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Using Behavioral Parent Training to Treat Disruptive Behavior Disorders in Young Children: A How-to Approach Using Video Clips

Joaquin Borrego, Jr. and T. Lindsey Burrell, *Texas Tech University*

This article describes the application of a behavioral parent training program, Parent-Child Interaction Therapy (PCIT), in the treatment of behavior disorders in young children. PCIT is unique in that it works with both the child and parent in treatment and it focuses on improving the parent-child relationship as a means to improving parent and child behaviors and interactions with each other. A case illustration is provided and video components are included to highlight the procedures and concepts used in PCIT.

It is not uncommon to observe young children in public or at home engaging in transgressions such as whining or not complying with a command. For some children, these behavior problems persist over time and become severe enough to warrant clinical attention. Oppositional-defiant disorder (ODD), a disorder characterized by a pattern of defiance, disobedience, and hostile behavior toward authority figures, is one of the most common childhood diagnoses (American Psychiatric Association [APA], 2000). Persistence of these symptoms, specifically noncompliant behavior, has been found to contribute to conduct problems (Chamberlain & Patterson, 1995) that could lead to conduct disorder (CD), which is usually diagnosed in middle childhood to middle adolescence (APA, 2000). Symptoms of CD include aggression toward people and animals, destruction of property, deceitfulness or theft, and other serious rule violations (APA, 2000). Long-term outcomes have shown that approximately 80% of children who meet criteria for CD will likely have a psychiatric disorder in adulthood (Kazdin, 2005). Children with CD also typically have difficulty in academic tasks, have poor social skills, and have deficits in cognitive processes contributing to problems in interpersonal relations (Kazdin). Additionally, children with externalizing behavior problems pose stressors on the parent-child relationship that may interfere with their interactions (Buschbacher, Fox, & Clarke, 2004). Due to the poor outcomes of children who exhibit these symptoms early in life and the impact it has on the parent-child relationship, it is important to address these symptoms to prevent future behavioral and social problems.

[1] Video patients/clients are portrayed by actors.

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Conceptualization of Child Behavioral Problems

As stated above, it is common for young children to engage in behavioral transgressions such as whining and noncompliance. There is a subset of children where these behavior problems persist and worsen over time. We use Patterson's (1982) *coercion model* to explain the development and maintenance of behavior problems in young children. Patterson's model emphasizes the influence that a parent's behavior has on a child and the impact that the child's behavior has on the parent. More specifically, in some families, a coercive interaction pattern develops over time between the parent and the child. In some families, parent-child relationships are characterized by aversive patterns of negative interactions (e.g., parent yells at the child and, in turn, the child whines) and the tendency to handle problems in a coercive, negative manner (e.g., resorting to spanking as a discipline strategy). In addition to having negative interaction patterns, there are generally lower rates of positive parent-child interactions and children also tend to model their parents' physical and verbally aggressive behaviors (e.g., yelling). Parents are usually unsuccessful in using noncoercive parenting strategies (e.g., redirection) in managing their child's behavior and an escalation of negative interactions between the parent and the child occur over time (Patterson).

In these types of interactions parents and children use aversive control strategies to influence each other's behavior (Chamberlain & Patterson, 1995). As an example, a parent may give a command and the child may start whining in efforts of not having to comply with the command. The parent may withdraw the command in

attempts to get the child to stop whining. By withdrawing the command, the child's whining behavior is negatively reinforced. The parent is also negatively reinforced as the child stops whining once the command is withdrawn.

Children can also be positively reinforced for their negative behaviors. One example is when parents provide positive attention to the child during a temper tantrum. Parents may also provide other types of reinforcers (e.g., candy, toy, or soda) in efforts of getting the child to terminate the tantrum. Finally, in addition to reinforcing inappropriate behaviors, parents often fail to positively reinforce the child for engaging in prosocial behaviors. An example of this is when a parent does not socially reinforce a child for sharing toys with other children or sitting at the table for an extended period of time. Parents may erroneously think that children should be left alone when behaving appropriately.

From these types of parent-child interactions, interventions are needed that target parent-child relationships. More specifically, interventions that teach parents to (a) attend to the child's prosocial behaviors, (b) ignore the child's inappropriate behaviors, (c) decrease the use of punitive and coercive discipline strategies, and (d) increase the use of effective, noncoercive child management strategies could assist in changing coercive patterns of interactions and teach parents effective child management skills.

Behavioral Parent Training Interventions

Behavioral Parent Training (BPT) is a group of treatments derived from social learning principles that focus on parent-child interactions (Wierson & Forehand, 1994) where parents are trained to implement specific procedures to increase children's prosocial behaviors and decrease problematic behaviors (Kazdin, 2005). This treatment approach has been shown to be efficacious for the treatment of externalizing behavior problems in children (Serketich & Dumas, 1996). Several BPT interventions have been developed to target this population. These interventions share many common features such as developing positive parent-child interactions and decreasing disruptive behaviors by teaching parents to attend to prosocial behaviors and learning appropriate and effective discipline practices. However, these goals are achieved through various means, depending on the intervention. Several BPT interventions have been developed to target children with behavior problems and several evidence-based treatments have been shown to be effective in reducing child behavior problems for children between the ages of 2 and 8 (please see Brestan & Eyberg, 1998; Eyberg, Nelson, & Bogs, 2008; Farmer, Compton, Burns, & Robertson, 2002, for reviews of these interventions).

One of these treatments is Parent-Child Interaction Therapy (PCIT). PCIT is an evidence-based treatment generally used for preschool to early elementary school age children with externalizing behavior problems (Hembree-Kigin & McNeil, 1995; Neary & Eyberg, 2002). Although there are numerous BPT interventions, PCIT differs in some important ways. First, PCIT focuses on both the parent and the child in treatment where other BPT interventions primarily focus on teaching the parent skills to use at home with the child. By having the parent involved, this allows parents to use the skills they are learning in treatment with the child. Additionally, in-vivo coaching is used in which the trained therapist coaches the parent on appropriate verbalizations and behaviors to use while interacting with the child. This provides the opportunity for the parents to practice using the skills taught in PCIT while the child is engaging in either positive or problematic behaviors with the therapist available for immediate guidance and feedback. More specific treatment procedures used in PCIT will be highlighted in the following sections.

PCIT Overview

As discussed above, PCIT is an evidence-based psychosocial intervention developed for families with young children with socially disruptive behavior disorders (Bell & Eyberg, 2002; Brinkmeyer & Eyberg, 2003; Eyberg et al., 2008; Hembree-Kigin & McNeil, 1995; Neary & Eyberg, 2002). Children who present for PCIT services usually meet diagnostic criteria for either ODD or CD. PCIT is conducted in 1-hour weekly sessions and parents average between 12 to 16 sessions to complete the program (Eyberg et al., 2008). Although PCIT is usually carried out via a bug-in-the-ear device while the therapist coaches behind a one-way mirror, the therapist can also coach the parent while in the therapy room if the technology is not readily available. In PCIT, the therapist generally targets two domains in treatment: (a) improving the parent-child relationship, and (b) providing the parent with effective, noncoercive discipline techniques. Completion of the program is based on the parent meeting mastery criteria of certain behavioral skills (described below) in addition to a clinically significant decrease in the child's behavior problems.

There are numerous studies documenting the efficacy of PCIT in reducing child disruptive behavior problems (e.g., Hood & Eyberg, 2003). Treatment gains obtained in PCIT have been found to generalize across time (Eyberg et al., 2001) and effects have been found to generalize to siblings (Brestan, Eyberg, Boggs, & Algina, 1997). Recent work has focused on expanding the applicability to other populations such as physically abusive families (Chaffin et al., 2004; Timmer, Urquiza, Zebell, & McGrath, 2005),

children with chronic illness (Bagner, Fernandez, & Eyberg, 2004), developmental disabilities (McDiarmid & Bagner, 2005), and children with separation anxiety (Choate, Pincus, Eyberg, & Barlow, 2005). In addition, PCIT has also been applied with ethnic minority populations (e.g., Capage, Bennett, & McNeil, 2001; McCabe & Yeh, 2009) and in different languages such as Spanish (e.g., Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; Matos, Bauermeister, & Bernal, 2009) with promising results. Although most of the PCIT treatment outcome studies only include the parent and child in treatment, there is recent data to suggest that PCIT is also beneficial in group format (Niec, Hemme, Yopp, & Brestan, 2005). Most of the efficacy data available regarding PCIT is for families with young children between the ages of 2 and 8. In addition, although some outcome studies have included fathers, most of the outcome data available are from mothers in treatment.

PCIT Structure

One of the features of PCIT is that it is assessment driven. Before treatment begins, an intake session is conducted in which the therapist collects different types of information and data from the parent and/or other adult caregivers (e.g., grandparents) via a semistructured interview, self-report rating scales, and a 15-minute structured behavioral observation of the parent and child interacting with each other (Bell & Eyberg, 2002). The therapist uses the interview to gather a detailed history regarding when the problematic behaviors started and in what contexts they occur. This information assists the therapist with a conceptualization of the case. In addition, the therapist formulates a treatment plan and the goals of therapy are discussed and agreed upon by the parent(s) and therapist.

In addition to interviewing parents and other primary caregivers, the therapist also has the primary caretaker(s) complete the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) during the intake. This allows the therapist to quantify the child's behavior problems. The ECBI is a 36-item self-report measure that has two scales: the Intensity scale assesses the frequency of the behavior problems and the Problem scale assesses if the specific behaviors are problematic for the parents. The Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R; Eyberg & Pincus, 1999) is similar to the ECBI but is completed by daycare providers and teachers. In addition to assessing for child behavior problems, the therapist may also want to assess and monitor other important parent factors such as level of stress, depression, tolerance for behavior problems, etc.

The last integral component of the pretreatment assessment phase is to observe the parent-child dyad interacting with each other. The Dyadic Parent-Child Interaction Coding System–third edition (DPICS-III; Eyberg, Nelson, Duke, & Boggs, 2005) is used to code parent-child interactions. Using the DPICS-III allows the therapist to track verbalizations (e.g., behavioral descriptions, labeled praises), vocalizations (e.g., whining), and physical behaviors (e.g., positive touch) that allows the therapist to assess the quality of the interactions. The Revised Edition of the School Observation Coding System (REDSOCS; Jacobs et al., 2002) can be used to assess the child's disruptive behaviors in a daycare or school setting.

The 15-minute observation is broken down into three standard 5-minute segments. During the first segment, Child-Directed Interaction, the therapist instructs the parent that the child can pick any toy to play with and the parent is to follow the child's lead. This allows the therapist to assess how the parent follows and interacts with the child. In the second 5-minute segment, Parent-Directed Interaction, the parent is instructed to tell the child that it is the parent's turn to pick the play activity and that the child is supposed to follow the parent's lead. The last 5-minute segment involves a "clean-up" scenario in which the parent instructs the child to pick up the toys without the parent's assistance. This segment allows the therapist to assess how the parent gives commands and how they handle compliance or noncompliance.

Following the intake session, the parent attends a didactic session in which the first phase of treatment is explained in detail. The first phase of PCIT, Child-Directed Interaction (CDI), primarily focuses on *relationship enhancement* between the parent and child. This session allows the therapist to explain the concepts, provide rationales for each technique, and provide examples. In addition, the therapist models for the caretaker and also uses role-playing to practice the skills used in treatment.

In CDI, the goals are to increase a parent's positive and nurturing behaviors such as praising the child and reducing any potential coercive behaviors such as being critical toward the child. During this phase, the parent is also taught to reinforce the child's prosocial behaviors (e.g., engaging in appropriate play) and to ignore minor behavior transgressions (e.g., whining or throwing toys). Through the use of *differential attention,* the PCIT therapist works with the parent in attending to and playing with the child when the child is engaging in prosocial behaviors and start extinguishing negative behaviors by not reinforcing them (e.g., active ignoring). This is done through teaching parents the PRIDE skills: *Praising, Reflecting, Imitation, Descriptions,* and *Enthusiasm.* Parents are taught to *praise* the child for engaging in prosocial behaviors, *reflect* what the child is saying, *imitate* the child's appropriate play, *describe* what the child is doing, and use *enthusiasm* while interacting with the child.

In addition to learning the PRIDE skills, the parent is taught how to *actively ignore* when the child is engaging in inappropriate transgressions (e.g., banging a toy on the table). The working assumption during this phase is that the child is engaging in inappropriate behaviors to get the parent's attention. Since the child leads play during this phase, the parent is taught to avoid using commands and asking questions so that attention is not taken away from the child and parents can focus on the child's positive behaviors. Rather than using commands and asking questions during this phase, parents are taught to model and praise appropriate behaviors for the child. Additionally, the parent can use the third person to describe acceptable behaviors they want to see from the child instead of using commands (e.g., *I like it when Matthew plays nicely with the toys*). Third person is used so that the child is not directly receiving attention, but is able to learn what is expected of him or her. In addition, parents are taught to avoid using the words *No*, *Don't*, *Stop*, *Quit*, or *Not* to reduce negative interactions. These techniques are further described in the case demonstration below and in the following video component, which demonstrates a therapist teaching the parent how to use the PRIDE skills in PCIT. The parent was presented with a worksheet explaining each of the PRIDE skills and they were discussed in various contexts with examples and role-playing. Video 1 highlights a CDI didactic session between the therapist and a parent.

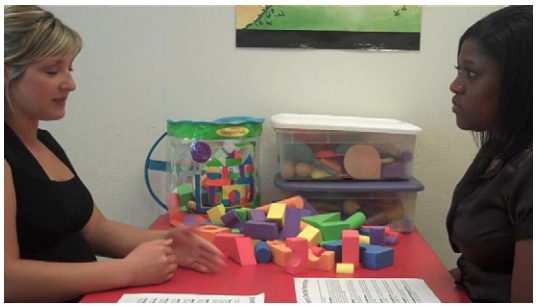
In addition, parents are assigned "special play time" with their children on a daily basis. This 5-minute homework exercise helps parents practice their CDI skills during the week. The CDI treatment phase continues until parents have met the designated criteria required to move to the next treatment phase. The goal is for parents to be able to emit 10 behavioral descriptions, 10 reflective statements, 10 labeled praises, and no more than 3 commands, questions, or critical statements during the initial 5-minute coding segment of the session before coaching begins.

After the parent has met mastery criteria, the therapist conducts a midtreatment assessment similar to the pretreatment assessment described above. The parent is then introduced to the Parent-Directed Interaction (PDI) phase. As with the CDI phase, the PDI didactic session highlights the concepts and techniques used in the PDI phase. In PDI, also known as the *Discipline* phase, parents are taught child management skills such as giving effective commands and being consistent in following through with positive consequences for compliance and negative consequences for noncompliance. Positive consequences for compliance are mainly in the form of having the parent provide the child with social reinforcement by being enthusiastic and giving praises for complying with the command.

In PCIT, effective commands are those that are direct, given one at a time, specific, and positively stated. In addition, effective commands are developmentally appropriate, given only when necessary, and given with a rationale. As an example, instead of using a vague, indirect command (e.g., *Would you hand me that?),* parents learn to give commands in a neutral tone of voice while being polite and respectful to the child (e.g., *Matthew, please hand me the red plate that is on the kitchen table*). Successful completion of PDI involves the parent giving 75% of their commands that meet the "effective command" criteria and also correctly follow through with the appropriate response given child compliance or noncompliance (Bell & Eyberg, 2002). Video 2 shows a therapist talking to the parent about transitioning to the PDI phase of treatment and using effective commands.

For noncompliance, parents are taught to follow through by counting to 5 and giving the child a warning in the form of two choices: either they comply with the initial command or go to time-out. Put simply, the parent is taught to give clear and simple commands that the child can understand, wait 5 seconds to allow for compliance, and then give the child two choices. The child is given the choices of either complying with the command or going to the time-out chair. The child is then given another 5 seconds to comply after the warning. If the child still does

Video 1. CDI didactic session example between a therapist and a parent.



Video 2. PDI didactic session example: Giving effective commands.

not comply, the parent escorts the child to the time-out chair or area. The parent is instructed to go back to the play table and continue to engage in a prosocial task and describe how he/she is playing. If the child acts inappropriately (e.g., kicking the wall, screaming), the parent is asked to ignore this behavior. However, if the child refuses to sit in the chair, he would be escorted to a time-out room. Once the child is quiet and agrees to return to the time-out chair, he can complete time-out in the chair. After the child has been sitting in the time-out chair for 3 minutes with 5 seconds of silence at the end, the parent goes back to the child and asks them if they are ready to return to the table. If the child agrees, the child is escorted back to the play table. At that point, the child has to comply with the initial command. After compliance with the initial command, the child is praised for complying. This is followed by having the parent give the child another command. If the child complies, the parent praises the child for complying and reminds the child that they do not have to go to the time-out chair when they comply with the parent's command. In Video 3, the therapist demonstrates effective time-out procedures to the parent using Buster the Bear.

Potential Obstacles in Treatment

During PCIT, therapist and parents may encounter obstacles that need to be addressed. At the onset of treatment, some parents may report feelings of awkwardness using the new PRIDE skills or skeptical of their usefulness. To lessen these concerns, it is important to provide a clear and detailed rationale for why these particular skills are used in PCIT. For example, by using labeled praises, the likelihood the child will engage in the behavior being praised will increase while decreasing the opportunity for the child to display inappropriate behaviors. To help the parents feel more comfortable using the skills, the therapist can model the skills when interacting with the child. In addition, the therapist may want to assess the treatment acceptability of the CDI skills to ensure the techniques taught are socially valid.

Video 3. PDI didactic session example: Demonstration of effective time-out procedures.

Additionally, parents sometimes find it difficult to ignore some of their child's inappropriate behaviors during the CDI phase. This is a particularly difficult time for parents because they want to either correct their child's behaviors immediately or may not tolerate the child's behaviors. It is important to guide the parent through this process, socially reinforce them for their progress, and encourage them to continue using these skills. Once the parent has been through this process in treatment and the therapist discusses the observed progress (e.g., child returning to the seat for attention rather than pulling on the parent's leg), parents can start noticing the benefits of these techniques. It is important during the CDI didactic session to discuss in detail reasons why this procedure is used. Ignoring inappropriate nondestructive behaviors teaches the child that s/he only receives positive attention when s/he behaves appropriately, which decreases the frequency of inappropriate behaviors.

Throughout treatment, parents may report difficulty completing daily homework tasks. As stated earlier, parents are encouraged to schedule a daily time when they can incorporate 5 minutes of special play time. If the parent states that it is impossible, the therapist can help problem-solve to find a time for a homework play activity during a time that the parent has something else scheduled. As an example, parents usually have time scheduled for the child's bath time. Although not ideal, the parents can incorporate play activities that the child could enjoy during this time period.

As parents complete the CDI phase of treatment and move to the PDI phase, parents may have a difficult time implementing time-out procedures in a public place (e.g., department store). Once parents have learned the PDI skills, the therapist can add a session in a public place so that the parent can be coached in a real-life setting. Parents are taught that time-outs still need to occur in public places to reduce behavioral problems across settings. Parents can choose what they want to use to signify a time-out but a handkerchief may serve as the time-out location. To decrease the frequency in which time-outs are used in public, parents are instructed to tell the child exactly what is expected of them before entering the location. For example, before the parent and child enter the grocery store, the child can be told about what are appropriate behaviors (e.g., stay by parent's side, keep hands to self, use inside voice). The child would be informed that if s/he complies, s/he will not have to go to time-out.

Many of the obstacles in PCIT involve generalization to real-life situations. In these cases, options for home sessions and public sessions can be offered to parents to

increase their level of confidence in implementing the skills and problem solving any difficulties that may arise in these situations.

Case Description

Matthew[2] was a 3-year-old male who was referred by his pediatrician due to his foster mother's report of oppositional behavior. He lived with his foster mother, a college student, and his foster father, who was a computer technician. Matthew was removed from his biological parents' home approximately 6 months prior to the onset of treatment and began living with his foster parents at that time. The foster mother, Simone[2], sought treatment for his behavior problems after discussing Matthew's behaviors with his pediatrician and several meetings at daycare. The foster mother reported that Matthew did not follow rules, had temper-tantrums, was aggressive with his younger brother and peers, and yelled, whined, and cried when he did not get his way. Matthew's teachers at daycare agreed that his behaviors were problematic and interfered with his developmental progress. They reported Matthew sometimes hitting and throwing objects at other children and at times engaging in off-task behavior (e.g., jumping off tables). Matthew did not respond to the overcorrection procedures used at school such as practicing to raise his hand before he talked during reading circle. Matthew's foster parents stated that they did not know how to manage Matthew's behaviors at home and that he did not respond to their discipline strategies. They reported using spanking as their primary discipline strategy but had used time-out, restriction of privileges, and threats with Matthew in the past with no success. They admitted to not being consistent in their use of discipline and making threats of punishment but not following through. His foster parents reported feeling stress and marital strain due to Matthew's behaviors.

His foster parents reported that his behavior problems had been present since he came to live in their home but had progressively become worse. His foster parents believed that Matthew would adjust to their home, but his behaviors had worsened since his placement. His parents reported being fearful that he would harm his younger brother and that his brother would also begin to display these behaviors.

Information gathered at the initial session suggested that Matthew met criteria for ODD. The mother's ECBI results showed that Matthew's behaviors were in the clinical range. Matthew's foster mother indicated that he frequently argued, became angry when he did not get his way and fought with friends his age. The foster mother was also given the Parenting Stress Index-Short Form (PSI-SF; Abidin, 1990) to complete. Please see Table 1 for the mother's pre-, mid-, and post-treatment scores for the ECBI and PSI-SF.

The therapist also observed Simone and Matthew interact with each other during a DPICS coding session to assess the quality of the dyadic interaction. During the first 5 minutes of taping, Simone had 0 labeled praises, 2 behavioral descriptions, and 14 questions. These verbalizations were tracked throughout the duration of treatment (see Fig. 1).

The following week was used to teach the PRIDE (praises, reflections, imitation, descriptions, and enthusiasm) skills used in the CDI phase of PCIT. The therapist went over each of the CDI skills in detail with Simone. This was done through introducing the skills, the rationale for using each technique, and examples of what the skills would look like when she interacted with Matthew. Modeling and role-playing were used to teach the treatment techniques, and Simone was shown examples of how to avoid using critical statements, asking questions, and giving commands. Since CDI was meant for Matthew to lead the play activity and Simone to follow, it was important for her not to ask questions or give commands during the CDI phase of treatment. Simone was also shown how to ignore attention-seeking and inappropriate behaviors, with the premise being that if Simone withholds the positive attention from Matthew, he will begin to behave appropriately again to gain his foster mother's attention and praise.

Overall, Simone appeared to understand the skills used in CDI and was enthusiastic about the impact they could have in changing Matthew's behaviors and improving her relationship with him. During the CDI didactic session, the therapist also emphasized the importance of devoting at least 5 minutes a day at home so she and Matthew could have special play time together. This special play time would allow her to practice the skills learned in therapy and it would also allow an opportunity for her and Matthew to have a fun time together.

Simone had expressed concern implementing the techniques at home due to time constraints with her need to complete her school work and her husband's lack of cooperation. Simone was encouraged to develop a schedule that incorporated the 5 minutes of play time at home, and the therapist helped her problem solve some of Matthew's more challenging behaviors. Simone reiterated her dedication to treatment even though she had encountered some difficult situations at home. During the initial few therapy sessions, Simone had trouble avoiding using questions and commands. She was encouraged to use descriptions to attain the same

[2] Matthew is the name of the child in the video. Matthew is not the name of the client who received PCIT services. Matthew's biological mother provided consent for him to be in the video. The foster mother in the video and case description, Simone, is not the actual foster mother. Names were changed to protect privacy.

Table 1
Pre-, Mid-, and Posttreatment Scores

Measures	Pre	Mid	Post
Eyberg Child Behavior Inventory (ECBI)			
Intensity Score	202 (80 TS)[a]	165 (69 TS)[a]	99 (51 TS)[b]
Problems Score	30 (80 TS)[a]	22 (69 TS)[a]	10 (54 TS)[b]
Parental Stress Index (PSI)			
Child Domain Score	96%-tile[a]	90%-tile[a]	65%-tile[b]
Parent Domain Score	30%-tile[b]	25%-tile[b]	19%-tile[b]
Total Stress Score	84%-tile[a]	63%-tile[b]	60 %-tile[b]

Note. [a]clinically significant scores; [b]normal limits scores. TS = *T*-Score.

behavioral results, and thereafter her use of questions and commands began to decrease. Initially, the therapist had to model for Simone what to say when interacting with Matthew. The following video illustrates the first CDI session with Matthew and his foster mother. Video 4 demonstrates the therapist coaching Simone on using PRIDE skills to encourage appropriate verbalizations and behaviors from Matthew.

After a couple of coaching sessions, Simone gradually increased her use of labeled praises. By the fifth CDI coaching session, Simone had met mastery criteria by using 10 labeled praises, 15 behavioral descriptions, and 10 reflections. During that same 5-minute observation, she had 2 questions, 0 commands, and 0 critical statements. Simone reported also using these skills at home and had recognized improvements in Matthew's behaviors, such as a decrease in temper tantrums and yelling and screaming. Simone noted that Matthew's main behavior problem was inappropriate attention-seeking (e.g., being aggressive with toys). The therapist also observed this in session and instructed that Simone practice *active ignoring* when the opportunity arose.

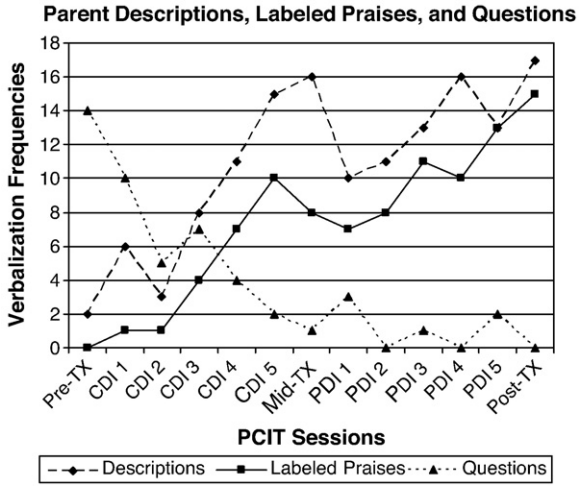


Figure 1. DPICS Coding.

Video 5 highlights an example of a CDI coaching session where the foster parent practices active ignoring.[3]

Because Simone had met CDI mastery criteria, the therapist conducted a midtreatment assessment. Although results showed a reduction in her ECBI Intensity and Problem scores, they were still in the clinical range. Simone expressed excitement to move to the discipline phase of treatment. The therapist emphasized to Simone the importance of continuing to use the CDI skills everyday with Matthew and to continue special play time.

During the PDI didactic session, Simone was taught how to give appropriate and effective commands through interactive instruction such as role-playing with specific situations that were particularly problematic for her. She reported that Matthew's aggressive behavior was at times difficult for her to manage. Simone stated that she tends to instruct Matthew to "stop hitting." The therapist worked with Simone on rephrasing the command to a positive statement, telling Matthew what *to* do rather than what *not* to do. Through explanation and practice, Simone stated that she could instruct Matthew to keep his hands to himself or to use soft hands. Other important aspects of effective commands were also discussed, such as being direct, polite and respectful, using single rather than compound, age-appropriate, and specific commands while using a neutral tone of voice. After Simone stated that she understood how to give an effective command, she was taught the time-out procedure to use when Matthew is noncompliant. Buster the Bear was used to demonstrate the correct time-out procedure. Simone was instructed to give Buster a command, allow 5 seconds for compliance, and then give Buster the warning of time-out if he does not comply. When he did not comply after the warning, Simone was instructed to guide Buster to the time-out chair, where he would sit for 3 minutes with 5 seconds of silence. Afterwards he was asked if he was ready to return to the table to comply with the initial command.

[3] Although large dinosaurs are not used in PCIT during special play time; Matthew was allowed to bring in his favorite dino to show the therapist and to play with him.

Video 4. Using PRIDE skills to encourage appropriate verbalizations and behaviors.

Once he complied, he would be praised and another command would be given. After Buster complied again, Simone was instructed to praise Buster and continue to play together.

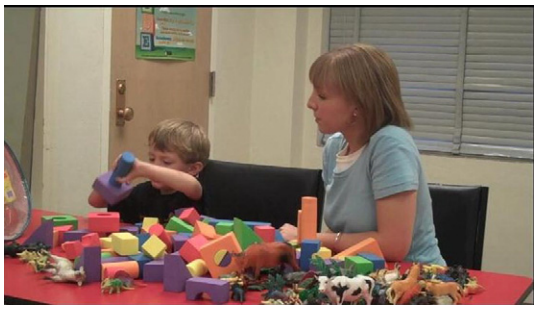
During the first PDI coaching session, Matthew did not like that his foster mother led the play activity. Matthew whined and began throwing toys off the table. Simone instructed Matthew to keep the toys on the table, but Matthew ignored his foster mother and continued to throw the toys. Simone was coached on how to use the warning and to continue through with the time-out procedure. Matthew did not comply and was sent to time-out. He whined on the way to time-out, but he remained in the chair. While in time-out, Matthew engaged in attention-seeking behaviors such as kicking the wall. These behaviors were ignored and his foster mother continued to play at the table and described her behaviors. After 3 minutes had passed, Matthew was still disruptive in the chair. Simone was instructed to say, "*Once Matthew sits quietly in the chair he can return to the table to play.*" Following this statement, Matthew was quiet and was then asked if he was ready to return to the table and comply with the initial command. Matthew did comply and was praised for his compliance. Simone followed up with another command and praised Matthew for complying. Throughout the duration of the session, Matthew was sent to time-out one more time for refusing to follow his foster mother's commands.

After the first session of PDI coaching, Simone seemed distressed about Matthew's behaviors and was concerned about implementing the time-out procedure at home. The therapist discussed with Simone the best places to use as time-out and procedures to follow if Matthew did not stay in the time-out chair at home. Simone stated that she believed restriction of privileges would work best if he did not stay in time-out. Simone was encouraged to talk to Matthew about privileges that could be restricted if he did not stay in the time-out chair. If he left the chair, he was given the warning that the privilege would be taken away and he would be guided back to the chair. If he left the chair a second time, he would be told that since he chose to leave the time-out chair, he would not be able to have his favorite toy for the rest of the night. Restriction of privileges has been recommended as part of PCIT treatment (Hembree-Kigin & McNeil, 1995).

Throughout the following sessions, the frequency that Matthew was sent to time-out decreased over time. He eventually began to request praise after he complied with commands and reported to the therapist all of his good behaviors each week at home and school. Simone learned how to use effective commands and time-out quickly. The time-out procedure in the therapy room became somewhat of a routine as Matthew knew when he needed to go to time-out and went without a struggle. Video 6 shows a PDI coaching session using PRIDE skills and commands to guide Matthew's behaviors. Matthew complies with commands and does not have to go to time-out. However, the clip demonstrates the appropriate way to give commands and how to follow-up with initial noncompliance.

After the third coaching session, Simone required little instruction by the therapist and was providing Matthew with all of the necessary praise and attention for positive behaviors and following through with time-out for noncompliance. Simone reported that Matthew was still being aggressive with his younger brother at home and that even after using positively stated commands with Matthew, he continued to engage in this behavior. The "house rules" procedure was then introduced to Simone:

Video 5. CDI coaching session: Active ignoring.



Video 6. PDI coaching session: Giving effective commands.

targeting a behavior that is problematic at home yet easy for Matthew to understand, Simone would need to sit down with Matthew and explain the new rule and and inform him that, if it is broken, he will immediately be sent to time-out. The following week, Simone reported that Matthew had decreased the frequency of hitting.

At the end of the fifth PDI coaching session, Simone reported improvements in compliance at home and in public places. She also recently had a meeting with Matthews' teachers at school who reported improvements in his behaviors. Simone was given the ECBI at posttreatment to assess her perception of Matthew's behaviors. The mother indicated that Matthew was no longer exhibiting severe behavior problems. A session was held to discuss the continued implementation of skills and to schedule a follow-up session with Simone and Matthew. The posttreatment DPICS showed that Simone was able to maintain her CDI skills throughout treatment.

Conclusion

This article illustrates the use of PCIT concepts and skills by utilizing video components. It is often the case with trainees and clinicians who haven't had exposure with a certain type of intervention to ask what the technique actually looks like after reading about certain skills. Thus, it may be useful for novice therapists to observe via video PCIT treatment components. The video clips included in this manuscript highlight three didactic sessions between a therapist and a parent in which the therapist illustrates skills used in PCIT and how to use them. In addition, two video components highlight a CDI coaching session and a session in which the parent actively ignores a child for engaging in inappropriate behaviors. The last video component highlights an example of a PDI coaching session.

Although there is a sufficient amount of outcome data supporting the efficacy of PCIT in clinic settings, recent work is emerging on the usefulness of PCIT in home settings (Ware, McNeil, Masse, & Stevens, 2008). This information is crucial in demonstrating the transportability of PCIT to settings such as community mental health centers and home environments, and will also add to the social validity of this intervention. As stated in the case illustration, it is important to assess for the social validity of the interventions we use with parents. Because parents are asked to play with their children in PCIT, it may be important to assess for the treatment acceptability of different techniques used in CDI and PDI. In addition, it is important to assess for the social validity of the intervention as it relates to the improvement of child behavior across settings such as home and public places.

In this case illustration, there were two occasions in which the mother expressed concerns in implementing the procedures at home. One concern was finding time during the week to practice the CDI skills by having special play time at home. The other concern was being able to implement the time-out procedure effectively in the home. With both scenarios, the therapist was able to help the foster mother problem-solve ways in which she could find time for special play time and find a place in the home for a time-out area. Although asking parents to allot at least 5 minutes of play time may not seem like a big commitment, it is important to remember that the demands of work and family are significant. In addition, families may be living in environments where space or privacy is an issue, so it is essential for therapists to work closely with parents in finding a viable solution for the time-out procedure in the home. Having therapists work closely with parents and having parents develop or refine their problem-solving skills can assist with treatment gains.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at doi:10.1016/j.cbpra.2009.10.003.

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Address correspondence to Joaquin Borrego, Department of Psychology, MS 42051, Texas Tech University, Lubbock, TX 79409-2051; e-mail: Joaquin.Borrego@ttu.edu.

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