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Commentary on Regulation Focused Psychotherapy for Children (RFP-C) with Externalizing Behaviors: Comparing the Successful Case of "Jack," and the Unsuccessful Case of "Oliver"

Comparing Parent Child Interaction Therapy (PCIT) to Regulation Focused Psychotherapy for Children (RFP-C) with Externalizing Behavior Problems: The Cases of "Jack" and "Oliver"

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ABSTRACT

This commentary examines the case studies by Brooks et al. (2025) of "Jack" and "Oliver," two children with externalizing behavior problems. Both cases were drawn from a successful randomized control trial (RCT) using the model of Regulation Focused Psychotherapy for Children (RFP-C), with Jack being a successful case, and Oliver, an unsuccessful case. We first commend Brooks et al. in a number of ways for the contributions their RCT and the cases of Jack and Oliver make to the psychotherapy research literature. At the same time, we raise methodological questions about the selection of Jack and Oliver and the fact that Jack's pre-test questionnaires were completed by Jack's mother, while the post-test measures were completed by Jack's father, introducing the unassessed variable of inter-rater reliability.

We next compare the psychodynamic, RFP-C theoretical approach with the behavioral theoretical approach we employ–Parent Child Interaction Therapy (PCIT). This comparison includes (a) our suggestion of behavioral alternatives to Brooks et al.'s psychodynamic interpretations of Jack's and Oliver's therapeutic interactions; and (b) an alternative case formulation and treatment plan for Jack and Oliver if they were to be seen in PCIT therapy. Regarding the case formulations and the treatment plans, utilization of standard PCIT is illustrated with the case of Oliver. Because Jack presents with many symptoms of anxiety, an adaptation of PCIT ("CALM") for young children with anxiety is also presented.

We suggest that PCIT is able to produce large magnitude improvements that last over time in part due to the use of parents as change agents who employ treatment techniques in their everyday interactions with their children. In addition, PCIT relies on weekly direct coaching as the most potent method for teaching parents therapy skills. This is contrasted with RFP-C's

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reliance on two hours per week of therapist child interactions and four total hours of parent education. We conclude with suggestions for incorporating a key feature of PCIT into RFP- C, which may enhance its potency and efficacy.

Key words: Parent Child Interaction Therapy (PCIT), Regulation Focused Psychotherapy (RFP- C), Oppositional Defiant Disorder, Childhood Anxiety, Child Directed Interaction, Parent Directed Interaction, Externalizing Behavior Problems, Direct Coaching, CALM, case study, clinical case study

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OVERALL CONTRIBUTIONS OF THE "JACK" AND "OLIVER" CASE STUDIES

Prout et al. (2022) published a randomized control trial (RCT) that investigated the efficacy of a new short-term psychodynamic therapy named "Regulation Focused Psychotherapy for Children" (RFP-C) to treat children with externalizing behaviors. RFP-C consists of 16 sessions with the child and four sessions with the parents over 10 weeks, with the goal being to reduce oppositional behavior by acclimating children to their emotions in a play setting (Prout et al., 2022).

At the beginning of RFP-C therapy, the child enters a room that contains various games they can play, and the therapist attempts to join play and point out any distressing emotions they deduce from the child's behavior. The theory behind RFP-C's potential efficacy is that children expressing oppositional behaviors have under-developed emotional regulation skills, and that by pointing out their emotions to them they will develop these skills. At the beginning and end of therapy, parents completed six questionnaires measuring oppositional behavior and the child completed a self-report questionnaire assessing emotional regulation (Prout et al., 2022). At post treatment, the researchers found that 79% of children were rated by their parents as improved on one of the measures of oppositional behavior. No improvements were found on the Child Behavior Checklist or on any of the measures of emotional regulation (Prout et al., 2022).

After the completion of the RCT, Brooks et al. (2025) selected two out of the original 36 cases for further analysis on the basis that one was successful, and the other was unsuccessful. The goal of the dual case study was to determine why the therapy was successful for one patient, but not the other. The two cases that were selected were the case of Jack (the successful case), and the case of Oliver (the unsuccessful case). According to the researchers, the main differences between these cases were that (a) Jack engaged in imaginative play while Oliver played board games; (b) Jack was open with the therapist while Oliver was quiet; and (c) Oliver was wary of the camera used to record sessions while Jack was not.

There are clearly facets of this dual case presentation that are laudable. These include (a) working with the parents to increase the chance that therapeutic effects extend into the home; (b) examining in-depth a successful versus an unsuccessful case to attempt to elucidate factors

influencing outcome (e.g., Jack was more interactive than Oliver); and, most importantly, (c) systematically evaluating how RFP-C works.

Overall, increasing the number and availability of evidence-based therapies is important in furthering the field of child psychotherapy (American Psychological Association, 2021). In line with this, historically, psychodynamic interventions have lacked well designed studies evaluating their effectiveness. Notably, the RFP-C RCT and the present case studies of Jack and Oliver utilized reliable and valid outcome measures, such as the Eyberg Child Behavior Inventory (ECBI) and the Child Behavior Checklist (CBCL), a large step in the right direction. The authors correctly note the need for effective interventions that are economical to deliver. That being said, there are methodological concerns and treatment alternatives that need to be addressed.

CASE STUDY METHODOLOGICAL COMMENTS

Potential Bias in Case Selection

To investigate the degree to which selection bias influenced the study findings, it would be helpful to know how these particular cases were chosen. Unfortunately, the researchers did not state the method they used to select the successful versus unsuccessful cases. It is unclear whether all the cases in the RCT were sorted into "successful" and "unsuccessful" categories and then a case randomly selected from each, or if Jack and Oliver represent the most extreme outcomes in the RCT subject pool. Alternatively, the case study authors may have had hypotheses about child and therapist factors that would affect outcome and then selected cases that would confirm those hypotheses.

Rater Confound for the Case of Jack

In addition to how the cases were chosen, there is a design problem with including the successful case of Jack in the larger data set. This is because the pre-test questionnaires were completed by Jack's mother, while the post-test measures were completed by Jack's father, introducing the unassessed variable of inter-rater reliability. This is particularly important since six out of the seven measures in this study are based on parental reports, and the only measures under which Jack significantly improved were among these six (Brooks et al., 2025, Table 1).

Because differences in how Jack's mother and father view his behavior are unknown, the data should either not be assessed, or heuristics related to gender differences have to be assumed and applied to the data. For example, gender heuristics related to the perception of oppositional defiant behavior point to mothers rating oppositional behavior more severely than fathers (van der Veen- Mulders et al., 2017), a point acknowledged by Brooks et al. (2025) and apparent in Jack's case (Brooks et al., 2025, p. 42). Jack's mother rated his oppositional defiant behavior higher in pre-test, and Jack's father rated it lower post-test (Brooks et al., 2025, Table 1). This

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means the effect seen in Jack's case might have been due to the difference in the rater rather than the effect of treatment. In future studies, it would be beneficial to consider taking pre/post-test measurements from both parents to prevent this issue from occurring. Nevertheless, in the current dual case study examination, we suggest that the case of Jack should have been excluded from the selection pool in favor of one that did not contain the rater confound.

PSYCHODYNAMIC VERSUS BEHAVIORAL INTERPRETATIONS OF JACK'S AND OLIVER'S BEHAVIOR IN THERAPY

The case study authors offer a number of psychodynamic explanations for various behaviors exhibited by Jack and Oliver throughout the course of treatment. To provide a theoretical contrast, we examine these children's behaviors from a behavioral and cognitive-behavioral perspective.

The Case of Jack

Intake

On intake, Brooks et al. describe Jack as having a tendency to resort to verbal and physical aggression when things do not go his way, as well as seeming to exhibit anxiety behaviors relating to separation from his mother. In addition, he was diagnosed with a sensory processing disorder and received speech therapy when he was in preschool. Brooks et al. interpret Jack's verbal and physical aggression as a result of displacing feelings of threat from others, and they posit that his sensory processing issues cause overstimulation and augment his feelings of threat and anxiety (Brooks et al., in press).

An Early Appointment

During one of his first appointments, Jack wanted to play with Legos, but asked the therapist to open the Lego box for him, appearing afraid of what could be inside. Brooks et al. interpret this behavior as a sign that Jack is distancing himself from his therapist, communicating that he is avoiding "looking 'inside.'" (Brooks et al., 2025, p. 14). In contrast, from our behavioral perspective, we would view Jack as communicating that he is uncertain about the contents of the box, that he is having difficulty opening the box, and that he is reaching out to the therapist for assistance despite his shy nature. Our behavioral perspective does not support the idea that Jack is distancing himself and symbolically communicating his reluctance to reflect on his feelings.

A Later Session

In another of Jack's sessions, he expresses his fear that he will be nuked by saying "...me and my friend Joe made a joke. Technically we're just waiting to be…have a nuclear bomb bomb us." (Brooks et al., 2025, p. 15). The therapist makes no attempt to dissuade Jack of the idea he might be nuked, instead allowing him to ruminate and create a dialogue about it. A

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therapist practicing cognitive-behavioral strategies would send messages of safety to Jack, perhaps making efforts to address these worries and categorize them as realistic or unrealistic (LaFreniere & Newman, 2020). Allowing Jack to ruminate on these worries and discussing them as if they are plausible provides reinforcing attention for anxiety behavior and could likely increase its frequency (Puliafico et al., 2020).

The therapist then goes on to ask what we see as a leading question:

> Therapist*: When you hear noises do you usually think that it might be something dangerous?*
>
> Jack*: Yes.*
>
> Therapist*: Yea? What does that feel like? That must feel scary.*
>
> Jack*: It's very scary.*
>
> Therapist*: It is scary?*
>
> Jack*: It isn't very scary.*
>
> Therapist*: Oh, it isn't very scary.*
>
> Jack*: I'm gonna tase you for that* [pretends to use Taser gun leg].
>
> Therapist*: Ouch. When we do tasing we're just gonna pretend to touch the other person, ok, like this* [demonstrates tasing without touching child's body]. *Ok?*
>
> Jack: [No response - silently points gun at therapist head.]
>
> Therapist*: The gun is pointing at me (pause) I don't know what's gonna happen. I have so many thoughts in my head. Am I gonna be okay?*
>
> Jack: [No response - silently makes gun bigger.]
>
> Therapist*: I wonder if I'm…*
>
> Jack*: Pew* [shoots therapist].
>
> Therapist*:* [falls to the ground] *You got me. And now I'm dead. What happens now?*
>
> Jack*: Pew, pew, pew, pew , pew* [shoots therapist].
>
> Therapist*: Oh, every time I get up I get shot again.*
>
> Jack*: Mmm-hm.*
>
> Therapist*: I can't feel safe at all.*
>
> Jack*: Mmm-hm* [pause] *I'm making a gun…second gun…* (Brooks et al., 2025, p. 16).

Brooks et al. explain this dialogue as a self-protective response exhibited by Jack because of the previous mention of him being scared of getting nuked. From our behavioral standpoint, Jack is playing war and the therapist is playing along, as has happened during seemingly every session.

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The reason behind why Jack always plays war could be any of or a mix of the following reasons: war being on his mind due to anxiety related to being bombed; potentially playing war at home with friends and siblings; and/or habit formation because playing war is reinforced by therapist interest and attention.

The Case of Oliver

Intake

On intake, Brooks et al. describe Oliver as being rude, argumentative, and a bully. At the beginning of therapy, Oliver was noted to have a flat affect and his play was characterized as socially appropriate, but lacking imagination. Oliver chose to play board games during most of his sessions (we would suggest that if playing board games reduces the effectiveness of treatment by hindering imaginative play, perhaps they should be excluded from the game room in the future). The researchers also stated that Oliver was difficult to engage in conversation, which made it hard for the therapist to guide the play and create effective therapeutic outcomes.

Second Session

During the second session, the following dialogue was used to support this claim:

> Therapist*: It's going to be a colorful motorcycle.*
>
> Oliver: [No response – continues building.]
>
> Therapist*: Oh wow. You're stacking those pieces on there.*
>
> Oliver: [No response - continues building.]
>
> Therapist*: Oh, that's a new piece.*
>
> Oliver: [No response - continues building.]
>
> Therapist*: What part of the motorcycle is that?*
>
> Oliver*: Steering wheel.* (Brooks et al., 2025, p. 20).

Brooks et al. interpret Oliver's lack of or brief responses during this dialogue as pointing to his awareness that the treatment was only short-term, invoking the feelings of loss they believe are responsible for his disruptive behavior and causing him to keep the therapist at an arm's length.

Our alternative, overt behavioral interpretation of this dialogue would be that Oliver's lack of or brief responses to comments made by the therapist while building his motorcycle was because when children are engrossed in play, it is common for them to give short answers to questions they do not find interesting in an attempt to move past them and get back to playing. In this perspective, Oliver does not appear to be a child experiencing feelings of loss and choosing to act out by ignoring the therapist. Rather, he appears to be a child focused on building a Lego motorcycle.

Session Six

During session six, there is an incident in which Oliver freezes when he notices the camera in the room:

> Therapist*: I wonder why you're sitting all the way over there behind the door?*
>
> Oliver: [No response - silently points to the camera.]
>
> Therapist*: Oh, the camera?*
>
> Oliver: [No response – silently nods.]
>
> Therapist*: Hmm. What's with the camera. Remember I told you that the camera is just on so that I can remember everything that we do in here.*
>
> Oliver*: Mhm.* (Brooks et al., 2025, p. 22)

Brooks et al. went on to explain that Oliver had told his mother he was unwilling to speak in front of the camera, and they point to this as a possible reason why the therapy did not work in Oliver's case. In our behavioral view, while the camera might have affected Oliver's responsiveness during treatment, it seems like session six was not the first instance when Oliver was introduced to the camera because the therapist said: "Remember I told you that the camera is just on so that I can remember everything that we do in here" (Brooks et al., 2025, p. 21). If Oliver knew about the camera previously, why did the issues begin to occur in the 6th session as opposed to when Oliver first learned about the existence of the camera? It is possible that Oliver used the existence of the camera as an excuse to not speak, an idea that might have been inspired by the therapist when they said "Hm. I wonder if it's easier to play checkers than to talk when the camera is there" (Brooks et al., 2025, p. 22). Regardless, we suggest it would be wise to have the camera hidden (perhaps behind a two-way mirror) for future trials of RFP-C so it does not influence the outcome of the therapy.

Session 10

The camera continued to be an issue until session 10, during which the therapist presented Oliver with a new game to play, and Oliver responded with excitement and engagement. Brooks et al. characterized this action by the therapist as a way of communicating her understanding that Oliver did not want to talk, and believed Oliver's engaged response was an acknowledgement of this. From our behavioral perspective, it seems that Oliver was excited for a change of pace after having played the same board games repeatedly. We believe that while the therapist may have intended to convey a deeper message, it is unlikely that Oliver received it and was instead focused on this new game he was about to play.

Session 12

Moving on to the 12th session, Oliver was resuming an arts and crafts activity he was

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described as "eager to complete" when this dialogue occurred:

> Therapist*: Which one are you thinking?*
>
> Oliver*: I'll finish this one.*
>
> Therapist*: You want to finish that one?*
>
> Oliver: [No response - continues opening box.]
>
> Therapist*: Do you remember which one you had?*
>
> Oliver*: Yeah. This one.*
>
> Therapist*: I don't remember the one I was doing.*
>
> Oliver*: You were doing that one (points).*
>
> Therapist*: Oh, that one. How did your weekend go?*
>
> Oliver*: Good.*
>
> Therapist*: Did your [sibling] have [their] birthday party?*
>
> Oliver*: Yeah.*
>
> Therapist*: How was that?*
>
> Oliver*: What?*
>
> Therapist*: How was it?*
>
> Oliver*: Good.* (Brooks et al., 2025, p. 22-23)

Brooke et al. felt that this dialogue supported the idea that Oliver was distancing himself from the therapist as a self-protective measure. Behaviorally, it seems to us as if Oliver is reacting as any child would: avoiding questions about daily events he no longer cares about and instead focusing on the task at hand he was "eager to complete."

The Last Session

A similar event happened during the last session while Oliver was showing the therapist magic tricks:

> Oliver*: And now for, for the paperclip one.*
>
> Therapist*: So, we have about five more minutes.*
>
> Oliver*: This one's also very similar. It doesn't have, it doesn't have any secret. It's just really about how you fold them.*
>
> Therapist*: Ok.*
>
> Oliver*: You go like...you fold it like in eight, like this – like you make sure that this paper*

> *clip goes here and that this paper clip holds this together.*
>
> Therapist*: Seems like it's a bit hard to hear that we have five more minutes left.*
>
> Oliver*:* [continues to show the trick] *Now that we pull. Oh..*
>
> Therapist*: Instead it's easier to keep showing me the trick.*
>
> Oliver*:* [continues to show the trick] *Now when we pull, like this, they join together…* (Brooks, 2025, p. 23-24).

This dialogue was used to further evidence that Oliver was distancing himself from the therapist in a self-protective measure to avoid the feelings of loss he would soon encounter with the end of the session. Behaviorally, it seems to us like Oliver is trying to show the therapist a magic trick he is excited about while she interrupts him, causing him to pause for a second due to his train of thought being disrupted only to continue a few seconds later. In behavioral and cognitive behavioral interventions, children are seen as engaging in behaviors that they find rewarding—behaviors are not seen as driven by inferred self-protective mechanisms as posited by Brook et al. . An example of one of these behaviorally based interventions for children with oppositional behavior is presented in the next section.

AN ALTERNATIVE APPROACH: PARENT CHILD INTERACTION THERAPY (PCIT)

Parent-Child Interaction Therapy (PCIT) is an intensive behavioral family therapy program developed by Dr. Sheila Eyberg and is designed to improve disruptive behavior in young children (McNeil & Hembree-Kigin, 2010). With more than four decades of systematic research evaluating its efficacy, PCIT is considered to be one of the most effective treatments for young children with Oppositional Defiant Disorder (Lieneman et al., 2017). As PCIT research has grown exponentially, so has its dissemination. PCIT is practiced widely across the United States and is used in community mental health clinics, university settings, inpatient hospital units, group homes, foster care, schools, daycare centers, Head Start, telehealth, dental practices, and private practice settings (Scudder et al., in press). PCIT has gained international attention with clinical and research teams in countries such as Japan, South Korea, Australia, Mexico, Taiwan, Iran, Turkey, Germany, Sweden, Denmark, and Norway (Bussing et al., in press). To facilitate international collaboration and dissemination, an annual PCIT International Convention is held in rotating countries (https://www.pcit.org). Clinical and research teams have been developing and evaluating adaptations of the PCIT model to address a wide range of populations including children with anxiety disorders, autism, selective mutism, obsessive compulsive disorder, problematic sexual behavior, maltreatment and trauma, callous and unemotional affect, attention deficit hyperactivity disorder, older children, toddlers, siblings, deaf and hearing impaired, Latinx families, and African American families. A comprehensive clinical handbook on PCIT including nearly 50 chapters that detail these clinical and research advances is now in

press (Scudder et al., in press).

Standard PCIT is a manualized, two-stage model in which parents are directly coached, usually via a bug-in-the ear device, as they interact with their children in both relationship enhancing and behavior management strategies (Eyberg & Funderburk, 2011). In the first stage of treatment (Child Directed Interaction, or CDI), parents learn to provide positive attention to their children in a daily child directed play session in which they describe, reflect, imitate, and praise their child's appropriate behavior while withdrawing attention from disruptive behaviors.

Over the course of this parent-administered child directed play therapy, improvements are found in the warmth of parent child interactions; parenting stress decreases; negative-attention seeking behaviors diminish; frustration tolerance improves; and children show more cooperative behavior (Hembree-Kigin et al., 1993; Thomas et al., 2017).

In the second stage of treatment (Parent Directed Interaction, or PDI), parents are taught how to give effective commands and to follow compliance with enthusiastic praise, and noncompliance with a warning and a brief time out in a chair consequence that ends when the child complies. Therapists directly coach parents in several sessions as PDI rolls out in steps that include the time out sequence, standing household rules, and generalization of behavioral improvements to public settings. By the end of treatment, most children's compliance has improved from less than 40% to more than 75% of their parents' direct commands on the first request (Hembree-Kigin et al., 1993), and disruptive behaviors move from outside normal limits before treatment to well within normal limits by the end of treatment (Thomas et.. 2017).

PCIT Training is both Economical and Accessible

One rationale given by Brooks et al. for the development of RFP-C is that it is inexpensive to train novice therapists as providers. Specifically, they indicated that graduate students were trained in one 8 hour workshop and provided weekly clinical supervision. In contrast, training in PCIT is much more intensive yet financially reasonable. If the training cost for PCIT was really the $73,000 that Brooks et al. (2025, p. 3) suggest is common for parent training programs, its dissemination would have been seriously hampered. The truth is that there are now PCIT programs in every state (see listing in https://www.pcit.org/) and the therapy is widely available to families. The cost of basic online training in PCIT is approximately $4500 per trainee (Kuchta et al., in press) and includes 50+ hours of workshop training, weekly consultation for one year, session review, and all clinical materials. Certification requires 40 hours of training, ongoing consultation, mastery of 14 core competencies covering areas of assessments in PCIT, CDI skills, PDI skills, coaching skills, as well as treatment review and the graduation of two PCIT cases. PCIT training can occur at either the professional or graduate level; training can be implemented independently, within a practice or agency either virtually, in person, or via a hybrid model.

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Most providers, universities, and community agencies find the cost of PCIT training to be well worth it given the ability to deliver highly effective treatment services that generalize across settings and maintain over time. The average cost of a PCIT session is $150 and the course of treatment may range from 12 to 20 sessions (https://www.pcit.org/) In most settings, the cost of training is quickly recouped with the first two to three treatment cases.

Theoretical Underpinnings of PCIT

PCIT therapists conceptualize disruptive behavior problems as arising or being maintained by dysfunctional parent child interactional patterns. More specifically, oppositional children develop noncompliant and negative attention seeking behaviors that are reinforced by parental attention, while their prosocial behaviors are largely taken for granted and receive little parental focus. When children are corrected or criticized at a high rate, their desire to please their caregiver diminishes and negative behavior becomes their most reliable way to get attention (McNeil & Hembree-Kigin, 2010). In PCIT, parents are taught to flip the script by giving frequent and enthusiastic attention for positive and neutral behaviors and withdrawing attention for many negative behaviors. As children learn to access positive attention through prosocial behavior, the parent child relationship improves, children are happier, and disruptive/oppositional behavior diminishes. PCIT is founded on the idea that a complete parent is both a nurturer and a calm, predictable limit setter. To improve parent child interactions around discipline and limit setting, parents are coached in calm, effective command giving, structured use of time-out, and consistent enforcement of standing household rules. Thus, improvements in oppositional defiant child behavior come as a result of an improved parent child relationship and consistent consequences for misbehavior (McNeil & Hembree-Kigin, 2010).

PARENT CHILD INTERACTION THERAPY (PCIT) CASE FORMULATION WITH OLIVER AND JACK

Although both Jack and Oliver were reported to display symptoms of Oppositional Defiant Disorder (ODD: American Psychiatric Association, 2013), there appear to be significant clinical distinctions between the two cases warranting somewhat different interventions. As such, we will describe the use of standard PCIT for the case of Oliver and then the use of an adaptation of PCIT for anxious children called "Coaching Approach behavior and Leading by Modeling" ("CALM") with the case of Jack. See Eyberg and Funderburk (2011) for the complete PCIT session by session protocol; and see Puliafico et al. (2020) for the complete CALM protocol.

The Case of Oliver

Oliver presented as classically oppositional, engaging in conflict with parents, teachers, and peers. The case study authors noted that two "emotionally significant events" occurred when Oliver was 2 years old—the birth of a sibling and the death of a pet—inferring that the emotional trauma of these events may have led to emotional dysregulation and ODD. However, there is no

evidence that either of these events was directly causally related to Oliver's acting out behavior problems. In fact, it is common for a 2 year old to experience the birth of a new sibling and very few develop clinically significant symptoms of ODD as a result. It is also common for families with toddlers to have a pet die and there is no evidence that that experience leads to ODD. On the other hand, it is common for two year olds to begin presenting challenging, noncompliant, and oppositional behavior as a normal part of early development (Lyman & Hembree-Kigin, 1994).

Brooks et al. also note that several of Oliver's close extended family members moved out of state when he was in second grade, the same year when his teachers began reporting oppositional behavior at school. The expected result of such a loss would be episodic feelings of missing the absent family members, not pervasive oppositionality in the home and school settings.

We suspect that the etiology of Oliver's behavior problems was likely chaotic parenting in which developmentally common negative attention seeking was reinforced and prosocial behavior largely ignored by parents who may have been overwhelmed with a new baby. It may also be that the departure of close extended family members when he was in second grade may have further stressed Oliver's parents and contributed to inconsistent and coercive parenting.

In addition, the increasing classroom behavioral and learning expectations of second grade may have led to more oppositional behavior at school. Although no familial genetic history of mental health conditions was reported for Oliver, it is also possible that he had biological predisposition toward acting out behavior problems. Indeed, research shows that the heritability for Oppositional Defiant disorder is approximately 50% (Mikolajewski et al., 2017). An overview of the course of standard PCIT for Oliver is presented in Table 1.

Pre-treatment Assessment Session

Our first session with Oliver and his parents (we strongly encourage participation of both parents when possible) would have been used to administer parent report measures of child behavior and parenting stress. In addition, parent child interaction observations would have been collected and coded using a standardized behavioral coding system. Oliver's parents would have also been given a teacher report measure to assess classroom behavior and asked to return it at the next session. In addition to standardized measures (see Table 2), a clinical interview would have been conducted to collect a full history, establish rapport,

Child Directed Interaction (CDI) Teach Session

In the Teach session, the therapist (and co-therapist if available) would have talked with both Oliver's parents about the importance of improving the quality of the parent child relationship prior to implementing discipline strategies.

As Brooks et al. note, many parents of oppositional children indicate that although they

love their children, they often feel like they don't like them. One on one child directed play is the perfect situation for parent child relationship strengthening because it sets children up for their best behavior when they have their parent's full attention in play (Bodiford & Hembree-Kigin, 2010). In this session, parents are taught to provide positive attention using the PRIDE (Praise, Reflect, Imitate, Describe, Enjoy) skills through explanation and therapist modeling. Parents are taught to avoid questions (they take the conversational lead away); commands (take the behavioral lead away and set up the possibility of noncompliance); and negative talk (hurts self-esteem and the parent-child relationship).

Parents are also taught how to use ignoring to selectively shape appropriate behavior. Constructional toys (e.g., Legos, magnet blocks, toy garages or farms) and play activities are selected that set children up for prosocial behavior, avoiding activities that elicit aggression (e.g., superhero figurines, dinosaurs).

Parents are sent home with a handout on the PRIDE skills and a tracking sheet to record their home practice. We would have asked each of Oliver's parents to begin practicing CDI at home with him in a daily 5 to 10 minute play session. Although Oliver would have been the identified client, we would have encouraged his parents to utilize their CDI skills with his younger sibling at home as well.

CDI Coaching Sessions

In every CDI coaching session, Oliver's parents would have completed the ECBI and would have been coded with the DPICS doing CDI prior to any coaching (see measures in table 2). This ongoing assessment provides information about both parent skill acquisition and changes in child behavior, and this information guides the therapist's focus during coaching. The therapists review with parents how their CDI home sessions went and problem solve regarding any logistical or behavioral issues.

Oliver's parents would have been coached via a bug in ear device while playing with Oliver. As parental skills improved, coaching would become less directive, and move from focusing specifically on PRIDE skills to parental use of selective attention. Anytime Oliver engaged in rude talk or rough play, his parents would be coached to turn partially away and start describing their own play while modeling the behavior they wished Oliver to display. As soon as Oliver displayed any positive or neutral behavior, his parents would quickly return their attention and describe his play or praise his behavior.

In this way, Oliver would have quickly learned that when he used gentle hands and kind words, his parents would enthusiastically describe, imitate, and praise him; but when he talked rudely, demanded things, grabbed from their hands, and/or was rough with the toys, he would quickly lost his parent's attention. As selective attention was mastered, coaching would have shifted to qualitative aspects of their interactions (e.g., physical closeness/affection, eye contact,

vocal and facial expression, developmentally sensitive teaching, task persistence, frustration tolerance, sharing, polite manners).

After several coaching sessions, Oliver's parents would have both reached the mastery criteria of 10 behavior descriptions, 10 reflections, and 10 labeled praises with no more than 3 commands, questions, or negative talk in a 5 minute coding session. Oliver's interactions with his parents would have looked much warmer and their report of behavior problems on the ECBI would likely have decreased, but not to within normal limits. They would likely have reported that both they and Oliver looked forward to their home play sessions and that they found themselves using their PRIDE skills spontaneously throughout the day. Oliver's tolerance for frustration would have significantly improved and his parents would have reported that his "fuse" did not seem so short. Oliver's parents would have likely noted that Oliver and his younger sibling had begun to imitate the PRIDE skills and were now praising each other and using descriptions and reflections in their play with each other and with other children. However, they would have reported that Oliver still did not comply well enough with their directions at home and in public places, and that they were continuing to get reports from his teacher that he was not cooperating in the classroom.

Parent Directed Interaction (PDI) Teach Session

In the PDI Teach session, Oliver's parents would have been encouraged to continue their use of PRIDE (Praise, Reflect, Imitate, Describe, Enjoy) skills in daily home play and would have been introduced to the discipline skills that will be focused on for the remainder of treatment. The parents would have been taught to give direct commands that are polite, positively stated, specific, simple, within Oliver's developmental capability, and stated with a calm, neutral voice.

When Oliver complied, he would be praised for his first time listening, and when he would not comply, he would be given a time-out warning. Compliance with the warning again results in praise while noncompliance leads to a short time-out in a time-out chair. The time out sequence ends when the child complies with the original command. Oliver's parents would be instructed in back up contingencies in case Oliver refused to go to the chair. These skills would have been taught through didactic presentation, therapist modeling, and role-plays with parents (McNeil & Hembree-Kigin, 2010).

Parent Directed Interaction Coaching Sessions

In every PDI coaching session, therapists conduct a 10 minute check in with parents on treatment progress and code the parent's use of PRIDE skills in a 5 minute observation. Early coaching sessions emphasize parental use of direct instead of indirect commands, and consistent follow through with praise or the time-out sequence. Oliver's parents would have been encouraged to gradually phase in the timeout procedure at home in a planned sequence. As

Oliver's parents demonstrated skill acquisition in 2 minute PDI coding sessions, they would have been taught to institute a small number of standing household rules (e.g., no hurting, no mean talk) that automatically result in time out when broken. As Oliver's compliance with parental commands and disruptive behaviors improved, attention would have turned toward generalizing behavioral improvements to public settings such as the homes of extended family members, grocery stores, car rides, and shopping malls. In the latter sessions, Oliver's parents would been encouraged to include his younger sibling in the appointments so they could practice managing the behavior of both children in real life interactions. Mastery of the second phase of PCIT occurs when 75% of commands are effective (direct, positively stated, single commands that provide an opportunity to comply or non-comply); 75% of the time parents follow through correctly with a labeled praise after compliance, or a warning after non-compliance; and parents follow through with time-out correctly. Oliver's family would have been ready for termination of treatment when these PDI skill criteria were met; the PRIDE skills were still maintained in session coding; and the weekly ECBI showed Oliver's behavior to be within normal limits (Eyberg & Funderburk, 2011).

Post Treatment Assessment Session

All measures administered at pretreatment would have been repeated and they would have been completed by the same person that initially completed them. If Oliver responded to PCIT in the way that most young children with Oppositional Defiant Disorder respond, his ratings on the ECBI and CBCL would have moved from outside normal limits to within normal limits and his parents would have reported significantly less parenting stress on the PSI. Because PCIT demonstrates strong cross setting generalization (McNeil et al., 1991), the measure of classroom behavior, the SESBI (see Table 2), would also have shown clinically significant improvement. In addition to parent and teacher reports of behavioral improvement, outcome would have been assessed through direct observation using the DPICS coding system (see Table 2). Prior to treatment, Oliver would have likely been complying with less than 20% of his parents' commands, but by the end of treatment, his rate of first-time listening would have likely been 70% or more.

An additional measure of consumer satisfaction specifically tailored to PCIT treatment would have been administered to both of Oliver's parents. The results of all pre to post treatment measures would have been reviewed with Oliver's parents and recommendations made for follow up maintenance appointments, usually at 6 weeks, 3 months, and 6 months.

The Case of Jack

Although Jack also displayed anger and aggression, his behavior problems are likely to be secondary to or at least co-morbid with his clinically significant anxiety. Jack appears to have specific phobias of a military attack and going to the hospital, as well as both separation anxiety

and social anxiety. His overall anxious and sad presentation also suggests that he may be experiencing generalized anxiety.

In contrast to Oliver, Jack was rated outside normal limits on the CBCL for anxiety and mood problems, as reflected in Brooks et al.'s (2025) statement: "Jack's mother also reported clinically elevated affective problems and anxiety problems on the CBCL" (2025, p. 10). It is not surprising that his parents reported familial history of both anxiety and depression; it is common for young children with anxiety and mood problems to present with oppositional and aggressive conduct (Drabick et al., 2010). Anxious children feel out of control when not getting their way and may respond with verbal and physical aggression instead of with flexibility and problem-solving.

Because Jack's anxiety plays a significant role in his sour affect, frustration, and aggression, he would be better served with an adaptation of PCIT designed for young children with anxiety called the Coaching Approach behavior and Leading by Modeling (CALM; Puliafico et al., 2020) program (See Table 3).

Similar to Oliver's standard PCIT treatment, the CALM program involves two phases of therapy starting with Child Directed Interaction (CDI). During the CDI phase of treatment, caregivers are taught skills for improving their relationships with their children and are provided with anxiety education.

Parents learn how to reduce their child's anxiety symptoms through selectively attending to brave or approach behavior while limiting attention and reinforcement of avoidant/anxious behavior. This is counter intuitive for many of our families, especially those with an anxious parent. At pretreatment, we commonly observe parents reinforcing their child's fearful behavior with their own anxious facial expressions, overly solicitous questions ("Are you sure you're ok, honey?"), and over comforting (hugging child while saying, "I know it's really scary").

As in standard PCIT, the second phase of CALM is parent-directed. However, instead of teaching parents effective command-giving and time-out consequences, they are taught to use a modeling and prompting procedure during graduated exposure tasks. The DADS (Describe, Approach, Direct command, Selective attention) sequence is a method that parents can use to increase their children's movement through levels of personalized fear ladders (Puliafico et al., 2020). Just as in standard PCIT, the CALM skills are presented to parents didactically and then shaped through in vivo coaching of parent child interactions. In this way, parents become the "therapists" and are able to implement therapy strategies throughout the week and in the child's natural environment. A detailed description of the implementation of CALM is available in Puliafico et al. (2020).

The CALM program has received strong empirical support in case studies (e.g., Cooper-Vince et al., 2016; Puliafico et al., 2013), a pilot open trial (Comer et al., 2012), and in a waitlist-

controlled trial (Comer et al., 2021). In the pilot open trial, Comer et al (2012) reported that 80% of families completed treatment and 67% of children were no longer diagnosable with an anxiety disorder by post treatment. In Comer et al.'s (2021) wait-list controlled trial, children diagnosed with social anxiety, separation anxiety, and generalized anxiety who participated in CALM were compared to waitlist controls. More than half of treated children were judged to be "responders" compared with 6% in the waitlist condition. Treatment effects were maintained at 6 month follow up. CALM was found to be particularly effective for families in which the primary caregiver displayed accommodating and overprotective behavior.

Pretreatment Assessment.

Just as in standard PCIT, pretreatment assessment includes the measures listed in Table 2. In addition, measures of child anxiety symptoms are administered such as the Top Problems Assessment (TPA; Weisz et al., 2011) and the Youth OASIS (OASIS- Y; Comer et al., 2022). The TPA is administered in each session as an ongoing assessment of symptom change. As mentioned above, Brooks et al. noted that Jack's mother reported clinically elevated affective and anxiety problems on the CBCL; it is likely that Jack also would have scored well outside normal limits on anxiety symptoms on the TPA and OASIS-Y.

Teach Session.

A great deal of content would have been covered with Jack's parents in the Teach Session, including anxiety psychoeducation. They would have learned how avoidance behavior maintains fears and how parents may inadvertently maintain their children's fears through accommodation (allowing children to retreat from non-dangerous situations they fear) and excessive reassurance (relying on others' reassurance instead of self-soothing).

Jack's parents would be taught to provide labeled praise for "brave" approach behaviors and to utilize small rewards for cooperation with treatment procedures. The idea of "brave ladders" would have been introduced and four targets for fear reduction were identified (see Table 4). The first brave ladder for Jack's fear of a Military Attack would have been generated with the parents.

The remainder of the session would have focused on teaching and role playing the PRIDE skills of CDI as well as the use of selective attention for brave behavior and actively ignoring anxious-avoidant behaviors, such as distancing oneself from a feared object, refusing to engage with a feared object, crying, whining, negotiating, excessive reassurance-seeking, or hiding (Javadi et al., in press).

CDI Coaching and Exposure Sessions.

During the first two coaching sessions, Jack's parents would be coded and coached in the PRIDE skills of standard PCIT. In the third coaching session, Jack's parents would be coached to

introduce him to a low level of fear exposure on his military attack hierarchy. They would tell Jack "now we are going to practice being brave. I am going to use these toys to act out a pretend military attack and you get to stay close to the table and watch." Then Jack's parents would have been coached to describe and praise his brave approach behavior and to selectively ignore any fear behavior. Jack might initially scowl and protest, stepping back from the table. His parents would have been coached to ignore his avoidance behaviors. As the military attack play continued, Jack would likely have started to watch from a step away. His parents would have been coached to praise how brave he was to keep watching the play and staying in the room. As the exposure continued, Jack would likely have moved toward the toys and been praised for his approach behavior. Remaining coaching sessions would have continued to present low level exposures with coaching of contingent attention. Daily homework would have included 5 minute home CDI sessions and low level exposure exercises.

DADS Teach and Exposure Preparation Session

Jack's parents would have been taught how to actively model approach behavior for Jack and to guide him in approaching feared situations. These skills are known as the "Describe, Approach, Direct command, Selective attention," or DADS skills. They include sequences of describing, approaching, giving a direct command, and selectively attending to brave approach behavior (Puliafico et al., 2020). Plans would have been made for how to use this procedure with moderate fear level exposures.

Jack's level of oppositional conduct and noncompliance would have been reviewed with parents. If he continued to have high rates of noncompliance even with use of small reinforcers, the therapist would have recommended including a few sessions of standard PDI to prepare Jack to be able to comply with the approach commands in DADS (Javadi et al., in press)..

DADS Coaching and Exposure Sessions

In the remaining DADS coaching sessions, Jack's parents would have been coached in using the DADS sequence for increasingly moderate to high level exposures on his bravery ladders. By the end of treatment, Jack would have been successful with all exposures on his Military Attack bravery ladder and would have been progressing on the other three ladders.

Jack's family would have been ready for termination of treatment when: (1) Jack was more consistently approaching feared situations; and (2) Jack's parents were demonstrating competent use of positive attention, active ignoring, and the DADS skills. All pretreatment measures would have been repeated at posttreatment and Jack would likely have shown clinically significant improvements in both internalizing and externalizing symptoms.

CONCLUSION

Creating and analyzing the efficacy of a new treatment like Brooks et al.'s (2025)

psychodynamically based model of Regulation Focused Psychotherapy (RFP-C) for ODD is commendable. In spite of our methodological concerns about the cases of Jack and Oliver, we welcome the development of alternative treatments for ODD and encourage the authors to continue to systematically evaluate the RFP-C model.

As a contrast, we have provided a detailed description of the behaviorally based model of Parent Child Interaction Therapy (PCIT), and we have demonstrated how the model could be applied to the cases of Jack and Oliver. We are happy to see that RFP-C (like PCIT) is being subjected to empirical research evaluating its efficacy and mechanisms of change.

We note that in the cases of Jack and Oliver, RFP-C had the potential to affect a child for a total of 16 hours (16 sessions, 1 hour per session) and 4 parent sessions over an 8-week period (Brooks et al., 2025, p. 6). In contrast, parent training programs like PCIT extend treatment into the home by teaching and coaching parents to use therapy techniques throughout the day, every day. As advocates of PCIT, we suggest that RFP-C might be made more potent by borrowing from evidence-based treatment programs like PCIT and using parents more explicitly, extensively, and systematically as change agents. If a graduate student can be trained in RFP-C in 8 hours (Brooks et al., 2025, p. 3), it is feasible that parents can be taught and coached in RFP-C treatment techniques to use throughout their interactions with their children at home.

REFERENCES

Abidin, R. R. (2012). Parenting stress index (4th ed.). Lutz, FL: PAR.

Achenbach, T. M. (2009). *The Achenbach system of empirically based assessment (ASEBA): Development, findings, theory, and applications*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families.

Aggarwal A, & Marwaha R. Oppositional Defiant Disorder. [Updated 2022 Sep 19]. In: StatPearls[Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available From: https://www.ncbi.nlm.nih.gov/books/NBK557443/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*(5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2021). APA guidelines on evidence-based psychological practice in health care. Washington, DC: American Psychological Association Publications, 1-27.

Brestan, E., Jacobs, J., Rayfield, A., & Eyberg, S.M. (1999). A consumer satisfaction measure for parent-child treatments and its relationship to measures of child behavior change. *Behavior Therapy, 30,* 17-30.

Brooks, C., Kufferath-Lin, T., Prout, T.A., Di Giuseppe, M., Bate, J., Aafjes-Van Doorn, K., Hoffman, L., & Rice, T. (2025). Regulation Focused Psychotherapy for Children (RFP-C) with externalizing behaviors: Comparing the successful case of "Jack," and the

unsuccessful case of "Oliver." *Pragmatic Case Studies in Psychotherapy*, *21*(1), Article 1, 1-68. Available: https://pcsp.nationalregister.org/

Bussing, R., Briegel, W., Morgan, S., & Nelson, M. (in press). An introductory overview of PCIT around the world. In Scudder, A., Hembree-Kigin, T.L., & McNeil, C.B. (eds.) *Clinical Handbook of Advancements in Parent Child Interaction Therapy*. Springer.

Campbell, S.M., Hawes, T., Swan, K., Thomas, R., & Zimmer-Gembeck, (2023). Evidence-based treatment in clinical practice: PCIT research on addressing individual differences and diversity through the lens of 20 years of service. *Psychology Research and Behavior Management*, *16*, 2599-2617.

Comer, J.S., Conroy, K., Cornacchio, D., Furr, J.M., Norman, S.B., & Stein, M.B. (2022). Psychometric evaluation of a caregiver-report adaptation of the Overall Anxiety Severity and Impairment Scale (OASIS) for use with youth populations. *Journal of Affective Disorders, 300*, 341-348.

Comer, J.S., Furr, J.M., del Busto, C., Silva, K., Hong, N., Poznanski, B., Sanchez, A.L., Cornacchio, D., Herrera, A., Coxe, S., Miguel, E., Georgiadis, C., Conroy, K., & Puliafico, A.C. (2021). Therapist-led, internet-delivered treatment for early child social anxiety: A waitlist-controlled evaluation of the iCALM Telehealth Program. *Behavior Therapy, 52*(2), 1171-1187.

Comer, J.S., Puliafico, A.C., Aschenbrand, S.G, McKnight, K., Robin, J.A., Goldfine, M., & Albano, A.M. (2012). A pilot feasibility evaluation of the CALM Program for anxiety disorders in early childhood. *Journal of Anxiety Disorders, 26*, 40-49.

Cooper-Vince, C., Chou, T., Furr, J.M., Puliafico, A.C., & Comer, J.S. (2016). Videoteleconferencing early child anxiety treatment: A case study of the Internet-delivered CALM (I-CALM) Program. *Evidence-Based Practice in Child and Adolescent Mental Health, 1*, 24-39.

De Los Reyes A, & Kazdin AE. Informant discrepancies in the assessment of childhood psychopathology: A critical review, theoretical framework, and recommendations for further study. *Psychological Bulletin.* 2005;131:483–509.

Drabick, D. A., Ollendick, T. H., & Bubier, J. L. (2010). Co-occurrence of ODD and Anxiety: Shared Risk Processes and Evidence for a Dual-Pathway Model. *Clinical psychology : a publication of the Division of Clinical Psychology of the American Psychological Association, 17(4), 307–318.*

Eyberg, S. M., Funderburk, B. W., Hembree-Kigin, T. L., McNeil, C. B., Querido, J. G., & Hood, K. K. (2001). Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family. *Child & Family Behavior Therapy*, *23*(4), 1-20.

Eyberg, S., & Funderburk, B. W. (2011). *Parent-Child Interaction Therapy Protocol.* Gainesville, FL: PCIT International.

Eyberg, S.M., Nelson, M.,M., Ginn, N.C., Bhuiyan, N., & Boggs, S.R. (2013). Dyadic Parent-Child Interaction Coding System: Comprehensive Manual for Research and Training (4th ed.). Gainesville, FL: PCIT International.

Eyberg, S.M., & Pincus, D. (1999). *Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory-Revised: Professional Manual.* Odessa, FL: Psychological Assessment Resources.

Hayes, J., Stewart, I., & McElwee, J. (2017). Children's Answering of Yes-No Questions: A Review of Research Including Particular Consideration of the Relational Evaluation Procedure, *Behavioral Development Bulletin* , *22* (1), 173–182.

Hembree-Kigin, T. H., Eyberg, S., McNeil, C. B., Newcomb, K., & Funderburk, B. (1993).Parent-child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome. *Journal of Clinical Child Psychology*, *22*, 42-51.

Javadi, N., Puliafico, A.C., Pincus, D.B., Comer, J.S. Parent-Child Interaction Therapy for early childhood anxiety: The Coaching Approach behavior and Leading by Modeling (CALM) program, In Scudder, A., Hembree-Kigin, T.L., & McNeil, C.B. (Eds.) (in press) *Clinical Handbook of Advancements in Parent Child Interaction Therapy*. Springer: New York.

Kuchta, J. S., Yearsovich, M., & Abner, J. How to Become a PCIT Therapist, In Scudder, A., Hembree-Kigin, T.L., & McNeil, C.B. (Eds.) (in press) *Clinical Handbook of Advancements in Parent Child Interaction Therapy*. Springer: New York.

LaFreniere, L. S., & Newman, M. G. (2020). Exposing Worry's Deceit: Percentage of Untrue Worries in Generalized Anxiety Disorder Treatment. *Behavior therapy*, *51*(3), 413–423. https://doi.org/10.1016/j.beth.2019.07.003

Lieneman, C.C., Brabson, L.A., Highlander, A., Wallace. N.M., & McNeil, C.B. (2017). Parent Child Interaction Therapy: current perspectives. *Psychological research and behavior management, 10,* 239-256.

Lyman, R.D., & Hembree-Kigin, T.L. (1993). Mental health interventions with preschool children. Springer.

McNeil, C. B., Eyberg, S., Hembree-Kigin, T., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology, 20*(2), 140– 151.

McNeil, C.B., & Hembree-Kigin, T.L. (2010) *Parent-Child Interaction Therapy. Issues in Clinical Child Psychology (2nd ed.)*. Springer.

Mikolajewski, A. J., Taylor, J., & Iacono, W. G. (2017). Oppositional defiant disorder dimensions: genetic influences and risk for later psychopathology. *Journal of child psychology and psychiatry, and allied disciplines*, *58*(6), 702–710.

Prout, T. A., Rice, T., Chung, H., Gorokhovsky, Y., Murphy, S., & Hoffman, L. (2022). Randomized controlled trial of Regulation Focused Psychotherapy for children: A

manualized psychodynamic treatment for externalizing behaviors. Psychotherapy Research, 32(5), 555–570. https://doi.org/10.1080/10503307.2021.1980626

Puliafico, A.C., Comer, J.S., & Albano, A.M. (2013). Coaching Approach behavior and Leading by Modeling: Rationale, principles, and a case illustration of the CALM Program for anxious preschoolers. *Cognitive and Behavioral Practice, 20*, 517-528. DOI: 10.1016/j.cbpra.2012.05.002

Puliafico, A.C., Furr, J.M., Hong, N., & Comer, J.S. (2020). *Coaching Approach behavior and Leading by Modeling: The CALM Program – Version 2.0*. Florida International University.

Scudder, A., Hembree-Kigin, T.L., & McNeil, C.B. (Eds.) (in press) *Clinical Handbook of Advancements in Parent Child Interaction Therapy*. Springer.

Thomas, R., Abell, B., Webb, H. J., Avdagic, E., & Zimmer-Gembeck, M. J. (2017).

Parent-Child Interaction Therapy: A Meta-analysis. *Pediatrics*, *140*(3), e20170352. https://doi.org/10.1542/peds.2017-0352

Valero-Aguayo L, Rodríguez-Bocanegra M, Ferro-García R, Ascanio-Velasco L (2021) Meta-analysis of the efficacy and effectiveness of parent-child interaction therapy (PCIT) for child behaviour problems. Psicothema 33(4):544–555.

van der Veen-Mulders, L., Nauta, M. H., Timmerman, M. E., van den Hoofdakker, B. J., & Hoekstra, P. J. (2017). Predictors of discrepancies between fathers and mothers in rating behaviors of preschool children with and without ADHD. *European child & adolescent psychiatry*, *26*(3), 365–376. https://doi.org/10.1007/s00787-016-0897-3

Weisz et al. (2011) Weisz, J.R., Chorpita, B.F., Frye, A., Ng, M.Y., Lau, N., Bearman, S.K., Ugueto, A.M., Langer, D.A., Hoagwood, K., and the Research Network on Youth Mental Health (2011). Youth top problems: Using idiographic, consumer-guided assessment to identify treatment needs and track change during psychotherapy. *Journal of Consulting and Clinical Psychology, 79*(3), 369-380.

Table 1. Standard PCIT Course of Treatment

Session 1- Pretreatment Assessment
Session 2- Child Directed Interaction Teach Session Presenting the Rationale for CDI and each of the PRIDE Skills
Session 3- CDI Coaching Emphasizing Description, Reflection, & Imitation
Session 4- CDI Coaching Emphasizing Labeled vs Unlabeled Praise & Avoiding Questions and Commands
Session 5- CDI Coaching Emphasizing Differential Attention and Ignoring
Session 6- CDI Coaching Emphasizing Qualitative Aspects of Interactions, Assess for CDI Mastery Criteria
Session 7- Parent Directed Interaction Teach Session Presenting Effective Command Giving, Command-Compy-Praise Sequence, and Time-out for Noncompliance
Session 8- PDI Coaching Emphasizing Play Commands and Be Direct Skills
Session 9- PDI Coaching of Command-Comply-Praise sequences and Implementation of Time out for Noncompliance
Session 10- PDI Coaching of Real Life Commands Throughout Session
Session 11- PDI Coaching and Explanation of House Rules Procedure
Session 12- PDI Coaching and Explanation of Managing Behavior in Public Settings
Session 13- Posttreatment Assessment
Maintenance Check Ins at 6 weeks, 3 months, and 6 months post treatment

Table 2. Standard PCIT Pre- and Post-treatment Measures

Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999) *available from Psychological Assessment Resources, Inc.*
Sutter Eyberg Student Behavior Inventory - Revised (Eyberg & Pincus, 1999) *available from Psychological Assessment Resources, Inc.*
Child Behavior Checklist (Achenbach, 2009) *available from Aseba.org*
Parenting Stress Index - 4 (Abidin, 2012) *available from Psychological Assessment Resources, Inc.*
Dyadic Parent Child Interaction Coding System (Eyberg et al., 2013) *available for purchase from PCIT.org*
Therapy Attitude Inventory (Posttreatment only; Brestan et al., 1999) *available for free download at PCIT.org*

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Table 3. CALM (Adapted from PCIT) Course of Treatment

Session 1- Pretreatment Assessment
Session 2- Child Directed Interaction Teach Session, Introduce exposure therapy, create individualized fear hierarchy
Session 3- CDI Coaching, introduce child to treatment, review child's anxiety
Session 4- CDI Coaching and low level exposure preparation
Session 5- CDI Coaching and coach through low level exposure in session
Session 6- CDI Coaching and again coach through low level exposure in session
Session 7- DADS (Describe, Approach, Direct command, Selective attention) Teach Session, moderate level exposure preparation
Session 8- DADS Coaching through moderate level exposure and preparation for moderate level exposure in next session
Session 9- DADS Coaching through moderate level exposure and preparation for high level exposure in next session
Session 10- DADS Coaching through high level exposure and preparation for high level exposure in next session
Session 11- DADS Coaching through high level exposure and preparation for high level exposure in next session
Session 12- DADS Coaching through high level exposure and preparation for high level exposure in next session
Session 13-DADS Coaching through high level exposure, Repeat pretreatment measures, Review treatment progress; Encourage continued use of treatment strategies; Graduation ceremony

Table 4. Sample of Brave Ladders for Jack

Fear of Military Attack	Fear of Separating	Fear of Interacting with Peers	Fear of Going to the Hospital
10. Jack acts out what he would experience and do in a military attack	10. Jack stays with the clinician in an unfamiliar nearby park without knowing when parent will return	10. Jack initiates and maintains extended verbal interaction with peer in waiting room	10. Leave Jack with hospital nurse while parent uses the restroom
9. Jack closes eyes and imagines experiencing a military attack	9. Jack stays with the clinician while parent goes to pick up treat for Jack	9. Jack introduces self and has brief verbal exchange while playing	9. Jack sits in lobby of hospital
8. Jack watches nongraphic news accounts of military attacks in middle east	8. Jack stays with clinician and waves goodbye to parent who gets into the car	8. Jack asks other Jack question about his play activity	8. Jack and parent briefly enter lobby of hospital
7. Jack listens to book read about a military attack	7. Jack takes a walk outside with the clinician while the parent stays in the waiting room	7. Jack comments on play of another Jack	7. Jack walks around the grounds of the hospital without entering
6. Jack watches airplanes take off and land at airport	6. Parent leaves Jack with babysitter in waiting room for 30 minutes	6. Jack quietly greets other Children but does not converse	6. Jack and parent sit in car in parking lot of hospital
5. Family visits a military aircraft museum	5. Caregiver leaves Jack in office for 5 minutes with lights turned low (to simulate night time or part of house no one is using)	5. Jack plays silently in same room with other children	5. Jack and parent do a quick hospital drive by
4. Jack watches airplanes through a window	4. Parent leaves Jack in office to use bathroom	4. Jack approaches nearer to other children in waiting room	4. Jack watches video of nurse welcoming child to the hospital
3. Jack watches videos of military attack	3. Jack sits in waiting room alone for 5 minutes	3. Jack watches children in waiting room interact from a distance	3. Jack is read a children's book about going to the hospital
2. Jack listens to sounds of airplane	2. Clinician reads story to Jack while mother walks around the waiting room	2. Jack watches video of children playing together	2. Jack looks at photos of hospitals
1. Jack watches parent enact a military attack with toy props	1. Parent walks away from Jack in waiting room to pick up a magazine (30 seconds)	1. Jack looks at picture books of children playing together	1. Jack looks at cartoon pictures of a hospital with friendly staff