

Preface

Why a Second, Expanded Clinical Edition?

The first edition of this book, *Parent-Child Interaction Therapy*, was published in 1995 as part of a series called “Issues in Clinical Child Psychology.” As the first book written about PCIT, it was designed to be a readable clinical guidebook describing how to conduct the therapy. At the time the original text was written, PCIT was used in only a few clinical child psychology research laboratories. Having experienced great success with this treatment approach in our own clinical work, we felt an urgent need to make PCIT more available to families. It was our hope that the treatment would be embraced by mental health professionals from a variety of theoretical orientations. Indeed, the book – along with Sheila Eyberg’s programmatic research effort – sparked a tremendous amount of interest and served as a catalyst for more than a decade of rapid dissemination and empirical evaluation of PCIT.

In 2008, circumstances have changed tremendously. Instead of being available only in university-based clinics in a few states, PCIT is now being provided to families across the country in community mental health settings, private practices, hospital-based clinics, and head start programs. In addition to clinical child psychologists, providers of PCIT now include social workers, counselors, marriage and family therapists, play therapists, and other masters-level clinicians. For example, in California alone, approximately 100 agencies provide PCIT, and there is even a mobile unit delivering PCIT in a 35-foot long Winnebago! In addition to widespread delivery in the United States, PCIT is now available in many other countries including Norway, Australia, Hong Kong, Russia, South Korea, England, The Netherlands, Taiwan, and Canada. PCIT’s strong empirical base also has grown tremendously resulting in both academic and governmental recognition. PCIT currently is recognized as an evidence-based program by numerous professional groups and state and federal agencies including the Kauffman Foundation’s Best Practices Project, Society of Clinical Child and Adolescent Psychology, and the National Child Traumatic Stress Network.

As a result of the rapid dissemination of PCIT, much more information has been generated regarding both clinical applications and treatment effectiveness. The scope of PCIT has broadened greatly with published reports of its use with a variety of children other than oppositional preschoolers. PCIT has shown

promising results with victims of maltreatment, anxious children, children with ADHD, and those with developmental disabilities. The body of empirical data available on PCIT has grown exponentially. Whereas in our first book, we devoted three paragraphs to describing the outcome literature, the new edition requires a full chapter to overview the wealth of outcome data now available. In the second edition of *Parent-Child Interaction Therapy*, our goal is to compile this rich new clinical and research information into a readable sourcebook for therapists and researchers.

Organization of the Second Edition

The second edition is broadly divided into two sections. In Part I, we describe the fundamentals of PCIT as it was developed by Dr. Sheila Eyberg and is described in her 1999 manual entitled, “PCIT: Integrity Checklists and Session Materials.” We strongly recommend that therapists obtain Dr. Eyberg’s manual and use the checklists to guide each therapy session. The treatment integrity checklists and other session materials currently are available for download on Sheila Eyberg’s web site (www.pcit.org). With regard to the first section of the second edition, you will find that this part of the book greatly resembles our original PCIT text, with some important modifications. Notably, we have updated the text to reflect the current research-based treatment protocol being used in Dr. Eyberg’s laboratory at the University of Florida. For example, Dr. Eyberg’s mastery criteria have changed since the publication of the original book. Also, the use of a backup time-out room is now the standard for teaching children to stay in the time-out chair. It is critical for both clinicians and researchers to know about changes to the treatment protocol and to update their own practices accordingly. It is important for clinicians to know that the changes made by Dr. Eyberg are based on solid empirical and theoretical rationales. Over the past decade of dissemination, we have seen many therapists make their own changes in procedures based on personal preference and experience. In many cases, their therapies have evolved into treatments that bear little resemblance to standard PCIT. When this occurs, effectiveness is generally diluted and research findings on PCIT are no longer applicable to the work being conducted in their clinics.

With respect to the dangers of therapeutic drift, we find it helpful to consider a boating analogy. Let us imagine that Dr. Eyberg’s research-based protocol is the “mother ship” anchored off the coast of Florida. In order to provide a therapy that resembles the evidence-based anchor, it is important for therapists to be knowledgeable about and adhere to the standard protocol. The cumulative effects of multiple small changes to the treatment protocol (i.e., letting out some line) may cause such substantial drift that the therapist ends up off the coast of Mexico providing a version of PCIT that looks almost nothing like the “mother ship” protocol anchored near Florida. The danger to letting out so much line is that the new treatment may not work as well as standard PCIT. Ultimately, widespread drift could undermine our efforts to disseminate this potent treatment to families. When therapists provide ineffective treatments under the guise of PCIT, they erode its standing as an evidence-based intervention. Therefore, Part I of the book serves as our

PCIT “anchor” encouraging therapists to provide PCIT with the greatest treatment integrity.

Part II of the book goes beyond the fundamentals of PCIT to present rich clinical examples of how one can expand PCIT to address a spectrum of child and parent concerns in diverse settings. For example, in Part II, we discuss the application of PCIT to special populations other than the preschoolers with oppositional defiant disorder addressed by the standard protocol presented in Part I. We are excited to share with our readers recent developments in the use of PCIT as a prevention model with babies and toddlers. We also highlight interesting work being conducted in the adaptation of PCIT to older elementary school age children and siblings. A PCIT protocol has been developed and evaluated for young children with anxiety disorders. To illustrate, we provide the reader with a case example to demonstrate the addition of an exposure phase to PCIT, which Donna Pincus termed, “bravery-directed interaction.” Ground-breaking research demonstrating the success of PCIT in reducing future incidents of abusive parenting is presented in this section of the book. We enumerate specific clinical guidelines for working with parents who have anger control problems and their children with trauma histories. In addition, the second part of the book provides clinicians with helpful insights and tools for working with culturally diverse and multi-problem families. New approaches are outlined for the use of PCIT in varied settings such as residential treatment facilities, schools, and homes. The book concludes with a discussion of training issues including minimum qualifications and skills necessary to represent oneself as a PCIT therapist.

Contributors to the Book

When we were invited to write *Parent-Child Interaction Therapy: Second Edition*, we grappled with whether to write the book entirely ourselves or to make it an edited book compiling chapters written by our PCIT colleagues. On the one hand, we have heard from readers that a strength of the original PCIT book was that it was written with a clinical voice. They appreciated that the book incorporated language that we actually use in our interactions with clients. We wanted to preserve that practical clinical tone in the expanded edition. On the other hand, we wanted to present cutting edge work that is being conducted with special populations. In some instances, we felt that particular chapters might be better written by individuals immersed in this specialized work. In the end, we decided to combine the best of both approaches by writing the majority of the book ourselves, while inviting select experts to contribute certain chapters. We are grateful for the contributions of the following colleagues: *Karla Anhalt, Åse Bjørseth, Joaquin Borrego, Gus Diamond, Kimberly P. Foley, Matthew Goldfine, Amy D. Herschell, Joshua Masse, Ashley Tempel, Jennifer D. Tiano, Stephanie Wagner, Lisa M. Ware, and Anna Kristine Wormdal*. Additionally, we want to thank Melanie Nelson for reading several chapters from this book and providing us with valuable feedback about treatment integrity.

Acknowledgments

Much of what we have learned about working with families of young preschoolers has been taught to us by the thousands of parents and children we have seen in PCIT. We are indebted to these families. The energy and resources for completing this book would have run dry long ago if not for the ever-present love and encouragement of our husbands, Dan McNeil and Tim Kigin. We appreciate their patience in taking care of our children while we worked through snow storms, corneal abrasions, car accidents, back injuries, and many childcare crises. We also want to thank our amazing children Danny (13), Will (10), Molly (13), Sean (10), and Patrick (7) for giving up so much “mom time” to support this endeavor over the past year.

Finally, this book would never have been written without the tutelage and support of our mentor and colleague, Sheila Eyberg. We hope this book does justice to her work. Dr. Eyberg is to be credited for all that shines in PCIT, and we bear full responsibility for all shortcomings of this book.

Morgantown, West Virginia
Mesa, Arizona

Cheryl Bodiford McNeil
Toni L. Hembree-Kigin

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<http://www.springer.com/978-0-387-88638-1>

Parent-Child Interaction Therapy

McNeil, C.; Hembree-Kigin, T.L.

2010, XVIII, 484 p., Hardcover

ISBN: 978-0-387-88638-1