

**Examining Trainee Treatment Session Fidelity: Impact on the Implementation  
of Parent-Child Interaction Therapy (PCIT)**

by

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## Abstract

Research supports the impact of empirically-based treatments (EBTs), such as Parent-child Interaction Therapy (PCIT), on producing positive treatment outcomes for clients. However, achieving outcomes in community settings that are similar to those found in research settings can be challenging and little research has been conducted on how to best train community providers to implement PCIT with fidelity. This study assessed trainee implementation fidelity to the PCIT protocol in community settings. Session fidelity was reviewed for trainees using pre-established session integrity checklists and post-hoc video review of key sessions. A total of 71 sessions from 21 trainees across 6 community mental health settings were reviewed. Analyses revealed that the average fidelity percentage across all six sessions was 87.2%, indicating that the trainees maintained strong overall session fidelity although fidelity percentages varied by session. Results also show that the average fidelity score for Teach sessions was statistically higher than the average score for Coach sessions and that there was not a significant difference between trainees' performance on CDI and PDI sessions. Implications of these findings, limitations, and future directions for PCIT workshops and consultation are discussed.

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## List of Abbreviations

APA American Psychological Association

CDI Child Directed Interaction

DPICS Dyadic Parent-Child Interaction Coding System

EBPP Evidence-Based Practice in Psychology

EBT Evidence-Based Treatment

IRR Inter-Rater Reliability

MST Multi-Systemic Therapy

PCIT Parent-Child Interaction Therapy

PDI Parent Directed Interaction

## **Introduction**

In a 2005 policy statement, the American Psychological Association (APA) endorsed the use of evidence-based practice in psychology (EBPP; (APA, 2005)). EBPP refers to clinical practice that integrates evidence in support of interventions, clinical expertise, and knowledge of patients' needs, preferences and values (APA, 2005; Kazdin, 2008). One of the main facets involved in implementing EBPP concerns a clinician's ability to effectively use interventions that show therapeutic change in controlled trials, known as evidence-based treatments (EBTs), with their clients (Kazdin, 2008). The President's New Freedom Commission on Mental Health (2003) Subcommittee on Children and Families, which analyzed the strengths and weaknesses of the current mental health service system, described the importance of informing children and families about EBPPs and providing families with access to these services. It also stressed the importance of prioritizing the implementation of early childhood interventions as a way of preventing potential negative trajectories for children. This emphasis on EBPPs is likely due to the growing evidence base in support of the use of EBTs in the field of children's mental health. The research that has been conducted on the efficacy of EBTs for children and adolescents indicates that EBTs are more effective than usual care (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Spielmans, Gatlin, & McFall, 2010; Weisz, Jensen-Doss, & Hawley, 2006).

The reported efficacy of EBTs and the call to action from the APA and the President's New Freedom Commission Subcommittee on Children and Families has created a demand for services that are based on science and best clinical practice, such as EBTs. This demand has led to a push for the dissemination of EBPPs, yet there is a lag in the dissemination of evidence-



based practice and the use of these EBTs in clinical practice. One of the challenges with disseminating EBTs into community settings is that these services are primarily developed, researched, and implemented in highly controlled settings, such as universities, making it hard to determine the treatment's ecological validity and applicability to clients seen in community settings who are generally more diverse and have multiple presenting problems and co-occurring conditions (Southam-Gerow, Marder, & Austin, 2008; Weisz, Doss, & Hawley, 2005).

Therefore, it is important to investigate the transportability of EBPP treatments into community settings by properly training community-based mental health providers in implementing EBTs with fidelity. One specific area of child mental health that warrants further enquiry regarding implementing EBTs with fidelity in the community is the treatment of childhood conduct problems.

### **Overview of Conduct Problems in Children**

The treatment of childhood disruptive behaviors, or conduct problems, is a commonly researched topic in the child mental health field. Childhood conduct problems are the most common referral problem for which parents seek professional intervention (Kazdin, Bass, Ayers, & Rodgers, 1990; McMahon, Wells, & Kotler, 2006). Data from a national survey suggest that the prevalence of conduct problems in preschool and early school-age children is between 10% and 25% (Snyder, 2001). This finding has important social implications due to the many documented long-term costs associated with untreated childhood conduct problems. For example, research has shown that young children who display early-onset conduct problems are more likely to abuse drugs, participate in delinquent behavior, drop-out of school, and experience academic problems, peer rejection, and depression as adolescents (Campbell, 1991; Loeber, 1991; Snyder, 2001). Furthermore, having conduct problems in early childhood is also associated

with negative outcomes such as adult criminality and substance abuse (Abramowitz, Kosson, & Seidenberg, 2004; Kratzer & Hodgins, 1997). There is also evidence to suggest that, in the absence of early intervention, these conduct problems in young children may become set patterns by the age of 8 (Eron, 1990). These findings indicate that it may be particularly important to treat aggressive and defiant behavior in children prior to age 8 in an effort to avoid negative outcomes. Therefore, disseminating and implementing EBTs aimed at treating young children with conduct problems into community organizations may help to change the trajectory for children who show early signs of aggression, defiance, and noncompliance.

### **Recommendations to Reduce Child Conduct Problems**

Parent-child interactions and parenting practices have been proposed as an important risk factor for early-onset conduct problems in children. Research shows that parents of children with conduct problems lack, or infrequently and inconsistently use, fundamental parenting skills (Patterson, 1982). In an effort to combat this deficit in parenting skills, a variety of behaviorally based parent-training programs focused on teaching parents to effectively manage child behavior have been used to treat early-onset conduct problems. Behavioral parent-training programs are based on social-learning theory and include didactic instruction, modeling, skills practice, and differential reinforcement (Maughan, Christiansen, Jenson, Olympia, & Clark, 2005; Serketich & Dumas, 1996). Parent-training treatment programs have been found to be efficacious for addressing conduct problems and disruptive behavior in young children, producing significant improvements in children's behaviors, significant change in parental behavior, and reducing negative outcomes for these children during adolescence and adulthood (Brestan & Eyberg, 1998; Eyberg, Nelson, & Boggs, 2008; Lundahl, Risser, & Lovejoy, 2006; Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009; Webster-Stratton, 1985). As a result of these findings,

evidence-based parent training programs are becoming the standard treatment for childhood conduct problems, especially in young children (Eyberg, et al., 2008; Serketich & Dumas, 1996).

### **Parent-Child Interaction Therapy**

Parent-Child Interaction Therapy (PCIT) is one evidence-based parent-training program used to treat young children with conduct problems and the focus of this proposed study (Eyberg & Boggs, 1989; McNeil & Hembree-Kigin, 2010). PCIT is a manualized EBT which is based on Hanf's (1969) model of parent training and aims to improve the parent-child relationship and correct maladaptive parent and child behavior patterns. To accomplish this goal, PCIT is completed in two phases. First, parents are taught relationship enhancement skills during the Child-Directed Interaction (CDI) phase and are then taught effective discipline skills to use with their child during the Parent-Directed Interaction (PDI) phase. Evaluations of PCIT have found that participating in PCIT decreases children's disruptive behavior and improves child compliance and parental positive attention.

Like other parent-training programs, PCIT has a strong basis in behavioral principles and developmental psychology. However, there are a few key differences between PCIT and other parent-training programs (Kazdin, 2005). In PCIT, parenting skills are taught to the parents using in-vivo instruction during which the therapist coaches the parents in real time, providing them with immediate feedback on the use of their skills. This skills coaching and immediate feedback had been shown to improve parents' skill acquisition and to be an important component of effective parent-training programs (Kaminski, Valle, Filene, & Boyle, 2008; Shanley & Niec, 2010). Furthermore, PCIT is structured so that treatment is performance-based rather than time-limited. This means that parents are assessed on their use of the parenting skills with their child during their weekly sessions and are required to demonstrate a certain level of mastery over the

parenting skills they've learned before they are able to progress in treatment or graduate from treatment.

There is significant empirical support for the efficacy of PCIT for children with conduct problems both at post-treatment and follow-up (Herschell, Calzada, Eyberg, & McNeil, 2002; Hood & Eyberg, 2003; Nixon, Sweeney, Erickson, & Touyz, 2004; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). Because evidence-based parent-training programs produce such salient outcomes for families, learning more about how to effectively disseminate and implement EBTs, such as PCIT, is an important first step in improving the effectiveness of mental health services for children and families dealing with conduct problems. The unique structure of PCIT, including in-vivo coaching and assessment-based skill mastery, has implications for training community mental health providers in PCIT. In particular, PCIT may require a longer training time and more interactive instructional methods for providers to learn relative to more traditional parent-training formats.

Similar to many other EBTs, PCIT has historically been disseminated in university settings during the training of graduate students, interns, and post-doctoral fellows following a mentor-mentee model. However, in line with the call to disseminate EBTs into community settings, PCIT has been disseminated to providers in the community. The developer of PCIT, Dr. Shelia Eyberg, recently established PCIT International, Inc., a company devoted to fostering the growth and expertise of PCIT therapists. As a part of PCIT International, a PCIT Advisory Board training committee created PCIT Training Guidelines in 2009, which are available at [www.pcit.org](http://www.pcit.org) (See Appendix A). These guidelines were intended to inform PCIT trainers of the key components that should be included in all PCIT trainings, however, little research has been conducted on how to best train PCIT therapists and the few studies evaluating the dissemination

of PCIT have not yet examined the impact of their training process on trainee implementation fidelity (Funderburk, Ware, Altshuler, & Chaffin, 2008; Herschell et al., 2009; Pearl et al., 2011; Wilsie, 2011).

### **Dissemination and Implementation of EBPP**

The successful transport of EBPP to community settings is particularly important for programs designed to help children and adolescents. This is because children and adolescents are more likely to be identified for mental health services by primary care providers or professionals within the school system, welfare system, or detention facilities and, therefore, are more likely to receive services outside of traditional psychological clinic settings (Hoagwood, et al., 2001). Training community mental health providers in EBTs would provide families with better access to EBTs and the opportunity to make informed decisions about treatment that can improve outcomes for their child and their family (Huang et al., 2005).

Research in the area of EBPP dissemination has shown that prevention and intervention programs that are known to be successful in producing meaningful treatment outcomes are not being disseminated to the community in a manner that allows these programs to effectively benefit consumers and society, creating a “science to service” gap (Clancy, 2006; Fixsen & Blase, 2009; Woolf & Johnson, 2005). For that reason, researchers are interested in determining the best way to transport EBPP from research settings to agencies and providers in the community who can utilize them.

Durlak and DuPre (2008) propose four steps involved in the successful transfer of effective programs into community settings including 1) Dissemination, 2) Adoption, 3) Implementation, and 4) Sustainability. The authors describe dissemination as the distribution of information about the existence and value of a treatment program, adoption as whether

community organizations decide to obtain training and try a new program, implementation as how well a program is conducted, and sustainability as whether a program is maintained over time. This four-step model indicates that in order for families to benefit from EBTs, community providers need to not only be informed about and trained in EBTs, but they need to evaluate the manner in which they implement EBTs with their clients. Simply providing community mental health providers with access to training in EBTs is not sufficient to close the “science to service” gap; however, improving program implementation methods can.

This knowledge has encouraged researchers to better evaluate current implementation practices in an effort to guide the implementation of EBTs in the future (Aarons, Hurlburt, & Horwitz, 2011; Schoenwald et al., 2011). Current research has shown that passively relying on clinicians to read treatment manuals and attend training workshops does not lead to the successful implementation of EBTs (Herschell, et al., 2009; Sholomskas et al., 2005). Rather, we know that the implementation process needs to be active and should include extended training formats, interactive training techniques including modeling, role-play, case discussion, and coaching, and the effective monitoring of staff performance regarding implementation fidelity (Fixsen, Blase, Naoom, & Wallace, 2009; Moncher & Prinz, 1991).

### **Importance of Implementing EBPP with Fidelity**

This study focuses on the importance of implementation in the process of treatment diffusion. Taking time to evaluate the implementation of EBTs is essential for determining the internal and external validity of interventions. Community treatment outcomes are susceptible to a variety of barriers related to the implementation of EBTs. One such barrier to implementing a successful community-based intervention is achieving and maintaining fidelity to the original program model. The Treatment Fidelity Workgroup of the National Institute of Health Behavior

Change Consortium (NIH BCC) defined treatment fidelity as “the methodological strategies used to monitor and enhance the reliability and validity of behavioral interventions” (Ory, Jordan, & Bazzarre, 2002). Unless program disseminators are aware of which aspects of the original intervention model were delivered, and the extent to which they were delivered appropriately, it is impossible to accurately interpret the outcomes of the intervention. Research demonstrates that if EBTs are implemented inconsistently, and EBT implementation is not monitored to assure fidelity, program effectiveness may be compromised (Dane & Schneider, 1998; Mihalic, 2004). Consequently, in order to increase the effectiveness of EBTs when used in community settings, and to eventually predict stronger treatment outcomes for consumers, maintaining high fidelity to treatment protocols is of the utmost importance (Durlak & DuPre, 2008; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; Schoenwald, Sheidow, & Chapman, 2009).

Aside from the impact of implementation fidelity on treatment outcomes, obtaining implementation data is a useful way to evaluate the core components of an intervention (Durlak & DuPre, 2008). This could be done by assessing which components of an intervention were present or absent during treatment implementation and then comparing treatment outcomes to the presence or absence of the various intervention components. Without evaluating treatment fidelity it would be impossible to evaluate the core components. Assessing implementation fidelity also creates the opportunity to “establish [an] innovation monitoring feedback system,” which can facilitate high quality intervention implementation (Aarons, et al., 2011). For example, participating in implementation monitoring early on in the intervention diffusion process allows for the identification and correction of barriers impacting successful program implementation (Durlak & DuPre, 2008; Mihalic, 2004). Additionally, early and consistent

monitoring of treatment fidelity could help to identify providers who are struggling with implementing specific parts of the intervention so that they have access to feedback.

### **Methods of Measuring Fidelity**

There are a variety of methods available to measure treatment fidelity. When possible, it is best to use fidelity assessment instruments which are designed by the program developers to provide feedback to the program implementers (Mihalic, 2004). When choosing an appropriate measure of treatment fidelity, it is also important to remember that the measure must first and foremost be both ecologically valid and feasible, otherwise taking the time to assess treatment fidelity may lose its value or become overly burdensome (Hayes, 1998). These points are particularly important to keep in mind when implementing EBTs in the community as utilizing fidelity monitoring techniques that are too time-, cost-, and labor-intensive may deter providers from assessing fidelity in the first place.

The three main methods of assessing treatment fidelity include objective behavior observation, client report, and practitioner self-report (Schoenwald, et al., 2011). Behavior observations can occur in real-time, either in-person or using telemedicine equipment, or can be completed post-hoc by reviewing session videos or audiotapes. These observations are traditionally coded for adherence to the predetermined treatment session content. The data collected from these observations can then be analyzed either categorically by grouping implementers into low vs. high implementation groups or continuously by assigning percentages to the level of fidelity achieved (Durlak & DuPre, 2008). At this point, utilizing behavior observation by an independent observer is the preferred way of monitoring treatment integrity (Lee et al., 2008; Mowbray, Holter, Teague, & Bybee, 2003). The second method of measuring fidelity relies on the client's report of therapist adherence to treatment protocols. This method of



assessing treatment fidelity has been used in the evaluation of Multisystemic Therapy (MST) and the clients' report of provider adherence have been linked to short- and long-term outcomes in both randomized controlled trials and community based implementation studies of MST (Henggeler, Schoenwald, & Borduin, 2009). Alternatively, practitioner self-report measures can also be used to assess treatment fidelity. However, self-report measures are less likely to be linked to treatment outcomes than objective observation data, making objective observation data preferable to self-report data (Lillehoj, Griffin, & Spoth, 2004).

### **Measuring Fidelity in the Implementation of PCIT**

In line with the recommended treatment monitoring techniques, evidence-based parent-training programs have described using a variety of objective behavior observation measures to monitor treatment fidelity. The reported methods include post-hoc reviews of video and/or audiotaped sessions and direct observation of sessions conducted either in-person or using advanced telemedicine technology (Eames et al., 2008; Forgatch, Patterson, & DeGarmo, 2005; Funderburk, et al., 2008; Lyon & Budd, 2010; Tiwari, 2010; Webster-Stratton, Reid, & Stoolmiller, 2008). More specifically, all of these forms of direct behavior observation measures have been used to assess treatment fidelity while evaluating PCIT outcomes either in randomized controlled trials or community dissemination efforts. The methods used have varied according to the needs and desires of the implementation sites and available funding.

Current assessments of treatment fidelity in PCIT often examine how closely providers adhere to the PCIT manual based on PCIT fidelity checklists (Eyberg & UF, 2010). In randomized controlled trials looking at the efficacy of PCIT, adherence levels of 97% have been reported (Bagner & Eyberg, 2007; Werba, Eyberg, Boggs, & Algina, 2006). However, in a recent study looking at the effectiveness of PCIT when delivered in community settings,

treatment adherence to the PCIT protocol was 91% (Lyon & Budd, 2010). This difference in levels of adherence suggests that implementing PCIT with fidelity may be more difficult in community settings than it is in the controlled-study environments. Additionally, the providers implementing the PCIT protocol in all of these studies were researchers and graduate students who have learned PCIT through the traditional mentor-mentee model of EBT training. This is an important distinction because adherence levels may be impacted when community providers, who were trained following the PCIT Training Guidelines, implement the PCIT protocol. It is also important to note that in all of these studies, assessing treatment fidelity in the implementation of PCIT was a secondary goal to determining treatment outcomes. This emphasizes a significant gap in the literature related to assessing PCIT treatment fidelity as a means of informing future trainings on PCIT and determining the necessary, core components of PCIT.

### **Goals of the Study**

As the dissemination of EBPP into community settings evolves and expands, it is vital that the implementation of EBTs is monitored to ensure treatment fidelity. PCIT trainings and dissemination efforts are ongoing, yet little is known about the best way to train PCIT therapists to ensure fidelity to the original program model. In order to ensure the proper implementation of PCIT, inform future PCIT training and consultation, and eventually obtain strong treatment outcomes for clients it is important to evaluate session fidelity for PCIT trainees. This study seeks to add to the body of literature concerning implementation, extend the limited literature base of PCIT training and implementation, and evaluate session fidelity for PCIT trainees across four different training periods.

## **Hypotheses**

Archival data from four PCIT training workshops were used to evaluate trainee session fidelity. It was hypothesized that inter-rater reliability (IRR) between fidelity monitors would be strong, reaching at least the 80% agreement criterion across sessions. Due to the unique and complex nature of the PCIT coach sessions, it was also hypothesized that trainees would obtain higher fidelity scores on teach sessions than on coach sessions. Finally, it was hypothesized that trainees would obtain higher fidelity scores on CDI sessions than on PDI sessions because CDI sessions were conducted closer in time to the trainees' completion of the 40-hour PCIT training workshop.

## Method

### Participants

Participants in this study, called “trainees,” were mental health professionals from various agencies. All trainees completed a Demographic Questionnaire (See Appendix B) during the initial 40-hour training workshop. This questionnaire was designed to gather information about the professional characteristics of the trainees. A total of 31 trainees attended training workshops across the four training times, however, not all of the trainees were able to continue PCIT training following the training workshop. Therefore, the trainees included in this study represent only the 21 trainees who submitted at least one video-recorded treatment session for post-hoc review during the consultation phase of training.

The mean age of these 21 trainees was 38.9 (SD = 9.3) and 95.2 percent of trainees were female ( $n = 20$ ). Seventy-one percent of trainees indicated their race or ethnicity as White or Caucasian ( $n = 15$ ) and 29 percent identified as Asian ( $n = 6$ ). Regarding place of employment, 42.9 percent of the trainees worked in a hospital or medical center setting ( $n = 9$ ), 42.9 percent in a non-profit community mental health clinic ( $n = 9$ ), and 14.2 percent in a for-profit community mental health clinic ( $n = 3$ , see Table 1). Highest degree obtained was acknowledged as a bachelor’s degree for 10 percent ( $n = 2$ ), a master’s degree for 30 percent of trainees ( $n = 6$ ), a MSW for 40 percent ( $n = 8$ ), and a Ph.D. for 20 percent ( $n = 4$ ). On average, trainees worked 42.2 hours per week (SD = 6.7) with an average of 18.1 hours per week spent in direct contact with clients (SD = 9.8). Trainees reported having worked with children and families an average of 12.8 years (SD = 8.2), with a range from 3 to 31 years. The average number of parent training

courses completed by trainees prior to the PCIT training workshop was 1 ( $SD = 1.9$ ), with a range from 0 to 8. These demographics illustrate the diversity in the individual community providers and organizations that have sought out and received PCIT training from Auburn University, including a group of trainees from Singapore.

### **Trainers**

The lead trainer, Elizabeth Brestan-Knight, Ph.D., is recognized as a PCIT Master Trainer by PCIT International. Other co-trainers included graduate students with a research and clinical background in PCIT who are a part of the Parent-Child Research Lab at Auburn University. The graduate student trainers ranged in their years of graduate training and their experience implementing PCIT (from 1 to 6 years).

### **Measures**

This study evaluated archival data collected from the PCIT certification process for a sample of 21 trainees across 6 different community mental health settings. For certification, key treatment sessions from the PCIT protocol were video recorded by trainees and then sent to Auburn University for review. The sessions sent in for review include the CDI Teach, CDI Coach 1, PDI Teach, PDI Coach 1, House Rules, and Public Behavior sessions. Session fidelity was reviewed for trainees using integrity checklists and post-hoc video review. Treatment sessions were originally reviewed by PCIT-trained graduate students and then checked and given a fidelity score by the PCIT Master Trainer. Additionally, a trained undergraduate research assistant reviewed 50% of the first-session videos submitted by trainees. The undergraduate research assistant's completed checklists were then compared with the checklists generated by the graduate students in order to assess IRR.

## **Procedure**

At individual or agency request, trainees attended a live, face-to-face PCIT training workshop presented by Auburn University. The workshops occurred at four different time periods at four separate locations. All training workshops were completed over a period of 5 days and included 40 hours of training. The structure of all training workshops followed the most recent version of the PCIT Training Guidelines (2009, see Appendix A) as closely as possible and included didactic presentations, modeling, and the role-playing of skills.

The curriculum for the 40-hour training workshop was based on original materials posted by the developer of PCIT, Dr. Shelia Eyberg, on the University of Florida's PCIT website (<http://pcit.php.ufl.edu>). Didactic presentations were included in the training workshops in order to provide trainees with an overview of the core components of PCIT. In particular, trainees were taught about the history of PCIT, the theoretical frameworks that serve as its basis, and the empirical research related to PCIT. Trainees were also exposed to the assessment measures used during PCIT and were taught how to administer, score, and interpret each measure. Other didactic sessions focused on teaching trainees the material that is typically taught to parents during the different phases of PCIT. These didactic sessions presented trainees with information about the specific relationship enhancement skills employed during the CDI phase, how to give effective commands, the time out procedure utilized during the PDI phase, and the generalization of these skills to the home environment and public places.

Interspersed with these didactic sessions were role-played parent-child interactions, which provided trainees with the opportunity to practice their CDI and PDI skills and their ability to code parent behaviors using the Dyadic Parent-child Interaction Coding System, 3<sup>rd</sup> Edition (Eyberg, McDiarmid, Duke, & Boggs, 2004). Role-plays were commonly organized to

contain 3 trainees and 1 trainer, where 2 trainees role-played a five-minute observation of a parent and child playing while the remaining trainee and trainer coded the interaction using the DPICS-III Abridged Manual (Eyberg, et al., 2004). This structure allowed trainees multiple opportunities to meet mastery for the CDI and PDI skills as they role-played the role of a parent, just as parents are required to meet CDI and PDI mastery during treatment. The mastery criteria for CDI required the trainees to use 10 labeled praises, 10 reflections, and 10 behavior descriptions while using less than three questions, commands, and criticisms during a single, five-minute role-play. Similarly, the PDI mastery criteria required trainees to give at least 4 commands, 75 percent of which were effective commands, and to follow through correctly on the time-out procedure as described in the PCIT manual. Because DPICS coding skills are imperative for determining when parents have met the pre-established mastery criteria, it is important that trainees are given time to practice DPICS coding. Therefore, these role-plays also provided trainees with multiple opportunities to become a reliable DPICS coder, as demonstrated by meeting 80 percent agreement with an advanced, reliable coder. Once trainees met reliability on DPICS coding, they were given the opportunity to practice coaching during role-play situations.

Following the completion of the 40-hour training workshop, trainees returned to their agencies and began implementing PCIT with clients seeking treatment for conduct problems. As stipulated in the 2009 PCIT Training Guidelines, in order to be eligible to sit for the PCIT certification exam, trainees are required to participate in follow-up consultation until they have completed the PCIT protocol with two families. Follow-up consultation included group supervision calls, post-hoc video reviews of trainee treatment and assessment sessions, and attendance at a two-day advanced training workshop. The frequency of supervision calls ranged

from weekly to monthly depending on agency funding, availability, and trainee caseload. The format of the supervision calls varied but generally followed a structure in which trainees were given the opportunity to provide updates on their ongoing cases, trouble-shoot any perceived difficulties in their caseload, and discuss the appropriateness of potential new cases. Video reviews included a total of 7 sessions from the PCIT protocol including the baseline DPICS observation assessment session and 6 treatment sessions (CDI and PDI Teach, CDI and PDI Coach 1, and House Rules and Public Behavior). The included treatment sessions provided trainers with an overview of the trainees' ability to conduct the structured didactic teach sessions, the dynamic coaching sessions, and the generalization of skills to the home and public places. The majority of trainees also attended an advanced training workshop, which occurred 5 to 7 months following the trainees' participation in the initial PCIT training workshop. These advanced trainings occurred at the trainees' agencies and provided trainees with the opportunity to refine their coaching skills, practice DPICS coding, and conduct co-therapy with the PCIT Master Trainer.

Analyses for this study were conducted using archival data from the treatment session videos submitted by trainees to the Auburn University Parent-Child Research Lab for review. Trainees submitted a total of 114 video-recorded sessions, or work samples, for post-hoc review. However, of these 114 work samples, 7 were unable to be reviewed due to errors that occurred during the video recording process leaving a total of 107 work samples eligible for review. Of note, some trainees submitted more than one work sample to be reviewed for each of the key sessions. In order to best assess the trainees' ability to maintain fidelity to the treatment protocol following the PCIT training workshop and to maintain independence of data, only the *first* work sample of the key sessions submitted by each trainee was considered for review. This reduced



the total number of videos eligible for review to 71. Please see Table 2 for more specific information about the work samples submitted by the trainees for each key session.

The 71 treatment session videos that were submitted by trainees for post-hoc review were evaluated and a fidelity score was assigned. Because the number of items on the fidelity checklists varied by session, the fidelity score was calculated as a continuous variable by dividing the number of completed items on the fidelity checklist by the total number of items listed on the checklist. Fidelity was measured using the pre-established session integrity checklists provided by the program developer in the PCIT Manual for the CDI Teach, CDI Coach 1, PDI Teach, and PDI Coach 1 sessions (Durlak & DuPre, 2008; Eyberg & UF, 2010).

Because the 2009 Training Guidelines outlined by PCIT International are not clear regarding the details of the required review of the House Rules and Public Behavior segments, only the specific segment detailing the steps of House Rules and Public Behavior were assessed. This is in contrast to the CDI and PDI teach and coach sessions, which were viewed in their entirety. Because the specific House Rules and Public Behavior segments were reviewed rather than the entire PDI session that includes these segments, it was necessary to develop integrity checklists that are more detailed than the session outlines included in the PCIT Manual for these segments. Therefore, additional integrity checklists for these sessions were developed based on the House Rules and Public Behavior Handouts that are presented in the PCIT manual (Eyberg & UF, 2010).

## **Results**

### **Preliminary Analyses**

In order to evaluate the reliability of the treatment session integrity checklists that were used to assess the trainees' fidelity to the PCIT protocol, IRR was calculated using Percent Agreement for session content items on 50% of all completed first sessions ( $n = 38$ ). Items were coded such that 1 = agreement on a checklist content item and 0 = disagreement on a checklist content item. Percent agreement was calculated for each session by dividing the sum of the agreements between primary and reliability coders for each content item on the checklist by the sum of agreements and disagreements. It was hypothesized that IRR across all first treatment sessions should reach the 80% agreement criterion. As expected, the overall mean percent agreement across the 6 sessions was 92.9 ( $SD = 9.3$ ), indicating strong IRR between the graduate student coders and the undergraduate research assistant coder. In fact, the 80% agreement criterion was met for all of the submitted treatment sessions (i.e., CDI Teach, CDI Coach 1, PDI Teach, PDI Coach 1, House Rules, and Public Behavior; see Table 3).

### **Descriptive Statistics**

Descriptive analyses were conducted in order to determine trainee overall session fidelity by calculating the average fidelity percentage for all 6 submitted treatment sessions including the Teach sessions, Coach sessions, and generalization sessions. The average fidelity percentage across all 6 sessions was 87.2 ( $SD = 16.8$ , Range = 37.5 to 100), indicating that the trainees maintained relatively strong overall session fidelity. Average fidelity percentages were also calculated for each submitted session individually (i.e., CDI Teach, CDI Coach, PDI Teach, PDI

Coach, House Rules, and Public Behavior). Fidelity percentages varied by session with the trainees maintaining an average of 90.5 ( $SD = 13.1$ ) for CDI Teach, 80.2 ( $SD = 20.0$ ) for CDI Coach 1, 92.3 ( $SD = 9.5$ ) for PDI Teach, 82.2 ( $SD = 17.9$ ) for PDI Coach 1, 91.1 ( $SD = 17.6$ ) for House Rules and 87.8 ( $SD = 22.5$ ) for Public Behavior (see Table 4).

It was hypothesized that trainees would obtain higher fidelity scores on teach sessions than on coach sessions. In order to evaluate any potential differences in the trainees' ability to implement the different session types (teach vs. coach) a paired samples  $t$ -test was conducted for those trainees that submitted at least one session tape for the various session types and treatment phases ( $n = 12$ ). Results from this analysis show that the average trainee fidelity score for teach sessions was 91.3 ( $SD = 9.7$ ) while the average trainee fidelity score for coach sessions was 79.9 ( $SD = 17.8$ ) indicating a statistically significant difference in trainees' objective performance on teach and coach sessions ( $t(11) = 3.17, p = .009$ ). The calculated effect size was large ( $d = 1.91$ ), indicating, as hypothesized, a clinically significant difference between trainees' average fidelity score on teach and coach sessions (see Table 5). Furthermore, a Pearson product-moment correlation coefficient was computed to assess the relationship between the length of treatment sessions and the trainees' fidelity scores in order to ensure that the difference in the trainees' ability to implement teach sessions with higher fidelity than coach session was not due to a discrepancy between the amount of time trainees spent on each session type. Results of these analyses show that there is no correlation between the trainees' fidelity scores on teach sessions and the length of the teach sessions ( $r = .096, n = 24, p = .327$ ) or between the trainees' fidelity scores on the coach sessions and the length of the coach sessions ( $r = -.134, n = 22, p = .275$ ).

Additionally, it was hypothesized that trainees would obtain higher fidelity scores on CDI sessions than on PDI sessions. In order to evaluate any potential differences in the trainees'

ability to implement the different treatment phases (CDI vs. PDI) a paired samples *t*-tests was conducted for those trainees that submitted at least one session tape for the various session types and treatment phases ( $n = 12$ ). Contrary to the initial hypothesis, results show that the average trainee fidelity score for CDI sessions was 85.8 ( $SD = 16.0$ ) and the average trainee fidelity score for PDI sessions was 87.3 ( $SD = 12.2$ ) indicating there is not a significant difference between trainee' objective performance on CDI and PDI sessions ( $t(11) = -.340, p = .740$ ). The calculated effect size was small ( $d = .21$ ) indicating that there is not a clinically significant difference between trainees' average fidelity score on CDI and PDI sessions (see Table 6). Again, a Pearson product-moment correlation coefficient was computed to assess the relationship between the length of treatment sessions and the trainees' fidelity scores. Results of these analyses show that there is no correlation between the trainees' fidelity scores on CDI sessions and the length of the CDI sessions ( $r = .326, n = 23, p = .064$ ), but that there is a significant negative correlation between the trainees' fidelity scores on the PDI sessions and the length of the PDI sessions ( $r = -.417, n = 23, p = .024$ ).

Procedural fidelity was also examined for the various content items *within* each session in order to determine areas to improve during future training workshops and to examine trends in fidelity based on individual session criterion. Each checklist content item was coded such that 1 indicated the presence of a checklist content item and 0 indicated the absence of a checklist content item. Therefore, if a trainee discussed a particular content item with the family during the treatment session it was coded as one, but if the trainee forgot to discuss a particular content item during the session it was coded as zero. Averages were calculated for each content item on the various integrity checklists in order to determine what percentage of trainees covered the required content items during the recorded treatment session. The average percent of trainees

who covered particular session content items ranged from 43.6 percent to 100 percent. Session content items that were not discussed by at least 80% of trainees during a given session were categorized as having low fidelity.

Four of the 29 content items on the CDI Teach integrity checklist demonstrated low fidelity while 11 of the 44 content items on the PDI Teach integrity checklist demonstrated low fidelity. Additionally, 3 of the 8 content items on the CDI Coach 1 integrity checklist demonstrated low fidelity while 4 of the 10 content items on the PDI Coach 1 integrity checklist demonstrated low fidelity. Finally, none of the 5 content items on the House Rules integrity checklist demonstrated low fidelity while 2 of the 7 content items on the Public Behavior integrity checklist demonstrated low fidelity. For further information on the specific content items that had low fidelity on each session please see Table 7.

## **Discussion**

The purpose of this study was to assess trainee treatment session fidelity to the PCIT protocol for community providers who were trained using the training guidelines recently established by PCIT International in 2009. Findings in this study indicate that community-based providers were able to maintain strong overall treatment fidelity, with their overall average treatment fidelity score reaching 87.2 percent and fidelity scores across individual sessions remaining consistently above 80 percent. This finding is relatively consistent with the treatment adherence rate of 91 percent that was reported by Lyon and Budd (2010) in their examination of the effectiveness of PCIT when delivered in community settings.

However, the current study differs from the Lyon and Budd (2010) study in an important way. As previously noted, the providers in the current study were community providers who have been trained in PCIT following the PCIT Training Guidelines, while the providers in the Lyon and Budd study (2010) were graduate students and a licensed clinical psychologist and researcher who had been trained in PCIT using the traditional mentor-mentee model. Therefore, the current study represents the first examination of treatment fidelity when community-based providers implement the PCIT protocol in community settings. As previously discussed, findings from this study indicate that the complex nature of PCIT protocol may slightly hinder community providers from implementing PCIT in community settings with the same level of fidelity as providers who have been trained following the traditional mentor-mentee model. These findings suggest that the current PCIT Training Guidelines, which include a 40-hour face-to-face workshop and extended follow-up consultation, may benefit from some specific

improvements to better prepare trainers to teach providers how to implement the key treatment sessions. While workshop and consultation content most likely varies across trainers and training sites, this study provides a strong foundation to start generating ideas of how to best structure the PCIT training process and what should be included during the workshop and consultation phase.

Looking more specifically at trainee fidelity across session type, results indicate that the trainees maintained higher fidelity to the treatment protocol during teach sessions relative to coach sessions. This finding supports the initial hypothesis. One explanation for this finding could be that the more straightforward nature of the teach sessions make them easier to implement. Teach sessions are more clear-cut than coach sessions because the child is not present, no technology is required, and the provider has a detailed outline that designates the material that he or she needs to cover with the parent. Additionally, during teach sessions the provider spends the majority of the session explaining specific parenting skills while parents listen and ask questions about concepts that require clarification. In this way, teach sessions resemble traditional psychoeducation, which the majority of providers have probably utilized with previous clients. On the other hand, coach sessions are more dynamic in nature because they include both the parent and the child in session and require the provider to use the DPICS coding system while simultaneously coaching parents on the use of the PCIT skills using unique technology. Therefore, the structure of the teach sessions is likely familiar to trainees, which might make them easier to implement than the novel coach sessions.

Given that the sample size was small in this study, the difference between trainees' ability to implement the teach and coach sessions cannot be generalized to other samples. However, the results of this study do have some implications for PCIT trainers to consider given the dearth of information available regarding the implementation of PCIT in community settings.

The discrepancy between fidelity scores for the PCIT coach and teach sessions suggests that trainers may need to spend more time during the training workshop preparing trainees to manage the dynamics of a coaching session including transitioning the parent from check-in and review of homework to the coaching component and allowing sufficient time to review the parents' skills and assign homework before ending the session. These results also suggest that co-therapists may be an important component for training cases because it would be easier to handle the more complex dynamics of a coaching session if two therapists were present. Therefore, PCIT International may want to consider revising the current PCIT Training Guidelines to ensure that PCIT trainees conduct at least one of their training cases with a PCIT-trained co-therapist. Finally, because it is extremely difficult to effectively coach a parent prior to learning the DPICS coding system, coaching practice does not typically occur until later in the training workshop, after DPICS reliability has been met, if at all. It is recommended that coaching practice become a staple of PCIT training workshops and the subsequent consultation process in order to allow trainees to become more comfortable with this skill set prior to attempting to conduct coach sessions on their own. These recommendations are particularly important because the majority of the PCIT protocol is spent in coaching sessions and low fidelity to the treatment protocol on these sessions may impact treatment outcomes for families.

The finding that there is no statistical difference between trainees' ability to maintain session fidelity across treatment phases is discrepant from the initial hypothesis. The initial hypothesis proposed that trainees would have higher fidelity scores on CDI sessions than on PDI sessions because trainees would be implementing the CDI sessions closer in time to the completion of the 40-hour training workshop. Proximity to the 40-hour training workshop would have given trainees more recent contact with the session material, which we hypothesized would



increase trainee fidelity rates. The fact that there was no statistical difference between trainee fidelity on the CDI and PDI sessions does not, however, directly refute this initial hypothesis. Rather, it suggests that other factors may have been present to motivate providers to maintain or improve fidelity during the second part of the treatment protocol, lessening the impact of the proximity of the initial training workshop on session fidelity and leading to no significant results. For example, it is possible that trainees may have been motivated to maintain or improve their fidelity score during PDI sessions because they had already received feedback from the trainers on their initial CDI sessions or because they may have recently received additional training and feedback during the on-site advanced training workshop. Another possibility is that trainees may perceive PDI sessions as being more difficult to conduct than CDI sessions, due to the complex nature of the time out procedure, and therefore may be prone to follow the manual more closely resulting in higher fidelity scores. The complexity of the PDI sessions is highlighted by the fact the trainees' seemed to have a more difficult time maintaining fidelity on PDI sessions the longer the session went on. Finally, the trainees who complete the PDI portion of treatment with their clients may simply be more committed to the PCIT training process and/or may have been better at maintaining fidelity during the earlier PCIT sessions than other trainees, leading them to maintain higher fidelity to the treatment protocol.

The results of the within session procedural fidelity check indicate that trainees consistently complete most of the essential items in the session protocols such as describing the CDI “do” and “don’t” skills, discussing the steps to giving a proper command, and coding and coaching parents. Although these findings cannot necessarily be generalized to other samples and training sites, they are encouraging because they indicate that treatment dose is not being compromised in the transition of PCIT from academic to community-based settings when the

PCIT Training Guidelines are followed. That is, trainees are consistently providing parents with the information they need to learn the new parenting skills and are giving parents the opportunity to implement these skills during in-vivo coaching sessions. The regular use of the in-vivo coaching component is particularly important because we know that the skills coaching and the immediate feedback available through live coaching have been shown to improve parents' skill acquisition and to be an important component of effective parent-training programs (Kaminski, et al., 2008; Shanley & Niec, 2010). Additionally, trainees are consistently taking the time to code parent behaviors in order to assess their skill level and determine mastery of the skills. This form of progress monitoring is a core component of PCIT, as stipulated in the PCIT Training Guidelines, and, when discussed with parents, provides them with the opportunity to improve their skills.

However, the within session check of content items also indicates that trainees seem to struggle with items related to monitoring the families' treatment gains, including reviewing parents strengths and areas of improvement following coaching, discussing the ECBI graph, and collecting and discussing client homework. These shortcomings suggest that trainees are not fully utilizing opportunities to provide feedback to families, which may delay the time it takes families to meet mastery criteria and subsequently advance through the treatment protocol. Ultimately, this delay has the potential to lead to client dropout due to frustration with the rate of progress in treatment. Additionally, the "use of standardized assessment instruments to guide treatment," is a core component of PCIT that trainees appear to be overlooking. Therefore, it may be beneficial for trainers to emphasize the importance of monitoring treatment gains to trainees during the training workshop and the follow-up supervision calls. One way to do this is for trainers to ask about the clients' use of the "do" skills, the clients' ECBI scores, and the

frequency with which clients' complete homework at every supervision call. Frequent monitoring by trainers of trainees' knowledge of their clients' skill levels and treatment gains will ensure that trainees take the time to monitor these important components of treatment.

Of note, evaluating the within session content items also revealed that trainees struggle with addressing issues related to using the PCIT skills at home, such as addressing potential barriers to implementing special time, and offering clinician support to the clients when they are practicing at home. This finding is somewhat surprising as these content items are more therapeutic in nature. It is possible that trainees are so concerned about following the specific PCIT protocol that they forget to take the time to preemptively address potential problems that may arise in the home environment. This may be especially true if the trainees are not used to working with manualized treatments. Therefore, it may be useful for trainers to emphasize the balance required between covering the session content and individualizing the protocol to the family.

Finally, the review of within session content item fidelity demonstrated that trainees have a difficult time covering all of the steps in the timeout procedure during the PDI Teach session. This is a concern because parents need to be able to conduct the timeout procedure in a consistent manner with their child and, in order to do so, need to have a solid understanding of the timeout procedure steps. This finding suggests that it may be beneficial to restructure the PDI Teach session outline to make it easier for providers to use. Currently, the session outline is organized in a way that incorporates tips on how to manage certain problem behaviors during the timeout session, such as how to get your child safely to the timeout chair and how to determine if the child is "off" the chair, in with the specific steps to the timeout procedure. It may be beneficial to restructure the session so that the steps to the timeout procedure are separated from

the tips on problem solving during the time out procedure. For example, parents could be given a complete overview of the timeout procedure first, allowing them to learn the steps for the timeout procedure in a sequential manner. Then, once the parent is comfortable with the timeout procedure, the therapist could work with the parent to address common problem behaviors that arise during the timeout procedure and any other concerns the parents have with implementing the protocol with their child. Adding this separation between teaching the steps of the timeout procedure and problem solving may increase trainee fidelity on the PDI teach session by allowing the trainee to focus his or her attention on covering all the details of the timeout procedure before attempting to problem-solve with the parents.

Another way to attempt to increase trainee fidelity on the PDI Teach content items related to the timeout procedure may be to make a specific therapist version of the timeout diagram that could function as a checklist for the therapist (see Appendix F). The timeout diagram included in the PCIT manual is quite effective in helping parents understand the complex steps in the timeout procedure and it is not uncommon for therapists to discuss the timeout procedure with the parents while looking at this diagram (Eyberg & UF, 2010). Therefore, if trainees were able to transition from the session outline, which is numbered and includes checkboxes next to all the items trainees need to cover, to a timeout diagram that is also numbered and includes checkboxes, it may be easier for them to cover all the steps in the timeout procedure.

### **Limitations**

This study attempted to address the fidelity of trainees' first work sample as indicated by session date, however, trainees were not required to send in their first work sample for each session. The primary reason for this accommodation was that some trainees simply forgot to record the required session the first time they conducted it while others were unable to send their

first work sample due to technical difficulties during the recording process. Therefore, one limitation for this study is that it is difficult to determine if practice effects may have impacted trainee fidelity percentages. In the future, trainers should emphasize the need for trainees to send in their first attempt at each session in order to get a clearer picture of the impact the training workshop and consultation process had on trainee fidelity to the treatment protocol. However, it is unlikely that these difficulties in data collection during the consultation process can be completely avoided.

Additionally, in order to allow for client attrition and potential technical difficulties, trainees were permitted to send work samples from different clients, rather than sending in all sessions from one family. Because some clients may be more difficult to work with than others, the variety of work samples may have influenced the trainees' fidelity scores overall and across session type and treatment phase. Furthermore, there is a potential for trainee fidelity scores to be inflated if trainees picked which sessions to send in for review based on their perception of how they performed during the session. Unfortunately, client dropout is a reality of implementing EBPPs in community settings, with 40% to 60% of clients dropping out of treatment before termination is recommended (Baekeland & Lundwall, 1975; Wierzbicki & Pekarik, 1993). Therefore, it will likely be difficult to examine trainee implementation fidelity across treatment sessions with one family.

The fact that the current study did not assess whether the included work samples occurred prior to or following the trainees' participation in an advanced training workshop further complicates the interpretation of the results in this study. Because the advanced training workshop was intended to help trainees refine their coding and coaching skills it is possible that sessions that occurred after the advanced training would have inflated fidelity scores relative to

the fidelity scores earned prior to the advanced training. Additionally, the timing and structure of the advanced training workshops varied between sites based on the trainees' current caseloads and the needs of the trainees. Future research should examine the impact of the advanced training workshop on trainee treatment fidelity. In particular, it would be interesting to assess differences in treatment fidelity across session type and treatment phase for sessions occurring before and after trainees complete the advanced training.

Another limitation of this study is the small sample size, which limits the generalizability of these results. Because the training process requires extensive time and resources on the part of both the trainees and trainers, one training team can only train a limited number of therapists at any given time. The time required to conduct a training workshop and the consultation phase of training, including video reviews and frequent supervision calls, results in a time commitment from the trainers of approximately 100 hours per training cohort. The PCIT consultation phase, which follows trainees through two completed PCIT cases, can range from one to three years. This time commitment is in line with reports from Fixsen et al. (2009) who stated that the successful implementation of an EBPP will likely take two to four years to complete. Therefore, the time commitment required from trainers makes it difficult to obtain a large sample of trainees for research. Unfortunately, the presence of technical difficulties in the recording process also led to the deletion of data for this study, which further limited this study's sample size and may limit statistical power.

Sample size was also limited in this study as a result of a decrease in the number of session tapes submitted by trainees for the later treatment sessions. As seen in Table 4, the number of first session tapes submitted by trainees is highest for the earlier treatment sessions and steadily decreases as the treatment sessions continue. This decrease in the number of work

samples is a result of both client and trainee attrition during the consultation phase of treatment. Of the 21 trainees who submitted at least one work sample for review during the consultation phase of training, 10 have completed the training process and are now eligible to sit for the PCIT certification exam, 6 are still participating in the consultation process, and 5 have dropped out. Trainees terminated the consultation phase of training for multiple reasons including leaving the agency ( $n = 2$ ), a difference in theoretical orientation between the trainees and PCIT's strong behavioral base ( $n = 2$ ), and not having access to the client population best-suited for PCIT ( $n = 1$ ). In the future, trainers should be conscious of provider turnover rates in agencies seeking training in PCIT as turnover rates have been found to negative predict fidelity scores when implementing EBTs for mental health (Woltmann et al., 2008). Additionally, trainers should be sure to conduct an evaluation of organizational readiness looking at clinical competence, family and client engagement, and organizational support systems prior to beginning the training process with providers (Niec, Eyberg, & Chase, 2011).

### **Future Directions**

Given the absence of published studies available on the implementation of PCIT in community settings there are multiple possible areas of interest for future research to consider. First, future research in this area should consider conducting similar analyses on a larger sample of trainees to increase power. Ideally, future samples of trainees would have a more proportional number of sessions from each session type and would be made up of the trainees' first work sample for each session. Having a larger sample of trainees would also make it possible to meaningfully examine any differences in trainee fidelity across training time and trainee variables. Of interest would be if trainee fidelity improves as the training team gains experience

in conducting PCIT trainings and if trainee fidelity varies across trainee characteristics such as trainee education level, training site, and hours of direct client contact per week (Wilsie, 2011).

As previously noted, all of the trainees in this study received feedback regarding their implementation fidelity for the identified key treatment sessions as is recommended by the PCIT Training Guidelines. Trainees were informed during the initial training workshop that they would need to submit the key treatment sessions for review and were told that they would receive feedback on the submitted sessions. Therefore, all trainees were aware that their ability to implement the session protocols would be monitored during the ongoing consultation phase. Research in the area of Applied Behavior Analysis indicates that when teachers who have been asked to implement new interventions for children are monitored on their performance and given feedback, there are improvements in their implementation fidelity (Coddington, Livanis, Pace, & Vaca, 2008; DiGennaro, Martens, & Kleinmann, 2007). Therefore, it is possible that the process of overt fidelity monitoring may have impacted the trainees' implementation fidelity scores. If possible, future research should consider examining treatment fidelity for two distinct groups of trainees, one that is informed of the fidelity monitoring process and receives feedback and one that does not, in order to determine the impact of fidelity monitoring and feedback on trainee fidelity scores.

One potentially valuable part of the session integrity checklists that was not addressed in this study were the qualitative comments made by the trainers regarding the trainees' ability to complete the session requirements. All of the integrity checklists in the PCIT manual have a place for both the therapist and the trainer to write comments about the session. In this study, trainees received both the completed integrity checklist and qualitative feedback on their performance. Future research could examine the type of qualitative comments made by the



trainers. It would be interesting to determine what themes come up most frequently in feedback regarding areas where the trainees need improvement and areas where the trainees excel. It would also be fascinating to examine the trainers' use of labeled praise in the written qualitative feedback to begin to determine how effectively trainers' model the use of PCIT skills for trainees during the consultation phase of training. Finally, it would be particularly interesting to compare comments about the session made by the trainer to those made by the trainee. Therefore, it may be beneficial to require trainees to conduct a self-assessment of their fidelity by filling out the integrity checklist following the completion of the session and asking them to assess their strengths and potential areas for improvement.

Since the start of this study, PCIT International has released an updated version of the PCIT manual, which includes minor changes to the session outlines and treatment integrity checklists (Eyberg & Funderburk, 2011). Therefore, it would be beneficial for this study to be replicated using the updated manual and treatment integrity checklists. In this replication it would be interesting to assess the relationship between a trainee's treatment fidelity scores and their ability to utilize the other integral skills that they learned during the workshop and consultation phase of PCIT training including the *quality* of their DPICS coding and coaching (Wilsie, 2011). Looking at this relationship will allow trainers to assess the trainee's ability to cover session content items and the quality of their skills.

Additionally, because we know that client outcomes vary as a result of provider fidelity to the treatment protocol, it would be beneficial to track trainee session fidelity along with client treatment outcomes during this replication in order to examine the benefits of maintaining treatment fidelity in PCIT specifically (Dane & Schneider, 1998; Mihalic, 2004). One way to assess treatment outcomes for clients would be to assess the parents' use of the "do" skills and

effective commands during pre- and post-treatment DPICS observations. Alternatively, treatment outcomes could be assessed by looking at client ECBI change scores between pre- and post-treatment.

Future research in this area could also compare trainee fidelity scores across different methods of monitoring fidelity. The current study utilized the post-hoc video review of treatment sessions but it may be interesting to compare trainee fidelity scores between video and audio recorded sessions as audio recording would likely be a more feasible option for trainees and may help prevent lost data due to technical error. It would be particularly interesting to conduct cost-effectiveness analysis comparing the cost difference between video and audio recording methods to the benefits of video or audio recordings as methods of monitoring fidelity as this may help trainers determine which form of fidelity monitoring to use.

Because PCIT International is working to “promote fidelity in the practice of PCIT through well-conducted research, training, and continuing education of therapists and trainers,” trainers can utilize the information in the current study to improve training for therapists during both the workshop and the consultation phase of PCIT training ([www.pcit.org](http://www.pcit.org)). In addition to the recommendations already made for the future training of PCIT therapists, future versions of the PCIT Training Guidelines should be more specific in their requirement for trainers regarding fidelity monitoring. The current guidelines simply state that in order “to check skill development, trainers must review the following sessions conducted by the trainee: 1) CDI Didactic, 2) PDI Didactic, 3) CDI coaching (ideally the first CDI coaching session), and 4) PDI coaching (ideally the first PDI coaching session).” These guidelines do not necessarily require the use of the integrity checklists available in the manual, leaving the level of evaluation of trainee skill development up to the PCIT trainer. Therefore, it would be beneficial for the next version of the

PCIT Training Guidelines to require the use of the integrity checklists provided in the PCIT manual for fidelity monitoring as their use will allow for the best assessment of trainee fidelity to the treatment manual and help to standardize the assessment process (Mihalic, 2004). Relatedly, future PCIT Training Guidelines should consider how fidelity monitoring requirements should be outlined for master trainers, regional trainers, and in-house trainers respectively. The diverse nature of each of these roles and concurrent job responsibilities may require that the structure and frequency of fidelity monitoring provided by each form of trainer be varied in order to ensure that fidelity monitoring is feasible. However, it will be important to confirm that the monitoring procedures used by all forms of trainers ensure that trainees are able to implement the session protocol with high fidelity.

Furthermore, the large range in trainee session fidelity scores found in this study suggests that additional, more specific guidelines are needed in order to ensure that certified PCIT therapists are implementing session protocols with fidelity to the treatment manual. It is recommended that the updated guidelines require trainees to earn a predetermined fidelity percentage score for each session. Once the required fidelity percentage is established, specific steps regarding the submission of additional session tapes for review should be outlined for those individuals who fail to meet the predetermined fidelity percentage on the first, or subsequent, attempts. PCIT International may also want to consider what steps for remediation should be required between a trainee's initial and subsequent attempt at completing a key session for review. Remediation could simply involve the trainee taking time to review their initial checklist and the comments made by the trainer or could be more extensive to include watching a pod-cast or taking a quiz about the session of interest.

## **Conclusion**

Scarcely any research has been conducted on how to best train PCIT therapists and the few studies evaluating the dissemination of PCIT have not yet examined the impact of the training process on trainee implementation fidelity. Therefore, there is a great need to continue research related to the dissemination and implementation of PCIT in community settings (Eyberg, et al., 2008; Herschell, Kolko, Baumann, & Davis, 2010; Wilsie, 2011). The current study has some preliminary findings that could help to refine the methods currently being used in the dissemination and implementation of PCIT. It is clear that trainers need to emphasize the more unique components of PCIT to ensure that trainees are implementing the core components of PCIT. It is also evident that training needs to extend the information taught during the training workshop into the consultation phase and that PCIT trainers and trainees would benefit from a better-developed set of training guidelines that are more specific in their measurements of trainee progress and fidelity.

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## Appendix

Table 1

*Trainee Characteristics Across Training Times*

Training	Number of Trainees	Type of Agency
Time 1	5	Non-profit CMHC
Time 2		
Cohort A	2	Non-profit CMHC
Cohort B	3	Medical Center
Time 3		
Cohort A	2	Non-profit CMHC
Cohort B	3	For-profit CMHC
Time 4	6	Medical Center

---

Total Number of Trainees = 21



Table 2

*Work Samples Submitted by Trainees during the Consultation Phase*

Session	Total Number Submitted	Number of First Samples
CDI Teach	31	16
CDI Coach 1	25	15
PDI Teach	17	13
PDI Coach 1	15	11
House Rules	11	9
Public Behavior	8	7
Total	107	71

*Note.* CDI = Child Directed Interaction, PDI = Parent Directed Interaction

Table 3

*Summary of Inter-Rater Reliability Using Percent Agreement*

Session	Number of Tapes Reviewed for IRR	Mean % Agreement	<i>SD</i>
CDI Teach	8	94.83	5.53
CDI Coach 1	8	92.50	10.35
PDI Teach	7	96.41	3.90
PDI Coach 1	6	93.94	7.42
House Rules	5	84.00	16.73
Public Behavior	4	92.86	8.25
Overall	38	92.86	9.26

*Note.* IRR = Inter-Rater Reliability, CDI = Child Directed Interaction, PDI = Parent Directed Interaction

Table 4

*Overall Session Fidelity by Session*

Session	Number	Mean Fidelity Score	Standard Deviation
CDI Teach	16	90.52	13.12
CDI Coach 1	15	80.17	20.01
PDI Teach	13	92.31	9.49
PDI Coach 1	11	82.15	17.94
House Rules	9	91.11	17.64
Public Behavior	7	87.76	22.48
Total	71	87.16	16.77

*Note.* CDI = Child Directed Interaction, PDI = Parent Directed Interaction

Table 5

*Comparison of Mean Fidelity Scores from Teach to Coach Sessions*

Teach		Coach		Statistics		
<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>d</i>
91.33	9.68	79.94	17.79	3.17	.009	1.91

*Note.*  $N = 12$ ,  $M$  = Mean,  $SD$  = Standard Deviation

Table 6

*Comparison of Mean Fidelity Scores from CDI to PDI Sessions*

CDI		PDI		Statistics		
<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>d</i>
85.84	15.98	87.27	12.17	-.340	.740	.21

*Note.* *N* = 12, *M* = Mean, *SD* = Standard Deviation

Table 7

*Integrity Checklist Content Items with Low Fidelity by Session*

CDI Teach	CDI Coach 1	PDI Teach	PDI Coach 1	Public Beh.
1 Begin (68.75)	8 Summary (73.33)	1 Concerns (76.92)	2 Collect HW (63.64)	4 Don't Push (71.43)
4 Attendance (68.75)	9 ECBI (66.67)	19 Model Chair (76.92)	9 Review (63.64)	5 Make it Fun (71.43)
24 CDI at Home (75.00)	10 Homework (66.67)	20 Discuss Chair (61.54)	10 Homework (72.73)	
27 Barriers (43.75)		23 Ask Child (76.92)	11 Call for Help (63.64)	
		28 If Yes (76.92)		
		29 2 <sup>nd</sup> Command (76.92)		
		31 TO Room (76.92)		
		34 Room (61.54)		
		35 1 min 5 sec (76.92)		
		36 Stay Here (76.92)		
		44 Homework (76.92)		

*Note.* The number in parentheses indicates the percentage of of trainees who completed these content items

## Appendix A

### **Training Guidelines for Parent-Child Interaction Therapy**

These guidelines were developed by the PCIT Training Committee, a subcommittee of the National PCIT Advisory Board made up of expert PCIT trainers. The “PCIT Guidelines” is a living document that will evolve as new research arises in intervention, training and dissemination. At this time, the Guidelines reflect what is considered to be the *minimum* training necessary to develop competence as a PCIT therapist.

#### **What is PCIT?**

PCIT is a behavioral family intervention for children 2-7 years of age with disruptive behavior disorders. It has been identified as a best practice for physically abusive parents. Developed by Sheila Eyberg at the University of Florida, PCIT integrates concepts from social learning theory, traditional play therapy, and attachment theory to enhance the parent-child relationship, increase children’s pro-social behaviors, and increase parents’ behavior management skills. The program is implemented in two phases: The first phase is the Child Directed Interaction (CDI) phase during which parents develop child-centered interaction skills. The second phase is the Parent-Directed Interaction (PDI) phase during which effective discipline skills are the focus.

PCIT gives equal attention to the development of the parent-child relationship and the development of parents’ behavior management skills. Because parent-child interactions in families with conduct-disordered children are frequently negative and coercive in nature, a

critical goal of PCIT is to increase positive, nurturing interactions. PCIT includes the child in treatment, both in session and during daily homework assignments. In contrast to the traditional approach to parent training that focuses on didactic and role play, parents in PCIT rehearse new skills weekly in session through live interactions with their children. This active practice facilitates skill development and allows therapists to conduct ongoing assessments of parents' progress. In addition, it provides the opportunity for live-coaching by the therapist. During parent-child interactions, immediate feedback is given by the therapist from an observation room, while the parent wears a radio frequency earphone. Therapists use behavioral principles such as modeling, reinforcement, and selective attending in their coaching to shape the parents' behaviors. The use of live coaching and immediate feedback is key to PCIT. Therapists directly observe parents' behaviors and can modify them as they occur.

To understand the PCIT training guidelines, one should first be aware of the core components that define Parent-Child Interaction Therapy. Core components of PCIT include...

- Use of standardized assessment instruments to guide treatment (e.g., Eyberg Child Behavior Inventory, Dyadic Parent-Child Interaction Coding System-III)
- Inclusion of both the Child Directed Interaction and Parent Directed Interaction phases of treatment
- Coaching of parents in live interactions with their children for the majority of non-didactic sessions
- Coding of parent-child interactions almost every coaching session
- Assignment of homework between sessions

## **I. Workshop training for practitioners**



## A. Agency and clinician entry requirements

- Trainee must have a master's degree or higher in the mental health field and must be actively working with children and families.
- Trainee must be licensed in his or her field *or* receive supervision from a licensed individual trained in PCIT.
- Trainee's agency must provide appropriate space and equipment for conducting PCIT. Appropriate space includes a stripped therapy room, a separate observation room with either two-way mirror or video monitoring, and a communication system that allows the therapist to speak in real time to the parent during parent-child interaction.
- Trainee's agency must serve a population of clients within the age range for PCIT services; and must allow time for trainees to participate in ongoing training and consultation. (See *V. Recommendations for Optimal Training* below for further discussion.)

## B. Training requirements

- **40-hours of face-to-face contact with a PCIT trainer** that includes an overview of the theoretical foundations of PCIT, coding practice, case observations, and guided coaching with families, with a focus on mastery of CDI and PDI skills and coaching.
- **Advanced live training** with real cases approximately 2-6 months after the initial training that focuses on refining coaching skills, addressing complex treatment issues, and a check-off on coaching criteria (See criteria below).
- **Case Experience:** The trainee must treat a minimum of two PCIT cases to completion as primary therapist or co-therapist. Until the two PCIT cases are completed, trainees must

remain in regular contact (i.e., recommended weekly, but no less than monthly)—via telephone, live observation, or tape review—with a PCIT trainer. This tends to be a year.

- **Skill review** – Trainees must have their treatment reviewed by a PCIT trainer. Review can be conducted through videotapes, live observation, or online/telemedicine system. To check skill development, trainers must review the following sessions conducted by the trainee: 1) CDI Didactic, 2) PDI Didactic, 3) CDI coaching (ideally the first CDI coaching session), and 4) PDI coaching (ideally the first PDI coaching session).

### **C. Skill Requirements**

#### **Assessment (Pretreatment, Posttreatment, Weekly)**

##### **By the end of the training process, a trainee should be able to...**

- Administer, score, and interpret the required standardized measures for use in assessment and treatment planning (Required measures: ECBI, DPICS-III; Recommended measures: PSI-SF, BASC or CBCL, SESBI).
- Administer and reliably code DPICS-III Abridged behavioral observations.

#### **DPICS-III Abridged Coding**

##### **By the end of the training process, a trainee should be able to...**

- Achieve a minimum of 80% reliability with a PCIT trainer in five minutes of live coding or in continuous coding with a criteria tape. Reliability checks of live coding will be conducted, with additional training scheduled as needed.

#### **CDI-Related Therapist Skills**

##### **By the end of the training process, a trainee should be able to...**

- Present the CDI didactic, adequately explaining all non-optional items on the treatment integrity checklist in the PCIT manual by Eyberg as observed by the trainer.

- Meet the parent criteria for CDI skills (10 labeled praise, 10 behavioral descriptions, 10 reflections; 3 or fewer negative talk, questions, and commands) in a 5-minute interaction with child or 5-minute role play.
- Use the session by session CDI coded information (i.e., DPICS) to guide the coaching session.

### **PDI-Related Therapist Skills**

#### **By the end of the training process, a trainee should be able to...**

- Present the PDI didactic, adequately explaining all non-optional items on the treatment integrity checklist in the PCIT manual by Eyberg as observed by the trainer.
- Effectively manage a PDI discipline session and accurately demonstrate the discipline sequence with a client. In the rare case when a full timeout procedure does not occur or cannot be taped, the therapist should demonstrate the skills through a role play.
- Accurately explain the House Rules procedure as described in the PCIT manual by Eyberg. Accuracy can be assessed through role play and does not require observation of a session with an actual client. However, the trainer must observe the role play either live or via tape.
- Accurately explain the Public Behaviors procedure as described in the PCIT manual by Eyberg. Accuracy can be assessed through role play and does not require observation of the session with an actual client. However, the trainer must observe the role play either live or via tape.

### **Coaching Skills**

#### **By the end of the training process, a trainee should be able to...**

- Demonstrate adequate and sensitive coaching as observed by the trainer.

## General

### By the end of the training process, a trainee should be able to...

- Model CDI skills during all interactions with parents and children throughout the course of therapy.
- Demonstrate the ability to structure the opening and closing of sessions (including homework review and assignment; feedback on skills; and general session management and timing).

## II. Standards for In-house Trainers of PCIT Therapists

In-house trainers are individuals who have received such PCIT training as to be qualified to teach and supervise staff within their own program or agency. In-house trainers at this level are not considered to have the experience or expertise to conduct large-scale trainings or the training of individuals not under their direct supervision.

A trainer of PCIT should have a demonstrated *history of expertise* in provision of PCIT, PCIT supervision, and PCIT training. Before being considered competent to train others in PCIT, trainers will...

- Meet all therapist-skills criteria above
- Maintain a relationship with their Master Trainer for consultation for a minimum of one year from the time they begin training as trainers. Thereafter, it is recommended that trainers attend at least annual training (e.g., national or regional conference or workshop) to keep their skills and knowledge of PCIT current.
- Complete of *at least 4 PCIT cases* in consultation with a PCIT Master Trainer

- Be observed in the provision of supervision by a PCIT Master Trainer for a minimum of one CDI session and one PDI session. The Master Trainer will provide feedback on the content and style of the novice trainer's supervision.
- Remain active in PCIT service delivery either through a clinical caseload or live supervision of PCIT therapists.

### **III. Standards for Master Trainers of PCIT**

- Master Trainers are individuals responsible for maintaining fidelity of in-house trainers and providing broader dissemination of the PCIT protocol (e.g., nationally and internationally). To be considered a PCIT Master Trainer, individuals must be approved through a process defined by the developer of PCIT, Sheila Eyberg. Contact Dr. Eyberg for more information.

### **IV. Principles for In-house Trainers of PCIT Therapists for Special Populations**

#### **Trainers of PCIT for special populations should...**

- Meet all standards for PCIT trainers (section above)
- Provide evidence of extensive experience with the cultural group of interest.
- Not disseminate any changes in PCIT without adequate empirical evidence to support the change.

### **V. Recommendations for Optimal Training**

The following recommendations are provided to describe training situations that approximate the ideal. Based on the experiences of expert PCIT trainers, these recommendations increase the likelihood that agencies will develop and maintain effective PCIT programs.

- A *minimum* of two clinicians within a single agency are trained at one time.

When only one clinician within an agency can be trained, individuals participate in an ongoing PCIT supervision/networking group for long-term support and consultation.

- PCIT programs are clinic-based. If home-based PCIT is offered, it is adjunct to the in-clinic services.
- Because PCIT training has a short “shelf-life”—that is, therapists are likely to lose their new skills if they do not practice them within three weeks of receiving their training—it is recommended that therapists identify two or three families potentially appropriate for PCIT *prior* to receiving training and that therapy is initiated with these families immediately upon completion of the training.
- Weekly supervision is recommended for at least the first month of a case, with contact tapering to not less than monthly through the completion of at least two cases.

## **VI. Exceptions**

- Agency administrators may observe PCIT trainings without participating in the experiential components. However, such observation does not qualify administrators to conduct PCIT or train others.
- Graduate students who are enrolled in a masters or doctorate program in a mental health field (e.g., clinical psychology, counseling, social work) and are receiving PCIT training from a trainer within the context of their program do not have to meet the Clinician Entry Requirements regarding licensure and previous experience.

## **PCIT Training Committee**

Sheila Eyberg, PhD  
University of Florida  
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Central Michigan University  
Anthony Urquiza, PhD  
UC Davis Children’s Hospital  
Nancy Zebell, PhD  
UC Davis Children’s Hospital

Appendix B

Trainee Background Information

(circle all that apply)

Age: \_\_\_\_\_ Education: M.A. or M.S.  
MSW  
Gender: Male PsyD  
Female PhD  
Other: \_\_\_\_\_

Race/Ethnicity: American Indian or Alaska Native  
Asian  
Black or African American  
Hispanic or Latino  
Native Hawaiian or Other Pacific Islander  
White or Caucasian

Place of Employment: Advocacy Center  
Counseling Center  
Hospital  
Private Practice  
Other: \_\_\_\_\_

Counseling or theoretical orientation: Cognitive  
Behavioral  
Cognitive-Behavioral  
Psychodynamic  
Humanistic-Existential  
Systemic  
Solution-Focused  
Gestalt  
Eclectic or Integrative  
Other: \_\_\_\_\_  
I don't know

Hours worked per week (on average): \_\_\_\_\_  
Hours per week with direct client contact: \_\_\_\_\_  
Years of experience working with children and/or families: \_\_\_\_\_  
Number of years in current position: \_\_\_\_\_  
Number of courses taken to learn about parent training: \_\_\_\_\_

## Trainee Contact Information

Name:

---

Address:

---

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Preferred Phone Number: \_\_\_\_\_ Okay to leave a message? Y or N

Optional Phone Number: \_\_\_\_\_ Okay to leave a message? Y or N

Email:

---

Are you interested in joining our PCIT listserv? Y N

Are you interested in continuing PCIT supervision with the Auburn University Parent-Child Lab? Y N



Appendix C

Relevant Integrity Checklists from the PCIT Manual

Participant ID: \_\_\_\_\_

Session Title: CDI Teach

Coder Initials: \_\_\_\_\_

Integrity Checklist

ITEM NUMBER	✓	N/A	X
1. Begin Session			
2. Give Overview			
3. Explain Structure			
4. Attendance Policy			
5. CDI Overview			
6. CDI Taught First			
7. CDI Basic Rule			
8. Avoid Commands			
9. Avoid Questions			
10. Avoid Criticism			
11. Parents Recall			
12. Praise			
13. Reflection			
14. Imitation			
15. Description			
16. Enthusiasm			
17. Parent Recall			
18. Ignoring			
19. Ignore with PRIDE			
20. Stop Play			
21. Role Play			
22. Review Toys			
23. Ask About Toys			
24. CDI at Home			
25. Practice at Home			
26. Discuss Time/Room			
27. Address Barriers			
28. Give Handouts			
29. Give Homework			

**Fidelity to the Protocol:**

TOTAL NUMBER OF CHECK MARKS: \_\_\_\_

TOTAL NUMBER OF N/A's: \_\_\_\_

TOTAL NUMBER OF X's: \_\_\_\_

**Integrity Checker Comments about Session**

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**Participant ID:** \_\_\_\_\_ **Session Title:** CDI Coach 1- 1 & 2 Parents **Coder Initials:** \_\_\_\_\_

**Integrity Checklist**

ITEM NUMBER	✓	NA	X
One Parent:			
1. Discuss Concerns			
2. Review Homework			
3. Orient Child			
4a. Code Parent			
7a. Coach Parent			
10. Review Summary			
11. Show ECBI Graph			
12. Give Homework			
Two Parents:			
1. Discuss Concerns			
2. Review Homework			
3. Orient Child			
4b. Code Parent 1			
7b. Coach Parent 1			
6c. Code Parent 2			
9c. Coach Parent 2			
10. Review Summary			
11. Show ECBI Graph			
12. Give Homework			

**Fidelity to the Protocol:**

TOTAL NUMBER OF CHECK MARKS: \_\_\_\_

TOTAL NUMBER OF N/A's: \_\_\_\_

TOTAL NUMBER OF X's: \_\_\_\_

**Integrity Checker Comments about Session**

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Participant ID: \_\_\_\_\_

Session Title: PDI Teach

Coder Initials: \_\_\_\_\_

### Integrity Checklist

ITEM NUMBER	✓	N/A	X
1. Discuss Concerns			
2. Review Homework			
3. Explain PDI Process			
4. Overview of PDI			
5. PDI Starts with a Command			
6. Direct vs. Indirect			
7. Commands Stated Positively			
8. Give Commands One at a Time			
9. Be Specific			
10. Give Age-Appropriate Commands			
11. Be Polite and Respectful			
12. Explain Before/After			
13. Only When Necessary			
14. Child Response			
15. Explain 5 Second Rule			
16. Praise for Obey			
17. Give Chair Warning			
18. Praise for Obey			
19. Model the Chair			
20. Discuss Chair			
21. "Stay on Chair"			
22. Explain Steps			
23. Ask What Child Will Do			
24. Ignore			
25. 3 minutes with 5 seconds of Quiet			
26. Ask Question			
27. If Child Says "No"			
28. If Child Says "Yes"			
29. Acknowledge and Give Another Command			
30. Labeled Praise for Comply			
31. Explain Time-Out Room			
32. Define "Off-Chair"			
33. Warning			
34. Take to the Room			

35. 1 minute with 5 seconds of Quiet			
36. "Stay Here"			
37. Role-Play			
38. Switch to CDI			
39. Don't Start PDI			
40. Give Handouts			
41. PDI Diagram			
42. Schedule Extra Time			
43. Therapist Will Explain to Child			
44. Give CDI Homework			

**Fidelity to the Protocol:**

TOTAL NUMBER OF CHECK MARKS: \_\_\_\_

TOTAL NUMBER OF N/A's: \_\_\_\_

TOTAL NUMBER OF X's: \_\_\_\_

**Integrity Checker Comments about Session**

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Participant ID: \_\_\_\_\_ Session Title: PDI Coach 1- 1 & 2 Parents Coder Initials: \_\_\_\_\_

**Integrity Checklist**

ITEM NUMBER	✓	N/A	X
One Parent:			
1. Discuss Concerns			
2. Collect Homework			
3. Review Time-Out			
4. Review Coaching			
5. Explain Time-Out to Child			
6. Explain Sequence			
7a. Coach for 40 min.			
9. Review Session			
10. Discuss Homework			
11. Phone Call for Help with PDI			
Two Parents:			
1. Discuss Concerns			
2. Collect Homework			
3. Review Time-Out			
4. Review Coaching			
5. Explain Time-Out to Child			
6. Explain Sequence			
7b. Coach 1 <sup>st</sup> Parent (20 min)			
8b. Coach 2 <sup>nd</sup> Parent (at least 10 min)			
9. Review Session			
10. Discuss Homework			
11. Phone Call for Help with PDI			

**Fidelity to the Protocol:**

TOTAL NUMBER OF CHECK MARKS: \_\_\_\_\_

TOTAL NUMBER OF N/A's: \_\_\_\_\_

TOTAL NUMBER OF X's: \_\_\_\_\_

**Integrity Checker Comments about Session**

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## Appendix D

### House Rules and Public Behavior Worksheets

#### Setting Up House Rules

##### What kinds of behaviors may need a house rule?

- Behaviors that are aggressive  
*Your son hits you when you don't give him what he wants*
- Behaviors that are destructive  
*Your daughter throws toys when she's angry*
- Negative behaviors that happen all of a sudden," before you have a chance to give a command for a "positive opposite" behavior  
*Your daughter yells at her baby brother and frightens him when he gets in her way*
- "Sneaky" behaviors that you don't discover until after they have happened  
*Your son repeatedly eats the desserts in the refrigerator prepared for dinner guests*

##### How to set up a house rule

1. Decide what behavior you want your child to stop  
*Example: Saying mean things to her sister, like "I hate you," or "You're ugly"*
2. Choose a word for the behavior that your child understands  
*Example: "Picking on your sister"*
3. If you're not sure your child knows what you mean, label the behavior for 2 or 3 days before you start giving time outs for it  
*Example: "When you say things like that, that's picking on your sister."*
4. Explain the new house rule to your child  
*"You've been nice to your sister this morning, and I like that. But sometimes you forget. I am starting a new house rule to help you remember. It goes like this, "Any time you pick on your sister, you'll have to go to the timeout chair. But if you remember to be nice to your sister, like this morning, you won't have to go to the chair."*

##### How to use the house rule

- Your child does **not** get a warning if he breaks a house rule - If he does the problem behavior, take him immediately to the timeout chair for 3 minutes plus 5 seconds of quiet
- Take your child to the chair **every time** he does the behavior.
- On the way to the chair, say nothing except, "You [picked on your sister], so you have to sit on the timeout chair." When you leave, say only "Stay on the chair until I say that you can get off."

- If your child gets off the chair, take him to the timeout room for 1 minute plus 5 seconds of quiet.
- After your child's time on the chair is up, say, "You can get off of the chair now." Do not give a command or discuss the bad behavior.
- As soon as possible, praise the "good opposite."  
*"You're being so nice to your sister. She thinks you are the best big brother in the world."*

**To begin another house rule**

- You may begin a new house rule after your child is going to time out less than twice a day for the first rule. When this happens, that first rule is no longer an "active" house rule. It is still a house rule, though, and your child should still go to timeout when he breaks it.
- Your child should have not more than two "active" house rules at a time.



## Dealing With Your Child In Public Places

If your child has behavior problems, it can be hard to take him places like the grocery store or the doctor's office. Sometimes children will do things that make parents feel bad, like whining, yelling, or saying mean things. And sometimes when parents tell them to stop, kids just act worse. Strangers may turn and watch the child, and the parents may feel embarrassed. So sometimes kids can get away with doing things in public that they would not be allowed to do at home. Here are some things to do to help your child be good out in public.

### Make a Plan Before You Leave the House

Tell your child where you will be going, and how you want him to act.

☺“We are going to Wal-Mart. I want you to stay right by me and talk nicely.”

If there are things that you know your child will probably do, like whining, tell your child that if he whines on this outing, he will get a small punishment (tell him what the punishment will be, like no TV for the evening).

☺“If you don't stay by me or if you whine, you will not get to watch TV tonight.”

Always give the punishment if your child does not do what you told him. If he is good, praise him and maybe even give him a little something special.

☺“You stayed right by me in the store, and you talked so nicely, so we're going to stop and get an ice cream cone on the way out.”

Sometimes when parents are busy trying to get things done, they forget to praise their kids when they're being good. But taking the time to praise your child will mean you have to spend less time dealing with bad behavior.

☺“I like how quietly you stood and waited while I talked to the lady behind the counter. That's my big girl!”

Don't push your child too hard. Most kids can't be good in public for more than a couple of hours (or less for some kids). If you see that your child is getting tired, hungry, or bored, it is a good idea to go home or at least take a break. Try not to take your child out past his bedtime or during times that he is usually taking a nap.

Try to plan some part of your trip that will be fun for your child. For example, if you are at the mall, you could walk through a store your child enjoys, like a pet store or toy store. Even though this takes more of your time, it will give your child something to look forward to and help him act better.

☺“We have to go to the doctor's office today. After the doctor's office, we will stop for lunch at the McDonald's with the Playland that you like. Then we will go to the grocery store.”

Bring along small toys, books, and snacks to help keep your child from getting bored and hungry.

## Effective Ignoring

- Ignoring can be really hard for parents to do in public. You may feel bad about ignoring your child in front of strangers because they may think you do not care about your child. Or, you may feel bad about how your child is acting and want to make him stop right away. Sometimes it may seem easier just to give the child what he wants.

*Jane and her daughter Tasha are at the grocery store in the checkout line.*

*Tasha says, "Mom, can I have a candy bar?"*

*Jane says, "No, because it's almost time for dinner."*

*Tasha yells, "But mom, I want one! I'm hungry! You're a mean mom!" She starts to cry and stomp her feet.*

*People are looking over at Jane and Tasha. Jane feels embarrassed. So she buys Tasha the candy bar so she will be quiet.*

*The next time Jane and Tasha go to the grocery store, Tasha knows what she has to do to get a candy bar. She just has to yell and cry until her mom feels bad and buys it for her.*

- When you ignore your child when he acts up in public, your child learns that he is not going to get his way by yelling and crying. Your child will probably "test" you, to see if you can keep this control even if he whines, screams, or lies on the floor and kicks. But if you keep ignoring him, your child will know that crying and yelling don't work any more.
- Remember that the longer you and your child have been dealing with this problem, the longer it might take to show your child that you are in control. So, you may have to ignore him more than once before he gets the point.

## Public Time-out

- Public time out is the same as time out at home, with a few small changes.
- Before going out, tell your child that you are going to use time out in the place you are going. Explain that time out will be the same as time out at home.
- Keep a small blanket or placemat with you to use as the —time-out chair, ll so that time-out can be done anywhere.
- When you need to choose a time out spot, choose a place where there is nothing fun for the child to do and where the child is not likely to get attention from others.
- Some parents have put their children on benches in the mall, the front steps during church, or the corner of a grocery store. When their car is close, some parents find they can put the child in the back seat with the windows half open, while they lean against the car. But if it is very hot outside, this is not a good thing to do unless the windows are completely down.
- Always watch your child when she is in time out.
- Talk with your PCIT therapist about any problems that come up.

Appendix E

**Integrity Checklists for House Rules and Public Behavior**

**Participant ID:** \_\_\_\_\_

**Session Title:** House Rules

**Coder Initials:** \_\_\_\_\_

**Integrity Checklist**

ITEM NUMBER	✓	N/A	X
1. Types of behaviors that need a house rule			
2. How to set up a house rule			
3. Explaining the house rule to your child			
4. How to use the house rule			
5. Beginning another house rule			

**Fidelity to the Protocol:**

TOTAL NUMBER OF CHECK MARKS: \_\_\_\_\_

TOTAL NUMBER OF N/A's: \_\_\_\_\_

TOTAL NUMBER OF X's: \_\_\_\_\_

**Integrity Checker Comments about Session**

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Participant ID: \_\_\_\_\_

Session Title: Public Behavior

Coder Initials: \_\_\_\_\_

**Integrity Checklist**

ITEM NUMBER	✓	N/A	X
1. Tell your child where you are going and how you want him/her to act			
2. Follow through on discipline if needed			
3. Praise your child for appropriate behavior			
4. Don't push your child too hard			
5. Make the trip fun			
6. Use effective ignoring when appropriate			
7. How to do time-out in public			

**Fidelity to the Protocol:**

TOTAL NUMBER OF CHECK MARKS: \_\_\_\_\_

TOTAL NUMBER OF N/A's: \_\_\_\_\_

TOTAL NUMBER OF X's: \_\_\_\_\_

**Integrity Checker Comments about Session**

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## Appendix F

### Time Out Diagram

