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ScienceDirect

Cognitive and Behavioral Practice xx (2016) xxx-xxx

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Enhancing Parent–Child Interaction Therapy With Motivational Interviewing Techniques

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Parent–child interaction therapy (PCIT) is an evidence-based family intervention for young children with disruptive behavior. Parents and children who complete PCIT show greater immediate and long-term treatment gains than those who discontinue treatment prematurely. PCIT is a time- and effort-intensive treatment, and parents ambivalent about its value for their child or their ability to master the treatment skills may discontinue treatment before engaging sufficiently to experience change. Motivational interviewing (MI) is a client-centered therapeutic method of increasing motivation for change through the resolution of ambivalence. This paper describes how clinicians may incorporate MI strategies into PCIT to enhance parental motivation when signs of ambivalence arise. Vignettes and scripted therapy exchanges illustrate use of the strategies to decrease ambivalence in PCIT, improve homework adherence, increase parenting self-efficacy, and reduce attrition, thereby improving outcomes for young children with disruptive behaviors and their families.

Disruptive behavior disorders (DBDs) are estimated to affect one in eight preschoolers in the United States (Lavigne, LeBailly, Hopkins, Gouze, & Binns, 2009) and are the most common referral of children to mental health services (Loeber, Burke, Lahey, Winters, & Zera, 2000). Early-onset DBDs are associated with significant impairments in social, emotional, and educational functioning (Frick & Nigg, 2012), and represent the most powerful risk factor for subsequent delinquent behavior, including interpersonal violence, substance abuse, and property destruction (Loeber, Green, Lahey, Frick, & McBurnett, 2000; Tremblay, 2006). These negative outcomes result in higher costs for educational, mental health, law enforcement, and social service—estimated at 10 times higher for children with DBDs than for children without these problems (Lee et al., 2012). Given the high prevalence and persistence of DBDs and the costly trajectories of affected children, effective early intervention is essential for these children.

Parent–child interaction therapy (PCIT) is an evidence-based behavioral treatment for young children with DBDs that places emphasis on improving the quality of the parent–child relationship and changing parent–child interaction patterns (Eyberg, Nelson, & Boggs, 2008). The effectiveness of PCIT has been studied for almost 40 years, with studies demonstrating significant reductions in children's observed noncompliance and disruptive behaviors with their parents and in their classroom after treatment (Eyberg, Boggs, & Jaccard, 2014; Thomas & Zimmer-Gemback, 2007; Zisser, Herschell, & Eyberg, in press). Studies also document significant improvements in the misbehavior of untreated siblings, in parenting distress and depression, and in observed parenting practices for both fathers a
nd mothers (Eyberg et al., 2014; Zisser et al., in press). Maintenance of treatment gains has been demonstrated for up to 6 years following treatment (Hood & Eyberg, 2003). Attrition in PCIT is approximately 35% (Fernandez & Eyberg, 2009; Werba, Eyberg, Boggs, & Algina, 2006).

There are two phases of treatment in PCIT. In the first phase, parents learn child-directed interaction (CDI) skills, which serve to enhance warmth in the parent–child relationship. Parents give positive attention to their child as they play together while imitating their child's play, reflecting their child's speech, describing their child's behaviors, giving specific praise for behaviors incompatible with negative behavior, and enjoying quality time with their child. At the same time, parents use active ignoring to withdraw their attention when the child shows negative behavior and resume positive attention as soon as the child resumes appropriate behavior. By using this differential social attention (DSA) paradigm of attending to positive behavior (e.g., sitting nicely and playing quietly with parent) and ignoring negative child behavior (e.g., turning backward on the chair and loudly bossing

Keywords: motivational interviewing; parent-child interaction therapy; motivation; parent training

Please cite this article as: N'zi et al., Enhancing Parent–Child Interaction Therapy With Motivational Interviewing Techniques, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.03.002

the parent), children learn a new approach to "attention seeking"—most children learn quickly that now it is positive, cooperative behaviors that work to get parental attention (e.g., "It's fun building block towers with you because you are sharing the blocks with me").

In the second phase of PCIT, parents learn to direct the parent–child interaction when necessary. They learn to give clear, direct commands to the child, to praise enthusiastically when the child obeys, and to alert the child that time-out will follow if the child does not obey. In this parent-directed interaction (PDI), time-out becomes effective as a discipline procedure because (a) during the CDI phase of treatment parental attention has become a powerful positive reinforcer for the child, and (b) the parents and child learn, through repeated practice in sessions and at home, that once the parent gives a direct command, the parent will always follow-through. With such consistency, many children learn to obey and obtain positive parental attention in just a few weeks' time (Eyberg et al., 2014).

Parents first learn the PCIT skills in a didactic "teach" session (one for CDI and one for PDI) in which the therapist models and role-plays the skills with the parents alone. This session allows parents to discuss any concerns they may have, anticipate how their child may react, and practice relevant situations with the therapist. The teach session is followed by "coach" sessions during which parents spend most of the session practicing the skills with their child while the therapist coaches them. In coaching, therapists provide immediate positive feedback for parental skill use, in a DSA process parallel to what the parent is learning to provide for their child. In the coaching sessions, therapists code parent skills to guide their coaching and plan daily homework practice of the skills for the upcoming week.

The Importance of Parent Engagement in Child Treatment

Psychosocial treatments for children that entail high levels of parent involvement show maximum effectiveness (Bratton, Ray, Rhines, & Jones, 2005; Kaminski, Valle, Filene, & Boyle, 2008), and literature reviews indicate that parenting styles strongly influence child behavior (Luyckx et al., 2011). When the effectiveness of a child's treatment is dependent on the parent's active participation, parent motivation to engage in treatment is a significant concern.

Families that complete evidence-based treatments typically demonstrate substantial and lasting improvements in child behavior. Long-term follow-up studies have shown significantly better child outcomes for treatment completers than noncompleters years later (Boggs et al., 2005; Kazdin, Mazurick, & Siegel, 1994). Parent factors that influence treatment completion include parents' beliefs in the credibility of the treatment and their expectation that it will be successful with their child (Nock, Ferriter, & Holmberg, 2007).

Parent expectancies predict adherence to treatment procedures as well as parent retention (Nock et al., 2007). PCIT is a time- and effort-intensive treatment that requires a considerable commitment from parents. If parents are uncertain about whether treatment will help their child or about whether they have the ability to learn the treatment skills, they may be apprehensive about treatment procedures, not put their best effort into mastering the skills, or discontinue treatment altogether. When parents present uncertainty, motivational interviewing (MI) strategies can help refocus them toward expectations for treatment success.

Motivational Interviewing

MI is an evidenced-based, client-centered therapeutic method of enhancing motivation for change through the resolution of ambivalence (Miller & Rollnick, 2013). Ambivalence refers to an uncertainty or inability to make a choice because of the simultaneous or fluctuating desires to engage in two opposite or conflicting activities. In PCIT, it is the parents' conflict between making changes in their parenting behaviors that will likely be beneficial versus not making parenting changes that seem difficult and possibly ineffective for their child. When parents experience ambivalence about PCIT, MI can help move them toward "change talk," statements that indicate the parent is considering, motivated, or committed to change (Miller & Rollnick, 2013). MI uses four key principles designed to facilitate the resolution of ambivalence and encourage positive change: (a) express empathy, (b) develop discrepancy, (c) roll with resistance, and (d) support self-efficacy (Miller & Rollnick, 2013).

The first principle, *express empathy*, focuses on expressing an attitude of acceptance of the parent's ambivalence in order to facilitate change through reflective listening. An environment in which a person feels accepted and understood encourages change, whereas an environment in which a person feel judged, patronized, or "told" to change can hinder the change process (Miller & Rollnick, 2013). A nonempathic exchange between parent and therapist in PCIT is exemplified by the following response to a parent who stated: "I had to work overtime this week and was just too tired most nights to practice with Charles when I got home." The therapist responded, "Homework is essential for progress in treatment. Please find some way to get in that 5 minutes, perhaps in the morning before you get ready for work." A therapist response consistent with MI principles would instead be, "It's hard to practice when we feel exhausted. How did you feel the nights you were able to practice?"

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