

Tailoring and Adapting Parent-Child Interaction Therapy to New Populations

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Abstract

This paper discusses the processes of tailoring and adapting empirically supported treatments (ESTs) for application to new populations, using examples from the five papers in this special issue on innovative approaches to parent-child interaction therapy (PCIT). The applications of PCIT in this issue represent a range of approaches to tailoring and adapting ESTs in ways likely to maintain and improve upon efficacy or efficiency in the new population. The discussion emphasizes the ways in which the new applications maintain the theoretical and empirical foundation of PCIT and its core defining features as they address new populations, target problems, belief systems, and settings.



The empirically supported treatment (EST) movement, with its rigorous standards for evaluating the efficacy of mental health treatments (Chambless & Hollon, 1998), is increasingly influencing child treatment research as investigators attempt to move evidence-based treatments into the real world with wider applications. To be designated an EST, the research base of the treatment must include at least two well designed, randomized controlled studies conducted with similar, but not overlapping, samples that find treatment group outcomes meaningfully superior to control group outcomes on the targeted measures. Once identified as efficacious in the laboratory, the generalizability of an EST may then be examined in new settings and with new populations.

The five papers in this special issue illustrate innovative applications of Parent-Child Interaction Therapy (PCIT), an EST for disruptive behavior in young children. These papers represent a range of approaches to applying an EST to new child and family populations in ways likely to main-

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tain and improve upon efficacy or efficiency in the new population. McCabe and her colleagues (this issue) present a cogent method for creating optimal acceptance as well as efficacy of PCIT in culturally diverse populations. The paper by McDiarmid and Bagner (this issue) offers useful ideas for training parents of children with developmental delays to enhance their children's learning of new, more cooperative behavior. Herschell and McNeil (this issue) review ways that various investigators have applied PCIT in families with child abuse histories. Pincus and colleagues (this issue) illustrate how PCIT can be applied to new presenting problems and diagnostic groups, with new procedures incorporated into the PCIT model when indicated. Finally, the paper by McNeil and her colleagues (this issue) describes the delivery of PCIT in a workshop format for foster parents. Thus, the papers in this issue illustrate a range of innovative approaches in the application of PCIT to new populations.

What are the Core Features Parent-Child Interaction Therapy?

PCIT is a manualized treatment with certain core defining features. First, the parent and child together in treatment sessions are actively engaged in learning new and more positive ways of interacting with one another. The therapist first observes and codes their interactions (tallies the relevant behaviors) to assess progress and determine the behaviors of the parent and child that have most immediate need for change. The therapist then teaches positive parenting skills by coaching the parent (verbally shaping the parent's behaviors by cueing and reinforcing closer and closer approximations to the goal behaviors determined from coding) in two initially distinct patterns or templates for parent-child interaction: following the child's lead (called child-directed interaction) and leading the child (called parent-directed interaction). These two interactions represent the two aspects of Baumrind's authoritative parenting, nurturance and firm limits, required for optimal psychological development of the child. The papers in this special issue demonstrate many ways in which these two PCIT interactions may be fine-tuned for application to specific populations. The applications described in this issue also demonstrate fidelity to the behavioral foundation of PCIT, so that what parents learn in all of these applications of treatment is the same. I am not referring here to the "PRIDE skills" or the "PDI skills," but to the functions of these behaviors, which parents learn as they are coached in following or leading their child in play. That is, parents are not taught specific statements to use in response to specific child behaviors (e.g., "Say 'good asking nicely' whenever your child asks nicely for a toy"). Instead, parents learn broad classes of behavioral antecedent and response behavior (e.g., "Give specific positive attention whenever your child is behaving acceptably;" Bell, Boggs, & Eyberg, 2003). Therapists teach these parenting behaviors (principles) to parents through the intensive operant conditioning that occurs during coaching. Simultaneously during coaching, the parents' new skills serve to teach their child

new behaviors (social interaction skills; cooperation) through the same mechanism of operant conditioning, with the CDI and PDI "rules" serving to cue the concrete examples of these principles. The coaching sessions, then, constitute a moment-by-moment functional analysis in which the behaviors of both the parent and the child are shaped toward healthier interpersonal interactions that characterize positive parent-child attachment and collaborative social functioning.

Two other features important in PCIT are exemplified by the applications described in this issue. One is the clinical validity of the applications. The papers clearly convey the influence of clinical experience in accommodating PCIT to the new populations. The authors are not only scholars and scientists, but also highly trained and talented clinicians with extensive experience in treating the populations they describe, and the clinical applications reflect their own expertise.

A second feature is the evolution of these innovative approaches to PCIT in lock step with the empirical basis for the changes that are made. As Chambless and Hollon (1998) emphasized, treatments are not empirically supported or efficacious *per se*, but are efficacious for a specific problem or population. Thus, precisely speaking, PCIT is an empirically supported treatment for disruptive behaviors in Caucasian preschoolers. One recent study in our lab has demonstrated retrospectively a positive treatment effect for disruptive behavior in African American children (Fernandez & Eyberg, 2004). Yet PCIT is not established as an "empirically supported treatment for disruptive behavior in African American children." For designation as efficacious within a specific population, a treatment application in that population must have its efficacy demonstrated on the relevant target measures in studies meeting the same methodological criteria as the established treatment. Each of the applications in this special issue is recognized by its authors as a hypothesis in testing, with a solid research foundation that bodes well for its ultimate designation as an empirically supported application of PCIT in the new population.

Changes in PCIT

To this point I have emphasized the common elements that define PCIT, the elements that do not change when PCIT is applied to new populations. Yet, when ESTs for one population are examined for use in a new population, alterations may be needed. For example, differences in family attitudes, beliefs, or behaviors that are relevant to the treatment (such as parenting beliefs), or differences in the target behaviors of the new population, may require changes in the treatment.

The applications of PCIT described in this special issue represent different kinds of change. *Tailoring* refers to changes made in the focus or delivery style of essential elements in an established treatment, based on the unique features of the individual case. When these kinds of changes are thought to enhance the treatment of families in a specific population more

generally, such as the emphasis on playfulness in CDI with separation anxious children described Pincus et al. (this issue), the changes may be manualized and examined formally. Treatment *adaptations* refer to changes in the structure or content of an established treatment. Adaptations are typically made when aspects of the standard treatment are not feasible or sufficient in the new population, such as the “in-room coaching” (Rayfield & Sobell, 2000) used in pediatric primary care and other community settings without observation room facilities. Finally, treatment *modifications* refer to universal changes in established treatments, made by the treatment developer. Treatment modifications typically result from treatment component research examining changes that improve efficiency or effectiveness of the treatment in the original population, such as the inclusion of individual parent support for stressors unrelated to child behavior in each PCIT session (e.g., Harwood & Eyberg, 2004). All changes to an empirically supported treatment require empirical validation of the changed treatment as a whole, in the intended population, to assure that the treatment remains efficacious.

PCIT is by definition tailored to the individual family in treatment, both in process and content. As an example, the extent of abstract versus concrete explanation used in teaching parenting skills varies with each parent. Tailoring the content of PCIT to the individual family occurs as well. For example, PCIT delineates basic verbal behaviors (e.g., reflection, description) that parents use in response to positive child behaviors. Yet because problem behaviors within each dyad are expressed uniquely, different parents may be taught to respond to identical child behavior in very different ways: With a shy withdrawn child, a parent may be coached to use elaborated reflection after every child comment; with a loud noisy child a parent may be coached to wait for an “inside voice” before reflecting. The McDiarmid and Bagner paper (this issue) provides many suggestions for tailoring PCIT in ways that may extend across families of children with developmental delay, derived from the literature and their clinical experience with this population. They describe two studies underway that promise not only to inform our understanding of PCIT efficacy with families of children with developmental delay but also to examine issues of training and dissemination of PCIT in community agencies working with these families.

With increasing emphasis on the dissemination of efficacious treatments (Herschell, McNeil, & McNeil, 2004), many adaptations of PCIT from the laboratory to the community are beginning to appear. The paper by McNeil and colleagues (this issue) is one of the first published studies examining a community adaptation of PCIT, historically delivered in a clinical context with an individual family format of treatment delivery. This study points to many of the difficult issues that must be examined not only when changing the format and setting of treatment but also when changing the performance-based feature of PCIT to a time-limited adaptation. The results of the McNeil et al. study are provocative and raise many important ques-

tions for future study.

The research of Pincus and colleagues illustrates an important next step in empirically fitting PCIT to a population with new treatment goals. The mechanisms of change in PCIT involve operant principles of behavior change, which map well onto several target behaviors of SAD, and the relationship changes of CDI seem to calm tensions in the mother-child attachment in this population. Yet the structure of standard PCIT did not lend itself well to the classical conditioning paradigm of exposure to separation, a fundamental mechanism of change in SAD. The innovative design of the "bravery-directed interaction" seems to fit seamlessly into PCIT, and the rigorous test of efficacy of this adaptation of treatment, as well as its comparison to standard PCIT, will inform the scope of PCIT application.

Finally, the process described by McCabe et al. (this issue) to identify and then test the potential incremental validity of tailoring or adapting aspects of PCIT for Mexican American families presents a gold standard for developing cultural applications of empirically supported treatments that retain the effectiveness (retention, outcome, satisfaction) of the established treatment. Adherence to this standard for all applications of PCIT, including its modifications, will assure that effectiveness is not only retained but enhanced. The recommendations for GANA teachers resulting from the careful research of McCabe and her colleagues may improve treatment retention, outcome, and satisfaction for all families in PCIT.

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