North Carolina Child Treatment Program (NC CTP)
Evidence-Based Treatment (EBT) Service Delivery Time Model Series

Clinical Service Delivery Time Model for Parent-Child Interaction Therapy (PCIT)

Case-level Time Estimate

PCIT Time Model Template

The *NC CTP Clinical Service Delivery Time Model (PCIT)* template was developed to support service utilization data collection, aggregation, and analysis at the level of the client, caseload, and agency. NC CTP populated this template with case-level utilization *estimates* in order to provide guidance regarding the development and sustainment of an outpatient PCIT program. *

PCIT service utilization estimates and data should be interpreted with caution, under the guidance of a PCIT clinical expert, when applied to: clinical network development and contracting, establishment of service delivery payment rates, utilization management, and clinical performance monitoring. This template should not be used to facilitate training, treatment, fidelity monitoring, and/or clinical supervision, as these standards are established by the PCIT model developer and PCIT International (www.pcit.org).

The *NC CTP Clinical Service Delivery Time Model (PCIT)* defines a "typical" case as one in which PCIT is delivered in an outpatient setting, to a client presenting with moderate clinical complexity, in the primary language of both client and caregiver. Service delivery is described in terms of: **a)** total number of clinical encounters (in-session treatment); **b)** total clinical encounter time (hours); and **c)** total out-of-session clinical support activity time (hours). Case-level service utilization data may fall outside the "typical" range, yet remain acceptable clinically, due to case complexity and implementation-related factors.

*Estimates are based on the peer-reviewed literature, endorsed PCIT trainer experience, and service utilization data from a small cohort of North Carolina PCIT clients associated with NC CTP trainees and graduates.

Hagele D, White D, Pane Seifert H, Gurwitch R (authors)
PCIT Clinical Service Delivery Time Model (case-level time estimate)
Version January 2020; available: www.NCChildTreatmentProgram.org

PCIT Service Delivery Overview

- PCIT is a dyadic treatment model for young children with significant externalizing symptoms. It includes a minimum of eleven required clinical encounters (treatment sessions); the majority of community-based clients exceed eleven clinical encounters. Families typically progress through treatment as caregivers demonstrate PCIT skills mastery, and as clients demonstrate a reduction in targeted behaviors.
- The majority of clinical encounters include a client and primary caregiver; at least two caregiver-only sessions are conducted during a typical course of PCIT.
- Clinical encounters are conducted on a weekly basis over several months; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client may participate in two clinical encounters during a single week.
- A clinical encounter is typically 60 minutes in duration; however, PDI Coach sessions may exceed 60 minutes, up to three (3) times during the course of treatment.
- A typical course of community-based PCIT includes an estimated: **a)** 26 clinical encounters; and **b)** 36 minutes of clinical support activity time (out-of-session) for every 60-minute clinical encounter. Client and caregiver in-session participation time is approximately equal over the course of treatment.
- Case-level service utilization (clinical encounter number and time, and out-of-session clinical support time) may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.
- Treatment content and intensity, clinician fidelity, and clinical outcomes vary across a PCIT caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level factors.

Table One: PCIT Total Treatment Time Estimate Summary
(Case-level)

Clinical Activities (Case-level)		**Treatment Time**	
		Typical Case [a] (Hours)	Typical Range [b] (Hours)
Total In-Session Activities		**26.0**	**12.0 - 39.0**
PCIT-specific activities [c]	(Table Two)	21.0	11.0 - 30.0
General clinical activities [d]	(Table Two)	5.0	1.0 - 9.0
Total Out-of-Session Activities [e]	(Table Three)	**15.2**	**6.0 – 28.1**
Total Treatment Time	(In-Session + Out-of-Session)	**41.2**	**18.0 – 67.1**
Ratio [f]	(In-Session) : (Out-of-Session)	(1.0) **:** (0.6)	(1.0) **:** (0.5) – (1.0) **:** (0.7)

[a] "Typical case" included PCIT delivery in a community-based setting, to a client presenting with moderate clinical complexity, in the primary language of both client and caregiver.

[b] Service utilization data may fall outside the "typical" range, yet remain acceptable clinically, due to case complexity and implementation-related factors.

[c] PCIT-specific activities are defined per the PCIT protocol. [1-2]

[d] General clinical activities are conducted in-session and include: clinical intake, extended assessment, treatment and discharge planning, crisis response, and clinical care coordination.

[e] Clinical support activities are conducted out-of-session by a treating clinician and include: clinical intake, clinical assessment, treatment and discharge planning, crisis response, clinical care coordination, case-level fidelity monitoring, and clinician travel. These services are critical to successful PCIT implementation and to the achievement of targeted clinical outcomes.

[f] A typical course of treatment includes an estimated 36 minutes of clinical support activity time (out-of-session) for every 60-minute clinical encounter.

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Table Two: PCIT Clinical Encounter Estimates

(In-Session Activities)

In-Session Activities [a] (Case-level)	**Clinical Encounters** (# Sessions)			**Total Treatment Time** (Hours) [b]		
	Typical Case	Typical Range		Typical Case	Typical Range	
		Minimum	Maximum		Minimum	Maximum
PCIT-specific Activities [c]						
Pre-treatment DPICS assessment	1	1	2	1.0	1.0	2.0
CDI Teach	1	1	2	1.0	1.0	2.0
CDI Coach	8	3	10	8.0	3.0	10.0
PDI Teach	1	1	2	1.0	1.0	2.0
PDI Coach [d]	8	4	10	8.0	4.0	10.0
Post-treatment DPICS (and graduation)	1	1	2	1.0	1.0	2.0
Optional graduation session [e]	0	0	1	0	0	1.0
PCIT Booster session [f]	1	0	1	1.0	0	1.0
Subtotal	**21**	**11**	**30**	**21.0**	**11.0**	**30.0**
General Clinical Activities						
General intake [g]	1	0	1	1.0	0	1.0
Additional clinical assessment [h]	1	0	2	1.0	0	2.0
Treatment planning	0.5	0.5	1	0.5	0.5	1.0
Discharge planning [i]	0.5	0.5	1	0.5	0.5	1.0
Clinical care coordination [j, k]	1	0	2	1.0	0	2.0
Crisis response [k]	1	0	2	1.0	0	2.0
Other	-	-	-	-	-	-
Subtotal	**5**	**1**	**9**	**5.0**	**1.0**	**9.0**
TOTAL	**26**	**12**	**39**	**26.0**	**12.0**	**39.0**

[a] Includes general and PCIT-specific clinical activities delivered during a clinical encounter (treatment session); multiple activities may be delivered during a single clinical encounter.

[b] Assumes that clinical encounters are 60 minutes in duration.

[c] Defined by the PCIT protocol[1-2]; specifically includes DPICS observation and *Eyberg Child Behavior Index* (ECBI) administration, scoring, interpretation, and feedback.

[d] Extended PDI Coach sessions (61 minutes to 3 hours) may occur 2-3 times during a typical course of treatment.

[e] Typically addressed during post-treatment DPICS observation session; however, activities may also be conducted during a dedicated session.

[f] Conducted one to six months following completion of treatment.

[g] Includes consent and other agency-specific documentation and activities.

[h] Includes additional pre- and post-treatment clinical assessment, as well as interval/periodic clinical assessment.

[i] Typically addressed during the PCIT post-treatment assessment and graduation session.

[j] Critical to successful PCIT implementation and achievement of targeted clinical outcomes; typically, these services are delivered by a treating clinician.

[k] Highly variable across clients.

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Table Three: PCIT Clinical Support Activities Estimates
(Out-of-Session Activities)

Out-of-Session Activities [a] (Case-level)		**Time per Activity**		
		Typical Case (Hours)	Typical Range (Hours)	
			Minimum	Maximum
Case Support Activities	General intake [b]	0.5	0	1.0
	Clinical assessment [c]	1.0	1.0	2.0
	Treatment planning	0.5	0.5	1.0
	Clinical encounter (session) preparation [d]	2.2	1.0	3.3
	Clinical encounter (session) documentation [e]	4.3	2.0	6.5
	Discharge planning	0.5	0	1.0
	Clinical care coordination [f,g]	2.0	0	4.0
	Crisis response [g]	1.0	0	4.0
	Other	-	-	-
PCIT Fidelity Support Activities	Clinician fidelity self-monitoring [d,h]	2.2	1.0	3.3
	Clinical supervision or peer fidelity review [i]	1.0	0.5	2.0
	Other	-	-	
General Support Activities [g]	Non-clinical documentation	-	-	-
	Insurance + billing support	-	-	-
	Clinician travel	-	-	-
	Court preparation + testimony	-	-	-
	Other	-	-	-
TOTAL		**15.2**	**6.0**	**28.1**

[a] Conducted out-of-session by a treating clinician; critical to successful PCIT implementation and achievement of targeted clinical outcomes.
[b] Includes consent and other agency-specific documentation and activities.
[c] Includes out-of-session: scoring and interpretation of clinical assessment measures; collateral contact; client record review; case conceptualization; and documentation of assessment process, findings, and conclusions.
[d] Assumes five (5) minutes per 60-minute clinical encounter.
[e] Assumes ten (10) minutes per 60-minute clinical encounter.
[f] Includes case-specific: treatment/multidisciplinary team participation; collateral contact; service coordination and monitoring; provision of consultation to professionals; and direct caregiver support.
[g] Highly variable across clients.
[h] Self-monitored by a treating clinician at the clinical encounter level.
[i] A treating clinician should participate in case-specific: a) clinical supervision provided by a trained supervisor; and/or b) fidelity-driven peer case review. Frequency depends upon caseload size, case complexity, supervision structure, agency requirements, and other factors.

Agency-level PCIT Program: Additional Resource Requirements

The following should be considered when determining the resource allocation necessary to develop and sustain an outpatient PCIT program:

Clinician Training and Certification

To become or remain nationally certified, a clinician must complete all training and certification/re-certification requirements, as outlined by the PCIT developer and PCIT International (www.pcit.org).

The cost associated with participation in a PCIT training program is variable and depends upon: curriculum content and format; costs incurred by trainer- and trainee-participants; and direct and indirect funding sources.

Post-Training Clinical Supervision

While maintaining an active caseload, PCIT clinicians should participate in case-specific: **a)** clinical supervision provided by a trained supervisor; and/or **b)** fidelity-driven peer case review. Additionally, clinicians should self-monitor fidelity across their caseload, using a structured fidelity metric, throughout treatment delivery.

When allocating resources to support supervision or peer case review, consider: caseload size and complexity; PCIT fidelity requirements; supervision structure; agency requirements; and other factors.

Clinical Assessment Measures

PCIT requires the administration of the *Eyberg Child Behavior Inventory* (ECBI)[3] to each caregiver, during each clinical encounter (treatment session). It is recommended that a client also be evaluated for trauma history and symptoms, neurodevelopmental status, internalizing symptoms, and other clinically-relevant concerns. Further, it is recommended that caregivers be evaluated for parenting stress, depression, and other relevant domains.

The cost associated with purchase or licensing of clinical assessment measures should be considered when allocating resources to support an agency-level PCIT program.

Space, Technology, and Materials

PCIT is typically delivered in a dedicated treatment room containing PCIT-appropriate interactive toys, basic furniture, and a designated clinical "time-out" space. PCIT clinicians conduct treatment from a separate observation room or designated observation position within the treatment room. When a separate observation room is used, communication is facilitated through a one-way mirror or a closed-circuit monitoring system.

The cost associated with space and technology requirements should be considered when allocating resources to launch an agency-level PCIT program.

Clinician Travel

A PCIT clinician may participate in activities that require travel, including: public PDI sessions, clinical support activities (out-of-session), and/or home-based treatment delivery.

When allocating resources to support an agency-level PCIT program, consideration should be given to the cost associated with clinician travel time, as well as direct travel expenses.

North Carolina Child Treatment Program
Evidence-Based Treatment (EBT) Service Delivery Time Model Series

Clinical Service Delivery Time Model for Parent-Child Interaction Therapy (PCIT)

Model Overview, Research Base, and Outcomes

Section One: PCIT Overview

Model Developer

Sheila Eyberg, Ph.D.
Chief Executive Officer
Parent-Child Interaction Therapy – International (PCIT-International)

Treatment Protocols

- Eyberg, S. M., & Funderburk, B. W. (2011, rev 6/16). *Parent-Child Interaction Therapy Protocol.* Gainesville, Florida: PCIT International, Inc.[1]
- Eyberg, S. M., Chase, R. M., Fernandez, M. A., & Nelson, M. M. (2014). *Dyadic Parent-Child Interaction Coding System (DPICS) Clinical Manual (4th Edition)*. PCIT International, Inc.[2]

Model Description

PCIT is an evidence-based, mental health treatment for children who are experiencing behavioral and/or emotional difficulties, unhealthy attachment, or dysfunctional caregiver-child interactions. PCIT supports the development of both child emotional self-regulation and authoritative parenting skills and, thus, positive behaviors and healthy caregiver-child interaction. PCIT is a strengths-based, assessment-driven, manualized intervention that is delivered through weekly client-caregiver sessions.

Treatment Theory

PCIT is based on attachment, behavioral modification, coercive cycle, family systems, and social learning theories.

Target Population

PCIT is indicated for children from 2 to 7 years of age who are demonstrating externalizing behaviors, attachment difficulties, or dysfunctional caregiver-child interaction. Treatment delivery may be tailored based on the developmental age, rather than chronological age, of a client with intellectual and/or developmental disabilities.

Targeted Clinical Outcomes

PCIT outcomes include: increase in adaptive child behaviors and compliance; decrease in disruptive child behaviors; increase in authoritative parenting skills; decrease in negative parenting behaviors; and decrease in parental stress.

Treatment Participants

PCIT delivery typically includes a child (client) and at least one primary caregiver. The child-caregiver dyad attends all treatment sessions together, with the exception of at least two caregiver-only sessions conducted during the course of treatment.

Treatment Delivery Professionals

PCIT is delivered by a licensed mental health clinician who is actively engaged in training with an endorsed trainer or has successfully completed all clinical training requirements, as defined by the model developer and by PCIT International (www.pcit.org).

Service Setting and Type

PCIT is typically delivered in an outpatient clinical setting, with several sessions conducted in a public (non-clinical) setting; in select clinical circumstances, treatment may be offered in a home setting.

PCIT may be offered through a variety of service delivery models, including: outpatient services, enhanced outpatient services, intensive in-home services, and other service delivery models.

Treatment Delivery and Intensity

- PCIT includes eleven (11) mandatory clinical encounters (treatment sessions), although the majority of community-based clients exceed eleven clinical encounters. Families typically progress through treatment as caregivers demonstrate PCIT skills mastery, and as clients demonstrate a reduction in targeted behaviors.
- The majority of clinical encounters include a client and primary caregiver; at least two caregiver-only sessions are conducted during a typical course of PCIT.
- Clinical encounters are conducted on a weekly basis over several months; less frequent sessions may adversely impact the achievement of targeted clinical goals. In select circumstances, a client may participate in two clinical encounters during a single week.
- A clinical encounter is typically 60 minutes in duration; however, PDI Coach sessions may extend beyond 60 minutes, up to three (3) times during the course of treatment.
- A typical course of community-based PCIT includes an estimated: **a)** 26 clinical encounters; and **b)** 36 minutes of clinical support activity time (out-of-session) for every 60-minute encounter. Client and caregiver in-session participation time is approximately equal over the course of treatment.
- In select circumstances, two primary caregivers may wish to participate in PCIT, but are unable or unwilling to participate together; this may necessitate the initiation of two separate courses of treatment.
- Case-level service utilization (clinical encounter number and time, as well as out-of-session clinical support time) may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.

Clinical Supervision

While maintaining an active caseload, PCIT clinicians should participate in case-specific clinical supervision provided by a trained supervisor or fidelity-driven peer case review. Additionally, clinicians should self-monitor fidelity across their caseload, using a structured fidelity metric, throughout treatment delivery.

Factors Impacting Treatment Delivery and Outcomes

Treatment content and intensity, clinician fidelity, and clinical outcomes vary across a PCIT caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level barriers and supports.

Section Two: PCIT Clinical Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Child (client)	○ 2 to 7 years of age [a] ○ Clinical indication: ▪ Externalizing symptoms ▪ Internalizing concerns, including mood disorders ▪ Relationship and/or attachment difficulty with primary caregiver ○ Receptive language skills ≥ 24 months of age ○ Available to participate in regularly scheduled treatment sessions [b] ○ Regular contact between client and participating primary caregiver [c]	○ Receptive language skills significantly < 24 months of age ○ Unable to participate in regularly scheduled treatment sessions [b] ○ Limited contact between client and participating primary caregiver [c]
Primary Caregiver	○ Available to participate in regularly scheduled treatment sessions [b] ○ Regular contact between client and participating primary caregiver [c]	○ Perpetrator of sexual abuse ○ Active perpetrator of domestic violence, physical abuse, or psychological abuse ○ Actively psychotic, significantly thought-disordered, or significantly cognitively-impaired (IQ < 65) ○ Unable to participate in regularly scheduled treatment sessions [b] ○ Limited contact between client and participating primary caregiver [c]

[a] PCIT may be delivered at the developmental, rather than chronological age, of a client with intellectual and/or developmental disabilities.

[b] Clinical encounters are typically conducted on a weekly basis; less frequent sessions may adversely impact the achievement of targeted clinical outcomes.

[c] Clients and caregivers must engage in PCIT skills practice on a consistent basis, minimally including three, 30-minute face-to-face contacts per week (outside of PCIT clinical session time).

Section Three: PCIT Assessment Strategy

Case-level PCIT clinical assessment should be individualized and include: administration, scoring, and interpretation of standardized clinical assessment measures; clinical interview and observation; collateral contact; record review; case conceptualization; documentation of the assessment process, findings, and conclusions; and the provision of feedback.

PCIT minimally requires the administration of the *Eyberg Child Behavior Inventory* (ECBI) to each caregiver, during each clinical encounter, to monitor client behavior. The Dyadic Parent-Child Interaction Coding System (DPICS) is also administered throughout treatment to assess parent-child interaction.

Per best practices standards, it is recommended that each client be assessed for trauma history and symptoms, neurodevelopmental status, internalizing symptoms, and other concerns. Further, it is recommended that each caregiver be evaluated for parenting stress, depression, and other clinically-relevant concerns.

PCIT Clinical Assessment Strategies

(Per Treatment Phase)

		Pre-Treatment Phase	Treatment Phase	Post-Treatment Phase and Booster Session
Assess Client	**Required**	○ Externalizing symptoms per *Eyberg Child Behavior Inventory* (ECBI)	○ Externalizing symptoms per *Eyberg Child Behavior Inventory* (ECBI)	○ Externalizing symptoms per *Eyberg Child Behavior Inventory* (ECBI)
	Recommended	○ Trauma history and symptoms ○ Internalizing and additional externalizing symptoms ○ Neurodevelopmental status	-	○ Trauma history and symptoms ○ Internalizing and additional externalizing symptoms ○ Neurodevelopmental status
Assess Caregiver	**Required**	○ Parent-child interaction per *Dyadic Parent-Child Interaction Coding System* (DPICS)	○ Parent-child interaction per *Dyadic Parent-Child Interaction Coding System* (DPICS)	○ Parent-child interaction per *Dyadic Parent-Child Interaction Coding System* (DPICS)
	Recommended	○ Parenting stress ○ Caregiver depression ○ Caregiver trauma history and symptoms	-	○ Parenting stress ○ Caregiver depression ○ Caregiver trauma history and symptoms

Section Four: NC CTP PCIT Service Delivery Checklist

The *NC CTP Clinical Service Delivery Checklist (PCIT)* was developed to support the collection, aggregation, and analysis of service utilization data within an outpatient PCIT program. The *Checklist* describes core clinical and fidelity requirements for the delivery of PCIT, per standards established through the PCIT manual[1,2]. *Checklist* adaptation may be required to support service utilization analysis within other service delivery models or treatment environments.

PCIT service utilization data should be interpreted with caution, under the guidance of a PCIT clinical expert, when applied to: clinical network development and contracting, establishment of service delivery payment rates, utilization management, and clinical performance monitoring.

The *Checklist* should not be used to facilitate training, treatment, fidelity monitoring, or clinical supervision. Rather, the PCIT protocol [1-2] and/or clinical fidelity monitoring tools should be used for this purpose.

PCIT Treatment Phase	Session	Activities	Requirement
Pre-Treatment Assessment	Pre-Treatment DPICS Assessment	1. Conduct clinical interviews and observation 2. Administer and score ECBI 3. Administer DPICS, including Child-Led Play, Parent-Led Play, and Clean-up situations 4. Administer additional, standardized clinical assessment measures, as indicated 5. Contact collaterals and review records 6. Document assessment process, findings, conclusions, and treatment plan 7. Provide feedback to caregiver 8. Conduct out-of-session case support activities, as clinically indicated 9. Self-assess and document fidelity	1 session (minimum) Administer ECBI and DPICS
Child-Directed Interaction (CDI)	CDI Teach	1. Administer and score ECBI 2. Teach CDI skills 3. Document treatment strategies and caregiver progress 4. Conduct out-of-session case support activities, as clinically indicated 5. Self-assess and document fidelity	1 session (minimum) Caregiver(s) only
	CDI Coach	1. Administer and score ECBI 2. Review previously assigned CDI homework 3. Review caregiver PCIT skills 4. Code PCIT skills and provide feedback to caregiver 5. Coach PCIT skills 6. Provide additional feedback to caregiver 7. Assign CDI homework 8. Review relationship between the ECBI scores, caregiver skills, and homework completion 9. Document treatment strategies and client-caregiver progress 10. Conduct out-of-session case support activities, as clinically indicated 11. Self-assess and document fidelity	3 sessions (minimum) Conducted weekly

PCIT Service Delivery Checklist - continued

PCIT Service Delivery Checklist - continued

PCIT Treatment Phase	Session	Activities	Requirement
Parent-Directed Interaction (PDI)	PDI Teach	1. Administer and score ECBI 2. Teach PDI skills 3. Document treatment strategies and caregiver progress 4. Conduct out-of-session case support activities, as clinically indicated 5. Self-assess and document fidelity	1 session (minimum) Caregiver(s) only
	PDI Coach	1. Administer and score ECBI 2. Review previously assigned CDI and PDI homework 3. Review caregiver CDI and PDI skills 4. Code CDI and/or PDI skills and provide feedback to caregiver 5. Coach CDI and PDI skills 6. Provide additional feedback to caregiver 7. Assign CDI and PDI homework 8. Review relationship between the ECBI scores, caregiver skills, and homework completion 9. +/- Conduct a sibling session 10. Document treatment strategies and client-caregiver progress 11. Conduct out-of-session case support activities, as clinically indicated 12. Self-assess and document fidelity	4 sessions (minimum) Conducted weekly
	Post-Treatment DPICS Assessment	1. Administer and score ECBI 2. Administer DPICS, including Child-Led Play, Parent-Led Play, and Clean-up situations 3. Administer additional, standardized clinical assessment measures, as indicated 4. Document assessment process, findings, conclusions, and post-PCIT plan 5. Provide feedback to caregiver 6. Conduct out-of-session case support activities, as clinically indicated 7. Self-assess and document fidelity	1 session (minimum)
	+/- Graduation	1. Conduct graduation session activities 2. Document treatment strategies and client-caregiver progress 3. Conduct out-of-session case support activities, as clinically indicated 4. Self-assess and document fidelity	+/- 1 session Conducted if not completed during post-treatment DPICS session
Post-Treatment	Booster	1. Administer and score ECBI 2. Review post-treatment use of CDI and PDI skills 3. Code CDI and PDI skills, providing feedback to caregiver 4. Coach CDI and PDI skills, as indicated 5. Provide additional feedback to caregiver 6. Provide clinical recommendations to ensure maintenance of caregiver PCIT skills and client progress 7. Refer for additional PCIT sessions, if indicated 8. Document treatment strategies and client-caregiver skill maintenance 9. Conduct out-of-session case support activities, as clinically indicated 10. Self-assess and document fidelity	+/- 1 session Conducted 1-6 months post-treatment

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Section Five: PCIT Research Base

As of May 2017, 37 randomized controlled trials (RCTs) support the efficacy of PCIT treatment for young children with significant externalizing symptoms and related difficulties. Other studies have examined PCIT model adaptations (n=84), adjunct treatment (n=3), assessment (n=48), effectiveness (n=37), and process (n=30). The PCIT literature also includes qualitative and case studies (n=16) and literature reviews (n=48).

Ratings of Research Evidence

- California Evidence-Based Clearinghouse for Child Welfare (CEBC): PCIT has been determined to be "well-supported" by the research evidence, with "medium" child welfare system relevance level (www.cebc4cw.org).
- Kauffman Best Practices Project: PCIT has been rated one of three best practices for treatment of symptoms associated with child maltreatment (2004).

Populations Studied

PCIT has been studied with the following child populations:

- 2-6 years of age with disruptive/externalizing behavior problems or disorders, including Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder [3–5,51-57,59,63-71,73-77]
- 12-15 months of age with behavioral concerns[6,69,72]
- Exposed to physical maltreatment and/or neglect[7–14,58]
- Exhibiting trauma symptoms[15,16]
- Witnessed domestic violence[17–19]
- In foster care[20–22,74]
- With comorbid anxiety disorders[23]
- With primary anxiety[24–30]
- With comorbid problematic sexual behaviors[75]
- With developmental disabilities, including Intellectual Disability Disorder[31]
- With speech delays[32]
- With autism spectrum disorders[33–37]
- With prenatal substance exposure[38]
- Born prematurely[39–42]

- Diverse racial and ethnic U.S. child populations, including: African American[43], Mexican American [44,45], Puerto Rican [46], and Native American [47]
- Children living in countries outside of the United States, including: Australia[8,48], China[49,70], and Norway[50]

Section Six: PCIT Research Outcomes and North Carolina Outcomes

Client Outcomes	
Immediate Post-Treatment Outcome	**Outcome Sustained Following Treatment**
Improvement in child compliance[13,34,40] to caregiver commands	At 3 months[34] At 6 months[6] At 18 months[51] At 2 years[52]
Decrease in disruptive/externalizing behavior[3,4,5,6,7,8.13,15,19,34,36,38,40,44,46,53–56,68,70-75,77]	At 1 month[13] At 3 months[6,34,70] At 4 months[40] At 6 months[6,71] At 12 months[51] At 18 months[73] From 3-to-6 years[57]
Decrease in trauma symptoms[15]	--
Decrease in physical abuse and/or neglect recurrence[7,9,12,13,58]	--
Decrease in primary anxiety symptoms[24,24–29]	--
Decrease in comorbid anxiety symptoms[23]	--
Decrease in comorbid internalizing symptoms[4,7,8,13,15,36,40,70-71,74,77]	At 3 months[70] At 6 months[6,71]
Decrease in emotional reactivity[15]	--
Decrease in sleep problems[15]	--
Decrease in problematic sexual behaviors[75]	--
Decrease in delinquency[15]	--
Decrease in thought problems[15]	--
Improvement in social competency[34,35,36,59]	At 6 weeks[37] At 3 months[38] At 12 months[38]
Increase in different/diverse types of and total utterances[72]	At 3 months[72] At 6 months[72]
Improvement in communication among children with delayed language[32]	--
Improvement in communication among children diagnosed with autism[33]	--
Decrease in atypicality among children diagnosed with autism[36]	--
Increased child adaptability/adaptive behaviors[34,35,71]	At 3 months[34] At 6 months[71]

Primary Caregiver Outcomes	
Immediate Post-Treatment Outcome	**Outcome Sustained Following Treatment**

Decrease in caregiver burden associated with child disruptive/externalizing behavior[8,13,19,34,38,40,63,68,70,74,77]	At 6 weeks[37] At 3 months[34,70]
Improvement in positive parenting skills[4,5,6,8,9,11,13,32,34,40,68-71,73,77]	At 1 month[13] At 6 weeks[37] At 3 months[6,34,69,70] At 4 months[31] At 6 months[5,6,69,71,73] At 18 months[5,73] At 2 years[52]
Decrease in negative parenting behaviors[4,5,6,7,8,9,11,13,40,68-71,73,77]	At 1 month[13] At 3 months[6,69,70] At 4 months[31] At 6 months[5,6,71,73] At 18 months[5,73] At 2 years[52]
Decrease in inconsistent discipline[19]	--
Decrease in use of corporal punishment[70]	At 3 months[70]
Decrease in overall behavioral health symptoms[19]	--
Decrease in depression symptoms[7,57,60]	--
Decrease in parenting stress[4,8.13,15, 31,38,40,58,70-71,77]	At 1 month[13] At 3 months[70] At 6 months[71]
Decrease in parental distress[49]	--
Decrease in parental loneliness[7]	--
Improvement in perceived social support[71]	At 6 months[71]
Improvement in responsive caregiving behaviors (warmth/positive affect and/or sensitivity/responsiveness)[8,13,69]	At 1 month[13] At 3 months[69] At 6 months[69]
Improvement in parent locus of control[19,57]	From 3-to-6 years[57]
Decrease in parental intrusiveness/over control[69]	At 3 months[69] At 6 months[69]
Decrease in child abuse potential[13]	--

Untreated Sibling Outcomes
Decrease in behavior problems among untreated siblings[61]
Decrease in perceived severity of behaviors among untreated siblings[61]

System Outcome	
Child welfare	Decrease in child welfare recidivism[9,13]
Education	Improvement in conduct problem behavior[51,59]

PCIT Delivered in Non-Clinic Setting	Outcome
Internet-delivered PCIT (I-PCIT)	Decrease in caregiver-perceived barriers to treatment, comparted to clinic-based PCIT[63]
Group PCIT	Decrease in externalizing behavior problems[71,76] Decrease in internalizing symptoms[71,76] Improvement in positive parenting skills[71,76]
Home-based PCIT	Increase in child compliance to caregiver commands[64] Decrease in child disruptive/externalizing behavior problems[64,67,68] Decrease in negative parenting behaviors[64] Improvement in positive parenting skills[64,67] Improvement in parent attitudes Decrease in parenting stress[64] Increase in caregiver tolerance of child's behavior (when home-coaching used to augment clinic-based care)[65] Decrease in risk of child abuse[66] Increase in positive parent-child interactions[67] Improvement in developmentally appropriate parent expectations[67] Improvement in responsive caregiving behaviors (nurturing or behaviors that promote a child's psychological growth)[67] Decrease in caregiver use of verbal and corporal punishment[67] Twice as likely to complete treatment, compared to clinic-based PCIT treatment[68]

North Carolina Clinical Outcomes

The NC Child Treatment Program provides intensive PCIT training and clinical coaching to 30-40 licensed clinicians each year. NC CTP monitors clinical outcomes for a minimum of two clients per clinician-trainee. Additionally, NC CTP monitors caregiver skills mastery.

Across cohorts, comparison of pre-and post-treatment assessment results demonstrates a statistically significant decrease in externalizing behaviors among the majority of children associated with a NC CTP clinician-trainee. Additionally, analysis demonstrates a statistically significant increase in caregiver use of effective behavioral management strategies, with a corresponding decrease in negative or otherwise ineffective strategies.

Section Seven: References

References under annual faculty review as of January 2020. Draft version not for dissemination.