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**CHILDREN'S
SOCIAL
CARE**

EMMIE SUMMARY

**Parent-child
interaction therapy**

March 2019

Acknowledgements

We thank our research colleagues at CASCADE who supported the preparation of this EMMIE summary report;

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This evidence summary is based on the following systematic review

Batzer, S., Berg, T., Godinet, M.T. & Stotzer, R.L. (2018). Efficacy or Chaos? Parent-child interaction therapy in maltreating populations: A review of research. *Trauma Violence Abuse*, 19(1), 3-19. DOI: 10.1177/1524838015620819.

What is the intervention?

Parent-Child Interaction Therapy (PCIT) was developed in the 1970's and aims to enhance the parent-child relationship and teach parents how to respond effectively to children's disruptive behaviour (Eyberg, 1988). The intervention was designed for children aged between 2 and 7 years. It combines aspects of play therapy, to reinforce good behaviour and behaviour therapy, to reduce negative behaviour. This is a two-phase intervention that focuses on enhancing the parental response to the child's prosocial behaviours, before providing parents with the skills necessary to establish limits and boundaries for the child. The average length of PCIT is 12 to 14 sessions.

Whilst PCIT is an established evidence-based treatment for children presenting with disruptive behaviour, the intervention has recently been adapted for other child and parent populations. Batzter et al's (2018) narrative review focuses on abused children and consequently shifts the therapeutic focus from child behaviour to parenting behaviour. This review addresses the question of whether an intervention designed to impact severe child disruptive behaviour can be effective in reducing re-referrals for child abuse and parent-child abuse risk.

Which outcomes were studied?

The review examined the following outcomes:

- Reducing re-referral rates for child abuse
- Reducing risk of child abuse

Effectiveness: how effective are the interventions examined?

Outcome 1: Reducing re-referral rates for child abuse

Effect rating	1
Strength of Evidence rating	2

PCIT was found to be effective in reducing re-referral rates for child abuse. Findings from four studies involving 572 parent-child pairs, revealed that PCIT was effective for reducing re-referral rates of child abuse for cases involving physical abuse but not those involving neglect. Lower levels of re-referral were also found in a longitudinal study which looked at re-referral rates over a two-year period.

Of the nine studies which examined the risk of child abuse, six found that PCIT was effective in reducing child abuse risk based on outcome scores for parenting beliefs, expectations and external stressors. This was based on findings from 604 parent-child pairs.

The reviewers highlight the lack of data for parent-child pairs who did not complete the intervention. Without this information it is not possible to comment on whether parents and children benefit from partial completion of PCIT. This is particularly noteworthy given the drop-out rates reported in the included studies, which ranged from 17-47%.

Mechanisms: When, where and how does it work?

The review considers the causal mechanisms for PCIT highlighting its basis in attachment (Bowlby, 1969) and social learning theories (Bandura, 1977). The reviewers note the included studies do not consistently or reliably assess attachment but rather focus on concrete interactions between parent and child. Of the 11 studies, only two studies measured parent sensitivity, with varying results.

The type of attachment style was found to interact with the intervention effects. The intervention was found to be effective in the context of child physical abuse, but not in cases involving child neglect or inter-parental violence. The reviewers hypothesise that PCIT is less successful in cases of neglect due to the nature of the attachment between parent and child. PCIT is well-suited to the avoidant attachment styles commonly displayed by physically abused children as it is designed to develop parent skills within dynamic interactions with their child. However, it is less suited to the anxious or ambivalent attachment styles of children who have experienced neglect or inter-parental violence (Finzi, et al, 2000).

Whilst the effectiveness of delivering PCIT in the home is established in its original format, families with abused children may be chaotic and unstable rendering in-home delivery impractical. Further, the intervention relies on repetition to cement behaviour change, which involves a commitment of 30 minutes each day to practice new skills. In cases where a child has been removed from home, the intervention is less effective as opportunities to practice are unavailable and newly learned skills begin to degrade, with parents reverting back to previous, negative behaviours (Chaffin et al, 2012).

The reviewers observe that PCIT was not designed for populations of abused children and as such, more research is needed when applying the intervention to this group.

Moderators: who does it work for?

The intervention was designed to address the disruptive behaviour of young children aged between 2 and 7 years. There is no evidence presented for older children and, consistent with previous research on disruptive behaviour, most children were male. Mothers were over-represented as the sample consisted of over 85% mother-child pairs. The effects of PCIT upon the father-daughter pairs is less well represented.

The review found that PCIT was most effective with parents who were motivated to engage with the intervention. This is particularly important as PCIT includes homework activities. The reviewers hypothesise that parents who were referred or court-mandated to attend may not have had the same expectations or desire to repair their relationship with the child as those who choose to attend. This may account for the high drop-out rates across all 11 studies. For those parents with low motivation, the coupling of PCIT with motivational interviewing techniques benefited more than motivational interviewing combined with treatment as usual. Where parents are receiving other therapies such as drug treatments and interventions for domestic violence, PCIT is less effective (Chaffin, et al 2004).

The findings presented were unclear as to the optimal duration of PCIT. Whilst the original PCIT format requires that parents must master phase one before embarking on phase two, for abused children this extended the intervention from an average of 12 to 14 sessions to 53 weeks (Thomas and Zimmer-Gembeck, 2011). A later study by the same authors suggested that prolonging the intervention may negatively impact drop-out rates (Thomas and Zimmer-Gembeck, 2012). This finding is inconsistent with interventions that have positive results where PCIT is prolonged with the inclusion of motivational interviewing.

Implementation: How do you do it?

The review looked at some key aspects of implementation and found that whilst PCIT is amenable to adaptation there are still some areas that require further research. In its original format, PCIT is a manualised intervention but the relevance of these manuals to the adapted version is unclear. The authors highlight mixed findings in relation to the optimum duration and emphasise that parent motivation is a key influence on engagement and drop-out.

The intervention is delivered in two phases. Phase one, the 'child-directed intervention' (CDI) focuses on enhancing the parent-child relationship and increasing the child's pro-social behaviours. Parents must master these skills before moving on to phase two. Phase two, the 'parent-directed intervention' (PDI) provides parents with the skills necessary to establish limits and boundaries for the child. During both phases, parents receive coaching by a therapist who is positioned behind a two-way mirror. Parents are given homework activities throughout the intervention.

Finally, with regard to implementation, a key question is whether the findings of this review are generalisable to the UK. All but two of the studies included were from the USA, with the remaining two from Australia.

Economics: What are the costs and benefits?

No economic analysis is included. However, the reviewers note that PCIT is an expensive method of treatment due to the inclusion of therapists, their training, and the need for modified treatment rooms.

What are the strengths and limitations of the review?

This review is a comprehensive attempt to assess the effects of PCIT in reducing re-referral rates for child abuse and risk of child abuse through strengthening parent-child attachments. A thorough discussion of theoretical underpinnings of the intervention is included which provides a good understanding of how the intervention is meant to work. The review clearly articulates the complexities of PCIT and gives a useful overview of the key issues of implementation of the intervention.

The review does, however, have a number of limitations. Whilst the review comprehensively reported search and inclusion criteria it lacks the reporting rigour of a systematic review. It does not therefore report on how inter-rater selection of studies was addressed, nor does it provide a diagram of this process.

Whilst it is difficult to assess how these limitations impact on the knowledge base this paper provides, it does provide an overview of the effectiveness of PCIT as an intervention for reducing re-referral rates for child abuse and reducing the risk of child abuse.

Summary of key points

- PCIT appears to have a positive effect in reducing re-referral rates or re-offending in physically abusing families. However, no effects were found for child neglect.
- Drawing on attachment and social learning theories, PCIT aims to improve parent-child attachment and the potential of child abuse re-occurring by re-shaping parental expectations of their child and reducing parental distress.
- The effectiveness of PCIT in reducing child abuse is reliant on parent motivation and the completion of both phases of the intervention. Mastery of phase one is a requirement for progression on to phase two. This, however, appears to contribute to a high drop-out rate.
- Whilst PCIT is amenable to adaptation, evidence suggests a lower impact when parents undertake the intervention in parallel to other interventions.
- It has been suggested that PCIT could be a costly intervention.

References

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