Training and Supervision Around the World

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Abstract

Increasingly, evidence supports the utility of using parent–child interaction therapy (PCIT) to address childhood disorders in a number of populations. To increase the reach of PCIT to a greater number of families and insure the faithful application of PCIT with clients, effective dissemination efforts must also be investigated. This chapter describes the PCIT International training model and investigates the extant international research on PCIT training and supervision. Attention is paid to how training and training materials have been adapted for audiences outside the United States, although many studies have not fully described the training process used. The chapter also attempts to translate the current research findings into specific guidance in how trainers can address organizational (e.g., lack of agency support) and trainee (e.g., aversion to manualized treatments) barriers and increase trainee fidelity to the PCIT model. For example, it may be useful for trainers to have open discussions of trainees' personal views of the treatment, provide information on how PCIT can be applied to meet the unique needs of each family, work extensively with agency administrators to prepare the organization for implementing PCIT, and continue to follow-up on these issues throughout the supervision process. The chapter also describes how components of the PCIT model, such as an emphasis on in vivo practice and feedback and the integration of assessment, can be applied to the training process. Finally, a case scenario is provided to explicate how these suggestions can be used to meet the needs of specific trainees.

Parent–child interaction therapy (PCIT) is an adaptive treatment—both for individual clients and larger cultural groups—with the potential to improve the functioning of a multitude of children and families in need. While behaviorally based treatments in general are shown to yield greater improvements in child externalizing behavior than other types of child interventions (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013), PCIT in particular has some unique attributes that heighten its therapeutic potential. Specifically, a meta-analysis of 77 parent trainings by Kaminski, Valle, Filene, and Boyle (2008) indicated that treatments which included coaching with the parent's own child in session yielded larger effect

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sizes. In fact, a number of the components of PCIT were found in the Kaminski et al. (2008) meta-analysis to be related to larger effect sizes. These included promoting positive parent–child interactions, focusing on consistent parental responding, and the use of time-out as a discipline procedure. This may explain why another recent meta-analysis investigating both PCIT and Triple P (Positive Parenting Program, another widely used parent training for difficult child behavior) found that PCIT generally had large effect sizes on child behavior while Triple P generally resulted in moderate effect sizes (Rae & Zimmer-Gembeck, 2007). It is therefore not surprising that PCIT across studies results in decreases in child externalizing behavior, parenting stress (Thomas & Zimmer-Gembeck, 2012) and the potential for harsh or abusive parenting (Thomas & Zimmer-Gembeck, 2011), while also resulting in increases in positive parenting skills (Rae & Zimmer-Gembeck, 2007).

With the development of evidence-based treatments (EBTs) the need for empirically supported dissemination models are also needed to ensure that effective care reaches families experiencing dysfunction (Ruzek & Rosen, 2009; Southam-gerow, Marder, & Austin, 2008). While it is encouraging that PCIT and other evidence-based treatments exist that have the potential to positively impact the lives of children and families, such treatments will have limited impact if effective methods of dissemination are not in place to spread them more broadly (Fixsen, Naoom, Blase, Friedman, Wallace, 2005). In fact, despite the existence of evidence-based treatments for child externalizing behavior, coded recordings of actual treatment sessions within community-based clinics indicate that utilization of evidence-based techniques is quite low (Haine-Schlagel, Fettes, Garcia, Brookman-Frazee, & Garland, 2014), indicating a gap between best practices and what is actually being done in real-world settings. Pearl et al. (2012) note that few graduate students receive extensive, if any, training and mentorship in PCIT, despite the fact that it "has some of the strongest evidence for improving disruptive behaviors and parent–child relationships" (p. 212).

PCIT requires adept, in-the-moment application of theory and techniques during situations that may be stressful for both the caregiver and therapist (e.g., a child tantrum). This is compounded by the fact that many therapists will have no previous experience with in-vivo coaching, one of the cornerstone attributes of PCIT. For therapists to develop this skillset, they will require both extensive training and sufficient supervision to support the application of PCIT with initial clients. These tasks are paramount to the goal of increasing the reach of PCIT to those who need it. The purpose of this chapter is, therefore, to summarize the current state of the research on both EBT training and supervision in general and PCIT training specifically and discuss the implications of such research on the process of PCIT dissemination.

Training and Supervision Research

Unfortunately, very few studies have specifically focused on PCIT therapist training outcomes. However, the research on EBT trainings in general can still be informative, and are included here. Overall, the main goals of PCIT training and supervision include not only teaching skills necessary to conduct PCIT but also ensuring trainees can overcome barriers to implementing the treatment with fidelity with appropriate families. A strong training program is essential to meeting these goals, as research suggests that, although studying the PCIT manual itself is helpful, it is not enough for trainees to develop adequate PCIT competency (Herschell et al., 2009). Furthermore, Beveridge et al. (2015) have stressed that, beyond covering the specific components of PCIT, training also needs to address therapist and agency barriers (see below) to successful PCIT utilization, while Christian, Niec, Acevedo-Polakovich, and Kassab (2014) wrote that "the lack of effective communication [with agencies], agency readiness, as well as clinician factors, create[s] or maintain[s] barriers to completing [PCIT] training" (p. 15).

Although the research literature has not adequately delineated what trainee attributes (e.g., education level, clinical experience, caseload)

predict more successful training outcomes—and in many cases studies do not fully describe these characteristics in the training sample (Beveridge et al., 2015)—some trainee barriers are notable. While a recent survey found generally favorable views towards manualized treatments in child advocacy center workers (Staudt & Williams-Hayes, 2011), not all therapists (and thus not all trainees) will enter trainings with high levels of confidence in manualized, evidence-based treatments such as PCIT. Clinicians with more years of experience tend to have more negative attitudes towards manualized treatments (Barry et al., 2008; Becker, Smith, & Jensen-Doss, 2013), which may reflect shifting attitudes towards EBTs in treatment programs over time. Shafran et al. (2009) note that clinician attitudes which may be barriers to the dissemination of evidence-based practice include the belief that research studies do not sufficiently relate to the characteristics of actual clinical practice, that therapist attributes are more important to treatment outcomes than specific treatments, or that choosing specific components of treatments to match client needs is more valuable than following specific protocols. Clinicians may also incorrectly believe that comorbidity reduces the effectiveness of evidence-based protocols (Shafran et al., 2009). For PCIT specifically, trainees have described certain components of the PCIT protocol (e.g., the mastery criteria) as barriers to implement PCIT in their practice; in this same study, clinicians who dropped out of training or failed to meet mastery criteria were less likely to report positive views of core PCIT components such as coaching, mastery criteria, CDI and PDI teaching sessions, and co-therapy (Christian et al., 2014).

Conversely, clinicians with a cognitive-behavioral theoretical orientation tend to view EBTs more favorably (Gray, Elhai, & Schmidt, 2007) with a recent national survey of 756 clinicians indicating that those with a cognitive-behavioral orientation were the most frequent users of treatment manuals (Becker et al., 2013). Southam-Gerow et al. (2008) note the trainees will represent a number of fields and training programs with "different core beliefs about the etiology and maintenance of mental health problems as well as the best ways to treat clients" (p. 462). As such, PCIT trainees may have little experience with behavioral theories and techniques that form the basis of this treatment, or may even disagree about the utility of behavioral techniques. However, one study of PCIT training showed improvements in trainee skill, but theoretical orientation was not a significant predictor of skill acquisition (Herschell et al., 2009). Another study related to EBTs for trauma found that disbelief in the effectiveness of the treatment reduced from 20% to 0% following training, and the belief that the treatment did not fit within trainees' theoretical models dropped from 29% to 6% (Couineau & Forbes, 2011). Trainings therefore offer an important opportunity to reduce therapist barriers to implementing EBTs.

Thus, trainees who believe that empirically supported treatments are rigid and reductionistic may be less likely to utilize the PCIT protocol with fidelity. Untested alterations to the protocol could at best dampen the therapeutic effects of treatment and at worse lead iatrogenic exacerbation of symptoms. Kendall and Beidas (2007) propose a *flexibility within fidelity* model to address the concerns of such clinicians. This model suggests that the prescribed components of a given intervention can be applied to meet the individual needs of each client without impacting treatment fidelity. The PCIT manual specifies that most PCIT sessions involve in vivo coaching of the parent through interactions with the child, but the content of coaching can (and should) be tailored to the unique needs of the child and family (Eyberg & Funderburk, 2011). The PCIT protocol ensures that clinicians are aware of the specific strengths and needs of each family through the use of comprehensive assessment. Furthermore, while the 5-min observation period at the beginning of each observation session guides clinicians in which skills to coach, the application of those skills can be artfully applied to the needs of each family. An effective trainer can highlight the numerous ways in which PCIT is more than "a cookbook." For example, if a parent reports that her child is aggressive or plays roughly, coaching can help the parent attend to

gentle behavior. The trainer can highlight how the ECBI, in addition to being a useful indicator of treatment progress, can be used each week to identify specific areas that can be focused on each session (e.g., identifying which items are rated as occurring frequently and being seen as problems by caregivers). Specific discussions of how various problem areas and other unique needs of clients can be focused on in coaching can be an impactful part of training.

Recently trained community PCIT therapists also tend to have higher fidelity to the relatively straightforward teaching sessions than the coaching sessions, and more commonly fail to collect and review homework, discuss treatment progress/ECBI scores, and provide post-coaching feedback (Travis & Brestan-Knight, 2013). Whether these procedural omissions are due to the complexity of coaching sessions or due to therapists' personal views about these aspects of treatment, they represent a missed opportunity to provide clients with helpful feedback. This further highlights the need to stress these components in training, which may be achieved by framing them in a way that "makes sense" to trainees. For example, post-coaching feedback is an opportunity not only to help clients improve their skills but also to provide validation and to help clients plan on how to apply the skills to the unique needs of their families after they leave the therapy office.

In addition to framing the treatment in ways that make sense to trainees, open discussion is another away to deal with trainee-level barriers. Trainees may feel reluctant to bring up concerns or to say that they disagree with components of the program—and, actually, trainers may be uncomfortable having these conversations. However, it is always preferable for trainees to speak about their concerns than to leave them unaddressed, potentially increasing the likelihood that trainees leave out key components of the treatment when working with their own clients. Trainers can facilitate this process by frequently inviting questions or comments. Simply asking, "Any questions?" and allowing only a few moments before moving on to the next topic will not be sufficient. Trainers should be sure to ask for responses from each trainee throughout the course of training. Asking neutral, open-ended questions such as "How is this similar to your usual way of working with families? How is it different?"; "What concerns do you have?"; or "what barriers might you foresee coming up when using PCIT with your typical client?" may be more helpful in facilitating a conversation. To validate concerns and model that it is okay to talk about them, statements such as, "some therapists wonder how manualized treatments such as PCIT can be used to meet the unique needs of clients, so we want to be sure that we talk about those concerns and answer any questions you have," can be helpful. Because some trainees may tend to over-exclude potential clients (i.e., believing that certain client attributes make the client "not right" for PCIT), questions such as, "are there any clients who you might be unsure of how to use PCIT with?" can provide an opportunity to assuage such concerns. Trainers can also show respect for the views and expertise of trainees by inviting them to help address the questions and concerns of colleagues. For instance, if a trainee brings up potential barriers to implementing PCIT with the types of clients they see, it is useful for the trainer to ask the group to help problem solve. Trainers may also ask questions such as "how might you all use the PCIT skills to address [insert particular client problem]."

Although providing empirical evidence of PCIT's effectiveness and having discussions may be useful, therapists with negative views towards manualized treatments tend to value clinical experience over research results (Staudt & Williams-Hayes, 2011). For this reason, it is helpful to illustrate the fidelity of treatment through actual case examples and incorporate practice with actual children into the training process. As is discussed below, these components are built into the standardized training process. In past trainings, we have selected families who have successfully completed PCIT who would be willing to serve as volunteers during trainings. While trainees will get to practice their coaching skills with these families, it is also helpful to have a very brief discussion with the caregivers beforehand about what their experiences were

going through PCIT and the impact PCIT had on the family. A common response is that treatment was a lot of work, but ultimately lead to a lot of positive, necessary change for the family. Prior to the practice coaching, it may also be helpful to discuss if there are any behaviors the caregiver wants to focus on in coaching. Briefly strategizing with trainees about how to work on the given behavior is another chance to model how PCIT can be adapted to meet specific family needs. During the practice coaching itself, the positive influence of the PCIT skills can also be highlighted by pointing out to trainees (and having trainees point out to the parent being coached) how the use of skills are impacting the child's behavior—"you had his mom praise him for sharing and now he is sharing a lot more things with her!"

In addition to trainee attributes, the social and work climate of trainees are also relevant to the training process, as research indicates that providers with colleagues who use EBTs, who perceived that the treatment program was supported by workplace administrators, or had opportunities for EBT trainings were more likely use EBTs themselves (Bride, Kintzle, Abraham, & Roman, 2012; Cunningham et al., 2012). Some research indicates that organizational factors may even outweigh helpers' personal views in predicting the utilization of EBTs following training (Segre, McCabe, Stasik, O'Hara, & Arndt, 2012). One qualitative study of PCIT training outcomes found that lack of agency support (e.g., reluctance to follow a co-therapy model, inadequate provision of resources towards necessary equipment) was a notable barrier to clinicians' implementation of PCIT following training (Christian et al., 2014). Institutional barriers may also include lack of technical support, too few appropriate referrals, and too little time for therapists to prepare for sessions (Beveridge et al., 2015). PCIT trainers can help to mitigate this barrier by working collaboratively with agencies, even prior to the beginning of training, insuring they are prepared to implement PCIT and able to support newly trained therapists (Beveridge et al., 2015). Organizations may also benefit from advice regarding the selection of candidates for training. In a qualitative study of the barriers to training faced by PCIT trainees, all the clinicians who ended training unsuccessfully were those who had participated in the training involuntarily (Christian et al., 2014). Trainers can also incorporate discussions of possible agency barriers within the training process, such as discussing how to set up PCIT-appropriate treatment rooms at the agency, which trainees might have overlapping availability for co-therapy, which recent intakes might be appropriate for PCIT, and how to appropriately select time-out spaces within the agency specifically.

Finally, while the length of training may present a barrier to dissemination, it is important to note that short trainings are unlikely to sufficiently prepare clinicians for skillful practice of PCIT. Perhaps the most rigorous study specifically focused on PCIT training outcomes was conducted by Herschell et al. (2009), who examined two training formats—simple didactic versus an experiential group involving role-plays and additional, personalized feedback—both of which were part of a 2-day training. Trainee skill was assessed through both direct observation of coaching and knowledge-based quizzes, with only 5% of trainees meeting the study's criteria for mastery in all domains assessed. Furthermore, the highest percentage reaching mastery in any one domain was 31%. This suggests that, regardless of format, greater than 2 days of training may be necessary. Furthermore, in one quasi-experimental study, agencies that received more intensive training including discussion, demonstrations, and behavioral rehearsal were more likely to make changes to their work with families than agencies who received only didactic training (Dixon et al., 1999). At the same time, agencies may not have the resources or staffing to send a large number of trainees to long trainings. The PCIT international model discussed later in the chapter requires 40-h of training with a certified trainer. However, some trainers choose to mitigate the time commitment by splitting the training, such as having an initial 3-day workshop focused on CDI skills and 2-day training later focused on PDI skills. For agencies who already have certified PCIT therapists, it may be

financially more feasible to determine if one of their current therapists could complete additional training to become a Level 1 trainer (i.e., a person capable of training other therapists within the agency) to help sustain the program over time.

Unfortunately, dissemination research has often found that training alone does not lead to sufficient changes in trainee behavior or implementation of evidence-based practices, despite increases in trainee knowledge and skill (see Fixsen et al., 2005, for a review). Furthermore, the skills of new PCIT trainees are unlikely to be commensurate with the skills of more advanced practitioners (Herschell et al., 2009), and additional skill shaping and encouragement will be necessary. Despite the best efforts of agencies, trainees, and trainers, barriers to implementation of PCIT will also often arise following training. These may include difficulties identifying appropriate cases, inadequate spaces for conducting PCIT, and technical issues with equipment. For these reasons, continuing supervision and consultation is necessary for newly trained PCIT therapists. Unfortunately, there is little data on PCIT supervision and consultation, as they have rarely been examined separately from the training itself.

Multiple models of therapy supervision in general have been proposed. For example, Watkins and Scaturo (2013) proposed a model of supervision focusing on three components: an emotional/relational component (forming an alliance with the supervisee and providing moral support for the emotions that can arise from work with patients), a cognitive component (providing education, feedback, case conceptualization, and correcting supervisee cognitive biases) and a behavioral component (practicing skills). However, there are numerous other models, including Falender et al.'s (2004) supervision competencies framework focusing on knowledge (e.g., knowing about the specific area or type of therapy in which one supervises), skills (e.g., the ability to teach the necessary techniques of a given therapy) and values (e.g., accepting responsibility for both client and trainee outcomes). Despite the plethora of supervision models, there is a notable dearth of empirical investigation into supervision outcomes (Falender, 2014). Thus, the suggestions below represent what can be gleaned from the current research base.

One role of supervisor is to provide support to new PCIT therapists, as implementing a new treatment is often stressful, and can lead trainees to doubt their ability to administer the treatment or the treatment's ability to help clients. In one study of a state-wide PCIT dissemination effort, 58.3% of trainees responding to an online survey reported that PCIT was moderately or very different from their usual treatment of child behavior problems (Beveridge et al., 2015). Furthermore, PCIT might bring added distress above what is typically encountered in traditional talk therapy, as therapists often need to react quickly and efficiently to escalated child behavior in session. While we suggest that providing supportive consultation is helpful for trainees to overcome these stressors, over-focus on emotional support can be detrimental. A study by Schoenwald, Sheidow, and Letourneau (2004) examined the impact of different consultation styles following therapist trainings in multisystemic therapy (MST)—another evidence-based treatment for child behavior problems. The clinical trainees rated their consultants in terms of how much support was provided (e.g., feeling that the consultant listened to them and gave positive feedback) and how much instrumental guidance was provided (e.g., by giving specific advice on applying MST principles to specific cases). Results indicated that there was a negative correlation between amount of support provided by consultants and both child outcomes and therapist fidelity to the MST model, while the opposite was true for instrumental guidance. Thus, PCIT consultants need to balance their support giving with specific practical guidance; it is also possible that practical guidance itself can help trainees feel more prepared for session and vicariously reduce distress.

It is also notable that client attrition tends to be higher for new PCIT trainees than is typically reported in controlled PCIT studies (Pearl et al., 2012). Although this is not necessarily atypical given that treatment clients may have more difficulties than those in research studies and are,

unlike research participants, not paid, a qualitative study with PCIT suggested that covering additional topics such as client engagement and motivation may also be useful for trainees (Christian et al., 2014). While this can be covered in training itself, issues of client engagement will often come to the forefront of continuing supervision as clinicians begin their work with new clients. Although beyond the scope of this chapter, trainers and supervisors need to be familiar with motivational techniques and literature. Supervisors can guide new PCIT therapists to increase engagement in several ways beyond additional motivation techniques as well. For example, clients who routinely neglect to bring in their homework forms can be instructed to fill out forms at the beginning of each session anyway. This models the importance of the forms for clients and shows that leaving their form at home will not let them "get out of it." Supervisors can also suggest that the trainee link homework completion with child outcomes by comparing weekly homework completion with client's ECBI graphs.

The PCIT International Training Model

As with any evidence-based treatment, effective training requires standardized procedures to ensure quality and consistent outcomes. As dissemination experts assert, "… systematic implementation practices are essential to any national attempt to use the products of science – such as evidence-based programs – to improve the lives of its citizens" (Fixsen et al., 2005, p. vi). Thus, it is not surprising that PCIT International, an organization which promotes PCIT practice and research and oversees PCIT certification, has developed a specific training system to promote fidelity in the dissemination of PCIT. The model also encompasses a tiered certification system for PCIT trainers including Level 1 Trainers (individuals certified to train other therapists within their own agencies), Level 2 Trainers (individuals certified to train other therapists within their own region) and Master Trainers (individuals certified to train nationally or internationally). This chapter focuses on the initial PCIT therapist training, but additional information on trainer training can be found at www.pcit.org.

In their extensive review of the dissemination and implementation literature, Fixsen et al. (2005) noted that, while "the content of [EBT trainings] will vary considerably depending on the evidence based practice or program … [t]he methods of training seem less variable." (p. 39). Specifically, typical training components include lecture/didactic instruction, live or video demonstrations, role-plays and behavioral rehearsal, and personalized feedback. PCIT International (2013) incorporates each of these elements into the initial 40-h PCIT training, which can be completely face-to-face or as a 10-h online training with 30-h of follow-up face-to-face training. The training should cover "an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol" (PCIT International, 2013, p. 2). An additional minimum of 1 year of consultation and supervision or co-therapy with a trainer is also required, during which time the trainee must complete two PCIT cases to graduation, at least one of those as the primary therapist. The trainer must also observe specific sessions conducted by the trainee throughout the course of PCIT.

In accordance with the PCIT model's emphasis on progress monitoring and calls by authors to integrate assessment into the EBT training process (e.g., McHugh & Barlow, 2010), PCIT training must also include several specific assessment procedures. For example, by the completion of training, the trainee must be able to meet the same CDI criteria as caregivers are required to meet to complete the CDI phase (ten each of labeled praises, behavior descriptions, and reflections and no more than three negative talks, questions, or commands) during a 5-min interaction with an actual child or during a 5-min standardized role-play. They must also display at least 80% agreement on the DPICS-IV with their trainer during a 5-min observation or a standard video recording. Though not a formal part of

trainee evaluation, we also recommend that trainees are asked to complete an inventory related to their opinions of EBTs and their knowledge of behavioral techniques, as such information may be informative to the trainer.

While additional research into the effectiveness of the PCIT international model is necessary, following the 40-h PCIT training clinicians in community settings displayed high levels of fidelity to the protocol, and fidelity levels were similar across both phases of treatment (Travis & Brestan-Knight, 2013). Similarly, although not investigating specific therapist-level outcomes, Pearl et al. (2012) found significant pre-to-post-treatment symptom and parental behavior improvement even within the initial PCIT clients of new trainees who attended five days of training (three initially and another two several weeks later). However, in a study of 143 trainees, only a quarter of participants completed all training requirements needed to become certified PCIT therapists for various reasons (Beveridge et al., 2015), indicating that some additional components related to reducing barriers or trainee motivation and retention may be helpful.

Training and Supervision Abroad

While recent years have seen increased efforts to disseminate PCIT globally (see chapter "Tailoring PCIT for Latino/a Families"), few studies have examined cultural adaptations of PCIT using rigorous research designs and even fewer studies specifically investigated dissemination and implementation (Baumann et al., 2015). Specifically, the international implementation of PCIT has increased over the past decade (see Gardner, Montgomery, & Knerr, 2016), yet relatively little is known about the therapists' training process abroad. The PCIT International website (www.pcit.org) provides descriptions of PCIT trainings across nine countries outside of the United States (Australia, Germany, Hong Kong-China, Japan, The Netherlands, New Zealand, Norway, South Korea, and Taiwan). Overall, international training has consisted of a "first generation" of therapists from each country undergoing an initial 5-day training and a subsequent advanced training (in the United States or in their home-country) provided by a PCIT expert/master trainer. Therapists have then received subsequent training on how to become "in-house" PCIT trainers, which has been followed up by site-visits by PCIT experts to ensure that the "second generation" of therapists are receiving the same quality training. Therapists have received ongoing consultation and supervision provided by PCIT experts/master trainers, and in some cases, the original therapist(s) have co-facilitated advanced PCIT trainings, "in-house", with master trainers such as Dr. Cheryl McNeil. All international sites currently have ongoing PCIT research studies (e.g., evaluating psychometric properties of the ECBI, assessing feasibility, effectiveness, and acceptability of PCIT within their country), as well as have actively participated (e.g., presented posters, given symposiums/workshops) at PCIT International conferences. A few sites (e.g., Japan, Germany) have translated PCIT materials/manual in their native language. There is no information provided as to whether these trainings have been conducted in English or with the use of an interpreter (or both).

The PCIT International website (www.pcit.org) provides a useful overview of international training efforts. In an effort to further understand the training process abroad, a literature search was conducted to identify published research studies which: (1) implemented PCIT internationally (i.e., in a country outside of the United States-including U.S. territories); (2) describe (even if minimally) the type of training the therapists have received; and (3) were available in English. This search yielded a total of 26 potentially relevant studies, 11 of which met all three inclusion criteria. Seven studies were excluded because they were written in a language other than English or the authors were not able to obtain a copy of the manuscript. Eight were excluded as their purpose was the validation of the Eyberg Child Behavior Inventory (ECBI) in languages other than English, not on the implementation of PCIT. The following countries are represented: The Netherlands (Abrahamse et al.,

2012; Abrahamse, Niec, Junger, Boer, & Lindauer, 2016); Taiwan (Chen & Fortson, 2015); Hong Kong (Leung, Tsang, Heung, & Yiu, 2009; Leung, Tsang, Ng, & Choi, 2017; Leung, Tsang, Sin, & Choi, 2015); Puerto Rico (Matos, Bauermeister, & Bernal, 2009); and Australia (Nixon, Sweeney, Erickson, & Touyz, 2003; Phillips, Morgan, Cawthorne, & Barnett, 2008; Thomas & Zimmer-Gembeck, 2011, 2012).

Table 1 compares the type of therapist training described in the 11 published studies, compared to the minimum training requirements for PCIT therapists set forth by PCIT International guidelines. All studies ($N = 11$) reported on and met the education criteria of at least a Master's degree or higher (or international equivalent) in a mental health services field (licensed or receiving supervision by a licensed provider). Only 27% ($N = 3$) of the studies reported that therapists underwent the standard 40-h face-to-face training with a PCIT Trainer. Two studies reported that training was provided by an "in-house" PCIT therapist who had been previously trained by a PCIT Trainer. Of note, close to half of the studies did not provide a description of the type of training therapists received, although it was implied that the lead trainer had undergone prior PCIT training. None of the studies provided specific information as to what these trainings consisted of (e.g., theoretical foundations of PCIT, Case observations, CDI and PDI skills mastery). This may be a function of limited journal space, however, and the fact that training was not the primary focus of these studies. All studies reported successful treatment completion with at minimum two or more PCIT cases (given these were outcome

Table 1 Description of PCIT therapist training abroad

PCIT international training criteria	Published studies of international PCIT implementation ($N = 11$)		Adaptations
Education	Percent (*N*)	Countries represented	
Master's degree or higher/international equivalent in a mental health field (licensed or under supervision of licensed provider) OR doctoral student ≥third year under supervision of licensed provider	100% (11)	N, T, H, P, A[a]	One study based in Australia used nurses to deliver PCIT
Initial training[a]			
40 hours of face-to-face training OR 10 h of online training and 30 h of face-to-face contact with a PCIT Trainer	27% (3)	N; H	Two studies provided training "in-house" by previously trained PCIT Therapist
Description of initial PCIT training not provided	45% (5)	P, A	
Continuation of training			
Minimum of two PCIT cases (one being the primary therapist) that meet graduation criteria	100% (11)	N, T, H, P, A	
Twice a month consultation (e.g., telephone, live, telehealth) with a PCIT Trainer	91% (10)	N, T, H, P, A	
Skill Review—treatment sessions observed by a PCIT Trainer (live, telehealth, or video recording) to formally assess for competency	55% (6)	N, T, H, P, A	Treatment sessions assessed for fidelity by lead therapist/researcher with PCIT expertise. No articles provided information as to whether this was done to obtain official PCIT International Therapist certification
Description of type of consultation/ supervision received not provided	9% (1)	A	

[a]*N* Netherlands, *T* Taiwan, *H* Hong Kong, *P* Puerto Rico, *A* Australia

[b]One study was not included as therapists were the same whose training had been described in two previous studies

research studies) and 91% (N = 10) of studies reported that therapists received ongoing supervision and consultation. Over half (N = 6) assessed adherence to the PCIT model via fidelity checklists. All reported significant improvements in targeted symptoms at post-treatment, with large effect sizes comparable to PCIT studies conducted in the United States. These results suggest that the training and supervision that therapists received was conducive to achieving clinically meaningful improvements for children and their caregivers within their respective countries.

Challenges relevant to the training of therapists internationally included: (1) premature termination of the dyad (child's behavior was not yet within the normal range of functioning; Abrahamse et al., 2012); and (2) addressing caregiver concerns in a culturally sensitive manner (e.g., allotting additional time for check-ins with caregivers for treatment buy-in, addressing skepticism about skills such as labeled praises or child-led play; Chen & Fortson, 2015; Leung et al., 2009). These challenges suggest that, just as in the US, therapists conducting PCIT internationally would benefit from ongoing supervision with a focus on treatment fidelity. Furthermore, therapists would benefit from the inclusion of training in culturally sensitive ways to identify and address caregiver concerns about the PCIT skills (e.g., reluctance to give labeled praises, over-directiveness in child-led play, negative views of the ignoring technique) in a manner that is sensitive to caregivers' parenting values, beliefs, and practices (Chen & Fortson, 2015). Training should also focus on the ongoing assessment of caregivers' perceived barriers to engage in treatment, as well as consider the role that extended family members may play in the life of the child (Leung et al., 2009).

Case Example

Marilyn Crawford was a 48-year-old, African-American therapist working for a child advocacy center in an urban Midwestern setting and specializing in reactive attachment disorder. She had been working for her agency for over 15 years, but had gained some additional clinical experiences prior to that after earning her Master of Social Work. While she described her therapeutic orientation as eclectic, she drew primarily from attachment and Rogerian theories. She did most of her work directly with children through play therapy, but had a strong ability to establish rapport with parents and keep them engaged in therapy. She accomplished this with her effective communication abilities and her awareness of the intricate interplay of social, cultural, interpersonal, economic and other factors affecting families. Her years of experience were also an asset, making her comfortable with complex clinical presentations and severe child disruptive behavior. Another strength that was helpful to the training processing was her willingness to openly discuss her questions, concerns, and engage in active dialogue with trainers.

Marilyn also had a number of important factors that needed to be considered by her trainers, who included a PCIT Master Trainer and her team of graduate students. First, she was selected along with several other employees by her agency to receive the training and was uncertain as to whether she had any interest in using PCIT with her clients. In her pre-training assessment, her responses to an attitudes about evidence-based treatment inventory indicated that she had some skepticism about the utility of EBTs, and in particular she felt that manualized treatments failed to consider the unique attributes of each client. Similarly, she believed that assessment instruments can be reductionistic and that translating clients into "just numbers" does not capture the complexity of individuals. Her initial knowledge check also revealed that she was not as familiar with many behavioral principles, which was reflected in her belief that behavioral techniques are "Band-Aid treatments" that don't address deeper client issues.

The trainers addressed these barriers in several ways. At the beginning of training, part of the time allotted to providing the background and theoretical foundation was used to discuss how PCIT incorporates play therapy techniques and principles (e.g., teaching patents to engage in therapeutic play with their child, following the

child's lead, etc.) to help caregivers build a strong foundation of attachment before focusing on discipline later in therapy. The focus on attachment and the idea of helping parents to be play therapists for their child appealed strongly to Marilyn. The trainers also emphasized the ways in which PCIT, although using behavioral techniques, is informed by attachment theories and research on parenting styles. Reframing the use behaviorist techniques with language that made sense to Marilyn was instrumental in increasing her buy-in. The trainers also framed the use of assessment as a method to ensure that treatment is tailored to a family's specific needs. Throughout training, but especially during the early informational sections when engagement is especially important, trainers actively elicited questions and concerns. To prevent any single trainee from feeling singled out, trainers took care to specifically ask for the thoughts and contributions of each trainee throughout discussions. For trainees like Marilyn, *seeing is believing*. Her trainers found that the most useful training activities for Marilyn were experiential: when she saw the skills being used with children, both through viewing taped sessions and live. In particular, she reported enjoying the interactions with a family who had completed PCIT before and participated in the training by sharing how the therapy had worked for them and led to positive changes.

Trainers also worked to increase Marilyn's comfort with PCIT by helping her build her skills using reinforcement as much as possible, as too much correction is likely to cause frustration and discouragement with trainees who feel less confident with behavioral skills. When Marilyn first practiced CDI skills, the trainer who was coaching her initially focused on the things Marilyn already did well and had pride in. For example, the trainer was quickly able to praise Marilyn's warmth with the child and her ability to follow the child's lead. Although Marilyn, like most people new to CDI, asked several questions, the trainer chose to ignore questions initially in favor of praising any time Do Skills were used. The trainer was also very attuned to how Marilyn's use of skills impacted the volunteer child's behavior through statements such as "I can tell she's really feeling comfortable with you because you're giving her lots of positive attention" or "you praised her for being gentle and now she's playing so nicely with the toys!" Connecting Marilyn's use of skills with child behavior in this way helped to increase her confidence that PCIT skills can help clients.

When coaching Marilyn's coaching, the trainer similarly focused on providing positive feedback and differentially reinforcing skill use (e.g., ignoring when Marilyn mislabeled or failed to praise a CDI skill during coaching). Because coaching is a skill that is often entirely new for trainees, some, such as Marilyn, feel nervous or pressured when being observed or coached during their coaching. The trainer addressed this by providing space for Marilyn to try to formulate coaching statements on her own since providing too many suggestions early on creates tension in some trainees who may feel like either they are not doing a good job or their trainer does not have any confidence in them. At same time, providing too little assistance can make trainees feel like they are floundering. Thus, when Marilyn appeared to be stuck, the trainer offered specific suggestions and modeled skills for her. As a rule of thumb, the trainer gave a suggestion within about 5–10 s of Marilyn making no coaching statements.

By the end of the 40-h training, Marilyn could easily reach CDI mastery criteria and felt comfortable coaching. She had even identified several clients on her caseload who would be good candidates for PCIT. She was eager to see how PCIT would work for her in practice, and, while she was less enthusiastic about use of assessment throughout treatment, she understood assessment was necessary to the process. In the consultant role, the trainer helped Marilyn to interpret assessment results and, more importantly, translate those results into actual work with clients.

One challenge came 3 months into the consultation process when one of Marilyn's new PCIT families came for their first CDI coaching with a "Crisis of the Week" (COW). In addition to not having brought in their homework sheets, the client's mother stated that, "this isn't working; my son has some issues he needs individual help

with." Specifically, during the last week the 5-year-old client had been physically fighting with his sister several times, often over toys. When his mother took one of the toys away, the client began screaming at her, telling her that nobody loved him. He then fell on the floor crying and screaming until she gave him the toy back. Marilyn responded by being very supportive. She let the couple spend the session talking about their feelings about what happened. The couple left feeling some relief, but with no new skills.

To her trainer, this situation represented a missed opportunity—first Marilyn did not address the client's view that her son needed individual help. Not understanding how PCIT can be used to address her son's problems could make such a parent less engaged or more likely to drop out early. It may have also been helpful for Marilyn to have had the parent fill out homework forms in session and discuss how homework completion did or didn't relate to the client's behavior. Were they doing homework? Was his behavior better on the days homework was completed? The answers to these questions were unknown, and asking these questions to Marilyn helped her see how this information was helpful instead of assuming that treatment "wasn't working."

The supervisor praised Marilyn for validating the client's concern, which is normally done during the 5 min prior to coaching, but framed coaching as the key to changing family behavior and reducing their stress: "When it comes to those child-related family crises, the goal of PCIT is not just to 'give a family a fish, but to teach them how to fish.' Coaching is a powerful way for parents to learn skills in real time with their children." The trainer posed questions with Marilyn about how the family might use the PCIT skills to prevent another similar crisis in the future and how coaching could have been used to build those skills. Marilyn was allowed time to brainstorm, increasing her confidence and competence in PCIT. The trainer let the clinician develop her own plan of action, but also helped "fill in the gaps" with some of her own thoughts and suggestions as needed. Following a year of consultation, Marilyn had completed her required number of cases and became a certified PCIT therapist.

Conclusions

PCIT is a well-validated and widely studied treatment for child behavior problems, parent–child conflict, and harsh parenting practices, but research into the mechanisms of PCIT training and dissemination has not yet reached a level commensurate with the treatment itself. We suggest that effective training will follow the PCIT international model, including active learning techniques such as role-plays and practice with actual children, illicit feedback and discussion with trainees, and insure that trainees not only develop the requisite skills for conducting PCIT but will also address community, institutional, and clinician barriers to implementing treatment. The contents of this chapter attempt to summarize and draw conclusions based on the extant literature, but additional research is needed, particularly with larger sample sizes (Travis & Brestan-Knight, 2013). Larger sample sizes would not only yield in more generalizable results but also provide additional power to determine, for example, what specific characteristics of training, trainees, and organizations lead to more successful implementation of PCIT. Questions worth exploring include: What makes coach coaching/role-playing/etc., most effective to maximize training outcomes? This information can inform the development of more specific, well-developed training guidelines (Travis & Brestan-Knight, 2013). Testing these questions will also require more advanced research methods than has typically been used in the dissemination literature; in the previously mentioned work by Fixsen et al. (2005) only 22 of the 377 implementation articles reviewed utilized experimental or meta-analytic methods to examine dissemination efforts. Studies of PCIT training have also tended to focus on either therapist knowledge and skills or client symptom improvement; it would be informative to investigate both outcomes simultaneously and determine their relationship to each other. As new and relevant instruments are developed such as the TPICS

(see chapter "Therapist-Parent Interactions in PCIT: The Importance of Coach Coding"), the range of variables to investigate can also be expanded. Because coaching specifically is related to client outcomes and is a unique component of PCIT, uncovering the methods by which trainees can improve their coaching skills are a paramount goal. Finally, as new technologies such as telemedicine (Funderburk, Ware, Altshuler, & Chaffin, 2008) and online viewing systems (Wilsie & Brestan-Knight, 2012) are incorporated in training and supervision, the impact of such technology on trainee and client outcomes warrants investigation.

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References

Abrahamse, M. E., Junger, M., Chavannes, E. L., Coelman, F. J. G., Boer, F., & Lindauer, R. J. L. (2012). Parent–child interaction therapy for preschool children with disruptive behaviour problems in the Netherlands. *Child and Adolescent Psychiatry and Mental Health, 6*, 2–9.

Abrahamse, M. E., Niec, L. N., Junger, M., Boer, F., & Lindauer, R. J. L. (2016). Risk factors for attrition from an evidence-based parenting program: Findings from the Netherlands. *Children and Youth Services Review, 64*, 42–50.

Barry, D. T., Fulgieri, M. D., Lavery, M. E., Chawarski, M. C., Najavits, L. M., Schottenfeld, R. S., & Pantalon, M. V. (2008). Research- and community-based clinicians' attitudes on treatment manuals. *The American Journal on Addictions, 17*(2), 145–148.

Baumann, A. A., Powell, B. J., Kohl, P. L., Tabak, R. G., Penalba, V., Proctor, E. K., … Cabassa, L. J. (2015). Cultural adaptation and implementation of evidence-based parent-training: A systematic review and critique of guiding evidence. *Children and Youth Services Review, 53*, 113–120.

Becker, E. M., Smith, A. M., & Jensen-Doss, A. (2013). Who's using treatment manuals? A national survey of practicing therapists. *Behaviour Research and Therapy, 51*(10), 706–710.

Beveridge, R. M., Fowles, T. R., Masse, J. J., McGoron, L., Smith, M. A., Parrish, B. P., … Widdoes, N. (2015). State-wide dissemination and implementation of Parent–Child interaction therapy (PCIT): Application of theory. *Children and Youth Services Review, 48*, 38–48.

Bride, B. E., Kintzle, S., Abraham, A. J., & Roman, P. M. (2012). Counselor attitudes toward and use of evidence-based practices in private substance use disorder treatment centers: A comparison of social workers and non-social workers. *Health & Social Work, 37*(3), 135–145.

Chen, Y.-C., & Fortson, B. L. (2015). Predictors of treatment attrition and treatment length in Parent-Child Interaction Therapy in Taiwanese families. *Children and Youth Services Review, 59*, 28–37.

Christian, A. S., Niec, L. N., Acevedo-Polakovich, I., & Kassab, V. A. (2014). Dissemination of an evidence-based parenting program: Clinician perspectives on training and implementation. *Children and Youth Services Review, 43*, 8–17.

Comer, J. S., Chow, C., Chan, P. T., Cooper-Vince, C., & Wilson, L. A. S. (2013). Psychosocial treatment efficacy for disruptive behavior problems in very young children: A meta-analytic examination. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(1), 26–36.

Couineau, A., & Forbes, D. (2011). Using predictive models of behavior change to promote evidence-based treatment for PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(3), 266–275.

Cunningham, C. E., Henderson, J., Niccols, A., Dobbins, M., Sword, W., Chen, Y., … Schmidt, L. (2012). Preferences for evidence-based practice dissemination in addiction agencies serving women: A discrete-choice conjoint experiment. *Addiction, 107*(8), 1512–1524.

Dixon, L., Lyles, A., Scott, J., Lehman, A., Postrado, L., Goldman, H., & McGlynn, E. (1999). Services to families of adults with schizophrenia: From treatment recommendations to dissemination. *Psychiatric Services, 50*(2), 233–238.

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

Falender, C. A. (2014). Supervision outcomes: Beginning the journey beyond the emperor's new clothes. *Training and Education in Professional Psychology, 8*(3), 143–148.

Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., … Grus, C. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology, 60*(7), 771–785.

Fixen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Walace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Funderburk, B. W., Ware, L. M., Altshuler, E., & Chaffin, M. (2008). Use and feasibility of telemedicine technology in the dissemination of parent-child interaction therapy. *Child Maltreatment, 13*(4), 377–382.

Gardner, F., Montgomery, P., & Knerr, W. (2016). Transporting evidence-based parenting programs for child problem behavior (age 3–10) between coun-

tries: Systematic review and meta-analysis. *Journal of Clinical Child & Adolescent Psychology, 45*, 749–762.

Gray, M. J., Elhai, J. D., & Schmidt, L. O. (2007). Trauma professionals' attitudes toward and utilization of evidence-based practices. *Behavior Modification, 31*(6), 732–748.

Haine-Schlagel, R., Fettes, D. L., Garcia, A. R., Brookman-Frazee, L., & Garland, A. F. (2014). Consistency with evidence-based treatments and perceived effectiveness of children's community-based care. *Community Mental Health Journal, 50*(2), 158–163.

Herschell, A. D., Mcneil, C. B., Urquiza, A. J., Mcgrath, J. M., Zebell, N. M., Timmer, S. G., & Porter, A. (2009). Evaluation of a treatment manual and workshops for disseminating, parent-child interaction therapy. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(1), 63–81.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36*(4), 567–589.

Kendall, P. C., & Beidas, R. S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice, 38*(1), 13–20.

Leung, C., Tsang, S., Heung, K., & Yiu, I. (2009). Effectiveness of Parent—Child interaction therapy (PCIT) among Chinese families. *Research on Social Work Practice, 19*, 304–313.

Leung, C., Tsang, S., Ng, G. S. H., & Choi, S. Y. (2017). Efficacy of Parent–Child Interaction Therapy with Chinese ADHD children: Randomized controlled trial. *Research on Social Work Practice, 27*, 36–47.

Leung, C., Tsang, S., Sin, T. C., & Choi, S.-y. (2015). The efficacy of parent–child interaction therapy with Chinese families: Randomized controlled trial. *Research on Social Work Practice, 25*, 117–128.

Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-child interaction therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. *Family Process, 48*, 232–252.

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist, 65*(2), 73–84.

Nixon, R. D., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-child interaction therapy: a comparison of standard and abbreviated treatments for oppositional defiant preschoolers. *Journal of Consulting and Clinical Psychology, 71*, 251.

PCIT International. (2013). Training requirements for certification as a PCIT therapist [Web document]. Retrieved from http://www.pcit.org/uploads/6/3/6/1/63612365/therapist_-_pcit_certification_training_requirements_final_03-02-13.pdf.

Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J., & Putnam, F. (2012). Effectiveness of community dissemination of Parent–Child Interaction Therapy. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(2), 204–213.

Phillips, J., Morgan, S., Cawthorne, K., & Barnett, B. (2008). Pilot evaluation of parent–child interaction therapy delivered in an Australian community early childhood clinic setting. *Australian and New Zealand Journal of Psychiatry, 42*, 712–719.

Rae, T., & Zimmer-Gembeck, M. (2007). Behavioral outcomes of parent-child interaction therapy and Triple P-positive parenting program: A review and meta-analysis. *Journal of Abnormal Child Psychology, 35*(3), 475–495.

Ruzek, J. I., & Rosen, R. C. (2009). Disseminating evidence-based treatments for PTSD in organizational settings: A high priority focus area. *Behaviour Research and Therapy, 47*(11), 980–989.

Schoenwald, S. K., Sheidow, A. J., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child and Adolescent Psychology, 33*(1), 94–104.

Segre, L. S., McCabe, J. E., Stasik, S. M., O'Hara, M. W., & Arndt, S. (2012). Implementation of an evidence-based depression treatment into social service settings: The relative importance of acceptability and contextual factors. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(3), 180–186.

Shafran, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A., … Wilson, G. T. (2009). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy, 47*(11), 902–909.

Southam-Gerow, M., Marder, A. M., & Austin, A. A. (2008). Dissemination of evidence-based manualized treatments for children and families in practice settings. In R. G. Steele, T. D. Elkin, & M. C. Roberts (Eds.), *Handbook of evidence-based therapies for children and adolescents: Bridging science and practice; handbook of evidence-based therapies for children and adolescents: Bridging science and practice* (pp. 447–469). New York, NY: Springer Science + Business Media Chapter x, 585 pages.

Staudt, M., & Williams-Hayes, M. (2011). A state survey of child advocacy center therapists' attitudes toward treatment manuals and evidence-based practice. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 20*(1), 1–13.

Thomas, R., & Zimmer-Gembeck, M. (2012). Parent–Child interaction therapy: An evidence-based treatment for child maltreatment. *Child Maltreatment, 17*(3), 253–266.

Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for parent–child interaction therapy in the prevention of child maltreatment. *Child Development, 82*(1), 177–192.

Travis, J. K., & Brestan-Knight, E. (2013). A pilot study examining trainee treatment session fidelity when Parent–Child interaction therapy (PCIT) is implemented

in community settings. *The Journal of Behavioral Health Services & Research, 40*(3), 342–354.

Watkins, C. E., & Scaturo, D. J. (2013). Toward an integrative, learning-based model of psychotherapy supervision: Supervisory alliance, educational interventions, and supervisee learning/relearning. *Journal of Psychotherapy Integration, 23*(1), 75–95.

Wilsie, C. C., & Brestan-Knight, E. (2012). Using an online viewing system for parent–child interaction therapy consulting with professionals. *Psychological Services, 9*(2), 224–226.