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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

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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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The second principle, *develop discrepancy*, highlights the incongruity between a person's present behavior and his or her desired goals. Therapists reflect a person's conflicting desires or goals in order to develop the person's awareness of the discrepancy. Therapists guide individuals to present the arguments for change rather than presenting the reasons themselves (Miller & Rollnick, 2013). For example, a therapist might say, "Our weather this winter makes the trip here pretty stressful—we haven't been able to coach you regularly in the skills, and I know how much you want Jennifer to learn to be polite and cooperative. How could we schedule the sessions more effectively to help you meet your goals for Jennifer?"

The third principle, *roll with resistance*, means that therapists do not directly oppose or argue for change but rather invite new perspectives while encouraging a person to be the primary agent for discovering new solutions (Miller & Rollnick, 2013). A permissive parent hesitant to face an angry outburst from his or her child when the child is told what to do might say, "I know we decided last week to have Sammy put his toys away before bedtime, but it's really not that big a problem for me. I realized this week that it is just easier for me to do it myself." A defensive response, such as "But we need to teach him to clean up at home to help him learn to clean up at day care," strengthens parents' efforts to validate their own perspective, thus further committing themselves to their preexisting beliefs. When resistance occurs, therapists engage in reflective listening while inviting, not imposing, new perspectives (Miller & Rollnick, 2013). A therapist's response such as "It is a lot quicker to clean up his toys on your own. I know you mentioned before that Sammy gets in trouble at day care for not cleaning up. How might you be able to help him learn more about this skill?" encourages the parents to consider a new perspective about cleaning up.

The final principle, *support self-efficacy*, urges therapists to elicit independent problem-solving strategies, and it fosters autonomous thinking. The therapist encourages parents to carry out their own change by highlighting their past successes and expressing their belief in the parents' ability to maintain changes resulting from treatment (Miller & Rollnick, 2013). A PCIT therapist might encourage a parent who is nervous about his or her ability to maintain treatment gains after treatment ends by saying, "I remember when you first started PCIT you felt overwhelmed by ShaDay's behavior. Now her attitude has improved at home and school, and she is listening to you much more quickly. You have worked hard to make these changes. What do you think you can continue to do when treatment ends so that she can continue making progress?"

These four guiding principles provide an empathic atmosphere in which parents can explore their desire for change and can build on their own intrinsic motivation. The MI therapist uses specific communication strategies to help achieve the goals these principles set forth. These strategies are called "OARS" strategies, and include open-ended questions, affirmations, reflections, and summaries (Miller & Rollnick, 2013). Originally developed for people with substance abuse disorders, the MI principles and strategies have been found effective for enhancing motivation for change in a number of difficult populations (Miller & Rollnick, 2013).

Studies of PCIT with maltreating parents mandated into treatment have shown that adding a motivation enhancement module before standard PCIT can improve attendance and adherence in treatment for certain families (Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Chaffin et al., 2009). For these studies, a 6-week protocol based on MI was created. This protocol included the decisional techniques of weighing the pros and cons of changing harsh discipline patterns, listening to testimonials from families that completed PCIT, and encouraging parents to set goals and plan for change in their parenting. The investigators found that this motivational module was effective for parents in the child welfare population with initially low to moderate motivation for change (Chaffin et al., 2009). Unfortunately, parents with initially high motivation had a higher rate of attrition after the motivational enhancement module (Chaffin et al., 2009). The investigators speculated that lower levels of PCIT completion in the latter group may have been due to their initial eagerness to begin and waning motivation during the 6-week motivational component or, alternatively, the reexamination of their parenting beliefs during the 6-week period may have decreased their motivation to change their parenting behaviors (Chaffin et al., 2009). Incorporating motivational principles and strategies throughout treatment may maintain motivation and facilitate adherence and retention not only for parents initially resistant to treatment but also for parents excited to begin PCIT.

Integrating MI Into PCIT

Attrition from PCIT can have negative, long-term consequences on the maintenance of child treatment gains (Boggs et al., 2005). Studies investigating attrition from PCIT have identified several predictors, including low socioeconomic status, low maternal praise and high maternal criticism during parent–child interactions at pretreatment assessment, high levels of parent-reported barriers to treatment, and a less engaging therapist verbal style (Fernandez & Eyberg, 2009; Harwood & Eyberg, 2004). Among the most frequent reasons for dropout reported by parents of children with DBDs are disagreement with the treatment approach, logistical concerns such as transportation and child care for siblings, and

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maternal stress (Boggs et al., 2005; Capage, Bennett, & McNeil, 2001; Fernandez & Eyberg, 2009). Understanding parents' specific concerns can help therapists be alert to situations in which timely application of MI techniques may benefit treatment continuation.

The use of MI strategies can help the therapist work in partnership with the parent to resolve resistance arising at any point in treatment. Even with the skilled use of MI strategies, some parents may remain unwilling to change their parenting. The role of MI is to help resolve ambivalence, not to force a behavioral change. Even if the therapist uses MI, a family might come to the conclusion that they cannot follow-through with the discipline procedures outlined in the PCIT protocol. If that happens, it would be important to explain to the parents that it is not possible to complete PCIT without such a core component and the therapist should help the family find an alternative approach, inviting them to return to PCIT in the future if they change their mind.

Most frequently, it is through MI that the parent and therapist identify a common goal they could achieve together, such as increasing the warmth in the parent–child interaction. It is through this goal that the parent and child create a powerful working alliance. Parents are the experts on their child. A PCIT therapist is an expert on behavior change. A solid partnership between the parent and PCIT therapist is crucial to success.

Ideally, strong rapport is established with families and treatment ambivalence is addressed in the first meeting. Even with successful engagement strategies, though, ambivalence can arise during treatment, and dealing with this when it first appears can increase treatment retention. Clinical experience tells us where in PCIT ambivalence is most likely to occur, such as around completing homework consistently, attending treatment sessions regularly, believing that CDI has therapeutic value, or using the time-out procedure in PDI.

In this section we present three hypothetical PCIT case vignettes with transcripts that exemplify ways in which the MI principles may be used to resolve ambivalence and enhance parent motivation to change. The first case addresses initial engagement in PCIT. The second case illustrates how common barriers that arise in CDI can be dealt with using MI strategies. The final case demonstrates how the MI principles and strategies can improve the parents' confidence in treatment procedures that have been difficult for them to implement successfully in the past.

Case Examples

Case 1: Addressing Treatment Engagement in PCIT

Disagreement with the treatment approach is a common reason for dropout in PCIT (Fernandez & Eyberg, 2009). When a family presents initially with resistance to the treatment approach, MI can be used to enhance motivation for PCIT.

Maria and her 5-year-old son, Anthony, were referred by Anthony's pediatric oncologist following complaints of disruptive behavior. Anthony has a history of leukemia as a toddler and has been in remission for 1 year. Maria is most concerned with his noncompliance, aggression, and running away in public. She has struggled unsuccessfully for 3 years to manage his behavior, having tried multiple disciplinary techniques that her friends suggested or that she read about in parenting books. Maria is convinced that behavioral techniques are ineffective with her son because he is "unique" and "unpredictable," and there is little she can do to help his behavior. At this point, she is considering placing Anthony in a group home.

Maria and Anthony were seen initially for a consult in the pediatrician's office, and Maria agreed to try PCIT because the pediatrician was so enthusiastic about the intervention. She and Anthony traveled nearly an hour from their home to attend the first session, the clinical interview, and observational assessment. As the therapist was providing feedback and an overview of PCIT, Maria stated her reluctance to commit to a treatment in which she would be primarily responsible for facilitating Anthony's behavior change.

To improve motivation for PCIT in this case, the therapist must create a supportive environment in which to help Maria explore her ambivalence about beginning a treatment program that involves changing her parenting approach to improve her son's behaviors. Maria's ambivalence is rooted in her lack of self-efficacy about her ability to change Anthony's behavior. To improve her self-efficacy, the therapist uses several MI strategies: (a) open-ended questions to help Maria consider treatment options that could meet the behavioral needs of her son, (b) affirmations to help her feel supported by the therapist, and (c) summary statements to guide her toward arguments supporting self-efficacy for changing Anthony's behaviors.

	Statement	Commentary
MARIA:	I appreciate what you are trying to do for us, but I have tried things like this before, and they just don't work. Anthony's behavior is different than other kids. He is erratic. The doctor told me your program has helped other families a lot, but honestly I just	Maria begins to express her concerns about this treatment approach.

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	Statement	Commentary
	don't feel it is worth an hour-long drive every week.	
THERAPIST:	It is frustrating to hear people tell you what might work for you and your son. You have read a lot about different ways to manage his behavior. What are your thoughts on what is best for Anthony?	Therapist resists the urge to lecture or convince Maria about how PCIT could help her and her son. Instead, the therapist communicates empathic understanding of Maria's frustration and creates an opportunity for her to share her opinion on the solution.
MARIA:	I don't know what is best. I've been thinking about placing him in a group home because I feel out of options. I would love to keep him at home, but I can't cope with his behaviors. He's always playing tricks, like hiding my purse and laughing when I can't find it. At church he yells out, just to see what people will do. Or, when we're out, he just runs off and hides from me.	Maria becomes less defensive and begins to share her concerns about her son, her feelings of hopelessness, and her reasons for considering a group home placement.
THERAPIST:	His behavior has really been difficult to manage on your own, so you have considered a group home and, at the same time, you also really want to keep him at home with you. What do you need help with to feel like you could keep Anthony at home?	Therapist begins to develop discrepancy between Maria's conflicting desires. The therapist asks an open-ended question to help Maria consider alternative solutions.
MARIA:	Ha—what I need is a person to just follow him around and guard him! (laughs) I know that's unreasonable. But I really do think Anthony needs a professional with him all the time to manage his behavior. I tried to learn how to help him by reading parenting books, but what I learned doesn't seem to be enough.	Maria has a difficult time arguing for change because her feelings of self-efficacy are low.
THERAPIST:	You have tried very hard to help Anthony. You drove an hour to come here today. You are reading books. And, you are considering other options to get more support for him. You need support. You really feel Anthony needs a behavior coach with him all the time.	Therapist builds Maria's self-efficacy by highlighting all the positive steps she has taken to try to help her son. The therapist validates Maria's need for behavioral support for her son and social support for herself.
MARIA:	I really do. If I tried this, I'd be worried that if something goes wrong, we would be an hour away with no support nearby. I need someone to help me do the things that will change his behavior. That's been my problem with reading books and people telling me what I need to do differently. They don't know Anthony, and they don't know how different he is. They've never really helped me parent him. When Anthony finds a loophole then whatever others suggested no longer works and I'm back at square one, on my own.	Maria's resistance begins to decrease. She expresses her initial goals and expectations for what a successful treatment approach might look like for her and her son.
THERAPIST:	I want to make sure I've heard all of your concerns. Anthony *has* had more tough times than other kids his age because of all his chemo treatments and doctors' appointments. You know his past better than anyone, and you know what it's like to try to manage him every day. To change his behaviors now, it will be very important that you have someone to collaborate with you and see how he reacts when you try new skills.	Therapist summarizes Maria's concerns, making sure to end the summary with Maria's self-identified goals for change in order to build motivation for treatment.

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	Statement	Commentary
MARIA:	Yes, I really do know Anthony and I want to keep him at home. We definitely need coaching to make new skills work. Can you tell me how PCIT works again?	Maria begins to consider PCIT as a treatment option for her and her son.

Case 2: Addressing Barriers in the CDI

Scenario 1: Engagement in CDI

Research has shown that children's hyperactive and disruptive behavior problems improve in the classroom as well as at home after PCIT (Bagner, Boggs, & Eyberg, 2010; Eyberg, 2015; Funderburk et al., 1998); however, children's behavioral changes in both settings typically occur gradually over weeks. In the following vignette, the parent of a child who is hyperactive and oppositional is receiving pressure from teachers and other caregivers to change the child's behavior quickly.

Amber, a single, working mother, has come to treatment with her 3-year-old son, Benjamin. Benjamin displays many hyperactive and disruptive behaviors at home and in his day care class. He defiantly refuses to obey Amber's requests. He also ignores the directions of his day care teacher if asked to change activities. His refusals escalate to temper tantrums if the requests are repeated, and persist until the requests are withdrawn. His teacher has told Amber that if his behavior does not improve, he will be removed from the day care. Amber is fearful that she may not be able to find day care for Benjamin if he is removed from this day care, threatening her employment. She has tried many discipline strategies unsuccessfully and is feeling anxious and angry with Benjamin.

This case illustrates how a therapist can express empathy for the mother's concern about her employment while building her motivation to continue in treatment. The therapist combines reflections and open-ended questions to help Amber commit to a plan of action that can address her concerns about Benjamin's school. The therapist helps Amber elucidate her own solutions rather than assuming the expert role and attempting to convince her with facts and figures about the effectiveness of PCIT changing her son's school behaviors.

	Statement	Commentary
THERAPIST:	I'm wondering what you are thinking about these skills so far.	Noticing Amber's hesitancy, the therapist asks for Amber's opinions using an open-ended question to create a nonjudgmental environment.
AMBER:	I know he will love CDI. But, I am not sure this will change his behavior fast enough. I am afraid Benjamin might get kicked out of day care if his behavior doesn't improve, and I don't know what I would do if I lost my job.	Amber expresses concerns that treatment will not progress quickly enough to prevent serious consequences to her family.
THERAPIST:	It is really scary to think about losing your job if he is not able to stay in day care.	Therapist resists the urge to convince her that sticking to the course of treatment is what she and her son need. Amber expresses empathy by reflecting her affective experience to allow her to explore her conflicting feelings.
AMBER:	Yes. I know this will help his behavior in the long run, but I am not sure that it will change his behavior fast enough for his day care to keep him enrolled.	Amber expresses tension between her long-term goals, changing Benjamin's behavior, and her short-term needs, keeping her son in day care so she does not lose her job.
THERAPIST:	You are feeling pressure from day care to make quick changes in Benjamin's behavior. What do you think might be able to change his behavior overnight?	Therapist asks an exaggerated, open-ended question to help Amber argue for a realistic solution to this predicament.
AMBER:	Well, I don't think anything can change his behavior that fast. I really need the school to be patient with me while we are in therapy.	Amber begins to express change talk as she identifies what would need to happen to proceed with PCIT and prevent the loss of her job.
THERAPIST:	You know what you are doing here will work and you need the school to give you the time to do that work.	Therapist summarizes Amber's argument to help her move toward creating a concrete goal.
AMBER:	Right. Maybe I should talk with the school and let his teacher know I am getting him help. Is there anything I could give the	Amber identifies a goal, talking to his teacher about therapy, which demonstrates commitment to

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	Statement	Commentary
	teacher to let her know what we are doing in therapy?	continuing therapy.
THERAPIST:	That sounds like a good idea. I will give you some teacher handouts before you leave. Some families have also found it helpful for the therapist to speak to the teacher. What do you think is best?	Therapist affirms and supports Amber's decision. The therapist suggests an alternative solution as well, but poses it as a question to increase Amber's commitment to change by helping her verbalize the best plan to address this issue.
AMBER:	I think it would be good to do both. I will give Mrs. Green the handouts, and I'll give you the school's phone number.	Amber expresses commitment to the plan made with the therapist to address her son's behavior.

Scenario 2: Homework Completion in CDI

Daily homework completion is a necessary component of treatment and an essential element to ensure success in PCIT. Practicing fewer than 4 days a week signals the need to enhance homework motivation and resolve whatever barrier may be interfering. It is important to address homework nonadherence the first time it occurs by increasing parent motivation for consistent practice and application of PCIT skills at home.

At the end of the CDI teach session, Amber was given a homework sheet and asked to practice the CDI at home for 5 minutes a day and mark it on the sheet along with any concerns that might arise in the home sessions. When she returns for the first CDI coach session, the therapist asks for her homework sheet and notices she practiced only twice in the preceding week. Knowing that inconsistent practice will slow treatment progress, the therapist begins the session by exploring the barriers to homework completion.

The therapist listens to the mother's explanations for inconsistent homework completion and responds by paraphrasing statements in a neutral, nonjudgmental manner. Through affirmations, the therapist creates a supportive environment in which to discuss the sensitive topic of homework completion. An accusatory tone could trigger a defensive response from Amber and inadvertently reinforce her current position of being "too busy." The therapist helps develop discrepancy between Amber's desire to change Benjamin's behavior quickly and her inability to practice the skills consistently during the week. After building discrepancy, Amber can identify what is preventing her from completing daily homework and can make a concrete plan for practice for the following week.

	Statement	Commentary
THERAPIST:	How did homework go this week?	Therapist uses an open-ended question to start the conversation.
AMBER:	Well, work is crazy. It just zaps all my energy. I know practice will really help Benjamin. I really want to do it, but I just can't do it every day.	Amber expresses resistance to committing to consistent, daily homework practice.
THERAPIST:	You are busy with work and parenting Benjamin as a single mother. You are also demonstrating your commitment to changing Benjamin's behavior by coming in today. And even with a difficult work schedule, you practiced 2 days last week.	Therapist avoids confronting the parent directly; direct confrontation could evoke a defensive response from the parent. Instead, the therapist creates an empathic environment and builds self-efficacy by highlighting the positive goals the parent achieved since last session.
AMBER:	That's true. I am glad I came. I enjoyed the 2 days of practice, but I just don't know how to practice every day and still do everything else that I have to get done.	Amber acknowledges her success resulting in a reduction in her resistance.
THERAPIST:	You want to make a quick change in his behavior, and 5 minutes a day is too much to ask in the middle of a busy schedule.	Therapist takes a risk by attempting to build motivation for practice by setting up a situation where the mother will argue the position that 5 minutes is a reasonable time commitment for daily practice.
AMBER:	Well, when I think about it that way, 5 minutes is really not much time. I think my problem is that the first 2 days we practiced for almost an hour because we were having fun, so I guess I forgot that it is only 5 minutes.	Amber engages in change talk. She self-identifies her barrier to changing parenting practices and moves toward a commitment to consistent change.
THERAPIST:	That makes sense. It	Therapist reinforces

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	Statement	Commentary
	seemed exhausting to do homework every day because you were practicing for a long time. What do you think it would be like if you limited practice to 5 minutes?	Amber's change statement through a reflection. The therapist encourages a commitment to change by asking her to make a specific goal.
AMBER:	I think if I tried to keep it to 5 minutes I could do it just before bath time and it would work well.	Amber comes up with her own solution for increasing the consistency of her homework practice.
THERAPIST:	You came up with a great solution. Practicing before bath will help in your busy schedule.	Therapist affirms Amber's choice and summarizes her decision to increase commitment to change.

Case 3: Addressing Common Barriers to Implementing the PDI

Scenario 1: Engagement in PDI

In PCIT, behavior problems begin to improve in CDI (Harwood & Eyberg, 2006). This pattern continues in PDI where the family is taught how to address specific discipline procedures. Completing both phases of treatment, the CDI and the PDI, is crucial to maintaining behavioral improvements years after PCIT ends (Boggs et al., 2005), so MI skills can be helpful in retaining parents to the end of PCIT treatment.

Chauncey has been in treatment for 7 weeks with his 6-year-old daughter, Aliyah. Aliyah's behavior has improved during CDI, although she still dawdles and acts defiant when told what to do. Her defiance causes many problems, particularly when it is time to go to school in the morning or when she is with her father in the grocery store. Chauncey has tried a number of discipline techniques in the past, including removal of privileges, time-out, and spanking.

Chauncey has mastered the CDI skills and has come to his first PDI session, PDI teach. The therapist remembers from the intake that Chauncey found time-out procedures ineffective for managing his daughter's behavior in the past, so the therapist explores Chauncey's perceptions of time-out before introducing the PDI procedure.

In this example, the therapist uses reflections and open-ended questions to understand Chauncey's ambivalence toward time-out. Summary statements are used to facilitate change talk by identifying a mutual goal (i.e., a consistent and effective discipline approach) and by creating action steps to follow to achieve that goal (i.e., learning a new approach that other families have found helpful, the PDI time-out procedure). The therapist does not fall into the trap of directly opposing the father's hesitancy about trying time-out again, which could increase resistance. Instead the therapist allows the father to examine what has been unsuccessful in the past to help him reframe his thoughts about time-out as an effective discipline procedure.

	Statement	Commentary
THERAPIST:	What do you know about using time-out as a discipline technique for children?	Therapist starts with an open-ended question.
CHAUNCEY:	I don't know about other kids, but I'm not sure that time-out will work with Aliyah. I used time-out a lot in the past, but it was a joke.	Chauncey expresses resistance toward time-out.
THERAPIST:	It didn't work before. Tell me about what happened when you tried time-out.	Therapist uses a simple reflection to "roll with" the parent's resistance and an open-ended question to explore the parent's perspective further.
CHAUNCEY:	Well, I tried making her sit on her bed, but she wouldn't stay there. If I'd tell her to go to her room, sometimes she'd just say "no." If I carried her, she'd just giggle and run out. It didn't seem like discipline. It seemed more like a game.	Chauncey further explores reasons for his resistance to trying time-out again.
THERAPIST:	Before, Aliyah made time-out into a game and wouldn't stay in the chair. What else has made using time-out difficult?	Therapist again uses the combination of a simple reflection and open-ended question to continue exploring his resistance.
CHAUNCEY:	Well, even if she stayed on the chair, it just didn't seem to work. I would tell her to think about what she did. I'd talk to her about it afterward, but it doesn't stop her behavior. Sometimes she would do it again just a few minutes later, so I gave up.	Chauncey continues to list the reasons why time-out would not work for his daughter.
THERAPIST:	So talking to her about it afterward and making her try to explain why it	Therapist reflects and continues with an open-ended question to

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(*continued*)

	Statement	Commentary
	was wrong didn't work. What else made time-out hard?	understand all the information related to the argument for not using time-out.
CHAUNCEY:	I think that is it.	Chauncey indicates he has expressed all his concerns.
THERAPIST:	Okay. When you're thinking about the discipline that would be best for you and Aliyah, you're looking for a discipline procedure that will change her behavior long term and one that you can use consistently without her finding a way to make it into a game.	Therapist summarizes everything the parent said and reframes the content to more goal-focused, change talk.
CHAUNCEY:	Yep. That's what I need to get her behavior under control.	Chauncey begins expressing change talk.
THERAPIST:	You need a discipline procedure to help you control her behavior. I wonder if you would be interested in learning about some time-out, discipline techniques that other parents have used here to help manage their children's behaviors and keep it from turning into a game.	Therapist uses a reflection to set a mutual goal and then uses an open-ended question to elicit agreement to work toward that goal.
CHAUNCEY:	I definitely want to learn! I am ready to use something that will work.	Chauncey commits to change and expresses openness to learn about a new time-out procedure.

Scenario 2: Building Self-Efficacy in PDI

To end PCIT treatment successfully, the parent must meet PCIT graduation criteria. One of these criteria is that the parent must feel confident in his or her ability to manage child misbehavior (Eyberg & Funderburk, 2011). Sometimes parents need some help to increase their self-efficacy regarding their ability to manage their child's behavior effectively and MI strategies can be a great way to achieve this goal.

Chauncey has been using the PDI skills successfully at home throughout the day. However, in public Aliyah continues to have tantrums when not given her way, and Chauncey reports feeling helpless at these times. During the fifth PDI coaching session, the therapist describes the PCIT public behavior procedure for handling these behaviors in public. Chauncey voices concerns about implementing PDI in a public setting because he is worried that implementing the PDI procedure in public might be embarrassing.

To build Chauncey's confidence in following through with time-out in public, the therapist first uses reflection to validate Chauncey's feelings. The therapist then combines open-ended questions and affirmations to help restructure Chauncey's thoughts about time-out and build his self-confidence. Enhancing parent self-efficacy to manage child behavior independently is especially important as the end of treatment approaches, and affirmations are ideal for meeting this goal.

	Statement	Commentary
CHAUNCEY:	I understand what you're saying about treating public situations the same as situations at home, but I would rather just carry her out of the store if she starts acting up. Aliyah can get really out of control in public, and I can't see myself sitting her on the floor and letting people stare at her.	Chauncey expresses resistance toward changing his parenting behaviors in public.
THERAPIST:	Time-out in public can be very uncomfortable. You feel it would be so uncomfortable that you would want to leave the situation.	Therapist uses an affective reflection to validate the parent's position and emotions.
CHAUNCEY:	Yes. It would be embarrassing for both of us because people would be staring at us.	Chauncey indicates that the therapist understood his point of view.
THERAPIST:	What would you think if you saw a dad doing time-out in public?	Therapist asks an open-ended question to elicit change talk.
CHAUNCEY:	I would be impressed. It takes a lot of guts to do that!	Chauncey considers a new perspective.
THERAPIST:	So, you would be an impressed by a father doing time-out in public. What else?	Therapist uses a simple reflection and an open-ended question to further explore alternative interpretations.
CHAUNCEY:	I bet that child would learn to listen because they would take their dad seriously.	Chauncey continues to consider a new perspective.

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(*continued*)

	Statement	Commentary
THERAPIST:	On the one hand, time-out feels embarrassing and on the other hand, kids learn to listen and other people might be impressed that a father is practicing good parenting in public.	Therapist uses a double-sided reflection to summarize both the pros and cons of the Chauncey's position, moving him toward change talk.
CHAUNCEY:	I guess time-out in public won't be that bad.	Chauncey begins to change his perspective.
THERAPIST:	And you are able to do time-out successfully at home; no matter what happens you stay consistent.	Therapist uses an affirmation to improve self-efficacy.
CHAUNCEY:	It's true that she has gotten so good at listening at home that it won't be like it was before we started coming here. I know after we practice next week in session, I will be ready to do it on my own.	Chauncey demonstrates evidence of improved confidence and willingness to commit to change.

Clinical Implications and Future Directions

Treatment adherence and retention are critically important challenges in evidence-based treatments for children (Boggs et al., 2005; Kazdin et al., 1994). Incorporating MI into PCIT cannot guarantee treatment engagement, but by using the MI strategies the therapist creates a nonjudgmental environment that allows parents to explore their ambivalence. In this environment, the parent and the therapist collaborate to strengthen the parent's self-efficacy and motivation for change.

Evidence-based treatment protocols do not "work" simply by faithfully following steps in a manual. Clinicians must have a strong working knowledge of the theories that underlie the treatments they use to address the many issues that arise in therapeutic interactions. When learning to implement a new treatment model, therapists also require extensive training and consultation from experts to implement the treatments effectively; this is true for both PCIT (Funderburk et al., 2015) and MI (Miller, Sorensen, Selzer, & Brigham, 2006; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). The ideas presented herein assume underlying competency in both approaches to apply them together successfully. Skillful use of the principles and techniques of MI at critical points in PCIT is consistent with research indicating that therapist style and approach to discussing treatment with families increases treatment retention and success in PCIT (Harwood & Eyberg, 2004).

Future research should examine the best ways to apply the principles and strategies of MI to PCIT and other evidenced-based parenting programs for young children. PCIT is particularly effort intensive for parents and requires high parent motivation and self-efficacy to acquire and sustain the new parenting skills. As the primary agents of change, it is essential that parents maintain commitment throughout treatment to provide consistent parenting skills that support child behavior change.

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