REVIEW ARTICLE

# Parent-Child Interaction Therapy: A Unique and Effective Family-Centered Approach

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## BACKGROUND

Parent-Child Interaction Therapy (PCIT) is a collaborative family-centered approach. It empowers caregivers with the knowledge and skills to manage their child's behavior with positive attention while nurturing the parent-child relationship. Together with their therapist, parents and caregivers work on strengthening the parent-child relationship through daily homework exercises. They also learn ways to set healthy, age-appropriate limits and implement safe consequences for their child. With the support of their therapist, they can learn to navigate the many challenges of parenting using consistent and predictable strategies. This framework allows the child to feel safe and secure in their environment, eventually leading to decreased disruptive behaviors and increased cooperation.[1]

## SUBJECT PRESENTATION

A 4-year-old female is referred to the psychology clinic by her pediatrician for worsening aggressive and defiant behavior. During the initial clinical interview with the clinical psychologist, the mother revealed that the child had displayed an increase in behavior issues, including physical aggression, hitting a baby sibling and parents, defiance, throwing toys, refusing to follow directions, and frequently screaming and running inside the house. The family relocated eight months ago for her father's employment. She has a 10-year-old brother and 4-month-old baby sister. Her current behaviors started after their relocation and escalated in intensity and frequency when her baby sister was born. She is enrolled in a Voluntary Prekindergarten Education Program (VPK), but the teacher denies any significant current behavior concerns. The teacher described the child as "clingy" around when her sister was born, but this subsided after about one month. The mother of the child (MOC) shares that behaviors begin immediately upon picking her up from school. The child enters the car and starts crying and whining. She reports that these behaviors are additionally triggered by asking her to do something or during transitions from preferred to non-preferred activities.

The child is healthy with age-appropriate milestones. She has no history of medical issues. Sleep is normal, though; since the birth of her sister, she has begun getting out of her toddler bed and walking to her parents' bed in the middle of the night. Appetite is described as "picky."

PCIT sessions are initiated with parents and the child by conducting a baseline observation of the parent-child interactions and completing a behavior screener. A follow-up is scheduled with the parents to discuss appropriate therapy and provide a teaching session on phase 1 skills. Due to the father's work schedule, the child attends the subsequent sessions with her mother. Her mother begins to complete the homework assignment consistently.

By session 5 of coaching, the behavior screener reveals a 12-point decrease in concerns. MOC reports that the child is more compliant, calmer around the house, and gentler with her baby sister.

By session 7, MOC had mastered the PRIDE (see below) skills in treatment and was ready to move on to Phase 2.

Session 8 includes a teaching session with the father present, who reports he has not consistently practiced the skills with the child and feels he has a bit more difficulty with her.

MOC consistently practices phase 2 skills in sessions 9-11 and says the child is increasingly compliant at home, responding when MOC uses only a warning and does not require time out. Sessions 11 and 12 focus on implementing public behavior and house rules for aggression. At this point, MOC feels that additional treatment is not needed due to a significant decrease in aggression. Her father is able to participate in some of the phase 2 sessions and reports he has begun using the skills with her and observes an overall improvement.

By session 13, MOC reported a slight increase in negative attention-seeking behaviors and shared that she was inconsistent with skills due to a family vacation, followed by the father's work trip, which changed the family schedule. She consistently uses skills and reports behavior stabilization by session 14. An end-of-treatment behavior screener reveals a 30-point decrease from the initial score, now within the "average" range of behavior concerns.

Session 15 addresses the remaining concerns and graduates the child from treatment, marking a significant positive change in the child's behavior and family dynamics.

## DISCUSSION

PCIT is an evidence-based, family-centered treatment approach for children ages 2.4 to 7 years.[10] The treatment focuses on children who present with disruptive behaviors across various settings. All caregivers, including birth, adoptive, or foster parents, grandparents, or other relatives, can use PCIT. PCIT is typically provided in 8-16 sessions that last approximately one hour each. The treatment is manualized, and the curriculum uses two phases, each with session goals, handouts, and homework exercises.

Once the parent masters phase one, they can move on to phase two. A child behavior screener is also used to monitor progress. PCIT incorporates a treatment method of live coaching, in which the therapist is typically in one room using a one-way mirror (Figure 1) while the parent, wearing a small wireless earpiece, is in another room with the child (Figure 2). Live coaching allows the parent to receive immediate feedback and guidance on the PCIT skills.[2,3]

PCIT has been tested and appears promising for both anxiety and depression in preschool children.[4] PCIT is also beneficial for reducing externalizing symptoms in children with autism spectrum disorder or ADHD with reductions in behavioral problems and improvements in parenting skills.[5,6]

***Figure 1: Observation room with one-way mirror.***

***Figure 2: Playroom for the child and parent.***

**Phase I: Child Directed Interactions**

During this phase, parents learn strategies to enhance the parent-child interaction and promote positive behaviors in the child. To achieve this, they are taught the PRIDE skills through child-directed interactions.[7] PRIDE is an acronym used to refer to the following five skills that they will learn and master in this phase:

- Praise: Provide specific and labeled praise for appropriate behaviors to encourage them and make the parent and child feel good. For example, "Thank you for sharing the toys with me." Labeled praise increases self-esteem and often increases the behavior that is praised.
- Reflection: Repeat or paraphrase your child's statements to let them know you are listening and improve communication. For example, the child says, "That is a red block," and the parent says, "Yes, that is a red block." Reflections can also improve speech and provide your child with positive attention.
- Imitation: Copy what your child is doing, which lets your child know you approve of their actions and can teach prosocial behaviors. If your child is coloring, you will be encouraged to color with them.
- Descriptions: Describe what your child is doing with the toys. For example, "You are building a tall tower with red and blue blocks." This often leads to an increased attention span; your child knows you are watching and paying attention to them. Descriptions also encourage your child to slow down and think about their actions.
- Enjoy: Use an enthusiastic and playful tone of voice and be engaged in the interaction. Let your child know how much you enjoy time spent with them. This increases the warmth of the interaction and makes it fun for you and your child.

Parents practice these skills in daily homework exercises called special time. Special time is one-on-one playtime between the parent and child, during which the parent follows the child's lead while decreasing their use of commands, questions, and criticism and using the five PRIDE skills. During the treatment sessions, parents are coached on mastering the PRIDE skills and using selective attention. Selective attention is giving full attention to desirable behaviors and withholding attention from unwanted behaviors.

**Phase II: Parent-Directed Interactions (PDI)**

During PDI, the therapist teaches how to give the child clear and direct "commands" or instructions and to provide consistent and predictable consequences. When a child obeys a command, parents are instructed to give the child labeled praise for listening, such as, "Thank you for doing what I asked." If the child disobeys, the parent initiates the timeout procedure, which entails a 3-minute time out in a chair. Parents are given daily homework exercises once the procedure has been successfully practiced in the clinic setting under the therapist's guidance.

## LIMITATIONS

While PCIT is proven effective in addressing many types of behavioral problems in children, specific populations would not be appropriate for this treatment, and a provider may refer the family/child to another treatment, or specific modifications may need to be made. For example, parents who:

- have been sexually or physically abusive to their children
- have no ongoing or minimal contact with their child
- have a serious mental illness, such as untreated schizophrenia or active hallucinations
- engage in active substance use
- have impaired cognition, hearing, or speech

**Internet Delivered PCIT (IPCIT) during COVID-19 and beyond**

During the COVID-19 pandemic, limitations of social distancing necessitated a shift to telemedicine to continue supporting children and their families. While the core service and interventions remained the same, adjustments were made so that sessions were successful.[8,9] Once the family is referred to PCIT, a virtual intake takes place, and instructions about internet-delivered PCIT are provided. The popularity of IPCIT has continued to date as a method of virtual therapy. Parents and therapists alike prefer the ability to see the child's behaviors in their natural environment.

## REFERENCES


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