# PCIT Adaptations for Anxiety Treatment

Sim Yin Tan, PhD, Shanee Toledano, PhD, and Mina Yadegar, PsyD

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## Disclosures

**Sim Yin Tan, PhD, Shanee Toledano, PhD, and Mina Yadegar, PsyD,** have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. Drs. Tan, Toledano, and Yadegar each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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## Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe the standard PCIT components and at least two differences and two similarities with adaptations for anxiety.
2. List two ways PCIT parenting skills can be applied to exposure-based treatment for anxiety.

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## What we'll cover in this webinar

**An overview of PCIT**
- PCIT and its treatment components
- Child-directed interaction (CDI)
- Parent-directed interaction (PDI)
- Diverse populations

**PCIT adaptations for anxiety**
- What is a PCIT adaptation? What is the difference between practicing PCIT and applying PCIT skills or components?
- Rationale for adapting PCIT to address anxiety
- Evidence for adaptations for anxiety
- Exposure therapy principles and theories
- Description of evidence-based interventions
- Adapting CDI for anxious children

**Applying and integrating PCIT components**
- Integrating CDI and exposure-based phases
- Reward chart and contingency plan
- Case example

**Moderated Q&A**

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## Overview of PCIT

- Developed in the 1970s by Dr. Sheila Eyberg
- Evidence-based intervention that incorporates play and behavioral parent training
- Based on attachment and social learning theories
- Originally developed for children ages 2-7 with disruptive behavior problems such as:
  - Oppositional defiant disorder
  - ADHD
  - Conduct disorder

(Eyberg & Funderburk, 2011)

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## Defining features of PCIT

- Parent and child together in treatment
- Individualized live parent coaching sessions – “bug in ear”
- Assessment-driven
- Progression is contingent on meeting expected competency criteria

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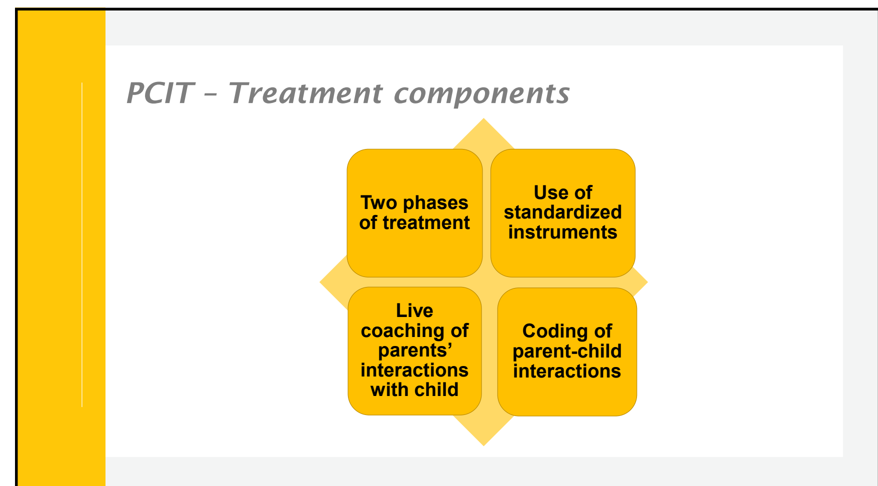


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## Two treatment phases of PCIT

**Child-directed interaction (CDI)**
- Play skills
- Warm and accepting parent behavior
- Differential attention

**Parent-directed interaction (PDI)**
- Continue showing warmth
- Effective commands
- Time Out for noncompliance
- Generalization to home
- Generalization to public settings

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## Child-directed interaction (CDI)

- Fundamental principle: *Follow the child's lead*
  - **DO skills:**
    - **P**raise
    - **R**eflect
    - **I**mitate
    - **D**escribe
    - **E**nthusiasm
  - **DON'T skills:**
    - Give commands
    - Ask questions
    - Criticize
  - Ignore minor misbehaviors
  - Stop play for aggressive or destructive behaviors

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## Child-directed interaction (CDI)

- Homework
  - 5 minutes of "special time" (every day)
- Suggested toys for CDI: Creative and constructional activities
- Toys to avoid: Rule-bound, activities that could lead to rough play/aggression, or the need for limit setting
- CDI expected competency criteria:
  - 10 behavioral descriptions, 10 labeled praises, and 10 reflections
  - < 3 commands, questions, and criticisms
  - Observed during 5-minute coding session

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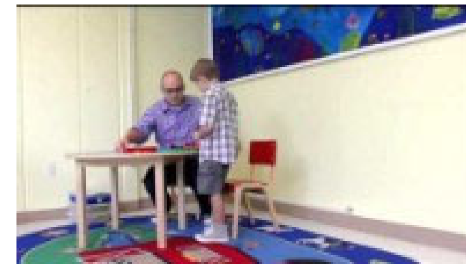
## CDI video example



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## Parent-directed interaction (PDI)

- Goal to decrease noncompliant behaviors that do not respond to differential attention
- Parents learn to give effective commands
  - Direct, positive, one at a time, specific, age-appropriate, calm tone of voice, explanations before commands, and use commands only when necessary
- Parents also learn to follow through with calm and predictable responses to child's behaviors
- PDI expected competency criteria:
  - >75% commands with correct follow-through
- Generalization of skills to other settings outside of play

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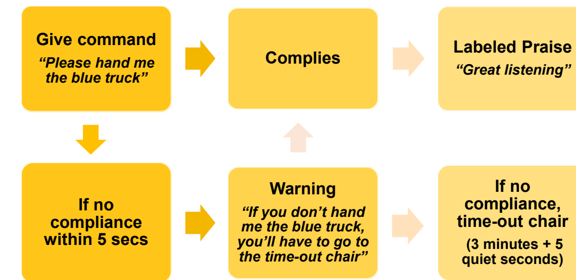
## PDI command sequence

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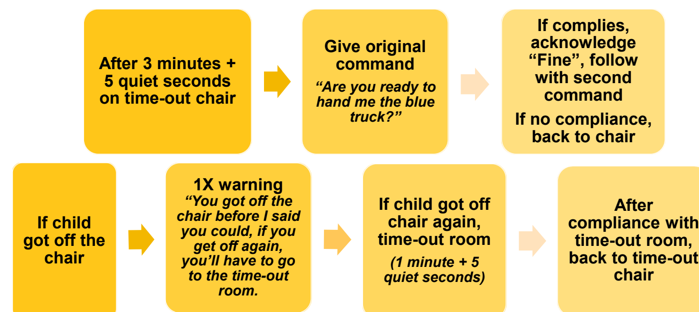
## PDI command sequence, continued

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## Position statement on use of time-out

*Written by the PCIT International Policy and Advocacy Task Force:*

- PCIT has been recognized by the NCTSN and other agencies as a trauma-informed intervention
- Time-out is one component of treatment, after parents have focused on building a nurturing relationship
- Predictable, consistent
- Parent remains in place throughout procedure
- Always followed by a return to CDI skills
- Following PCIT, trauma symptoms in children decrease; parents are less likely to use physical punishment; shows children even when they misbehave, parent will be calm

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## Assessment in PCIT

**Dyadic Parent-child Interaction Coding System (DPICS-IV)**

- Full observation pre- and post-treatment
- 5-minute observation throughout treatment
- Microanalytic: counts of specific behaviors
- Training required

**Eyberg Child Behavior Inventory (ECBI)**

- Parent ratings administered at the beginning of each session

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## DPICS-IV coding categories

**8 parent categories**

Neutral Talk
Behavior Description
Reflection
Labeled Praise
Unlabeled Praise
Question
Negative Talk
Direct Command
Indirect Command

**3 child categories**

Comply
Non-comply
No Opportunity to Comply

(Eyberg, Chase, Fernandez, & Nelson, 2014)

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## Use of the DPICS-IV in PCIT

- Determines coaching goals for each session
- Enables therapist to give feedback to parents on weekly progress
- Determines when CDI and PDI expected competency are met
- Quantifies the quality of the parent-child interaction

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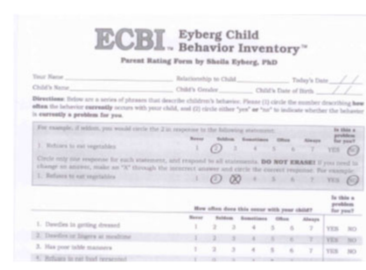
## Eyberg Child Behavior Inventory (ECBI)



ECBI Eyberg Child Behavior Inventory™
Parent Rating Form by Sheila Eyberg, PhD

(Eyberg & Pincus, 1999).

- 36 items
- Two types of scores:
  - Intensity: Frequency of problem behaviors, rated on a 7-point scale (Never to Always)
  - Problem: Yes/No rating whether parent considers a behavior as problematic
- Provides information about:
  - Parent expectations (and between caregivers)
  - Stress levels
  - Progress over time

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## Effectiveness of PCIT

**Research examining the effectiveness of PCIT has found:**

- Reduction in child disruptive behaviors
- Improvement in child compliance
- Improvement in positive parenting skills
- Improvement in parents' confidence in managing difficult behaviors
- Reduction in parenting stress
- These improvements are found to be maintained at 1-year and 2-year posttreatment follow-ups

(Thomas, Abell, Webb, Avdagic, Zimmer-Gembek, 2017)

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## PCIT applications to diverse populations

**PCIT has been successfully adapted to other populations**

- Older children, toddlers, ASD, child maltreatment/trauma, cognitive impairments, DHH, callous-unemotional traits, anxiety, etc.

(Batzer, Berg, Godinet, & Stotzer, 2018; Fleming & Kimonis, 2018; Gibson, Motzenbecker, Harvery, Han, & McKneil, 2021; Girard, Wallace, Kohlhoff, Morgan, & McNeil, 2018; McNeil, Quetsch, & Anderson, 2019)

**PCIT has been translated and applied to various cultural backgrounds within and outside of the United States**

- Chinese, Korean, Japanese, Dutch, and German
- Puerto Rican, Mexican American, American Indian and Alaska Native, and rural Appalachian families within the US

(Abrahamse, Junger, Chavannes, Coelman, Boer, & Lindauer, 2012; BigFoot & Funderburk, 2011; Leung, Tsang, Sin, & Choi, 2015; Matos, M., Torres, Santiago, Jurado, & Rodríguez, 2006; McCabe, Yeh, Lau, & Argote, 2012; Taubenheim & Tiano, 2012)

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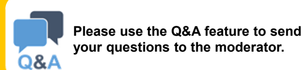
## PCIT adaptations for anxiety

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## Behavioral parent training for anxiety treatment

- Behavioral parent training long recognized as the leading intervention strategy for disruptive behaviors in children (Forehand, Jones, & Parent, 2013)
- Less common to address parenting as part of CBT interventions for anxiety (Forehand et al., 2013)
- Research support has been inconsistent, with meta-analyses finding little additive benefit to parent + child treatments as opposed to child only (Breinholst et al., 2012; Wei & Kendall, 2014)

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## Parenting targets in the treatment of anxiety

**Parental factors**
- Over-involvement, over-control
- Reinforcement of avoidance/ "family accommodation"
- Modeling of anxious behavior
- Maladaptive cognitions
- Negative or rejecting interactions

**Key intervention components**
- Grant autonomy to the child
- Enable parent to tolerate child's distress
- Teach contingency management
- Challenge beliefs and assumptions
- Increase warmth, positive interactions

Breinholst et al., 2012; Lebowitz et al., 2013; Manassis et al., 2014; Wei & Kendall, 2014

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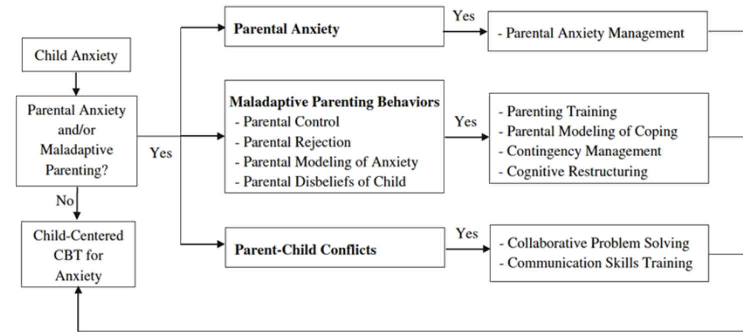
## Wei & Kendall, 2014

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## Manassis et al., 2014

- Transfer of control (TC) from therapist to parent
- Contingency management (CM)
- Reinforcing "courageous" behavior, encouraging autonomy and independence
- Minimizing attention to anxious behavior and setting limits to prevent avoidance
- Meta-analysis indicated:
  - Active parental involvement in treatment was not associated with improved outcomes in terms of clinical severity or anxiety and other internalizing symptoms
  - Active parent involvement with specific focus on CM and TC was associated with a better rate of remission at 1-year follow up

Forehand, Jones, & Parent, 2013; Manassis et al., 2014

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## Parenting components addressed in PCIT

| ***Traditional PCIT*** | |
|---|---|
| ✓ | Transfer of control (therapist-to-parent) |
| ✓ | Teaching contingency management |
| ✓ | Promoting child autonomy and decision-making (CDI phase) |
| ✓ | Increasing warmth, approval |
| ***PCIT adaptations for anxiety*** | |
| ✓ | Reducing parental modeling of anxious behavior |
| ✓ | Reducing family accommodation – Promoting exposure to feared stimuli |

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## Exposure therapy principles and theories

### *Negative reinforcement cycle of anxiety and avoidance*

Worry

Anxiety

Avoidance

Exposure

Anxiety decreases

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## Exposure therapy principles and theories

### *Habituation mechanism of exposure (Foa & Kozak, 1986)*

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## Exposure therapy principles and theories

### *Habituation mechanism of exposure (Foa & Kozak, 1986)*

- Exposures activate the feared structure
- Breaking conditioned responses via habitation
- CS – US is “un-learned” as exposures produce decreased fear overtime

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## Exposure therapy principles and theories

### ***Inhibitory learning*** *(Craske et al., 2008)*

- Learning of a new non-threatening CS-noUS association that inhibits the original CS-US
- Such inhibitory learning takes place regardless of decrease in anxiety
- Distress tolerance
- Clinical implications:
  - Instead of continuing exposures until anxiety decreases, sustain anxiety until patient learns non-threatening connections or until able to tolerate anxiety

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## Bravery ladder / Fear hierarchy

| Exposure challenge | Fear Thermometer |
|---|---|
| Going to a sleepover | 10 |
| Mom leaving to run an errand during swim class | 7 |
| Mom leaving to use bathroom during swim class | 6 |
| Sleeping independently in my room | 5 |
| Mom running errands during session | 5 |
| Getting dropped off at school | 4 |
| Mom waiting in waiting room during session | 3 |
| Getting dropped off at a playdate | 3 |
| Using the bathroom without Mom waiting outside | 3 |

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## Two adaptations of PCIT for anxiety disorders

### 1. PCIT for separation anxiety

4- to 8-year-old

(Choate, Pincus, Eyberg & Barlow, 2005; Pincus, Eyberg & Choate, 2005; Pincus, Santucci & Ehrenreich, 2008)

### 2. CALM (Coaching Approach Behavior and Leading by Modeling)

3- to 8-year-old

(Comer, del Busto, Dick, Furr, & Puliafico, 2018; Comer, Puliafico, Aschenbrand, McKnight, Robin, Goldfine, & Albano, 2012; Puliafico, Comer, & Albano, 2013)

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## PCIT for separation anxiety

- Following the intake assessment:
  1) **Child Directed Interaction (CDI):** 1 parent only CDI Teach session + 2-3 CDI Coach sessions until parent reaches CDI competency
  2) **Bravery Directed Interaction (BDI):** 1 parent only BDI Teach session + 2 BDI Coach sessions (exposures assigned as homework)
  3) **Parent Directed Interaction (PDI):** 1 parent only PDI Teach Session + 2-3 PDI Coach sessions until a family reaches criteria for treatment termination
- Do not use time out procedure for separation anxiety situations
- Exposures continue throughout PDI by assigning exposures from Bravery Ladder each week

(Choate, Pincus, Eyberg & Barlow, 2005; Pincus, Eyberg & Choate, 2005; Pincus, Santucci & Ehrenreich, 2008)

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## PCIT for separation anxiety – BDI phase

- Psychoeducation about anxiety
  - CBT triangle
  - Negative reinforcement cycle of anxiety and avoidance
- CDI during separation situations
- “Bravery ladder” (aka fear hierarchy)
- Rewards
- **Exposure homework**
- Decreasing parental accommodation by not encouraging avoidance, and instead applying CDI skills to reinforce approach of separation exposures

(Choate, Pincus, Eyberg & Barlow, 2005; Pincus, Eyberg & Choate, 2005; Pincus, Santucci & Ehrenreich, 2008)

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## CALM

- For children ages 3-8 with separation anxiety, social anxiety, GAD, and specific phobias
- Parents receive live coaching in guiding child through exposures
- Two phases:
  1. **Phase 1: CDI + exposure hierarchy + low-level exposures**
     CDI Teach + 4 or more CDI Coach sessions until parent reaches CDI criteria
  2. **Phase 2: DADS skills (In-session exposure sessions)**
     DADS Teach + 6 or more DADS Coach sessions

(Comer, del Busto, Dick, Furr, & Puliafico, 2018; Comer, Puliafico, Aschenbrand, McKnight, Robin, Goldfine, & Albano, 2012; Puliafico, Comer, & Albano, 2013)

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## *Child-directed interaction: Skills and components*

In PCIT, CDI is a set of parent behaviors and skills applied in particular settings with goals of improving the parent-child relationship and eliciting desired behaviors

- Coached during PCIT sessions
- Required as a daily, home-based practice ("Special Time")
- Intended to be generalized across settings

CDI is generally practiced without significant modification across PCIT adaptations

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## *Child-directed interaction (CDI) skills*

**PRIDE skills:**

Labeled **P**raise
**R**eflection
**I**mitation
Behavior **D**escription
**E**njoyment

Equally important to coach when to use the skills as when *not* to use the skills.

**Don't skills:**

Questions
Commands
Negative Talk

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## Labeled Praise

**Typical PCIT example:**
***"I like how you are sitting quietly."***

**Targeting social anxiety or selective mutism**:
***"I like how you are using a loud speaking voice."***

**Targeting specific fears (e.g., fear of contamination):**
***"Great job opening the door with your hand."***

**When *not* to provide labeled praise:**
Being "soft spoken" or "well-mannered," washing hands

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## Reflection

**Typical PCIT example:**
***Child: "This piece doesn't fit."***
***Parent: "It doesn't fit."***

**Targeting social anxiety or selective mutism:**
***Reflect any word, phrase; reflect speaking at any volume***

**Targeting specific fears (e.g., fear of contamination):**
***Child: "I can open the door by myself."***
***Parent: "You can open the door by yourself."***

**When *not* to reflect:**
Unverbalized thoughts; Child states "This is dirty." "The dog is going to bite me."

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## Imitation

**Typical PCIT example:**
***Child pretends a car is flying through the air.***
***Parent picks up another car and pretends alongside the child.***

**Targeting social anxiety or selective mutism:**
***Child initiates a conversation with a peer on the playground.***
***Parent initiates a conversation with an adult.***

**Targeting specific fears (e.g., fear of contamination):**
***Child touches bottom of shoe.***
***Parent touches bottom of shoe.***

**When *not* to imitate:** Child uses hand sanitizer.

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## Behavior Description

**Typical PCIT example:**
***Parent: "You're feeding the cow."***

**Targeting social anxiety or selective mutism:**
***You walked all by yourself to the classroom.***

**Targeting specific fears (e.g., fear of contamination):**
***You ate a piece of chicken that fell on the table.***

**When *not* to describe:**
"You're throwing away the chicken that touched the table."

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**Enjoyment**

**Typical PCIT example:**
***Parent showing warmth through smiling, tone, physical affection***

**Targeting anxiety:**
***Parent modeling a positive attitude toward approaching feared stimuli: bravery, enthusiasm, and (when appropriate) enjoyment***

**What *not* to convey:**
Fear, disgust, reluctance

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## *Applicability of the CDI "Don't" skills*

- During child-directed interaction, parents are instructed not to:
  - Direct behavior with instructions or commands
  - Ask questions of any kind
  - Provide critical feedback, or tell a child what not to do
- Reduction of questions and commands remains a goal beyond the CDI or treatment setting
- Negative talk can usually be avoided
  - Applied to anxiety, important not to criticize or convey disappointment in the anxious behavior

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## CALM

### *Phase 2: DADS*

Describe at least 3 statements about the feared situation → Approach the feared situation and continue to describe → Direct Command for child to approach the feared situation → Selectively attend to child's behavior

(Comer, del Busto, Dick, Furr, & Puliafico, 2018; Comer, Puliafico, Aschenbrand, McKnight, Robin, Goldfine, & Albano, 2012; Puliafico, Comer, & Albano, 2013)

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## CALM Program: DADS example for a dog phobia case

### Describe

- At least three descriptive statements

  ***"The dog is brown and white"***

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## CALM Program: DADS example for a dog phobia case

### Approach

- Parent models approach behavior

  ***"I am going to sit next to the dog"***
- Wait at least 5 seconds

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## CALM Program: DADS example for a dog phobia case

### Direct command

- Direct commands are:
  - A declarative statement that clearly tells the child specifically what to do (the positive behavior)
  - The subject is the child (e.g., "you", "your" instead of "our")
  - Stated confidently and clearly

***"Please come here and sit next to me and the dog"***

***"Please pet the dog"***

- Avoid indirect commands
  - If child does not follow direct command and approach the exposure, parent provides a brief statement about remaining in the exposure

***"I'm going to keep petting the dog"***

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## CALM Program: DADS example for a dog phobia case

### Selective attention

- Use labeled praise

  ***"I'm really proud of you for being brave and petting the dog"***

  or behavioral descriptions for approach behaviors

  ***"You are stepping closer to the dog"***
- Active ignoring of avoidance behaviors

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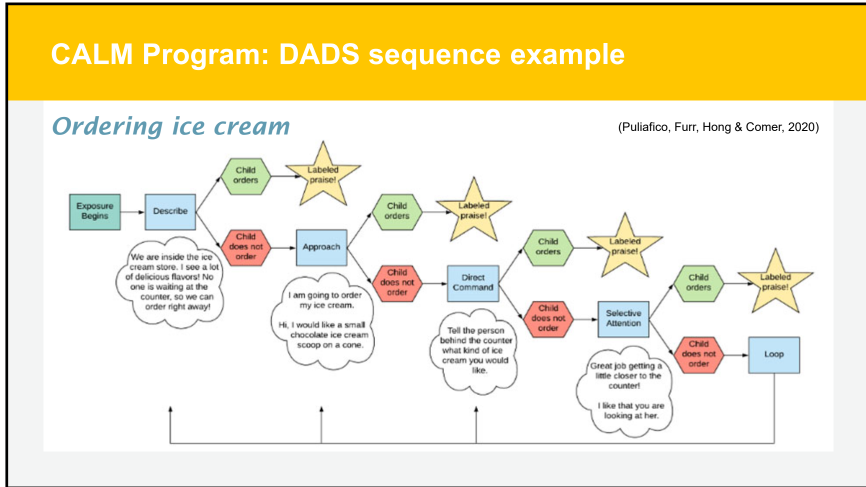


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## DADS homework

| Date | Exposure | Did your child approach the exposure? | Did you approach the exposure | Did you provide any direct commands? | Fear thermometer rating | Notes / Questions |
|---|---|---|---|---|---|---|
| 10/8 | Ordering cheese pizza | Initially looked at me to order, but then ordered in a low voice | Yes, I ordered my pizza | No, not needed | 7 | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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## *Reward system and contingency plan*

Please use the Q&A feature to send your questions to the moderator.

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### *When and why?*

- Reward system and contingency plan are considered when labeled praise, verbal encouragement, and selective attention are not enough

***Goals:***

- To establish a formal and consistent system that makes rewards contingent upon child's expected behaviors (e.g., approaching anxiety-provoking situations, completing exposure homework)
- To increase parental attention and positive reinforcement for expected behaviors
- To decrease the unpredictability in parental responses
- To set the child up for success

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## Tips for setting up reward systems

- **Be clear** – define expected behaviors and the expected rewards for each behavior
- **Be open** – to child's involvement in identifying a variety of rewards that they find motivating and are realistic and attainable
- **Be consistent and immediate** – reward as soon as expected behaviors occur, also consistency between parents/caregivers
- **Be positive** – remind them of other opportunities to earn the reward
- **Be flexible** – adjust reward system over time if it appears too easy or too hard or when previously established rewards are no longer motivating
- **Be creative** – make it fun for the child

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## Troubleshooting parental responses to reward systems

| Common parental responses: | Solutions: |
|---|---|
| *"It feels like bribery."* | Correct the misunderstanding of the concept of bribery, rewards can be a helpful tool to improve self-regulation and motivational deficit |
| *"It is too time consuming."* | Acknowledge that it take a little more time initially, but it will reduce time in the long run |
| *"It won't be fair to my other child."* | Discuss with parents the feasibility of implementing similar reward systems for other children in the family |
| *"How long do we need to implement this?"* | Reinforce the importance of consistency and discuss plan for gradually phasing out |

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## Reward system examples

**Token systems**

- Reward bravery behaviors with stars, stickers, smiley faces, points, etc.
- Tokens can be cashed in for specific rewards

**Behavioral contracts**

- For older children who may have outgrown reward charts

**Allowance limit for reassurance seeking**

- For example: Five tickets/day, when child resist reassurance seeking, tickets can be cashed in for specific rewards

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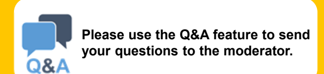
## Case example

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## Outpatient case example

Lilly is a 6-year-old Japanese American (second generation) female who lives with her mother, father, and maternal grandmother. Parents sought treatment primarily for separation anxiety.

Lilly has difficulty being in a room by herself and using the restroom independently. She has been sleeping in her parent's bed. When parents have encouraged her to go to the bathroom or sleep in her own bed, she often tantrums (e.g., yelling and throwing her stuffed animals) until parents accommodate by co-sleeping with her or accompanying her to the bathroom.

She also has difficulty listening to her parents, as parents often need to repeat themselves for Lilly to perform simple grooming tasks (e.g., brushing her teeth).

Lilly has no difficulty following directions and listening at school.

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## Outpatient treatment outline

1) Intake assessment
2) CDI Teach + exposure hierarchy building
3) CDI Coach until parent(s) reaches CDI criteria + low level exposures (parent leaves room for a few minutes to go to the bathroom)
4) DADS Teach + Exposure preparation
5) DADS Coach
   - Reward system to motivate exposure completion

Outcome monitoring throughout

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## DPICS coding sheet

| CDI Coach | 1 | 2 | 3 | 4 | 5 | Criteria |
|---|---|---|---|---|---|---|
| Labeled Praise | 2 | 4 | 7 | 8 | 11 | 10 |
| Unlabeled Praise | 0 | 1 | 0 | 2 | 3 | |
| Reflection | 1 | 5 | 6 | 9 | 10 | 10 |
| Behavior Description | 4 | 7 | 4 | 9 | 10 | 10 |
| Criticism/Negative Talk | 0 | 0 | 0 | 0 | 0 | < 3 |
| Command | 1 | 0 | 0 | 0 | 0 | |
| Question | 1 | 2 | 2 | 5 | 2 | |

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## Exposure hierarchy

| Exposure challenge | Fear Thermometer |
|---|---|
| Sleeping in my room alone | 10 |
| Showering in the bathroom alone with door closed | 7 |
| Showering in the bathroom alone with door open | 6 |
| Sleeping on a separate mattress in my parent's bed | 6 |
| Child goes to the bathroom alone with door closed during the day | 5 |
| Child goes to the bathroom alone with door open and during the day | 4 |
| Parent leaves child alone in own room for a few minutes during the day | 4 |
| Parent and therapist leaves room for a few mins | 4 |
| Parent leaves therapy room for a few mins during CDI while child continues to play with therapist | 3 |

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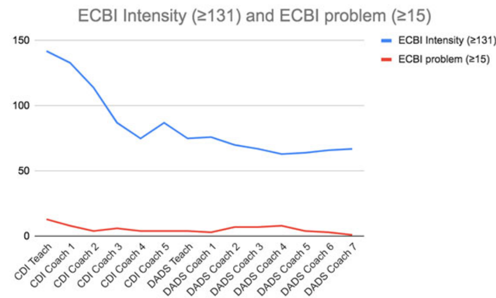
## *ECBI outcome monitoring*

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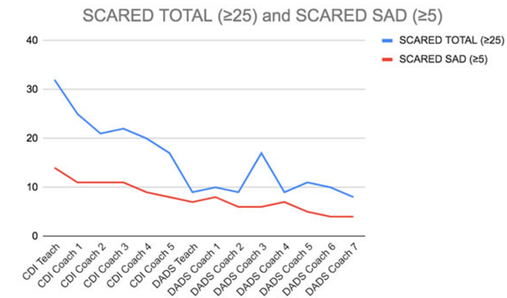
## *SCARED (parent version) outcome monitoring*

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## *If Lilly had more severe and debilitating separation anxiety and needed a higher level of care?*

In addition to avoidance of sleeping and using the bathroom independently, Lilly has been increasingly avoided attending school to the point when she has not been attending school for the past few weeks.

This has been impacting Lilly's social functioning, as she no longer sees her friends at school, and only has playdates at home when a parent is present.

Parents are considering homeschool.

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## *Adaptations to PCIT for anxiety in a PHP setting*

**Possible differences:**

- More intensive treatment allows for more exposures in the clinic with clinician's support
- Increasing periods of separation overtime to work towards a full school day, which is equivalent or longer than a day of PHP.
  - Exposures start small with parent being in next door room, in waiting room, taking short bathroom breaks and then lunch breaks outside of the clinic
- Live in the room coaching can be considered if equipment is not available
- Skill groups to learn coping skills with peers
- Separate parent groups (Parent University)
- If needed, psychiatrist within the PHP treatment team can prescribe medication

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## Adaptations to PCIT for anxiety in a PHP setting

**Similarities:**

- Core behavioral components and skills are the same (exposures + parent coaching)
- Outcome monitoring

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## Time for questions and answers…

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## Where to get additional information…

PCIT International
http://www.pcit.org/

Supporting Parenting for Anxious Childhood Emotions (SPACE) Program
https://www.spacetreatment.net/

CDI and PDI Teach resources from WVU PCIT Lab
https://sites.google.com/view/wvupcitlab/pcit-resources/cdi-and-pdi-teach?authuser=0

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## About the presenters….

*Sim Yin Tan, PhD*
Dr. Tan is a licensed psychologist and clinical supervisor at Rogers Behavioral Health in Tampa.

*Shanee Toledano, PhD*
Dr. Toledano is a licensed psychologist and serves as the clinical director at Rogers Behavioral Health in Atlanta.

*Mina Yadegar, PsyD*
Dr. Yadegar is a licensed psychologist and clinical supervisor at Rogers Behavioral Health in Los Angeles.

*Call or visit:*
800-767-4411 | rogersbh.org

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