Adapting Parent-Child Interaction Therapy for Young Children with Separation Anxiety Disorder

Donna B. Pincus
Department of Psychology, Boston University, Boston, MA

Sheila M. Eyberg
Department of Clinical and Health Psychology, University of Florida, Gainesville, FL

Molly L. Choate
Department of Psychology, Boston University, Boston, MA

Abstract

Separation Anxiety Disorder (SAD) is currently the most prevalent, yet most under-researched anxiety disorder in childhood. To date, there have been few studies investigating the efficacy of interventions for young children with SAD. The primary purpose of this paper is to describe the process of tailoring Parent Child Interaction Therapy (PCIT) for young children aged 4-8 with SAD. The paper provides a theoretical rationale for using PCIT to treat young children with SAD. The first randomized clinical trial for young children with SAD is then described. The paper focuses on the process of adapting PCIT to make it most relevant for children with SAD. The specific challenges and rewards of conducting PCIT with anxious children and their parents are presented.

Over the past decade, there has been burgeoning interest in the study of the etiology, maintenance and effective treatment of anxiety disorders in childhood. Of the anxiety disorders experienced by children, separation anxiety disorder (SAD) has been shown to be the most prevalent, accounting for approximately one-half of the children seen for mental health treatment of anxiety disorders (Bell-Dolan, 1995). Despite the growing evi-
ence that SAD is so prevalent in early childhood and may be linked to later psychopathology (Lease & Strauss, 1993), there has been a paucity of empirical studies investigating the efficacy of interventions for SAD in young children. Although treatment studies have typically included children aged seven and above, thus far, treatment research of children under aged seven with anxiety disorders has been limited to case reports with expected methodological limitations (Ollendick, Hagopian, & Huntzinger, 1991). Existing treatment studies and case studies that have been conducted with children with SAD have not typically included children in the preschool and early childhood years (aged 4-7), despite the frequent early onset of SAD (Eisen, Engler, & Geyer, 1998; Eisen & Kearney, 1995). This may be due to the fact that it is more difficult to assess young children using standard self report questionnaires, or due to the fact that many of the intervention strategies currently being evaluated with older children contain large cognitive components, which would likely be developmentally inappropriate and beyond the capabilities of a very young preschooler with SAD. Furthermore, the young preschooler may not yet have developed the cognitive and communicative abilities to verbalize their fears or to engage in self control procedures that would be commonly taught to older children (Eisen & Kearney, 1995). To date, there are no known interventions that have been designed or tested specifically to treat SAD in the preschool and early childhood years. The development of such an intervention seems critical to promoting young children’s healthy functioning and positive developmental trajectories.

**Phenomenology of Separation Anxiety Disorder in Early Childhood**

Children with SAD experience developmentally inappropriate distress and unrealistic fear when confronted with separation from a caregiver, and experience significant interference in daily functioning (American Psychiatric Association, 2000). Children often display excessive and persistent worry about separation, behavioral and somatic distress when faced with separation situations, and persistent avoidance or attempts to escape from such situations (Albano, Chorpita, & Barlow, 1996; Bell-Dolan, 1995). Separation worries commonly reported by children include worries about harm befalling either an attachment figure or themselves, worry that a parent may never return, or worries that they themselves will be lost, kidnapped, or killed. Particularly for young children, nightmares with themes of separation are quite common (Francis, Last, & Strauss, 1987). Young children with SAD often display disruptive, oppositional behaviors as well as avoidance behaviors that cause significant interference in child and family functioning. Children may have tantrums, may cling to parents, may shadow parents from room to room, or may refuse to play without a parent present. Some children may become quite desperate in their attempts to contact parents, even feigning illness, devising excuses to escape or avoid separation situations, refusing to sleep alone, or pleading to have parents
ADAPTING PCIT FOR YOUNG CHILDREN WITH SAD

sleep with them (Tonge, 1994). Although some separation anxiety is certainly part of normal early development, once the symptoms of separation anxiety begin to exacerbate and interfere with daily functioning, significant social, familial, and academic dysfunction may occur (Strauss, Frame, & Forehand, 1987; Turner et al., 1987). Children with SAD may be at risk for school avoidance and for impaired social interactions with other children (Beidel & Turner, 1998). Children with SAD are also more likely to report somatic complaints (e.g., headache, stomachache) than children diagnosed with phobic disorders (Last, 1991). In a review of 95 children admitted to a psychiatry inpatient unit, children with SAD reported a significantly greater number of medically unexplained physical symptoms than those with other diagnoses (Livingstone, Taylor, & Crawford, 1988), with reports of abdominal pain and heart palpitations significantly more likely in children with SAD compared to children with other disorders. These physical symptoms can lead to the child eliciting immediate care and attention from the parent, which can result in positive reinforcement and secondary gain that may further perpetuate the problem.

Early Childhood Separation Anxiety Disorder: Risks for Later Psychopathology

Childhood anxiety disorders such as separation anxiety disorder appear to have a chronic course if left untreated (Keller et al., 1992). In fact, child anxiety disorders appear to be linked to anxiety disorders in adulthood. Retrospective studies suggest that childhood anxiety disorders frequently precede adult anxiety disorders (Aronson & Logue, 1987; Delito, Perugi, & Marenmani, 1986). Adult patients with panic disorder have been shown to report high rates of separation anxiety disorder in childhood (Klein, 1981; Silove, Parker, Hadzi-Pavlović, Manicavasagar, & Blaszczynski, 1991). A prospective study of subjects diagnosed with separation anxiety in childhood has supported modest associations with panic disorder with agoraphobia as well as with major depression (Klein, 1995). Another study found that childhood separation anxiety disorder conferred a risk for comorbidity of anxiety disorders in adulthood (Lizpitz et al., 1994; Lipsitz, Mannuzza, Liebowitz, Klein, & Fyer, 1997). In one longitudinal study of young children with clinical, sub-clinical and non-clinical levels of separation anxiety (Kearney, Sims, Pursell, & Tillotson, 2003), separation anxious children were assessed at age three years and 3.5 years later. Results indicated that children with clinical SAD, compared to those with sub-clinical SAD or no symptoms of SAD, had a disproportionately higher number of comorbid diagnoses and experienced significantly greater somatic concerns, anxiety and general internalizing behavior 3.5 years later. In addition, their parents experienced greater depression, obsessive-compulsive behavior, phobic anxiety, and general distress. Thus, while most children with non-clinical SAD symptoms experience a natural dissipation of SAD symptoms in childhood, children with clinical levels of SAD may continue to experience stable, significant distress. Without proper
treatment, these young children may go on to experience further emotional difficulties. Given that the developmental period of early childhood is seen as such a sensitive period of development, and given that SAD is associated with psychopathology later in life, it seems critical to begin to establish effective treatment procedures for SAD at its earliest stages.

Parenting Style and Early Childhood Anxiety

Numerous studies across several different child anxiety research centers have suggested that parents of anxious children may inadvertently facilitate anxious responses in children through modeling fear or avoidance (Muris, Steerneman, Merckelback, & Meesters, 1996), attempting to control the child's behavior in a way that limits psychological autonomy (Hock, 1992; Hudson & Rapee, 1997; Siqueland, Kendall, & Steinberg, 1996), overprotecting the child (Hirshfeld, Biederman, Brody, Faraone, & Rosenbaum, 1997b; Stubbe, Zahner, Goldstein, & Leckman, 1993), or facilitating avoidant coping responses (Barrett, Rapee, Dadds, & Ryan, 1996; Chorpita, Albano, & Barlow, 1996; Dadds, Barrett, Rapee, & Ryan, 1996). Other studies have indicated that parents may affect children's development of healthy emotion focused coping strategies by trying to manage their child's anxiety or reinforcing anxious responding in their children (Spence, 1994). Even though parents may have the best of intentions, negative and aversive parent and child interactions may develop when parents become critical of children's inability to separate, resulting in children crying or displaying other signs of behavioral or emotional distress. Any attention to this distress could easily reinforce children's behavior, thus reinforcing the cycle of anxiety and continuing the aversive parent child interactions. Eisen, Engler, and Geyer (1998) suggest that parents of children with SAD, in particular, can fall prey to three "traps" that can inadvertently facilitate childhood anxiety: (a) overprotection, (b) excessive reassurance, and (c) aversive parent child interactions. Each of these traps could encourage child anxiety because the parent provides attention during a child's fearful displays. In addition, numerous other research studies on parenting styles of parents of anxious children have found some evidence that parents of anxious children may tend to grant less psychological autonomy, evidence less warmth and acceptance, and are more critical of their children compared to parents of children without a psychiatric diagnosis (Hudson & Rapee, 2000; Siqueland et al., 1996).

Parent Training Treatment Approaches for Child Anxiety: Targeting Maladaptive Parenting Styles and Aversive Parent Child Interactions

Findings from existing treatment studies suggest that interventions aimed at modifying maladaptive parenting styles, improving family member functioning and increasing positive parent child interaction could be helpful in preventing or ameliorating SAD in young children. In fact, in
one of the most recent controlled trials of child anxiety treatment, Barrett, Dadds, and Rapee (1996) compared CBT to a condition that included CBT plus a parent-training component and to a waitlist control condition. In the parent-training component, parents were taught how to reward courageous behavior using verbal praise, they were taught to ignore non-brave behaviors, and they were taught how to extinguish excessive anxiety in their child. At post-treatment, results showed that CBT plus a parent-training component was better than CBT alone. CBT plus parent training was found to be superior even at one year post-treatment for reducing children's anxious behaviors. Although this study did not include children younger than age 7, it is likely that such a parent training component might be especially beneficial to parents of even younger children. In an effort to develop effective parent training programs for very young children with anxiety, researchers have begun to draw upon empirically validated parenting treatments that have been shown to be effective for childhood behavior disorders. The following skills have been viewed by child anxiety researchers as important components to include in a parent training program to reduce child anxiety: (a) enhancing parent attention (teaching parents to be more effective monitors of children’s behaviors), (b) command training (teaching parents to deliver clear, direct commands), (c) differential reinforcement (teaching parents to ignore or minimize attention for fearful displays), and (d) shaping (positively rewarding children for brave behaviors) (Eisen, Engler, & Geyer, 1998; Ginsburg, Silverman, & Kurtines, 1995). For the period of early childhood, it has been suggested that a successful parent treatment component should involve rearranging dyadic caregiving interactions or family interactions to promote secure, healthy attachment between parents and children (e.g., Barkley, 1987; Schuhmann et al., 1998). Thus, there is growing evidence such a parent training approach may be especially useful for young children with SAD.

**Parent Child Interaction Therapy**

**Brief Overview of Standard PCIT Treatment**

Parent Child Interaction Therapy (PCIT; Brinkmeyer & Eyberg, 2003) is an empirically supported treatment designed to treat children with disruptive behavior disorders and their families. The treatment is designed to help parents build a warm and responsive relationship with their child and to manage their child’s behavior more effectively. PCIT is based on the assumption that improving the parent-child interaction will result in improvement in both child and family functioning (Foote et al., 1998). PCIT draws on both attachment and social learning theories in training parents to interact in attentive, responsive and warm ways with their child (Hood & Eyberg, 2003). The standard PCIT protocol has two phases, labeled Child-Directed Interaction (CDI) and Parent Directed Interaction (PDI). The CDI portion focuses on changing the quality of the parent-child relationship;
parents are taught nondirective interaction skills and are taught to increase warmth, responsiveness, attention and praise during playtimes with their child. Differential reinforcement of child behavior through praise for appropriate behavior and consistent ignoring of undesirable behavior helps provide a positive form of behavioral management throughout CDI. Parents are coached to utilize these skills as they play with their child. In the PDI portion of treatment, parents are taught methods of incorporating clearly communicated and age appropriate instructions to the child. Using techniques based directly on operant principles of behavior change, parents are taught to provide consistent positive and negative consequences following the child’s obedience and disobedience. The therapist also assists the parent to learn how children’s behavior is shaped and maintained by the child’s social environment. In PCIT, the treatment is performance based and does not end until the parents have demonstrated mastery of the skills; the average number of weekly 1 hour sessions ranges from 9 to 16, with an average of 13 sessions (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998).

**PCIT Outcome Studies**

There have been numerous studies demonstrating statistically and clinically significant improvements in children’s behavior at the end of treatment, and at long term follow up (e.g., Eyberg & Robinson, 1982; Foote, Eyberg & Schuhmann, 1998; Hood & Eyberg, 2003; McNeil, Capage, Bahl, & Blanc, 1999; Schuhmann et al., 1988). PCIT outcome studies have documented change in the interactional style of parents with their child, significant improvements in child compliance and disruptive behaviors, improvements in parents’ level of distress, and improved family functioning. In addition, parent behaviors have been shown to generalize to interactions with other children in the family as reflected by improved behavior of siblings (Brestan, Eyberg, Boggs & Algina, 1997; Eyberg & Robinson, 1982). Because the specific goals of PCIT are to teach parents to build a more positive relationship with their child, to teach their child desirable, appropriate behaviors, and to decrease their child’s inappropriate behaviors, the treatment can be readily applied to a patient’s unique problems. PCIT treatment programs have already been adapted for use with children with Attention Deficit Hyperactivity Disorder (Nixon, 2001), language delays (Eyberg & Boggs, 1998), chronic illness (Bagner, Fernandez, & Eyberg, 2004), for neglected children (Mcrae, 2003), for physically abusive families (Urquiza, 1996), for children at risk for physical abuse (Singer, 2000), and for use by teachers (Collett, 2002; McIntosh, 2000). However, PCIT has yet to be applied to families with separation anxious children.

**Parent Child Interaction Therapy for Young Children with SAD**

Given that PCIT is a well-established parent training program that has
been specifically developed for use with preschool age children, and given that PCIT aims to promote warmth, acceptance, and positive interactions between parents and children, it is likely that PCIT will improve the secure attachment between parents and young children. The improved attachment and warmth following PCIT may help strengthen the child’s feeling of security and thus help the child to separate from the parent with less distress. Furthermore, PCIT incorporates each of the specific skills child anxiety researchers have indicated as essential to teach parents in treatment to reduce child anxiety, such as enhancing parent attention, teaching parents differential reinforcement, teaching parents to shape children’s behavior, and teaching parents to deliver clear commands to children, and thus, could be expected to be effective in reducing children’s separation fearful behaviors. The PCIT treatment protocol appears to directly alter the parenting styles found to be associated with parents of anxious children. Thus, it seems that PCIT could be a potentially useful treatment if adapted for children with SAD.

_Applied PCIT for Young Children with SAD: A Randomized Clinical Trial_

Clinical Trial Applying PCIT to children with SAD: Overview of Design

The first randomized controlled clinical trial is currently being implemented at Boston University to investigate the efficacy of applying PCIT to the treatment of young children ages 4-8 with separation anxiety disorder. The specific goals of this project are: (a) to evaluate the efficacy of PCIT for reducing separation anxious behaviors in young children; (b) to assess long term maintenance of change at 3, 6, and 12 months following treatment; and (c) to investigate potential mechanisms of action in treatment. This research project is the first controlled clinical trial for childhood anxiety that has included children younger than age 7, and thus, has the potential to fill in a significant gap in our knowledge of this at-risk population. Through this project, 58 children with a principal diagnosis of SAD are being randomly assigned to one of two conditions following a pre-treatment assessment. In the first condition, participants receive an immediate full course of PCIT over approximately 9 weekly sessions (PCIT condition). The second condition consists of a waitlist (WL) (attentional control) condition in which participants are required to wait 9 weeks prior to receiving treatment, at which point they receive a post-waitlist assessment. After the post-waitlist assessment, waitlist participants then receive a full course of PCIT. Randomization occurs within gender so that the ratio of males to females is equal across conditions. All participants are undergoing a post-treatment assessment, as well as three follow-up assessments (conducted 3 months, 6 months and 12 months following completion of treatment).
Recruitment of Participants

Participants are currently being recruited through the normal patient flow into the Child and Adolescent Fear and Anxiety Treatment Program at the Center for Anxiety and Related Disorders at Boston University. The study includes both males and females from all ethnic backgrounds. The age range of 4-8 was selected due to the prevalence of SAD in early childhood, and due to the lack of existing anxiety treatment investigations including young children. All patients must receive a principal diagnosis of SAD assigned at pre-treatment, based on DSM-IV criteria, and at least one parent or caregiver must be available to accompany the child to all treatment sessions.

Measures

The study includes a multimodal assessment of anxiety, including diagnostic interviews with the parent and child, parent self report instruments, child self report instruments, and behavioral observation and coding measures of parent child interaction. Specifically, the Anxiety Disorders Interview Schedule (Child and Parent Version) (ADIS-IV-C/P: Silverman & Albano, 1997) is being utilized as the diagnostic interview measure. Although reliability data does not exist for children younger than age 7, the ADIS-IV C/P has been utilized with younger children; however, the Parent Interview has typically been relied upon more heavily for diagnostic purposes. While the full ADIS-IV-CP is being used during the initial diagnostic assessment, a shorter version of the ADIS is being utilized for all post-treatment and follow up assessments to track the maintenance of children’s improvement.

Child self-report measures were included in the present study to allow for the assessment of the young child’s perspective of his or her own feelings of anxiety. In reviewing potential measures for this project, it was determined that very few child anxiety self-report measures have been validated for use with children younger than age 7. Measures were included that had specific separation anxiety subscales, such as the Multidimensional Anxiety Scale for Children (MASC; March et al., 1997). Other measures, such as the Fear and Avoidance Hierarchy, was included based on our and our colleagues’ previous experience successfully utilizing the FAH with children younger than age 7. Several developmental adaptations were implemented in the administration of these measures, such as providing reading assistance to children and using visual aids when necessary, such as the “fear thermometer”, which shows a visual analog scale of “degrees” of fear. Parent self report measures being utilized include the Child Behavior Checklist (CBCL: Achenbach & Edelbrock, 1983), the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999), the Parenting Stress Index (PSI: Abidin, 1997), the Parental Locus of Control Scale (PLOC; Campis, Lyman, & Prentice-Dunn, 1986), the Weekly Record
of Anxiety at Separation (WRAS; Choate & Pincus, 2001), and the Therapy Attitude Inventory (TAI; Eyberg, 1993). In addition to self-report measures, the Dyadic Parent-Child Interaction Coding System II (DPICS-II; Eyberg, Bessmer, Newcomb, Edwards, & Robinson, 1994) is being utilized as an observational measure of parent and child behaviors in the laboratory during four 5-minute standard situations that vary in the degrees of parental control expected. The DPICS has been modified to include a separation situation in which the parent is called out of the room for five minutes. All situations in the DPICS are being videotaped and coded.

**Process of Adapting PCIT for Families with a Child with SAD**

**Utilizing Parent Feedback and Clinical Observations to Modify PCIT Treatment for Anxious Children and Families**

In the course of treating the first ten children who entered the study, we gathered useful information and feedback from parents about the most and least useful parts of treatment, areas of concern that were not addressed through PCIT treatment, and any difficulties or concerns parents had in implementing PCIT treatment with their anxious child. All parents from this initial group of families reported increased feelings of warmth and closeness with their child, and reported that they were quite surprised by the child's overwhelmingly positive reaction to the new five minute “special playtime.” In addition, although the majority of parents reported that their anxious children were, on the whole, very compliant, they stated that the PDI skills came in handy when dealing with other siblings in the house, or when managing the occasional misbehavior of their anxious child. Nine out of ten parents reported that the PDI skills increased their confidence in their parenting abilities.

Although this initial group of families reported many positive effects of PCIT, we noticed that children were not naturally being encouraged by parents to enter new, more challenging separation situations. When asked, parents reported that they did not always encourage their child to enter new situations if the situation could cause the child excessive anxiety or undue distress. Several parents noted that in an effort to not feel like a “bad parent,” they often found themselves being overly reassuring to children when approaching a new situation. We observed several parents asking children questions perhaps more to reassure themselves than to reassure the child (e.g., “Are you sure you’re going to be ok if I leave for five minutes? I’ll be right in the waiting room, no need to worry...you can come find me if you need me”). Thus, although parents came to treatment because they wanted their child to become more independent and have an easier time with separation, we observed that many parents seemed intolerant of having their child experience distress due to their own concerns that anxiety might be harmful to their child. Parents questioned whether
they “gave” anxiety to their child, and asked PCIT therapists for ways to encourage children appropriately to enter new situations without being forceful and without engaging in a power struggle with their child. Furthermore, parents asked how to begin to help their child enter new situations, and whether they should just let the child cry or whether they should be comforting. All of these clinical observations and parent questions led us to determine that although the CDI and PDI components seemed to be helping parents, an anxiety education component seemed necessary to include in a treatment of early childhood SAD. In addition, we determined that parents needed guidance to know how to help children to begin practicing entering new developmentally appropriate situations while enduring parental separation. Thus, we determined that to make PCIT most relevant to families with children with separation anxiety, we needed to add something to the existing protocol that would formally and systematically address common concerns of parents with anxious children, and that would help children to make progress toward being less distressed during everyday separation situations. We considered many issues with regard to designing this “anxiety specific” phase of treatment, including session length, number of sessions, the positioning of this treatment phase, and the ways to maximize the clinical effectiveness of treatment so that it would be most germane to families of differing backgrounds. We determined that the most efficient and seamless way to integrate these skills into PCIT would be adding these skills in a new phase of treatment that could complement the existing CDI and PDI components.

Integrating Anxiety Education for Parents into PCIT: Designing the “Bravery Directed Interaction” (BDI) Phase

The Bravery Directed Interaction Teach Session (BDI TEACH). The BDI Teach Session was designed to provide parents with education about the nature of anxiety, the cycle of anxiety, the importance of teaching children not to avoid situations, and instruction in the ways to set up an effective exposure practice for children so that separation situations can begin to be practiced. An important first goal of the BDI TEACH session is to educate parents about the cycle of anxiety and about the factors that maintain anxiety in children. A second goal is to teach parents the importance of applying PCIT-CDI skills in separation situations. A third goal is to explain to parents the importance of not avoiding situations that may involve separation, and appropriate ways to conduct “separation practices” with their young children. The session begins with an explanation of the nature of anxiety, and parents are taught that anxiety is a natural human emotion that is not harmful to children. They are also provided education about the etiology of anxiety. Parents are taught that they do not “give” children an anxiety disorder but rather that anxiety disorders likely arise from the synergistic effects of several factors. The relationship between a child’s thoughts, feelings and behaviors are explained to parents, and parents are
assisted in completing a blank "cycle of separation anxiety" handout in which parents insert a child's thoughts/worries about separation, their child's common physical symptoms/complaints, and their child's behavioral reactions. Parents are also taught about ways that certain parenting behaviors may inadvertently reinforce separation anxious behaviors in children, and are taught how modifying these behaviors can affect the overall cycle of separation anxiety. Finally, parents are taught the concept of exposure, and the rationale for helping children to begin to practice small steps toward the larger goal of becoming more tolerant of separation from a parent or caregiver. Parents are given a handout, "The Do's and Don'ts of Helping Your Child with Separation Practices," which summarizes the information from the session, similar to handouts from CDI and PDI. The Fear and Avoidance Hierarchy is discussed with parents to determine which situations parents feel are most important to focus on in treatment. Parents are instructed to continue CDI practices during the week, and to bring their child in for the first BDI Coach Session the following week.

**BDI Coach #1.** The BDI Coach session was designed to help parents and children begin the process of exposure practice. An important first goal of the SAD COACH #1 session is to explain the purpose of the "Bravery Ladder" to the child and to encourage the child to engage in choosing the first step to practice over the week. The second goal is to encourage parents to apply CDI skills to encourage children's approaching of new situations. A third goal is to have children and parents brainstorm at least five rewards that have to do with spending special time with mom and/or dad that could be earned by practicing situations on the bravery ladder. The fourth goal of the session is for therapists, parent(s) and child to agree upon a clearly stated homework assignment (exposure practice) for the week, and for parents to use CDI and BDI skills to praise the child for their efforts in taking a step on the bravery ladder. One aspect of the BDI Coach Session that was purposefully implemented was to have children choose the first exposure practice rather than having parents choose the first exposure practice. As research has shown that children with anxiety disorders often are given less psychological autonomy and control, we thought it would be important to allow the child some choice in which situation would be worked on first. Further, allowing the child to choose is comparable to the child's experience through CDI; whereas children were able to choose the game or toy in CDI, they now get to choose the exposure practice in BDI.

**BDI Coach #2.** The purpose of the BDI Coach session is to follow up with parents and children about their progress and success in beginning exposures. An important first goal of the SAD Coach Session #2 is to review the child's and parents' homework from the previous week, and to discuss whether child was successful in entering the first activity on the Bravery Ladder. The second goal is to discuss with parents the ways that parents reacted if child had separation incidents this week, and to coach
parents in applying CDI and BDI skills to encourage children's approaching of new situations. Parents are reminded that separation anxiety is not to be punished; rather, brave behavior should be reinforced. A third goal of the BDI Coach Session #2 is to apply stickers to the Bravery Ladder next to any achieved situations. The fourth goal of the session is for therapists, parent(s) and child to agree upon a clearly stated homework assignment (new step on the Bravery Ladder) for the next week, and for parents to use CDI skills to praise the child for their efforts in taking another step on the bravery ladder. Parents are informed that the next treatment session will be the PDI Teach Session, and that this is a parents-only session. However, parents are instructed to continue BDI practices each week. This session is designed to help children to begin to gain some momentum in working their way up bravery ladder; they are reminded that they may choose a reward from their reward list (e.g., special time with mom and/or dad) for each new situation achieved.

Modifying the Treatment Structure: Treatment Format and Length

We decided that the Bravery Directed Interaction phase of treatment would be best positioned after CDI and before PDI. By starting with CDI skills, parents are able to gain concrete skills for improving the warmth and positive interaction with their youngster. These skills are practiced throughout the remainder of treatment, consistent with the original PCIT treatment protocol. We noted that most parents were able to reach criterion for CDI within 3-4 sessions. By the end of CDI, parents reported that they felt successful and were “ready” to help their child to become more brave during separation. Further, children had developed a relationship with study therapists and seemed motivated to make gains that would impress both parents and the PCIT therapists. Thus, the Bravery Directed Interaction phase naturally seemed to fit after CDI. Parents were taught about the nature and cycle of anxiety, and ways to facilitate their child in entering new situations. They were also taught to apply CDI skills such as labeled praise to separation practice situations. Consistent with the format of the rest of PCIT, the BDI Coach Sessions #1 and #2 followed naturally after the BDI Teach Session, and children were given control of where to start with practicing steps on the Bravery Ladder. Just like CDI practices that continue throughout the rest of treatment, BDI practices also continue throughout the remainder of treatment, giving children ample time to make progress on their Bravery Ladders. Finally, after children have had time to make some gains in their BDI practices, parents are then brought in for the PDI teach session, followed by the coach sessions. With this new modification, treatment appeared to flow well from one phase of treatment to the next phase of treatment, with parents learning specific skills during each phase that would help modify the aversive parent child interactions that had been occurring during separation situations. Children were being reinforced for their gains on the Bravery Ladder with more
special time with mom and dad, thus increasing natural positive reinforc-
ers in the child’s environment. Furthermore, placing BDI prior to PDI al-
lowed for continued check up with children on their progress throughout
treatment.

One challenge to conducting PDI after BDI is to be sure to help distin-
guish the difference between misbehavior and refusal to engage in a situ-
ation due to anxiety. We have had to modify PDI slightly so that we clearly
communicate to parents that we are not instructing them to utilize time
out procedures when children refuse to separate; rather, they are to only
use time out procedures during situations where children refuse to com-
ply with commands unrelated to separation. During situations where chil-
dren refuse to separate, parents are taught to utilize CDI skills of praising
even small steps toward compliance, breaking down the situation into sev-
eral smaller steps, ignoring tantrums, and shifting positive attention to
brave behaviors. Further, since CDI practice continues throughout the treat-
ment, we have found that this helps children who perhaps are not truly
“anxious” about separating, but receive the most attention from parents
during their separation refusal and anxious displays. Thus, this structured
positive time, combined with parents’ new CDI skills, perhaps work in
tandem to contribute toward shifting the attention from separation situa-
tions to more positive playtime, thus increasing children’s desire to com-
ply with parents’ requests and to “show off” their new brave skills that
will be reinforced rather than crying or whining, which they learn will be
ignored.

In terms of treatment length, it appears that PCIT for children with SAD
is still comparable in length to standard PCIT, but the sessions are distrib-
uted differently. For example, we noted that all sixteen parents in our
sample thus far have been able to reach criterion levels on their CDI skills
in approximately 3-4 sessions. The BDI component, as we have designed
it, now comprises three sessions (one teach session and two coach sessions
including the child). The PDI component has lasted 3-4 sessions, depend-
ing on whether the child has an additional diagnosis of ODD. Unlike
treating children where the primary problem is ODD, we have found that
children with SAD are generally quite compliant when parents ask them
to do something. It is likely that the nature of the interaction is different
between parents and children with behavior problems and parents and
children with anxiety difficulties, and thus, fewer PDI sessions may be
sufficient for parents with children with SAD. Overall, total average length
of this modified PCIT treatment with children with SAD has been 10 ses-
sions.

Modifying the DPICS to Measure Separation Distress.

The Dyadic Parent Child Interaction Coding System-II (DPICS-II; Eyberg,
Bessmer, Newcomb, Edwards, & Robinson, 1994) is an integral compo-
nent of PCIT. We made one modification to the standard DPICS situations
to attempt to better assess for changes in children’s ability to tolerate brief separations from parents. We have now included observation of a “separation situation” in which parents are called out of the room for 5 minutes, and a female graduate student confederate enters the room to play with the child. Parents and children’s reactions are captured on videotape as parents are asked to initiate the separation situation. Children’s and parent’s behaviors are then coded using an expanded DPICS coding scheme that includes coding of anxious behaviors displayed by the child (e.g., crying, clinging, nailbiting, refusing to separate, etc.), behaviors displayed by the parent (e.g., reassuring child, questioning child, ignoring inappropriate behavior, etc.), as well as parent and child verbalizations (e.g., command, praise, critical statement), vocalizations (e.g., laugh, yell), and physical behaviors (e.g., destructive behavior, positive touch). Thus, the modified DPICS now includes four 5-minute standard situations: the first standard situation requires the child to lead the play for 5 minutes, the second standard situation requires the parent to lead the play for 5 minutes, the third standard situation requires the parent to leave the room for 5 minutes, and the fourth standard situation requires the parent to instruct the child to clean up the toys. Thus, the total time for the modified DPICS is now 20 minutes.

Treatment Acceptability: Utilizing Parent Feedback to Improve Treatment

We are gathering parents’ feedback about treatment acceptability through a structured exit interview, through a self report questionnaire (Therapy Attitude Inventory), and through our treatment session log sheets, where we record any notable comments parents or children make during PCIT sessions regarding the nature or format of treatment. Thus, we are gathering information about parents’ views of the most effective components of PCIT for SAD for reducing their child’s separation distress, their views of the least helpful parts of treatment, and their views or suggestions for ways the treatment format could be even more beneficial to them. We also are assessing concomitant changes parents’ report that may occur as a result of treatment, such as child’s improved academic functioning, improved sibling behavior, decreased parenting stress, etc. with the aim of designing a treatment that is acceptable to parents and young children.

Challenges to Conducting PCIT with Children with SAD and their Parents

Although we have found working with parents of anxious children to be very rewarding, we have encountered several specific challenges when attempting to coach parents using traditional PCIT coaching procedures. Although the standard coaching procedures are in fact utilized with coaching parents of children with SAD, we have observed that the emphasis and focus of coaching may need to be slightly different with parents of anxious children. Based on research showing that parents of anxious chil-
Adapting PCIT for young children with SAD

Children tend to grant less psychological autonomy, evidence less warmth and acceptance, and tend to be more rigid in their parenting, and based on our clinical observations during sessions, we have tailored our coaching in CDI to encourage parents to allow children to lead the play. Many parents have been observed “taking over” the play situation, putting play pieces together for the child, and solving any “problems” that came up in the play instead of allowing children to solve problems on their own (e.g., telling child how to put something together correctly, or how a toy should be used). In order to help parents with this, therapists have been taught to focus on praising parents for letting children choose the toy and lead the play activity. Further, therapists are taught to praise parents for utilizing “play talk” with their child, as it promotes a warm and fun interaction, but requires the parent to “let go” and be playful with their children. Parents are also coached and praised for not asking questions, and for rephrasing questions as statements as to not inadvertently lead the play. Parents of anxious children, who may be anxious themselves, have also been observed being verbally critical of themselves for accidentally asking the child a question during CDI. PCIT therapists have been taught to handle this by teaching parents to remember that the focus of the playtime is to create a warm interaction, and that their success in CDI is guaranteed if the playtime is mutually enjoyable, warm, and fun. Thus, parents are taught to be “easy” on themselves if they accidentally ask a question, and are given lots of praise by therapists for focusing on making the interaction positive and enjoyable for themselves and their child, and for not being critical of themselves. In this way, parents are, in a sense, being coached and praised for exhibiting behaviors that are incompatible with anxious parenting styles. In addition, when coaching parents of anxious children, we emphasize the importance of reflecting the child’s emotions as well as the child’s behaviors, in order to help the child develop more appropriate emotion identification skills and a “feelings” vocabulary to use to express themselves more effectively to parents when they are in distress. Finally, parents who initially have been observed to be somewhat uptight and reserved with their child are encouraged to “let go” and have fun during the CDI playtime. Thus, though the majority of coaching techniques utilized are identical to those utilized in the standard PCIT protocol, we have found that coaching anxious families are often largely focused on these specific skills: Parents are coached for utilizing labeled praise for appropriate child behaviors, for not asking questions, for allowing the child to lead the play, and are encouraged to let go, relax, and enjoy the playtime with their child.

Rewards of Conducting PCIT with Children with SAD and their Parents

Though data collection from the randomized clinical trial will continue for three more years, we have already discovered numerous rewards of conducting PCIT with separation anxious children and their families. First, parents who seek treatment for their child’s SAD are often ready for some
concrete skills that they can utilize with children when they are anxious. Parents have already reported that the skills learned in all three phases, CDI, BDI and PDI, have all been helpful and useful at different times for helping their anxious child as well as the other children in their home. Before seeking help at our Center, a number of families reported that they either had never sought help before for their child’s separation anxiety, or that they had sought the wrong kind of therapy (e.g., one parent had her 8 year old child in more traditional talk therapy for several years prior to seeking help at our Center, and was frustrated with her child’s lack of progress). Two families had been advised to put their young children on medication and sought alternative treatment because they were hesitant to do so. As separation anxiety is disruptive for the parent and family as well as for the child’s functioning, one benefit of utilizing a tailored version of PCIT with this population is the ability to help change the nature of the parent-child interactions to make them more positive, and to help quickly return the child to normal everyday activities. Another benefit and reward of utilizing PCIT with families of anxious children is that we have found parents in this population to be very compliant, perhaps due to their own anxiety, and perhaps due to other factors. In any case, parents’ compliance with all homework and high degree of involvement in session may be two additional factors that could be contributing to children’s observed success. Parents report that they are pleased to not have to put child on medication for anxiety, are appreciative of having skills for improving attachment and warmth, and have reported that the benefits of their new parenting skills are being reaped by all members of the family. One mother and father even noted that they noticed themselves utilizing the CDI skills with each other in their marriage, and that these skills have been extremely helpful in promoting warmth in their relationship. Overall, through ongoing data collection in our randomized clinical trial, we will be better able to determine the efficacy of this modified version of PCIT for treating clinically significant separation anxiety disorder in young children.

References


