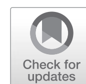

18 Core Training Competencies for PCIT and ASD

Christina M. Warner-Metzger

Abstract

Rooted deeply in behavioral theory and knowledge of Patterson's coercive cycle, Parent-Child Interaction Therapy (PCIT) works with both caregivers and children to restore balance and positivity to family dynamics. PCIT uniquely implements live coaching to change maladaptive interactional patterns within caregiver-child dyads, with therapists collecting observational data to inform the progress of therapy. Due to the specialized skillset necessary to delivery this highly specified therapy, standardized training requirements and a certification process guide the practice of PCIT internationally. This chapter reviews the prerequisite education, basic training, clinical competencies, and case consultation required to become a PCIT Therapist. Additional recommendations are provided for supplemental training in autism spectrum disorders (ASD), including knowledge of diagnostic methods, connection with available ASD resources, and identifying ongoing educational outlets. Considerations for PCIT-ASD training are suggested.

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18.1 The Importance of Interaction to PCIT Core Components

18.1.1 Putting the "I" in PCIT

To fully understand the necessary steps to become trained in Parent-Child Interaction Therapy (PCIT), it behooves us to first return to the basic premise of the treatment. As the name suggests, Parent-Child *Interaction* Therapy (italics added) works with the caregiver and child together to impact change within the family. The point of intervention is neither the child alone nor the caregiver alone; rather, PCIT targets the *interaction* between the parent and child as the focal point of conflict. As such, it is not the child's symptoms of oppositionality in isolation that are problematic (i.e., on rare occasion has a child sought treatment admitting their defiance disrupts the family), and it is not the caregiver's parenting style in isolation that is problematic (indeed, many caregivers report their parenting style works well with other children in the household). However, when the mismatch of the child's behaviors collides with the caregiver's parenting style, subsequent maladaptive patterns may form. Thus, PCIT accepts the basic tenet that both caregiver and child contribute to the relational pattern developed over time, with some interactional styles leading to more or less conflict.

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18.1.2 Underlying Interactional Theory

Family conflict is repeatedly indicated in the literature as a direct contributor to the maintenance of child disruptive behaviors. One of the most comprehensive models of negative parent-child interactions is Patterson's coercion cycle (1982, 2002; Patterson, Reid, & Dishion, 1992). This model explains how negative exchanges between a caregiver and child become increasingly coercive and cyclical in nature, further intensifying the child's disruptive behaviors and the caregiver's inconsistent discipline practices over time. Patterson's model posits that the caregiver reacts to the child's expression of disruptive behavior with aggressive responses (e.g., yelling, threatening, hitting), nonresponsive discipline (e.g., concession to the child's defiant and aggressive behavior), or a combination of both practices.

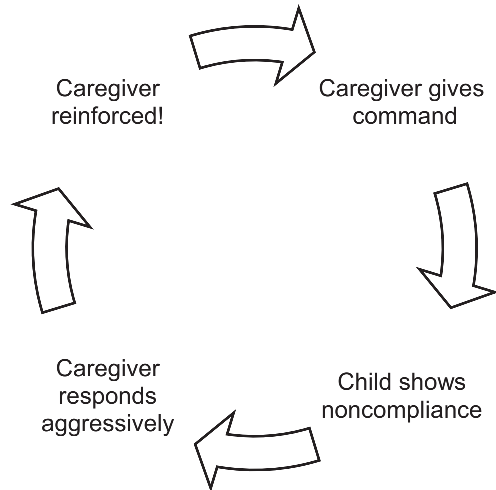

Fig. 18.1 Patterson's coercive cycle: Aggressive discipline

The use of aggressive responses results in temporary cessation of the child's negative behavior, which reinforces the parent to engage in such discipline practices in the future. Problematically, this approach models the use of threatening and aggressive tactics for the child. Moreover, caregivers also develop a pattern of inconsistency within the coercive cycle, as they may vary the number of threats delivered in this process before applying aggressive punishment. However, children may "play the odds" of their noncompliance by testing the likelihood of their caregiver's inconsistent threats coming to fruition. Anecdotally, caregivers caught in this cycle often report "my child only listens to me when I yell or threaten to spank them." As referenced in Fig. 18.1, the following steps contribute to the cycle:

1. The caregiver gives a command: Put on your shoes.
2. The child does not comply with the command: (*whining*) But I don't want to leave!
3. The caregiver responds to the child's noncompliance with aggression: (*yelling*) I've had it with you! Either put on your shoes, or I'll give you something to cry about!
4. The child puts on the shoes to avoid harsh punishment, reinforcing the caregiver's use of aggression.

Similarly, the use of nonresponsive discipline results in the parent negatively reinforcing the child's escalation of oppositionality and aggression as the child escapes from a parental command or avoids punishment. Over time, the child becomes more noncompliant and the caregiver becomes less directive, which in turn increases child noncompliance in the future. Clinically, caregivers gripped in this cycle frequently comment "I find it easier if I just do it for my child or if I don't enforce too many rules." Figure 18.2 depicts the following cyclical events:

1. The caregiver gives a command: Put on your shoes.
2. The child does not comply with the command: (*whining*) But I don't want to leave!
3. The caregiver responds to the child's noncompliance with nonresponsiveness by conceding to the child: I know it's hard, honey, so I'll just put your shoes on for you. Mommy will make it better.
4. The child avoids punishment for noncompliance and is reinforced to act defiantly to future parental directives.

The coercive cycle is further complicated when both nonresponsive and punitive discipline are used inconsistently. With caregivers

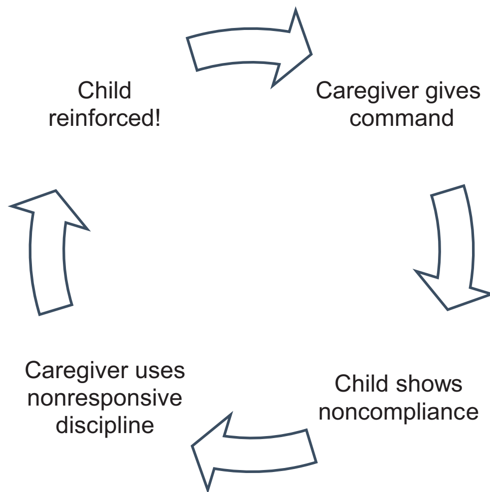

Fig. 18.2 Patterson's coercive cycle: Nonresponsive discipline

occasionally implementing discipline while periodically acquiescing to the child's demands, the child learns to escalate until demands are met. Consequently, caregivers may fall into a contradicting pattern of frustration and aggression combined with permissiveness and accommodations in attempts to manage their child's noncompliance or disruption.

Of importance, coercive caregiver-child interactions are recognized as bidirectional patterns, meaning the child's behavior influences the caregiver's reaction and vice versa (Lytton, 1990; Patterson, Reid, & Eddy, 2002). In essence, over an extended period of time, family members "train each other to be aversive and aggressive" (Patterson et al., 2002, p. 9). Regardless of whether the caregiver initially takes an aggressive or nonresponsive role, with ongoing coercive exchanges, the child's aggression can escalate from minor oppositionality to violent behavior (Snyder & Stoolmiller, 2002). In addition to affecting family functioning, the coercive cycle also begins to generalize to the child's interactions with peers and teachers (Patterson et al., 1992). With increasingly maladaptive interactions with others, the coercive cycle maintains disruptive behavior by generalizing to contexts outside the home.

Unfortunately, engaging in the coercive cycle with children who have disruptive behaviors tends to worsen the problem by teaching them ineffective social skills, rather than achieving the intended amelioration of behavior problems. Therefore, it becomes necessary to intervene specifically within the caregiver-child interaction to interrupt the negative cycle at its source. Further, a new adaptive interactional style must be built to restore balance to the family dynamic. While many other evidence-based parent management training programs similar to PCIT provide caregivers with behavioral techniques via psychoeducation or behavioral practice (such as role-playing), PCIT uniquely uses live coaching to leverage the caregiver-child interaction as the mechanism for change within the dyad and consequently the family structure.

18.1.3 Core Components of PCIT

In Eyberg's (2005) discussion of tailoring and adapting PCIT, the author identifies several core components that characterize PCIT. Specifically, both the caregiver and child are required to attend sessions together. With few exceptions in protocol, each therapy session includes the therapist using an observational coding system as the caregiver and child interact in play. Data from the observation drives the goals for each session and informs the therapist to coach the caregiver in a prescribed set of parenting skills intended to restructure interactional patterns. The therapist remains "outside" the caregiver-child interaction (usually behind a one-way mirror), but guides the caregiver through a bug-in-ear device (e.g., Bluetooth ear piece) to use positive parenting skills (labeled praises, reflections, behavior descriptions, imitation, enjoyment), avoid negative parenting skills (commands, questions, negative talk/criticism), and decrease the likelihood of child defiance or noncompliance. Through select "teach" sessions and coaching, caregivers learn overarching behavioral principles (e.g., antecedents, behaviors, and consequences). A therapeutic "parallel process" occurs in which the therapist uses a particular set of skills

with caregivers, and caregivers in turn recreate (or parallel) the use of the skills with their children. While PCIT is considered a child-oriented therapy, it interestingly allots minimal interaction between the therapist and child during sessions, but for good reason: the mechanism for change is delivered directly via the caregiver to the child.

18.2 PCIT International Therapist Training Requirements

Because PCIT focuses on collecting observational data using a structured coding system and delivering live coaching during caregiver-child interactions (skillsets that are rarely employed in other child therapies), standards for training were developed to ensure those interested in becoming certified PCIT Therapists could adhere to the rigorous PCIT protocol (Eyberg & Funderburk, 2011) and use the robust techniques proven efficacious by almost 50 years of research. In other words, families should experience a consistent intervention from one PCIT Therapist to another. Furthermore, PCIT is currently implemented in approximately 12 countries worldwide, requiring standardized training to ensure the core components of PCIT are retained despite adaptations to address cultural sensitivity. To this end, PCIT International, Inc., determines and approves the *Training Requirements for Certification as a PCIT Therapist*. The *Training Requirements* in their most current form, available trainings, certified trainer information, and contact information for training and certification inquiries, among other professional resources, are available at www.pcit.org. The following narrative provides an overarching description of the basic components for PCIT training, but it does not constitute or replace the published *Training Requirements*, which are subject to change.

18.2.1 Overview of Training Models and Trainer Types

Although models of PCIT training vary in structure, number of total training days, and consultative methods, PCIT International Certified Trainers engage in teaching a common set of essential elements. Modalities of trainings may also differ by the certification level of the trainer. Specifically, there are three levels of trainership defined by PCIT International (see Fig. 18.3):

1. *Level I Trainers* are designated as within program or within agency trainers at their physical site and may train providers to become PCIT Therapists.
2. *Level II Trainers* are qualified as regional (typically defined as a state) trainers who may teach and oversee therapists who reside within the trainer's region, as well as train Certified Therapists to become Level I Trainers.
3. *Master Trainers* are vetted as international trainers who may train providers to become PCIT Therapists, Level I Trainers, or Level II Trainers.

18.2.2 Prerequisite Education

Since PCIT is deemed a mental health therapy, potential trainees are required to possess a master's degree or higher in a mental health field. This includes Board Certified Behavior Analysts (BCBAs) at the master's level. In turn, as PCIT is implemented worldwide, international equivalents of a master's degree or higher in a mental health field are welcomed. Practitioners must also maintain an independent license as a mental health service provider or function under the supervision of a licensed mental health provider. As a standard of comparison, those who are eligible to bill services as "psychotherapy" often meet the educational and licensure requirements to practice PCIT. As an inclusive measure for psychology students in training, students may begin their PCIT training early in their graduate careers, but must complete their master's degree or third year of doctoral training before becoming eligible to apply for PCIT Therapist certification. When conducting PCIT under student status, the individual must perform their clinical work under the supervision of a licensed mental health service provider.

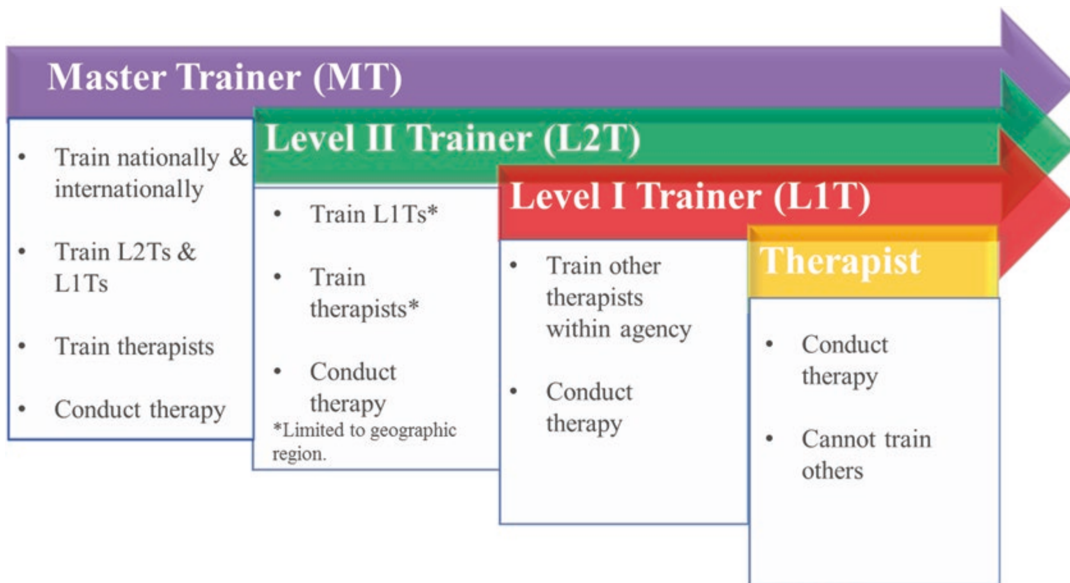

Fig. 18.3 Levels of PCIT certification

18.2.3 Initial Training

To begin training, potential PCIT Therapists must complete a minimum of 40 h of face-to-face training with a Certified PCIT Trainer. A portion of the face-to-face time may be conducted via online or video training. The initial training incorporates discussion of the theoretical underpinnings of PCIT, review of the current PCIT protocol, practice in a specified coding system (Dyadic Parent-Child Interaction Coding System; DPICS; Eyberg, Chase, Fernandez, & Nelson, 2014), observation of cases, and exercises in coaching. For those receiving face-to-face training from Level I Trainers within their agency, a mentorship model of training is used with the Level I Trainer completing a minimum of 20 h of face-to-face training in co-therapy and/or live supervision with the trainee. Thus, training accrued in a mentorship model contributes to the overall minimum 40 h of face-to-face time.

18.2.4 Continuation Training

Potential PCIT Therapists must also undergo a period of case consultation with a Certified PCIT Trainer covering complex treatment issues. During this time, the trainee actively implements PCIT with clients, practices DPICS coding, and builds coaching skills. Continuation training lasts approximately 1 year in which the trainee may be involved in an amalgamation of workshops, online training, and/or activities within a mentorship model. This phase of training must include skill review, case experience, and ongoing assessment of therapist competencies. When training under a Level II Trainer or Master Trainer, trainees attend at least twice monthly consultation. Consultation is typically conducted via phone or web conference and may be delivered in an individual or small group format. For those working with a Level I Trainer, consultation occurs within the mentorship model until therapist competencies are met; thereafter, trainees attend at least

twice monthly consultation until training case requirements are met.

While select competencies are assessed during the initial face-to-face training, to determine competency in applied skill, a Certified PCIT Trainer observes video recordings or live sessions conducted by therapists. Competencies evaluated include assessment skills (i.e., appropriately using the ECBI, administering the DPICS, and achieving coding reliability), CDI-related therapist skills (i.e., performing the CDI Teach session with integrity, meeting the CDI Mastery criteria, and using DPICS to set CDI coaching goals), PDI-related therapist skills (i.e., conducting the PDI Teach session with integrity, and managing initial and advanced PDI coach sessions), and general coaching skills (i.e., exhibit "adequate and sensitive" coaching, model CDI skills in interactions with caregivers and children). As a capstone to continuation training, trainees must complete at least two (2) cases to PCIT graduation criteria while under consultation with a Certified PCIT Therapist.

18.2.5 Recommendations from the Field

Before embarking on PCIT training, it is highly recommended that providers consider the fit of their general clinical practice to PCIT implementation. Potential PCIT trainees should consider the resources necessary to conduct sessions (e.g., money to fund technology, space for therapeutic facilities; refer to Chap. 13 in this handbook), as well as the agency's tolerance for treating children who may become highly destructive and loud during sessions. While a seasoned PCIT Therapist may endure long sequences of ignoring a screaming child, the therapist's professional neighbor may be less inclined. Additionally, while experimental approaches exist for children in younger and older age ranges, the primary application of PCIT as an empirically supported treatment is for children between the ages of 2–6 years, 11 months (Eyberg & Funderburk, 2011, p. 7). Importantly, agencies should have a

Table 18.1 Recommended PCIT training readiness assessment

Considerations for general PCIT training
1. I receive adequate referrals for children between 2 years and 6 years, 11 months with primary or secondary disruptive behavior problems to support an ongoing caseload of four to six PCIT clients for the upcoming year.
2. I agree to use the ECBI at every session (average 16–20 sessions) for each client throughout the course of therapy.
3. I agree to use the current DPICS during each session to ascertain treatment progress and coaching goals.
4. I have an installed audiovisual system that allows me to observe caregiver-child interactions from a separate room.
5. I have a reliable bug-in-the-ear device that allows me to discretely coach the caregiver.
6. I have 6–10 toys appropriate for children between the ages of 2 years and 6 years, 11 months that are consistent with PCIT requirements.
7. I am aware PCIT uses a specified time-out procedure and am willing to follow the step-by-step protocol.
8. I have the necessary space to safely and appropriately implement the time-out backup as indicated by the current PCIT protocol.
9. I have the video and audio equipment necessary to produce recordings of sessions (including audio and video of the caregiver-child, as well as audio of the coach) for review by a Certified PCIT Trainer.
10. I have consulted with my compliance office regarding procedures necessary to release video recordings of client sessions to my Certified PCIT Trainer for the purposes of training.
11. If training with a Level II Trainer or Master Trainer: I have administrative support and the necessary technology (e.g., phone, tablet, computer with web camera) to attend a minimum of twice monthly consultation (or more, if prescribed by my trainer) via phone or web conference.
If training with a Level I Trainer: I have administrative support to engage in a mentorship model for a minimum of 20 h of face-to-face time. Upon completion of my therapist competencies, I am available to attend a minimum of twice monthly consultation until case requirements are met.
12. I have identified common barriers to treatment participation within the population I serve. I have planned accordingly to provide supports around these issues to decrease the likelihood of attrition (e.g., providing transportation vouchers, child care, appointment reminders).

plan for recruiting families of children with externalizing behavior problems within this age range if a referral flow is not established. Questions to assist therapists in determining their professional and agency readiness for PCIT are presented in Table 18.1.

18.3 ASD Training Recommendations

18.3.1 Understanding the Assessment and Diagnosis of ASD

While the reader is referred to earlier chapters in Part I of this handbook regarding the specific diagnostic criteria and assessment methods for autism spectrum disorder (ASD), it is worth revisiting the need to develop a clinical sense and familiarity for the symptom clusters that uniquely define ASD, as well as the methods that constitute adequate ASD assessment. When working with children with ASD, therapists should consider the source and methods used for determining the child's ASD diagnosis.

Possible questions the therapist should ask include:

- What is the professional background of the provider who assigned the diagnosis of ASD?
- Were multiple disciplines involved in determining the diagnosis?
- What standardized ASD assessment measures were used?
- Did the ASD evaluation include "gold standard" measures, such as the *Autism Diagnostic Observation Schedule* (Lord et al., 2012) or the *Autism Diagnostic Interview—Revised* (Rutter, LeCouteur, & Lord, 2008)?
- Were assessment methods multi-modal (e.g., clinical interview, rating scales, clinical observation, direct test administration) and comprehensive across developmental spheres (e.g., cognitive, speech/language, adaptive, socioemotional, and motor skills)?
- Were other diagnoses considered and ruled-out?

Although the *Diagnostic and Statistical Manual of Mental Disorders—fifth edition* (DSM-5; American Psychiatric Association, 2013) subsumes communication within the social communication/interaction domain (Criterion A), prominent ASD assessments—such as the *Autism Diagnostic Observation Schedule*—categorically separate social affective characteristics from communication skills for evaluative purposes. From a symptoms-level perspective, therefore, ASD is not merely a social disorder, rather it is a unique combination of deficits in social affective, communication, and restricted/repetitive behaviors. Thus, each cluster of symptoms and the presence or absence of symptom overlap with other domains should be considered during differential diagnosis to determine the categorization that most accurately represents the child's presenting concerns. Referrals for an ASD rule-out assessment often describe a child who is socially awkward, who becomes irritated with peers who do not follow the child's prescribed rules or rituals, and who demonstrates variable eye contact. While these symptoms are consistent with those of ASD, they may also indicate signs of other disorders (e.g., an obsessive-compulsive disorder, possible social anxiety presentation), which underscores the importance of a careful evaluation. Other children may instead be referred for difficulties with social communication without accompanying restricted interests. Further, some children may present with language delays combined with hand-flapping and repetitive play without apparent restrictions in social affect or interaction, which is often found in children with cognitive or developmental delays.

As these differential diagnosis considerations illustrate, it is imperative those working with the ASD population recognize the unique overlay of social, communicative, and repetitive behavior symptoms that specify an ASD diagnosis. Figure 18.4 depicts one possible conceptualization of various symptoms contributing to an ASD diagnosis, as well as similar symptom clusters representing other conceivable diagnostic categories. This visual highlights how therapists working with the ASD population should be

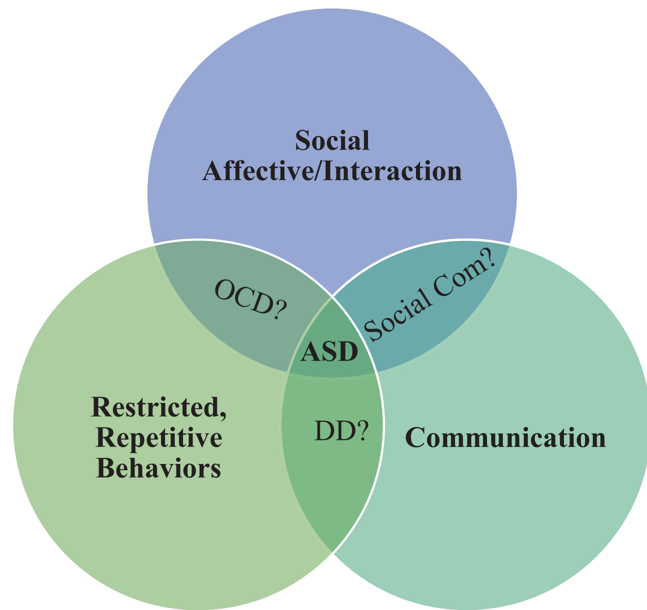

Fig. 18.4 Conceptual example of ASD symptoms and differential diagnosis. *DD* developmental delay, *OCD* obsessive compulsive disorder, *Social Com* social communication disorder

professionally comfortable comparing and contrasting differential diagnoses that share the intersecting features similar to ASD.

18.3.2 Connecting with Professional and Family Resources for ASD

Therapists who work with children with ASD quickly recognize the value of the ASD community, both in terms of family and professional resources. As a practitioner who is interested in using PCIT with the ASD population, it is wise to familiarize oneself with ASD professionals working in the community and region. Because ASD mental and medical health is often considered a specialty area and such professionals may be scarce in rural areas, children often travel to larger medical centers to receive a formal diagnosis. Since coordination of care is often key to the successful treatment and support of an ASD diagnosis, PCIT Therapists will benefit from identifying the spheres of professional influence around them, creating partnerships and collaborative consultation models with area ASD professionals. Researching and creating a list of evidence-based providers in a practitioner's particular location not only provides caregivers with quick connections to additional supports (if needed), but also develops a referral network for the therapist's PCIT practice. Reputable ASD organizations at the national level, including Autism Speaks and the toolkits provided by the Autism Treatment Network, may also provide valuable clinical and family resources.

18.3.3 Possible Mechanisms for ASD-Specific Training

When committing to work with children on the autism spectrum, it is imperative to develop a strong background in the understanding and application of behavioral theory. At basic levels, a clear comprehension of classical conditioning, and, more importantly, operant conditioning, is critical to working with children with ASD. Because PCIT is strongly rooted in behavioral theory, PCIT-trained therapists may naturally take to the extension of PCIT to ASD populations. For those with less behavioral background, determining the antecedent, trigger, or reason for particular behaviors demonstrated by a child with ASD may be more difficult. In particular, therapists should grasp the basic concepts of functional behavioral assessment. A fundamental

working model suggests behaviors are initiated for a reason and in response to discernible events, behaviors are strengthened or weakened by their consequences, behaviors are a form of communicating needs, and perceived misbehavior may be adaptive within particular circumstances. Thus, to decrease undesired behaviors, the therapist must aptly identify target behaviors, the purpose for the behaviors, and the mechanism maintaining the behaviors. Logically, the additional overlay in skillset and training of a BCBA, behavioral specialist, or applied behavior analysist background may nicely compliment an eligible PCIT Therapist's work with the ASD population.

If considering professional training in ASD, undergraduate or graduate students should seek opportunities early in their educational training, when possible. Students are encouraged to strategically develop foundational skills with coursework in child development, psychopathology, and assessment, as well as specific study in developmental disabilities and behavioral approaches. Also pursuing practica, internships, and fellowships focused on developmental disabilities and ASD will build the strong clinical sense necessary to work with the often complex presentation of ASD. Respected national programs dedicated to education, research, and service in developmental disabilities include Leadership Education in Neurodevelopmental and Related Disabilities (LEND), University Centers for Excellence in Developmental Disabilities (UCEDDs), Intellectual and Developmental Disability Research Centers (IDDRCs), and Association of University Centers on Disabilities (AUCDs).

For providers established in their careers who are interested in further education regarding the ASD population and related areas, several professional education outlets exist. First, seek local, regional, and web-based continuing education programming focused on ASD and developmental disability topics. Second, collaborate with local hospitals, attend public grand rounds, or pursue professional presentations focused on specialty topics. Third, consider course offerings and graduate certificates in ASD-related curriculum from accredited colleges or universities. Fourth, research the possibility of training in ASD-specific batteries or evaluative methods. Lastly, identify self-guided training opportunities, including publications and online resources from nationally recognized organizations on ASD, such as the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the Autism Centers of Excellence (ACE) Program, and Autism Speaks/Autism Treatment Network professional toolkits.

18.3.4 Consideration for Specified PCIT-ASD Training Requirements

At the time of this publication, PCIT International did not have established or endorsed training requirements specific to PCIT-ASD. Experienced PCIT trainers who also work with children with ASD find it beneficial for beginning PCIT practitioners to first meet therapist competencies with an understanding of basic PCIT implementation (i.e., within intended age range, with "classic" clinical presentation of disruptive behaviors). Once these foundational skills are developed and a therapeutic framework is set for working with children with "neurotypical" (non-ASD) development, PCIT Therapists should consider seeking additional training and consultation with a Certified PCIT Trainer before making adaptations to protocol or before applying PCIT to novel populations (see Table 18.2). Likewise, therapists who may be skilled in using PCIT with the general population but who are newly embarking on implementing PCIT with the ASD population should consider consultation specific to applying PCIT to children with ASD. Moreover, as PCIT with the ASD population evolves, interested practitioners are encouraged to attend updated research presentations and clinical workshops offered by expert trainers at PCIT regional and international conventions, as well as hosted by centers of PCIT-ASD expertise.

In summary, when considering competency in implementing PCIT with the ASD population, therapists are recommended to develop a solid

Table 18.2 Recommended PCIT training readiness assessment—ASD supplement

Considerations for applying PCIT to the ASD population
1. I have training and experience in diagnosing children with ASD.
2. I have training and experience working therapeutically with children with ASD.
3. I have a solid background in behavioral theory, including foundations in functional behavioral analysis and an understanding of operant conditioning (e.g., reinforcement and punishment).
4. I am aware of local and/or national advocacy and supports for children with ASD.
5. I understand that treating children with ASD, a population that presents with a true spectrum of symptomatology, may require additional training and consultation from a Certified PCIT Trainer.

Notes. *ASD* autism spectrum disorder, *DPICS* Dyadic Parent-Child Interaction Coding System, *ECBI* Eyberg Child Behavior Inventory, *PCIT* Parent-Child Interaction Therapy

understanding of behavioral and interactional theories impacting the caregiver-child dynamic. Interested practitioners should assess their eligibility in meeting the prerequisite education requirements and ascertain their practice readiness or “fit” for PCIT before seeking formal PCIT training from a Certified PCIT Trainer to achieve competency in the core components of the intervention. Clinical experience suggests it is beneficial for PCIT Therapists to first conduct the therapy with the primarily disruptive behavior population before embarking on PCIT practice with the ASD population. Additionally, familiarity with ASD assessment, diagnosis, and professional and family resources further bolsters a therapist’s PCIT-ASD work. Where identified gaps in clinical knowledge, experience, or skill exist, it may be beneficial to seek additional training and consultation to sustain PCIT implementation with the ASD population.

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