Chapter 8
Parent-Child Interaction Therapy for Maltreated Children

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There are many pathways that drive a family toward physical abuse – some of these pathways are easy to discern; while others are complex and reflect a series of interconnected behaviors, attitudes, and expectations. It has previously been argued that escalating coercive exchanges and harsh disciplinary strategies are primary contributors – and perhaps the most proximal – to physically abusive parent-child relationships (Cicchetti & Valentino, 2006; Urquiza & McNeil, 1996). It is suggested that negative coercive exchanges focus many, if not most, of the parent-child interactions that eventually lead to parental use of aggression to secure compliance (Milner, 2000). Chronic failure to comply with parental commands – even for common child expectations such as taking out the trash, doing homework, washing dishes – can lead to both reinforcement of negative attitudes about the child and increased anger with the child. Eventually, repeated instances of reinforced negative attitudes and continued non-compliance lead to parental aggression – as a means to secure child compliance and/or as an expression of parental frustration.

Neglectful parent-child dyads, like physically abusive, show a similar deficit in positive interactions, though their interactions typically are not characterized by the negative coercive cycle (Wilson, Rack, Shi, & Norris, 2008). In a meta-analysis of over 30 studies, Wilson and colleagues (2008) found that neglectful dyads could be discriminated from non-maltreated dyads by their lack of involvement, or detachment from each other, unlike physically abusive dyads.

To address the issue of child maltreatment, it is therefore essential to shift the fundamental characteristics of the negative coercive relationship and the detached relationship to contain a stable pattern of positive reciprocal cognitions and behaviors. This is an important intervention element, as both parent and child cognitions need

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to be changed, as well as the sequences of behaviors that guide and are produced by these cognitions (i.e., the coercive cycle). So, the task of intervening with maltreated children should have several goals: improving parenting skills, decreasing child behavioral problems (i.e., increase in child compliance), and increasing the frequency of positive parent-child interactions. One evidence-based intervention that provides these elements is Parent-Child Interaction Therapy (PCIT), an intensive parenting intervention, classified by Chambless and Ollendick (2000) as an empirically supported treatment. When considering providing PCIT to maltreated children, one might legitimately ask, "How could a behaviorally-oriented, evidence-based, parenting program benefit a child who has been maltreated? What about the trauma?" On the following pages, we describe ways in which PCIT can benefit certain types of children and families who have experienced maltreatment – especially when children exhibit significant behavioral disruption. Following this, there is a discussion of the role in PCIT in addressing trauma symptoms in young children. The application of PCIT to young traumatized children is included because many maltreated children exhibit trauma symptoms; and because development of positive parent-child relationships may be one of the most effective and naturalistic trauma interventions for young children. Finally, we provide a description of a 'typical' case of an abused and severely traumatized young boy – incorporating many of the elements of the PCIT protocol (e.g., results of pre- and post-treatment assessments, development of treatment objectives, examples of efforts to enhance parent-child relationship quality, strategies to manage non-compliant behavior, and inclusion of coaching text from a PCIT treatment session). The goals of this chapter are to inform the reader of the value of PCIT in meeting the unique treatment needs of maltreating parent-child dyads, provide an overview of the evidence supporting PCIT with maltreating families, explain some of the mechanisms by which PCIT can benefit both abusive parents and maltreated children, and discuss the value of significant positive relationships in reducing child trauma symptoms in young children.

Theoretical Foundation

PCIT (Eyberg & Robinson, 1982) is one of several programs that emerged from Constance Hanf's lab at Oregon Health Sciences University in the late 1960s. Hanf's two-phase model was founded on the principles of operant conditioning, believing that through strategic social reinforcement it would be possible to change caregivers and children to modify maladaptive parent-child interactions (Reitman & McMahon, 2012). While focused on increasing discrete behaviors like parent's attention to the child and praise, Hanf, and subsequently Eyberg, also incorporated attachment theory's belief in the importance of maternal warmth and responsiveness (e.g., Ainsworth, 1979), Diana Baumrind's work (1966, 1967) which conceptualized healthy parenting as authoritative, with clear communication and firm limit setting, as well as the work of Virginia Axline (1947) and Bernard Guerney (1964),

which promoted non-directive parental warmth and acceptance (Eyberg, 2004). Using Hanf's (1969) ideas of *in vivo* parenting and use the structure of a 'coaching' paradigm, Eyberg's innovation was to break down these skills into even more discrete parts – into specific verbalizations, which were behaviors she could easily teach parents. When combined together, the discrete behaviors could foster the construction of less tangible skills employed by child therapists, like nurturing, warmth, and responsiveness, and the skills needed for managing children's difficult behavior (like selective attention, positive reinforcement for compliance). Hanf's model was built on the belief that coaching parents in specific parenting skills was more effective way to change their behavior than psychoeducational, modeling, or role play.

What Is Parent-Child Interaction Therapy?

Parent-Child Interaction Therapy (PCIT) is a 14- to 20-week, manualized intervention founded on social learning and attachment theories. PCIT is designed for children between 2 and 7 years of age with disruptive, or externalizing, behavior problems (Eyberg & Robinson, 1983). The underlying model of change is similar to that of other parent-training programs. These programs promote the idea that through positive parenting and behavior modification skills, the parents themselves become the agent of change in reducing the child's behavior problems. However, unlike other parenting-focused interventions, PCIT incorporates both parent and child in the treatment sessions and uses live, individualized therapist coaching for an idiographic approach to changing the dysfunctional parent-child relationship.

PCIT is conducted in two phases. The first phase focuses on enhancing the parent-child relationship (Child-Directed Interaction; CDI), and the second on improving child compliance (Parent-Directed Interaction; PDI). Both phases of treatment begin with an hour of didactic training, followed by sessions in which the therapist coaches the parent during play with the child. From an observation room behind a two-way mirror, via a 'bug-in-the-ear' receiver that the parent wears, the therapist provides the parent with feedback on their use of the skills. Parents are taught and practice specific skills of communication and behavior management with the child. In addition to practicing these skills during clinic sessions, parents are asked to practice with the child at home for 5 min every day.

In CDI (typically 7–10 sessions), parents are coached to follow their children's lead in play by describing their activities, reflecting their appropriate verbalizations, and praising their positive behavior. The skills parents learn during this phase of treatment are represented in the acronym, PRIDE, which stands for Praise, Reflection, Imitation, Description, and Enjoyment. By the end of CDI, parents generally have shifted from rarely noticing their children's positive behavior to more consistently attending to or praising appropriate behavior. When caregivers master the skills taught in CDI by demonstrating that they can give ten behavior descriptions (e.g., "You are building a tall tower"), ten reflections (i.e., repeating back or paraphrasing the child's words), and ten labeled praises (e.g., "Thank you for

playing so gently with these toys"), with fewer than three instances of asking a question, giving a command, and eliminate criticizing the child in a 5-min assessment, they move to the second phase of treatment. The following is an example of CDI coaching:

(Parent and child are playing with Legos; the therapist is watching from an adjacent observation room and talking to the parent through the 'bug-in-the-ear' system)

Therapist:	Describe what Robert is doing with his hands.
Robert:	(plays with blue Legos)
Parent:	You put all of the blue Legos on the table.
Therapist:	That was a great behavioral description!
Child:	Yes, I'm going to make a big blue tower.
Parent:	Oh… you're going to make a big blue tower
Coach:	You got it! That was a perfect reflection of what Robert said. He knows you are paying attention to what he is doing. When you give him praise and attention for his good behavior, he will do more of that behavior.
Child:	And I'm going to make a red barn too!
Therapist:	You make a red barn too, Mom.
Parent:	That's a great idea! I'm going to make a red barn just like you.
Therapist:	Great imitating! He really knows you're paying attention when you imitate his play.
Child:	Okay, you build yours right here, and the cow will go in it.
Therapist:	Robert is playing very gently with the toys today. And so creative!
Parent:	Robert, you are so creative with these Legos. You know just what to do!
Child:	Yeah!
Therapist:	Nice labeled praise, Mom.

In the example, you can see that therapists alternate between leading (and sometimes redirecting) the parent, following the parent, and giving brief psychoeducation: interpreting children's behavior, explaining the meaning and long term effects of using the skills. These coaching strategies gently lead the parent to try out, practice, and incorporate these skills into the fabric of their parenting.

In PDI (typically 7–10 sessions) therapists train parents to give only essential commands, to make them clear and direct, maximizing chances for compliance. Parents participating in PCIT traditionally learn a specific method of using time-out for dealing with noncompliance. Parents also may be taught "hands-off" strategies (e.g., removal of privileges) if indicated. These strategies are designed to provide caregivers tools for managing their children's behavior while helping them to avoid using physical power, focusing instead on using positive incentives and promoting children's emotional regulation. Mastery of behavior management skills during PDI is achieved when therapists observe that caregivers are able to use the behavior management strategies they were taught without being coached and when parents report that these strategies are effective in reducing problem behaviors. By the end of PDI, the process of giving commands and obtaining compliance are predictable

and safe for parents and children. Increasing predictability and safety in families helps break the cycle of violence in abusive families (Dodge, Bates, & Pettit, 1990). The following script is an example of PDI coaching:

(Parent and child are playing with Legos; the therapist is watching from an adjacent observation room and talking to the parent through the 'bug-in-the-ear' system)

Therapist: It is now time to clean up the toys. Tell Robert to put the Legos back in the box.
Parent: Robert, it's time to clean up. Can you put the Legos back in the box? [Indirect Command]
Therapist: Make it a direct command.
Parent: Please put the Legos back in the box, Robert.
Therapist: That was a perfect Direct Command. Now Robert knows exactly what he is supposed to do.
Child: (Robert starts to put a couple of Legos in the box)
Therapist: Now Robert is putting Legos away like you told him.
Parent: Thank you for listening, Robert! [Labeled Praise]
Therapist: Excellent labeled praise. That will help Robert want to listen more in the future.

As in CDI, the PCIT therapist alternates between leading, following and explaining to the parent. However, unlike CDI, the therapist is more corrective, never ignoring mistakes, and can be more directing, particularly in the midst of a child's time-out or time-out refusal. During these mini-crises, the therapist may give the parent the words to say, or prompt the parent with the beginning of a well-practiced phrase to keep the parent on track.

Therapists coach parents to recognize and provide appropriate responses for the child's behavior (e.g., recognizing and responding to praise for compliance; recognizing and ignoring minor inappropriate behavior – such as whining). As parents acquire these PCIT skills, therapists give fewer directives and instead use the coaching time to describe and praise the positive parenting they see, making connections between this behavior and the bigger picture of parenting and child development. An additional important element of PCIT coaching involves shifting *both* parent responses and cognitions about child behavior. While coaching, therapists often provide supplemental information about the child's behavior, to correct or minimize distortions in parent cognitions (especially negative or hostile cognitions). An example of this would be:

Child: (Child is coloring with a marker and paper. In the process of coloring, the child accidentally moves the marker off of the paper and draws on the table.)
Therapist: (Noticing that the child has colored on the table and the parent is irritated about the child drawing on the table) Oh… that happens all of the time. It is common for a child of his age to accidently draw on the table. The marker washes off the table easily – so no harm done. As soon as he starts to draw on the paper, give him a labeled praise for drawing on the paper.

Child: (Starts to draw on the paper again) I am drawing a truck.
Parent: That is an awesome truck [Labeled Praise]; and you are doing a great job drawing on the paper! [Labeled Praise]
Therapist: Awesome Labeled Praise, Dad! He wasn't misbehaving by drawing on the table – he is just not old enough to always draw on the paper. And now you've starting teaching him that it's good to draw on the paper.

Through the process of coaching, therapists can give parents immediate and accurate feedback about the child's behavior. We argue that when the therapist whispers into the parent's ear a different view of the child's behavior – a different interpretation of the child's intent – the therapist 'interrupts' the parent's previously held negative attribution (and negative affect) about the child's behavior. Over time, children's behaviors which were previously viewed through a lens of negative parental attributions and expectations shift to recognition and acknowledgement, then acceptance of the a more positive attribution of the child's behavior (prompted by therapist/coach's observation and positive attribution of the child's behavior).

Empirical Support for PCIT with Oppositional, Defiant Children

There have been numerous studies demonstrating the efficacy of PCIT for reducing child behavior problems (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg, 1988; Eyberg & Robinson, 1982). Positive effects have been maintained for up to 6 years post-treatment (Hood & Eyberg, 2003). In addition, treatment effects have been shown to generalize to the home (Boggs, Eyberg, & Reynolds, 1990), school settings (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991), and to untreated siblings (Eyberg & Robinson). In addition, there is research indicating that PCIT yields positive treatment outcomes with different types of cultural and language groups, including Spanish-speaking families (McCabe, Yeh, Garland, Lau, & Chavez, 2005), Chinese-speaking families (Leung, Tsang, Heung, & You, 1999), and African-American families (Fernandez, Butler, & Eyberg, 2011).

Empirical Support for PCIT with Abusive Families

While numerous studies demonstrated the value of PCIT with oppositional and defiant children, Urquiza and McNeil (1996) argued that some (if not many) of the symptoms of child victims of physical abuse or domestic violence were consistent with the disruptive behaviors of children in the PCIT studies. They proposed using PCIT with maltreated children and those exposed to domestic violence. There are

many reasons to expect that PCIT would be a beneficial treatment for maltreating families. Effective treatments for these families should incorporate both the parent and the child because the behaviors of each contribute to the maladaptive responses of each, feeding a cycle of hostility and coercion. The treatment should also provide a means to directly decrease negative affect and coercive control, while encouraging (i.e., teaching, coaching) greater positive affect and discipline strategies. In the last decade, research findings have shown positive outcomes with maltreating parent-child dyads (Timmer, Urquiza, Zebell, & McGrath, 2005), children exposed to domestic violence (Timmer, Ware, Zebell, & Urquiza, 2008), and children with their foster parents (Borrego, Timmer, Urquiza, & Follette, 2004; Chaffin et al., 2004; Timmer, Borrego, & Urquiza, 2002; Timmer, Urquiza, & Zebell, 2006). In summary, while PCIT was initially developed as an intervention specifically for children with disruptive behavioral problems, there is currently ample research that identifies PCIT as an effective evidence-based parenting program for high-risk and abusive families.

Traumatized Children Have Behavioral Problems

It is not uncommon for maltreated children to have trauma symptoms in addition to problems with disruptive behavior. Trauma symptoms may derive from their experience of being physically abused and/or as a result from other traumatic events (e.g., exposure to domestic violence, community violence, sexual victimization). That is, children who experience traumatic events exhibit multiple symptoms consistent with Posttraumatic Stress Disorder (American Psychiatric Association, 2000), including nightmares, affective dysregulation, intrusive imagery, and intense distress related to internal or external cues associated with the traumatic event (Copeland, Keeler, Angold, & Costello, 2007). It is often more difficult to detect the effects of trauma in young children, because they do not recognize or cannot articulate the connection between the traumatic event and how they feel and behave (i.e., traumatic symptoms) – because of their developmental limitations (e.g., expressive language ability, social cognition, intellectual functioning). Although it can reasonably be argued that any type of traumatic event can lead to anger and defiance – the range of responses that lead to a specific child being labeled as defiant or oppositional can be complicated to determine. For example, we know that some traumatized children are also exposed to domestic violence or child physical abuse (Jouriles & Norwood, 1995). Further, there is a wealth of literature describing the experience of violence (i.e., being abused) and exposure to violence (i.e., exposure to domestic violence) as a significant predictor of aggressive, noncompliant, defiant behavior in children (e.g., Brown, 2005; Cohen, 2003; Milner, 2000). This pattern of disruptive child behavior appears to stem from a combination of parents' frequent modeling of aggressive and hostile behavior, and the child's own angry emotional responses and resulting oppositional behavior tied to being raised in such coercive and hostile environments.

One characteristic of many violent families that contributes to children's disruptive behavior problems is the absence of positive, warm, and nurturing parenting (Fantuzzo et al., 1991). When traumatized children live in families with chaotic lifestyles, in which consistent and positive parent-child relationships are infrequent or nearly nonexistent, their behavioral problems may be less related to their trauma than the overall chaotic and dysfunctional lifestyle in which they are being raised. The population of children who have disruptive behavioral problems resulting from inconsistent and poor parenting is the group for whom some type of intensive parenting intervention may be most effective (Kaminski, Valle, Filene, & Boyle, 2008); although it should be understood that this type of intervention may not *directly* address the cognitions and affect related to the child's trauma.

A Dyadic Parent-Child Intervention with Young Traumatized Children

Younger and older children respond differently to trauma, with younger children appearing to be more responsive to the stability (or lack of stability) of parental functioning and older children less likely to be adversely impacted by parent instability (Scheeringa & Zeanah, 2001). In particular, younger children (i.e., toddlers, preschool-age, elementary-age children) are highly responsive to parent cues of affective stability, instability, and distress related to adverse family events (e.g., interpersonal violence), often because their means of coping is still co-regulated by the parent (Chu & Lieberman, 2010; Fogel, Garvey, Hsu, & West-Stroming, 2006). In contrast, older children (i.e., school-age, adolescents) tend to rely more on their own coping skills and cognitions, may be more independent from distress experienced by a parent figure, and may develop other sources of support (e.g., peers, extended kin) (Werner, 1995). Because of these factors, approaches to treatment including both the parent and child are likely to be more effective with younger than older children (Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004).

PCIT and Traumatized Children

Recent research has shown that young traumatized children who complete PCIT show significant reductions in trauma symptoms (Mannarino, Lieberman, Urquiza, & Cohen, 2010). This finding – that participation in a behavioral, intensive parenting program is related to a reduction of trauma symptoms – may be initially puzzling to some. However, there are several reasons why young traumatized children would benefit from a parenting intervention – and especially PCIT.

Management of Disruptive Behavior

As stated earlier, some traumatized young children come from chaotic and dysfunctional families, experiencing poor and inconsistent parenting. They exhibit defiant, oppositional, and aggressive behavior. This family history and behavioral profile qualifies them as an appropriate clients for PCIT. There are also indications that externalizing behavior problems are symptoms of a traumatic response to a frightening event (Valentino, Berkowitz, & Stover, 2010). For some children, their traumatic response is exhibited through defiant and disruptive behaviors. It is therefore possible that by helping parents manage the child's disruptive behavior in a positive, consistent, and firm manner – a primary objective of PCIT – that the anxiety underlying that behavior may also subside, resulting in an overall decrease in trauma symptoms.

Improved Child Relationship Security and Stability with Their Primary Caregiver

Helping parents by enabling and supporting a more positive parent-child relationship is another primary objective of PCIT. One of the avenues to recovery from child trauma involves eliciting support from important caregivers. Supportive parenting is associated with positive child outcomes in many domains (Greenberg, 1999; Kim et al., 2003) – especially when a child is exposed to a traumatic event (Valentino et al., 2010). Therefore, it is essential to sustain a positive parent-child relationship and parental support in order to optimize the child's ability to deal with any adverse or traumatic experience. The combination of parental stress associated with child trauma and problematic child symptoms can erode a parent's ability to be supportive, warm, and understanding. One benefit of PCIT is that parents who used the PRIDE skills (i.e., parenting skills promoted within the first portion of PCIT) in their interactions with their children, particularly Praise and Reflection, are also more likely to be rated as sensitive, showing warmth and positive affiliation increase (Timmer & Zebell, 2006), which should strengthen the parent-child relationship. Throughout the course of PCIT, coaches focus on helping parents to recognize and attend to their children's positive behavior by describing and praising it. At the same time, parents are taught to ignore minor negative and inappropriate behaviors so that they can maintain a warm and supportive relationship with their children. As stated earlier, in the development of PCIT Eyberg incorporated play therapy goals and techniques proposed by the Axline's (1947) and Guerney's (1964) therapeutic approaches, because they promoted warmth and acceptance (Eyberg, 2004). An intervention that promoted warm, responsive, and authoritative parenting, and that combined nurturing, clear communication and firm limit-setting, may be an effective way to address a wide range of child mental health problems – including child trauma symptoms.

Parents as Therapists: Supporting Parent-Child Communication

Although there are many perspectives on what exactly constitutes psychotherapy, there is a rich literature describing the benefits of parents functioning in a supportive, therapeutic-like role with their children (see Guerney, 2000; Hutton, 2004). The central aspects of this type of filial therapy relationship include the following: (1) a positive relationship between a child and parent; (2) focus on development of appropriate and safe expression and communication; and (3) the use of play as a central theme (Urquiza, Zebell, & Blacker, 2009). In PCIT, parents are instructed about how to engage their children in positive and collaborative play (especially in the first component of PCIT). As a result, there is typically a more warm, supportive and affectionate relationship developed between the parent and child. Often, this includes positive verbal statements and physical affection exhibited by both the parent and the child. Similarly, the focus on safe and effective communication is a central tenet of PCIT. Parents are directed to communicate issues of safety, concern for the child's well-being, and positive regard for all appropriate and nonaggressive interactions. Because both parents and children generally perceive play activities as positive and enjoyable – sharing positive play experiences in PCIT sessions strengthens the communication between the dyad and helps rebuild a relationship history that is overall more positive and strengthening and less negative.

Management of the Traumatized Child's Affect

Traumatized young children have difficulty managing their feelings in emotionally difficult situations (Graham-Bermann & Levendoskly, 1998). These young children also have underdeveloped coping skills and a limited understanding of the traumatic experience they have endured (Eigsti & Cicchetti, 2004). These developmental limitations can hinder therapeutic efforts to directly address the child's trauma, traumatic symptoms, and help children to understand their responses (especially their feelings) to their trauma. In addition to developing a more positive and secure parent-child relationship, PCIT provides a mechanism to directly address many of the feelings that a child experiences – especially feelings associated with safety, fear, avoidance, and security. In the 'PCIT for Traumatized Children' protocol, a variation of PCIT for use with traumatized children (PCIT Training Center, 2012), therapists are instructed to help parents identify a child's thoughts, feelings, and behaviors, should the child act out the trauma in play or refer to the trauma during the treatment session. For example, if a child acted out an event, displaying anger, aggression, or fear – which are often shown by traumatized children – parents would be coached to respond appropriately to the child (A separate parent-only treatment session may be needed to assist the parent in common child responses to trauma and strategies to response to *their* traumatized child). In some cases with young children, the parent might be coached to play out a resolution to the traumatic event that involved keeping the child safe. With older children, the parent might be coached to

recognize and identify the feelings the child was showing. Past research has shown that distressing events that are resolved appropriately are less distressing to children than unresolved events (McCoy, Cummings, & Davies, 2009). Additionally, cognitive-behavioral research has shown that when children have the experience of the feeling paired with the affect label presented by parents, they begin to understand the meaning of the distressing affect, which is one of the first steps to being able to discuss and manage these feelings (Widom & Russell, 2008). As children continue to understand these feelings, then parents can help them engage strategies to manage these feelings (e.g., safety planning, deep breathing, counting, progressive relaxation). An example of coaching to assist a child through this process might be like:

Child:	(A child who has been exposed to domestic violence is playing with a dollhouse, and simulates a father coming to the door and banging hard on the door – while yelling) Let me in! Let me in!
Therapist:	It looks like she is pretending through her play that she is afraid that her father is going to come back. Tell her that you understand that she is scared and remind her that there's a plan to keep you safe
Parent:	I think you get really scared when daddy comes over to our house and is angry. But we have a plan to stay safe. I call …
Parent & Child:	"9…1…1"
Parent:	Right! Then the police will come and we will be safe!
Therapist:	That was great. You are helping her to understand her feelings of being scared and that you can keep her safe– even if her father comes back. Maybe Mr. Potato Head can be a policeman, and you show her how the plan will work.
Parent:	Here comes Mr. Policeman! "Let's go Mister. No yelling and pounding doors is allowed here." [takes Dad doll away]. If daddy comes back and you get scared, you come and find me – I'll make sure you are safe.

In order to assist parents to be appropriately responsive to the child's concerns, the therapist may need to have a separate 'parent only' session or talk with the parent on the phone (between sessions) to educate them about the child's concerns and how they might be able to respond during the treatment sessions. As with traditional PCIT coaching processes, repetition of parental responses to child trauma increases the parents understanding and use of supportive resources to alleviate trauma behaviors (i.e., symptoms and cognitions).

Decreasing Child Behavioral Problems May Increase Parental Competence

For relationship-based interventions to be effective, the caregiver must be able to participate and implement the skills learned or ideas discussed during therapy sessions. When primary caregivers have other sources of stress and trying to cope with

the effects of their own traumatic experiences, these problems can not only contribute to children's mental health problems, dampening parents' warmth and sensitivity and interfere with effective parenting (Lovejoy, Graczyk, O'Hare, & Neuman, 2000) but also can disrupt treatment effectiveness (Stevens, Ammerman, Putnam, & Van Ginkel, 2002). Symptoms of post-traumatic stress, such as depression, fatigue, dissociation and poor concentration can interfere with the acquisition of parenting skills (Reyno & McGrath, 2006). Furthermore, parental depression increases the likelihood of early treatment termination (Kazdin, 2000), completely removing the children from the possibility of being helped. However, research has shown that if traumatized parents can overcome their tendencies to drop out of treatment and participate in a relationship-based treatment, their own psychological symptoms can be relieved (Timmer et al., 2011).

In 'PCIT for Traumatized Children', parents are taught how to cope with the emotions that often accompany their children's disruptive behavior by using anxiety reduction skills such as deep-breathing and counting silently. They are coached to observe, notice, and react to their children's positive behavior. They are coached to show warmth, enthusiasm, and enjoyment in their interactions with their children. When traumatized parents repeatedly perform these positive and adaptive behaviors throughout the course of PCIT, it is thought that these adaptive responses may begin to generalize, or "spill over" into other parts of their lives, replacing maladaptive responses (Timmer et al., 2011).

PCIT Case Study

The family in treatment was a 30-year-old Latino father and his 7 year-old son, "Marco." The father reported that he had never married, but had been living with Marco's mother for approximately 9 years and had two children with her. The father sought treatment for his son because he believed that Marco had "a lot of anger issues with me and especially his mother," and felt that it was important to "get to the core" of his anger and resentment while he was young. The father reported that Marco was irritable, depressive, hyperactive, defiant, and aggressive towards him. He was also bossy and overbearing with his friends and other students at school.

Child History – Marco

At the time of the pre-treatment clinical intake interview, Marco lived with his father and 3-year-old sister in a homeless shelter, while Marco's mother was in an inpatient clinic for treatment of her alcohol and drug dependency. Their homelessness appeared to be a natural consequence of drug involvement and violence that ruled their lives up to that point. Marco's mother's history of alcohol and drug

dependency dated back at least to Marco's birth. When Marco was 4, he was diagnosed with ADHD and Oppositional Defiant Disorder, and prescribed Adderall for treatment of the hyperactivity and attention deficit. For several years, the parents were mostly compliant with this treatment. Approximately a year earlier, the mother moved to Southern California. The father, Marco, and his baby sister followed. The mother was using methamphetamines and alcohol heavily during this time; the father reported using "some cocaine." The father told the therapist that during this time, Marco's behaviors were so disruptive they interfered with his schooling. He was often asked to leave school after 45 min. After 4 months, they moved back north. Shortly afterward, the father was arrested on possession of substances with intent to sell and was jailed for 60 days. While he was in jail, the father reported that the mother's substance use "got out of control," and they were evicted from their apartment. In addition to the drugs and housing insecurity, Marco was exposed to domestic violence between his parents. The last incidence of violence was approximately 5 months before coming into treatment: the mother and father began fighting while driving. The father pulled over to the side of the road, and the parents continued yelling, screaming, kicking and punching each other with the children looking on. The police were called to the incident and took the father into custody.

In the initial clinical interview, the father reported that Marco had been aggressive, destructive, defiant, and impulsive "for years." He believed that the child's behavioral problems resulted from his and the mother's drug and alcohol abuse and witnessing domestic violence. In addition to the disruptive behaviors, the father also reported that Marco wet the bed at night five out of seven nights. At this time, Marco was enrolled in the school associated with the homeless shelter. In the 3 weeks he had been attending school he had been suspended twice. The father reported some support from family and friends and being fairly happy living at the shelter, though he anticipated a move to transitional housing in the near future.

'PCIT for Traumatized Children' Assessment and Treatment Procedures

PCIT is an assessment driven treatment. Before beginning treatment and upon graduation, parents complete a battery of standardized assessments including the following measures: Child Behavior Checklist (CBCL, 1½–5 years; Achenbach & Rescorla, 2000) and the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999), two standardized measures of the severity of children's behavior problems; the Trauma Symptom Checklist for Young Children (TSCYC; Briere et al., 2001), a measure of the severity of children's trauma symptoms; the Brief Symptom Inventory (BSI; Derogatis, 1993), a self-report measure of the parent's psychological symptoms; and the short form of the Parenting Stress Index (PSI; Abidin, 1995), a measure of the severity of three sources of stress in the parent role: parental distress, dysfunction in the parent-child relationship, and difficult child behavior.

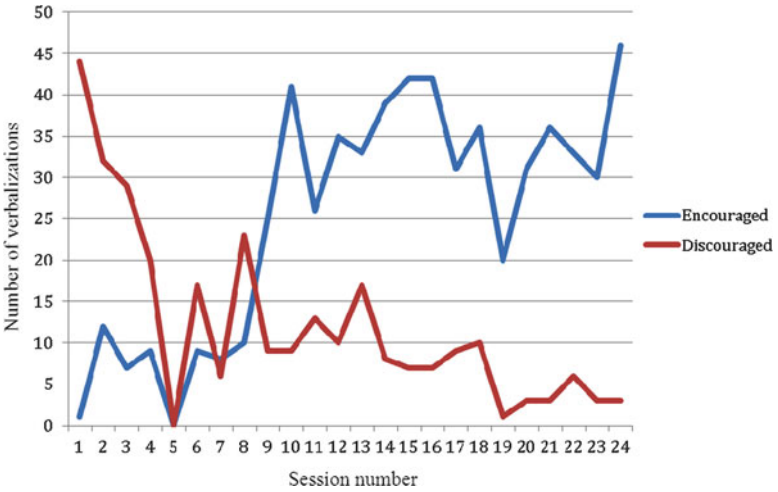

Fig. 8.1 Process of skill acquisition from pre- to post-treatment: numbers of encouraged and discouraged verbalizations in the weekly 5-min observational assessment

In addition, the therapist conducts a behavioral assessment pre- and post-treatment, observing the dyad as they play together in three semi-structured activities, using the Dyadic Parent-child Coding System-III (DPICS-III; Eyberg, Nelson, Duke, & Boggs, 2005), a micro-analytic coding system, designed by Eyberg and her colleagues (2005) to categorize parent verbalizations in parent-child interactions. The three play situations vary in the amount of control the parent is asked to use. In the first situation (Child Directed Interaction), parents are told to let the child pick an activity and to play along, following the child's lead in play. In the Parent Directed Interaction, parents are instructed to pick an activity and have the child play with the parent according to the parent's rules. In the third, and final situation, the parent is directed to have the child to 'clean up' without the parent's assistance.

In addition to the observational assessment of the parent and child in the DPICS sessions, the therapist uses the first 5 min of each weekly treatment session to observe the parent-child interactions in child-directed play. The therapist remains silent during this time, coding the parent verbalizations. Figure 8.1 summarizes the results of the therapist's weekly coding over the course of treatment.

Results

Course of Treatment in PCIT

Marco's intake assessment was conducted in September 2011. The father agreed with the therapist's suggestion that PCIT would fit their needs, and weekly sessions were scheduled. After the therapist conducted a didactic session, teaching the father

about the skills he would need in the first phase of treatment and what to expect from treatment, once coaching sessions began. At the beginning of each session, the therapist talked briefly with the father, asking how Marco had behaved since they had last been seen, and how the father was doing.

Marco and his father made slow progress over the first 2 months of treatment. They consistently attended PCIT and did their "homework" (5 min of Special Time every day, practicing PCIT skills). Furthermore, the therapist reported that the father was responsive to coaching. However, Marco had a habit of trying to get the father's attention by asking "rapid fire" questions, swearing, or making critical comments during the 5-min behavioral observation at the beginning of the coaching session. The father would get upset, have a hard time recovering, and hence would not demonstrate much skill acquisition. At CDI 8, when the father mastered the skill of ignoring these disruptive behaviors, he made speedy progress in mastering encouraged verbalizations such as labeled praise, reflective statements, and behavioral descriptions. The dyad moved to the second phase of treatment three sessions after the father mastered the skill of ignoring.

The second phase of treatment (PDI) began in January and was completed in May. Altogether, the dyad received 10 PDI coaching sessions before the therapist was confident that the father could manage his son's behavior, and that his son's behavior problems were sufficiently diminished. During this time, the father learned to give clear, direct commands, and to react consistently, using time out when Marco was defiant. Marco was not always compliant with the time out, however. On two occasions, he was argumentative and defiant in response to his father's direct command, and refused to sit in the time-out chair. In these situations, the therapist used a "Swoop and Go" technique, in which the father picked up the toys and exited the room, and left Marco in the room alone until he sat in the chair. Once he sat in the chair, the father came back in the room, and the time out began. With a child Marco's age, the therapist considered using removal of privileges as a back-up, or incentive for taking the time out. However, with Marco's sassiness and love of an argument, the therapist decided that the Swoop and Go was the most expedient method for getting him to comply with the time out. Indeed, the session after his second (and final) Time Out-Swoop and Go, Marco's younger sister, who was participating in the session, required a time out. Marco happily demonstrated how to take the time out, showing off his time out expertise.

Mother's Involvement in PCIT

As noted above, Marco's mother was in an alcohol and drug rehabilitation program when Marco and his father began PCIT. She moved back home at about the 6th CDI coaching session (CDI 6). It is interesting to note that the father's skills showed a marked drop at CDI 7, just after the mother moved back with the family, but then recovered, showing the vulnerability of these skills to family stressors and the need for therapeutic support. Initially the mother showed no interest in participating in treatment, ridiculing the father's parenting behavior. Then, after living

Table 8.1 Scores on standardized assessments at pre-, mid-, and post-treatment

	Assessment point		
	Pre-treatment	Mid-treatment	Post-treatment
CHILD MEASURES			
ECBI (raw scores)			
Intensity scale (cutoff = 130)	158	144	125
Problem scale (cutoff = 15)	27	16	8
CBCL (T-scores)			
Internalizing	60		50
Externalizing	69		68
Total problems	70		52
TSCYC (T-scores)			
PTS total score	55		51
Depression	51		41
PSI (percentile scores)			
Parental distress	97	87.5	92.5
Parent-child dysfunctional relationship	90	70	55
Difficult child	97	97	85
PARENT MEASURES			
CAPI-abuse scale	338		251
BSI- depression	68		73

with the family for nearly 3 months, she expressed interest in having some PCIT training, realizing that Marco was much more responsive and compliant with his father than with her. The therapist quickly arranged for adjunct, in-home PCIT, so that the mother could also learn and practice the PCIT skills. After three in-home sessions, the number of the mother's encouraged verbalizations increased from 2 to 13; and discouraged verbalizations decreased from 27 to 0. However, shortly after her third session (at PDI 8 for Marco and his father), the mother was kicked out of the transitional housing program for substance use and re-entered a detoxification program.

Standardized Measures

Child Behavior Problems

The father's ratings of his son on the ECBI and the CBCL reflected behavior problems in the clinical range at pre-treatment (see Table 8.1). In particular, the father noted problems with Marco's oppositional and rule breaking behavior, his verbal expression (e.g., argumentative, yells, sassy), aggressiveness (e.g., provokes fights), and attention, yielding elevated scores on the externalizing and total

behavior problems scales. The symptoms the father reported were consistent with the diagnoses of Oppositional-Defiant Disorder and ADHD.

By mid-treatment, the intensity of disruptive behavior problems reported on the ECBI had dropped a half of a standard deviation, but was still in the clinical range. By the end of treatment, the intensity of problems had dropped another half of a standard deviation to a level just below the clinical range. On the CBCL, the father reported decreases in the severity of Marco's internalizing and total behavior problems, but no significant change in the severity of his externalizing behaviors.

Child Trauma Symptoms

Marco's scores on the TSCYC pre-treatment per father's report showed clinical levels of arousal related to post-traumatic stress, and aggression. However, the most severe symptoms he reported on the arousal scale appeared to be related to his attention problems, which predated the most recent violent event he had witnessed. By post-treatment, however, all scales had dropped down into the normal range.

Parent Functioning

In addition to measures of his child's functioning, Marco's father completed the BSI, rating his own psychological symptoms, and the short form of the PSI, a measure of the severity stress in the parent role. Pre-treatment, his symptom profile on the BSI showed general symptomatic distress in the clinical range, endorsing among other things clinical levels of symptoms on the depression, anxiety, hostility, and phobic anxiety. Post-treatment, scores on these scales reflecting self-reported psychological symptoms decreased at least 1.5 standard deviations and were within normal limits. The father's response to questions on the PSI pre-treatment suggested that he was experiencing considerable stress in the parent role. He reported parental distress resulting from feelings of a lack of competence, of being restricted in other parts of his life because of being a parent, depression, and conflict with his spouse. He reported significant stress in his relationship with Marco, noting that he would "do things that bother him just to be mean." He also reported clinical levels of stress resulting from parenting a child with difficult behaviors. By post-treatment, the father's perception of stress resulting from Marco's difficult behaviors and dysfunction in the parent-child relationship decreased significantly. However, his parental distress remained elevated.

Summary of Gains

When Marco and his father came into treatment, Marco was sassy and mostly disrespectful to his father. He was aggressive towards him, grabbing toys from him, hitting him, appearing to try to dominate the play and provoke his father. Marco's

father was not intimidated in the least by his aggressive behavior, but was upset by the sassy lack of respect, yelling, and swearing. The father was mostly irritated with Marco's behavior at pre-treatment; at his best, his tone with him was neutral and flat. Over the course of PCIT, Marco's father learned to attend to his positive behaviors and even more important, ignore his sassiness and rudeness. Marco, likely because he was 7 years old, was very sensitive to the genuine quality of his father's statements. As a rule, he was irritated by behavior descriptions and labeled praises unless the verbalizations showed attention to some aspect of his play that he valued. For example, when the father said, "you put the red gear next to the blue gear," Marco replied, "how about if we just play and don't talk?" The father (ignoring the sassy talk) followed by saying, "…and you put three orange gears together. I like that because it's so colorful!" Marco agreed with his father's observation, continuing to talk about the gears they were playing with. The father also was able to obtain Marco's compliance at least 75 % of the time, though in cases where Marco really did not want to comply (e.g., stopping playtime), the father still had to count and occasionally give him a time out. Overall, Marco's behaviors improved substantially. While he still was somewhat sassy and bossy post-treatment, the father was able to redirect his attention and engage him in relaxed, reciprocal play for long stretches of time. Marco's father showed that he understood Marco and could help him stay emotionally regulated. Marco's behavior and comments showed that he enjoyed being with his father, and above all, felt safe.

While we believe the potential gain of strengthening the parent-child relationship is great, the case presented within this chapter illustrates the complexity of people's lives and their ongoing vulnerability to risk. At several points in the course of treatment, this family could have terminated services. The father was depressed and not really making speedy positive changes; the mother re-entered the family's life and for a while was a destructive force in the fragile reconstruction of the father's relationship with his son. It is a tribute to the social worker, therapist, and – most of all – the father himself, that the family continued to participate in treatment. In the face of seemingly overwhelming obstacles, the father felt helped and supported, retaining his belief that the services would make a difference for his son's future.

Conclusion

A wealth of research over the last few decades testifies to the value of PCIT as a tool in improving parenting skills, decreasing child behavioral problems, and enhancing the quality of parent-child relationships. Replacing negative, hostile, and coercive parent-child interactions with a stable, predictable pattern of affection, praise, and other positive relationship-building behaviors appears to decrease behavior problems. The addition of effective behavior management skills insures that when troubles arise (as they always do), the parent will be able to handle them. However, even more than the curriculum content, PCIT uses coaching – an effective strategy for teaching and training parents. While coaching parents to adjust certain discrete

behaviors in the moment, it is also possible reframe cognitions, point out competing attributions, and alter expectations. These are all important contributors to family's risk of abuse (Milner, 2000). However, simply viewing decreasing risk of abuse as a result of improvements in behavior change fails to appreciate the overall impact of PCIT on abusive parent-child relationships. Through repeated coaching related to parenting behaviors, therapists have an effective means to alter both parent and child cognitions (Dumas, 2005) – an element of treatment essential in abusive parent-child relationships. Further, the shift to more positive interactions and cognitions provide the foundation for changes the affective quality of the parent-child relationship (Timmer et al., 2011). It is suggested that the combination of Eyberg's formulation of PCIT as a means to improve parenting skill and decrease child behavior problems, combined with shifts in parental cognitions, lead to the decreases in risk of child maltreatment.

The case described in this chapter illustrates the ways in which PCIT can support and build a secure and nurturing parent-child relationship – which becomes the mechanism by which some abusive and high-risk families can shift to a position of relationship safety. Additionally, it is hoped that the case highlights that while PCIT can effect important behavioral change, there is much more to PCIT than simply changing behavior. As a powerful relationship teaching tool, *in vivo* coaching offers opportunities to extend interventions to the realm of automatic cognitions, attributions, and relationship expectancies.

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