

# Tailoring Parent-Child Interaction Therapy (PCIT) for Older Children: A Case Study



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**Abstract:** Parent-Child Interaction Therapy (PCIT) is an evidence-based intervention designed for families of 2- to 6-year-old children with disruptive behavior disorders. This article illustrates the application of PCIT in a 10-year-old boy with attention deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD). Both parents and the patient attended PCIT sessions. The course of therapy included minor changes to the PCIT protocol. After 13 PCIT sessions, the patient displayed disruptive behaviors within normal limits, and 12 months later he no longer met diagnostic criteria for ODD. Results remained stable at a 17-month follow-up assessment. This case study suggests that the use of PCIT in families of children with ODD markedly older than the recommended age range might be a promising approach for improving family functioning and reducing behavior problems. Further research with larger samples of older children with ODD is needed to replicate and elaborate the findings of this case study.

**Keywords:** Parent-Child Interaction Therapy; oppositional defiant disorder; attention deficit/hyperactivity disorder; tailoring; case study

## Modifikation von Parent-Child Interaction Therapy (PCIT) für ältere Kinder: ein Fallbericht

**Zusammenfassung:** Parent-Child Interaction Therapy (PCIT) stellt eine evidenz-basierte Intervention dar, die für die Behandlung von 2-6-jährigen Kindern mit expansiven Verhaltensstörungen entwickelt wurde. Der vorliegende Fallbericht beschreibt die Behandlung eines 10-jährigen Jungen mit kombinierter oppositionell-verweigernder Störung des Sozialverhaltens und Aktivitäts- und Aufmerksamkeitsstörung mittels PCIT. An der Behandlung nahmen beide Eltern und der Patient teil, es waren dabei nur kleinere Modifikationen des Standardvorgehens erforderlich. Nach 13 PCIT-Sitzungen zeigte der Patient kein auffälliges expansives Verhalten mehr, 12 Monate später erfüllte er auch nicht mehr die diagnostischen Kriterien einer Störung des Sozialverhaltens. Diese Veränderungen waren auch noch 17 Monate nach Behandlungsende stabil. Der Fallbericht zeigt, dass PCIT auch bei deutlich älteren Kindern mit oppositionell-verweigernder Störung des Sozialverhaltens eine erfolgversprechende Behandlungsform sein könnte, um das familiäre Miteinander zu verbessern und kindliche Verhaltensprobleme zu reduzieren. Allerdings sind Studien mit größerer Fallzahl erforderlich, um die Ergebnisse dieses Fallberichts zu überprüfen.

**Schlüsselwörter:** Parent-Child Interaction Therapy; Störung des Sozialverhaltens mit oppositionellem, aufsässigem Verhalten; Aktivitäts- und Aufmerksamkeitsstörung; Therapie-Individualisierung; Fallbericht.

## Introduction

Parent-Child Interaction Therapy (PCIT) is an evidence-based intervention designed for families of 2- to 6-year-old children with disruptive behavior disorders (Eyberg, 1988). Randomized controlled studies suggest that standard PCIT with some modifications is also effective in 2- to 6-year olds with autism spectrum disorder, separation anxiety disorder, and depression (Briegel, 2016).

PCIT aims to help parents develop an authoritative parenting style (Baumrind, 1967), which includes being empathic and supportive while using clear communication and setting firm, age-appropriate limits. To achieve these

goals, PCIT combines play therapy and behavioral therapy approaches (Eyberg, 1988).

PCIT is an assessment-driven intervention that regularly uses the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999), a parent questionnaire to monitor the course of disruptive child behavior during therapy, and the Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg, Nelson, Duke & Boggs, 2013) to assess parental management skills and to guide coaching. The treatment typically consists of two phases: the child-directed interaction (CDI) and the parent-directed interaction (PDI). Each phase starts with a teaching session followed by coaching sessions in which parents are coached in

vivo by the therapist while interacting with their child. In CDI, parents learn to follow their child's lead. They are encouraged to use the "PRIDE" skills [P for (labeled) praise, R for reflect, I for imitate, D for describe, and E for enjoy] to provide positive attention to prosocial behaviors, while ignoring negative behaviors. Parents also learn to model appropriate behaviors for their children like sharing and to avoid behaviors that take away the lead from the child (asking questions, giving commands, or criticizing the child). After having achieved mastery of the CDI skills (i.e., 10 behavioral descriptions; 10 reflections; 10 labeled praises; and no more than three questions, commands, and criticisms in total) and a significant improvement of their relationship with their child, parents can proceed to PDI. In most cases PDI is necessary for parents with a child with severe disruptive problem behavior, but in some cases CDI alone suffices for parents to manage their child's disruptive behavior quite well (the so-called CDI cure). In PDI, parents learn to give specific, age-appropriate, direct commands if they want their child to do something. Parents are taught to provide positive reinforcement for compliance and to begin a time-out sequence following noncompliance (Eyberg & Funderburk, 2011). Generalization from play situations to real-life situations and regular homework are crucial for therapy progress. PCIT is considered successfully completed when parents achieve mastery of the CDI and PDI skills, when the children's ECBI intensity scores lie below a *t*-score of 55, and when parents express confidence in managing their children's behaviors on their own (Eyberg & Funderburk, 2011).

While PCIT was originally developed for young children, the existing evidence-based interventions for elementary-school-aged children do not typically include the components of PCIT that help make it so powerful (e.g., in vivo coaching, child and caregiver together in sessions). It has been suggested that an adaptation of PCIT might be effective for children of this age group (McNeil & Hembree-Kigin, 2010). However, several elements of PCIT may not be developmentally appropriate for older children, among them CDI mastery criteria, toys and activities recommended in CDI (like blocks and crayons), and only 5-minute homework play sessions (McNeil & Hembree-Kigin, 2010, pp. 204–208). Because PCIT with younger children is very hands-on, which seems inappropriate for older children, especially highly aggressive and defiant 7–10-year-olds, some authors have suggested dividing the PDI portion into three modules: Command Training (CT), Time-Out with Incentive Chart (TIC), and Time-Out with Suspension of Privileges (TSP) (McNeil & Hembree-Kigin, 2010, pp. 208–221).

So far, PCIT outcomes in older children have been reported only in a case study on an 11-year-old boy with a

severe traumatic brain injury (Cohen, Heaton, Ginn, & Eyberg, 2012).

The present case study, which is presented with the consent of the family, strives to demonstrate that discrete changes might be sufficient to tailor PCIT to be an effective intervention for managing disruptive behavior problems in elementary-school-aged children.

## Case Description

The patient was a 10-year-old Caucasian male. His mother reported that her son had a low frustration tolerance, resulting in many conflicts with peers and adults and temper tantrums at home (especially following restriction of media use) and at school. At his daycare center he repeatedly showed physical aggression toward peers.

The patient was born full-term with normal birth weight, height and head circumference. He achieved developmental milestones at or before the developmentally expected timepoints. At the age of 3 years he was diagnosed by a child and adolescent psychiatrist to have attention-deficit/hyperactivity disorder (ADHD), combined type. Oppositional-deviant disorder (ODD) was subsequently diagnosed 3 years later. His ADHD was treated with methylphenidate from age 3 to 10 years, followed by a switch to lisdexamfetamine (50 mg in the morning). Because of his behavior problems, the patient had to attend specialized daycare centers and a school for children with disciplinary problems. The patient's history was not significant for any major physical illnesses or injuries.

His immediate family lived together and consisted of his biological parents, who had graduated from German "Realschule" (middle school, grades 5–10). The patient's mother had taken fluoxetine to combat a previous major depressive episode. His father reported no health issues. Both parents reported that they were unable to agree on several parenting aspects with subsequent parental conflicts. The patient's father admitted to react with irony or anger to the challenging behaviors of his son, including sometimes rapping him on the head. His mother reported that she was often inconsistent with her discipline and tended to surrender to her son's charm.

## Measures

Outcome measures comprised the following validated instruments (for further information see the electronic supplemental material, ESM):

- The *Diagnostisches Interview bei psychischen Störungen im Kindes- und Jugendalter* Kinder-DIPS; Schneider, Suppinger, Adornetto, & Unnewehr, 2009).
- The German version of the *Eyberg Child Behavior Inventory* (ECBI; Heinrichs, Bussing, Henrich, Schwarzer, & Briegel, 2014).
- The German version of the *Strengths and Difficulties Questionnaire*, parent version (SDQ; Woerner, Becker, Friedrich, Klasen, Goodman, & Rothenberger, 2002).
- The German version of the clinical *Dyadic Parent-Child Interaction Coding System* (DPICS; Eyberg and Members of the Child Study Lab, 2010).

## Pretreatment Assessment and Treatment

Pretreatment assessment comprised unstructured interviews with the patient's parents and his teacher as well as assessment of psychopathology and overall behavioral functioning (for results see Table 1). Previous assessment results were taken into account. Altogether, the findings indicated behavior problems consistent with ADHD-combined presentation and ODD. The KABC (Kaufman & Kaufman, 2009) showed average performance in all domains; the physical examination revealed no physical illness.

The combination of an effective ADHD medication and PCIT as an intensive family intervention (including both parents and the patient) to establish a parenting style accepted by both parents seemed to be indicated.

The therapist decided to maintain fidelity to the PCIT protocol as much as possible, with the exception of making the following a priori changes to the CDI phase: using more developmentally appropriate toys such as construction games; planning 10-minute homework play sessions; teaching the parents to reflect in a more summarizing and paraphrasing way; avoiding direct imitation in favor of joi-

ning in the patient's activities and having fun. The parents were also encouraged to use both behavioral and informational descriptions, alternating between describing the patient's actions and their own thoughts, interests, and activities.

Weekly clinic-based PCIT sessions were planned. With the exception of one CDI coaching session, all sessions were attended by both parents. CDI sessions followed the session outline of the German version of the 1999 PCIT manual (Eyberg & Members of the Child Study Lab, 1999), with coaching being conducted through a one-way mirror using a "bug in the ear" device.

Early in treatment, severe conflicts between parents during sessions became an increasing obstacle to therapy. Therefore, PCIT had to be interrupted after the fourth CDI coaching session in order to clarify the situation. It took nine sessions with the parents to establish their willingness to focus on the PCIT treatment. At that time, ECBI intensity and problem scores still were in the clinical range.

After this decision, the therapist was able to coach the patient's parents to CDI mastery, which they demonstrated for the first time at CDI 9 (father) and CDI 10 (mother). At the tenth CDI coaching session, ECBI intensity scores of both parents were below a *t*-score of 50, qualifying for PCIT graduation. Although ECBI intensity scores remained low during the next 4 weeks without further PCIT sessions, the parents and their PCIT therapist agreed to have a modified PDI teaching session as a precaution. Based on the recommendations by McNeil and Hembree-Kigin (2010), in this didactic session the parents were taught how to give effective commands and to praise compliance (Command Training). The therapist particularly stressed the importance of using direct commands only if really necessary and giving an explanation before a command and/or after a labeled praise for compliance. Once the parents had agreed to this proposal, this procedure was practi-

**Table 1.** Mother-Reported Behaviors at Pre-Treatment and 17-Month-Follow-up Assessment.

Measure	Scale	Pre-Treatment	17-month Follow-up
SDQ-Deu Classification (raw score)	Total difficulties score	Clinical (24)	Normal (12)
	Emotional symptoms	Normal (3)	Normal (0)
	Conduct problems	Clinical (6)	Normal (2)
	Hyperactivity / inattention	Clinical (10)	Clinical (7)
	Peer relationship problems	Clinical (5)	Borderline (3)
	Prosocial behavior	Normal (7)	Normal (8)
ECBI raw score	Intensity scale	155	97
	Problem scale	16	3

ced during the next two PCIT sessions. As it turned out, the patient complied to all commands during the following sessions without needing a warning. Moreover, ECBI intensity scores remained below a *t*-score of 50, and the parents were confident that they could handle their son's behavior on their own. Thus, no time-out procedure was needed, and PCIT could be successfully completed after ten CDI sessions and three modified PDI sessions over 10 months. The last eight sessions took place over 4 months after the parents had decided to focus on PCIT.

## Follow-Up Data

The ECBI Intensity Scale scores of both parents remained below a *t*-score of 55 at all follow-up assessments, and Problem Scale scores were  $\leq 3$  (*t*-score: 44) for both parents. Reliable change indices (Jacobson & Truax, 1991) suggested that the patient had recovered (see Table 2).

At the 3-month follow-up, CDI skills showed significant improvement over baseline assessment (do skills: mother: 16 vs. 3; father: 38 vs. 2; don't skills: mother: 3 vs. 6; father: 2 vs. 7).

At the 12-month follow-up, the results of the Kinder-DIPS indicated that the patient who was now attending "Realschule" continued to meet diagnostic criteria for ADHD (grade of severity: 4), but no longer met criteria for ODD (grade of severity at baseline: 6–7). For further child outcome data at 17-month follow-up assessment, see Table 1.

Medication with lisdexamfetamine was stable from pretreatment to 17-month follow-up, and there was no need to add another therapy for the patient.

## Discussion

The current case study examined preliminary feasibility for the use of PCIT in treating a 10-year-old boy with ADHD and ODD. Tailoring PCIT to his special needs included only minor modifications of the CDI phase, and a modified PDI phase of three sessions was introduced to the parents only

as a precaution. However, the complete treatment did not only comprise PCIT, but two further interventions: medication with lisdexamfetamine and couples counseling. With this treatment, the child and parent outcomes indicated significant reductions of child disruptive behaviors and parenting stress from baseline to 17-month follow-up assessment.

To date, only the case study of an 11-year-old boy with traumatic brain injury and premorbid ADHD whose behavior problems worsened after his injury but improved with standard PCIT (Cohen et al., 2012) has suggested that PCIT might be effective in older children as well as in younger ones. The current case study adds support to the proposition that the age range of PCIT might indeed be extended. Moreover, this case report indicates that minor modifications of CDI might be sufficient to tailor PCIT to older children with ODD. In this case only CDI was needed to improve family functioning and reduce long-standing and severe behavior problems. Therefore, no conclusions can be drawn from this case study regarding the challenging question of how to adapt PDI for older children, especially very aggressive ones.

In addition to limitations inherent in case-study designs, especially lack of control group and limited generalizability, the following specific limitations of the current case study are important to consider. First, other intervention components were implemented concurrently with PCIT. Medication should not have played a major role as the dosage of lisdexamfetamine was not changed from pretreatment to 17-month follow-up. In contrast, couples counseling obviously made a huge contribution as thereafter both parents were motivated to focus on PCIT instead of repeatedly addressing their conflicts during treatment. Because ECBI scores remained significantly elevated after couples counseling, it seems unlikely that changes in child behavior could have occurred without PCIT. Thus, couples counseling seemed to allow PCIT to have its typical effects on parent-child interaction and child behaviors. Second, in this case study exclusively parent-reported information and therapist observations were used to document child and parent outcomes. It would have been helpful to add confidence to outcome results, if teacher ratings had been included.

**Table 2.** Reliable Change Indices (RCIs)\* of ECBI Scores at Graduation and 17-Month Follow-up

Parent:	RCI: ECBI Intensity Score		RCI: ECBI Problem Score	
	Graduation	17-month follow-up	Graduation	17-month follow-up
Mother	7.68	5.18	4.63	4.01
Father	6.86	4.19	3.15	3.15

\* Jacobson & Truax (1991): Patients with a RCI  $\geq 1.96$  are considered to be recovered.



Despite these limitations, this case study suggests that the use of PCIT with families of older children with ODD might be a promising approach for improving family functioning and reducing behavior problems. Moreover, PCIT with some modifications might be effective in older children with other psychological disorders (e.g., autism spectrum disorders) as well. Further research with larger samples of older children is needed to replicate and elaborate the findings of this case study.

## Electronic Supplementary Material

The electronic supplementary material is available with the online version of the article at <http://dx.doi.org/10.1024/1422-4917/a000536>.

### ESM 1. Text.

Detailed description of assessment instruments.

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## CME-Fragen

### 1. Frage: Welche Aussage ist falsch?

- a. Die Wirksamkeit von PCIT ist nur für die Anwendung bei Störungen des Sozialverhaltens erwiesen.
- b. PCIT wurde in zahlreichen Studien auch bei älteren Kindern (8 bis 12 Jahre) angewandt.
- c. PCIT besteht typischerweise aus zwei Behandlungsphasen.
- d. PCIT kombiniert Ansätze aus der Spieltherapie und der Verhaltenstherapie miteinander.
- e. Bei PCIT wird regelhaft kindliches Problemverhalten mit der CBCL erfasst.

### 2. Frage: Welche Strategien werden Eltern bei PCIT typischerweise vermittelt?

- a. Loben.
- b. Ein Vorbild sein.
- c. Logische Konsequenzen einsetzen.
- d. Fragen vermeiden.
- e. Konstruktiv Kritik äußern.

### 3. Frage: Was zeichnet den autoritativen Erziehungsstil typischerweise aus?

- a. Empathisch-unterstützendes Verhalten.

- b. Immer zu wissen, was das eigene Kind gerade tut.
- c. Klare Grenzen zu setzen, wo nötig.
- d. Kindern möglichst viele Freiheiten zuzugestehen.
- e. Enge Kooperation mit anderen Eltern.

### 4. Frage: Kernmerkmal der Anleitung bei PCIT ist nicht:

- a. Live-Coaching.
- b. Befund-geleitete Anleitung.
- c. Kind und Elternteil zusammen.
- d. Den Eltern Worte in den Mund legen.
- e. Deutungen des kindlichen Verhaltens.

### 5. Frage: Welche Aussage zu PCIT stimmt?

- a. PCIT sollte bei älteren Kindern nicht einfach unverändert in der Standardform angewandt werden.
- b. Für die erfolgreiche Beendigung von PCIT ist ausschließlich die Einschätzung des Therapeuten entscheidend.
- c. Wenn Eltern wollen, dass ihr Kind etwas tut, dann sollten sie indirekte und spezifische Anweisungen bevorzugen.
- d. Bei PCIT werden Veränderungen im Verlauf nur mittels elterlicher Einschätzungen erfasst.
- e. Das Eyberg Child Behavior Inventory wird bei PCIT nur vor und nach der Therapie eingesetzt.

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