

Parent–child interaction therapy and ethnic minority children

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Abstract

Disruptive behaviours constitute the most frequent reason for referral of young children to mental health services. Parent–child interaction therapy (PCIT) is a theoretically grounded, assessment-driven, empirically supported treatment for children with disruptive behaviour disorders. PCIT is based on Baumrind's research demonstrating positive outcomes for children of parents with an authoritative parenting style. The child-directed interaction phase of PCIT focuses on strengthening the parent–child bond and increasing positive parenting. The parent-directed interaction phase focuses on increasing parental consistency, predictability and fairness in discipline. This article presents an overview of PCIT and highlights PCIT research with ethnic minority children.

Keywords: *ethnic minority, conduct problems, racial minority, parent training, parent-child interaction therapy, disruptive behavior, empirically supported treatment, child*

Introduction

The pre-school period is a particularly challenging time for parents. Pre-school-age children naturally exhibit many behaviours that are difficult to manage, such as non-compliance, temper tantrums, whining and high-rate activity. Although misbehaviour during the pre-school period is normal and typically transient (Campbell, 1990), frequent and persistent negative behaviour in early childhood warrants assessment and intervention. In contrast to the normative misbehaviour of pre-schoolers, disruptive behaviour refers to a cluster of negative behaviours that occur at a higher rate than is typical for the child's age and developmental level and cause significant impairment in child functioning. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV, American Psychiatric Association, 1994), categorizes disruptive behaviour disorders into two categories – oppositional defiant disorder (ODD) and conduct disorder (CD) – with CD being a more severe form of disruptive behaviour that includes either serious violation of societal rules or the basic rights of others, or both.

Disruptive behaviour is the most common reason for referral of young children to mental health services (Lavigne et al., 1998). Without treatment, disruptive behaviour in early childhood tends to persist and worsen (Loeber, 1982), often with negative long-term outcomes including antisocial behaviour, adolescent delinquency and substance abuse (Kellam,

Werthamer-Larsson, & Dolan, 1991; Loeber, Keenan, & Zang, 1997). For these reasons, early treatment of disruptive behaviour is critically important.

Disruptive behaviour disorders may be particularly problematic for ethnic minority children. In the United States, ethnic minority children with disruptive behaviour are more vulnerable to impairment in family and peer functioning than European American children with the same diagnosis (Ezpeleta, Keeler, Erkanli, Costello, & Angold, 2001). Effective treatment of disruptive behaviour among ethnic minority children is therefore particularly important.

Parent-child interaction therapy

Parent-child interaction therapy (PCIT) is a behavioural parenting skills training programme for treating young children with disruptive behaviour. Based on Baumrind's (1966) developmental theory, PCIT teaches authoritative parenting – a combination of nurturance, good communication and firm control – in two phases of treatment. In the first phase, called the child-directed interaction (CDI) phase, parents learn skills to strengthen the parent-child bond, increase child prosocial behaviour and decrease negative child behaviour. In the second phase, called the parent-directed interaction (PDI), parents learn additional skills to reduce child non-compliance and other negative behaviours that show resistance to extinction in the CDI phase. Baumrind's (1991) research has shown that authoritative parenting produces optimal child mental health outcomes. An authoritative parenting style has been linked to fewer child behaviour problems in several studies (Linver, Brooks-Gunn, & Kohen, 2002), including studies of ethnic minority children (Querido, Warner, & Eyberg, 2002).

The role of assessment in PCIT

Assessment plays an integral role in PCIT, and several instruments have been developed specifically for use in guiding the content and course of this treatment and evaluating its outcome. Before treatment begins, an intake assessment is conducted to gather pertinent information about the history and current functioning of the child and family. This assessment begins with a semi-structured PCIT Clinical Interview, which covers information related to the child's developmental, medical, social and behavioural history and the parents' behaviour management and discipline strategies as well as their treatment goals and expectations.

Parents also complete the Eyberg Child Behaviour Inventory (ECBI; Eyberg & Pincus, 1999) at this assessment, which provides information on the frequency of common child behaviour problems (ECBI Intensity Scale) and the extent to which the behaviour is problematic for the parent (ECBI Problem Scale). The ECBI yields similar scores with African American and European American families (Butler, Eyberg, & Brestan, 2006), suggesting that clinical cut-offs established with primarily European American samples are valid for use with this ethnic minority group as well. Research with African American parents has also demonstrated that a discrepancy in scores on the two ECBI scales is related to parental tolerance for the child's misbehaviour (Butler, Brestan, & Eyberg, 2006). For example, a significantly higher ECBI problem than intensity score suggests an intolerant parent who might benefit from parent education on developmentally normative misbehaviour. Conversely, a significantly higher intensity than problem score suggests a permissive parent who might benefit from education about the importance of firm limits for achieving positive child outcomes.

The PCIT intake assessment also includes direct observation of the parent-child interactions, using the Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg, Nelson, Duke, & Boggs, 2005) to assess the quality of the relationship between parent and child and the ways in which they each attempt to control the behaviour of the other.

DPICS observations and ECBI data are also collected at each PCIT session to track parent skill acquisition and weekly changes in the child's behaviour at home.

Other instruments often used during pre- and post-treatment assessments are the Sutter-Eyberg Student Behaviour Inventory-revised (SESBI-R; Eyberg & Pincus, 1999), a teacher rating scale of disruptive behaviour, and the revised edition of the School Observation Coding System (REDSOCS; Jacobs et al., 2000). These instruments permit evaluation of child behaviour at school and the extent to which effects of PCIT generalize to the school setting. At the end of treatment, parents also complete the Therapy Attitude Inventory (TAI; Brestan, Jacobs, Rayfield, & Eyberg, 1999), a brief measure of satisfaction with the process and outcome of PCIT.

Format and phases of PCIT

In each phase of treatment – CDI and PDI – the first session is a teaching session in which the therapist explains and demonstrates the skills of the interaction and role-plays the skills with the parents alone. Following the teaching session, the parents and child attend coaching sessions together. During most of each coaching session, the therapist observes from an observation room and actively coaches the parent in the use of the skills via a bug-in-ear communication device while the parent plays with the child in the playroom and practices the skills. With two parents in treatment, parents take turns in each session being coached and observing with the therapist while their partner is being coached.

Child-directed interaction

In the CDI, parents learn to follow their child's lead in play. They learn to use specific types of positive attention that, for most children, function as positive reinforcement – describing and praising positive play behaviours and reflecting appropriate talk (see Table I for description). Parents also learn to avoid particular types of statements – commands, questions and criticism – that can be intrusive and often give attention to negative child behaviours. The therapist actively coaches parents to use differential social attention as they play with their child. That is, they teach parents to switch immediately from the positive attention skills to ignoring when a negative child behaviour (such as whining, yelling, back-talking) occurs, and to switch back immediately to positive attention when a positive child behaviour (any non-negative behaviour) occurs. The new parent behaviours learned in CDI serve to teach children new skills (positive social interaction skills, cooperation) in a play interaction that both the parent and child enjoy. Throughout the CDI phase of treatment, parents practice the new skills at home with their child during daily 5-minute sessions ('special time'). This treatment phase continues until parents demonstrate mastery of the CDI skills. The positive new parent-child interaction pattern learned in this first phase of PCIT provides the foundation for successful implementation of the discipline strategies introduced in the second phase of treatment. In fact, most children show substantial reductions in non-compliance during this initial CDI phase of treatment alone (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993).

Parent-directed interaction

In PDI, parents learn to lead and direct their child's behaviour when needed. They are taught to use specific kinds of directions, or 'commands', that children are most likely to obey. Specifically, parents learn to give commands that are direct, age-appropriate,

Table I. CDI positive attention skills.

Skill	Reason	Examples
Behavioural description Describe what your child is doing	<ul style="list-style-type: none"> • Lets child lead the play • Shows interest • Teaches concepts • Models good speech and vocabulary • Holds child's attention on the task • Organizes child's thoughts about the activity 	<ul style="list-style-type: none"> ■ You're making a tower • You drew a square • You are dressing Mr Potato Head • You put the girl inside the fire truck
Reflection Repeat or paraphrase what your child says	<ul style="list-style-type: none"> • Lets child lead the conversation • Shows interest • Demonstrates acceptance and understanding • Improves child's speech • Increases verbal communication 	<ul style="list-style-type: none"> ■ Child: I drew a tree ■ Parent: Yes, you made a tree ■ Child: The doggy has a black nose ■ Parent: The dog's nose is black ■ Child: I like to play with the blocks ■ Parent: You're having fun with the blocks
Labelled praise Say specifically what you like about what your child is doing or saying	<ul style="list-style-type: none"> • Causes child's good behaviour to increase • Shows approval • Increases child's self-esteem • Makes child feel good 	<ul style="list-style-type: none"> ■ Good job with that tower ■ You drew a pretty tree ■ Nice drawing ■ Thank you for sharing ■ I like how gently you're putting the crayons away

specific, positively stated and given one at a time. Parents also learn to explain the reason for a command before the command is given or after it is obeyed, but not between those times. This timing helps to assure that the child will 'hear' the reason, and it helps parents avoid reinforcing noncompliance (see Table II for description of effective commands).

To learn parental consistency in discipline, parents are taught a specific PDI algorithm to implement within the context of the positive interaction established in CDI. When the child obeys, the parent is taught to give very specific praise for obeying, to reinforce child compliance. Conversely, if the child does not obey, the parent is taught to initiate the time-out sequence. After parents master the basic PDI procedure, they learn variations of PDI for certain problem situations that may arise. To manage aggressive, destructive or other behaviours that are difficult to manage with only running commands for incompatible positive behaviours, they learn to implement house rules (e.g. 'no hitting'), which are standing commands, always in effect, that lead directly to time-out if disobeyed. Parents also learn and practice using the PDI skills in public places. Throughout treatment, parents are given handouts that describe the procedures they learn and practice in session, so they can review the procedures later as needed (materials used in PCIT sessions are available at www.PCIT.org).

PCIT is completed when parents demonstrate mastery of both CDI and PDI skills, report their child's behaviour is within normal limits on the ECBI and indicate confidence in their ability to manage their child's behaviour on their own. PCIT is a 'performance-based' rather than time-limited treatment, meaning that treatment completion is determined by the progress of the individual family. Therapists work actively to keep families in treatment until these goals are reached, which takes on average 13 sessions (Werba, Eyberg, Boggs, & Algina, in press).

Table II. Rules for effective commands.

Rule	Reason	Examples
1. Commands should be direct rather than indirect	<ul style="list-style-type: none"> Leaves no question that the child is being told to do something Does not imply a choice, nor suggest that the parent might do the task for the child Is not confusing for young children 	<ul style="list-style-type: none"> Please give me the crayon Put the car in the box Draw a square <p>Instead of</p> <p>Will you give me the crayon Let's put the cars in the box Would you like to draw a square</p>
2. Commands should be positively stated	<ul style="list-style-type: none"> Tells child what to do rather than what not to do Avoids criticism of the child's behaviour Provides a clear statement of what the child can or should do 	<ul style="list-style-type: none"> Sit in the chair <p>Instead of</p> <p>Don't stand on the chair</p> <ul style="list-style-type: none"> Draw a circle on the paper <p>Instead of</p> <p>Stop drawing on the table</p>
3. Commands should ask for one task at a time	<ul style="list-style-type: none"> Helps child to remember the whole command Helps parent determine if child completed entire command 	<ul style="list-style-type: none"> Comb your hair <p>Instead of</p> <p>Comb your hair, get dressed, pack your backpack</p> <ul style="list-style-type: none"> Brush your teeth <p>Instead of</p> <p>Get ready for bed</p>
4. Commands should be specific rather than vague	<ul style="list-style-type: none"> Lets child know exactly what they're supposed to do 	<ul style="list-style-type: none"> Walk down the hall <p>Instead of</p> <p>Be careful</p> <ul style="list-style-type: none"> Give the toy to your sister <p>Instead of</p> <p>Play nicely</p>
5. Commands should be age-appropriate	<ul style="list-style-type: none"> Makes it possible for the child to understand the command and be able to do it 	<ul style="list-style-type: none"> Put this car in the car box <p>Instead of</p> <p>Put the automobile in its container</p>
6. Commands should be given politely and respectfully	<ul style="list-style-type: none"> Increases the likelihood that the child will listen better Teaches children to obey polite and respectful commands Avoids child learning to obey only if yelled at Prepares child for school 	<ul style="list-style-type: none"> Child: (banging toy on window) Parent: (in normal tone of voice) Please give me the toy <p>Instead of</p> <p>Parent: (yelling) Give me that toy right now</p>
7. Commands should be explained before they are given and/or after they are obeyed	<ul style="list-style-type: none"> Avoids encouraging child to argue after a command as a delay tactic Avoids giving child attention for not obeying 	<ul style="list-style-type: none"> Parent: It's time to clean up and go home. Put that chalk back in its box. Child: (obeys) Parent: Thanks for listening! It's good to put the toys back when we're finished with them. <p>Instead of</p> <p>Parent: Put that chalk back in its box. Child: Why? (Child is running around)</p>
8. Direct commands should be used only when necessary	<ul style="list-style-type: none"> Decreases child's frustration Makes it easier for parent to follow-through Note. If it is not essential that the child obey, it is better to use an indirect command (or do it yourself in the first place) 	<ul style="list-style-type: none"> Parent: Please sit in this chair. (Good time to use command) <p>Instead of</p> <p>Parent: Please hand me my glass from the counter. (Not a good time to use this command)</p>

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PCIT has been identified as an empirically supported treatment (EST) for children with disruptive behaviour disorders (Eyberg, Nelson, & Boggs, *in press*). Studies supporting the efficacy of PCIT have shown that the treatment is superior to waiting-list control groups (Nixon, Sweeny, Erickson, & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998) and to parent group didactic training (Eyberg & Matarazzo, 1980). Support for the generalization of PCIT has been demonstrated in studies showing improvements in child behaviour in the school setting following treatment (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991). Positive changes demonstrated in the behaviour of untreated siblings support the generalization of the new parenting skills in the home (Brestan, Eyberg, Boggs, & Algina, 1997).

Long-term maintenance of treatment gains has been demonstrated in 1- and 2-year follow-up studies in the home (Boggs et al., 2004; Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001; Nixon, Sweeny, Erickson, & Toyuz, 2004) and at school (Funderburk et al., 1998). Further, maintenance of improvements as long as 6 years following PCIT has been documented (Hood & Eyberg, 2003).

Recent studies have examined the effectiveness of PCIT in reducing child behaviour problems in diverse pediatric populations. For example, significant declines in disruptive behaviour have been reported for children with mental retardation (Bagner & Eyberg, 2006) and with fetal alcohol syndrome (Gurwitch, Mulvihill, & Chaffin, 2006) compared to control groups. Chaffin et al. (2004) have also reported substantial reduction in re-abuse reports following PCIT for physically abusive parents.

New directions for PCIT research

The importance of using empirically-supported treatments to attain significant and lasting changes in child mental health outcomes for underserved populations is increasingly recognized. With ethnic minorities in the United States projected to constitute over 50% of the population by the year 2050 (US Census Bureau, 2004) and the existence of documented mental health disparities for these groups (US Department of Health and Human Services, 2001), examination of treatment effectiveness with ethnic minority children is critically important. Studies have identified differences between ethnic minority groups and European Americans in beliefs about the causes of child behaviour problems (Yeh, Hough, McCabe, Lau, & Garland, 2004), risk factors (Deater-Deckard & Dodge, 1997; Deater-Deckard, Dodge, Bates, & Pettit, 1998), help-seeking patterns (McMiller & Weisz, 1996) and service utilization settings (Yeh et al., 2002) – all of which may impact the effectiveness of a treatment. Studies also show that risk factors known to affect treatment attrition, such as socioeconomic disadvantage and parent stress, are over-represented among ethnic minorities (e.g. Kazdin, Stolar, & Marciano, 1995), and ethnic minority status has been associated with higher attrition in several child treatment studies (Kazdin et al., 1995; Kendall & Sugarman, 1997). Ethnic differences in values, beliefs, attitudes and behaviours are also likely to affect treatment response (Bernal, Bonilla, & Bellido, 1995; Forehand & Kotchick, 1996; Nagayama Hall, 2001). For these reasons, the effectiveness of any EST for use with children in individual ethnic minority groups must be examined specifically.

Review of the literature on ESTs within ethnic minority groups indicates that certain ESTs produce positive changes in child behaviour (Miranda, Bernal, & Lau, 2005). Similar improvements in disruptive behaviour among European American and ethnic minority children have been found with the 'Incredible Years' parenting programme (Reid, Webster-Stratton, & Beauchaine, 2001) and with multisystemic therapy (Henggeler, Melton, & Smith, 1992). Structural family therapy has also been found to decrease disruptive behaviours among

an ethnic minority group (Santisteban et al., 2003). Although most child treatments have been examined with European Americans (Chambless et al., 1996; Weisz, Doss, & Hawley, 2005), there is increasing recognition of the importance of examining child behaviour outcomes for ESTs within individual ethnic minority groups.

Examination of ESTs with specific ethnic minority groups can help to determine whether existing treatments are effective with these groups and whether they can be adapted to achieve better outcomes. Adaptations of existing ESTs for ethnic minority groups may improve treatment retention, engagement, outcomes and satisfaction with treatment, although few studies have yet examined whether adaptations to ESTs provide incremental improvement to standard ESTs.

PCIT treatment research with ethnic minority groups

McCabe, Yeh, Garland, Lau, and Chavez (2005) described a process of adapting PCIT for Mexican American families. They first gathered information from earlier studies and focus groups to identify potential adaptations expected to make PCIT more acceptable and effective for Mexican Americans. For example, based on their focus group data suggesting that Mexican American parents associate stigma with mental health treatment, they renamed the treatment 'Guiando a Ninos Activos' (GANA, translated 'Guiding Active Children') to de-emphasize the 'therapy' aspect of PCIT. Based on their qualitative research with Mexican American families indicating frequent collectivist family decision-making, another adaptation they made was the addition of an engagement protocol for parents and extended family members at the beginning of treatment to increase participation and reduce attrition. After consultation with the treatment developer on their final list of adaptations, McCabe et al. undertook examination of the incremental validity of the adapted PCIT by conducting a randomized controlled trial in which they compared it to standard PCIT for Mexican American families. This careful empirical approach represents a gold standard for developing culturally sensitive applications of PCIT that retain the effectiveness (retention, outcome, satisfaction) of the established treatment. Adherence to this standard for applications of PCIT to other ethnic minority groups will assure that efficacy is not only maintained but also enhanced.

PCIT assessment research with ethnic minority families

Because PCIT is an assessment-driven intervention, psychometric study of the assessment instruments that are integral to treatment must also be undertaken with ethnic groups who may be seen in treatment. Indices of both reliability and validity of measures may vary across populations (Haynes, Nelson, & Blaine, 1999), which could result in differences between ethnic groups in the reliability or validity of a measure.

The two instruments most central to PCIT process are the ECBI and the DPICS. Preliminary evidence of internal consistency reliability of the ECBI with African American children has been reported from data in the 1999 restandardization sample (Colvin, Eyberg, & Adams, 1999). That study also reported descriptive data for the ECBI scales with African Americans that suggested comparability in score interpretation across ethnic groups (see Eyberg & Pincus, 1999). However, to ensure the suitability of current PCIT criteria for treatment completion with ethnic minority families, it will be important to examine the specificity and sensitivity of published clinical cut-off scores in diverse groups. Examination of the clinical utility of ECBI discrepancy scores with diverse ethnic groups will also be important.

Psychometric properties of the DPICS with ethnic minority families have not yet been reported. The DPICS categories include indices used to evaluate child management strategies known to be beneficial or detrimental to child mental health within European American samples. However, for all DPICS categories, it will be important to examine normative data in different ethnic groups. Studies have found differences in the length of utterances (Welkowitz, Bond, & Feldstein, 1984) and frequency of utterances (Wheat & Hudson, 1988) between ethnic minority groups and European Americans. Differences in length of utterance (time) required to convey an idea as well as the frequency of utterances (speed of speech) during parent-child interactions may have significant implications for the criteria used to assess skill mastery in PCIT. Thus, future PCIT research with ethnic minority families must include psychometric research on the measures integral to treatment.

Conclusions

This article describes the PCIT treatment procedures and provides an overview of its theoretical and empirical base for the treatment of disruptive behaviour in young children. The evidence of efficacy has been demonstrated with largely European American samples. In line with recognition of the importance of not assuming 'one size fits all' for diverse cultural groups in the United States, PCIT assessment and treatment research is beginning to turn its attention to ethnic minority groups. This research has the promise of identifying ways to maintain and maximize the efficacy of PCIT for ethnic minority families, which have traditionally been under-represented in mental health services and treatment outcome research.

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