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Parent-Child Interaction Therapy: An Intensive Dyadic Intervention for Physically Abusive Families

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A designated priority in the field of child maltreatment is the development of empirical approaches for treating abusive families. This article describes parent-child interaction therapy (PCIT), an intervention that has been shown to be effective for helping parents manage young children with severe behavioral problems. The potential application of this treatment program to the child maltreatment field is examined by (a) providing a social learning perspective to explain the development and stability of some physically abusive parent-child relationships, (b) outlining the effectiveness of PCIT with similar populations, and (c) discussing the unique benefits that PCIT may offer the field of child maltreatment. The limitations of PCIT with physically abusive families are also discussed.

The physical abuse of children by their parents continues to be a major social problem in our country. Recent official reports of child physical abuse range from 3.5 children per 1,000 (American Association for Protecting Children, 1988) to 5.7 children per 1,000 (National Center on Child Abuse and Neglect, 1988). Much of the extensive research on this problem has focused on describing abusive families and the short- and long-term sequelae of maltreatment on children (Ammerman & Hersen, 1990; Cicchetti & Carlson, 1991; Kolko, 1992; Wolfe, 1987). However, relatively little attention has been given to empirical approaches to the treatment of abusive families, especially physically abusive parent-child dyads. This article provides a description of some underlying parent and child factors within physically abusive families. An intervention is described that has been shown to be

effective with a similar population and may be beneficial to some types of physically abusive parent-child dyads.

PHYSICALLY ABUSIVE FAMILIES:

PARENT FACTORS

Parents physically abuse their children for many reasons. In a recent article, Milner and Chilamkurti (1991) provide an excellent overview of the current literature concerning characteristics of individuals who physically abuse their children. They cite a constellation of factors including socialization factors (i.e., demographics, childhood history of abuse), biological factors (i.e., neuropsychological characteristics, physiological reactivity, physical health problems), cognitive and affective factors (i.e., self-esteem, locus of control, attributions of behavior, inappropriate child expectations, life stress, depression), and behavioral factors (i.e., alcohol and drug use, social isolation, parent-child interactions, and parent discipline strategies). Two of these factors, parent-child interactions and parent discipline strategies, have received a great deal of empirical support for their role in the cycle of physical abuse.

Parent-Child Interactions

Several research reports have indicated that physically abusive parents (usually mothers because they typically are the primary child caregivers) have difficult or problematic relationships with their children. Several researchers report that abusive parents either

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interact with their children less often than do non-abusive parents or are less supportive than nonabusive parents (Burgess & Conger, 1978; Dietrich, Starr, & Kaplan, 1980; Egeland, Breitenbucher, & Rosenberg, 1980). A consistent pattern in the literature indicates that abusive parents engage in more negative interactions (both verbal and nonverbal) than do non-abusive parents (Bousha & Twentyman, 1984; Reid, Taplin, & Lorber, 1981). Conversely, abusive parents engage in less positive interactions with their children than do nonabusive parents (Allesandri, 1992; Bousha & Twentyman, 1984; Kavanagh, Youngblade, Reid, & Fagot, 1988). Citing these patterns of interaction, Wolfe (1987) argues "that it appears to be the relative absence of positive interactions that set[s] members of abusive families apart from matched, nonabusive controls rather than the dramatic display of open conflict and aggression" (p. 77). This is supported by Milner and Chilamkurti (1991), who state that relatively low rates of positive interactions (e.g., cohesion, expressiveness) appear to characterize abusive families more accurately than do observed differences in negative interactions (e.g., conflict).

Parent Discipline Strategies

Numerous studies have indicated that abusive parents engage in less effective, more negative, and more physical discipline strategies than do nonabusive parents (Lahey, Conger, Atkeson, & Treiber, 1984; Monroe & Schellenbach, 1989; Oldershaw, Walters, & Hall, 1986; Trickett & Kuczynski, 1986). Oldershaw et al. found that abusive parents relied heavily on "power assertion strategies" (e.g., threats, disapproval, negative demands) and less on positively oriented strategies (e.g., reasoning) than did nonabusive parents. Abusive parents also have greater negative expectations of their children's behavior (Schellenbach, Monroe, & Merluzzi, 1991). The limited parental discipline strategies and the negative expectations of their children's behavior are likely to influence child acceptance or positivity (Mash & Johnson, 1990), which then becomes the framework for actual management practices at home. Related to this pattern of discipline, abusive parents perceive punishment to be more effective than reasoning and have a greater acceptance of corporal punishment than do non-abusive parents (Kelly, Grace, & Elliot, 1990; Trickett & Susman, 1988).

PHYSICALLY ABUSIVE FAMILIES: CHILD FACTORS

The characteristics of physically abused children have been described in numerous studies. These studies have cited medical/physical problems (Smith &

Hanson, 1974), psychiatric disorders (Famularo, Kinscherff, & Fenton, 1990), attachment problems (Lynch & Cicchetti, 1991), cognitive/developmental difficulties (Friedrich, Einbender, & Leucke, 1983), academic difficulties (Eckenrode & Doris, 1991), and affective/emotional difficulties (Allen & Tarnowski, 1989). One of the most common problem areas is a consistent pattern of behavioral disruption. Physical aggression, noncompliance, and antisocial behaviors are some of the most common characteristics of physically abused children (see Kolko, 1992, and Wolfe, 1987, for reviews), with physical aggression toward others being a behavioral hallmark of physically maltreated children (Bousha & Twentyman, 1984; Egeland & Sroufe, 1981; Howes & Eldridge, 1985; Howes & Espinoza, 1985; Wolfe & Mosk, 1983). Reports have also described the problems that physically abused children have with behavioral control. Gaensbauer and Sands (1979) report that physically abused children exhibit an array of social behavior including poor self-control, distractibility, negative affect, and resistance to directions. In a study examining parents' perceptions of children's behavior at home, Trickett and Kuczynski (1986) found that abused children exhibited greater rule violations involving aggression and oppositional behavior than did nonabused children.

The existing literature describing physically abusive families provides some insight into common characteristics and interpersonal dynamics. A wealth of reports describe predictors and sequelae of child physical abuse; however, the factors most relevant to this article focus on negative parent-child interactions, poor parental discipline skills, child behavioral disruption (i.e., aggression, negative affect), and problems in child compliance. Physically abusive parent-child relationships appear to be marked by parents who engage in a high rate of negative behavior (e.g., threats, punitive statements, aggression), low rates of positive affect (e.g., praise, support, positive physical touching), and ineffective parental disciplining strategies (e.g., yelling, negative demands, disapproval). Conversely, physically abused children appear to exhibit a stable pattern of physical aggression, defiance, noncompliance, and negative affect. Before providing a treatment for these abusive relationships, the underlying theoretical framework must be understood.

SOCIAL LEARNING FRAMEWORK

In describing the development of deviant child behaviors, Patterson (1975, 1976a, 1976b, 1982; also see Patterson, DeBaryshe, & Ramsey, 1989) provides a framework founded on the interchange of behaviors

between a parent and child. He presents a "coercion hypothesis" to account for the development and maintenance of deviant behaviors on the part of a child (or disrupted parent-child relationships). A simplistic version of this hypothesis suggests that rudimentary aversive behaviors on the part of a child may represent temperamental and/or developmental phenomena in an infant or young child. There is substantial variance in the severity of these aversive behaviors (ranging from mildly irritating to moderate/severe problems in temperament). Many such behaviors are related to developmental characteristics (e.g., the "terrible twos") and are of a temporary nature.

Patterson (1976a) argues that a number of conditions (e.g., a parent's failure to reinforce appropriate prosocial skills or a parent's inappropriate response to the child's coercive behavior) may ensure that some children continue to employ aversive control strategies. He proposes a paradigm: A parent command or direction is followed by child noncompliance (or other deviant behaviors such as yelling or whining), which is then followed by removal of the parent command or direction. The child can terminate the parent command by compliance or can engage in coercive behaviors as an alternate means of terminating the parent command. Over a period of time, a child learns to repeat or escalate the intensity of the coercive behaviors to terminate parental commands. According to Patterson (1976a, 1982), the parent may then withdraw the command (thus negatively reinforcing the noncompliance or deviant behavior on the part of the child) or may respond with coercive behaviors (e.g., yelling, threatening, corporal punishment).

Although Patterson does not specifically address parent physically abusive behaviors, one parent strategy may be to engage in an abusive physical hit as a means to get a child to comply with a direction. The child may then respond to the parent's "escalated behavior" (e.g., yell, threat, spanking, physically abusive hit) by complying, which then reinforces the parent's coercive behavior (or the child may intensify his or her behaviors once again). The result of this interaction with nonabusive families is a pattern of coercive behavior (i.e., coercive cycle) characterized by high-rate coercive parent behaviors (e.g., yelling, threatening, withdrawal of command, repeated commands) and child behaviors (e.g., yelling, whining, noncompliance). One strategy used by physically abusive families to achieve child compliance (and/or to terminate other child coercive behaviors) is to escalate the intensity of the response to include physically abusive behavior (e.g., slapping, hitting, punching, kicking). If a parent's physically abusive behavior re-

sults in child compliance, then it is reinforced, thus becoming a behavior with a greater likelihood of being used in future parent-child conflicts.

Wahler and his colleagues have contributed greatly to the literature on coercive parent-child interactions (e.g., Wahler & Dumas, 1986, 1989; Wahler, Williams, & Cerezo, 1990). Sansbury and Wahler (1992) explore some of the factors that are known to contribute to what they term the "maladaptive parenting style" (MPS) seen in parents of conduct-disordered children. The two primary components of the MPS are (a) parental compliance with child disobedience (i.e., parent gives in to child noncompliance and is negatively reinforced by the suppression of the child's negative behavior) and (b) parental inconsistency (i.e., parent does not consistently reward prosocial behavior but does consistently reward disruptive behaviors by providing negative attention). In addition, the MPS is conceptualized as being influenced by factors such as stressors in the mother's ecosystem (e.g., Webster-Stratton, 1990b), maternal depression (e.g., Griest, Wells, & Forehand, 1979; Webster-Stratton & Hammond, 1988), low socioeconomic status, and maternal perception of child behavior (e.g., Griest, Forehand, Wells, & McMahon, 1980). The work of Wahler and colleagues demonstrates the need to assess the various components of coercive parent-child interactions to determine the most effective focus of intervention. For example, parents who have relatively few stressors in their ecosystem may be successfully treated with an intervention that primarily emphasizes "compliance traps." Those with major life stressors and inconsistent parenting styles, however, may require a more comprehensive approach that focuses on a range of problem areas (Sansbury & Wahler, 1992).

All families that are physically abusive do not engage in the coercive parent-child pattern. There may be diverse etiologies for child physical abuse such as parent psychopathology, developmental delay (on the part of the parent and/or child), social isolation (Wahler, 1980), and physiological reactivity (see Wolfe, 1985, for a review of these issues). However, many physically abusive parent-child dyads may be aptly described by an extension of Patterson's coercive cycle, which incorporates physical violence as a mechanism of ensuring child compliance (or terminating aversive child behaviors). Even within families in which this coercive pattern of interaction is a dominant theme, it is likely that there are other compounding parent and/or child problems (e.g., substance abuse, parental prior history of abuse, parent or family stress). The basic pattern of parent-child interactions over time (characterized by high negative

interactions and low positive interactions) may be perceived as the centerpiece to most of these physically abusive relationships in which the child exhibits a chronic pattern of behavioral problems.

ABUSIVE PARENT-CHILD RELATIONSHIP STABILITY

Underlying the characteristics of abusive parent-child interactions is the transactional nature of the parent-child relationship. That is, actions on the part of both the parent and the child can contribute to an incident of physical aggression by the parent. A series of aggressive parent-child interactions, if stabilized as a consistent theme within the interactions of a parent and child, becomes the framework for what we call an abusive relationship. Central to the development of this process is the concept of "coregulation" (Fogel, 1993). This is defined as "a social process by which individuals dynamically alter their actions with respect to the ongoing and anticipated actions of their partners" (p. 34). Consequently, coregulated processes emerge from the constraints of the individual action and exhibit a patterning and ordering. This suggests that individuals are following underlying rules in the execution of their actions and that, once established, these actions promote complementary actions in their partners (i.e., parents to child, child to parents). This ongoing "mutual recruitment strategy," which Fogel describes as coregulated behavior (and which Patterson may describe as a coercive cycle), serves to stabilize the quality and tenor of the parent-child relationship (albeit an abusive relationship in this situation).

To make changes in the relationship, it then becomes essential to involve both parent and child. A therapeutic change in the behavior of one member of the relationship (i.e., an abusive parent or an abused child) is likely to have much less effectiveness than a therapeutic change that incorporates both parent and child in a dynamic interaction. This is a theme supported by previous "systemic" approaches to abusive families (Asen, George, Piper, & Stevens, 1989; Brunk, Henggeler, & Whelan, 1987; Dale & Davies, 1985), which cite the need to address more than the individual in the context of the family.

INTERVENTIONS WITH PHYSICALLY ABUSIVE FAMILIES

Many different types of interventions have been implemented to reduce the risk of physical abuse and to address existing problems with physically abusive families. These interventions incorporate most forms of individual, dyadic, group, and family therapy. Although they may not have been tested empirically, many have been reported to have generated positive treatment effects. One important reason for the

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breadth of treatment approaches is that causal models of physical child abuse are founded on many different theoretical perspectives (Azar, 1991). Some of the more commonly investigated interventions include child-focused interventions (see Mannarino & Cohen, 1990, for a review), different types of group therapy (Cohn, 1979), case management approaches (Hochstadt & Hardwicke, 1985), and different forms of family-centered, home-based intervention services (Kinney, Haapala, Booth, & Leavitt, 1990). Based on a broad ecological model framework, this last form of intervention was developed, in part, in reaction to a changing national agenda (i.e., the "family preservation movement"), which was aimed at reducing the rate of child placement outside the home (Barth, 1990; Frankel, 1988). A discussion of the many issues surrounding these programs, however, is beyond the scope of this

article.

It has been argued consistently that one of the most promising approaches with physically abusive families can be derived from parent-focused behavioral programs (Wolfe, 1994; Azar & Pearlmutt, 1993). Specifically, Wolfe (1994) asserts that parent-focused behavioral interventions may be most appropriate for physically abusive families for a variety of reasons. He suggests that "they demonstrate a relatively greater degree of effectiveness in modifying those parental characteristics that are most relevant to child maltreatment (e.g., parenting skills and perceptions and expectations of children)" (pp. 249-250). He adds that there have been several studies that have shown reduced recidivism rather than simply changed parental attitudes and perceptions. By virtue of their concrete, focused, skill-based approach, these types of programs may be especially useful for parents with limited intel-

lectual abilities and limited insight who require a more "hands-on" type of intervention. Also, parent-focused behavioral programs hold greater face validity and therefore may be more useful in helping clients work on problems that are more important and urgent to them. Finally, Wolfe (1994) states that because parent-focused programs tend to be perceived as more "educational" by parents, they may be less threatening—which may facilitate greater parent cooperation (a paramount issue in providing treatment to this population).

PARENT TRAINING WITH PHYSICALLY ABUSIVE FAMILIES

Most of the parent training approaches used with physically abusive families have primarily treated either the parent or the child (Fantuzzo, 1990; Kolko, 1986) or have employed a systemic case management approach (Asen et al., 1989; Brunk et al., 1987). For example, Wolfe, Sandler, and Kaufman (1981) report on a combination group parent education and intensive home-based training program with a small number ($N=8$) of physically abusive mothers. Results of this study suggest significantly greater child management skills on the part of the parents and fewer child behavior problems. Other studies examining intensive parent-child (dyadic or family) treatment programs have produced results that are promising. For example, Wolfe et al. (1982) obtained decreases in hostile parenting skills and increases in positive behaviors using a direct coaching approach. In this single-subject design, a low-functioning abusive mother received prompts and feedback from the therapist through a bug-in-the-ear device as she interacted with her child. In a larger scale investigation, 30 mother-child dyads were randomly assigned to either an information group or a behavioral parent training program that included a direct coaching component (Wolfe, Edwards, Manion, & Koverola, 1988). Families receiving parent training demonstrated significantly greater improve-

ments on a variety of measures than did those receiving the information component. The authors emphasize the importance of early intervention in improving negative parent-child patterns. According to the authors, "Innovative methods that strengthen parents' interest in and skills for promoting healthy child development are a high priority for future early intervention programming" (p. 46).

In developing treatments for child physical abuse, it is important to examine the specific problem behaviors of both the parent and the child. It is also important to examine the mechanisms by which these problem behaviors promote behavior and/or decrease behavior in the other person (the transactional perspective of the abusive relationship). To increase effectiveness, treatments for child physical abuse can (a) incorporate both the parent and the child (Patterson, Reid, Jones, & Conger, 1975; Reid, 1978), (b) alter the pattern of interactions within this relationship (Patterson & Forgatch, 1990; Patterson & Reid, 1984), and (c) provide a means to directly decrease negative affect and control while promoting (i.e., teaching, coaching) greater positive affect and discipline strategies.

HANF-MODEL PROGRAMS

While at the Oregon Health Sciences University, Hanf (1969) developed a two-stage operant model for modifying maladaptive interactional patterns between young children with multiple handicapping conditions and their mothers. In the first stage of treatment, parents were taught to use differential reinforcement. They were instructed to provide intensive attention for positive child behaviors while ignoring negative behaviors. During

the second stage, parents were taught to encourage compliance by giving clear directions and praising efforts to follow instructions. Parents were taught to discourage noncompliance through the use of time-out. Hanf's approach was unique in that it involved working with the parent and child together, providing direct coaching of parenting skills.

Several researchers have developed and evaluated aspects of Hanf's original model. In *Helping the Non-*

Although essentially a parent training program, PCIT is unique in that it is founded on social learning principles, contains an intensive positive interaction training component, incorporates both parent and child within the treatment session, provides a mechanism to change the pattern of the dysfunctional parent-child relationship, and involves the use of live coaching.

compliant Child, Forehand and McMahon (1981) describe a Hanf-model approach that is supported by a large body of literature demonstrating its effectiveness. This approach is characterized by a first stage that emphasizes the contingent use of attention and a second stage that focuses on improving compliance through command training and time-out. Throughout both stages, parents are coached as they interact with their children. Research by Forehand and colleagues demonstrates decreases in disruptive behavior both in the clinic and at home (e.g., Peed, Roberts, & Forehand, 1977), generalization to untreated siblings (Humphreys, Forehand, McMahon, & Roberts, 1978), and maintenance of treatment effects over time (e.g., Baum & Forehand, 1981; Forehand et al., 1979; Long, Forehand, Wierson, & Morgan, 1994).

In the book *Defiant Children*, Barkley (1987) describes the application of Hanf-model procedures to children with attention-deficit hyperactivity disorder (ADHD). This approach varies from the one used by Forehand and McMahon (1981) in that it includes an educational component regarding ADHD, relies on modeling and role-playing rather than coaching of parent-child interactions, and includes a token economy program. Webster-Stratton (1984, 1994) developed and evaluated a cost-effective version of the Hanf-model program. In this approach, groups of parents are taught parent-child interactional skills and operant techniques for managing behavior problems through the use of videotaped modeling. Research on this program has demonstrated reduction in behavior problems (e.g., Webster-Stratton, 1984, 1985) and maintenance across time (e.g., Webster-Stratton, 1984, 1990a).

Parent-child interaction therapy (PCIT) is a Hanf-model program developed by Eyberg (Eyberg & Boggs, 1989; Eyberg, Boggs, & Algina, 1995; Eyberg & Robinson, 1982; Hembree-Kigin & McNeil, 1995). PCIT differs from other Hanf approaches in that it emphasizes the importance of traditional play therapy techniques as a mechanism for promoting warm and nurturant relationships between parents and their conduct-problem children. Rather than focusing the first stage of treatment on the single goal of contingent attention, Eyberg coaches parents to follow the child's lead in play, to provide undivided attention, to reflect and expand on child verbalizations, to imitate, and to use appropriate physical affection (Hembree-Kigin & McNeil, 1995). Also, PCIT takes place within a strong developmental framework that emphasizes play. According to Eyberg (1988), "Play is the primary medium through which children develop problem-solving skills and work through developmental problems" (p. 35). Thus the first stage of treatment is

longer and more intensive than that of other Hanf-model approaches as parents work with their children through the medium of play. Goals for children include learning to share, to use polite manners, to take turns, to persist, to accept help, to use words rather than disruptive behavior to express feelings, and to display constructive play skills (Hembree-Kigin & McNeil, 1995). Arguably, any of these programs could be beneficial for interrupting the coercive patterns of physically abusive families. Yet literature applying these therapy approaches to the area of child abuse is rare.

In this article, we highlight PCIT as a particularly promising Hanf-model program that can bridge the gap between treatment of conduct disorders and physical abuse. There are several reasons for highlighting PCIT. First, PCIT emphasizes relationship enhancement more than does the program outlined by Forehand and McMahon (1981). In light of Milner and Chilamkurti's (1991) assertion that abusive and nonabusive parents can be distinguished by the relative absence of positive interactions, to explore the effectiveness of traditional play therapy skills for promoting attachment in this population seems logical. Second, PCIT may be more applicable to abuse than is Barkley's (1987) program because aggression, non-compliance, and antisocial behaviors are viewed as more problematic than ADHD symptoms in physically abused children (Kolko, 1992). Finally, although Webster-Stratton's videotaped modeling program holds much promise for the area of child maltreatment, PCIT's emphasis on direct coaching of individual families may be more beneficial than group training due to the high levels of parental psychopathology, risk for physical harm, and stress/disruption in these families.

PARENT-CHILD INTERACTION THERAPY

Although essentially a parent training program, PCIT is unique in that it is founded on social learning principles, contains an intensive positive interaction training component, incorporates both parent and child within the treatment session, provides a mechanism to change the pattern of the dysfunctional parent-child relationship, and involves the use of live coaching (Eyberg & Robinson, 1982). PCIT is conducted in two phases: child-directed interaction (CDI), or the relationship enhancement phase, and parent-directed interaction (PDI), or the discipline phase. Both phases of treatment are conducted within the context of an initial didactic training followed by therapist coaching in dyadic play situations. The coaching is conducted from an observation room using a bug-in-the-ear microphone device. Parents are

TABLE 1: Steps in Parent-Child Interaction Therapy

Step 1:	Pretreatment assessment of child (standardized behavioral checklist) and family functioning (standardized parent measures, coding videotaped play session) and feedback (one to two sessions)
Step 2:	Teaching behavioral play therapy skills
Step 3:	Coaching behavioral play therapy skills
Step 4:	Teaching discipline skills (parent-directed interaction)
Step 5:	Coaching discipline skills
Step 6:	Posttreatment assessment of child (standardized behavioral checklist) and family functioning (standardized parent measures, coding videotaped play session) and feedback (one to two sessions)
Step 7:	Boosters (as needed)

taught and practice specific skills of communication and behavior management with their child.

In the CDI portion (typically 7 sessions), the parents are taught to follow their child's lead during play. They are instructed to describe, imitate, and praise the child's appropriate behavior and to reflect appropriate child talk. Parents learn not to criticize the child and not to use commands and leading questions that make it difficult for the child to lead the play. The major goal of the CDI portion is to *create or strengthen a positive and mutually rewarding relationship* between the parent and the child (Eyberg, 1988; Hembree-Kigin & McNeil, 1995).

In the PDI portion (typically 7 sessions, which follow the 7 CDI sessions), the parents are taught techniques for directing their child's activity. They are instructed in the use of clear, positively stated, direct commands and consistent consequences for behavior (e.g., praise for compliance, time-out in a chair for noncompliance). The major goal of the PDI portion is to *provide specific and effective parenting skills* for parents to use in managing their child's behavior. Parents learn to establish and enforce "house rules" and to manage their child's behavior both at home and in public places (Hembree-Kigin & McNeil, 1995). The PDI portion is also used to decrease problematic behaviors while increasing low-rate prosocial behaviors (Eyberg & Boggs, 1989). Families receive approximately 14 weekly 1-hour sessions (7 sessions of CDI and 7 sessions of PDI). Session outlines are followed carefully to avoid divergence from the treatment protocols and to ensure treatment integrity (see Table 1 for a description of the steps in PCIT).

Numerous studies have demonstrated the effectiveness of PCIT (or variations of Hanf's two-stage model) for reducing child behavior problems (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg et al., 1995; Eyberg & Robinson, 1982). Treatment effects have been shown to generalize across time (Newcomb, Eyberg, Funderburk, Eisen-

stadt, & McNeil, 1990), to generalize to the home (Boggs, 1990), to generalize to school settings (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991), and to generalize to untreated siblings (Eyberg & Robinson, 1982). Although portions of PCIT may be applicable to many different types of behavioral problems and can be implemented with children of varying ages, it has been used most effectively with children who are aggressive and/or have behavioral problems (e.g., oppositional behavior, defiance, noncompliance) and with children between the ages of 2 and 7 years.

A notable absence in the PCIT literature is research examining the effectiveness of this program with physically abusive families. Considering the numerous studies demonstrating the effectiveness of PCIT with oppositional and defiant children, however, it could be argued that some (if not many) of the children in these PCIT studies were also victims of physical abuse. Certainly, there are many reasons to expect that PCIT would be a beneficial treatment for physically abusive families. As stated earlier, effective treatments for physically abusive families must incorporate both parent and child, alter the pattern of interactions within this abusive relationship, and provide a means to directly decrease negative affect and control—while promoting (i.e., teaching, coaching) greater positive affect and discipline strategies.

PCIT provides an approach that addresses all of these factors *and* has been demonstrated to be a highly effective treatment for a similar population (i.e., coercive parent-child relationships). This treatment program involves both parent and child throughout the treatment sessions. In addition, parents are instructed in both relationship enhancement and discipline strategies and are given an opportunity to practice in the session. Mastery of parenting skills is accomplished by having the therapist coach live parent-child interactions (e.g., positive play interactions, ignoring, limit setting, time-out procedures) via a bug-in-the-ear system. This approach provides a mechanism for altering the negative pattern of interactions, which may escalate to acts of physical violence. Finally, one of the strengths of PCIT is that it emphasizes the development and reinforcement of positive affect and behavior on the part of the parent throughout the treatment program.

In their excellent review of physically abusive parents, Milner and Chilamkurti (1991) assert that it is the relative absence of positive interactions that distinguishes abusive parents from nonabusive parents. By increasing the rate of positive parental interactions through PCIT and then stabilizing positive changes in behavior through mastery in treatment sessions, sev-

TABLE 2: Factors Influencing the Effectiveness of Parent-Child Interaction Therapy

<i>Parent Factors</i>	<i>Child Factors</i>	<i>Family Factors</i>
Factors increasing effectiveness		
Average or higher IQ	Age between 2 and 7 years	Marital adjustment
Strong motivation		Extended family support
Court ordered	Good receptive language skills	
Factors decreasing effectiveness		
Active substance abuse	Under age 2 years or over age 7 years	Severe marital discord
Severe psychopathology	Pervasive developmental disorder	Child in foster care
Mental retardation		
Unmotivated		

eral consequent changes are likely to occur in the parent-child relationship (e.g., less parental negative affect, greater positive affect exhibited by the child, increased child compliance, less parental stress, less parental physical aggression).

LIMITS OF PCIT WITH PHYSICALLY ABUSIVE FAMILIES

This article does not presume that PCIT will be effective with *all* physically abusive families. In addition, PCIT should not be perceived as a complete "package" of intervention that addresses a significant and common problem in abusive child-parent relationships. Further, because PCIT is primarily a treatment that focuses on developing positive parent-child relationships, enhancing limited parenting skills, and/or reducing coercive parent-child interactions, PCIT may not be effective if one or more of these characteristics is not present or some type of parent or child problem exists that might impair participation in PCIT (see Table 2 for a description of factors influencing the effectiveness of PCIT). Therefore, PCIT has been shown to be most effective with children in a specific age range (approximately 2 through 7 years) who have no substantial impairment in cognitive functioning (e.g., pervasive developmental disorder, significant developmental delay). Similarly, parents with some type of substantial cognitive or affective problems (e.g., significant developmental delay, thought disorder) or limited behavioral control (e.g., intermittent explosive disorder) may not be appropriate for PCIT. Related to this, the prevalence of and the impact of parental illicit drug and alcohol use on the physical maltreatment of children are not clear. Further, another factor that may hinder treatment effectiveness is a parent's reluctance or unwillingness to regularly attend therapy sessions. Wolfe,

Aragona, Kaufman, and Sandler (1980) have argued that treatment with physically abusive families is much more likely to be successful if parents have been court ordered to participate in treatment.

Another limitation of PCIT is the lack of research regarding the effectiveness of the treatment approach for various ethnic groups. Although cultural differences with regard to acceptability of various treatment skills have been observed clinically (e.g., Native Americans may be less comfortable using high rates of labeled praise [Hembree-Kigin & McNeil, 1995]), specific studies of cultural/ethnic differences have not been reported. Lack of research in this area is problematic in that it poses a potential confound in interpreting findings with physically abusive families from diverse ethnic backgrounds.

Another limitation of using PCIT with physical abuse populations is the issue of comprehensive treatment. It has been argued that, because of the many types of problems found with physically abusive families, effective treatment approaches will need to be multimodal (Kaufman & Rudy, 1991). Although this may be true, a substantial portion of the population of physically abusive families is likely to engage in the negative coercive cycle initially described by Patterson (1975, 1976a, 1976b, 1982). Therefore, a treatment approach must be developed that will target this problem, acknowledging that supplemental treatment components may be needed.

CONCLUSION

The purpose of this article is to lay out important dynamics in physically abusive families and propose one promising model for intervention. PCIT has been shown to be a highly effective parent training program for conduct-problem children and their families and may be successfully adapted as an effective early intervention for physically abusive parent-child dyads. We acknowledge that several additional issues may be involved in determining PCIT's efficacy with this population. These may include cultural differences in parenting practices, the applicability to substance-abusing parents, and the role of parenting interventions with psychiatrically involved parents. PCIT should not be perceived as an intervention that will address a broad range of issues related to physically abusive families (i.e., as a primary mechanism in family reunification). Instead, PCIT should be perceived as an intensive parent-focused dyadic intervention to address a range of basic, and perhaps a core set of, maladaptive skills found in physically abusive parent-child dyads. In this role, PCIT may have great potential to the field of child abuse maltreatment.

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