children will move up for simply not hurting another child for a few minutes, or for staying seated for a few seconds. These expectations should be increased when the child masters them.
    b. The teacher must monitor which children receive rewards. If some children continually are not receiving the reward, then that child's expectations must be lowered so that he or she may have equal access to the rewards.
9. The Level System should be used for most transitions (e.g., moving from circle time to structured activity, play time to clean-up). In other words, the teacher should move all of the names (either up or down) following most transitions.

What if a Child Is in the 3rd Cloudy Level?

If a child is in the 3rd cloudy level of the system, take the child aside and discuss the rules with that child. In addition, the teacher should lower his or her expectations for that child and focus on small positive behaviors so that the child will receive

positive feedback and be able to move up the Level System. For example, if a child is behaving aggressively, the teacher can tell the child that if he or she can play gently, the shape will be moved up a level. Another alternative would be to provide a reward to the class quickly and start all children back in the neutral zone.

What if a Child Is in the 3rd Sunny Level?

If a child is in the 3rd sunny level of the system, the child should still receive labeled praise for behaving appropriately even though he/she cannot move up any more.

Correct Use of the Level System

1. Moving children's shapes up a level for appropriate behavior.
2. Providing a warning for inappropriate behavior.
3. Providing a warning, and then moving the child's shape down when the inappropriate behavior continues.
4. Providing a warning, then moving the child's shape down, then providing a warning again, then moving the child's shape down again when the inappropriate behavior continues.
5. Providing a warning, then moving the child's shape down, then providing a warning again, then moving the child's shape down again, then providing a back up consequence (e.g., time out) when the inappropriate behavior continues.

Common Problems with the Level System

1. No warning is given for inappropriate behavior. The child's shape simply is moved down.
2. Providing a warning in a critical manner.
3. Forgetting to provide labeled praise for the child's behavior when the child's shape is moved up.
4. Providing a warning, but forgetting to move the child's shape down when the behavior continues.
5. Using criticism or nagging instead of providing a warning for misbehavior.
6. Providing a warning for hurting or destruction of property.
7. Forgetting to move children up a level when they behave appropriately.
8. Providing more than 1 warning before moving the child's shape down.
9. Not providing a warning or moving a child's shape down for inappropriate behavior.
10. Not providing enough consequences. Teachers should frequently use labeled praise, movement up a level, warnings, and movement down a level. For example, names should be moving on the board during most transitions, as well as sporadically during the regular classroom activities.

Subject Index

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