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Delivering Parent-Child Interaction Therapy in an Urban Community Clinic

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Extensive evidence supports the efficacy of Parent-Child Interaction Therapy (PCIT) for reducing behavior problems in young children; however, little is known about the use of PCIT in a community mental health center (CMHC). This paper provides four clinical case examples of families who were referred to and successfully completed PCIT in an urban CMHC. The families were ethnically and socioeconomically diverse and presented with a wide range of treatment concerns and needs (e.g., autism, severe maternal psychopathology, involvement in child protective services, and complex family configurations) in addition to disruptive behavior. Our data and clinical observations suggest that PCIT decreased behavior problems, improved parent-child interactions, and, in some cases, reduced parental stress, with differing levels of change across families. Overall, the cases demonstrate that PCIT can be transported into a CMHC, and they illustrate supplemental services or minor accommodations to the established treatment protocol used to address individual family needs. Issues regarding the balance between fidelity and flexibility in transporting PCIT to a community setting are discussed, and future research topics are recommended.

Several empirically supported treatments (ESTs) have demonstrated success at reducing children's externalizing behavior and are receiving widespread attention (Eyberg, Nelson, & Boggs, 2008; Weisz & Kazdin, 2010). Transporting ESTs from research settings to community service settings, however, is slow and challenging because it involves bridging differing client populations, organizational philosophies, and intervention goals and practices (Hoagwood & Johnson, 2003; Weisz, Doss, & Hawley, 2005). For example, whereas ESTs were designed for and tested with individuals meeting criteria for specific diagnoses, community mental health centers (CMHCs) serve clients without reference to a specific *DSM* diagnosis but nevertheless presenting with problems substantial enough to result in clinical referral (Snowden, Storey, & Clancey, 1989).

Slow integration of scientific evidence into practice has serious implications for public sector mental health systems, which serve many of the most vulnerable individuals and families (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009). Relative to participants in research settings, community clients often are of lower socioeconomic status (SES), more ethnically diverse, and more likely to present with conditions that would exclude them from controlled research studies (e.g., comorbidities, involvement in the child welfare system, and limited reading or cognitive functioning; Hawley & Weisz, 2002; McKay & Bannon, 2004). Further, ESTs present challenges for community service settings due to their standardized approach. In contrast to the manualized treatment protocols used in ESTs, CMHCs often combine and adapt services (e.g., case management, psychoeducation, assessment, and therapy) to address multiple treatment goals. The average length of care in community mental health settings has been reported to be as low as four visits, with less than 10% of clients remaining in treatment after 3 months (McKay & Bannon). This short duration of treatment would rarely be enough to complete an EST.

One EST that has received support for use with young children is Parent-Child Interaction Therapy (PCIT). PCIT is a manualized intervention for children ages 2 to 7 with disruptive behavior problems (Eyberg & Robinson, 1982; McNeil & Hembree-Kigin, 2010). Numerous PCIT efficacy studies have demonstrated substantial positive changes in parent and child behavior following treatment (e.g., Bagner & Eyberg, 2007; Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Nixon, Sweeney, Erickson, & Touyz, 2004; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998; Thomas & Zimmer-Gembeck, 2007), with research supporting treatment efficacy 3 and 6 years posttreatment (Hood & Eyberg, 2003). Studies examining

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PCIT with African American (Capage, Bennett, & McNeil, 2001; Fernandez, Butler, & Eyberg, 2011) and Latino families (McCabe & Yeh, 2009) provide preliminary indications that PCIT is effective across ethnic minority groups, although Fernandez and colleagues reported that dropout in their sample was higher than in other PCIT efficacy studies (56% compared to 32-41%). Data from community-based applications of PCIT are mixed, with some reporting relatively low attrition levels (Chaffin et al., 2009; Phillips, Morgan, Cawthorne, & Barnett, 2008) and others reporting considerably higher rates than efficacy trials (Lyon & Budd, 2010; McNeil, 2007; Timmer, Urquiza, Zebell, & McGrath, 2005).

This paper describes case examples of PCIT in an urban CMHC. Our program represents a useful transition point between the controlled research settings typical of most PCIT research and real-world service settings. Our program satisfies Weisz et al.'s (2005) criteria for clinical representativeness with regard to participant enrollment and treatment setting because it provides intervention to treatment-seeking youth in a clinical service setting. However, unlike typical clinical treatment providers, who usually consist of practicing clinicians (or even paraprofessionals), our therapists consisted of an LCSW and graduate students in a clinical psychology doctoral program who were supervised by a doctoral-level PCIT clinician and researcher. The latter characteristics are more commonly found in research settings. We provide an overview of the PCIT treatment model and case descriptions of four families involved in treatment, challenges we encountered, and lessons learned that have informed our community intervention program.

Treatment Overview

PCIT draws conceptually on Baumrind's developmental research on authoritative parenting style, social learning theory, and attachment theory to promote positive, consistent parenting practices (Zisser & Eyberg, 2010). Treatment entails two phases: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). Both phases begin with a Teach session to introduce skills through instruction, demonstration, and role-play. The Teach session is followed by Coach sessions, during which the therapist observes from behind a one-way mirror and provides immediate feedback and support on the parent's use of the skills through a "bug in the ear" device while the parent and child play. Session outlines and treatment details are outlined in a comprehensive PCIT treatment manual (Eyberg & Child Study Lab, 1999). Components identified as core elements of PCIT are inclusion of both CDI and PDI phases of treatment, individualized coaching sessions in live interactions during most sessions, coding of parent-child interactions in coaching sessions, assignment of homework between sessions, and use of standardized assessment instruments to guide treatment (Training Guidelines for PCIT, 2009).

The goal of CDI is to increase positive parenting practices and thereby build the child's self-esteem and improve social and communicative skills. During CDI, parents are taught to let the child lead the play and to use the PRIDE skills: Praising the child, especially by labeling specifically what they like about the child's behavior, Reflecting the child's statements or verbalizations, Imitating the child's play, Describing the child's behavior, and showing Enthusiasm during the play. Parents are also taught to avoid using questions, commands, and criticisms, or negative talk. In essence, parents learn to become play therapists. Parents learn to change the child's behavior by linking the PRIDE skills with appropriate behavior and concurrently ignoring inappropriate behavior. Mastery criteria for the CDI phase are met when the parent uses 10 behavior descriptions, 10 reflections, 10 labeled praises, and no more than 3 total questions, commands, and negative talk during a 5-minute play period.

The objective of PDI is for parents to manage their child's behavior by using direct commands and following through with a specific ladder of consequences (i.e., labeled praise for compliance and a warning, chair time-out, and a back-up time-out room if needed for noncompliance). In the PDI phase, parents are also instructed to use the skills mastered in CDI (i.e., PRIDE skills and ignoring) between commands. As PDI progresses, parents create and introduce the child to house rules for managing problematic behaviors in the home. Mastery criteria for PDI are reached when parents give at least four commands, 75% of which are direct, and follow through correctly on at least 75% of the total commands in 5 minutes. After mastery in CDI and PDI is reached, the therapist(s) guides the parents in applying their newly acquired skills to the child's behavior at home and other settings. Treatment ends when, in addition to skills mastery, parents' ratings of the intensity of child behavior problems drop to within one-half standard deviation of the normative mean and parents express confidence in managing the child's behavior.

Method

Participants

We describe the course of therapy with four families who participated in PCIT to address their child(ren)'s disruptive and oppositional behavior, provided research consent, and completed treatment. (Names of all clients have been changed to protect families' privacy.) We selected clients with differing background characteristics and clinical presentations in order to illustrate varied issues encountered in delivering PCIT in a community setting: comorbid child diagnoses, mental health issues for the parents, involvement in the child protection system, and more than one identified child in a family. Lyon and Budd (2010)

described results from the first 12 families seen in this PCIT clinic; one of the current families was included in their study, and the others engaged in therapy after completion of that study.

Setting, Therapists, and Procedures

The CMHC for this study has offered a range of preventive and mental health services for high-risk youth and their families for over 30 years. It is funded by the state Department of Human Services to serve primarily families with limited means (i.e., on public aid, noninsured, or underinsured). In fiscal year 2009, 88% of the CMHC's clientele were non-White, 86% were on public assistance, 4% were on a sliding fee, and 10% had private insurance. The center's PCIT program began in 2005; approximately 4 to 6 families are enrolled in PCIT at any one time.

Unlike most CMHCs, which are free-standing service centers, this CMHC is unique in the fact that it is located on a university campus and serves as a practicum training clinic for doctoral clinical psychology students. PCIT therapists (four female, one male) included three doctoral clinical psychology students, an LCSW, and a faculty supervisor. Four therapists were Caucasian and one was Asian-American. All therapists received specialized training in PCIT. For the student therapists, training consisted of a 24-hour workshop prior to working with families as well as weekly group supervision and individual supervision to discuss clinical concerns and adherence to the PCIT treatment protocol. Initial and ongoing training was led by the Ph.D.-level clinical psychologist and LCSW, both of whom had extensive experience with PCIT.

PCIT sessions were held in two CMHC therapy rooms equipped with living room furniture, a table, and chairs. The therapy rooms were connected by an observation room with one-way mirrors for monitoring sessions. One room served as the primary therapy room for meetings with families and observations of parent-child interactions. Following the beginning of PDI, the second room served as the time-out room, with slight modifications to remove potentially dangerous or easily damaged items (e.g., lamps, low-hanging pictures, easily movable chairs).

Following intake, families identified as potential candidates for PCIT attended two initial assessment sessions consisting of a clinical interview, parent-child observation, and administration of the child and parent functioning measures. In addition, the therapists provided an overview of PCIT and our ongoing research evaluation and reviewed the informed consent form. Two cotherapists conducted treatment sessions, which typically were scheduled weekly for 90 minutes. Posttreatment assessment (observation and the parent and child functioning measures) typically occurred 1 to 2 weeks following the session in which families met mastery criteria.

Measures

Various measures were used to assess child and parent functioning during the pre- and post-treatment assessment sessions. The measures pertinent to this study are described below.

Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999)

The ECBI is a 36-item measure of disruptive behavior developed for children between the ages of 2 and 16 years. Parents rate the frequency of behaviors on a 7-point scale (Intensity Scale) and endorse whether they perceive the behaviors to be problematic (Problem Scale). Intensity scores greater than or equal to 132 and problem scores of 15 or above are considered clinically significant (Eyberg & Pincus). One requirement for PCIT graduation is an Intensity score within one-half standard deviation of the normative mean (raw score less than or equal to 114). Strong inter-item correlations have been reported for both the Intensity Scale (.92 to .95) and the Problem Scale (.90 to .94) in low- to middle-income African American and Latino parents (Gross et al., 2007). In addition to pre- and posttreatment assessments, parents completed the ECBI Intensity scale at each session to gauge change in functioning and guide treatment.

Parenting Stress Index–Short Form (PSI-SF; Abidin, 1995)

The PSI-SF is a 36-item measure that assesses stress associated with parenting and the parent-child relationship. The measure provides a Total Stress score and the three factor analytically derived subscales of Parental Distress, Difficult Child, and Parent-Child Dysfunctional Interaction. PSI-SF scores above the 90th percentile are considered to be in the clinical range. The PSI-SF has demonstrated good reliability and is highly correlated with the original, longer PSI (Abidin, 1983). Higher scores on the PSI have been shown to be related to higher levels of disruptive behavior (Ross, Blanc, McNeil, Eyberg, & Hembree-Kigin, 1998). Reitman and colleagues demonstrated good inter-item consistency and construct validity for the PSI-SF in a sample of low-SES, African American parents (Reitman, Currier, & Stickle, 2002).

Dyadic Parent-Child Interaction Coding System–Third Edition (DPICS-III; Eyberg, Nelson, Duke, & Boggs, 2004)

The content and quality of parent-child interactions were assessed using the DPICS-III, a behavioral coding system. Extensive psychometric data are reported in the DPICS-III manual (Eyberg et al., 2004); however, there is a lack of psychometric research on the use of the DPICS with ethnic minority families (Butler & Eyberg, 2006). The DPICS coding system includes specific definitions for parent verbalizations and child responses to commands. Categories of parent verbalizations include behavior descriptions, reflections, labeled and unlabeled praise, neutral talk, questions, direct commands, indirect commands, and

negative talk. Child behavior following a parent command that provides an opportunity to comply is coded as compliance or noncompliance.

A 25-minute observation, including three 5-minute standardized situations of child-led play, parent-led play, and cleanup, was conducted during both the initial and posttreatment assessment sessions. Observations were videotaped, and graduate and undergraduate students independently coded tapes after comprehensive training and regular practice to prevent observer drift, as described in Lyon and Budd (2010). Kappa reliabilities on individual behaviors across 29 five-minute observation segments for the current cases ranged from .57 for negative talk to .89 for unlabeled praise. According to Landis and Koch (1977), Kappa values between .41 and .60 are considered moderate, between .61 and .80 substantial, and above .81 "almost perfect." For the purpose of this study, parental *Do Skills* (behavior descriptions, reflections, and labeled praises) were summed across the three standardized situations at initial and posttreatment assessment to create a total number of *Do Skills*. *Don't Skills* (questions, negative talk, and, during child-led play, direct and indirect commands) also were summed across the three situations.

Treatment length was calculated as the total number of weeks the family was enrolled in PCIT, from the initial assessment session to graduation, including missed or canceled sessions and holiday breaks. Attendance and number of treatment sessions provide measures of engagement. Failure to attend scheduled sessions was categorized as either cancelations (by the parent) or no-shows.

Case Descriptions and Results

Alex and His Mother

Referral Concerns and Family Context

Alex, a 5-year-old bilingual Mexican-American male, and his mother sought treatment after learning about it from another family at his school that had previously engaged in PCIT. Presenting concerns included aggressive behavior (e.g., hitting, scratching, and pushing adults and children) at home and school, temper tantrums, noncompliance, and low frustration tolerance. Alex resided with his biological mother, father, and 10-year-old sister. In PCIT, both parents are encouraged to participate whenever possible; however, due to the father's work schedule, Alex's father attended only the CDI and PDI Teach sessions. The family paid a sliding scale fee and fell in the middle-income range.

Alex had a history of motor, speech, and language delays and was diagnosed with an autism spectrum disorder (ASD) when he was 4 years old. Previous evaluations indicated that he fell within the high-functioning range. Alex attended a half-day kindergarten program and participated in physical, speech and language, and occupational therapies at school. Following the initial PCIT assessment, Alex was diagnosed with disruptive behavior disorder–not otherwise specified (DBD-NOS) in addition to ASD. There is a relatively small body of literature on the implementation of PCIT with children with ASD; however, PCIT recently has been used with ASD children in clinical and research settings (Solomon, Ono, Timmer, & Goodlin-Jones, 2008). Although our clinic generally does not provide services for children with primary diagnoses of ASD, PCIT was initiated after the assessment provided evidence of significant disruptive behaviors that met criteria for DBD-NOS. Alex had sufficient cognitive and language functioning to engage in PCIT, and he responded well to social reinforcement. Whereas many research-based PCIT programs require children to have a formal clinical diagnosis of an externalizing disorder and/or an ECBI Intensity score above the clinical level (i.e., ≥ 132) to be eligible for PCIT, our CMHC accepts children based on parental report and clinical interview confirming behavior problems, and thus Alex was accepted despite his mother's initial ECBI Intensity scale score of 131 (see Table 1).

Course of Treatment

Alex's mother was highly motivated and engaged in treatment, completing PCIT in a total of 13 treatment sessions (see Table 2). Because of Alex's ASD diagnosis, PCIT was tailored to fit the specific needs of this family, as suggested by McDiarmid and Bagner (2005) and Masse, McNeil, Wagner, and Chorney (2008). For example, coaching addressed particular concerns related to repetitive and stereotyped behaviors by teaching the mother to refrain from reflecting repetitive speech and describing stereotyped behaviors. Alex presented with sensory sensitivities and difficulty with mealtime (e.g., temper tantrums and aggressive behavior). Relevant food toys were used during live coaching to reinforce appropriate food-related behaviors and ignore negative behaviors while Alex and his mother engaged in pretend cooking and eating. For Alex, hugs were found to be particularly reinforcing.

During initial assessment, Alex's mother had a high rate of instructions and questions across all three situations. Numerous positive changes were demonstrated following treatment, including reductions in parent-reported problems and observed increases in maternal use of *Do Skills* (as shown in Table 1 and Fig. 1, respectively). Alex's mother became more comfortable allowing him to lead the play, as evidenced by a substantial decrease in number of Don't Skills (see Fig. 2), and Alex displayed increased positive engagement with his mother and the play activities. Alex's mother also demonstrated mastery of direct commands and consistent use of time-outs in PDI. Her ECBI scores declined steadily throughout treatment, and Alex did not meet criteria for DBD-NOS at the end of PCIT. Additionally, the mother's PSI-SF scores indicated a decrease in parental stress related to parent-child interactions and having a difficult child. A serious health issue of Alex's

Table 1
Scores on Parent-Report Measures at Pre- and Posttreatment Across Cases

	Alex	Justin	William	Aaron	Timmy
Eyberg Child Behavior Inventory (Raw Scores)					
Intensity Scale					
Pre	131	226*	139*	182*	148*
Post	84	104	68	51	45
Problem Scale					
Pre	15*	30*	3	36*	13
Post	7	18*	0	13	0
Parenting Stress Index-Short Form (Percentile)					
Parental Distress Scale					
Pre	90*	95-99*	55	65	5-10
Post	90-95*	20	50	75	5-10
Dysfunctional Interaction Scale					
Pre	80	95-99*	85	95-99*	35
Post	50	40	80	90-95*	5
Difficult Child Scale					
Pre	95*	>99*	85	95-99*	95-99*
Post	75	75	30	80	5
Total Stress Scale					
Pre	95-99*	>99*	80-85	95-99*	60-65
Post	85	45	55-60	85-90	1-5

* Indicates scores *above* the clinically significant cut-off: ECBI Intensity Scale≥132, ECBI Problem Scale≥15, PSI-SF (all scales)≥90th percentile.
Note: Parent for Aaron is Father 1; Parent for Timmy is Father 2.

grandparent at the end of treatment was reported as a significant stressor for the family; however, they were able to complete PCIT successfully.

Justin and His Parents

Referral Concerns and Family Context

Justin was a 4-year-old, Puerto Rican, African-American, and Caucasian male who attended a public school Montessori program. The family was self-referred due to aggressive behaviors such as biting, hitting, and spitting that had led to expulsion from a previous school placement and multiple suspensions from his current school. Additionally, Justin was frequently noncompliant at home, and instructions needed to be repeated in order for him to follow through on simple tasks. PCIT began with Justin and his mother, as his father had recently left the home due to substance abuse issues. Two months into treatment, Justin's father reentered the home and began participating in PCIT sessions. Although both parents were involved in the majority of treatment, pretreatment measures were collected only from Justin's mother; thus, we primarily address information gathered from her. The family was lower income, both parents worked in the service industry, and they paid a nominal fee ($5) for sessions.

Justin was diagnosed with attention-deficit/hyperactivity disorder (ADHD)–combined type and oppositional-defiant disorder (ODD) based on reports from multiple adult caretakers, school and clinical observations, and a full developmental and educational evaluation. During intake, information gathered about his mother's mental health indicated that she was displaying high levels of psychopathology. She reported a history of depression and anxiety, for which she had received treatment in previous years. Moreover, she appeared somewhat disheveled and lethargic in early sessions, was often late, and reported missing two late-morning sessions because she overslept.

Course of Treatment

Justin and his family successfully completed PCIT over the course of 41 weeks, attending a total of 29 treatment sessions (8 CDI sessions, 18 PDI sessions, and 3 "other" sessions to review treatment progress and Justin's school behavior), as shown in Table 2. Justin's mother solely attended 8 of the sessions, his father solely attended 3 sessions, and they jointly attended 18 sessions.

At initial assessment, Justin's mother reported high levels of behavioral concerns and parental stress (Table 1), and she displayed little positive attention to Justin in parent-child interactions (Fig. 1). Over the first four observations, Justin's mother had a low rate of verbalizations in CDI play sessions, and 17% of her total verbalizations were *Do Skills*, based on PCIT therapists' coding. As sessions progressed, however, the mother's proportion of *Do Skills* verbalizations to total verbalizations (i.e., labeled and unlabeled praise, behavioral descriptions, reflections, questions, commands, negative talk, and neutral talk) during the 5-minute play observations steadily increased (see Fig. 3). Specifically,

over the course of the next 12 sessions, 64% of her total verbalizations were *Do Skills*. This pattern indicated that, although the mother had low verbal fluency, she became increasingly proficient in *Do Skills*.

Due to complicating factors that arose in Justin's case, minor accommodations were made and supplemental treatment options were arranged for the family during PCIT. First, the PCIT therapists referred Justin's mother for individual therapy sessions with a separate CMHC therapist in order to address her depressive and anxiety symptoms. Second, the therapists consulted with Justin's teachers in order to teach PCIT skills for use with Justin in the classroom. Third, CDI mastery criteria were relaxed for Justin's mother. After five CDI Coach sessions, the mother displayed 14 behavioral descriptions, 8 reflections, and 6 labeled praises in a 5-minute observation period, yet the therapists decided to move on to the PDI phase before she reached the standard mastery criteria of 10 PRIDE skills in each category. These decisions were made based on the fact that the mother was highly distressed about Justin's home, school, and in-session behavior (e.g., he was openly defiant and difficult to redirect). She also appeared to have serious mental health issues that impeded her ability to reach mastery criteria, and she was at imminent risk of dropping out of therapy. Moreover, Justin's father began treatment and displayed a high rate of PRIDE skill usage within two CDI coaching sessions. Moving to PDI before mastery criteria for CDI have been reached is not typically recommended in PCIT, and in this case, the decision was made only after careful review and consultation with the doctoral supervisor.

After the 6th PDI Coach session, Justin was suspended from school again. His mother was highly distressed and reported that Justin required individual therapy. Based on the clinical conditions, a decision was made to convene a joint therapy session involving Justin's mother, her individual therapist, and the PCIT therapists. The goals of the meeting were to address the recent setback in Justin's behavior while continuing to focus on the progress that had been made in PCIT thus far, explain that individual therapy sessions for Justin were not recommended by the therapists at that time, and allow Justin's mother the option of terminating PCIT and obtaining a referral for another agency that might provide the therapy modality that she requested. This meeting appeared to be a turning point for Justin's mother, as she learned that all of the therapists were united in recommending PCIT for her family. This meeting also may have put Justin's recent school incident into perspective and helped her to recognize that PCIT was addressing their needs. The family eventually completed PCIT successfully, with both parents meeting standard mastery criteria for PDI.

By the end of treatment, Justin's ECBI Intensity score had decreased by 122 points, and the mother reported substantial decreases in parental distress (Table 1). Her level of *Do Skills*, while still below the rate expected for CDI mastery, was well above her baseline levels (Fig. 3). In the posttreatment DPICS observation, however, Justin's mother used minimal PRIDE skills (Fig. 1). Her demeanor was depressed and irritated, suggesting that she was still subject to periods of distress that affected her interactions. At posttreatment, Justin's teachers indicated that his aggressive and destructive behavior in the classroom had decreased; however, inattentive symptoms persisted. His parents and teachers reported that they felt confident in managing his behavior, and his mother stated that her anxiety and depressive symptoms were being addressed in individual therapy.

After completing PCIT, Justin and his family continued in services at the CMHC. Justin received individual therapy and family therapy, and one of the PCIT therapists continued to consult in the school. In addition, Justin's mother became an advocate for PCIT and provided referrals within the community.

William, His Biological Mother, and Foster Mother

Referral Concerns and Family Context

William, a 3-year-old African-American male, his biological mother, and his adult biological sister were mandated by child protective services to attend the PCIT program. William was born cocaine exposed and lived with his mother in a substance abuse treatment facility for his first year. At age 2, a relapse led to his removal from his mother, and he was placed with his adult sister (designated as his foster mother). Other adult relatives lived in the family home but were not engaged in PCIT. The child protective caseworker hoped to eventually return William to his biological mother's custody, and successful completion of PCIT was one of the benchmarks used to assess maternal progress toward that goal. Initial assessment at the CMHC indicated that the child met criteria for DBD-NOS due to oppositional behavior, argumentativeness, and frequent temper tantrums. William's mother was undergoing day

Table 2
Treatment Length and Attendance Across Cases

	Alex	Justin	William	Aaron & Timmy
Length of Treatment				
Weeks	19	41	49	23
Attendance				
CDI Sessions	7	8	7	6
PDI Sessions	6	18	12	10
Other Sessions	0	3	1	0
Cancellations	1	4	19	2
No Shows	1	2	3	0
% Sessions Attended	87	83	45	89

Note. CDI = Child Directed Interaction; PDI = Parent Directed Interaction.

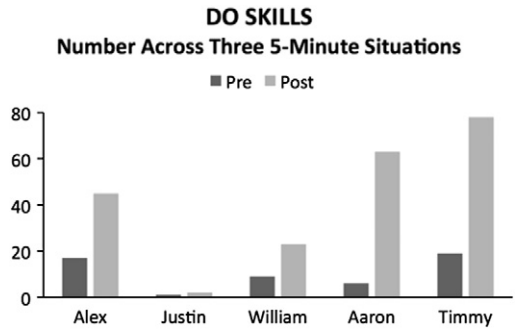

Figure 1. Frequency of *Do Skills* for each child's parent during DPICS situations at pre- and post-assessment.

treatment and outpatient therapy for drug and alcohol addiction through various nonaffiliated mental health agencies, and she lived in a halfway house for women with substance abuse problems. She was allowed to have supervised visits with William on the weekends and one night per week, and the amount of contact allowed increased across treatment.

Course of Treatment

William and his family were enrolled in PCIT over the course of 49 weeks. They attended 19 PCIT sessions (7 CDI, 12 PDI) and 1 "other" session called to discuss the family's inconsistent attendance. William's mother attended all of the held sessions, and his foster mother attended 13 (68%). A major factor affecting the family's progression through PCIT was the high rate of canceled appointments (Table 2). Their reported reasons for missing sessions included attending to ill family members, scheduling other appointments during regular session time, and occasionally oversleeping, even though appointments were scheduled in the late afternoon. In addition, they had transportation and logistical issues, likely related to the fact that the family resided over 10 miles away from the treatment facility and relied on public transit. A further complicating factor was

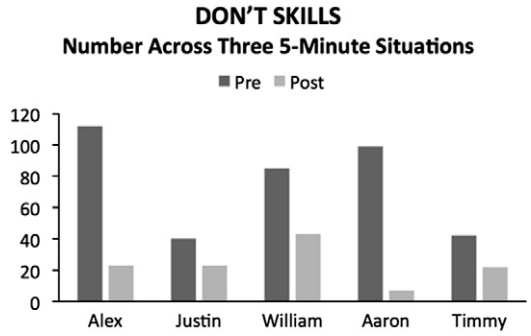

Figure 2. Frequency of *Don't Skills* for each child's parent during DPICS situations at pre- and post-assessment.

that William's mother was not allowed unsupervised visitation until late in treatment. If his foster mother or the family's social worker could not attend sessions, William and his mother were unable to attend. The PCIT therapists had regular contact with William's child protection caseworker in the first several months of treatment in order to coordinate care and search for possible solutions to the ongoing attendance issues (e.g., by having the caseworker bring the family to sessions). After a new caseworker was assigned, efforts to her coordinate care were no longer successful, although the PCIT therapists provided summary reports of the family's treatment progress and attendance pattern when requested by the caseworker or the court.

At the beginning of treatment, William's foster mother in particular struggled with his defiant behavior, which appeared to be maintained by her attention. Through treatment, she was able to learn how to attend to prosocial behavior and ignore aggravating behavior (e.g., humming loudly in a high pitched voice), which decreased when William no longer received as much attention for misbehaving as he had in the past. As a result, his foster mother appeared to relax and enjoy playing with him as sessions progressed. His foster mother unfortunately dropped out of PCIT prior to reaching mastery criteria, although her use of the skills improved notably. The foster mother did not provide reasons for dropping out of therapy. It is possible that the change in caseworker and the difficulty maintaining communication between the PCIT therapists and caseworker made it easier for the foster mother to disengage from treatment. Informally, it appeared that the new caseworker did not hold the foster mother accountable for missing sessions, and the new caseworker eventually said that the foster mother did not need to attend in order for the family to complete therapy. Moreover, there was some indication that the foster mother was receiving messages from the nonparticipating adults with whom she lived that problems are not to be shared with anyone outside the family, let alone "professionals."

Coincident with the foster mother's decision to stop attending sessions, William's biological mother was granted unsupervised visitation. Thus, she was able to bring William to PCIT sessions on her own. Although the pattern of inconsistent attendance continued, William's mother eventually displayed mastery with CDI and PDI skills. She was able to set limits (something that she reported was difficult for her due to guilt about not living with him) and manage William's behavior.

Because William's mother was considered the primary parent for PCIT, her data are reported in Table 1 and Figs. 1 and 2. At posttreatment assessment, William's mother reported markedly reduced levels of behavior problems and lower levels of parenting stress related to the child's

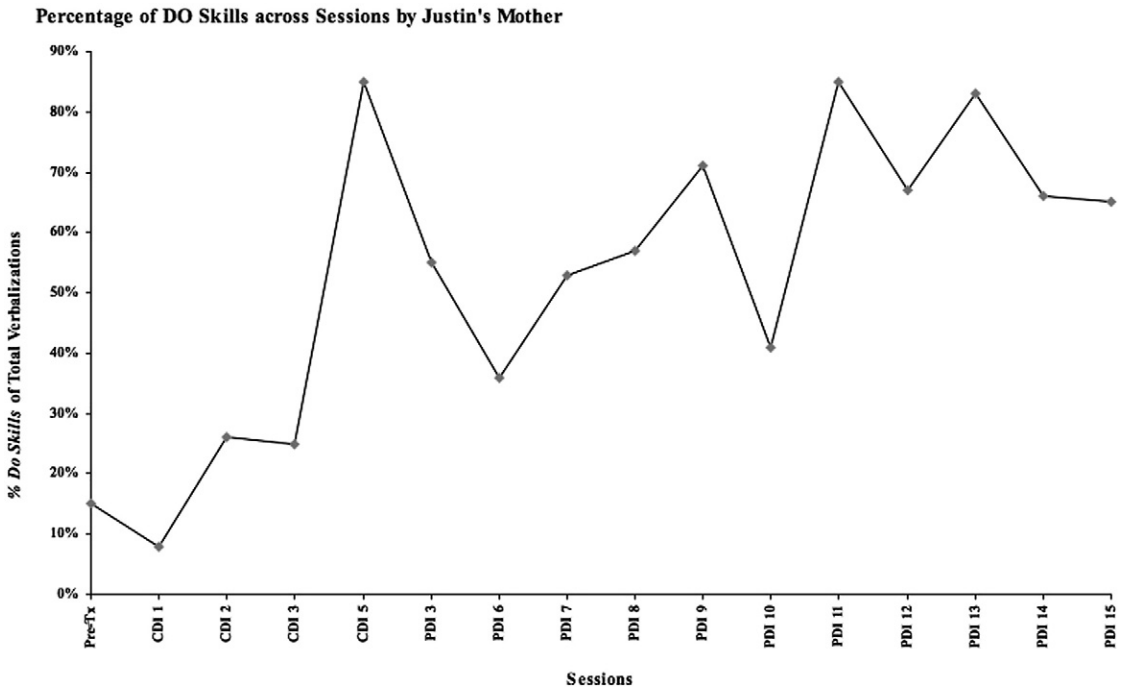

Figure 3. Percentage of *Do Skills* relative to total verbalizations across sessions by Justin's mother. Note: Coding of the mother did not take place in all sessions, sometimes due to time constraints, because the session focused on the father, or because the PCIT protocol did not call for coding in the session.

behavior (Table 1). Moreover, William no longer met criteria for DBD-NOS. Parent-child interactions at post-treatment assessment showed desired changes in both *Do* and *Don't Skills* (Figs. 1 and 2). During the graduation session, the mother requested booster sessions, stating that she knew she would need them. Regrettably, within 2 weeks after completing PCIT, the mother was found to have relapsed on drugs, and she moved away with William before being caught and losing custody of him yet again. This tragic ending led us to surmise that some of the missed sessions may have been related to the mother's return to using substances.

Timmy and Aaron and Their Parents

Referral Concerns and Family Context

The parents of Timmy and Aaron, 5-year-old, African American male twins, sought treatment for their sons' oppositional, defiant, and destructive behavior at home and school. According to their parents, the twins damaged thousands of dollars worth of property at home, and their school teacher said they were the "worst kids she has seen" in her long career. Timmy and Aaron were brought to the CMHC by their adoptive father (Father 1) of European American descent and his romantic partner (Father 2) of Latino descent. (Although Father 1 was the legal guardian, the family and clinicians referred to Father 2 as father as well.) The twins were adopted at the age of 2 from the state's child welfare services after a history of neglect. At the time the case was opened, the fathers had been dating for approximately 1 year. The fathers were professionally employed, were considered middle-to-upper income, and paid the full sliding scale rate, which is atypical in our clinic.

Aaron was diagnosed with ODD and ADHD-combined type. He had been prescribed psychostimulant medication to address inattention and hyperactivity symptoms by his psychiatrist before coming to our clinic and was taking medication during PCIT. Timmy was diagnosed with ODD. Parents' self-reports of stress and symptoms suggested that Father 1 may have underreported his own stress. Contrastingly, Father 2 reported experiencing high levels of personal stress and depressive and anxiety symptoms. He informed the PCIT clinicians that he had received treatment for depression in the past.

Course of Treatment

The standard PCIT protocol is conducted with one identified child client. Siblings may be included in later PDI sessions if parents have identified specific sibling concerns. This plan and the logic underlying it were discussed with the parents at intake; the fathers explained that both children presented serious concerns, and they requested that both children be included in PCIT. This

option has been suggested as an alternative when there are two identified children and two participating parents (Gurwitch & Funderburk, 2008). At the outset, the clinicians decided that each parent would complete pre-, during-, and posttreatment measures for only one child. The reason for this decision was twofold: (a) continuity of reporter for each child was important for maintaining accurate evaluation, and (b) the clinicians did not want to overburden the fathers with paperwork. To determine which parent would assess which child, clinicians asked fathers if they had a preference. The fathers, on their own accord, decided to choose the child they felt was "most challenging" to them: Father 1 chose Timmy; Father 2 chose Aaron.

Although the fathers completed assessment measures on only one child, they were coached interacting with both children individually and switched every other session. For example, during CDI Coach 1, Father 1 played with Timmy, and Father 2 played with Aaron. During CDI Coach 2, Father 1 played with Aaron, and Father 2 played with Timmy. After both parents met mastery criteria in CDI and PDI, one parent at a time was coached with both boys simultaneously in order to address sibling interaction problems, which were of particular concern to this family. For homework, fathers were assigned to work with both children daily, so as not to have the children feel favored by one father over the other.

At pre-assessment, both children had clinically elevated ECBIs (see Table 1). After four treatment sessions, the clinicians observed that Father 2's ECBI Intensity scores for Aaron were still very high, whereas Father 1's scores for Timmy showed steady declines and were below the clinical cutoff. The clinicians were concerned that the children's behavior might not be the only factor influencing ECBI scores: Perhaps the individual parents' stress and symptoms were biasing their reports. Additionally, the clinicians considered that the fathers' distinct family histories and cultural perspectives on parenting and child behavior might have influenced their reports. Consequently, the clinicians decided to have both fathers complete ECBIs for both sons every week.

After several weeks of further treatment, Father 1 reported large reductions in both children's EBCI Intensity scores, and Father 2 reported little to no improvement in either child (Fig. 4). What was surprising was that both parents were verbally reporting improvements in both children's behavior at home, at school, and in public. At Week 14 (PDI 7), clinicians decided to address directly the discrepancy in ECBI scores between fathers as well as the discrepancy between ECBI scores and verbal accounts of the children's behavior. The clinicians broached the subject by showing the ECBI graphs to the fathers and reviewing specific items on the ECBI. With minimal probing from the clinicians, the fathers communicated about how they perceived their children's behaviors. They recognized that they, in fact, defined certain behaviors differently, and Father 2 noticed that he was allowing his pretreatment views of the children to impact his weekly ECBI reports. Father 2 stated that he found it difficult to "compartmentalize" the children's behaviors. The next session, Father 2's scores declined below the clinical cutoff for both children, and the following session, scores further decreased, and the family graduated.

After a total of 16 treatment sessions, the family completed the PCIT program. At the end of treatment, ECBI scores for both boys were substantially reduced, Timmy no

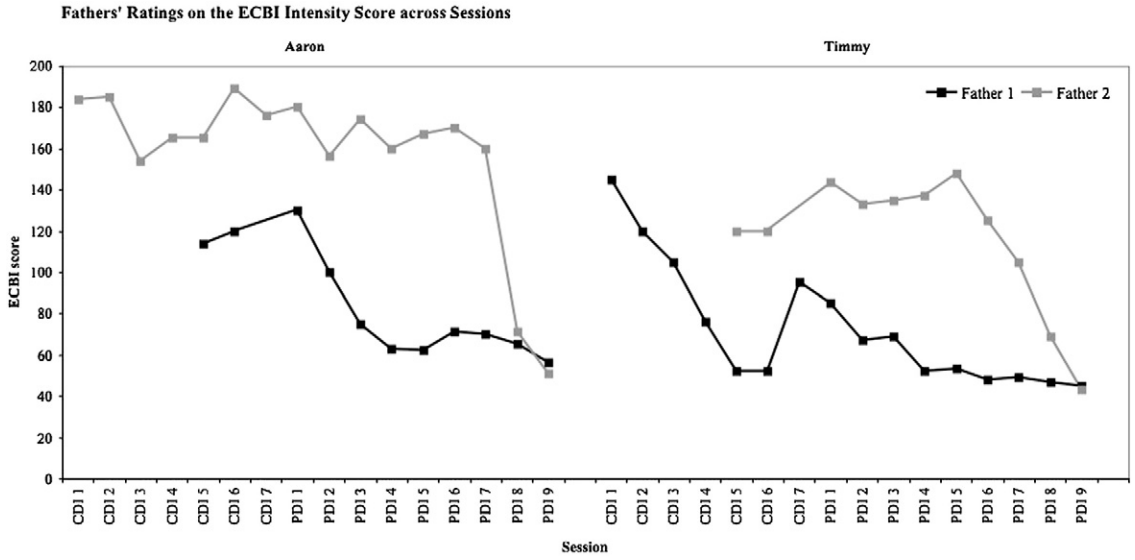

Figure 4. Aaron and Timmy's ECBI scores across sessions as reported by each father. Discontinuity in the lines is related to fathers not completing ECBIs for both children every week.

longer met criteria for ODD, and Aaron no longer met criteria for ODD and ADHD. Further, both parents displayed dramatic changes in *Do* and *Don't Skills* during parent-child interactions (Figs. 1 and 2). At posttreatment, Father 1 showed decreased stress levels, but Father 2 continued to report elevated stress levels (Table 1). Notwithstanding challenges faced during treatment, the family demonstrated significant gains in therapy and reached graduation.

Discussion

This study sheds light on an important, understudied topic by describing the course of PCIT for four families treated in an urban CMHC and highlighting treatment issues that arose in this setting. All families successfully completed treatment, yet each case likely would have been excluded in EST research studies due to various reasons. For example, Alex's primary diagnosis was ASD, Justin's mother presented with serious mental health problems, William was a ward of child protective services and was not living with his mother, and Timmy and Aaron were twins who were both identified clients and whose two fathers participated in treatment. All of the children were of ethnic minority backgrounds, and two of the families were very low income—conditions less likely to be encountered in research settings than among community mental health clientele. Transporting ESTs to service settings entails a balance between fidelity and adaptation in order to fit contextual and client issues of the setting (McHugh, Murray, & Barlow, 2009). Below, we summarize and reflect on the changes we made in response to individual issues that arose in delivering PCIT in a community setting.

Accommodations to the Treatment Protocol

Because our CMHC operates within a system that offers more flexibility than a controlled research setting, we had the opportunity to structure sessions, enroll families, and accommodate services to individual families. Typically, we scheduled 90 minutes rather than the traditional 50 or 60 minutes for PCIT sessions in order provide time for case management issues, rapport building, and periodic review of the treatment plan. Our entry criteria for PCIT did not require children to have ECBI scores above the clinical level, as long as parent report and clinical interview confirmed the presence of disruptive and oppositional behavior. This allowed us to treat clients such as Alex, whose pretreatment ECBI score was one point below the clinical cutoff but who presented with substantial behavior problems.

We also allowed flexibility in terms of which family members attended treatment and how often they attended. In three of our four cases, one of the two identified parents did not attend all PCIT sessions. For Alex, his father's work schedule permitted him to attend only CDI and PDI Teach sessions, Justin's father began to attend PCIT several months into treatment due to the fact that he was not living in the home at the time treatment began, and William's foster mother dropped out before she successfully completed treatment. In the current cases, the children's behavior improved in spite of the lack of full treatment participation by both caregivers, although they likely would have benefited further by both caregivers' involvement throughout treatment. The PCIT protocol allows for variations in the focus or delivery of essential ingredients based on the unique features of the individual case (Eyberg, 2005; McNeil & Hembree-Kigin, 2010). Flexibility in parent participation when dictated by changing family conditions represents one such characteristic. Families seen in CMHCs deal with circumstances (such as limited discretion in their employment conditions, transportation barriers, or family instability) that make regular session attendance by both parents difficult, so flexibility in which family members attend treatment may often be needed.

We also tailored the PCIT protocol to address clinical issues of the individual cases. Due to Alex's primary diagnosis of autism, his mother was coached not to imitate stereotyped behavior or reflect repetitive speech. Sensory issues involving food also were identified, and the therapists chose meal-related toys during PDI for the purpose of reducing those behaviors. In the case of the twins, Timmy and Aaron, the presence of two parents in treatment provided an opportunity to focus on both children as identified clients during PCIT. The therapists decided that both children would take turns interacting with one of their parents each week by alternating the parent-child dyad coached across sessions. Additionally, both parents completed daily homework with both of the children separately. These changes appear to fit within the tailoring built into the PCIT treatment protocol. This family was highly motivated to engage in treatment, whereas such recommendations might overburden families in which this is not the case.

The most substantive accommodations to the treatment protocol occurred in the cases of Justin and William. Specifically, we decided to move Justin's family to PDI before his mother met standard mastery criteria in CDI. This decision may have compromised the ultimate effectiveness of PCIT for Justin, in that it shifted the emphasis from building a positive parent-child relationship to also introducing behavior management techniques to deal with discipline concerns. Some applications of PCIT (i.e., in a group training format) have employed time-limited treatment for practical reasons (Niec, Hemme, Yopp, & Brestan, 2005); however, there are sound theoretical and clinical reasons for continuing CDI until mastery criteria are reached, and efficacy trials demonstrate desired outcomes of PCIT when applied with fidelity. The decision to move to PDI in this case involved several discussions between the PCIT therapists and the supervisor, and it was ultimately

made based on the severity of the child's behavior, the mother's psychopathology, the need for effective discipline by the family and the school, and the high risk of dropout. The PCIT protocol calls for therapists to continue to focus on CDI skills throughout PDI. Even so, it is possible that moving the family to PDI before the mother reached traditional mastery criteria for CDI lengthened treatment; the family required 18 PDI treatment sessions to achieve PDI mastery.

In the case of William and his family, we decided to maintain the family in PCIT despite highly irregular attendance. The family was initially referred for parent training services both due to the biological mother's involvement in the child protection system and William's behavior problems. Her primary issue was cocaine dependence, which had led her to make poor parenting decisions. William's foster mother was inconsistently engaged and ultimately dropped out before she completed treatment. Additionally, the family canceled as many appointments as they attended. Although efforts were made to coordinate with the child protection caseworker, these efforts were not sufficient to resolve the attendance issues. The family appeared to benefit from PCIT by strengthening the mother-child relationship and providing consistency and structure to the family system; however, William's mother relapsed after completion of PCIT. Thus, it remains an empirical question whether it is advisable to enroll and continue to engage a family with the aforementioned presenting problems and treatment concerns. At the least, it is recommended to have a structured plan for regular caseworker-therapist contact when providing PCIT to families involved in child protection services.

In spite of all four families successfully completing PCIT, the total length of time each family was involved in treatment varied widely, ranging from 19 weeks for Alex's family to 49 weeks for William's family. In these four cases, it appeared that the caregivers with more severe levels of current psychopathology (i.e., Justin and William's families) completed treatment at a much slower rate than the other families. Of the two families with high levels of parental psychopathology, variability in the type of mental illness and in the parents' ability to cope with their illness may have impacted the families' outcomes. For example, William's mother had a long history of substance dependence that led to poor judgment, and her substance abuse was substantial enough that her son was removed from her care. Although information on the mother's substance use during the course of PCIT is unknown, it is possible that she began using substances again before it became known that she had relapsed, and this may have contributed to her inconsistent attendance.

Justin's mother also displayed significant psychopathology in the form of depression and anxiety, but she continued to carry out her role as a parent. Justin's mother appeared to function somewhat better when her husband came back into the home and began attending PCIT sessions; furthermore, she seemed to become more engaged in PCIT after she began individual therapy for her own mental health issues. Thus, it is possible that the type of psychopathology and the presence of supportive resources affected post-PCIT outcomes for these families: Justin's mother became an advocate for PCIT in the community, whereas William's mother relapsed. Although PCIT has been shown to reduce distress related to parenting, addressing other aspects of parental psychopathology goes beyond the intended scope of PCIT. In some cases, parallel services (e.g., individual or group therapy) may be helpful for parents presenting with significant psychopathology, as appeared to be the case for Justin's mother. However, adjunctive services require a commitment of time, energy, and resources that may actually detract from parents' focus on PCIT (cf. Chaffin et al., 2004), so therapists should be cautious in generalizing from this case.

In two of the four families, Timmy/Aaron and Justin, the therapists held discussions with the parents to address obstacles in the treatment progress, and these discussions appeared to be turning points in the families' commitment to and progress toward successful PCIT completion. In the case of Timmy and Aaron, the discussion was initiated by the PCIT therapists due to concerns about Father 2's unchanging ECBI ratings of Aaron's behavior. The unchanging ratings were in contrast to both fathers' verbal reports of Aaron's (and Timmy's) improved behavior and both fathers' mastery of CDI and PDI skills. This inconsistency between quantitative and qualitative reports signaled to the clinicians that a conversation with the fathers about this discrepancy may be necessary for treatment to progress.

For Justin, the discussion was preceded by his mother calling the CMHC director to request individual therapy for her son after his school suspension for aggressive behavior. In addition to the immediately identifiable stressor, she had previously reported doubts about whether PCIT could meet her family's needs. PCIT therapists also had noticed a trend in missed sessions, which led them to believe that Justin's mother was struggling to "buy in" to the treatment. The PCIT therapists, in conjunction with the mother's individual therapist, were able to discuss examples of how the mother's depression and anxiety might have been contributing to her reaction to the recent event. Moreover, the overall tone of this session was to support his mother in making her own decision about whether to continue with PCIT, and this ultimately may have led to a stronger commitment to remain in therapy after she made that decision.

In addition to the therapy process factors that prompted the therapists to adapt treatment or meet with the family about progress in these cases, several other challenges may arise that potentially can derail treatment. Some of these issues (e.g., difficulties with homework completion,

resistance to using time-out consistently and in the recommended format) are likely to be encountered in any clinical setting, and others (e.g., acceptability of using positive attention rather than negative attention to control child behavior, lack of experience being played with as a child and awkwardness in that role) may be more commonly associated with cultural or ecological characteristics of clientele served in community-based settings. The PCIT protocol provides guidance for dealing with many therapy process issues, often by using behavioral instances during coaching as teaching opportunities to reinforce the principles underlying PCIT skills. Time is allotted at the beginning and end of PCIT sessions to review issues and problem-solve with parents about issues to facilitate engagement. As PCIT is applied more broadly in community settings, it will be important to learn if and how therapists have identified effective strategies for addressing these issues in PCIT treatment.

Limitations and Future Directions

There are several limitations of this study, including its case design nature that precluded experimental control and the lack of follow-up data. Another limitation of this study is that our CMHC differs from many other community service settings, and thus the results may be restricted in generalizability. Our center's placement in a university context provides resources to support treatment fidelity, such as access to a therapy room with a one-way mirror, audio-visual equipment, undergraduate research coders, and a research-oriented supervisor. The center's training mission supports our use of a cotherapy model and close supervision of trainees. The focus on treatment-seeking youth and families with limited means is similar to other community-based clinics, yet this center's philosophy of engagement allows for more flexibility than is available in some other community settings (e.g., a bendable attendance policy and access to supplemental therapy services when needed). It is unclear whether such flexibility would be possible or advisable in other settings.

On the other hand, because of the uniqueness of this CMHC and diversity of its clients, the case descriptions provide valuable information about the effectiveness and limitations of PCIT under circumstances unlikely to be encountered in controlled research settings. Each of the current families completed PCIT, without compromising the core elements of PCIT as defined by its founder and other PCIT experts (Training Guidelines for PCIT, 2009). The findings suggest areas for further research to determine whether the accommodations made in these cases might be effective with other families with similar circumstances.

Research has already demonstrated that PCIT is effective for diverse families, including children with moderate mental retardation (Bagner & Eyberg, 2007) and families with a history of physical abuse (Chaffin et al., 2004), and pilot work suggests its applicability for children with autism (Solomon et al., 2008). Questions to address in future research may include: To what extent is generalization facilitated by having a second caregiver participate in PCIT, even for a limited number of sessions, compared to having only one parent participate? How are PCIT outcomes affected by relaxing CDI mastery guidelines in the presence of clinical issues such as a parent's serious mental health condition? What is the relative effectiveness of treating a single identified child in PCIT as compared to including behaviorally disruptive siblings in treatment together, particularly when two parents participate? Do the costs of retaining families in treatment despite irregular attendance outweigh the benefits?

These and other questions, fueled by clinical research in community settings, offer new directions for PCIT researchers. In light of widespread national efforts to disseminate state-of-the-art empirical treatment approaches into clinical practice, there is a need for research into issues that arise in transporting ESTs into clinical settings. It is important to determine the conditions necessary for successful implementation of PCIT outside of controlled research settings, and how much versatility can be exercised by service providers without compromising the effectiveness of PCIT. This knowledge will add to the existing literature documenting the robust nature of PCIT treatment for families of young children with disruptive behavior disorders.

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