



Infusing parent-child interaction therapy principles into community-based wraparound services: An evaluation of feasibility, child behavior problems, and staff sense of competence

Nancy M. Wallace, Lauren B. Quetsch*, Cree Robinson, Kelsey McCoy, Cheryl B. McNeil

Department of Psychology, West Virginia University, Life Sciences Building, 53 Campus Drive, Morgantown, WV 26505, United States

ARTICLE INFO

Keywords:

Parent-child relationship
Parent-child interaction therapy
Adaptation
Home-based services

ABSTRACT

The current study examined the implementation of Parent-Child Interaction Therapy (PCIT) adapted to address problem behaviors of children (ages 2–9) through a home-based service program (i.e., wraparound). The current adaptation of PCIT was implemented by community-based wraparound clinicians and compared to treatment as usual (TAU). Results indicated a significant drop in child behavior problems for children receiving PCIT-informed services compared to TAU. In addition, PCIT-informed clinicians significantly increased their sense of competence. Feasibility and future directions regarding integration and expansion of this approach are discussed.

1. Introduction

The inception of the wraparound service model, more broadly known as the “systems of care” model, started as an approach to mobile community-based services for curtailing the advancement of individuals diagnosed with complex behavioral and emotional needs into higher levels of service. While wide variability exists between wraparound service lines across states and communities where it is implemented (e.g., Wisconsin, Vermont, Oklahoma), many areas providing this service aim to address the diverse needs of multi-problem families and prevent induction into institutional care (VanDenBerg, Bruns, & Burchard, 2008). Common elements between models include services that are often provided in the home environment with resources including case management, individual and family-based counseling, legal services, or vocational services (Winters & Metz, 2009). Theoretically, the approach resembles Bronfenbrenner's (1979) ecological model, which conceptualizes behavior and individual functioning in the context of many layered, interconnected environments and influences (Burchard, Bruns, & Burchard, 2002). Further, the model positions treatment directly within a youth's natural environment, namely the home, school, and community settings (Burchard et al., 2002). A core component of treatment, family choice, was prioritized as integral to treatment success (Bruns, Walker, & the National Wraparound Advisory Group, 2008; Suter & Bruns, 2009). This approach aims to assist in enabling the youth's natural environment to promote the generalization and maintenance of treatment gains across

time.

Throughout the past two decades, research investigating the implementation of the practice has grown. Currently, it is estimated that 200,000 children and families are affected by wraparound services (Walker, Bruns, Conlan, & LaForce, 2011). Often times, children in wraparound services are involved in more than one system of care (e.g., child welfare, juvenile justice; Clark & Clarke, 1996) and may be diagnosed with a wide variety of disorders (e.g., autism spectrum disorder, ASD; attention-deficit/hyperactivity disorder, ADHD; conduct disorder, CD; oppositional defiant disorder, ODD; Wraparound Milwaukee, 2013). While promising findings have emerged from implementation and outcome research on wraparound services (Bertram, Suter, Bruns, & O'Rourke, 2011; Painter, 2012), findings on these services have also been met with considerable skepticism related to a myriad of neutral, and in some cases, negative findings (Bertram et al., 2011; Stokes, McNeil, & Wallace, 2018; Suter & Bruns, 2009). In addition, small sample sizes, high attrition rates, and weak methodological designs have seriously compromised the validity of study results (Copp, Bordnick, Traylor, & Thyer, 2007; Hyde, Burchard, & Woodworth, 1996; Painter, 2012). Despite well-founded intentions, implementation of wraparound services in today's mental health care system differs between states, resulting in varying levels of quality and unsystematic program implementation (Clark & Clarke, 1996).

* Corresponding author.

E-mail addresses: leborduin@mix.wvu.edu (L.B. Quetsch), kelsey.mccoy@huskers.unl.edu (K. McCoy), cheryl.mcneil@mail.wvu.edu (C.B. McNeil).

2. Parent-child interaction therapy

While wraparound is one behavioral health service option for families, treatments are also available via community mental health agencies to reduce child behavior problems. Specifically, Parent-Child Interaction Therapy (PCIT; Eyberg & Funderburk, 2011; McNeil & Hembree-Kigin, 2010) is an evidence-based treatment for children ages 2–7 with behavior problems shown to work with a variety of children and families in different populations (e.g., Chengappa, McNeil, Norman, Quetsch, & Travers, 2017; Masse, McNeil, Wagner, & Quetsch, 2016). Moreover, the effects of PCIT have been found to extend up to six years following the conclusion of treatment (Hood & Eyberg, 2003).

PCIT is based on a number of models including attachment theory, social learning theory, and Patterson's coercion theory (Forgatch & Patterson, 2003). Conceptualized using Hanf's two stage operant model (Hanf, 1969; Reitman & McMahan, 2012) and Baumrind's authoritative parenting style (Baumrind, 1971), caregivers are taught to balance positive, attentive caregiving responses with consistent, firm limits to foster a balance between parental warmth and control. Therapy is divided into two phases: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). The focus of CDI is in the development of a warm, positive relationship between the caregiver and child. The relationship is built by therapists coaching caregivers to increase their use of positive attention (praise, reflection, imitation, description, enjoyment) for their child's appropriate behaviors. Additionally, techniques such as selective attention are used to minimize negative interactions. In PDI, caregivers are taught to add effective commands and a highly-structured discipline procedure (time-out) to increase children's compliance and decrease negative, attention-seeking behaviors. A course of PCIT typically lasts approximately 12–20 weeks, and graduation occurs once caregivers have achieved both CDI and PDI mastery, report typical levels of child behavior difficulties according to the Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999), and report feeling confident in their ability to handle the child's behavior.

While treatment delivery of PCIT is typically done in an outpatient community mental health agency, this delivery method is a significant barrier for many families (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). Despite overwhelming evidence demonstrating the effects of PCIT on improving child behavior problems, significant implementation and delivery-based weaknesses have negatively impacted dissemination of the model, particularly high attrition rates (Fernandez & Eyberg, 2009), costly initial training and treatment materials (Goldfine, Wagner, Branstetter, & McNeil, 2008), and a lengthy certification process (PCIT International; pcit.org).

2.1. Combining wraparound and evidence-based approaches

Researchers have compared the lack of studies on wraparound services to the wealth of literature on evidence-based treatment. Some have noted that the rate of research on evidence-based treatment has far exceeded that of wraparound services (e.g., Suter & Bruns, 2009). One notable study compared child physical abuse recidivism rates between parents receiving standard PCIT, PCIT plus individualized services, and a community parenting intervention. Outcomes indicated that standard PCIT resulted in the lowest recidivism rates (Chaffin et al., 2004). However, a recent state-wide study comparing clinic-based PCIT to an adapted, home-based PCIT model indicated comparable outcomes with regard to child behavior difficulties and parent skill acquisition (Fowles et al., 2017). Importantly, staggering differences in participant attrition indicated that despite their high-risk status, 64.66% of home-based families completed treatment as compared to 33.15% of clinic-based families (Fowles et al., 2017). Such research lends evidence to the necessity and potential wide-spread impact of integrating behavioral parent training methods into wraparound services. However, further evaluation to determine the viability of implementing an adapted, evidence-based approach within the

wraparound system is clearly needed.

2.2. Feasibility approach in PCIT effectiveness research

Significant methodological and clinical weaknesses of the wraparound service model have limited its impact. Past research examining the expense of wraparound services determined the cost of such services to be approximately \$27,000 per individual, per year (Bazron, 2012), while others estimate such costs to be even higher (Kamradt, 2011). Alternatively, Goldfine et al. (2008) estimated the initial, one-time start-up cost of a PCIT facility to be \$14,000 with a single course of PCIT treatment costing \$1000 from intake to termination per family. An additional 2015 cost estimate determined that the benefit-to-cost ratio of PCIT was \$13.68 with a 95% chance that the benefits would exceed costs for children with disruptive behavior (Washington State Institute for Public Policy, 2017). However, primary weaknesses of PCIT include the lack of effectiveness research, high attrition rates, and costly initial implementation (Goldfine et al., 2008; Pearl et al., 2012; Ward, Theule, & Cheung, 2016). These factors have limited the scope of PCIT's dissemination, particularly among complex cases most in need of treatment (Lyon & Budd, 2010). Notably, however, research on home-based models of PCIT has been promising (Fowles et al., 2017; Timmer et al., 2011; Ware, McNeil, Masse, & Stevens, 2008). The current researchers recognized the striking need to develop and test the implementation of a PCIT-based system of care within the existing home-based structure of wraparound services. This new model was developed to better understand the feasibility of implementing the novel service within the wraparound systems of care.

2.3. Adapting parent-child interaction therapy

According to Eyberg (2005), core components of PCIT which cannot be altered include (a) a parent and child in treatment together learning more adaptive ways of interacting, (b) the therapist observing the parent and child, then targeting behaviors in need of immediate change, (c) the therapist teaching the parent to follow the child's lead (CDI) and leading the child (PDI), (d) parents learning how to use functional assessment to appropriately understand and respond to a child's behaviors, and (e) a therapist using operant conditioning during coaching to teach parenting principles. However, Eyberg (2005) recognized that alterations to an established treatment may be necessary. Specifically, Eyberg (2005) stated that "adaptations" to evidence-based treatments are "changes in the structure or content of an established treatment... [that] are typically made when aspects of the standard treatment are not feasible or sufficient in the new population" (p. 200). A number of key adaptations (Eyberg, 2005) were made in the present study to address the unique needs of the families and structure of the wraparound service delivery model (Appendices A, B, and C). For example, due to the guidelines proposed by the wraparound service model and limited agency resources, bachelor's level clinicians were not allowed to deliver assessments unless a supervisor was present (therefore limiting weekly, standardized assessment measures [Eyberg Child Behavior Inventory] to pretreatment and posttreatment only). Due to the number of adaptations that were made to accommodate in-home wraparound, the researchers refer to the treatment as a PCIT-informed model. This treatment model was primarily designed for children between 2 and 9 years of age with disruptive behavior difficulties (e.g., compliance, aggression). The extended age requirement was added due to the high rate of children involved in wraparound services diagnosed with developmental disabilities (Solomon, Ono, Timmer, & Goodlin-Jones, 2008) yielding developmental levels closer to the standard PCIT age range (2–7 years; McNeil & Hembree-Kigin, 2010).

The researchers developed a wraparound PCIT manual to provide an overview of the PCIT-informed skills and outline the 18 sessions of step-by-step protocol to increase treatment fidelity (Norman & McNeil, 2015). The manual was created in line with core principles of PCIT

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات