CHAPTER 33

Parent–Child Interaction Therapy

Monica Stevens
Amanda N'zi

Parent–child interaction therapy (PCIT) was developed to promote optimal social–emotional development in the first 3 years of life in response to clear scientific evidence regarding the importance of early experiences. It is well established as an effective treatment for aggressive behavior disorders in young children. PCIT originated as a behaviorally oriented parent training program intended to treat oppositional and defiant behaviors in preschoolers (Eyberg & Boggs, 1989). Although the functional goal of the intervention was to reduce oppositional behavior, parent–child relationship enhancement was, and continues to be, the primary goal of treatment. PCIT derived from Baumrind's (1966, 1991) developmental theory of parenting styles and corresponding research demonstrating that an authoritative parenting style, consisting of nurturance, clear communication, and firm control, leads to healthy emotional development (Franz, McClelland, & Weinberger, 1991; Querido, Warner, & Eyberg, 2002).

Although PCIT did not originate from within the field of infant mental health, the goals of treatment align with infant mental health priorities. Facilitating young children's mental health requires a consistent and predictable caregiving environment in which the caregiver provides warmth, encourages exploration, and offers protection and limits. PCIT is a method for translating more abstract concepts into concrete, practical parenting techniques that promote a healthy caregiving environment. Decades of PCIT research have demonstrated that the model can be used effectively to treat a wide array of presenting problems and is useful in teaching basic parenting principles.

The techniques taught in PCIT change relationship patterns in a dyad. At the most basic level, PCIT provides instruction on building positive caregiver–child interactions through play by providing a framework for rewarding adaptive behavior with positive attention and shaping maladaptive behavior by selectively attending to the child. Furthermore, PCIT gives specific directions for how to respond to disruptive behavior in a way that significantly reduces incidents of noncompliance and negative attention-seeking behaviors (Hembree-Kigin & McNeil, 1995). Over time, coercive cycles between parent and child decrease, and an authoritative parenting style is established. On a deeper level, PCIT corrects unhealthy dynamics by teaching the parent to be the kind leader and the child to trust that his or her parent will be a consistent protector and nurturer.

In addition, PCIT therapists have an opportunity to reframe maladaptive behaviors as attachment-related behaviors. Therapists have an opportunity to teach parents to notice when the child may be miscommunicating or "miscueing" a need, a technique of focus in the

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

Circle of Security (COS; Cooper, Hoffman, & Powell, 2009) intervention. Therapists use their role as "coach" to help parents shape miscues into healthier and clearer ways of communicating basic needs. For example, consider a child who repeatedly hits his or her caregiver. Behavior and social learning theory suggest that hitting has been learned because the caregiver reliably responds to this behavior in a way that reinforces the behavior, or because the behavior is observed in others. In this case, it is possible that the caregiver inconsistently responds or is even oblivious to the child's bids for comfort (e.g., reaching for positive touch, searching for eye contact). A PCIT therapist helps a parent extinguish the miscue (i.e., hitting) while simultaneously increasing the caregiver's awareness and response to appropriate cues. Staunch behavioral therapists may conceptualize this as extinction and reinforcement, while infant mental health practitioners might consider this intervention to be improving attunement.

Overview of PCIT

PCIT consists of two phases in which parents are taught skills to improve warmth, as well as establish behavioral regulation of their child in the parent–child relationship. The scope and sequence of these phases are detailed in the PCIT protocol manual (Eyberg & Funderburk, 2011).

Child-Directed Interaction

In the first phase of PCIT, child-directed interaction (CDI), parents are taught skills that help them follow their child's lead in play by providing positive attention to prosocial child behaviors and ignoring negative behavior during specially designated play periods (Boggs & Eyberg, 2009). Specifically, the skills of CDI are called the "PRIDE" skills and include praising the child with specificity (labeled praise), reflecting or repeating what the child says (reflection), imitating child play (imitation), describing child behavior (description), and using enthusiasm (or enjoyment). Caregivers are instructed to avoid asking questions, giving commands, or being critical or sarcastic during these play sessions.

The primary mechanism for shaping behavior in this phase is through "differential social attention," a technique that increases attention to adaptive and preferred behaviors, while eliminating reinforcers of maladaptive behaviors (Boggs & Eyberg, 2009). The goal of this phase is to strengthen parent–child relationship in preparation for the second phase of treatment, parent-directed interaction (PDI). Participation in only the first phase of PCIT treatment has been shown to reduce child internalizing and externalizing symptoms, as well as parental stress (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993). Caregivers generally must meet preset mastery criteria of CDI skills before moving on to PDI to ensure skill maintenance.

Parent-Directed Interaction

In the PDI phase of treatment, parents learn how to give effective commands and follow through with limits if needed. The PDI phase also emphasizes positive attention for compliance and establishing clear expectations at home and in public. As with the first phase of treatment, PDI explicitly teaches caregivers to set developmentally appropriate expectations and use language that is clear and concise. Caregivers are taught how to help their child learn limits and expectations through the use of a specific time-out protocol. Successful completion of the CDI phase of treatment is essential to the efficacy of the time-out procedure in PDI due to the need for meaningful "time-in" to buffer the stress of time-out and to make time out (or time away) more salient. PDI sessions continue to rely on good use of the CDI skills, while expressing expectations of the child in order to practice the PDI skills. Empirical study of the PDI phase of treatment suggests that this phase produces high parental satisfaction with treatment and increased compliance, as well as decreased hyperactivity and parental stress (Eisenstadt et al., 1993).

Course of Treatment

To consider the appropriateness of PCIT for a dyad, a pretreatment assessment must be conducted. The assessment should include a thorough clinical interview and an observational, play-based assessment, in addition to any questionnaires the therapist deems appropriate, such as the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999). Information about the caregiver's responsiveness to coaching, ability to learn PCIT skills, and the child's receptive language skills and family trauma history can be helpful in determining whether PCIT is the

Copyright © 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

most appropriate intervention for a particular family. PCIT often serves as an excellent complement to other interventions, such as individual therapy for a caregiver, other relationship-based therapies, or case management, when family stressors are significant.

Once PCIT is determined to be the appropriate treatment, the therapist schedules a "teach" session with the caregiver in which feedback is given and the CDI skills are introduced. This session should be used to explain the principles underlying the CDI skills and establish strong rapport by showing active interest in the caregiver's approach to parenting and needs. Because PCIT becomes progressively more directive over time, the therapist's behavior toward caregivers should be focused on reinforcing what is going well in the parent–child relationship and parenting efforts, until strong rapport is established.

Subsequent CDI sessions involve both the parent and child, during which the child chooses several toys to play with while the parent is coached by the therapist, typically from a separate observation room. Just as the parent is instructed to do with the child, the PCIT therapist praises the parent each time a CDI skill is demonstrated and initially ignores any behavior in need of improvement. The therapist eventually provides direct feedback to the parent and begins to draw attention to verbalizations or behaviors in need of change.

PCIT with Maltreated Children

Patterson's coercion theory suggests that caregiver aggression and child misbehavior are developed though the unintentional reinforcement of child misbehavior by parental negativity that escalates cyclical patterns of coercion (Patterson, 1982). This type of harsh, reactive parenting style is related to child abuse potential and parent–child aggression (Rodriguez, 2010). PCIT disrupts this cycle by teaching parents warm and consistent parenting skills that improve child behavior problems (Eyberg, Nelson, & Boggs, 2008; Ward, Theule, & Cheung, 2016) and parental warmth (Thomas & Zimmer-Gembeck, 2011, 2012).

PCIT is an evidence-based treatment for children and families with histories of child abuse and neglect, particularly physical abuse or comorbid behavior problems associated with other forms of child abuse or neglect (Chadwick Center on Children and Families, 2004; Chaffin & Friedrich, 2004). PCIT may be effective in the child maltreatment population because it supports the development of strong attachment and improved parental consistency, and reduces child behavior problems, therefore disrupting the escalating coercive parenting cycles that can lead to physical maltreatment in child–caregiver interactions (Herschell & McNeil, 2005). Given its effectiveness, PCIT research in the child maltreatment population focuses on intervening to support the development of positive caregiver–child relationships through (1) prevention of maltreatment (Lanier, Kohl, Benz, Swinger, & Drake, 2014; Thomas & Zimmer-Gembeck, 2012); (2) treatment of trauma-related behavior problems (Fricker-Elhai, Ruggiero, & Smith, 2016; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005); (3) repairing disruption in caregiver-child relationships due to out of home placement (Mersky, Topitzes, Grant-Savela, Brondino, & McNeil, 2016; Mersky, Topitzes, Janczewski, & McNeil, 2015; N'zi, Stevens, & Eyberg, 2016; Timmer, Sedlar, & Urquiza, 2004, Timmer, Urquiza, Herschell, et al., 2006; Timmer, Urquiza, & Zebell, 2006); and (4) treatment of parents with prior histories of maltreatment to reduce recidivism rates (Chaffin et al., 2004; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Hakman, Chaffin, Funderburk, & Silovsky, 2009).

Since PCIT addresses parenting patterns that put families at-risk for child maltreatment, PCIT makes sense as a prevention strategy for high-risk families. A randomized controlled trial with parents at high-risk for child maltreatment indicated that following treatment, parents receiving PCIT had less child maltreatment potential and increased parental sensitivity than those not receiving PCIT. PCIT completers had a lower rate of future referrals to child protective services (Thomas & Zimmer-Gembeck, 2012). Preliminary research indicates that PCIT may be an effective method to prevent child maltreatment; however, more research with rigorous research designs is needed to further investigate the efficacy and effectiveness of using PCIT as a preventive measure for high-risk families.

PCIT as an intervention for children living in out-of-home placements, including kinship and non-kinship foster care placements, is another area of focus for the application of PCIT to families. The use of PCIT as a method of foster parent training is an important area of study. One

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

model for traditional foster caregivers is a 2-day training model, which holds promise for reducing child behavior problems after training and at a 5-month follow-up (McNeil et al., 2005). A randomized controlled trial using this 2-day training model with the addition of follow-up consultation has demonstrated that PCIT training for foster caregivers helps to improve both parental stress and parenting skills (Mersky et al., 2015) as well as reduce child internalizing and externalizing behavior problems (Mersky et al., 2016) when compared to foster caregivers receiving treatment as usual. Focusing only on portions of the intervention such as the CDI can be efficient and more appropriate to the needs of the dyad. Foster caregivers report fewer externalizing behaviors but lower warmth in their relationship with the child (Harden, 2004; Tarren-Sweeney, 2008). A pilot study conducting eight sessions of CDI training with kinship caregivers indicated improvements in parenting stress, parent depression, externalizing behaviors, and positive parental discipline (N'zi et al., 2016). Results from these studies indicate that PCIT can be adapted to support both kinship and non-kinship caregivers.

Children in kinship or foster caregiver placements may also present with high levels of behavior problems that may benefit from treatment in PCIT. Case studies in PCIT have displayed similar outcomes in PCIT for children in foster care as other children completing PCIT (Fricker-Elhai et al., 2016; Timmer, Urquiza, & Zebell, 2006). A pre–post comparison design between foster families and nonoffending biological parents indicates that there is no difference in the effectiveness of PCIT training on parental stress and child behavior problems, indicating that PCIT may hold similar outcomes for children in foster placements (Timmer et al., 2004). However, further research with well-conducted trials should be completed to better understand the effectiveness of this intervention as a type of foster parent training and for children in out-of-home placements.

PCIT has undergone the most rigorous research with physically abusive caregivers and has demonstrated the ability to improve child behavior and reduce recidivism rates. Parents with histories of maltreatment following PCIT demonstrate greater parental warmth and parenting skills in addition to reduced parenting stress and fewer child behavior problems when compared to waiting-list controls (Thomas & Zimmer-Gembeck, 2012). A randomized trial including maltreating parents demonstrated that those in the PCIT condition had recidivism rates of 19% compared to 36 and 49% in the PCIT with wraparound services as usual groups, respectively (Chaffin et al., 2004). It is important to note that both of the PCIT conditions in the previous study also use a group motivation component before treatment.

A motivational enhancement or engagement session should strongly be considered when working with maltreating parents. Families with high motivation for treatment should begin treatment right away, while families with low to moderate levels of motivation will likely benefit from motivation enhancement work before starting PCIT. A study comparing the use of PCIT with and without a motivational group enhancement indicates that a motivational component was key in reducing recidivism rates (Chaffin et al., 2009). A 6-week group protocol was developed to increase motivation. This included weighing the pros and cons of changing harsh discipline patterns, listening to testimonials from families that completed PCIT, and encouraging parents to set goals and plans for change (Chaffin et al., 2009, 2011). This type of model may be difficult to implement in a community setting due to difficulties assembling a group and including treatment completers to provide testimonials. However, it is important in the clinical setting to consider this research and the utility of using motivational enhancement to improve treatment engagement and attrition rates (N'zi, Lucash, Clionsky, & Eyberg, 2017).

PCIT in Community Settings

Mental health practitioners often encounter challenges delivering PCIT in community settings. Compared to research participants, families seeking services in community settings are typically of lower socioeconomic status (SES), more racially diverse, and often present with characteristics that would be considered exclusionary criteria in research studies (Weisz & Hawley, 2002). Particularly among low-income, urban populations, community mental health agencies tend to encounter rates of dropout in the 40–60% range. Dropouts in these settings tend to occur early in treatment, even before preliminary benefits are available to the family. Delivery of PCIT also may be different in community settings due to a variety of psychosocial

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

stressors that significantly exceed stressors in more selected research samples (Gopalan et al., 2010).

Due to differences in the characteristics and needs of families in community mental health settings, careful consideration must be given to the balance between flexibility and fidelity. Adaptations, such as longer treatment sessions, are often needed to build rapport, address basic needs, and accommodate unique family needs. Community clinicians must consider the need for tailoring the treatment to address relevant comorbidities such as limiting use of reflections if echolalia is a concern or providing learning accommodations for caregivers with limited cognitive functioning. In some instances, it may be prudent to forego the requirement of fully meeting CDI or PDI criteria, though consultation with an experienced PCIT therapist is highly recommended before making major deviations from the protocol. Budd and colleagues suggest that moving to PDI before CDI mastery should only be considered when multiple factors indicate a need to deviate from the manual (Danko, Garbacz, & Budd, 2016). For example, early PDI entry might be considered if problem behavior is so severe as to pose a risk to the safety of the child and family, if there appears to be a major barrier to the parent reaching full criteria in a reasonable time frame (e.g., pregnancy), and if the dyad can be said to qualitatively reflect the intent of CDI mastery, particularly when ECBI scores have significantly decreased and skills are approaching mastery criteria.

Diversity Issues in PCIT

Families in need of behavioral treatment for young children with behavioral problems span many cultural groups in the United States and around the world, creating a need for culturally sensitive adaptations of PCIT while maintaining treatment fidelity. The American Psychological Association Task Force on Evidence-Based Treatments in 2006 released a report highlighting the need for evidence-based practice in psychology to include not only the best available treatment, but also to apply these methods in the context of the patient's characteristics and culture. A cultural adaptation of an evidence-based treatment is "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Cultural adaptations should be implemented when the EBT is available to a population, the underlying theory of change matches the population needs, and the treatment is seen as acceptable by the population (Domenech Rodríguez & Bernal, 2012). Various forms of treatment adaptation framework exist to take into consideration language, content, context, goals, and methods that match the particular cultural group (Ferrer-Wreder, Snudell, & Mansoory, 2012).

The past decade in PCIT research has explored the implementation of PCIT in various cultural groups in the United States, where PCIT was originally developed, and around the world. While research is still needed to understand the effectiveness of PCIT in many cultures, countries in which adaptation and effectiveness work has begun include Puerto Rico (Matos, Bauermeister, & Bernal, 2009; Matos, Torres, Santiago, Jurado, & Rodriquez, 2006), China (Leung, Tsang, Heung, & Yiu, 2009; Leung, Tsang, Sin, & Choi, 2015; Yu, Roberts, Wong, & Shen, 2011), Australia (Nixon, Sweeney, Erickson, & Touyz, 2003, 2004; Phillips, Morgan, Cawthorne, & Barnett, 2008), and the Netherlands (Abrahamse et al., 2012). Results from these studies overwhelmingly indicate that PCIT effectively reduces child problematic behaviors and parenting stress, while improving parenting practices, regardless of the country in which it is delivered (Abrahamse et al., 2012; Leung et al., 2009, 2015; Matos et al., 2006, 2009; Nixon et al., 2003; Phillips et al., 2008; Yu et al., 2011).

The PCIT adaptation procedures for countries such as China (Leung et al., 2009) and Puerto Rico (Matos et al., 2006) have been thoroughly discussed in research and provide insight into the types of adaptations that improve acceptability of this treatment to these cultural groups. In China and Puerto Rico, cultural adaptations include (1) the impact and inclusion of extended family in treatment procedures, (2) culturally relevant metaphors, and (3) language translation of printed materials and the PCIT protocol (Leung et al., 2009; Matos et al., 2006). Culturally specific adaptations unique to Puerto Rican families include extended session time from 60 to 90 minutes, in order to lengthen the family check-in at the beginning of session to support therapist–family relationship devel-

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

opment and modification of the time-out procedures for children who are difficult to place in time out to include removal of privileges to make the time-out procedure more acceptable by families (Matos et al., 2004). For Chinese families in Hong Kong, special consideration was given to explanation of the importance of praise and ignoring to improve child behavior, as these parenting approaches contradict previously held cultural beliefs about the authority and control parents must display with their children (Leung et al., 2006). The resulting adaptations for Puerto Rican and Chinese families were tested in randomized controlled trials and demonstrated good efficacy (Leung et al., 2015; Matos et al., 2006). Results from these studies indicate that PCIT can be culturally adapted, especially by considering the role of extended family and relevant culturally held beliefs, to several diverse cultures, while maintaining treatment fidelity.

When looking at studies that explore the application of PCIT to diverse ethnic/minority groups in the United States, similar themes regarding the importance of considering the culture of the population receiving PCIT and fidelity to the evidence-based treatment emerge. Within the United States, publications regarding the acceptability and cultural adaptation needs for Mexican American (McCabe & Yeh, 2009; McCabe, Yeh, Garland, Lau, & Chavez, 2005; McCabe, Yeh, Lau, & Argot, 2012), African American (Fernandez, Butler, & Eyberg, 2011), American Indian/Alaskan Native (Bigfoot & Fuderburk, 2011), hard of hearing or deaf (Armstrong, David, & Goldberg, 2014; Shinn, 2013), and military (Pemberton, Kramer, Borrego, & Owen, 2013) families have been created to guide clinicians in how to provide PCIT to these families, while emphasizing the need for further research. With the exception of Mexican American families, limited research exploring the systematic development of cultural adaptation and resulting examination of the efficacy of these adaptations exists and is a needed area of future research if the use of PCIT is to be equitable.

A Mexican American adaptation of PCIT has been extensively studied and has yielded important information regarding the need for cultural adaptations of PCIT in practice. The Mexican American adaptation of PCIT, *guiando a niños activos* (GANA), was developed using a structured adaptation procedure to create and evaluate the efficacy of this cultural adaptation. GANA development incorporated a review of existing literature, focus groups with Mexican American families, and mental health providers experienced with this population to ensure that the adaptation was culturally acceptable. In addition, investigators invited a review of the suggested adaptations by the PCIT treatment developer to ensure that the adaptation maintained fidelity to the evidence-based protocol (McCabe et al., 2005). In GANA, wording of the PCIT skills was changed to be culturally relevant, handouts were simplified, the program was framed as an education skills building course instead of therapy, more time was devoted to rapport building than in traditional PCIT, and an initial engagement protocol was used (McCabe & Yeh, 2009).

GANA was tested in a randomized controlled trial comparing three conditions: (1) GANA, the cultural adaptation of PCIT, (2) standard PCIT translated into Spanish, and (3) treatment as usual. Results revealed that GANA was more effective at reducing child behavior problems, parenting stress, and negative parenting practices than treatment as usual, but PCIT delivered in Spanish and GANA were not statistically different from one another in family outcomes, although GANA did create some nonsignificant improvements above PCIT (McCabe & Yeh, 2009). A follow-up study indicated that while families receiving PCIT and GANA both maintained improvements overtime, GANA had an advantage in maintaining greater improvements especially in the area of child internalizing problems (McCabe et al., 2012). This research indicates that PCIT is a robust treatment for Mexican American families and that cultural adaptations to PCIT should be used whenever possible, but the absence of a cultural adaptation should not preclude the use of PCIT if it is not available (McCabe et al., 2012).

Other cultural adaptations for diverse groups in PCIT still need stringent research designs to investigate their efficacy, such as randomized controlled trials with comprehensive adaptation procedures (Butler & Eyberg, 2006), but current efforts in understanding the needs of various cultural groups that may benefit from PCIT have highlighted important considerations for delivering PCIT to these populations. One population is American Indian/Alaskan Native (AI/AN) families where a cultural adaptation called "Honoring Children-Making Relatives" was developed in collaboration with the Indian Country Child Trauma Center (Bigfoot & Fun-

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

derburk, 2011). This adaptation was created by considering current literature on AI/AN families, the core components of PCIT, feedback from cultural consultants, feedback from PCIT experts, and the culturally sensitive translations of materials (Bigfoot & Funderburk, 2011). While still needing further research, this adaptation takes into account the worldviews of AI/AN families and incorporates their traditional beliefs about storytelling and the interconnectedness of spirituality and healing to teach PCIT to families (Bigfoot & Funderburk, 2011). These considerations are intricately woven into every aspect of PCIT, from initial treatment engagement through treatment completion and incorporation of this strong history of cultural beliefs when delivering PCIT to AI/AN families, and are strongly recommended (Bigfoot & Funderburk, 2011).

Research exploring treatment outcomes for low-income African American families has demonstrated that these families have a higher dropout rate, over 50% (Fernandez et al., 2011), than other populations, approximately 36% (Fernandez et al., 2011). Among treatment completers, parental stress and maternal depression do not decrease as they do for other families after PCIT (Fernandez et al., 2011). Differential attrition rates may be related, in part, to lower SES (Fernandez & Eyberg, 2009; Harwood & Eyberg, 2004). Use of home-based PCIT appears to help close the dropout gap with African American families and may therefore be an effective way to reduce barriers to treatment (Gresl, Fox, & Fleischmann, 2014). Adaptations for African American families will likely need to consider ways to address parental stress, maternal depression, and barriers to obtaining mental health treatments, and would benefit from a collaborative development process similar to that used in AI/NA and Mexican American families.

Case studies and theoretical articles have offered guidance on working with other cultural groups in PCIT, including hard of hearing or deaf families and military families. Preliminary work highlights the importance of using mobile video technology to support PCIT procedures in the coaching of parents who are hard of hearing or deaf (Armstrong et al., 2014; Shinn, 2013) or in facilitating practice of skills with parents while on deployment in military families (Pemberton, Kramer, Borrego, & Owen, 2013). Case studies with families who are hard of hearing or deaf also highlight the importance of working effectively with interpreters, providing explicit explanations regarding the structure of language used in PCIT, knowledge of deaf culture, and the use of visual explanations for children (Shinn, 2013). Pemberton and colleagues (2013) highlight the importance of understanding military cultural norms and the acceptability of PCIT and working with established Veterans Hospitals to provide care for military families.

Conclusions

PCIT is well established for the original intent of treating oppositional defiant disorder in preschoolers and should be more broadly considered as an effective method of improving the parent–child relationship. Though promising, the effectiveness and efficacy of PCIT with subgroups of oppositional preschoolers and in a variety of settings are still under investigation. There is mounting evidence regarding the use of PCIT in traumatized populations and various cultural groups, but the need to systematically explore the development, efficacy, and dissemination of cultural adaptations continues. Overall, PCIT appears to reduce parental stress and child behavior problems, while increasing positive parenting practices. Implementing PCIT with fidelity, inclusive of cultural feedback, is the way to effectively deliver PCIT to diverse populations.

REFERENCES

Abrahamse, M. E., Junger, M., Chavannes, E., Coelman, F. G., Boer, F., & Lindauer, R. L. (2012). Parent–child interaction therapy for preschool children with disruptive behaviour problems in the Netherlands. *Child and Adolescent Psychiatry and Mental Health, 6,* 24.

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.

Armstrong, K., David, A., & Goldberg, K. (2014). Parent–child interaction therapy with deaf parents and their hearing child: A case study. *Clinical Case Studies, 13,* 115–127.

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

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. *Journal of Early Adolescence, 11,* 56–95.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Ro-

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

dríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 362.

Bigfoot, D. S., & Funderburk, B. W. (2011). Honoring children, making relatives: The cultural translation of parent–child interaction therapy for American Indian and Alaska Native families. *Journal of Psychoactive Drugs, 43,* 309–318.

Boggs, S. R., & Eyberg, S. M. (2009). Positive attention. In W. T. O'Donogue & J. E. Fisher (Eds.), *General principles and empirically supported techniques of cognitive behavior therapy* (pp. 494–499). Hoboken, NJ: Wiley.

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

Chadwick Center on Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA: Author.

Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26,* 1097–1113.

Chaffin, M., Funderburk, B., Bard, D., Valle, L., & Gurwitch, R. (2011). A combined motivation and parent–child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79,* 84–95.

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 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, 14,* 365–368.

Cooper, G., Hoffman, K. T., & Powell, B. (2009). *Circle of Security: COS-P Facilitator DVD Manual 5.0.* Spokane, WA: Marycliff Institute.

Danko, C. M., Garbacz, L. L., & Budd, K. S. (2016). Outcomes of parent–child interaction therapy in an urban community clinic: A comparison of treatment completers and dropouts. *Children and Youth Services Review, 60,* 42–45.

Domenech Rodríguez, M. M., & Bernal, G. (2012). Bridging the gap between research and practice in a multicultural world. In G. Bernal & M. M. Domenech Rodríguez (Eds.), *Cultural adaptations: Tools for evidence-based practice with diverse populations* (pp. 265–287). Washington, DC: American Psychological Association Press.

Eisenstadt, T., Eyberg, S., McNeil, C., 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*(1), 42–51.

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). Oxford, UK: Wiley.

Eyberg, S. M., & Funderburk, B. (2011). *Parent–child interaction therapy protocol.* Gainesville, FL: Parent–Child Interaction Therapy.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 215–237.

Eyberg, S., & Pincus, D. (1999). *Eyberg Child Behavior Inventory and Sutter–Eyberg Student Behavior Inventory—Revised: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Fernandez, M. A., Butler, A. M., & Eyberg, S. M. (2011). Treatment outcome for low socioeconomic status African American families in parent–child interaction therapy: A pilot study. *Child and Family Behavior Therapy, 33,* 32–48.

Fernandez, M. A., & Eyberg, S. M. (2009). Predicting treatment and follow-up attrition in parent–child interaction therapy. *Journal of Abnormal Child Psychology, 37*, 431–441.

Ferrer-Wreder, L., Snudell, K., & Mansoory, S. (2012). Tinkering with perfection: Theory development in the intervention cultural adaptation field. *Child Youth Care Forum, 41,* 149–171.

Franz, C., McClelland, D., & Weinberger, J. (1991). Childhood antecedents of conventional social accomplishment in midlife adults: A 36-year prospective study. *Journal of Personality and Social Psychology, 60,* 586–595.

Fricker-Elhai, A. E., Ruggiero, K. J., & Smith, D. W. (2016). Parent–child interaction therapy with two maltreated siblings in foster care. *Clinical Case Studies, 4,* 13–39.

Gopalan, G., Goldstein, L., Kathryn, K., Sicher, C., Blake, C., & McKay, M. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*(3), 182–196.

Gresl, B. L., Fox, R. A., & Fleischmann, A. (2014). Home-based parent–child therapy in low-income African American, Caucasian, and Latino families: A comparative examination of treatment outcomes. *Child and Family Behavior Therapy, 36*(1), 33–50.

Hakman, M., Chaffin, M., Funderburk, B., & Silovsky, J. F. (2009). Change trajectories for parent–child interaction sequences during parent–child interaction therapy for child physical abuse. *Child Abuse and Neglect, 33,* 461–470.

Harden, B. (2004). Safety and stability for foster children: A developmental perspective. *The Future of Children, 14*(1), 30–47.

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

Harwood, M., & 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*(3), 601–612.

Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent–child interaction therapy.* New York: Plenum Press.

Herschell, A., & McNeil, C. (2005). Theoretical and empirical underpinnings for parent–child interaction therapy with child physical abuse populations. *Education and Treatment of Children, 28,* 142–162.

Lanier, P., Kohl, P., Benz, J., Swinger, D., & Drake, B. (2014). Preventing maltreatment with a community-based implementation of parent–child interaction therapy. *Journal of Child and Family Studies, 23,* 449–460.

Leung, C., Tsang, S., Heung, K., & Yiu, I. (2009). Effectiveness of parent–child interaction therapy (PCIT) among Chinese families. *Research on Social Work Practice, 19,* 304–313.

Leung, C., Tsang, S., Sin, T. C., & Choi, S. Y. (2015). The efficacy of parent–child interaction therapy with Chinese families: Randomized controlled trial. *Research on Social Work Practice, 25,* 117–128.

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.

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., & Yeh, M. (2009). Parent–child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology, 38,* 753–759.

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. *Treatment of Children, 28,* 111–129.

McCabe, K., Yeh, M., Lau, A., & Argote, C. (2012). Parent–child interaction therapy for Mexican Americans: Results of a pilot randomized clinical trial at follow-up. *Behavior Therapy, 43,* 606–618.

McNeil, C. B., Herschell, A. D., Gurwitch, R. H., & Clemens-Mowrer, L. (2005). Training foster parents in parent–child interaction therapy. *Treatment of Children, 28,* 182–296.

Mersky, J. P., Topitzes, J., Grant-Savela, S. D., Brondino, M. J., & McNeil, C. B. (2016). Adapting parent–child interaction therapy to foster care: Outcomes from a randomized trial. *Research on Social Work Practice, 26,* 157–167.

Mersky, J. P., Topitzes, J., Janczewski, C. E., & McNeil, C. B. (2015). Enhancing foster parent training with parent–child interaction therapy: Evidence from a randomized field experiment. *Journal of the Society for Social Work and Research, 6,* 591–616.

Nixon, R. D., 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,* 236–271.

N'zi, A. M., Lucash, R., Clionsky, L., & Eyberg, S. M. (2017). Enhancing parent–child interaction therapy with motivational interviewing. *Cognitive and Behavioral Practice, 24,* 131–141.

N'zi, A. M., Stevens, M. L., & Eyberg, S. M. (2016). Child directed interaction training for young children in kinship care: A pilot study. *Child Abuse and Neglect, 55,* 81–91.

Patterson, G. R. (1982). *Coercive family process* (Vol. 3). Eugene, OR: Castalia.

Pemberton, J. R., Kramer, T. L., Borrego, J. R., & Owen, R. R. (2013). Kids at the VA?: A call for evidence-based parenting interventions for returning veterans. *Psychological Services, 10*(2), 194–202.

Phillips, J., Morgan, S., Cawthorne, K., & Barnett, B. (2008). Pilot evaluation of parent–child interaction therapy delivered in an Australian community early childhood clinic setting. *Australian and New Zealand Journal of Psychiatry, 42,* 412–419.

Querido, J. G., Warner, T. D., & Eyberg, S. M. (2002). Parenting styles and child behavior in African American families of preschool children. *Journal of Clinical Child and Adolescent Psychology, 31,* 272–277.

Rodriguez, C. M. (2010). Parent–child aggression: Association with child abuse potential and parenting styles. *Violence and Victims, 25*(6), 728–741.

Shinn, M. M. (2013). Parent–child interaction therapy with a deaf and hard of hearing family. *Clinical Case Studies, 12,* 411–427.

Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry, 21*(4), 345–349.

Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for parent–child interaction in the prevention of child maltreatment. *Child Development, 82,* 177–192.

Thomas, R., & Zimmer-Gembeck, M. J. (2012). Parent–child interaction therapy: An evidence-based treatment for child maltreatment. *Child Maltreatment, 17,* 253–266.

Timmer, S. G., Sedlar, G., & Urquiza, A. J. (2004). Challenging children in kin versus nonkin foster care: Perceived costs and benefits to caregivers. *Child Maltreatment, 9,* 251–262.

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,* 919–939.

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost

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, 1,* 1–19.

Ward, M. A., Theule, J., & Cheung, K. (2016). Parent–child interaction therapy for child disruptive behaviour disorders: A meta-analysis. *Child and Youth Care Forum, 45*(5), 675–690.

Weisz, J. R., & Hawley, K. M. (2002). Developmental factors in the treatment on adolescents. *Journal of Consulting and Clinical Psychology, 70*(1), 21–43.

Yu, J., Roberts, M., Wong, M., & Shen, Y. (2011). Acceptability of behavioral family therapy among caregivers in China. *Journal of Child and Family Studies, 20,* 272–278.

Zeanah, C. H., Jr. (Ed.). (2009). *Handbook of infant mental health* (3rd ed.). New York: Guilford Press.

Zeanah, C. H., Jr., & Zeanah, P. D. (2009). The scope of infant mental health. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (3rd ed., pp. 5–21). New York: Guilford Press.

Copyright @ 2019. The Guilford Press.
All rights reserved. May not be reproduced in any form without permission from the publisher, except fair uses permitted under U.S. or applicable copyright law.

EBSCO : eBook Collection (EBSCOhost) - printed on 7/2/2019 3:17 PM via TUFTS UNIV
AN: 1843598 ; Zeanah, Charles H..; Handbook of Infant Mental Health, Fourth Edition
Account: s3579704.main.ehost