

Parent Child Interaction Therapy – Live Remote Internet Training



Indian Country Child Trauma Center



Abstract

The Indian Country Child Trauma Center is developing a Train the Trainer Model using an evidence-based treatment intervention for children exposed to trauma. Parent Child Interaction Therapy (PCIT) has been proven to be effective; however the length of training can be difficult if the trainees/professionals are not on site. The ICCTC has developed a training model using live remote internet access to observe and coach during actual therapy sessions. This immediate access allows for the quick response time since behaviors that are being shaped for the therapist in training and the parent in therapy can receive real time feedback. The ability to connect via the internet, across state lines from a central location to various locations around the country has allowed the on-going training of professionals (trainees). The live remote internet training has proven to be highly effective with high satisfactory rating from all participants



Program Overview

Beginning in 2004, the Indian Country Child Trauma Center (ICCTC) began developing a Native American cultural adaptation for evidence based treatments including Parent-Child Interaction Therapy (PCIT). The Indian Country Child Trauma Center, directed by Dolores Subia BigFoot, PhD, at the University of Oklahoma Health Sciences Center, was to develop Native cultural adaptation with input from a national working group of Native cultural and mental health intervention experts. Parent-Child Interaction Therapy (PCIT) is an empirically well-supported, short-moderate term behavioral parent training program for reducing aggressive behavior in young children, and for reducing future rates of child physical abuse among abusive or at-risk parents. PCIT teaches a set of behavioral parenting skills very similar in nature to many other evidence-based parent training protocols, but the delivery system used in PCIT is fairly unique and is particularly well suited to skill acquisition for difficult-to-manage children.. Parenting skills are taught by coaching parents in live parent-child interactions using a wireless earphone. Skills are coached to behavioral criteria by the therapist who observes live parent-child interactions through a one-way mirror.



Parent-Child Interaction Therapy involves the parent receiving live coaching via a wireless earphone and the coach watching through a one-way mirror.

The Need

Although the evidence supporting PCIT is clear, and implementation demand is burgeoning, it is less clear how dissemination and implantation of the model in scaled-up service systems can proceed. Traditionally, PCIT training has been conducted within a small number of University-based graduate or post-graduate training programs. The training is over a 9-12 month training year with emphasis on skill development and theory driven treatment protocol. Trainees engage in co-therapy sessions under the direct observation and supervision of the PCIT trainer for several completed cases. A typical case is usually 14 sessions allowing a trainee to participate in several PCIT cases over the training year. The trainee engages in an intensive didactic component to understand the foundation of PCIT followed by approximately six months of post-didactic mentoring and co-therapy. This process is labor intensive and not well suited for large-scale field dissemination. One purpose of ICCTC was to develop a training plan for dissemination of PCIT to clinical providers in the field. Train the Trainer criteria is more intensive. For the ICCTC it was more challenging as the Indian Country clinical providers were spread out in very rural areas across the nation. They were not only isolated from coaching and training support but had a significant lack of access to these training services.



The Trainee is observing the Parent and Child through a one-way mirror while the Coach is observing the session and assisting the trainee via two-way videoconferencing.



The Solution

The ICCTC started exploring alternatives to provide easier access to direct observation and supervision of PCIT training. Initially the PCIT training of clinical providers was done in two intensive weeks with a three month follow up done via the post-hoc telephone consultation and video tape review approach. Because of concerns over the inadequacy of phone consultations, ICCTC began to explore the use of Interactive Videoconferencing. Working with the University of Oklahoma Health Sciences - Center for Telemedicine, a new delivery model using Polycom's two-way interactive videoconferencing equipment was tested in mock co-therapy sessions. It was determined that communication times had to be virtually instantaneous, video quality had to be very high in order to catch the nuances of parent-child interactions and the technology had to be very easy to install and use. The laboratory mock-ups using dedicated Polycom VSX 7000 at the trainee location along with a Polycom VSX 3000 at the trainer's location used high bandwidth, dedicated network connections and a dedicated IP address and performed quite well. The system allows screen refresh rates of at least 60/sec, producing a television quality image with multi-screen capability (split screen or PIP) and instantaneous dual channel voice communication. This system used for the remote real time training has now been feasibility tested at four ICCTC sites located in Oklahoma, Utah, Washington, and Oregon for the past six months and performed well. Remote real time live coaching sessions have become routine at these sites.

The Success

The ICCTC program continues to grow in number of locations receiving the PCIT and remote real time training. As increased acceptance and documented success of the Native American cultural adaptation of PCIT becomes published, there is also an increase in demand for the training and enhanced availability. Outcomes documentation of PCIT provides substantial reduction in future child welfare report rates. With the use of two way videoconferencing technology, access to the PCIT and remote real time coaching (training) and support allows for greater access in remote areas that would otherwise not have access to the treatment and training services. This then allows clinical providers in these remote areas to provide the Parent-Child Interactive Therapy to families in their service areas. Over time, ICCTC will increase the number of Trainers in PCIT.



The Coach is observing the live PCIT session via two-way videoconferencing.

The Coach can see and hear everything the trainee sees and hears.



Conclusion

The ICCTC program has observed that clinical providers in the remote real time training program have met training criteria faster and more reliably than those who receive training via the telephone consultation. A controlled study is underway to document these findings. PCIT Trainers have found the use of the two way videoconferencing technology very easy to implement in their training process. They have been pleased with the high quality of the video, ease of use, comparably low cost of equipment and availability of network infrastructure in the remote areas. PCIT Trainees have expressed great satisfaction with the ease of access and quality of co-therapy sessions. The only significant challenge that has been observed is the difference in time zones between the trainers' and trainees' locations. For scheduling treatment/coaching sessions, this can create significant challenges for the trainers and their availability at the time treatment sessions are scheduled with families across different time zones.

Acknowledgements

Indian Country Child Trauma Center
Dolores Subia BigFoot, PhD, Director
National Child Traumatic Stress Network

Univ. of Oklahoma Health Sciences Ctr
Center for Telemedicine
Candace Shaw, Director



OUHSCTV Television & Photo Services
John McGuinness, Director