Parent–Child Interaction Therapy for Children With Special Needs

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Carl Sheperis
Donna Sheperis
Alex Monceaux
R. J. Davis
Belinda Lopez

Parent–Child Interaction Therapy (PCIT) is an evidence-based method for reducing disruptive behavior in children and improving parent management of behavior. PCIT is a form of behavioral intervention that can be used in clinical, home and school settings. Although initially designed for intervention related to oppositional defiant disorder and conduct disorder, PCIT has been found to be a promising intervention for addressing behavioral issues among children with special needs. We present methods, research-based instructions and a case example of PCIT with a child diagnosed with autism. This article is intended to assist professional counselors in designing appropriate interventions for both children and parents.

***Keywords*: autism, parent–child interaction therapy, special needs, behavioral intervention, case example**

Counseling techniques for children stem from a myriad of theoretical perspectives, and professional counselors are often in the unique position to provide systems intervention and training to families when a child has disruptive behavior. Despite the seniority of behaviorism in the field of psychology, behavioral family approaches have only recently been acknowledged as an effective practice in professional counseling. According to Gladding (2011), the following three premises underlie behavioral family counseling: (a) all behaviors are learned, (b) maladaptive behaviors are the target for change and (c) not everyone in the family has to be treated for change to occur. With these assumptions, it is easily deduced that the following also are true: (a) behavior can be unlearned and that new behaviors can be taught, (b) underlying, unresolved issues are not the key components of treatment, and (c) positive changes for one family member will impact the entire family system and surrounding ecology.

When working with children of preschool or early elementary age, it is important to directly involve the child's caregivers. Parents' influence on their children is significant and some parenting practices may exacerbate some children's problems (McNeil & Hembree-Kigin, 2010). Behavioral family counseling models recognize the relationship between the child's behavior and the family system. One behavioral family counseling technique, Parent-Child Interaction Therapy (PCIT), helps families work together with their children in reaching therapeutic goals. PCIT involves teaching parents some fundamental relationship-building strategies, including therapeutic play techniques for parents to use in the home environment (Johnson, Franklin, Hall, & Prieto, 2000). The clinician typically teaches and models PCIT techniques for the parents over the course of 8–10 weeks.

Carl Sheperis, NCC, is the Chair of the Department of Counseling and Special Populations at Lamar University. Donna Sheperis, NCC, is an Associate Professor at Lamar University. Alex Monceaux is an instructor at Lamar University. R. J. Davis and Belinda Lopez are Assistant Professors at Lamar University. Correspondence may be addressed to Carl Sheperis, Box 10034, Beaumont, TX 77710, csheperis@lamar.edu.

The purpose of this article is to demonstrate the practicality of PCIT as a component of behavioral family counseling, to facilitate the professional counselor's understanding of the model through a review of PCIT and to illustrate the utility of this model for children with special needs through a case study.

An Overview of PCIT

PCIT (Neary & Eyberg, 2002) is an assessment-driven form of behavioral parent training designed for families with preschool-aged children. We present a brief overview of PCIT, define the key components integral to the process, provide the framework for implementation and discuss the application of PCIT to special populations. The core of PCIT is twofold—to create nurturing parent–child relationships and to model prosocial behaviors while increasing a child's appropriate, compliant behaviors (Eyberg & Boggs, 1989). Play therapy skills are introduced to parents within the PCIT model to enhance the relationship between the parent and child. Additionally, PCIT cultivates problem-solving skills with parents who can then generalize gains made in the therapeutic milieu into the family environment. Similar to other models of family counseling, PCIT begins with the assessment process. Counselors using PCIT collect psychosocial information from the family through either structured or semistructured clinical interviews. Because PCIT is a behavioral model, family dynamics also are assessed through direct observation of clients. Once clinical interview and observational data are collected and evaluated, the counselor can explore family relationship dynamics.

PCIT counselors attempt to identify family roles, interactions and maladaptive disciplinary techniques (e.g., yelling, lack of follow-through, unrelated consequences) inherent in the system. The ultimate goal of these observations is to derive methods for replacing current ineffective parenting strategies with more adaptive ones, thus creating greater stability in the family system. Similar to other parenting approaches, family counselors using PCIT offer support and assistance in improving parent–child relationships without placing blame on the child or the parents (Webster-Stratton & Herbert, 1993).

The Benefits of PCIT

There are many benefits to PCIT; it is a brief, short-term family counseling procedure that teaches effective parenting skills and helps parents interact better with their children on a daily basis. Fundamentally, PCIT's two-tailed approach benefits both parents and children (Asawa, Hansen, & Flood, 2008) by reducing the internalization of problems and parent–child stress. Additionally, PCIT empowers parents through teaching positive interactive techniques that build parent–child rapport. PCIT fosters creativity and increases child self-esteem, decreases noncompliance or disruptive behavior, and increases the quality of parent-provided positive regard through developmentally appropriate play (Eyberg et al., 2001). These positive interactions effectively decrease problem behavior, resulting in a reduction or elimination of emergency counseling visits. One PCIT study reported that only 19% of participants in a randomized controlled trial with physically abusive parents re-reported physical abuse more than 2 years after the implementation of the PCIT model (Chaffin et al., 2004).

While PCIT sessions may focus on home and play, the behavioral skills that the parent learns can be generalized to other children and additional settings, building stronger interactions across a spectrum of familial and social settings. According to Urquiza and Timmer (2012), PCIT focuses on the following three essential non-fixed elements: (a) increased positive parent–child interaction and emotional communication skills, (b) appropriate and consistent discipline methods, and (c) direct scaffolding for parent training in the interventions. Thus, once the parent has mastered these skills in the session with the child and therapist, the parent is able to transfer the skills to any location or setting to maintain positive interactions, emotional communication and disciplinary consistency with the child.

The Effectiveness of PCIT

Eyberg and her colleagues have researched and published extensively on the efficacy of PCIT and have empirically supported the effectiveness of PCIT with children exhibiting a range of behavioral and emotional problems (Neary & Eyberg, 2002). Specifically, PCIT has proven effective with problems including attention-deficit/hyperactivity disorder (ADHD), conduct disorders, separation anxiety, depression, postdivorce adjustment, self-injurious behavior and abuse (Eyberg et al., 2001; McNeil & Hembree-Kigin, 2010). For example, Nieter, Thornberry, and Brestan-Knight (2013) conducted a pilot study with 17 families completing PCIT treatment and found a significant decrease in disruptive child behaviors as well as a decrease in inappropriate parent behaviors over the 12-week group program. This study was the first to deliver PCIT via group sessions. The researchers found that treatment effects remained in place for more than 6 months after the group's completion.

Eyberg et al. (2001) investigated long-term treatment outcomes of PCIT for families of preschoolers with conduct disorders over a period of 1–2 years, and found that treatment effects were sustained over time. According to the researchers, the study was the first of its kind to include long-term follow-up with families receiving PCIT treatment (Eyberg et al., 2001). Hood and Eyberg (2003) established further evidence in another follow-up study on PCIT treatment effects over a period of 3–6 years. In the study of treatment effects on families with young children diagnosed with oppositional defiant disorder, the researchers found that treatment effects and behavioral change were again sustained over time. Thomas and Zimmer-Gembeck (2007) conducted a review of behavior outcomes in 24 studies on PCIT and another parenting intervention, Triple P—Positive Parenting Programs. All of the studies involved children aged 3–12 and their caregivers. Meta-analyses revealed positive effects for PCIT as well as the other intervention, adding support within the literature on the efficacy of PCIT.

To demonstrate the effectiveness of PCIT for treating ADHD, Guttmann-Steinmetz, Crowell, Doron, and Mikulincer (2011) examined the interactions of children with ADHD and their mothers. Their findings suggest that while Behavior Parent Training is useful in managing ADHD, PCIT may be highly effective in impacting the attachment-related processes during the child's later developmental stages. These researchers suggested that parents' successful adaptation of PCIT's verbal and behavioral skills during interaction with their child might increase the child's sense of security.

The effectiveness of PCIT has been expanded to other disorders such as separation anxiety. For example, Choate, Pincus, Eyberg, and Barlow (2005) conducted a pilot study involving three families with children 4–8 years of age diagnosed with separation anxiety disorder. The researchers found that the child-directed activities fostered children's sense of control and reduced separation anxiety symptomology to normative levels by the conclusion of treatment. Again, the treatment effects were shown to persist long after treatment ceased. This study was replicated by Anticich, Barrett, Gillies, and Silverman (2012), providing further support of PCIT's effectiveness in alleviation of separation anxiety disorder symptomology.

Individuals or populations with special needs also appear to respond positively to PCIT. Bagner and Eyberg (2007) found that mothers of young children diagnosed with mental retardation and oppositional defiant disorder reported a reduction in disruptive behaviors, increased compliance and less parenting stress after participating in a randomized, controlled trial study utilizing PCIT. PCIT also has been cited as a promising evidence-based intervention for autism (Agazzi, Tan, & Tan, 2013). Solomon, Ono, Timmer, and Goodlin-Jones (2008) conducted a randomized trial of PCIT for treating autism and found the same results as researchers studying other disorders have. PCIT was shown to reduce behavioral disruptions, increase adaptability and increase positive parental perceptions of child behavior. While PCIT was originally developed to address

behavioral disorders, it clearly serves as an intervention for various other disorders that impact parent–child interactions.

The impact of PCIT on parents. PCIT has been shown to have equally effective outcomes for parent-related issues as it does for child behavioral disruptions. For example, Luby, Lenze, and Tillman (2012) reported highly favorable results for using PCIT to reduce behavioral disruptions and improve executive function among preschoolers. However, PCIT also showed significant effects for parents. Specifically, PCIT interventions helped to reduce depression severity and parenting stress while increasing emotion recognition. Furthermore, Urquiza and Timmer (2012) found that parental depression decreases the likelihood that the child will complete the treatment course. However, if the parents are persuaded to continue until completion, their own psychological symptoms may be relieved.

PCIT has been shown to have positive effects on parents in a variety of circumstances. For example, Baker and Andre (2008) suggested that PCIT might offer a unique and promising advantage in the treatment of postdivorce adjustment issues in children. PCIT also has been found to be effective in working with abusive parents, many of whose histories included depression, substance abuse and violent behavior (Chaffin et al., 2004). Although still effective in reducing parenting stress and child behavior problems, Timmer et al. (2011) found that PCIT was less effective in foster parent homes than in non-foster parent homes. While PCIT is clearly an effective intervention for both children and parents, in cases with complex systems like foster care placement and abuse, PCIT could be used in conjunction with other interventions. The same is true for clients with special needs.

Diverse population efficacy. Although we recognize that one size does not fit all, PCIT has shown significant results with ethnic minorities and underserved populations. Different cultural and ethnic group parenting styles (strict vs. relaxed styles) vary across the United States. In addition to effectively increasing positive parenting behaviors and deceasing behavioral problems in children, treatment outcomes and efficacy studies support the notion that PCIT is culturally effective and produces robust modifications among diverse groups (see Bagner & Eyberg, 2007; Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; Matos, Torres, Santiago, Jurado, & Rodríguez, 2006; McCabe & Yeh, 2009). Additional literature and empirical research is available for review regarding work with specific populations such as African Americans and Asians. There also is promising evidence pointing to PCIT's efficacy in populations exhibiting neurological and behavioral disorders such as autism (Tarbox et al., 2009).

Efficacy through translation. Matos et al. (2006) conducted research in Puerto Rico with parents of children aged 4–6 with ADHD. The manual and handouts were translated into Spanish with a few modifications. Results showed significant decreases in behavior problems and hyperactivity. A recent follow-up study using the culturally adapted version further revealed that significant and robust outcome measures resulted from large treatment effect sizes. Mothers reported reductions in "hyperactivity-impulsivity, inattention, and oppositional defiant and aggressive behavior problems, as well as a reduced level of parent-child related stress and improved parenting practices" (Matos, Bauermeister, & Bernal, 2009, p. 246). Additionally, in a single-case study with a Spanish-speaking foster mother and a 3-year-old Mexican-Chilean-Filipina child, PCIT proved to be effective; reports from other family members noted substantive behavior improvement (Borrego et al., 2006). Thus, we can deduce that PCIT can be used effectively across cultural groups.

Key Components

There are three main components of PCIT: child-directed interaction (CDI), parent-directed interaction (PDI) and cleanup. Depending on the session being held, the components are presented in 5-minute segments with varying degrees of parent control required. CDI is characteristically the first stage in PCIT. Similar in approach

to filial play therapy, this first stage creates an opportunity to strengthen the parent–child relationship. Because PCIT is utilized in the context of dyadic play, it is conducted in a room conducive to play (McNeil & Hembree-Kigin, 2010). Thus, a room designated for CDI should contain a variety of toys, crayons, paper, modeling compounds and other developmentally appropriate activities for a child. As with other play techniques, in order to give children the opportunity to determine the rules by which they will play, games with rules are generally excluded from a CDI playroom. Children engaged in CDI should be allowed to play with any or all of the items in the room. Encouraging free play indicates to the child that he or she is the creator of the play, not the caregiver. This approach allows the time to truly be child-directed.

Within CDI, the establishment of a positive therapeutic relationship is a crucial step in building a foundation for the introduction of compliance training. Compliance training is simply teaching a child to mind or comply over a period of time, through small compliance goals set by the parents. To lay the groundwork for this process during CDI, the parents are instructed to praise, reflect, imitate and describe their child's play, while not asking questions, placing demands or criticizing the activities that transpire unless harmful to the child (McNeil, Eyberg, Eisentadt, Newcomb, & Funderburk, 1991).

Another essential concept introduced during CDI, includes fostering the enthusiasm and willingness of the parent. Although responding positively to a child's free play during CDI may appear simple, parents often need considerable practice to master this response set. For example, one of the toys in our clinic is a Mr. Potato Head. Young children can be very creative in their placement of the various accessories that come with the toy. Often they will place an arm on top of the head, lips on the ear hole or eyes over the mouth hole. In PCIT, we view this action as an expression of creativity. However, when we observe parents in free play with their children, we often witness the parents limiting their children's creativity by redirecting the placement of the appendages on Mr. Potato Head. Parents often say, "No, honey, the lips go here," or "That's not where the arms go." Instructing parents to refrain from making such comments is generally all that a PCIT counselor needs to do. PCIT counselors understand that this is a difficult skill for most parents to master, and they teach parents the acronym PRIDE for use during CDI as well as other elements of PCIT. PRIDE simply stands for praise, reflection, imitation, description and enthusiasm (Eyberg, 1999). Table 1 provides some practical examples of desired responses from parents during CDI using the PRIDE approach.

Table 1

Responses Using PRIDE model

Element	Example
Praise	Parent: "Thank you for putting away the toys."
Reflection	Child: "I'm drawing a dinosaur." Parent: "I see. You are drawing a dinosaur."
Imitation	Child is playing with a car. Parent gets a similar car and begins playing in the same manner.
Description	Child is playing with a toy airplane. Parent says, "You are making the airplane fly."
Enthusiasm	Parent: "Wow. Your drawing is very creative."

In the second stage of PCIT, PDI usually is initiated once parents master CDI. Mastery is evidenced during the child's play by the parents exhibiting proper implementation of the PRIDE responses. PDI also is conducted in the playroom or room selected for CDI. PDI consists of teaching parents how to manage their child's behavior and promoting compliance with parental requests (Bahl, Spaulding, & McNeil, 1999). Parents should understand that PDI is more difficult for children than CDI and will likely be challenging for both the child and parent. When beginning PDI, parents must understand the importance of appropriate discipline techniques and

receive training in giving clear directions to their children. Because children require a great deal of structure, professional counselors emphasize the importance of consistency, predictability and follow-through in this training (McNeil & Hembree-Kigin, & 2010). In order to initiate compliance training, parents practice giving effective instructions to their child. McNeil and Hembree-Kigin (2010) offered several rules for giving good instructions as part of the parent training element of PDI that can be conceptualized in the following ways: Command Formation, Command Delivery and Command Modeling:

Command Formation

A. Give direct commands for things you are sure the child can do. This increases the child's opportunity for success and praise.
B. Use choice commands with older preschoolers. This fosters development of autonomy and decision making. (e.g., "You can put on this dress or this dress" rather than "What do you want to wear?" or "Wear this").
C. Make direct commands. Tell the child what to do instead of asking whether they would like to comply (e.g., "Put on your coat").
D. State commands positively by telling child what to do instead of what not to do. Avoid using words such as "stop" and "don't."
E. Make commands specific rather than vague. In doing so, the child knows exactly what is expected and it is easier to determine whether or not the child has been compliant.

Command Delivery

A. Limit the number of commands given.
    - Some children are unable to remember multiple commands. The child's opportunity for success and praise increases with fewer, more direct instructions given at a time.
    - When giving too many commands, parents have difficulty following through with consequences for each command. Additionally, the parent's ignoring some minor behaviors may be best.
B. Always provide a consequence for obedience and disobedience. Consequences are the quickest ways to teach children compliance. Consistency when providing consequences is the key to encouraging compliance.
C. Use explanations sparingly. Some children would rather stall than know the answer. Avoiding the explanation trap prevents children from thinking they have an opportunity to talk their way out of it.

Command Modeling

A. Use a neutral tone of voice instead of pleading or yelling. Interactions are more pleasant in this manner and the child learns to comply with commands that are given in a normal conversational voice.
B. Be polite and respectful while still being direct. This models appropriate social skills and thus interactions are more pleasant.

After teaching parents to deliver effective instructions and allowing time for *in vivo* practice, professional counselors introduce appropriate discipline strategies to be used in PDI. The *in vivo* coaching model utilizes an observation room with a two-way mirror and the ability to for the counselor to communicate with the parent via microphone. The focus on training includes communication and behavior management skills with additional homework sessions (Urquiza & Timmer, 2012). In a study by Shanley and Niec (2010), parents who were coached via a bug-in-ear receiver with *in vivo* feedback during parent–child interactive play demonstrated rapid increases in positive parenting skills and interactions. Of these strategies, timeout is the most common as it is "a brief, effective, aversive treatment that does not hurt a child either physically or emotionally" (Eaves, Sheperis, Blanchard, Baylot, & Doggett, 2005, p. 252). Furthermore, Eaves et al. (2005) wrote that timeout

benefits both children with problematic behaviors and those who view the technique being used on other children, in addition to those children and adolescents demonstrating developmental delays, psychiatric issues and defiance. However, for the parent to experience timeout's full benefit, the technique must be appropriately and consistently administered. Eaves et al.'s (2005) article, "Teaching Time-Out and Job Card Grounding Procedures to Parents: A Primer for Family Counselors" is an excellent article on timeout and why it is an effective intervention.

All aspects of timeout are reviewed with the parents, such as the rationale for timeout, where timeout should take place in the home, what to do when the child escapes timeout, what to do if the child does not comply with timeout, the length of timeout, what should happen right before timeout and what should happen right after timeout. Parents receive written instructions illustrating each step of timeout and offering guidance on how to implement the procedure. These discipline strategies may not be necessary if a child is motivated to be compliant. Determining compliance is often a very hard decision for parents to make. According to McNeil and Hembree-Kigin (2010) there are several rules used to help parents determine compliance or noncompliance.

1. Parents must be sure that the instructions are developmentally appropriate for the child. If the child is asked to bring the orange cup to the parent, one must know that the child can determine which cup is actually orange.
2. Parents should know that the request is completely understood by the child. If there are any questions about this the parents should point or direct the child to help him or her fully understand the request.
3. Parents should allow the child approximately 3 seconds to begin to attempt the task. If the child has not begun to attempt the task by this time it should be considered noncompliance.
4. Parents should state the request only once. If the child pretends not to hear the request, this should be considered noncompliance.
5. Parents should not allow the child to partially comply with instructions. If parents accept half-compliance then children will often repeat the negative behavior because they know they can get away with it.
6. Parents should not respond to a child's bad attitude in completing a request. As long as he or she completes the instruction, it is compliance.
7. Parents should consider it compliance if a child does what is asked and then undoes what is asked. Compliance is compliance no matter how long it lasts.

When a parent determines that a child is compliant, verbal praise should be provided. This praise should be given immediately and focus on the child's compliance.

Parents are encouraged to practice the skills of giving good directions by delivering multiple commands to the child. These commands are given during the playtime and may include requests to hand things to the parent (e.g., "Give me the red block") or play with certain toys (e.g., "Place the blue car in the box"). This activity allows the child to practice following directions, while also affording the parent the opportunity to practice praise (McNeil & Hembree-Kigin, 2010). The child begins to learn that when he or she follows directions, his or her parents are very appreciative and excited. After the small tasks are accomplished, parents begin to place demands on the child that are less desirable, such as cleaning up the toys or moving on to another task (McNeil & Hembree-Kigin, 2010). By assigning less desirable tasks, parents find themselves in a position to practice a timeout procedure with the child. The professional counselor is there to model timeout and coach the parents when practicing timeout.

The third and final component to consider is called cleanup, which occurs as part of PDI. This time during the PCIT process is exactly what one might think; it is intended to teach the child to clean up the toys at the

end of the parent–child interaction in both the counseling and home milieus. Cleanup should be done without the parents' help but with the parents' direction. Although this component may seem simple, it tends to be a challenging situation, as significant behavior problems often are displayed during this phase. The expectation is that this phase lasts 5 minutes, but time varies depending upon the behavior of the child (McNeil & Hembree-Kigin, 2010). Cleanup occurs only at the end of parent-directed play, not at the end of child-directed play, to avoid confusing the child about the role of parental help during cleanup. All three components—CDI, PDI and cleanup—are opportunities for behavioral observation and data collection.

Implementing PCIT

According to McNeil and Hembree-Kigin (2010), there are six steps in conducting PCIT with a family. These authors have briefly described the contents of each step as well as provided guidelines for the number of sessions typically devoted to completing the tasks within each step. Step 1 requires one to two sessions for the intake process, Step 2 requires one session to introduce and teach parents CDI skills, and Step 3 requires two to four sessions in which the parents are coached on these skills. Steps 4 and 5 introduce and coach the PDI and may take up to six sessions. The final session is the follow-up session. These six steps complete a 10- to 15-session triadic training program.

Step 1 is the initial intake and can be accomplished in one to two counseling sessions, unless classroom or other observations are warranted. These sessions consist of assessing family dynamics, obtaining the family's perception of the presenting problems, probing for insights into the current disciplinary beliefs and methods held by the parents, and observing the natural interactions between parents and child. In addition to the information-gathering component, the clinician defines the parameters of the sessions as well as the rules and expectations. Certain parameters involve an understanding by the parents that this CDI time is designated for the child to lead and for the parent to follow—a time often described to the parents as *time-in* for the child. Thus, time-in is defined as a time when the child facilitates play by selecting the type of play and initiating all play interactions.

The initial informal observation usually takes place in a sitting area while the family is waiting to visit with the counselor. In this informal observation, the counselor looks 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 clinging and separation anxiety" (McNeil & Hembree-Kigin, 2010, p. 20). After this stage of observation, a more formal observation is completed using the Dyadic Parent–Child Interaction Coding System (DPICS; Eyberg & Robinson, 1983). This observation is typically accomplished in three 5-minute increments in which behaviors and verbalizations are marked on the DPICS sheet. The formal observation occurs over the three PCIT stages previously described—CDI, PDI and cleanup. Following the initial observations, a third observation may be executed as a classroom observation. This type of observation is done with students who attend day care, preschool or elementary school, and allows one to see the child interact within his or her daily environment. Observation occurring in an alternate setting increases the chances of obtaining normative behavior (McNeil & Hembree-Kigin, 2010).

In Steps 2 and 3, the counselor presents and provides coaching on the CDI skills. Step 2 typically requires one counseling session. During this time the parents are taught the behavioral play therapy skills of CDI. The third step, coaching the CDI skills, may take two to four sessions depending on how the family adopts these principles into their daily interactions with their child. Coaching is described as modeling the behavior for the family, allowing the family to practice in session with feedback and prompts as needed, assigning the family homework to practice, and then repeating these steps until the parents are comfortable and fluent in the process.

In Steps 4 and 5, respectively, the counselor teaches and coaches the parents about discipline skills. These skills include both PDI and compliance training. Step 4 is typically accomplished in one session. Coaching may last from four to six sessions. Again, coaching is described as modeling, in-session practice with feedback and prompts, assigning homework, and evaluating success.

Step 6 consists of having a follow-up counseling session. This session is an opportunity to assess the family's progress with proper implementation of each component of the PCIT model, gauge the strides made in compliance and assess the overall family satisfaction gained throughout the journey. Finally, one should use boosters to help parents maintain learned skills as they face new challenges with their children. Table 2 delineates the steps to implementing PCIT over a typical 10–15-session treatment plan.

Table 2

Implementing PCIT

Step	Number of sessions	Process
1	1–2	Informal and formal observation
2	1	CDI
3	2–4	Coaching CDI skills
4	1	Teaching discipline skills via PDI and compliance training
5	4–6	Coaching
6	1	Follow-up

Case Study

PCIT was selected for use in the treatment of Manny, a 6-year-old Hispanic male diagnosed with autism and noncompliant to his mother. Like many children with autism, Manny had difficulty with unpredicted changes and verbalization of concerns. As Manny's frustration with communication increased, he demonstrated stereotypies such as hand flapping and eventually progressed to tantrum behavior. The two goals of treatment were to increase the frequency of appropriate verbalizations and to decrease the frequency of inappropriate behavior including physical aggression, noncompliance and making noises. Manny was experiencing other issues related to autism, but his mother indicated that the behavioral problems were preventing him from making progress in other area.

As a result, we decided to conduct a functional behavior analysis prior to beginning treatment. This assessment of Manny's behavior indicated that some of the behavior disruptions were a means of seeking attention, and therefore it was determined that PCIT would teach the mother to provide more consistent attention for appropriate behavior and to encourage appropriate communication more effectively. If needed, the addition of the timeout component was available after the mother began adequately attending to Manny's appropriate behavior and ignoring inappropriate behavior.

Session 1

The counselor explained the procedure and rationale for PCIT to the mother, including CDI, PDI and timeout. CDI was modeled and demonstrated with Manny. The mother was uncomfortable about being judged on her parenting skills, so it was decided that she would practice the skills at home using the Child's Game nightly with Manny. The Child's Game is simply defined as any free play activity the child chooses. The family would return to the clinic in 1 week.

Session 2

The counselor reviewed CDI and had the mother conduct the Child's Game for 5 minutes. During CDI, the counselor observed and noted the mother's responses. The mother included 13 questions, one criticism and one demand in the 5-minute session. The mother praised Manny frequently, but did not use the other desired skills often. Manny was compliant with the demand that the mother gave and did not exhibit any of the disruptive behaviors. Following the CDI, feedback was given to the mother about increasing descriptions, reflections, imitations and praises, and reducing questions. The mother also was encouraged to recognize and praise communication attempts. Overall, the mother was directed to allow Manny to lead the play. When queried about CDI practice at home, the mother reported that the activity the family had used for the Child's Game was watching television. Because there is no inherent interaction in television viewing, the mother was directed to provide a choice to play with action figures or art materials, both indicated as reinforcing by Manny, in place of video games or television. The Child's Game was again given as homework.

Session 3

The professional counselor reviewed CDI and viewed the family during the Child's Game. The mother showed improvement using descriptions (16), reflections (3), imitations (1) and praises (15). She also limited her use of questions (6), criticisms (0) and demands (0). However, Manny exhibited disruptive behavior in 23% of the observed intervals. The mother also reported that Manny continued to be noncompliant and make noises at home. The professional counselor introduced PDI and timeout. Each was modeled with Manny, and his mother was allowed to practice and receive feedback. Homework was to continue the Child's Game, issue 10 demands throughout the day and follow through with the brief timeout procedure. Also, the mother was asked to develop five house rules to bring the following week. To keep a record of the number of instructions with which Manny complied before going to timeout, and the number of timeouts per day, the mother received a homework compliance worksheet to keep for 1 week. This log allows the parent to record the homework—in this case, using the Child's Game daily, issuing 10 demands throughout each day and recording the Manny's compliance to each, and using timeout as indicated.

Session 4

The counselor reviewed PDI, giving effective instructions and timeout to begin the session. The counselor then observed the family during CDI/PDI. The mother gave clear, concise instructions six out of nine times, only failing to wait before reissuing instructions when Manny did not immediately comply. Manny complied with all issued demands except when the mother reissued the demands too quickly. The mother followed Manny's compliant behavior with praise statements four out of nine times. Manny was put in timeout for disruptive behavior and the mother used the procedure correctly. Manny demonstrated disruptive behavior during 33% of the observed intervals. A review of the homework compliance worksheet from the previous week indicated that Manny complied with 10 out of 10 instructions on 5 out of 9 days, and nine out of 10 instructions the remaining 2 days. The mother was encouraged to continue generalizing the skills she had learned throughout the day. The house rules developed by the family over the previous week were discussed and worded in positive statements and then introduced to Manny. The rules were explained and both examples and non-examples were modeled. Homework was given to continue incorporating the Child's Game, issuing 10 demands in a brief period of time, using timeout as needed and recording compliance rates for 1 week.

Session 5

The counselor reviewed PDI, EID, timeout and the homework compliance worksheet. The mother indicated that Manny had been compliant before timeout 10 out of 10 times for 6 days and nine out of 10 times for 1 day. The mother also noted that Manny had been placed in timeout for breaking house rules. The mother reported that Manny's behavior had improved and he had had fewer tantrums related to schedule changes. She was encouraged to continue using the PCIT skills and adapting them to more situations. Because compliance was

increasing, it was not necessary to continue CDI and PDI in this session. The family was given homework to continue the Child's Game, PDI, using timeout as needed and recording compliance rates. This time, the family was to work at home for 2 weeks before the next session.

Session 6

The counselor reviewed the family's progress and addressed further generalization and concerns about daycare. The mother indicated that the child had been compliant before timeout on 10 out of 14 days. Two of the other days Manny had been placed in timeout 10 times and six times for violating house rules. The zero out of 10 compliance rating occurred during his birthday party, and the six out of 10 compliance rating was primarily the result of an unexpected trip to the grocery store. The family was again given homework to continue practicing generalizing CDI, PDI, using timeout as needed and recording compliance rates for 2 weeks.

Session 7

The counselor addressed concerns including the beginning of school in a few weeks and provided suggestions to ease the transition. While the mother indicated that Manny had been compliant before timeout on only 4 of the previous 14 days, a review of the compliance rates revealed that on the other 10 days, Manny was compliant no less than 80% of the time. These compliance rates from various family settings were indicative of behaviors being generalized across settings. The mother also showed evidence of her generalization of skills by adapting the house rules to address new problematic behaviors. The family was encouraged to begin reviewing material learned in the previous session and work on behavioral skills such as sitting for appropriate lengths of time. The mother was instructed to continue both the use of her attending skills in order to reinforce appropriate behavior, as well as the use of the timeout procedure to diminish inappropriate behaviors.

Session 8

For the final follow-up session, the counselor reviewed the family's progress and determined that treatment goals were met. Concerns about how to get other family, friends and teachers to use PCIT skills with Manny were addressed in this final session. The family noted the improvements made as a result of PCIT and felt equipped to maintain the behavioral changes gained as a result of this counseling approach. Termination of the PCIT intervention was appropriate at this time; the case provided clear evidence of the application and utility of the PCIT model. Manny's mother was offered the opportunity to continue interventions related to the other autism-specific issues that Manny was experiencing.

Conclusion

Professional counselors, whether working with children who have disruptive behavior or providing parenting training to families, should be knowledgeable of the application of various behavioral techniques in order to utilize them effectively and to teach them to parents. Researchers have proven that when implemented appropriately, PCIT procedures are effective in reducing undesirable and problematic behaviors in children and adolescents. Furthermore, it is clear that PCIT can be effectively applied to behavioral issues faced by children with special needs. We suggest that counselors who are interested in PCIT seek additional training to develop mastery of the techniques.

PCIT is a complex process that is often mistakenly viewed as simplistic. Thus, counselors who use PCIT without appropriate training will likely provide ineffective parental coaching. This point is especially poignant when working with children who have special needs. These children often present with numerous significant issues and deserve appropriate application of evidence-based intervention. We strongly suggest that counselors complete the web-based training provided by the University of California at Davis Children's Hospital. The

training is free and can be accessed at http://pcit.ucdavis.edu/pcit-web-course//. Given that PCIT is an effective approach and that the effectiveness of the model increases with appropriate education, professional counselors who further educate themselves on PCIT's uses and applications can benefit their practices and the families they serve through the correct use of this empirically validated method of behavioral family counseling.

Counselors who are interested in PCIT also should consider advancing research related to counseling applications. While PCIT has been shown to be an effective intervention for autism and other disorders, more research is needed. We encourage counselors to consider implementation of studies that determine outcomes of PCIT for various child disorders and to conduct program evaluation for PCIT-based clinics.

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References

Agazzi, H., Tan, R., & Tan, S. Y. (2013). A case study of parent–child interaction therapy for the treatment of autism spectrum disorder. *Clinical Case Studies*, *12*, 428–442. doi:10.1177/1534650113500067

Anticich, S. A. J., Barrett, P. M., Gillies, R., & Silverman, W. (2012). Recent advances in intervention for early childhood anxiety. *Australian Journal of Guidance and Counselling*, *22*, 157–172. doi:10.1017/jgc.2012.24

Asawa, L. E., Hansen, D. J., & Flood, M. F. (2008). Early childhood intervention programs: Opportunities and challenges for preventing child maltreatment. *Education* and *Treatment of Children*, *31*, 73–110.

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. doi:10.1080/15374410701448448

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.

Baker, A. J. L., & Andre, K. (2008). Working with alienated children & their targeted parents. *Annals of the American Psychotherapy Association*, *11*(2), 10–17.

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.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., . . . Bonner, B. L. (2004). Parent–Child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*, 500–510. doi:10.1037/0022-006X.72.3.500

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. doi:10.1016/j.cbpra.2005.09.001

Eaves, S. H., Sheperis, C. J., Blanchard, T., Baylot, L., & Doggett, R. A. (2005). Teaching time-out and job card grounding procedures to parents: A primer for family counselors. *The Family Journal: Counseling and Therapy for Couples and Families*, *13*, 252–258. doi:10.1177/1066480704273638

Eyberg, S., & Boggs, S. (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, NY: Wiley & Sons.

Eyberg, S. M. (1999). *Parent-Child interaction therapy: Integrity checklists and session materials*. Retrieved from http://pcit.phhp.ufl.edu/Presentations/PCIT%20Integrity%20Checklists%20and%20Materials%204-13-06.pdf

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 & Family Behavior Therapy*, *23*(4), 1–20. doi:10.1300/J019v23n04_01
Eyberg, S. M., & Robinson, E. A. (1983). Conduct problem behavior: Standardization of a behavioral rating scale with adolescents. *Journal of Clinical Child Psychology*, *12*, 347–354. doi:10.1080/15374418309533155
Gladding, S. T. (2011). *Family therapy: History, theory, and practice* (5th ed.). Upper Saddle River, NJ: Prentice Hall.
Guttmann-Steinmetz, S., Crowell, J., Doron, G., & Mikulincer, M. (2011). Associations between mothers' and children's secure base scripts in ADHD and community cohorts. *Attachment & Human Development*, *13*, 597–610. doi:10.1080/14616734.2011.609010
Hood, K. K., & Eyberg, S. M. (2003). Outcomes of parent–child interaction therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology*, *32*, 419–429. doi:10.1207/S15374424JCCP3203_10
Johnson, B. D., Franklin, L. C., Hall, K., & Prieto, L. R. (2000). Parent training through play: Parent-Child interaction therapy with a hyperactive child. *The Family Journal: Counseling and Therapy for Couples and Families*, *8*, 180–186. doi:10.1177/1066480700082013
Luby, J., Lenze, S., & Tillman, R. (2012). A novel early intervention for preschool depression: Findings from a pilot randomized controlled trial. *Journal of Child Psychology and Psychiatry*, *53*, 313–322. doi:10.1111/j.1469-7610.2011.02483.x
Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-Child interaction therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. *Family Process*, *48*, 232–252. doi:10.1111/j.1545-5300.2009.01279
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. doi:10.1111/j.1545-5300.2006.00091.x
McCabe, K. & Yeh, M. (2009). Parent–Child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology*, *38*, 753–759. doi:10.1080/15374410903103544
McNeil, C. B., Eyberg, S., Eisentadt, 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. doi:10.1207/s15374424jccp2002_5
McNeil, C. B., & Hembree-Kigin, T. L. (2010). *Parent-Child interaction therapy.* New York, NY: Springer.
Neary, E. M., & Eyberg, S. M. (2002). Management of disruptive behavior in young children. *Infants and Young Children*, *14*(4), 53–67.
Nieter, L., Thornberry, T., Jr., & Brestan-Knight, E. (2013). The effectiveness of group parent–child interaction therapy with community families. *Journal of Child and Family Studies*, *22*, 490–501.
Shanley, J., & Niec, L. N. (2010). Coaching parents to change: The impact of in vivo feedback on parents' acquisition of skills. *Journal of Clinical Child and Adolescent Psychology*, *39*, 282–287. doi:10.1080/15374410903532627
Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B. (2008). The effectiveness of parent–child interaction therapy for families of children on the autism spectrum. *Journal of Autism and Developmental Disorders*, *38*, 1767–1776. doi:10.1007/s10803-008-0567-5
Tarbox, J., Wilke, A. E., Najdowski, A. C., Findel-Pyles, R. S., Balasanyan, S., Caveney, A. C., . . . Tia, B. (2009). Comparing indirect, descriptive, and experimental functional assessments of challenging behavior in children with autism. *Journal of Developmental and Physical Disabilities*, *21*, 493–514. doi:10.1007/s10882-009-9154-8
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.
Timmer, S. G., Ho, L. K. L., Urquiza, A. J., Zebell, N. M., Fernandez y Garcia, E., & Boys, D. (2011). The effectiveness of parent–child interaction therapy with depressive mothers: The changing relationship as the agent of individual change. *Child Psychiatry & Human Development*, *42*, 406–423. doi:10.1007/s10578-011-0226-5
Urquiza, A. J., & Timmer, S. (2012). Parent-Child interaction therapy: Enhancing parent-child relationships. *Psychosocial Intervention*, *21*, 145–156. doi:10.5093/in2012a16
Webster-Stratton, C., & Herbert, M. (1993). "What really happens in parent training?" *Behavior Modification*, *17*, 407–456. doi:10.1177/01454455930174002