Interventional Use of the Parent–Child Interaction Assessment–II Enactments: Modifying an Abused Mother’s Attributions to Her Son

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We describe the assessment and treatment of a mother who was a victim of domestic violence and of her 10-year-old son, both of whom were living in a domestic violence shelter. The Parent–Child Interaction Assessment–II Modifying Attributions of Parents intervention (PCIA–II/MAP; Bohr, 2005; Bohr et al., 2008; Bohr & Holigrocki, 2005) is a structured brief treatment using video recordings from a parent’s play with his or her child. The play involves using toy people and animals to complete story stems related to a trip to the zoo (see Holigrocki, Kaminski, & Frieswyk, 1999, 2002). The therapist shows the parent video excerpts of the interaction, invites reflection and commentary, and collaborates with the parent to change how she makes sense of her child’s behaviors. The pretreatment assessment revealed a depressed, fearful, highly stressed mother with a harsh parenting style. Her son experienced significant distress; had behavior problems; and viewed adults as harsh, fragile, irresponsible, and unavailable. Posttreatment gains were evident in the parent’s reduced depression and greater parenting sensitivity; however, parenting stress and child behavior problems remained elevated. We emphasize the utility and application of a multimodal assessment that integrates rating scales, free response, and video-recorded interactions.

Due to the efforts of clinicians such as Connie Fischer and Stephen Finn, there has been increasing attention paid to the value of assessment and feedback models that elicit the assistance of the individual who is being assessed. Fischer (1985/1994, 2000) has described collaborative assessment as an activity in which the client and the assessor coconstruct an understanding of the client’s life world and try out alternative approaches to problematic situations. Finn and Tonsager’s (1997; see also Finn, 2007) assessment model also elicits a collaborative discussion of assessment findings, which includes a dialogue about the client’s ways of responding to problems. The aim is for clients to gain new ways of understanding that help them to change their behaviors, thoughts, and feelings so that they may better address their difficulties. Tests are used idiographically and nomothetically; and data may draw on the client’s subjective experience, the therapist’s subjective experience, and the dynamic interplay between the two. The assessor is fully embedded along with the client in the assessment process; and an assessment is considered successful when the client feels understood, learns new ways of being, is changed, and is able to sustain the change.

The removal of some barriers between assessor and client, or encouraging the client’s active role in the assessment process, is clearly part of humanistic and cognitive constructivist traditions. Elements of collaborative initiatives appear in the psychodynamic assessment literature as well. Many examples of this collaborative approach can be found in publications by the psychologists who were trained in the Menninger School of Assessment (see Allen, 1981; Berg, 1985; Schlesinger, 1973; Sugarman, 1981).

Whether construed from a humanistic, psychodynamic, or other theoretical framework, such constructivist methods of psychological assessment and treatment have often sought to draw on the expertise of the person who is being assessed. The assessor develops a coconstructed and experience-near picture of the client by using the client’s questions during the assessment and the client’s interpretations of her or his own responses. Accompanying the greater insight and understanding garnered from the process of assessment comes the opportunity for the client to generate more choices, have more influence in her or his change process, and experiment with alternative behaviors. The effective effort on the part of the assessor to develop such enhanced client capabilities yields an assessment that seamlessly merges into treatment.

In contrast to the therapeutic approach of assessment, traditional information-gathering models of assessment strive for accurate description to assist with communication between professionals to enhance decision making and the prediction of client behaviors (see Finn & Tonsager, 1997). Assessors strive to be objective observers who utilize measures for nomothetic comparisons. The primary source of data is test scores, and
clients participate as producers, not interpreters, of data. Assessment is successful when the data collected are reliable and valid, recommendations are heeded, and correct decisions are made.

Therapeutic assessment compared to traditional assessment not only involves an increase in the client’s active participation but also a systems focus. Tharinger et al. (2008), for example, commented on the disjunction between the widespread acknowledgment of the importance of family systems in influencing child functioning and the limited ways systems perspectives are incorporated into the psychological assessment of children. Traditionally, parents contribute to assessments by completing rating scales and a free-response measure to inform the upcoming treatment. Following a traditional model, we use several rating scales (Bugental, Johnston, New, & Silvester, 1998; Schechter et al., 2006) as critical variables in parent–child relationship quality (Bugental et al., 1998; Tharinger et al., 2008, 2009). Tharinger et al.'s (2008, 2009) work shares with these feedback sessions on changing parental attributions, a context and circumstances, whereas the converse is true when others interact with their children in a structured family intervention (see also Tharinger et al., 2009). Tharinger et al.'s (2008, 2009) work shares with our own a movement from an individual-centered assessment model to a model that expands to include systemic or relational assessment.

We describe a model of parent–child assessment and treatment that is based in collaborative and therapeutic assessment while employing aspects of traditional information-gathering assessment. We invite feedback from parents on video-recorded interactions with their children. Our efforts involve focusing these feedback sessions on changing parental attributions, a critical variable in parent–child relationship quality (Bugental, Johnston, New, & Silvester, 1998; Schechter et al., 2006). Following a traditional model, we use several rating scales and a free-response measure to inform the upcoming treatment process, develop a pretreatment baseline, assess posttreatment change, and measure treatment effects at follow-up.

**PCIA–II ASSESSMENT**

The Parent–Child Interaction Assessment–II (PCIA–II; Holigrocki, Kaminski, & Frieswyk, 1999, 2002) is a constructivist method of assessing parents and children. As part of this assessment, we film parent–child dyads as they play with toy people and animals during an imaginary trip to a zoo. Like other story stem measures, data are elicited about the parent and child across multiple contexts. A total of 15 scenarios are enacted such as when the child is lost at the zoo or the parent and child encounter a stranger. We refer to these PCIA–II scenarios as coconstruction tasks, as they involve constructive processes activated by both the parent and child.

During the standard PCIA–II inquiry procedure, the parent and child are individually shown excerpts from their video recording and asked questions pertaining to the mentalizing functions of each person (see Holigrocki & Hudson-Crain, 2004; Holigrocki & Kaminski, 2002; Holigrocki & Raches, 2006). For example, the child is shown a segment of the video and is asked to reflect on what he or she and the parent were thinking, feeling, and wanting. The parent completes a similar inquiry. What is of most interest to us is not the accuracy of what they are recalling, which is an objectivist concern; rather, inquiry data are viewed as the product of their current construction of the recently undertaken activities.

For clinical purposes, PCIA–II videos are usually coded using content analysis methods; however, specific observational codes have been developed by the authors for use in research (see Holigrocki, 2009). Coding systems, such as the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE; Bronfman, Parsons, & Lyons-Ruth, 2004; Lyons-Ruth, 2000) that was developed for classifying mother–infant interaction, is adequately conceptually robust to describe essential features of PCIA–II interaction with parents and school-age children.

**INTERVENTION**

**Attributions**

Hollon and Kriss (1984) organized cognitive factors into the mutually influencing domains of structures, processes, and products. Knowledge structures, such as schemata, consist of specific information, rules, and prototypes that serve to organize old and new information. Cognitive processes, such as assimilation and accommodation, describe how the cognitive structures are modified, maintained, and activated. Cognitive products are the output of the cognitive structures; hence, they are signs that stand for both the structures and the processing activity. Attributions are cognitive products, or interpretations, that refer to the ways in which we explain, evaluate, and predict the behavior of others and ourselves.

Attributions as mediators or moderators of behavior have been subject to much study and the generation of several implicit models. They have been conceptualized as stimulus-dependent appraisal events, reliant on information from the immediate context, but also as memory-dependent, or influenced by the interpreter’s history (Bugental et al., 1998). Much research has been based on the early work on attributional bias, starting with Ross’s (1977) seminal research on observer effects or the “fundamental attribution error.” This theory stipulates that individuals from Western cultures have a tendency to attribute others’ actions to internal factors (e.g., character) more than to context and circumstances, whereas the converse is true when those same individuals explain their own actions. Another type of attributional bias received attention in investigations of the information processing of aggressive youths. Hostile attribution bias, an unwarranted attribution of hostile intent to others, was seen to originate in schemata based on the observer’s background and to lead to unwarranted aggression (Dodge & Crick, 1990; Epps & Kendall, 1995). It is this type of bias, and aggression, which is of particular concern in maltreating parents.

Parental attributions are cognitions directed toward making sense of a child’s behavior. Research suggests that these attributions have an impact on the parent’s immediate affective and behavioral responses to the child as well as the long-term quality of the parent–child relationship (Bugental & Goodnow, 1998; Miller, 1995). Attributions vary across many dimensions such as their positive and negative valence and accuracy. However, in saying this, we are aware of the epistemological morass of attempting to determine whether an attribution is justified or accurate in any given situation. Nevertheless, if we allow consensus to be our guide, there are clearly some parental attributions that fall far from the mark, whereas other attributions tend to be shared or easily understood by skilled observers. This line of reasoning may bring to mind considerations of minus versus ordinary form quality on a Rorschach test, whereby consensus allows one to sidestep an objectivist conception of reality without sacrificing clinical utility.
Research has linked parental attributional bias to problematic parenting practices. Abusive or physically coercive parents are more likely to attribute defiant intentions to their children, view themselves as lacking power, and be highly controlling. Further, blame-oriented or hostile attributions may precede and foster ineffective, overreactive, or harsh disciplinary practices as well as child conduct problems (see Bradley & Peters, 1991; Bugental and Johnston, 2000; Nix et al., 1999; Smith & O’Leary, 1998; Snyder, Cramer, Afrank, & Patterson, 2005). Most relevant to our work is the empirical research by McGuigan, Vuchinich, and Pratt (2000), which demonstrated that the relationship between domestic violence and a family’s risk of child abuse was mediated by a parent’s negative views of the child. Efforts directed at modifying the parental attributions of victims of violence are expected to improve parental functioning. The modification of attributions in psychotherapy is nothing new, as it is a variant of the classic cognitive psychotherapy introduced by Beck (1976) in which clients are encouraged to examine dysfunctional interpretations of interpersonal events and replace them with more constructive cognitions about their relationships.

PCIA–II/MAP

Clinicians can draw inferences about parental attributions from the data gathered during the parents’ dialogue about the PCIA–II video-recorded interactions. Bohr (2005) and her clinical team in Toronto, Canada have been employing the PCIA–II in a treatment program for high-risk parents for the past 4 years. As part of this initiative, they expanded the PCIA–II inquiry and developed the PCIA–II Modifying Attributes of Parents intervention (PCIA–II/MAP; Bohr, 2005; Bohr et al., 2008; Bohr & Holigrocki, 2005), which is a structured intervention that integrates a cognitive-behavioral therapy brief-treatment model with direct observation and video-recall methods of assessment. The PCIA–II/MAP elicits parents’ interpretations of their children’s behaviors and provides a pathway for modifying parental attributions.

The assessment and treatment involve approximately 10 hours of time with the client (i.e., 2–3 hours for each pretreatment and posttreatment assessment, four 50-minute biweekly intervention sessions, and a mailed follow-up questionnaire). The assessor/therapist begins by using a traditional information-gathering model of assessment. The PCIA–II and a selection of rating scale and free response measures tailored to the clinician’s practice provide a pretreatment baseline that can be used for comparison to posttreatment and follow-up levels of functioning. The therapist or clinical team views the video recording and chooses critical problem moments and identified strengths that highlight areas of child or parent behavior problems and parent strengths.

After the standardized data are collected, nonstandardized techniques are used in the assessment intervention sessions. During the intervention sessions, the parent is shown the scenarios that include the critical problem moments and identified strengths. After watching a scenario in its entirety, the video is cued to an identified strength moment. The parent’s sensitivity and/or positive behavior toward the child is pointed out, with attention paid to the child’s response. Next, the parent is shown a specific critical moment and is asked a series of questions designed to identify parental attributions for the behaviors evident in the problem moment (see Table 1). The attributions are noted; and if they are deemed inappropriate, negative, or dysfunctional, the parent is asked a second set of questions. The latter are designed to assist the parent in generating alternative, more constructive attributions. If the parent is unable to do so, the therapist presents the parent with several options (e.g., “Is it possible that Rhonda was wanting your approval right there?”). The parent’s responses to these questions are recorded. During the final session, the PCIA–II and the other outcome measures are readministered to the dyad.

In Indianapolis, Indiana, we have started to empirically assess the efficacy of the PCIA–II/MAP intervention with women victims of violence who are residing in the Julian Center. We are conducting a randomized controlled trial with treatment and wait-list groups utilizing a pretreatment–posttreatment follow-up experimental design. Mothers and their school-age children are being filmed as they complete the PCIA–II/MAP (four session intervention model: pretreatment assessment, four intervention sessions, and posttreatment assessment). In addition, mothers complete a series of free response and rating scale assessments measuring key parent variables pertaining to attributions, stress, psychopathology, and life circumstances as well as child variables pertaining to personality, psychopathology, and intelligence. Women taking part in the study continue with their regular course of treatment and receive the PCIA–II/MAP intervention as an adjunctive treatment option.

We chose to implement the intervention with the domestic violence population because we expected that the mothers’ histories of intimate partner violence would leave them prone to inaccurate or negative attributions when attempting to understand their children’s behavior. For example, dysfunctional attributions are frequently linked to a parent’s misperception of the power balance in the relationship with his or her child. Women who have experienced themselves as helpless in a spousal relationship involving destructive power can be more vulnerable to cognitive distortions of this type. We were also responding to the widespread nature of intimate partner violence. The prevalence rate of severe partner violence in America is estimated at 8.64% of couples; and of these couples, 62.57% have children living in the household (approximately 7 million children; McDonald, Jouriles, Ramissey-Mikler, Caetano, & Green, 2006).

Last, mothers who have been victims of domestic violence experience a variety of associated psychological concerns. Among these difficulties are increased levels of depression, posttraumatic stress disorder, the development of learned helplessness, overall psychological distress and disturbance, as

<table>
<thead>
<tr>
<th>Type of Question</th>
<th>Identifying attributions</th>
<th>Modifying attributions</th>
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<tbody>
<tr>
<td>What do you notice here?</td>
<td>What was happening here? What were you thinking here?</td>
<td>What else might [his or her] intention have been? Could it be that [he or she] intended this?</td>
</tr>
<tr>
<td>What were you feeling?</td>
<td>What is [child’s name] intention here? or Where is [he or she] coming from?</td>
<td>What might [he or she] have meant to do? What might [he or she] have intended instead?</td>
</tr>
<tr>
<td>What was [he or she] thinking here?</td>
<td>What was [he or she] feeling?</td>
<td>What else might [he or she] have wanted or needing from you here? Is this behavior typical? Is this how you would ordinarily interpret, think, and feel about [his or her] behavior?</td>
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</table>
well as lowered self-esteem (e.g., Cascardi & O’Leary, 1992; Walker, 2000). In addition, parenting stress has been shown to be elevated, which may lead to a host of parenting difficulties. Among these parenting difficulties are decreased warmth and control, harsh and inconsistent discipline practices, and difficulties with overall parenting effectiveness (e.g., Levendosky & Graham-Bermann, 1998). It was hoped that an intervention such as the PCIA–II/MAP might provide the abused mother with increased awareness, insight, problem-solving skills, and the ability to reclaim a realistic understanding of her influence in her child’s life and of the power balance within their relationship. Additionally, based on the research that has shown that the effect of domestic violence on child abuse risk is mediated by a parent’s negative view of children (see McGuigan et al., 2000), interventions directed at modifying attributions may minimize the likelihood of child maltreatment.

**CASE DESCRIPTION: MS. A. AND ROBERT**

Ms. A., a resident in an agency providing housing for female victims of domestic violence and their children, volunteered for the PCIA–II/MAP intervention. She had been experiencing many difficulties as a parent and wanted to improve her relationship with her child. She is a 28-year-old African American woman with three children. She has a 12th-grade education and is employed full-time as a waitress. She is separated from her husband, who was physically abusive, and she has had several other abusive partners in her past. She carries a diagnosis of major depressive disorder and is in individual, family, and group therapy.

Robert, her oldest child, is 10 years old, in the 4th grade, of above average height, and moderately obese. He has two younger school-aged sisters. There is no reported history of physical abuse toward Robert, although he was frequently a witness to his father’s and stepfather’s violence toward his mother. Robert has been diagnosed by a psychologist as having an adjustment disorder with depressed features; in the past, he was diagnosed with attention deficit hyperactivity disorder and oppositional defiant disorder. He is in individual and family therapy.

**Ms. A.’s Pretreatment Assessment Findings**

Ms. A. was administered a battery of self-report, free-response, and observational measures that assess adverse life experiences, personality, and parenting. The rating scale data are presented in Table 2. We describe the test findings followed by their implications for treatment.

**Adverse life experiences.** On the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), Ms. A. reported that as a child she was a victim of significant emotional and physical abuse (e.g., feeling hated, insulted, often hit with a hard object).

### Table 2.—Pretreatment parent and child rating scale findings.

<table>
<thead>
<tr>
<th>Test</th>
<th>Score Type</th>
<th>Scales, Subscales, and Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTS–2</td>
<td>T</td>
<td>Psych Aggression 110** Sexual Coerc 99**</td>
</tr>
<tr>
<td>CTQ</td>
<td>Percentile</td>
<td>Emotional Abuse 95** Emot Neglect 80’</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>80’</td>
<td>Phys Neglect 80’</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCMI–III</td>
<td>Base rate</td>
<td>Schizoid 64 Schizotypal 85** Thought Dis 68</td>
</tr>
<tr>
<td>Dependent</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Histrionic</td>
<td>30</td>
<td>Anxiety 71 Disclosure 82*</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Antisocial</td>
<td>61</td>
<td>Somatoform 62 Desirability 47</td>
</tr>
<tr>
<td>Sadistic</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Compulsive</td>
<td>60</td>
<td>Alcohol Depen 59</td>
</tr>
<tr>
<td>Negativistic</td>
<td>72</td>
<td>Drug Depen 59</td>
</tr>
<tr>
<td>Masochistic</td>
<td>88**</td>
<td></td>
</tr>
<tr>
<td>BDI–II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td>Raw</td>
<td>Abuse 75**</td>
</tr>
<tr>
<td>CAP</td>
<td>T</td>
<td></td>
</tr>
<tr>
<td>AAPI–2</td>
<td>Percentile</td>
<td>Phys Punish 98**</td>
</tr>
<tr>
<td>PSI</td>
<td>Percentile</td>
<td>Low Empathy 84*</td>
</tr>
<tr>
<td>Robert</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KBIT–2</td>
<td>Standard</td>
<td>Verbal 111 Nonverbal 105 IQ Composite 97</td>
</tr>
<tr>
<td>CBCL</td>
<td>T</td>
<td>Anxious/Dep 72** Affective 70**</td>
</tr>
<tr>
<td>Internalizing</td>
<td>74**</td>
<td>Withdraw/Dep 73** Anxiety 68</td>
</tr>
<tr>
<td>Externalizing</td>
<td>76**</td>
<td>Somatic 68 Somatic 70**</td>
</tr>
<tr>
<td>Total Prob</td>
<td>75**</td>
<td>Social 78** Attention 66*</td>
</tr>
<tr>
<td>Thought</td>
<td>54</td>
<td>Thought 54 Oppositional 80**</td>
</tr>
<tr>
<td>Attention</td>
<td>67*</td>
<td>Attention 67 Conduct 76**</td>
</tr>
<tr>
<td>Rule Breaking</td>
<td>71**</td>
<td></td>
</tr>
<tr>
<td>Aggressive</td>
<td>84**</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** CTS–2 = Conflict Tactics Scale–2; CTQ = Childhood Trauma Questionnaire; MCMI–III = Millon Clinical Multiaxial Inventory–III; BDI–II = Beck Depression Inventory–II; CAP = Child Abuse Potential Inventory; AAPI–2 = Adult-Adolescent Parenting Inventory–2; PSI = Parenting Stress Index; KBIT–2 = Kaufman Brief Intelligence Test–2; CBCL = Child Behavior Checklist. Data were collected in Session 1. ‘Usually reverse scored, transformed for ease of comparison with other measures. Asterisks highlight scale elevations whereby * = borderline or marginal significance and ** = clinical or prominent significance based upon cutoffs established in test manuals.”
Additionally, she reported that she was neglected emotionally and physically (e.g., unsupportive family, sometimes not having enough to eat). Her Conflict Tactics Scales–2 (CTS–2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) results suggest that she has recently been the victim of significant maltreatment by a partner involving both psychological aggression (e.g., destruction of her possessions) and sexual coercion.

**Parenting.** Ms. A. is likely highly reactive to parent–child stressors. On the parenting inventories, Ms. A. scored above the conservative cutoff on the Abuse scale of the Child Abuse Potential Inventory (Milner, 1986), indicating that her parenting attitudes and behaviors are similar to individuals known to physically abuse their children. Her Adult Adolescent Parenting Inventory–2 (AAPI–2; Bavolek & Keene, 2001) indicated she has a strong belief in corporal punishment and has difficulties empathizing with her children. The parent–child role reversal score was not elevated, which would indicate appropriate family roles, although this was not in keeping with the videorecorded interactions described below. On the Parenting Stress Inventory (PSI; Abidin, 1995), she demonstrated signs of experiencing high levels of parenting stress.

**Personality.** Based on Ms. A.’s valid Millon Clinical Multiaxial Inventory–III (MCMI–III; Millon, Davis, & Millon, 1997) profile, she is often anxious and expects others to harm her, even in situations in which most would feel safe. To protect herself, she may withdraw, perhaps choosing the sadness and loneliness that accompanies her isolation to the fears that she experiences when with others. When she does enter relationships, she may expect deception and rejection and behave in a self-effacing and self-sabotaging manner. By presenting herself as weak, she appears to pose no threat and may stave off anticipated aggression from those around her. Occasionally, she may have angry outbursts and demean those she sees as critical of her, but such outbursts likely leave her feeling remorseful and sad and eventuate in further withdrawal. Her emotional world is erratic, often vacillating between intense anger and sadness. Her Beck Depression Inventory–II (BDI–2; Beck, Steer, & Brown, 2001) also indicates severe depressive symptoms.

Ms. A. was administered Thematic Apperception Test (TAT; Murray, 1943) Cards 1, 7GF, 6BM, 3BM, and 17BM. We include five of these stories in the Appendix, with one story omitted due to its limited content. The first 2 cards illustrate the detachment from and limited connection to others that Ms. A. experiences. The first card has a depressive cast, a tired little boy sitting in a dark corner trying to fix his violin. His parents are not available, which is a theme that is echoed in Card 7GF where the mother and daughter sit together without interacting. This theme of sad detachment converges with the self-report test findings and bring one closer to feeling her isolation. In response to the next card, Ms. A. tells a story about a victim of violence who has been assaulted and feels helpless. Through the story, she vividly communicates her lived experience of the adversity indicated by the CTQ and CTS–2. Her last story adds an element that our selection of self-report tests could not approach. In her telling of a story about a determined trapeze artist trying to do the impossible with the environment working against him, she conveys her struggle to improve.

From her TAT responses, we find that her method of coping involves the defensive withdrawal from others, whereas her defensive style includes the frequent use of denial and projection as indicated by Cramer’s (2002) Defense Mechanism Manual scoring system. Themes of denial occur throughout these TAT stories, involving a fall that is “not deadly,” a violin that is not necessarily broken, and unexpected happy endings; projection also occurs in the themes of violence and danger.

Taken together, we see that she is very depressed and is struggling to make changes but essentially feels helpless to do so. She is afraid of being harmed and has withdrawn from others, protectively isolating herself and imagining better situations.

**Parent–child interaction observations (PCIA–II).** On the pretreatment PCIA–II involving Ms. A.’s video-recorded play with her son at the toy zoo, Ms. A. demonstrated harsh parenting techniques. Although she sometimes set appropriate limits, she just as often attempted to change her child’s behavior through the use of inappropriate punishments involving abandonment. For example, when Robert indicated that he was hurt in one scenario, she threatened to leave him at the zoo. She displayed a range of affect that was usually appropriate, although she sometimes exhibited laughter following Robert’s misbehaviors. She was frequently misattuned to his distress and his efforts to obtain positive responses from her. Her anger peaked during what she perceived to be role reversals such as when he attempted to demonstrate autonomy. The AMBIANCE was used to code the videorecordings. The coding revealed problematic behavior in her affective communication, role/boundary confusion, and intrusiveness/negativity. For example, in the “Hurt Arm” scenario we present following, affective communication errors (contradictory signaling type) were apparent in Ms. A.’s sad, serious, and firm voice tone mixed with anxious laughter. Notably, Robert commented that her toy figure was smiling while Ms. A. was expressing concern to him, a perception on his part that her concern was insincere. Role/boundary confusion was noted in Robert’s attempt to take care of himself by telling his mother to get the first aid kit, and some intrusiveness was evident during the last portion of the scenario when Ms. A. made her figure chase Robert’s figure.

**Treatment implications.** Assessment findings suggested that Ms. A. has a significant trauma history and that her level of mistrust may make her particularly sensitive to feeling criticized by the therapist. The therapy sessions needed to be supportive, rather than confrontational, with attention paid to strengths and competencies to allow the therapist’s reflections on her attributions to be heard. Her parenting behaviors suggested that she needed assistance in attuning to Robert’s needs for care and autonomy. Results also suggested that she might require assistance in identifying her tendencies to withdraw from him when she is distressed and express anxiety through laughter, which he interprets as mocking.

**Robert’s Pretreatment Assessment Findings**

Robert was administered a free-response test and an intelligence test, and his mother completed a checklist evaluating his behaviors. We present the data from the Kaufman Brief Intelligence Test–2 (KBIT–2; Kaufman & Kaufman, 2004) and the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) also indicates severe depressive symptoms. From her TAT responses, we find that her method of coping involves the defensive withdrawal from others, whereas her defensive style includes the frequent use of denial and projection as indicated by Cramer’s (2002) Defense Mechanism Manual scoring system. Themes of denial occur throughout these TAT stories, involving a fall that is “not deadly,” a violin that is not necessarily broken, and unexpected happy endings; projection also occurs in the themes of violence and danger.

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**Treatment implications.** Assessment findings suggested that Ms. A. has a significant trauma history and that her level of mistrust may make her particularly sensitive to feeling criticized by the therapist. The therapy sessions needed to be supportive, rather than confrontational, with attention paid to strengths and competencies to allow the therapist’s reflections on her attributions to be heard. Her parenting behaviors suggested that she needed assistance in attuning to Robert’s needs for care and autonomy. Results also suggested that she might require assistance in identifying her tendencies to withdraw from him when she is distressed and express anxiety through laughter, which he interprets as mocking.

**Robert’s Pretreatment Assessment Findings**

Robert was administered a free-response test and an intelligence test, and his mother completed a checklist evaluating his behaviors. We present the data from the Kaufman Brief Intelligence Test–2 (KBIT–2; Kaufman & Kaufman, 2004) and the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001)
Intelligence and personality. Robert’s verbal and nonverbal intellectual functioning is in the average range as measured by the KBIT–2. His CBCL suggests that his behaviors are very aggressive and defiant. He is also experiencing a high level of anxiety and depression along with somatic discomfort. His social problems are notable, mostly involving peer rejection, and he has attentional problems.

Robert was administered TAT Cards 1, 3BM, 4, 13MF, 15, and 2. Of the stories he told, two stories are reproduced in the Appendix because of their relevance to the parent’s treatment.

What is notable about Robert’s first story is the role of the child and parent. The child refuses to meet the expectations placed on him, but he is not offered assistance. There is an absence of parents or helpful adults who step in to guide, mentor, or understand the boy. Rather, his behavior is brought into line through punishment. This story of a child alone is the other piece of the puzzle, complementing Ms. A.’s experience of detachment and difficulty providing attunement. In Robert’s next TAT story, he tells of an Olympian mother who is stressed by her children. The combination of stress, stroke, coma, and head injury prevent her from competing, and the coach feels guilty for having pushed her so far. In both stories, the protagonists refuse to complete their tasks: the first only doing so when punished and the second avoiding due to somatic complaints. Robert’s stories illustrate the defiance apparent in his CBCL but also reveal his experience of being with his mother. His narratives to two TAT cards richly condense all that was illustrated by Ms. A.’s own TAT stories, self-report inventories, and the observed play; that is, Robert’s stories reveal his experience of her as overtaxed, fragile, retreating, and unavailable.

Overall, we see that Robert is a boy of average intelligence who is experiencing significant psychological distress coupled with behavior problems and peer rejection. Although he seems to have the intellectual capacity to achieve, much is likely to interfere with his development. Not only is he taxed by psychological distress, but he may also view the adults who occupy his world as harsh, fragile, and irresponsible.

Child–parent interaction behaviors (PCIA–II). On the PCIA–II, Robert often made his toy figure engage in risky, self-injurious behaviors that seemed to be attempts to elicit nurturance from his mother. He was frequently defiant and rule breaking, complying partially, but rarely fully, with what his mother asked of him. He proudly described himself as a “daredevil,” and his reckless behavior was minimally curbed by his mother.

Treatment implications. Although Robert is only involved in the pretreatment and posttreatment assessments, not the treatment itself, we recognize that he has severe behavioral problems, and his aggression and defiance would challenge and stress most parents. Hence, it was important to acknowledge to Ms. A. the reality of the stresses involved in raising a child with such behavioral difficulties. Ms. A. may also need assistance in attuning to his depression and anxiety, recognizing how Robert may communicate distress by somatic means. She may also require guidance to understand that he may not trust in her ability to effectively parent him.

From his mother’s TAT and MCMI–III data, we can infer that she may not be available to him during the times she feels stressed. During such moments, she may attempt to protect herself by withdrawing. Robert’s TAT story about the Olympic athlete suggests this as well. Unless the dyadic pattern is recognized and broken, a cycle of further negative defiant and escapist behaviors on the part of Robert and detachment and cue-ignoring from Ms. A. can be expected.

Assessment Intervention Sessions

Following the pretreatment session, we watched Ms. A. and Robert’s PCIA–II video to choose critical problem moments. The video included their play in response to the 15 PCIA–II scenarios, 4 of which are considered in the treatment model to be attachment system activating (ASA) scenarios (i.e., Race, Lost, Hurt Arm, and Tunnel). These scenarios activate attachment based on Bowlby’s (1969/1982) description of the following set of conditions: distance and time away from the mother, a child’s condition (e.g., ill health), a mother’s location and behavior (e.g., absent), and other environmental conditions (e.g., alarming events). The Race scenario offers a competitive game of distance and proximity. Lost involves the absent parent, Hurt Arm begins with an injured child, and Tunnel sets up a potentially frightening event. As per the PCIA–II/MAP manual, we reviewed the ASA scenarios several times (i.e., viewing them first in their entirety and then with attention to child behavior problems, parent behavior problems, and parent strengths). Next, we reviewed the remaining 11 PCIA–II scenarios.

We identified strengths and critical problem moments that were explored in R. Crain’s intervention sessions with the parent in the absence of the child. Each critical moment video excerpt was shown to the parent, after which she was asked a series of questions pertaining to her attributions. Later in the session, the therapist collaborated with the client to develop alternate attributions for the child’s behaviors (See Table 1 for list of identifying and modifying attributions questions).

In what follows, we describe excerpts from two of the four assessment intervention sessions. Statements in italics indicate behavioral observations, and square brackets are used to insert editorial comments. Ellipses indicate pauses and dashes are inserted at the point of interruptions.

PCIA–II Race scenario. In the first intervention session, the therapist played the video of the Race scenario that Ms. A. and her child had completed a few days before. The scenario was as follows:

Examiner: (Examiner places two figures together on the zoo board beside a block). There is a contest to see who can run the fastest. This is the starting block and the two of you are to run to the tree and back. Play out what happens together.

Child: Okay, are you ready?
Parent: Uh huh.
Child: Set.
Parent Go.
Child: Go. (Parent and child both begin to move their figures toward the tree and back)
Parent: Oh, Robert.
Child: I win *(smiling)*
Parent: Please slow down *(laughing)*
Child: So you wanted me to be the first one?
Parent: I’m old.
Child: You wanna try it again?
Parent: *Sighs.*
Child: Ready, set, go.
Parent: Yeah.
Child: Go.
Parent: On your marks get set go.
Child: *(Child does not move figure)* You can have a – Parent: You’re not moving.
Child: You can have a head start *(Smiling at parent).*
Parent: I don’t want a head start. Go. *(Parent and child begin racing to the tree).* Okay, okay, I can’t do that no more.
Child: I’m getting tired.
Parent: You won. Oh well, what’s your prize?
Child: Uh, I get to go wander off all by myself. *(Child begins to move figure away from parent to the other end of the zoo board)*
Parent: No, that’s not a prize.
Child: Whee! I’m lost.
Parent: Robert, get back here. *[sternly]*
Child: I’m lost. *(Child moves figure back to parent.)*
Parent: That’s not a prize. You can’t wander off like that.
Child: Okay.
Parent: Maybe we can get some ice cream or something.
Child: Okay, ice cream. *(Child moves figure away from parent)*
Parent: I still didn’t say go. I’m standing here. Where are you going? *(Robert moves his figure back to parent smiling and looking at the examiner)*
Child: To ask you.
Parent: No, we go together.
Child: Okay.
Parent: Who’s going to pay for it when you get there if I’m still here?
Child: Uh, my allowance.
Parent: Okay where is your allowance?
Child: In, it’s in my pocket.
Parent: No it’s not.
Child: Yes it is.
Parent: Why would I give you money at the zoo to keep in your pocket?
Child: So the giraffes could eat it.

In this scenario, the parent’s presentation is that of sad detachment. She moves slowly, mentions she is old, does not praise Robert when he wins, and shows little concern when he says he is lost. At first, Robert tries to positively draw her in and engage her by giving her a head start; then his attempts to engage her become more negative when he wanders off as a prize for winning and pretends to be lost. Also, some role reversal/confusion was evident in Robert’s giving Ms. A. a head start and his paying for his own ice cream. The therapist and Ms. A. reviewed several of these critical problem moments during the first intervention session.

The critical problem moment chosen for discussion is Robert’s choice of wandering off by himself as a prize. This critical problem moment video excerpt was replayed for Ms. A., and she was asked a selection of the identifying attributions questions. Of note is that Ms. A. explained Robert’s behavior as due to his wanting “attention.” What was unclear to her was to what Robert wanted her to attend and why he wanted her to attend to him at this time. She also mentioned that his wandering was due to his being free spirited, wanting his own space, and feeling that there were no boundaries because he had achieved something. Ms. A. had not considered that Robert might have wanted her to engage in parenting and nurturing activities, and she did not recognize that he approximated these roles himself by offering her a head start in the race and paying for his own reward of ice cream.

Later in the session, the therapist asked Ms. A. to develop alternate attributions for the reasons for Robert’s choosing to wander off at the zoo. Although Ms. A.’s initial attributions involved Robert wanting attention, she developed several alternative explanations. She mentioned that his wandering off may be because he (a) wants to be the leader and have her follow him, (b) wishes for his own space away from his family difficulties, (c) is upset or angry at her and blaming her for leaving his father, (d) tries to take on a parenting role and is stressed by doing so, or (e) wants to be in control. By focusing specifically on this situation and allowing the parent the time to reflect on what was happening, it is apparent that there are multiple ways to interpret her initial attribution that he wanted attention. With assistance from the therapist, Ms. A. expanded her description to articulate how Robert was having conflicting needs for autonomy and caretaking and is a child who is very affected by the difficult family circumstances. It was good to see Ms. A. show some cognitive flexibility by entertaining alternative attributions. However, Ms. A. did not mention the possibility that Robert may have wanted her to follow him, reach out to him, and provide nurturing by preventing him from wandering off, all of which are typical parental behaviors.

**PCIA–II Hurt Arm scenario.** In the second intervention session, the therapist played the video from the Hurt Arm scenario. This scenario involved the following interaction:

Examiner: Robert has fallen and hurt his arm. Play out what happens together.
Parent: Are you okay?
Child: Mom, it hurts.
Parent: You okay? Can you get up?
Child: I think.
Parent: Come on. Let me help you up. Let me see, let me see.
Child: What are you smiling for? *[Child is referring to the smile on the parent’s figure.]*
Parent: *(laughs)* I’m not smiling. I’m trying to see about you. It’s bleeding a little, that’s scraped real good. You okay though?
Child: Well, get the first aid kit.
Parent: We’ll get one. I’m looking in my purse.
Child: *Child knocks his figure onto the ground.* I fell again.
Parent: Robert. *(Parent laughs.)*
Child: *Returns figure to upright position.*
Parent: You okay?
Child: Yeah.
Parent: You wanna sit down for a minute?
Parent: Okay, we’ll sit down for a minute. Let me see this. Your face looks okay. You’re okay. (Parent leans figure into child’s figure and makes kissing noises.)

Parent: Isn’t that how you fell the first time?

Parent: Why you wanna get up there for?

Parent: Now why you wanna get up there for?

Parent: That was excellent, the way that you attended to him when he fell again. You were very nurturing, [asking Robert,] “Do you want to go sit down for a while? Are you ok?” That was excellent, very, very good. It seems like he got that need for you to look at him, and kind of attend to him, that was definitely met, right there, and he was very compliant with you [as seen by him] coming over to sit down.

Therapist: That was excellent, the way that you attended to him when he fell again. You were very nurturing, [asking Robert,] “Do you want to go sit down for a while? Are you ok?” That was excellent, very, very good. It seems like he got that need for you to look at him, and kind of attend to him, that was definitely met, right there, and he was very compliant with you [as seen by him] coming over to sit down.

The parent agreed and was next shown the part of the video when Robert asked Ms. A. to get the first aid kit to help him with his hurt arm. In response to the identifying attributions questions, she explained that Robert was giving her advice and trying to act like an adult. She recognized that he was “feeling pretty needy emotionally.” The therapist explored these attributions, working with Ms. A. to help her generate alternate or deeper understandings of Robert’s behavior. Her modified attributions of Robert’s behavior with the first aid kit were that he (a) wanted to reiterate that he was really hurt, (b) wanted to find the first aid kit because he was adventurous and saw this as a chance to explore the zoo, and (c) was concerned that she would not understand or meet his needs.

Treatment Outcome

As we discuss gains made in treatment, we remind the reader that both the mother and son completed the PCIA–II/MAP as a conjoint treatment with other therapies. In this case study, the extent and nature of changes that were specifically caused by participation in the PCIA–II/MAP treatment could not be determined. Based on these constraints, we are limited to illustrating the treatment method with the knowledge that a sound test of the treatment’s efficacy calls for a randomized clinical trial.

We redid the BDI–2, PSI, CBCL, and TAT to the parent during the final meeting and the rating scale measures were completed by her during a 5.5 month follow-up. Some improvement following the four treatment sessions was evident, mostly in Ms. A.’s reduced depression. Ms. A.’s BDI–2 scores showed a change from a pretreatment total score of 26 (severely depressed range) to moderate range scores of 18 at posttreatment and 14 at follow-up (equivalent to a clinically significant T score reduction of T = 64 to T = 51). On the TAT, her pretreatment Card 7GF story about the mother and child showed some improvement. Initially, she told a story about a self-focused mother who was reading the bible alongside a physically distant daughter. The posttreatment story was as follows:

Card 7GF. Looks like a mother reading to her daughter. She’s lookin’ out the window daydreaming. Maybe she’s daydreaming about what the story is about. It seems like she is not really sittin’ down. Maybe her mother just told her to come over. She may be thinking about something else. Something else is on her mind but her mother stays with her. Maybe she looks at the kids outside and she feels like she doesn’t belong. Maybe the mother is trying to downplay it—read her a story to make her feel better.

Although the characters in the posttreatment TAT story are not talking to each other, and efforts at comforting seem minimal, there are signs of shared activity, sensitivity to the daughter, and maternal attempts to be helpful. All of these story elements are positive changes that were not apparent during the pretreatment TAT. In the posttreatment PCIA–II compared to the pretreatment observation, the parent’s play showed brighter affect, greater playfulness, some improved responsiveness, and no intrusiveness.

There were several areas that the four-session intervention did not directly impact. Ms. A.’s posttreatment TAT stories continued to show themes of helplessness, victimization, and the fear of failure. Her parenting stress remained elevated on the PSI. The brevity of the intervention and its focus on modifying parental attributions did not decrease Mrs. A.’s significant parental distress, nor did it lessen her fears associated with her maltreatment. Also, Robert’s CBCL scores were stable, and themes in his posttreatment play suggested he still expected that Ms. A. would not attend to his needs or appreciate his distress. This brief parent-focused intervention was not expected to lead to immediate effects in the child, so we had not expected signs of an immediate reduction of Robert’s symptoms. We remain open to the possibility that change may have occurred in the child, but our assessment measures were not sensitive enough to discern child improvement. Adjunct treatments directed at Robert’s behavioral problems will be necessary, as will be continued treatment of Ms. A. beyond the brief parent-focused cognitive-behavioral therapy treatment described here.

Of note, during the 5.5-month follow-up, we invited the parent to comment on her experience of the intervention. In response to the question of whether she found the intervention helpful, she wrote the following:
Yes, I really enjoyed the feedback that I was given. I’m still applying things I remembered learning from the program, now. The feedback, the “virtual” interaction was helpful also, rather than talking out a scenario. The zoo “trip” was surprisingly very effective.

In her second sentence, Ms. A. contrasts “virtual” with “talking out a scenario.” She may be referring to something she gained from the posttest PCIA–II assessment. Perhaps completing the zoo task again with her child, after having received the verbal feedback during the assessment intervention sessions, added a consolidating element to her learning experience.

**DISCUSSION**

Our assessment paradigm involves the integration of self-report, free response, and direct observation methods. The trained researcher or clinician can employ each of these three modalities toward a conceptualization encompassing symptoms, organizing structures, and evolving interpersonal dynamics. Self-report scales such as the BDI–2 or CBCL effectively describe symptoms, whereas the MCMII–III reveals patterns that help to explain observed behavior. One drawback to rating scale results is that psychologists may be left with the feeling that they know enough to diagnose but do not know the person they are diagnosing. The TAT stories deepen and extend psychologists’ empathy for clients and enrich psychologists’ understanding of their experiences. In addition to developing such a feel for the participants, the TAT can be used to develop structural hypotheses that assist in understanding verbal, behavioral, and affective content. Through the PCIA–II, psychologists can witness the dyadic dynamic system as a whole, as each member of the dyad is affected by and affects the other.

Ms. A., depressed and withdrawn on self-report scales, reveals fears of attachment on the TAT and detachs herself from play when with Robert. Robert, with severe symptoms on the CBCL, tells TAT stories of maternal fragility and retreat, and he tries to parent himself throughout the PCIA–II. Together, the rating scale, free response, and play assessments resolve into a portrait of a mother and child, both afraid and trying to get needs for safety met in the limited ways they have available to them. Although most assessment measures converged across modalities, the AAPI–II parent–child role reversal score was not elevated and indicated appropriate family roles. However, role reversals were present on the video recording as Robert attempted to fill the void left from Ms. A.’s depressive withdrawal and difficulty nurturing. Ms. A. was usually angered by these role reversals, which may have led her to downplay them on the self-report measure. Also worth considering is that some researchers have expressed concerns about the factor structure of the AAPI–II Role Reversal scale, although thorough validity tests have been hampered by the lack of a theoretically related comparison measure (see Conners, Whiteside–Mansell, Deere, Ledet, & Edwards, 2006).

The PCIA–II/MAP intervention model helps parents to recognize the power they hold, see the positive behaviors they demonstrate with their children, and develop alternative attributions when theirs have been too negative. When parents are able to find new, more constructive and sensitive ways of construing the meaning of their child’s behaviors, their relationship with their child has a chance to improve. Psychodynamically oriented clinicians may view operative aspects of this intervention as increasing the mentalizing capacity of clients (e.g., Allen, 2003; Fonagy & Target, 1997) whereby parents develop enhanced sensitivity to their children’s thoughts, feelings, and needs and increase their capacity to try alternate understandings. From a constructivist perspective, the activity is one of developing a new manner of construing and cocreating the play context, which re-presents in a microcosm key transactions that occur outside of the realm of play.

For the clinician, the intervention provides a manner of organizing what is learned from an assessment and offers a structured method for providing clients with feedback regarding some of what was seen. Similar to what has been described by Finn (2007) and Fischer (1984/1994), the intervention deeply involves the client in thinking about the information that was and is being gathered. In all implementations of collaborative assessment models, the client is not a passive recipient of a psychological assessment but, as we have seen with Ms. A., is invited to reflect on the data and became an active participant.

This article is limited to a demonstration of how the assessment and collaborative feedback model is employed in our current practice and clinical research. We hope that this report might add to ongoing work in the integration of assessment and intervention and the joint employment of traditional and interventional methods of assessment. Additionally, we provide in this article an example of how to implement the PCIA–II/MAP intervention, and the case itself will be of interest to those studying the relationship between domestic violence, cognition, and parenting.

In our qualitative analysis of high-risk family PCIA–II/MAP clinical outcomes in Toronto, Ontario, Canada; Indianapolis,


**INTERVENTIONAL USE OF PCIA–II**


Note. In each of the TAT stories, the Card’s name is followed by a summary of Murray’s (1943, pp. 19–20) description. The assessor’s questions are abbreviated and included within parentheses.