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PARENT-CHILD INTERACTION THERAPY (PCIT)

Rafael Ferro García and Lourdes Ascanio Velasco
Centro de Psicología Clínica [Clinical Psychology Centre] C.E.D.I. Granada

Parent-Child Interaction Therapy (PCIT) is a brief therapy for treating behavioral problems in childhood. It is a treatment that has been proven to be empirically valid and can be considereda well-established treatment for disruptive behavior in childhood according to the APA guidelines. This paper presents its fundamental characteristics, the clinical components, and the factors affecting effectiveness. It also reviews the literature of research on the effectiveness and efficacy of PCIT. Recent adaptations in different contexts, formats, problems and populations are also presented.
Key Words: *Parent-Child Interaction Therapy (PCIT), Disruptive behaviour, Effectiveness, Efficacy, Adaptations.*

La Terapia de Interacción Padres-Hijos (PCIT) es una terapia breve para tratar los problemas de conducta en la infancia. Es un tratamiento que está demostrado válido empíricamente y puede ser considerada como un tratamiento bien establecido para tratar conductas problema en la infancia según las normas de la APA. Este trabajo expone sus características principales, sus componentes clínicos, y los factores que afectan a la efectividad. Hace una revisión de la literatura existente de las investigaciones sobre su efectividad y eficacia. También, se exponen las últimas adaptaciones en diferentes contextos, formatos, problemas y distintas poblaciones.
Palabras Clave: *Terapia de interacción padres-hijos (PCIT), Conductas disruptivas, Efectividad, Eficacia, Adaptaciones.*

Problems of disruptive behaviour in childhood are currently very common, with a prevalence of 6.9% in boys and 2.4% in girls between 5 and 10 years of age (Robles & Romero, 2011). In general, the frequency of discipline problems varies between 5 and 8% in children (Barkley & Benton, 2000). These types of problems include difficulties such as disobedience, opposition, aggression, oppositional defiant disorder (ODD), attention deficit and hyperactivity disorder (ADHD) and conduct disorder (CD). These problems can lead to a social, family and/or school maladjustment.

Parent training programs (PT) are the most used treatment approach since the 70s. There are several reviews (Luiselli, 2009; Rey, 2006; Robles & Romero, 2011) that analyse their characteristics, components and findings. Most PT programs are based on, firstly, improving parenting skills (knowledge of child development, techniques for managing the child's problematic behaviours and problem-solving skills) and, secondly, the personal empowerment of the parents (social skills, stress management and anger management). In the review by Robles and Romero (2011) on the effectiveness of parent training for children with behaviour problems, two theoretical orientations are distinguished: the "behavioural" approach and the approach that is "based on interpersonal relationships". The difference between the two lies in the type of intervention; in programs with a behavioural approach the intervention is based on behaviour modification techniques, whereas in the approach "based on interpersonal relationships" the intervention is aimed at the processes of family interaction and communication. Using the findings of a large number of studies published between 1989 and 2009, these authors concluded that the programs of PT with a behavioural approach are considered to be a more useful and effective alternative than the other modalities. Furthermore, according to Robles and Romero (2011), some authors suggest that the effectiveness can be strengthened if these programs are complemented with skills of communication, empathy and resolving interpersonal conflicts, thereby improving the quality of family functioning. According to Rey (2006), the components, mechanisms and factors that determine the success of these programs are not clear. Moreover, the main limitation of the programs is the high dropout rate, around 40-60%, although in well-organized programs the number of dropouts is significantly reduced (Robles & Romero, 2011).

The program by Barkley (Barkley, 1997; Barkley &

Correspondence: Lourdes Ascanio Velasco. *Centro de Psicología Clínica CEDI. Avda. Constitución 25, 7 Izda. 18014 Granada. España. E-mail: psicolou22@hotmail.com*
Web site: http://www.cop.es/colegiados/GR00777

Benton, 2000) is one of the most used PTs with a behavioural approach. It consists of general objectives and a list of 10 steps. Greco and Eifert (2004) conducted a review of this program, pointing out that the effectiveness of the exercises has been proven in many studies in comparison with experimental control conditions and other treatments. But when there is comorbidity with ODD/ADHD, the effectiveness of these interventions has shown poorer results. For these authors, an idiographic intervention is needed, adapted to each level of family conflict, since the nomothetic intervention packages have worse results.

Parent-Child Interaction Therapy (PCIT; Eyberg, 1988, 1999; Hembree-Kigin & McNeil, 1995; McNeil & Hembree-Kigin, 2011) falls within the behavioural approach and incorporates problem solving and communication skills into its treatment. Moreover, it is an empirically validated intervention for reducing disruptive behaviours and disobedience in children (McNeil, Capage, Bahl, & Blanc, 1999). It was also considered an evidence-based treatment in 2009 by the Substance Abuse and Mental Health Services Administration, among other organizations (Shinn, 2013). Furthermore, it can be considered a well-established treatment for problem behaviours in childhood and for ODD, as it follows the criteria established in the report of Division 12 of the APA (Fernández Hermida & Pérez Álvarez, 2001).

This paper presents a critical review of the literature on PCIT. The bibliographical sources used have been the programs' own manuals and the literature presented in the therapy websites (www.pcit.org, and http://pcit.phhp.ufl.edu/).

PARENT-CHILD INTERACTION THERAPY

Parent-Child Interaction Therapy (PCIT) is a brief therapy for treating behavioural problems in childhood. It emerged at the end of the 80s (Eyberg, 1988). Currently there are several manuals on the subject: the first edition of the manual where the program is presented (Hembree-Kigin & McNeil, 1995), another detailing the rating scales and the equipment needed for the work (Eyberg, 1999) and there is also a second edition of the manual in which the program has been updated and new applications described (McNeil & Hembree-Kigin, 2011).

In the PCIT manuals, the influence of other therapeutic sources can be seen, such as traditional play therapy, operant methods and the influence of the work by Hanf using live interventions with the parents. In general, the basic idea is to generate a healthy and assertive parental relationship with a clear style of communication and setting limits in educating. Furthermore, it is necessary that the intervention adapts to the child's development, since many of the problems of parent-child interaction are related to inappropriate objectives of autonomy and developmental expectations of parents. PCIT maintains that the problems presented by children are established through their early interactions with parents, and in the same way that this negative influence is established it is also the most powerful way to influence positively. Play is the most natural behaviour of the child and it is the primary means through which children develop problem-solving skills. The proposal is to make parents the agents of change by teaching them through play and *in vivo*, to attain a positive parental role and behaviour modification skills. The fundamental difference between PCIT and other training programs is that it uses *in vivo* intervention through play.

CHARACTERISTICS

In applying PCIT, we start from a non-judgmental and positive philosophy regarding behaviour problems. As discussed above, one of the characteristics of the therapy is the direct training of parents and children *in vivo* and together, correcting the parents' mistakes and adapting to the idiosyncrasies of each case, presenting models of action and moulding the parents, taking into account the level of development of the child. The data collected are used to guide the treatment. The basis is that some problems stem from the parents' demands that are not adapted to the children's development. Intervention is carried out very early, since it has a better prognosis. The therapy focuses on patterns of interaction or response classes rather than specific behaviours. It is a useful therapy for a number of problems such as disobedience, verbal abuse, animal cruelty, physical abuse, lying, behaviour problems in the classroom, children with incendiary tendencies, hyperactivity, destructive behaviour, families of children from previous relationships, theft, self-injurious behaviour, whining and crying, after-effects of abuse, low self-esteem, moodiness, perfectionism, delayed development, acceptance of separation, and separation anxiety (Hembree-Kigin & McNeil, 1995; McNeil & Hembree-Kigin, 2011).

The novelty of PCIT is that it is an idiographic intervention adapted to each problem and which is carried out on parents and children *in vivo*, as has been

said before. This training is done using technical equipment that enables the observation of the family's interaction throughout the intervention and the provision of immediate feedback. This equipment can vary depending on the means available: from the use of one-way mirrors, tablets and mobile phones with video communication applications over the Internet, to radio listening or walkie-talkies, headphones or earpieces and video cameras, etc. The authors of this study use computers with programs such as Skype and telephones with Bluetooth for the live training.

PCIT has been applied to treat various problems such as Oppositional Defiant Disorder (Ferro, Vives & Ascanio, 2010; Hood & Eyberg, 2003; McNeil, Capage, Bahl, & Blanc, 1999, among others) and other problems with comorbidity with ODD: Attention Deficit Hyperactivity Disorder (Matos, Bauermeister & Bernal 2009; Verduin, Abikoff & Kurtz, 2008; Wagner & McNeil, 2008), mental retardation (Bagner & Eyberg, 2007), autism (Solomon, Ono, Timmer & Goodlin-Jones, 2008), Asperger syndrome (Armstrong & Kimonis, 2013), separation anxiety (Chase & Eyberg, 2008; Choate, Pincus, Eyberg & Barlow, 2005; Pincus, Santucci, Ehrenreich & Eyberg, 2008), childhood depression (Luby, Lenze & Tillman, 2012), cancer (Bagner, Fernández & Eyberg, 2004), hearing problems (Shinn, 2013), preterm infants (Bagner, et al. 2009, 2012), abused children and preventing abuse (Thomas & Zimmer-Gembeck, 2011; Urquiza & Timmer, 2014), with language problems (Allen & Marshall, 2011); with families exposed to violence (Timmer, Ware, Urquiza & Zebell, 2010), with deafness (Shinn, 2013), mothers with depression (Timmer et al., 2011) and with a history of antisocial behaviour (Rhule, McMahon & Spieker, 2004); in diverse cultural and linguistic groups, such as Spanish-speaking families (Borrego, Anhalt, Terao, Vargas & Urquiza, 2006), Chinese (Leung, Tsang, Heung & Yiu, 2009), African American (Capage, Benet & McNeil, 2001; Fernández, Butler & Eyberg, 2011), South American (McCabe & Yeh, 2009; McCabe, Yeh, Lau, & Argote, 2012) and native Indians (BigFoot & Funderburk, 2011).

BASIC CLINICAL COMPONENTS

The objectives are to increase pro-social behaviour through parental attention and to decrease the undesirable behaviours by ignoring them. There are two clinical components or phases. In the first phase, the treatment focuses on teaching parents to use selective attention, called Child-Directed Interaction (CDI). The aim is to establish a loving and caring relationship between the parent and child. The parents are helped to recognize the positive qualities of the child and to stimulate their development, based on what the child does. At this stage there are skills that must be put into practice, through the acronym PRIDE (Praise, Reflect, Imitate, Describe and Enthusiasm). These are defined as follows: **Praise**: Making a verbalization that expresses a favourable judgment of an activity, result or attribute of the child; **Reflect**: immediately repeating what the child has verbalized, which can be done by repeating exactly what the child has said or using synonyms; **Imitate**: immediately performing the same activity that the child is doing or a similar activity; and **Describe**: verbalizing phrases that allude to objects and/or persons that are present in the situation or activity that is occurring during the interaction; and generally performing these tasks with **Enthusiasm**. The following should also be avoided: giving orders, asking questions and/or criticizing. Table 1 shows the steps for teaching CDI. First, the objectives of CDI are presented. Then, the five minutes of daily homework with the child are explained. Next, the things to avoid and the PRIDE skills to be carried out are described. Models of all of these combined skills are presented and parents are trained through role-playing before beginning the interaction with the child. The logic of play at home is explained to them and they are assigned tasks.

The second component is called Parent-Directed Interaction (PDI) and focuses on discipline strategies. Parents are taught how to talk to their children and how to apply consistent consequences to their behaviour. In Table 2, the steps for teaching PDI are outlined. These are as follows: explain the exercises for following orders and

TABLE 1
STEPS FOR TEACHING CDI SKILLS
(MCNEIL & HEMBRE-KIGIN, 2012)

1. Review the homework tasks
2. Describe the objectives of CDI
3. Discuss the five minutes of daily practice at home
4. Explain and present models of the behaviours to be avoided
5. Explain and present models of the skills to be carried out
6. Discuss the use of strategic attention
7. Discuss the use of selective ignoring
8. Model all of the combined skills
9. Train the parents through role-play
10. Discuss the logic of play therapy at home
11. Assign new homework activities

how they must be carried out. Explain and discuss with parents how to give instructions. Reach agreement with the parents to determine when the child is obedient. Analyse and agree the consequences of obedience and disobedience. Explain how an effective time-out is carried out. Parents are also trained in discipline skills before the intervention, through role-playing.

In general, the order of these two components or phases can be altered depending on the analysis that is made of the problem. For example, in overly aggressive children the training would begin with PDI.

PCIT begins by evaluating through observing the parent-child interaction in three situations that vary in the degree of parental control that is required: a play situation directed by the child, i.e. the child chooses the game and what to do, another situation directed by the father/mother and a situation of "cleaning" the playroom. The session is usually recorded with the parents' permission so that the therapist can analyse what happens during the interaction. During the intervention, the sessions are recorded with a fixed video camera placed in the playroom and in addition, the technical equipment described above is used to observe, praise, shape and correct the parents in real time throughout the procedure.

TABLE 2
STEPS FOR TEACHING PDI SKILLS
(MCNEIL & HEMBRE-KIGIN, 2012)

1. Explain the use of the obedience exercises
2. Discuss how to give effective instructions
3. Determine when the child obeys
4. Discuss the consequences of obedience
5. Discuss the consequences of disobedience
6. Explain how an effective time-out is carried out
7. Train parents in discipline skills

TABLE 3
STEPS IN A TYPICAL PCIT COURSE
(HEMBRE-KIGIN & MCNEIL, 1995)

Step 1: Pre-treatment evaluation of family and child functioning (1 or 2 sessions)
Step 2: Teaching behavioural play therapy skills (1 session)
Step 3: Training in behavioural play therapy skills (2 to 4 sessions)
Step 4: Teaching discipline techniques (1 session)
Step 5: Training in discipline techniques (4-6 sessions)
Step 6: Post-treatment evaluation of family and child functioning (1 or 2 sessions)
Step 7: Follow-up and extra sessions, if these are necessary

The number of treatment sessions required will depend on how quickly the parents learn the skills and the type of problem presented by the child. The treatment is applied in 8 to 12 sessions, with extra sessions if needed, and follow-up at 1, 3, 6 and 12 months. The typical course of PCIT treatment would include the following steps (see Table 3). Step 1: Pre-treatment evaluation of family and child functioning (1 or 2 sessions). Step 2: Teaching of behavioural play therapy skills (1 session). Step 3: Training in behavioural play therapy skills (2 to 4 sessions). Step 4: Teaching discipline techniques (1 session). Step 5: Training in discipline techniques (4-6 sessions). Step 6: Post-treatment evaluation of family and child functioning (1 or 2 sessions). Step 7: Special sessions, if necessary, and follow-up.

FACTORS AFFECTING THE EFFECTIVENESS OF PCIT

There are a number of factors that influence the effectiveness of PCIT (Hembree-Kigin & McNeil, 1995). At the child level, the effectiveness increases when the child is between the ages of 2 and 7 years and has a good understanding of language. One child factor that decreases the effectiveness is showing a serious developmental disorder. Parental factors that increase effectiveness include having a strong motivation and an average or high IQ. Conversely, if the parents present substance abuse, severe psychopathology, and/or mental retardation, the effectiveness decreases. The application of this therapy is not recommended with parents who have high resistance to the treatment. The family factors that diminish the effectiveness are family chaos and serious disagreements.

EVALUATION MEASURES

Various scales have emerged from the research into PCIT (Hembree-Kigin & McNeil, 1995; McNeil & Hembree-Kigin, 2011): the Eyberg Child Behavior Inventory (ECBI), the Sutter-Eyberg Student Behavior Inventory (SESBI), the Dyadic Parent-Child Interaction Coding System Observation (DPICS) and the Therapy Attitude Inventory (TAI).

The ECBI Inventory is a self-register for parents, measuring problem behaviour for children aged between 2 and 16 years old. Two scores are obtained: one estimates how often the problem behaviours from a list appear (Intensity score) and the other measures whether these behaviours are perceived by the parents as a problem (Problem score). In addition, this inventory

identifies the expectations of parents regarding their child's behaviour. This inventory has been validated empirically (Eyberg & Ross, 1978).

The SESBI Inventory has the same structure as the ECBI, but its items are adapted to the behaviours shown by the child at school and recorded by the teacher.

The DPICS Coding System measures the quality of the interaction between the parent and child. The behaviour and words of the parents and the child are registered in three different five-minute situations, varying in the degree of parental control that the interaction requires: a Child-Directed Interaction, a Parent-Directed Interaction and a situation of "cleaning" the playroom.

The TAI Inventory is a record that measures parental satisfaction with the therapy through 10 items. It is usually applied after the treatment.

The inventories have recently been updated. Their revised versions can be obtained from the PCIT website.

STUDIES ON EFFECTIVENESS AND EFFICACY

There are numerous empirical studies on PCIT. In this paper, we do not present a comprehensive review of all of the literature due to limitations of space; the studies described below have been selected because they present statistically significant results and/or methodological rigor.

One of the first studies on the effectiveness of PCIT (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993) compares two treatment groups of children with behavioural problems (ADHD and ODD). The groups differ in the order of the phases, one started with CDI and the other with PDI. The pre-post results showed statistically significant improvements in all measures of the questionnaires (problem behaviours, obedience and parental stress), although no significant differences were found between the two groups. In this same line of research, the study by Eyberg, et al. (2001) measured the effects of the treatment of problem behaviours in two groups, altering the initial phases, with a follow-up of 1 and 2 years, producing results that showed statistically significant improvements which were maintained during the follow-up.

The effectiveness study with the longest follow-up was the one by Hood and Eyberg (2003), in which PCIT was applied to 50 families with children with ODD and follow-up measured over 3 to 6 years. The results show statistically significant improvements in both the behaviour of the children and the parents, at the post-treatment evaluation and in the follow-up. In another effectiveness study with a long follow-up (Pade, Taube, Aalborg & Reiser, 2006), an adaptation of PCIT was applied in groups with 73 families of children with behaviour problems with follow-up measures of 5 to 6 years. The pre/post data indicate statistical differences both in the frequency and the intensity of the behaviours. The 23 families that remained in the follow-up also presented statistical significance in their results.

The effectiveness study by Boggs et al. (2004) compared two groups of 23 families each, one group that completed the treatment and another that left before completing the treatment, in families with children who presented ODD and/or ADHD. The results indicate that there are statistically significant differences between the two groups, with better results in the frequency of problem behaviours, parental stress and behaviour tolerance presented by the group that completed PCIT. Another recent effectiveness study is the one by Galanter et al., (2012), in which the results of the intervention with this therapy at home were compared between the cases that completed the treatment and those who abandoned it, with a sample of 83 high-risk families. The results show that the group that completed the treatment showed statistically significant changes in the pre/post measures, whereas the statistical significance was lower in those that did not complete the treatment.

A pioneering study (McNeil, Eyberg, Eisenstandt, Newcomb & Funderburk, 1991) evaluated the effects of generalizing PCIT from home to school with 30 children aged between 2 and 7 years old with severe behaviour problems. Three groups were compared, one of PCIT, another of the usual school treatment and a third group that received no treatment. Statistically significant improvements were found in all measures of pre/post data in the PCIT group and of generalization in school, and these were higher than in the other groups. On the other hand, no differences were found regarding hyperactivity or prosocial behaviours at school. The study by Funderburk et al. (1998) compared a PCIT treatment group with three control groups with different degrees of disruptive behaviours (low, medium and severe). The results of the pre/post measures of the PCIT group showed significant differences and also in the follow-up at 12 months but not at 18. There were also significant differences between the groups at post-treatment and after one year.

Schuhmann, Foote, Eyberg, Boggs, and Algina (1998) also conducted a randomized trial of 64 families with clinical behaviour problems in two groups, one with PCIT and the other a waiting list control. The results showed clinical and statistically significant changes in the post-treatment evaluation and at follow-up after 5 months when compared with the control group.

The investigation by McNeil, Capage, Bahl and Blanc (1999) compared a PCIT treatment group with a waiting list control group for children with problem behaviours, presenting statistically significant results in both the pre/post data in the treatment group and in the difference between the groups. Using this same methodology, comparing PCIT and a waiting list control group, Thomas and Zimmer-Gembeck (2011) conducted a randomized trial with children presenting problem behaviours and a high risk of physical abuse confirmed through questionnaires. The results show statistically significant changes both in the evaluation questionnaires and in the observations made in the study on the pre/post measures for the PCIT group and there were also differences between the groups.

Furthermore, Bagner and Eyberg (2007) performed a randomized trial in children who had developmental delay and ODD. Two groups were used, one of PCIT and a waiting list. The results indicate that there were significant differences in the treatment group in the pre/post measures and there were also statistically significant differences between the groups.

Matos, Bauermeister and Bernal (2009) carried out a randomized trial of 32 children aged from 4 to 6 years old with ADHD from Puerto Rico, divided into two groups: one of PCIT and the other a waiting list. The measurements show significant changes in the pre/post measures and these were maintained in the follow-up after 3-5 months. Another application in a Hispanic population is the study of McCabe and Yeh (2009), a randomized clinical trial of 58 families of Mexican children with disruptive behaviour in three groups: standard PCIT, an adaptation to this population (GANA) and a usual treatment. There were statistically significant differences in the pre/post evaluations for the GANA and PCIT groups, with larger differences than the usual treatment group in the results of the questionnaires and in the observations of behaviours. There were no differences found between the two therapy groups.

The line of research by Nixon, Sweeney, Erikson, and Touyz (2003, 2004), in a randomized study compared two PCIT treatment groups (standard and short) and a waiting list control group. The results indicate that there were significant differences between the treatment groups and the control group in the pre/post measures and in the follow-ups at 6 months, 1 and 2 years. The standard treatment gave better results than the shortened treatment, with no difference in the long-term follow-up.

With regards to application with a single case design, Ware, McNeil, Masse and Stevens (2008) obtained good results applying PCIT at home with five families. They used a multiple baseline design across subjects, measuring the behaviour of the caregiver and the child. The results of the three families that completed the treatment show, through the children, how the measures changed, as the intervention progressed.

Choate, Pincus, Eyberg and Barlow (2005) also conducted an experimental single case study with multiple baseline design across subjects using standard PCIT. The participants were three families with children aged between 4 and 8 years old with separation anxiety. A clinically significant decrease in separation anxiety was obtained in the three children, and these results were maintained in the follow-up at 3 and 6 months.

As for the single case studies, Bagner, Fernandez and Eyberg (2004) applied PCIT to a 4-year-old child who suffered from cancer and ODD. The pre/post evaluations and the follow-up measures at 3 months showed clinically significant changes. Also Ferro, Vives and Ascanio (2010) applied PCIT in the case of a 3-year-old girl with ODD, reducing the frequency, duration and intensity of the problem behaviours, and increasing obedience. These results were maintained after a year.

ADAPTATIONS OF PCIT

PCIT has been applied in different contexts (at home and at school), through several formats (brief, and in groups), it has been adapted to different problems (separation anxiety and depression) and different populations (children under 2 years). The number of investigations of these adaptations is ever growing and the results obtained are promising.

ADAPTATION OF PCIT TO DIFFERENT CONTEXTS

PCIT at home

Over the last six years, research has been performed using an adaptation of PCIT in the home. Suggestions for its application have been proposed (Masse & McNeil, 2008; McNeil & Hembree-Kigin, 2011, Chap.23) relating to

environmental control, encoding the PRIDE rules in the same room where play occurs, the resources that the therapist has available; as well as advantages such as the ecological validity and greater adherence to treatment. Ware, McNeil, Masse and Stevens (2008) applied PCIT in five families with a multiple baseline across subjects design, obtaining good results in the disruptive behaviours of children. In a randomized group design Timmer, Zebell, Culver and Urquiza (2010) compared two groups: PCIT in the clinic and subsequently applying it at home, and another group with PCIT in the clinic and social support at home. No significant differences were found between the two groups, although the group with PCIT linked to the home had significantly better results in the pre/post measures. The study by Galanter, et al. (2012) applied PCIT at home, producing statistically significant changes in the improvement of the parent-child interaction and in the disruptive behaviour of the children.

PCIT at school

The adaptation of PCIT to school is called Teacher-Child Interaction Therapy (TCIT) (McNeil & Hembree-Kigin, 2011, chap. 21). The objective of TCIT is to improve the interaction between the teacher and child in the classroom. It consists of two components or phases: CDI (Child Directed Interaction) and TCI (Teacher Directed Interaction). The teacher is trained in the classroom itself and receives immediate feedback from the therapist. The goal of CDI is to train teachers to implement contingent attention to good behaviour to prevent behaviour problems of the students, using the PRIDE skills, emphasizing the importance of praise and describing pro-social behaviour and adding two more skills: selective ignoring and question reduction. In TDI time-out is adapted to the classroom. TCIT is the only training, to date, where the teacher receives advice on the skills to implement and feedback on their performance, *in vivo*, and adapted training in their own classroom (Fernández, Gold, Hirsch & Miller, 2014).

The first application of TCIT (McIntosh, Rizza & Bliss, 2000) was a single case design in a two-year-old child who presented disruptive behaviours with a teacher. The results showed an increase in the PRIDE rules by the teacher and a decrease in the disruptive behaviour of the child.

Later, Filcheck, McNeil, Greco, and Bernard (2004) measured the effectiveness of the application of PCIT in the classroom in comparison with a token economy through a single-case design study of alternative treatments in 17 pre-school children with disruptive behaviour. Although the study had methodological limitations, the results indicate that both groups obtained improvements in reducing the problem behaviours but when PCIT was introduced the use of the criticism by the teachers decreased.

Tiano and McNeil (2006) compared the efficacy of TCIT in one group with a control group without treatment in three classes. The improvement in student behaviour was significant in both groups, but the use of praise experienced a statistically significant increase in the treatment group.

Lyon, et al. (2009) designed a multiple baseline study across four classrooms with 78 pre-school children with three teachers in each, to measure the effectiveness of TCIT. The results obtained in the behaviours of both the children and the teachers were positive but moderate.

ADAPTATION OF PCIT TO DIFFERENT FORMATS

PCIT abbreviated version

The study by Nixon, Sweeney, Erikson, and Touyz (2003, 2004) compares two PCIT treatment groups (standard and short) and a waiting list control group, obtaining good results, although they were better with the standard version. The abbreviated version included videos and manuals and reduced the number of live sessions.

Berkovits, O'Brien, Carter and Eyberg (2010) compared two abbreviated packages of PCIT, which they called Primary Care PCIT (PC-PCIT) and Anticipatory Guidance (PCIT-AG). PC-PCIT consists of four abbreviated group PCIT sessions for the prevention of problems. PCIT-AG is a package of written materials describing the principles of PCIT and a guide for implementing it. This research was conducted to measure the effects of abbreviated PCIT on behaviour for children aged 3 to 6 years old who were beginning to have behavioural problems, but were still below the clinical range. Seventeen mothers were assigned to the group that received the PC-PCIT intervention and 13 to the group that received the PCIT-AG treatment. No significant differences were found between the two forms of abbreviated intervention. Both interventions were statistically effective at post-treatment and in the 6-month follow-up, both in improving the children's behaviour and in the reduction of stress in the parents, as well as in the latter's satisfaction and adherence to the treatment.

Group PCIT

The application of PCIT in groups has a number of advantages: time-saving (working with several families at once), seeing the interactions of other parents, and group cohesion, which may result in fewer dropouts from the therapy. According to Niec, Heme, Yopp and Brestan (2005) the recommended number of participating families would be between three and six. The structure of group PCIT is similar to the original format, introducing a discussion group in which each family is involved and given the opportunity to give and receive feedback from/to other families, among other interactions.

Niec et al. (2005) obtained good results applying PCIT group in three families and four children, aged between 26 and 56 months with disruptive behaviours. Three of the four children improved their behaviour significantly. Only one family had higher stress levels at post-treatment and their child's behaviour worsened.

Furthermore, Pade et al. (2006) evaluated a program that was implemented in groups. The results obtained in this study were statistically significant in both the pre-post measures and in the follow-up after 5-6 years.

ADAPTATION OF PCIT TO DIFFERENT PROBLEMS

Separation Anxiety

Choate, Pincus, Eyberg and Barlow (2005) conducted a single-case experimental design using standard PCIT. The participants were three families with children presenting separation anxiety who attained a clinically significant decrease in anxiety in all three children. These results were maintained at follow-up.

Pincus, Santucci, Ehrenreich and Eyberg (2008) have added a new phase to PCIT, which they have called Bravery Directed Interaction (BDI), to address the specific problems of anxiety. During this phase, the parents are educated about anxiety and the child is gradually exposed to the fears. After conducting a pilot study with 10 children who met the criteria for separation anxiety, these authors found that the children improved but were still within the clinical range. The line of investigation remains open and the authors are conducting a study to assess the effectiveness of PCIT with BDI in comparison with a waiting list group and using follow-up measures at 3, 6 and 12 months.

In childhood depression

For pre-school children with a diagnosis of depression, Luby, Lenze and Tillman (2012) propose an adapted PCIT intervention that they call Parent-Child Interaction Therapy-Emotional Development (PCIT-ED). The CDI and PDI phases are limited to four sessions each. The aim is to provide emotional skills to parents and children. The families of children aged between three and seven years old with depression participated in an efficacy study by the same authors. The families were randomly divided into two groups: one group was treated with PCIT-ED and the other with what the authors call Developmental Education and Parenting Intervention. The treatment was completed with 19 families in the first group and 10 in the second. In both groups, the severity of the depression in the pre/post measures improved, but there were no sufficient differences between the two groups at post-treatment.

PCIT ADAPTATION FOR CHILDREN UNDER THE AGE OF TWO

An adaptation has been made for children between the ages of 12 and 30 months who have been abused and/or are experiencing attachment problems. It is called Parent-Child Attunement Therapy (PCAT; Dombrowski, Timmer, Blacker & Urquiza, 2005). Its objectives are to strengthen the interaction between parents and children and to teach parents appropriate techniques for controlling their children's behaviour. It differs from the standard treatment in its brevity, in that PCAT emphasizes the use of physical contact (touching, cuddling) as a reinforcer, and in that it does not include a comparable stage to PDI (McNeil & Hembree-Kigin, 2011). The effectiveness study by Dombroswski et al. (2005) found no significant results with a mother and her 23 month old with a history of abuse; although it did achieve that the mother was more positive and less directing, improving her interaction with the child. In addition, McNeil and Hembree-Kigin (2011) devoted a chapter of their manual to children aged between 12 and 24 months (Chap. 9), and another to older children, aged 7 to 10 years (Chap. 10). Both chapters present slight adaptations of PCIT aimed at these populations.

CONCLUSIONS

Although behavioural parent training programs are a treatment option for treating behavioural problems in childhood, they have a number of limitations (unclear components and a high dropout rate). As discussed, PCIT is a clear alternative to this type of problem, including ADHD and ODD. It is an empirically validated treatment and can be considered to be well-established in treating

behavioural problems in childhood. Although it is not the only method of achieving positive parenting, it is unique in carrying out the training *in vivo* (Timmer, Zebell, Culver & Urquiza, 2010) and this is one of its novelties. Play is the most natural activity you can have with a small child, and therefore, it offers the best opportunity for developing appropriate behaviour and the best way to generalize the results. It works directly with the problems that arise in the session and allows us to generalize the treatment to daily life, in a line equivalent to Functional Analytic Psychotherapy (Kohlenberg & Tsai, 1991).

As mentioned, PCIT differs from other PT in the use of *in vivo* training and the ability to give immediate feedback to parents, and it provides the opportunity to practice the skills. Furthermore, it is an ideographic approach which is based on data (Wagner & McNeil, 2008). Moreover, in our experience of applying PCIT, virtually no treatment discontinuations occur, which is one of the limitations of PT.

We have described and analysed the fundamental characteristics, clinical components and factors that affect the effectiveness of PCIT. We have presented the new measures that have emerged from the investigations into PCIT and their contributions to the evaluation of the intervention. We have produced a critical review of the effectiveness and efficacy studies from the abundant literature, selected for their methodological rigor and statistically significant results. And finally, we have described the latest adaptations to different contexts, formats, problems and populations. The research in all these areas is ongoing, some producing promising results.

From our perspective, a line of research that we believe to be of interest is the combined application of PCIT and Acceptance and Commitment Therapy (ACT, Hayes, Strosahl & Wilson, 1999), on one hand, working with young children with PCIT so that the parents can understand and manage their children's behaviour better and, on the other hand, through ACT working on the emotional and motivational conflicts of parents, in the line exposed in the case study by Ascanio and Ferro (2013).

PCIT is still an unknown therapy in our country – unjustifiably so- and we hope that with this paper we can contribute in our own small way to its becoming more widely known.

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