



CAARE Center
Clinical Psychology Training Program
Department of Pediatrics
UC Davis Children's Hospital
An APA-Accredited Internship Program

Training Program Description

The University of California, Davis CAARE Center Clinical Psychology Training Program offers a one-year predoctoral internship opportunity for students who have attended APA-accredited clinical or counseling psychology programs. Psychology interns receive training and supervised experience in individual and group therapy, Parent-Child Interaction Therapy, psychological evaluations, child welfare evaluations, intake assessments, and consultation to local agencies. CAARE Center clients range in age from 2 to 18 years, although adults are seen for family treatment and evaluations.

The Training Program, which subscribes to a practitioner-scholar model, emphasizes knowledge of current research to guide assessment and intervention. Psychology interns develop competency in empirically supported treatments and make presentations on current research. In summary, the Clinical Psychology Training Program is a challenging and dynamic internship program with the goal of training ethical and competent future psychologists in the fields of clinical psychology and child maltreatment who will contribute both to the welfare of society and to the profession.

The CAARE Center

The CAARE Center (Child and Adolescent Abuse, Resource, Evaluation Diagnostic and Treatment Center) is an integral part of the Department of Pediatrics of the University of California, Davis Children's Hospital and School of Medicine. The mission of the CAARE Center is to provide superior clinical service to children and families, engage in clinical research, and provide training in the areas of child maltreatment and family violence. Training of pre/post doctoral clinical psychology students, medical residents, and other health professionals has been a longstanding priority. The CAARE Center has been recognized at the local and national levels as a model program for the evaluation and treatment of child maltreatment.

For over 20 years, the CAARE Center has been committed to offering high quality medical and psychological treatment for abused and neglected children. Approximately 38% of clients are African-American, 35% European-American, 21% Hispanic, and 6% other ethnicities. Although presenting problems typically include a history of abuse, neglect and/or exposure to domestic violence, there is a broad range of presenting diagnoses in both children and parents, including mood disorders, anxiety disorders, adjustment disorders, substance dependence, and personality disorders.

Ongoing research and training projects at the CAARE Center include a state funded project to provide crisis intervention and stabilization services for child victims of trauma, a California Emergency Management Agency (CalEMA) grant to develop a Trauma-Focused Cognitive Behavior Therapy program, grants to furnish training in Parent-Child

Interaction Therapy at designated mental health clinics throughout California, and a contract to expand services for children 0-3 years within the community. Additionally, the Medical Team has been funded to provide training in the medical evaluation of physical and sexual abuse for the state of California.

The University and the Medical Center

The University of California, Davis is one of ten University of California campuses. UC Davis was established in 1908 and the UC Davis School of Medicine in 1965. The UC Davis Medical Center is an integrated, academic health system encompassing a 530-bed acute care hospital, ambulatory care clinics, and an 800-member physician group. The Medical Center is one of five University of California teaching hospitals and is consistently ranked among the top ten medical schools and the top fifty hospitals in the country. The health system cares for approximately 9,000 adults and children each year and provides more charity care than any other hospital in the region. As the primary clinical education site for the School of Medicine and the only area provider of many medical services, the medical center plays an important part in the health and well-being of Northern California and has a major economic impact in the area.

The CAARE Center is located on the Medical Center campus which encompasses 140 acres in central Sacramento, three miles from the state Capitol, and 20 miles from the main UC Davis campus. Specialized clinical centers within the health system include the Cancer Center, Children's Hospital, Heart Center, M.I.N.D. Institute, Center for Health and Technology, Pediatric Neurology Program, and Trauma Center. The CAARE Center falls under the auspices of UC Davis Children's Hospital.

The Sacramento Community

Sacramento, California's capitol, is a relaxed, tree-filled suburban city which offers a variety of interesting and distinct activities. With a population of approximately 1.8 million, the Sacramento area provides multiple opportunities for historical, cultural, and recreational outings. Sacramento's rich historical heritage, revitalized in Old Sacramento, includes the Gold Rush era, as well as pioneering work in the mine and railroad industries. Culturally, Sacramentans enjoy theater, art museums, concerts, dance, the world's largest Dixieland Jazz Jubilee, and the recently opened UC Davis Mondavi Center for the Performing Arts. Hiking, cycling, boating, swimming, and other outdoor activities are readily enjoyed in this area of numerous parks, open spaces, two major rivers, and a lake. Professional sports teams including the Kings (basketball), River Cats (baseball), and Monarchs (basketball) call Sacramento home. It is this wealth of activities that contributed to *Newsweek* magazine naming Sacramento one of the ten best cities in the United States. In addition, Sacramento's rich ethnic and cultural diversity earned it *Time* magazine's "Most Diverse City" designation.

Sacramento is conveniently located near a number of Northern California's other beautiful areas. San Francisco is approximately 1½ hours southwest of Sacramento. The Napa and Sonoma Wine Country is within an hour's drive northwest, and Lake Tahoe is approximately 1½ hours northeast of the Capitol City.

The program is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC) and the California Association of Psychology Internship Council (CAPIC).

APPOINTMENT, STIPEND, AND BENEFITS

Appointment

The internship begins July 1 following application and concludes on June 30 of the following year. This is a full-time, 40-hour per week appointment. Clinical moonlighting is not permitted.

Stipend

The stipend for the 2010-2011 training year is \$24,000. Applicable federal and state taxes and social security deductions are withheld.

Benefits

Medical insurance is available under a variety of medical plans. Approximately three weeks vacation, all federal holidays, and twelve days of sick leave are offered. Interns receive time to attend the CAARE Center child abuse conference and PCIT conference for professional development. Additionally, interns are provided with workspace, a personal computer, voicemail and email, a pager, administrative assistance, and full access to the University of California, Davis libraries and associated services.

PROGRAM ADMINISTRATION

Training Directors

Dawn Blacker, PhD
Georganna Sedlar, PhD (Co-Director)

Training Supervisors

Anthony Urquiza, PhD
Dawn Blacker, Ph.D.
Blake Carmichael, PhD
Jayanthi Kasiraj, PhD
Michele Ornelas Knight, PsyD
Kim Lundquist, LCSW
Jean McGrath, PhD
Georganna Sedlar, Ph.D.
Forrest Talley, PhD
Nancy Zebell, PhD

Program Administrator

Bill Bullock, MS

For additional information, please contact:

<p>Clinical Psychology Training Program CAARE Center University of California, Davis Children's Hospital 3300 Stockton Boulevard Sacramento, CA 95820 Phone: (916) 734-6615 or (916) 734-6620</p>

ELIGIBILITY AND SELECTION PROCEDURES

Eligibility:

Applicants must be currently enrolled in an APA-accredited doctoral program in clinical or counseling psychology. Prior to the interview, applicants must have completed at least two years of graduate study, approximately 500 hours of supervised practicum work, all doctoral course work as required, and have an accepted dissertation proposal. Although not a requirement, the vast majority of applicants selected for the program have had practicum experience with children.

Selection:

Intern selection is made by a committee comprised of the Training Director and senior staff members. Applicants are rated on the basis of their clinical training (including assessment and psychotherapy), academic coursework, letters of recommendation, clinical and research interests, progress toward dissertation completion, and stated goals for internship. Those candidates assessed by the committee to hold interests and goals most closely matching those opportunities offered by our program will be asked to participate in on site interviews.

All applicants will be notified of their status by December 15. Highly-ranked candidates will be invited for interviews with the training director and senior staff members. Candidates also have the opportunity to meet with current interns and tour the clinic. These interviews are very helpful for both the program and the applicants to determine whether the program is appropriate for them. Interviews will take place in January. If due to economic reasons, an applicant cannot travel to Sacramento, other arrangements can be made.

The training program follows the Association of Psychology Postdoctoral and Internship Centers' policies regarding internship offers and acceptances. The internship program agrees to abide by APPIC policy that no person at this training facility will solicit, accept, or use any ranking-related information from any applicant. If you encounter violations of APPIC policy, please consider discussing it with your training director and reporting the violation to APPIC Standards and Review Committee, 733 15th Street NW, Washington, CA 20005, phone (202) 347-0022.

Nondiscrimination Policy:

The University of California prohibits discrimination against or harassment of any person employed by or seeking employment with the University on the basis of race, color, national origin, religion, sex, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran (special disabled veteran, Vietnam era veteran, or any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized).

The University of California, Davis, and the CAARE Center Clinical Psychology Training Program are interested in candidates who are committed to the highest standards of scholarship and professional activities, and to the development of a campus climate that supports equality of opportunity.

APPLICATION PROCEDURES

Please submit only the APPI online application located on the APPIC website (www.appic.org). Follow the directions on the APPIC website for submitting your application. Our application deadline is **November 1, 2009**.

The online application should include the following:

- ✓ Cover letter
- ✓ APPI application
- ✓ Curriculum vitae
- ✓ Three sealed letters of recommendation
- ✓ Official graduate transcripts

DEADLINE: Our application deadline is November 1, 2009.

TRAINING GOALS AND OBJECTIVES

Overview

The training year is viewed as an opportunity for interns to obtain extensive supervised clinical experience, while developing knowledge and attitudes that encourage a scientific approach to practice. The supportive, challenging atmosphere of the CAARE Center fosters the development of skills and a maturing professional identity.

Objectives

Over the course of the one-year program, it is expected that interns will develop the following competencies:

1. Become proficient in conducting intake assessments, making diagnoses, developing treatment plans, and conducting individual and group therapy for children, adolescents, and caregivers with a history of maltreatment.
2. Become proficient in administering, scoring, and interpreting psychological tests and writing comprehensive evaluation reports.
3. Develop cultural competency in assessing and treating a multicultural population.
4. Demonstrate the knowledge and skills needed to conduct two empirically-supported treatments (i.e., Parent-Child Interaction Therapy and trauma-focused cognitive behavior therapy).
5. Use knowledge of current research in the areas of intervention, assessment, and child maltreatment to guide assessment and treatment.
6. Develop and refine skills in consulting with school and other systems involved in client's life.
7. Develop ability to provide clinical case management as appropriate.
8. Make a professional and scientific presentation of a specific case or topic, present on research-based topics at journal club, and integrate research into case presentations.
9. Work collaboratively as part of a multidisciplinary team of medical and mental health professionals.
10. Become knowledgeable on issues concerning professional psychologists such as reporting laws, confidentiality, ethics, consultation, and supervision.
11. Demonstrate an ability to be self-reflective and make a realistic assessment of strengths and weaknesses.

General Training Duties

1. Interns will have approximately 18-25 clinical contact hours per week comprised as follows:

- a. 10-12 individual therapy clients (5 of which include designated TF-CBT cases)
 - b. 1 therapy group (co-facilitate)
 - c. 4 Parent-Child Interaction Therapy cases
 - d. 1 psychological evaluation or child welfare evaluation
2. Interns will be responsible for conducting intake assessments.
 3. Interns will participate in supervision, trainings, and meetings as follows:
 - a. 2 hours of individual supervision per week;
 - b. 2 hours of group supervision per week;
 - c. 4 hours of seminars per week;
 - d. ½ hour general staff meeting per week;
 - e. 1 hour Training Director's meeting per week for first six months;
 - f. 2 hours of Trauma-Focused Cognitive Behavior Therapy seminar and live supervision per week. This seminar usually lasts 6 to 9 months.
 4. Interns will be responsible for completing all required clinical documentation (e.g., treatment plans, progress notes, discharge summaries).
 5. Interns will have the opportunity to attend conferences sponsored by the CAARE Center, School of Medicine grand rounds, and other training activities.

PERFORMANCE EVALUATION

Intern Evaluations

At the beginning of the internship year, interns complete a self-assessment of their experience relative to training objectives of the internship. This helps focus the trainee and supervisor on the intern's needs. Progress is monitored throughout the internship period. At the end of three months and six months, verbal and written feedback are provided by the primary supervisor and/or Training Director. These performance evaluations are used to communicate an assessment of the intern's progress. At the end of the internship year, formal summative feedback is given to the intern and sent to the Training Director. Serious concerns regarding an intern's performance will be addressed through due process procedures (see Appendix A).

Grievance Procedures

Interns are strongly encouraged to first address grievances related to training, supervision, or evaluation with their primary supervisor and resolve concerns informally. Formal procedures are described in Appendix A.

ADDITIONAL INFORMATION

Any questions about accreditation may be addressed to: Office of Accreditation, American Psychological Association, 750 First Street, NE, Washington, DC 20002. Telephone: (800) 374-2721 or (202) 336-5500M

TREATMENT PROGRAMS

Individual Therapy – Forrest Talley, PhD, Coordinator

The individual therapy program provides therapy to children who have a history of abuse and/or neglect. Ages of children range from 3-18 years, although most of the children are latency age. A broad range of diagnostic presentations are treated (e.g., mood disorders, anxiety disorders, adjustment disorders). Interns also provide consultation to social workers, biological/foster parents, and make recommendations to the court based upon their clinical understanding of the child. Supervision/consultation includes one to one discussion, review of videotapes, and live observation using a one way mirror and audio receiver worn in the ear by the therapist. The ability to develop formulations that guide the therapist towards reflective interventions is stressed.

Required Reading:

Talley, P.F. (2005) *Handbook for the Treatment of Abuse and Neglected Children*. Haworth Press, Binghamton, NY.

Recommended Readings:

Schaefer, C. (1993). *The Therapeutic Power of Play*.

Brems, S. (1993). *Child Psychotherapy*.

Weiz, J. (2004) *Psychotherapy for Children and Adolescents: Evidence Based Treatments and Case Examples*.

Group Therapy – Kim Lundquist, LCSW, Coordinator

The group therapy program provides therapy in the format of social skills group and process-oriented groups for abused and neglected children. Groups for preschoolers through teenagers are offered. Interns will co-facilitate at least one ongoing therapy group. Supervision is both indirect and direct in the viewing of videotapes and co-facilitation of groups.

Recommended Readings:

Talley, P. F., & Terao, S. Y. (1998). *UCDMC Social Skills Group Manual*.

Dowd, T., & Tierney, J. (1995). *Teaching Social Skills to Youth*.

Parent-Child Interaction Therapy (PCIT) – Nancy Zebell, PhD, Coordinator

The PCIT program is an empirically supported treatment program designed to help both parents and children. The program works with caregivers and children together to improve the quality of the parent-child relationship and to teach parents the skills necessary to manage the child's behavior problems. Interns will follow PCIT cases with an experienced therapist and be responsible for four cases. Because interns are taught by an experienced therapist, direct supervision and feedback is ongoing.

Required Readings:

Hembree-Kigin, T., & McNeil, C. B. (1995). *Parent-Child Interaction Therapy*. New York, Plenum.

Urquiza, A. J. & McNeil, C. B. (1996). Parent-Child Interaction therapy: An Intensive Dyadic Intervention for Physically Abusive Families. *Child Maltreatment* 1: 134-144.

Borrego, Jr., J. B., Urquiza, A. J., Rasmussen, R., & Zebell, N. M. (1999). Parent-Child Interaction Therapy with a Family at High Risk for Physical Abuse. *Child Maltreatment*, 4, 331-342.

Trauma-Focused Cognitive Behavior Therapy (TF-CBT) – Georganna Sedlar, PhD, Coordinator

TF-CBT is an empirically supported treatment developed for youth with post-traumatic stress disorder, or emotional or behavioral problems (e.g., depression, anxiety) related to traumatic life experiences. This therapy is provided to children ages 3-18 years who have experienced physical abuse, sexual abuse, or other traumatic events (e.g., car accidents, witnessing violence). Treatment involves individual sessions with the child and parent as well as joint parent-child sessions. TF-CBT has been used effectively with children from all socioeconomic backgrounds, living in a variety of settings (e.g., parents, foster care, group home), and from diverse ethnic backgrounds. Interns will be responsible for seeing TF-CBT cases and implementing the entire TF-CBT protocol. To facilitate learning and comfort with the model, interns will be involved in case presentations/discussions and live supervision.

Required reading:

Cohen, J., Mannarino, A., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*, Guilford Press.

Required web-based training: TF-CBT Web (www.musc.edu/tfcbt)

Recommended reading:

Miller, A.L., Rathus, J.H., & Linehan, M.M. (2007). *Dialectical Behavior Therapy with Suicidal Adolescents*, Guilford Press.

Note: Additional readings may be assigned during seminar

Psychological Evaluations – Jayanthi Kasiraj, PhD, Didactic Supervisor / Blake Carmichael, PhD, Coordinator

The Psychological Evaluations program provides psychological testing for children and adolescents. Referral questions include differential diagnoses, assessment of the child's level of functioning, and treatment recommendations. Interns will be responsible for conducting psychological evaluations throughout the year. Testing instruments include cognitive (e.g., WISC-IV, CMS) and objective and projective personality tests (e.g., MMPI-A, Rorschach). In addition, interns will be trained in the K-SADS (a structured diagnostic interview) and conducting clinical interviews with children. Behavioral checklists (e.g., CBCL, BASC), school observations, and collateral contacts with caregivers are also utilized. Readings will be provided in the areas of child development, impact of child maltreatment on functioning, and review of measures.

References:

Anastasi, A. & Urbina, S. *Psychological Testing, 7th Ed.* Prentice Hall.

Kelly, F. D. (1999). *The Psychological Assessment of Abused and Traumatized Children*. Lawrence Erlbaum Association.

Marnat-Groth, G. (2003). *Handbook of Psychological Assessment*. John Wiley & Sons.

Sattler, J. M. (1992). *Assessment of Children – Cognitive Applications*. J. M. Sattler.

Wilson, J. P. (1997). *Assessing Psychological Trauma and PTSD*. Guilford Press.

Wolfe, D. (1999). A Developmental Perspective of the Abused Child in *Child Abuse Implications for Child Development and Psychopathology*, Chapter 3, 35-56.

Child Welfare Evaluations – Blake Carmichael, PhD, Coordinator

The Child Welfare Evaluation Program provides evaluation services for county child protective services in Northern California, as well as private referrals. Referral questions range from assessment of a parent's psychological functioning to evaluation of a child's level of attachment to the parents. Instruments typically used include the MMPI-A, PAI, Child Abuse Potential Inventory, Parenting Stress Index, Behavior Assessment System for Children, cognitive tests (WAIS-III, WISC-IV), and academic screening tests.

Recommended Readings:

Benjamin, L. S. (1993). Every psychopathology is a gift of love. *Psychotherapy Research*, 3 (1), 1-24.

Consultation and Research

In addition to providing treatment, interns will provide consultation to social workers, medical staff, foster parents and/or biological parents as appropriate. Postdoctoral interns will have the opportunity to participate in ongoing research projects.

SUPERVISION AND TRAINING

The Clinical Psychology Training Program provides a strong supervisory system to ensure that interns obtain individualized attention as they pursue their clinical training at the CAARE Center. In general, interns participate in two hours of individual supervision and two hours of group supervision a week. The use of “live” supervision is an integral part of training through the use of observation mirrors, videotaping of treatment sessions and assessment interviews, and co-facilitation of treatment and assessment for all treatment programs. Opportunities for topic and case presentations occur in seminars and group supervision.

Individual Supervision

Two hours of individual supervision are provided. When a case (therapy or evaluation) is assigned, the intern should consult with the supervisor about procedures and relevant information.

Group Supervision

Two hours of group supervision are provided for the PCIT program and group therapy program.

Didactic and Clinical Presentations

Several required didactic trainings are conducted each week. These are:

- Clinical staff presentations with topics related to the field of child maltreatment, psychopathology, and professional development
- Psychological Evaluation/Child Welfare Evaluation didactic
- Individual Therapy didactic
- Parent-Child Interaction Therapy seminar
- Trauma-Focused Cognitive Behavior Therapy seminar

Interns also participate in a twice monthly Group Therapy seminar.

Training Director's Meeting

This meeting provides interns an opportunity to share information and discuss problematic issues or general concerns about the internship experience. The meeting is conducted weekly for the first six months and bimonthly thereafter.

Other Training Opportunities

Interns have the opportunity to attend Pediatrics and Psychiatry Grand Rounds and the CAARE Center's two conferences: the Annual Child Abuse & Neglect Conference and the Parent-Child Interaction Therapy Conference. Release time for attending other professional conferences may be arranged with the Training Director and primary supervisor.

Post-Doctoral Opportunities

In addition to predoctoral training, there are postdoctoral positions available every year. Please contact Dr. Blacker (dawn.blacker@ucdmc.ucdavis.edu) for information regarding postdoctoral opportunities.

TRAINING STAFF

Anthony J. Urquiza, PhD, Director of Mental Health Services

Dr. Urquiza received his doctorate from University of Washington in 1988. He is the Director of Mental Health Services and provides supervision/consultation on child welfare evaluations. Dr. Urquiza's primary interests and publications center on all types of family violence, the sexual victimization of males, the treatment of children and adult survivors of childhood sexual abuse, mental health psychodiagnostic issues applied to child maltreatment, and cultural diversity. Theoretical orientation: Interpersonal.

Dawn M. Blacker, PhD, Training Director

Dr. Blacker graduated from the California School of Professional Psychology-Alameda in 1998. She currently serves as the Training Director and conducts psychological evaluations and Parent-Child Interaction Therapy. Dr. Blacker received postdoctoral training in developmental disabilities and psychological assessment. Current interests include: treatment of child physical and sexual abuse, developmental assessment of maltreated children, adolescent sex offenders, and early intervention. Theoretical orientation: Interpersonal, developmental, and cognitive-behavioral.

Blake Carmichael, PhD, Evaluation Program Coordinator

A graduate of University of California, Davis and Alliant International University, Dr. Carmichael specializes in psychological assessment and group/individual treatment of maltreated children and their families. He has extensive training and experience working with adolescent sex offenders and victims. Research interests include the impact of violence on families, the effectiveness of various parenting/leadership styles, and the biological bases of aggression and psychiatric disorders.

Jayanthi M. Kasiraj, PhD, Psychological Evaluations Didactic Supervisor

Dr. Kasiraj completed her undergraduate and master's degrees at Texas A&M University. She received her PhD in 1993 from the California School of Professional Psychology-Fresno. She completed a postdoctoral fellowship at UCLA Neuropsychiatric Institute specializing in developmental disabilities, pediatric liaison, and child psychopathology. Her interests include: diagnosis and assessment of toddlers, children and adolescents, family therapy, early intervention, and developmental disabilities. Theoretical orientation: Developmental and systems.

Michele Ornelas Knight, PsyD, Continuity of Care Coordinator

Dr. Knight graduated from the University of Denver Graduate School of Professional Psychology in 1999. Clinical experience includes child and adult outpatient, crisis intervention, and residential treatment. Current interests include: affect regulation in maltreated children, interpersonal relationships of maltreated children, and attachment based therapies for abused children. Dr. Knight is the Assistant Coordinator of the individual program and coordinates all cases that initiate, transfer, or terminate services within the CAARE Center. Theoretical orientation: Interpersonal.

Kim Lundquist, LCSW, Group Coordinator

Ms. Lundquist graduated from California State University, Sacramento in 1995 with a Master of Science in Social Work. She completed internships at El Dorado County Mental Health and the University of California, Davis Department of Psychiatry. Ms. Lundquist's clinical experience includes private practice with adults abused as children. She has broad experience working with maltreated children and their families, offending

and non-offending parents, and crisis intervention. Theoretical orientation: Psychodynamic and trauma-based therapy.

Jean McGrath, PhD, Manager of Operations and Community Development

Dr. McGrath graduated from Professional School of Psychology in 1997. She has extensive experience evaluating and treating maltreated children and their families, as well as program and policy development at the state level. Current responsibilities include coordinating mental health assessment services and providing statewide PCIT training to child abuse treatment agencies. Theoretical orientation: Cognitive-behavioral and interpersonal.

Georganna Sedlar, PhD, Trauma-Focused Cognitive Behavior Therapy Coordinator

Dr. Sedlar received her doctorate degree in clinical psychology from the University of Nebraska, Lincoln. She attended internship at the Medical University of South Carolina in Charleston. She has received specialized training in assessment and treatment of the effects of child trauma and child maltreatment. Dr. Sedlar's current responsibilities include providing assessment and therapy to abused and neglected children and their caregivers. Her research interests include the use of empirically-supported treatments and the effects of trauma on children. Theoretical orientation: Cognitive-behavioral.

Forrest Talley, PhD, Individual Treatment Coordinator

Dr. Talley received his doctorate from Vanderbilt University in 1988. He has broad experience in evaluating and treating maltreated children and their families. His current responsibilities include individual therapy supervision and providing individual and group treatment. Research interests include narrative structure in children's play and the therapeutic process. Theoretical orientation: Interpersonal.

Leslie Whitten, MFT, Parent-Child Interaction Therapy Trainer

Ms. Whitten completed her undergraduate degree at University of the Pacific and her Master's degree in Psychology at California State University, Sacramento in 2001. Clinical experience includes: adult outpatient therapy, crisis intervention, adoption transitions, and the evaluation and treatment of maltreated children and their families. Ms. Whitten additionally provides instruction and training to staff, as well as to community and statewide agencies regarding implementation of PCIT. Theoretical orientation: Interpersonal and cognitive-behavioral.

Nancy M. Zebell, PhD, Parent-Child Interaction Therapy Coordinator

Dr. Zebell graduated from Professional School of Psychology in 1996. Her interests include assessment and treatment of child abuse, parent-child relationships in abusive and high-risk situations, treatment of families involved with CPS, and the development of multidisciplinary and family systems approach to child maltreatment. Theoretical orientation: Interpersonal and cognitive-behavioral.

Recent Publications of Psychology Staff

- Dombrowski, S., Timmer, S.G., & Zebell, N. (2007). Parent-Child Attunement Therapy for Toddlers: A behaviorally-oriented play-based parent training model. In C. Schaefer (Ed.), *Play Therapy for Very Young Children*, in press.
- Dombrowski, S., Timmer, S. G., Blacker, D., & Urquiza, A. J. (2005). A positive behavioral intervention for toddlers: Parent-Child Attunement Therapy. *Child Abuse Review*, 14, 132 - 151.
- Elliott, K. & Urquiza, A. J. (2005). Conducting culturally responsive research in juvenile justice and child welfare systems. In J. E. Trimble and C. B. Fisher (Eds.), *Handbook of ethical research with ethnocultural populations and communities*. Sage: Newbury Park.
- Kalich, L., Carmichael, B.D., Masson, T., Blacker, D., & Urquiza, A. (2007). Evaluating the evaluator: Guidelines for legal professionals in assessing the competency of evaluations in termination of parental rights cases. *Journal of Psychiatry and Law*, in press.
- Peterson, M.S., Borrego, J., Terao, S., Urquiza, A.J. (2003). Psychological maltreatment. In M. S. Peterson and M. Durfee (Eds.), *Child abuse and neglect: Guidelines for identification, assessment, and case management*. Volcano, CA: Volcano Press.
- Talley, P.F. (2005). *Handbook for the Treatment of Abused and Neglected Children*. Binghamton, NY: Haworth Press.
- Talley, P.F. & Talley, C.O. (2004). Sperry's Solution to Conflict Between Science and Religion. *Journal of Psychology and Christianity*, 22, 43-38.
- Timmer, S. G., Urquiza, A. J., & Zebell, N. (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of Parent Child Interaction Therapy, *Child & Youth Services Review*, 28, 1 - 19.
- Timmer, S. G., Urquiza, A. J., Zebell, N., & McGrath, J., (2005). Parent-Child Interaction Therapy: Application to physically abusive and high-risk dyads. *Child Abuse & Neglect*, 29, 825-842..
- Timmer, S.G., Sedlar, G., & Urquiza, A.J. (2006). Challenging Children in Kin vs. Non-kin Foster Care: Perceived Costs and Benefits to Caregivers. *Child Maltreatment*.
- Timmer, S. G., Ware, L., & Urquiza, A. (2005). The effectiveness of Parent-Child Interaction Therapy for Victims of Interparental Violence. *Violence Against Women*, manuscript under review.
- Urquiza, A.J. (2003). Role of the psychologist. In M.S. Peterson and M. Durfee (Eds.), *Child abuse and neglect: Guidelines for identification, assessment, and case management*. Volcano, CA: Volcano Press.
- Urquiza, A.J. (2003). Point/Counterpoint: The mandated reporting debate. Yes, there should be mandated reporting for researchers. *American Psychological Association Monitor*, 34(6), 28-29.
- Urquiza, A.J. & Blacker, D.M. (2005). Clinical assessment of maltreated children. In P. F. Talley, (Ed.), *Handbook for the Treatment of Abused and Neglected Children*. Binghamton, NY: Haworth Press.
- Urquiza, A.J., McGrath, J., Terao, S. Kasiraj, J., & Wiser, C. (2003). When do you refer for mental health treatment and evaluation? In M. S. Peterson and M. Durfee (Eds.), *Child abuse and*

neglect: Guidelines for identification, assessment, and case management. Volcano, CA: Volcano Press.

Urquiza, A.J. & Stock, P. (2003). Parent-child interaction therapy. In M.S. Peterson and M. Durfee (eds.), *Child abuse and neglect: Guidelines for identification, assessment, and case management.* Volcano, CA: Volcano Press.

Urquiza, A.J., & Elliott, K. (in press). Interpersonal violence research with ethnocultural research populations. In J.E. Trimble and C.B. Fisher (Eds.), *The responsible conduct of research involving ethnocultural populations and communities.* Thousand Oaks, CA: Sage Publications.

Zebell, N. & Petersen, M. (2003). Special risk factors intensified by social isolation. In *Child abuse and neglect: Guidelines for identification, assessment, and case management.* Volcano, CA: Volcano Press.

Appendix A

Procedures for Handling Performance Issues

Whenever a supervisor becomes aware of a trainee's problem area or deficiency that does not appear resolvable by the usual supervisory support and intervention, the following procedures will be followed.¹ These procedures provide the intern and staff with a definition of competence problems, a listing of possible sanctions, and an explicit discussion of the due process procedures. Also included are important considerations in the remediation of problems or competence problems.

I. Definition of Competence Problems

Competence problems are defined broadly as an interference in professional functioning which is reflected in one or more of the following ways:

- 1) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior;
- 2) an inability to acquire professional skills in order to reach an acceptable level of competency; and/or
- 3) an inability to control personal stress, interpersonal difficulties, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning.

While it is a professional judgment as to when an intern's behavior becomes a competence problem, problems typically become identified as competence problems when they include one or more of the following characteristics:

1. the intern does not acknowledge, understand, or address the problem when it is identified;
2. the problem is not merely a reflection of a skill deficit which can be rectified by academic or didactic training;
3. the quality of services delivered by an intern is sufficiently negatively affected;
4. the problem is not restricted to one area of professional functioning;
5. a disproportionate amount of attention by training personnel is required; and/or,
6. the intern behavior does not change as a function of feedback, remediation efforts, and/or time.

II. Remediation and Sanction Alternatives

It is important to have meaningful ways to address competence problems once they have been identified. In implementing remediation or sanction interventions, the training staff must be mindful and balance the needs of the intern, the clients involved, members of the intern training group, the training staff, and other agency personnel.

1. **Verbal warning** to the intern emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept.
2. **Written acknowledgement** to the intern formally acknowledges:
 - a) that the Training Director (TD) is aware of and concerned with the performance rating;
 - b) that the concern has been brought to the attention of the intern;
 - c) that the TD will work with the intern to rectify the problem or skill deficits, and;
 - d) that the behaviors associated with the rating are not significant enough to warrant more serious action.

¹ Adapted from APPIC Due Process Guidelines

The written acknowledgement will be removed from the intern's file when the intern responds to the concerns and successfully completes the internship/fellowship.

3. **Written warning** to the intern indicates the need to discontinue an inappropriate action or behavior. This letter will contain:
 - a) a description of the intern's unsatisfactory performance;
 - b) actions needed by the intern to correct the unsatisfactory behavior;
 - c) the time line for correcting the problem;
 - d) what action will be taken if the problem is not corrected; and,
 - e) notification that the intern has the right to request a review of this action.

A copy of this letter will be kept in the intern's file. Consideration may be given to removing this letter at the end of the internship/fellowship by the TD in consultation with the intern's supervisor and Director. If the letter is to remain in the file, documentation should contain the position statements of the parties involved in the dispute.

4. **Schedule Modification** is a time-limited, remediation-oriented closely supervised period of training designed to return the intern to a more fully functioning state. Modifying an intern's schedule is an accommodation made to assist the intern in responding to personal reactions to environmental stress, with the full expectation that the intern will complete the internship/fellowship. This period will include more closely scrutinized supervision conducted by the regular supervisor in consultation with the TD. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:
 - a) increasing the amount of supervision, either with the same or other supervisors;
 - b) change in the format, emphasis, and/or focus of supervision;
 - c) recommending personal therapy;
 - d) reducing or redistribution of the intern's clinical or other workload;
 - e) requiring specific academic coursework.

The length of a schedule modification period will be determined by the TD in consultation with the primary supervisor and the Director. The termination of the schedule modification period will be determined, after discussions with the intern, by the TD in consultation with the primary supervisor and the Director.

5. **Probation** is also a time limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the intern to complete the internship/fellowship and to return the intern to a more fully functioning state. Probation defines the relationship that the TD systematically monitors for a specific length of time the degree to which the intern addresses, changes and/or otherwise improves the behavior associated with the inadequate rating. The intern is informed of the probation in a written statement, which includes:

- a) the specific behaviors associated with the unacceptable rating;
- b) the recommendations for rectifying the problem;
- c) the time frame for the probation during which the problem is expected to be ameliorated, and;
- d) the procedures to ascertain whether the problem has been appropriately rectified.

If the TD determines that there has not been sufficient improvement in the intern's behavior to remove the probation or modified schedule, then the TD will discuss with the primary supervisor and the Director possible courses of action to be taken. The TD will communicate in writing to the intern that the conditions for revoking the probation or modified schedule have not been met. This notice will include the course of action the TD has decided to implement. These may include continuation of the remediation efforts for a specified time period or implementation of another alternative. Additionally, the TD

will communicate to the Director that if the intern's behavior does not change, the intern will not successfully complete the internship/fellowship.

6. **Suspension of Direct Service Activities** requires a determination that the welfare of the intern's client or consultee has been jeopardized. Therefore, direct service activities will be suspended for a specified period as determined by the TD in consultation with the ADPS and Director. At the end of the suspension period, the intern's supervisor in consultation with the TD will assess the intern's capacity for effective functioning and determine when direct service can be resumed.

7. **Administrative Leave** involves the temporary withdrawal of all responsibilities and privileges in the agency. If the Probation period, Suspension of Direct Service Activities, or Administrative Leave interferes with the successful completion of the training hours needed for completion of the internship/fellowship, this will be noted in the intern's file and the intern's academic program will be informed. The TD will inform the intern of the effects the administrative leave will have on the intern's stipend and accrual of benefits.

8. **Dismissal** from the Internship/fellowship involves the permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the competence problems and the trainee seems unable or unwilling to alter her/his behavior, the TD will discuss with the Director the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the APA Code of Ethics, or when imminent physical or psychological harm to a client is a major factor, or the intern is unable to complete the internship/fellowship due to physical, mental or emotional illness. When an intern has been dismissed, the TD will communicate to the intern's academic department that the intern has not successfully completed the internship/fellowship.

III. Procedures for Responding to Inadequate Performance by an Intern

If an intern receives an "unacceptable" rating from any of the evaluation sources in any of the major categories of evaluation, or if a staff member has concerns about an intern's behavior (ethical or legal violations, professional incompetence), the following procedures will be initiated:

1. The staff member will consult with the Training Director (TD) to determine if there is reason to proceed and/or if the behavior in question is being rectified.
2. If the staff member who brings the concern to the TD is not the intern's primary supervisor, the TD will discuss the concern with the intern's primary supervisor.
3. If the TD and primary supervisor determine that the alleged behavior in the complaint, if proven, would constitute a serious violation, the TD will inform the staff member who initially brought the complaint.
4. The TD will meet with the Intern Supervisors Committee (ISC) to discuss the performance rating or the concern.
5. The TD will meet with the Director to discuss the concerns and possible courses of action to be taken to address the issues.
6. The TD, primary supervisor, and Director may meet to discuss possible course of actions.
7. Whenever a decision has been made by the Director or TD about an intern's training program or status in the agency, the TD will inform the intern in writing and will meet with the intern to review the decision. This meeting may include the intern's primary supervisor. If the intern accepts the decision, any formal action taken by the Training Program may be communicated in writing to the intern's academic department. This notification indicates the nature of the concern and the specific alternatives implemented to address the concern.

8. The intern may choose to accept the conditions or may choose to challenge the action. The procedures for challenging the action are presented below.

IV. Due Process: General Guidelines

Due process ensures that decisions about interns are not arbitrary or personally based. It requires that the training program identify specific evaluative procedures, which are applied to all trainees, and provide appropriate appeal procedures available to the intern. All steps need to be appropriately documented and implemented. General due process guidelines include:

1. During the orientation period, presenting to the intern, in writing, the program's expectations related to professional functioning. Discussing these expectations in both group and individual settings.
2. Stipulating the procedures for evaluation, including when and how evaluations will be conducted. Such evaluations should occur at meaningful intervals.
3. Articulating the various procedures and actions involved in making decisions regarding competence problems.
4. Communicating, early and often, with graduate programs about any suspected difficulties with interns and when necessary, seeking input from these academic programs about how to address such difficulties. Instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies.
5. Providing a written procedure to the intern, which describes how the intern may appeal the program's action. Such procedures are included in the intern handbook. The intern handbook is provided to intern and reviewed during orientation.
6. Ensuring that the intern has sufficient time to respond to any action taken by the program.
7. Using input from multiple professional sources when making decisions or recommendations regarding the intern's performance.
8. Documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

V. Due Process: Procedures

The basic meaning of due process is to inform and to provide a framework to respond, act, or dispute. When a matter cannot be resolved between the TD and intern or staff, the steps to be taken are listed below.

1. Grievance Procedures

There are two situations in which grievance procedures can be initiated. An intern can challenge the action taken by the TD or a member of the training staff may initiate action against an intern. These situations are described below.

a. **Intern Challenge:** If the intern wishes to formally challenge any action taken by the TD, the intern must, within five (5) workdays of receipt of the TD decision, inform the TD, in writing, of such a challenge. When a challenge is made, the intern must provide the TD information supporting the intern's position or concern. Within three (3) workdays of receipt of this notification, the TD will consult with the Director and will implement Review Panel procedures as described below.

b. **Staff Challenge:** If a training staff member has a specific intern concern that is not resolved by the TD, the staff member may seek resolution of the conflict by written request to the TD for a review of the intern's behavior. Within three (3) working days of receipt of the staff member's challenge, the TD will consult with the Director and a Review Panel will be convened.

2. Review Panel and Process

- a. When needed, a review panel will be convened by the Director. The panel will consist of three staff members selected by the Director with

recommendations from the TD and the intern involved in the dispute. The intern has the right to hear all facts with the opportunity to dispute or explain the behavior of concern.

- b. Within five (5) workdays, a hearing will be conducted in which the challenge is heard and relevant material presented. Within three (3) workdays of the completion of the review, the Review Panel submits a written report to the Director, including any recommendations for further action. Recommendations made by the Review Panel will be made by majority vote.
- c. Within three (3) workdays of receipt of the recommendation, the Director will either accept or reject the Review Panel's recommendations. If the Director rejects the panel's recommendations, due to an incomplete or inadequate evaluation of the dispute, the Director may refer the matter back to the Review Panel for further deliberation and revised recommendations or may make a final decision.
- d. If referred back to the panel, they will report back to the Director within five (5) workdays of the receipt of the Director's request of further deliberations. The Director then makes a final decision regarding what action is to be taken.
- e. The Training Director informs the intern and if necessary the training program of the decisions made.
- f. If the intern disputes the Director's final decision, the intern has the right to contact the Department of Human Resources to discuss the situation.

Due Process Procedures for Handling Intern Grievances

This document¹ provides interns a means to address general grievances related to training, supervision, and performance evaluations. Additionally, complaints regarding a specific university act that adversely affects the trainee's existing terms or conditions of employment are managed in similar fashion.

Step 1 – Informal Review

If an intern has specific concerns regarding training, supervision, and/or a supervisors' evaluations, it is first recommended that the intern attempt to resolve such concerns informally with appropriate persons involved and notify the Training Director of such concerns prior to filing a formal grievance. If the matter is not resolved to the intern's satisfaction, a meeting with the Training Director and Director of Mental Health Services will be requested and conducted in a timely manner (approximately two to three weeks). The next step, if the issue remains unresolved, is for the trainee to request a meeting with the faculty liaison, the Training Director, Director of Mental Health, and Executive Director.

Step 2 – Formal Review

A grievance that is not resolved by Step 1 may be presented in writing to Human Resources for review and written response by Department Chair. The grievance must be received within thirty calendar days after the date on which the trainee knew or could reasonably be expected to have known of the event or actions which gave rise to the complaint, or within thirty calendar days after the date of separation from the training program, whichever is earlier. A grievance form is available from the Human Resources Administrator. The Department Chair will respond in writing to the resident within fifteen days after the date the formal grievance is provided by Human Resources to the Department for processing.

Step 3- Hearing

A grievance not satisfactorily resolved at Step 2, which alleges violation of written notice of dismissal, may be appealed in writing to Human Resources for a final and binding hearing, within ten calendar days of the date the Step 2 decision was received or due. The appeal will set forth the issues and remedies remaining unresolved.

¹ Adapted from the University of California, Davis Health System Resident Medical Staff Personnel Policy Manual, 7/2000.

Appendix B

SAMPLE DIDACTIC SCHEDULES ¹

INDIVIDUAL THERAPY DIDACTIC OUTLINE

July 8	Introductions / Overview of Individual Therapy Program Structure and purpose of Individual Seminar
July 15	Topic: Child Welfare System Interns will listen to a 911 tape and conceptualize a video example of play therapy Required reading: Children in the Child Welfare system
July 22	Topic: Dynamics of abusive families Review conceptualizations Required reading: Child Maltreatment and Developmental Outcome
July 29	Topic: Interpersonal Theory – an overview Safran and Seigal: The development of interpersonal schemas and styles of relating Required reading: A theoretical model for integration
August 5	Topic: Therapeutic Use of Play Review of techniques using video examples and role-plays Required readings: What is play and why is it therapeutic? A rationale for selecting toys in play therapy Play therapy for victims of child abuse and neglect
August 12	Topic: Curative Factors in Psychotherapy Required Readings: The therapeutic relationship in the treatment of abused and neglected children Overcoming resistance
August 19	Topic: Clinical Assessment of Children Interns will watch a live therapy session Required Readings: Clinical Assessment of Maltreated Children
August 26	Empirically Validated Treatment Approaches Presented by Dr. June Paltzer Required readings: TBA

¹ Schedules are subject to change.

September 2	Formulation: how to recognize the story Required reading: Wallace Stegner's "The Volunteer"
September 9	Formulation continued: Finding the story using a case example/video Discussion of different theoretical frameworks Required readings: Therapy with neglected children Individual therapy with sexually abused children
September 16	Topic: Formulation continued: Required reading: Luborsky's CCRTs
September 23	Attachment theory applied to the treatment of abused children Required readings: Attachment: An overview Attachment: Individual therapy
September 30	Topic: Clinical Supervision Required readings: Describing and Facilitating Effective Supervision Behavior in Counseling Trainees Fundamentals of Clinical Supervision Becoming an Effective Supervisor
October 7	A case study example: Formulation to Intervention Required Readings: Personal Implications for the therapist Helping children express their feelings about maltreatment
October 14	Intern Case Study and Diagnostic Presentation
October 21	First Live Supervision/Observation
October 28	Second Live Supervision/Observation
November 4	Round Table Discussion
November 11	Veterans Day Holiday
November 18	Intern Case Study and Diagnostic Presentation
November 25	Thanksgiving Holiday
December 2	First Live Supervision
December 9	Second Live Supervision

December 16	Round Table Discussion / Mid-year evaluation of Program
December 23	Christmas Holiday
December 30	Intern Case Study and Diagnostic Presentation
January 6	First Live Supervision
January 13	Second Live Supervision
January 20	Round Table Discussion
January 27	Intern Case Study and Diagnostic Presentation
February 3	First Live Supervision
February 10	Second Live Supervision
February 17	Round Table Discussion
February 24	Intern Case Study and Diagnostic Presentation
March 3	First Live Supervision
March 10	Second Live Supervision
March 17	Round Table Discussion
March 24	Intern Case Study and Diagnostic Presentation
March 31	First Live Supervision
April 7	Second Live Supervision
April 14	Round Table Discussion
April 21	Intern Case Study and Diagnostic Presentation
April 28	First Live Supervision
May 5	Second Live Supervision
May 12	Round Table Discussion
May 19	Intern Case Study and Diagnostic Presentation
May 26	First Live Supervision
June 2	Second Live Supervision
June 9	Round Table Discussion/ End of the year evaluation

PSYCHOLOGICAL EVALUATION DIDACTICS *(sample)*

Program Coordinator: Jayanthi Kasiraj, Ph.D., 734-6641, pager 762-1889
Meeting Time: Wednesday, 8:00-9:45am, Donner I Building, Room E

Pre-test: Schedule and assess an individual by July 21st – administer an IQ test of your choice, brief MSE, and drawings. Submit 2-3 page report with summary of results. Name of individual to contact will be provided.

Weekly

July 7, 2004	Introduction Policy and Procedures, Documentation, Confidentiality
July 14, 2004	Format of the Report, Common writing errors
July 21, 2004	Reviewing court records and organizing the evaluation based on the referral question
July 28, 2004	Mental Status Exam and diagnostic interview of children Preliminary discussion on how to introduce drawings

Every other Wednesday

August 4, 2004	WISC-IV	
August 18, 2004	Memory and Intelligence (Children's Memory Scale, Leiter International Performance Scale – Revised, Vineland Adaptive Behavior Scale, WPPSI-III, WRAML, NEPSI, Bracken, MBA, etc.)	
September 1, 2004	New measure New measure	Intern Presentation Intern Presentation
September 15, 2004	New measure New measure	Intern Presentation
September 29, 2004	Live Demonstration – Interview of a child	
October 13, 2004	Mental Status Exam – diagnostic categories	
October 27, 2004	Developmental Assessments	
November 10, 2004	Field Trip to Child Development Clinic	
November 24, 2004	More New measures	

December 8, 2004	Genetic Disorders – FAS, Down’s Presenter Terry Wardinsky, MD
December 22, 2004	Discussion of assessment cases, obtaining information during school observations, integrating findings
<u>2005</u>	
January 5, 2005	Neuropsychological evaluations
January 19, 2005	Projective measures – Rorschach, Drawings, Apperception Tests
February 2, 2005	Live demonstration with Projectives
February 16, 2005	Continuation of Projective measures and Interpretation
March 2, 2005	Field Trip to the MIND Institute
March 16, 2005	How to assess psychosis in children
March 30, 2005	Case presentations on Psychological Evaluations
April 13, 2005	Case presentations on Psychological Evaluations
April 27, 2005	Integration of Test Results
May 11, 2005	Feedback session to families
May 25, 2005	Catch-up Day
June 1, 2005	Reviewing other agencies’ reports
June 15, 2005	Reviewing other agencies’ reports Discussion of integration
June 29, 2005	Farewell Breakfast

PCIT TRAINING CURRICULUM (sample)

Trainers:

Nancy Zebell, Ph.D./PCIT Coordinator
Leslie Whitten, MA/Clinical Specialist, PCIT Therapist
Lareina Ho, Ed.D./Clinical Specialist, PCIT Therapist
Susan Timmer, Ph.D./Research Analyst
Gabriela Siegel, BA/Community Support Counselor Supervisor

***PCIT Noon Meetings Every Wednesday in Donner I Conference Room**

First Wednesday of Every Month: Check-in & Case Presentations – All PCIT Staff
All other Wednesdays: Continuation of PCIT Training – PCIT Trainees (progression through phases may take longer or shorter depending on the information to be covered)

Pre-training Assessment – July 2nd

Assessment of baseline PCIT skills will be conducted.

Distribute PCIT books/binders:

Parent-Child Interaction Therapy, Hembree-Kigin & McNeil

PCIT Training Binder [includes articles for reading assignments: Section Eight (red)]

Provide overview of materials contained within books and binders.

Monthly PCIT meeting for all PCIT staff – July 7th

Case Presentation by Anne Walter, Psy.D., and discussion of topical issues.

Introduction to PCIT – July 14th

PCIT Book: Hembree-Kigin/McNeil pp. 1-13

Training Binder:

Section One (white section)

Section Two (yellow section)

Articles:

PCIT: An Intensive Dyadic Intervention for Physically Abusive Families/Urquiza & McNeil

Parent-Child Interaction Therapy/Hershell, et al.

Video Presentation: Pulse Tape & Pre/Post treatment sessions

Fundamental – July 21st, 28th, August 11th, 18th, 25th, & September 8th

Training Binder:

Section Four (purple section)

Dyadic Parent-Child Interaction Coding System DPICS-A (spiral-bound booklet in back pocket of binder)

Review PRIDE Skills

Begin Coding Instruction

Role Plays (Practice and Demonstrate CDI Mastery & Coding Accuracy)

Skills to Acquire:

- ✓ Meet Mastery Criteria for Child-Directed Interaction (CDI) Skills in five-minute role-plays.
- ✓ Code parent-child interactions in role-plays and video demonstrations with 85% accuracy.

Monthly PCIT meeting for all PCIT staff – August 4th

Updated PCIT intake procedure presentation by Susan Timmer, Ph.D.

Monthly PCIT meeting for all PCIT staff – September 1st

CDI Case Presentation by Tanda Almont, Psy.D., and discussion of topical issues.

PCIT Conference – September 15th & 16th

Trainees may attend presentations that they find interesting. No need to attend the PCIT overview presentation.

Article:

Reactive Attachment Disorder: What we know about the disorder and implications for treatment/Hanson & Spratt (last article in Section 8, red section of PCIT binder).

Intake Assessment – September 22nd

PCIT Book: Hembree-Kigin/McNeil pp. 15-26

Training Binder: Section Three (orange section)

Video Presentation: Robert

Skills to Acquire:

- ✓ Utilize standardized behavioral measurements in assessment and treatment planning.
- ✓ Conduct Structured Behavioral Observations (Dyadic Parent-Child Interaction Coding System) as a component of the assessment process.
- ✓ Code parent-child interactions with 85% accuracy using DPICS.

Relationship Enhancement (CDI) Didactic – September 29th

PCIT Book: Hembree-Kigin/McNeil pp. 27-47

Articles:

Clinical Issues in PCIT/Herschell, et al.

PCIT: New Directions in Research/Herschell, et al.

Video Presentations:

Relationship Enhancement Video

Examples of Active Ignore

Role Play (Practice Giving CDI Didactic)

Skills to Acquire:

- ✓ Teach and demonstrate behavioral play therapy skills (PRIDE).
- ✓ Teach and demonstrate use of selective attention/ignoring.
- ✓ Teach and demonstrate avoidance of questions, commands, and critical statements.
- ✓ Explain and provide rationale for completing daily homework.
- ✓ Review toys that are appropriate for special play-time.

Monthly PCIT meeting for all PCIT staff – October 6th

CDI Case Presentation by Georganna Sedlar, Ph.D., and discussion of topical issues.

Relationship Enhancement (CDI) Coaching – October 13th – Dec.

Level I & II discussion and video presentation – October 13th

Level I & II role plays – October 20th, 27th, & November 10th

Level III discussion and video presentation – November 17th

Level III role plays – December 8th, 15th, 22nd & January 12th

Level IV discussion and video presentation – January 19th

PCIT Book: Hembree-Kigin/McNeil pp. 49-69

Articles:

PCIT With a Family at High Risk for Physical Abuse/Borrego et al.

*Importance of Therapist Use of Social Reinforcement with Parents....*Borrego/Urquiza

Video Presentations: Coaching Levels I, II, III

Work Sheets: Coaching Words for Levels I, II, III (to be distributed)

Role Plays (Practice Coaching CDI Skills: broken-down into Levels I, II, & III)

Skills to Acquire:

- ✓ Model CDI Skills during all interactions with parent and child from the outset of contact to termination of session.
- ✓ Use ten-minute check-in phase of therapy to build rapport and briefly review progress/concerns/completion of homework.
- ✓ Code parent on PRIDE skills during 5-minute behavioral observation.
- ✓ Coach easier-to-master skills (e.g., description, imitation) before more difficult skills (labeled praise, avoiding questions).
- ✓ Coach basic PRIDE skills by initially modeling and providing parents with actual words if necessary.
- ✓ Progress from directive to less directive coaching by praising/reinforcing appropriate parent verbalizations (e.g. give more praise than correction).
- ✓ Coach qualitative aspects of parent-child interaction (e.g., physical closeness/affection, eye contact, vocal and facial expression, developmentally sensitive teaching, task persistence, frustration tolerance, sharing, polite manners, and generalization of positive behavior to other settings).
- ✓ Provide five minutes of positive feedback to parents on their mastery of skills and discuss homework plan.
- ✓ Document parent and child progress, strengths, concerns, and track skill mastery on frequency chart.

Monthly PCIT meeting for all PCIT staff – November 3rd

CDI Case Presentation by Lareina Ho Ed.D., and discussion of topical issues.

Monthly PCIT meeting for all PCIT staff – December 1st

CDI Case Presentation by Kimberly Lake, Psy.D., and discussion of topical issues.

Monthly PCIT meeting for all PCIT staff – January 5th

Case Presentation by Theresa Lawscha, MS and discussion of topical issues.

In-Home PCIT Overview – January 26th

Referral Process

Adjunct PCIT Services & RET Program

Video Presentation

Monthly PCIT meeting for all PCIT staff – February 2nd

PDI Case Presentation by Pamela Lueders, Ph.D., and discussion of topical issues.

Mid Treatment Assessment & Intro to PDI – February 9th

Video Presentation: Giving Effective Commands, Daniel, & Dawane

PCIT Book: Hembree-Kigin/McNeil pp. 71-80

Skills to Acquire:

- ✓ Utilize five-minute coding sessions & parent reports to assess parent/child readiness for transition to Parent-Directed Interaction Phase of treatment.
- ✓ Document mastery of CDI skills in at least two five-minute coding sessions prior to teaching discipline skills.
- ✓ Conduct Structured Behavioral Observations (Dyadic Parent-Child Interaction Coding System) as a component of the assessment process.
- ✓ Utilize standardized behavioral measurements in assessment and treatment planning.

Giving Effective Commands Didactic – February 16th

Role Play (Practice Giving Be Direct Didactic)

Skills to Acquire:

- ✓ Provide rationale for teaching discipline skills to parents and emphasize the importance of continuing to use PRIDE skills.
- ✓ Teach and demonstrate rules for giving effective commands (BE DIRECT).
- ✓ Teach and demonstrate importance of praise for compliance (COMMAND-COMPLIANCE-PRAISE).

Strategies to Improve Compliance Didactic – February 23rd & March 9th

PCIT Book: Hembree-Kigin/McNeil pp. 80-120

Video Presentations:

Strategies to Improve Compliance

Time Out Examples

Role Plays (Practice Teaching & Implementing Disciplinary Sequence & Practice Minding)

Skills to Acquire:

- ✓ Teach and demonstrate 'two-choices' time-out warning and time-out process.
- ✓ Provide strategies for preventing/managing resistive or aggressive behaviors.
- ✓ Develop favorite activities/privilege list and teach use of removal of favorite activities or privileges for failure to comply with time-out.
- ✓ Role-play 'practice-minding' and use of progressively more difficult commands.

Monthly PCIT meeting for all PCIT staff – March 2nd

PDI Case Presentation by Katherine Elliott, Ph.D., and discussion of topical issues.

Coaching Strategies to Improve Compliance – March 9th, 16th, & 23rd

PCIT Book: Hembree-Kigin/McNeil pp. 121-134

Case Presentations of PDI Coaching

Skills to Acquire:

- ✓ Continue to model CDI Skills during all interactions with parent and child from the outset of contact to termination of session.
- ✓ Use ten-minute check-in phase of therapy to briefly review progress/concerns/completion of homework.
- ✓ Code parent on PRIDE skills during 5-minute behavioral observation.
- ✓ Coach 'practice-minding' before 'real life' or more challenging commands.

- ✓ Progress from directive to less directive coaching by praising/reinforcing appropriate use of PRIDE skills, BE DIRECT skills, and time-out warning and procedures.
- ✓ Coach 'real life' directions and develop plan for implementing time-out procedures in other settings.
- ✓ Provide five minutes of positive feedback to parents on their mastery of skills and discuss plan for carefully selecting necessary commands to practice applying skills at home.
- ✓ Document parent and child progress, strengths, concerns, and track maintenance of PRIDE skill mastery on frequency chart.

Post Treatment Assessment – March 30th

PCIT Book: Hembree-Kigin/McNeil pp. 135-141

Skills to Acquire:

- ✓ Assess readiness for treatment termination with parent based on level of compliance at home, school, and in session, willingness to cooperate with time-out.
- ✓ Assess need for further therapy (e.g., trauma-focused therapy, social skills group) or adjunct services (e.g., home-visits, school consultation, medication assessment).
- ✓ Administer DPICS and obtain standardized behavioral measures to assess achievement of treatment objectives.
- ✓ Provide parent and child with certificate verifying achievement of skill.
- ✓ Document progress/objectives achieved and complete discharge summary.

Monthly PCIT meeting for all PCIT staff – April 6th

PDI Case Presentation by Patty Stock, MS, and discussion of topical issues.

Case Presentation – April 13th

Case Presentation by PCIT Trainee and discussion of topical issues.

Case Presentation – April 20th

Case Presentation by PCIT Trainee and discussion of topical issues.

Case Presentation – April 27th

Case Presentation by PCIT Trainee and discussion of topical issues.

Monthly PCIT meeting for all PCIT staff – May 4th

PDI Case Presentation by Kristen Alongi, Psy.D, and discussion of topical issues.

PCIT CDI & PDI Coaching Challenges – May 11th

Case Presentation and discussion regarding the identification and resolution of challenging issues.

PCIT CDI & PDI Coaching Challenges – May 18th

Case Presentation and discussion regarding the identification and resolution of challenging issues.

PCIT Overview – May 25th

A review of initiating a PCIT case and steps required at onset of treatment.

Monthly PCIT meeting for all PCIT staff – June 1st

PDI Case Presentation by Tylene Cammack-Barry, Psy.D, and discussion of topical issues.

TBA – June 8th, 15th, 22nd, & 29th

Content of these trainings will be based on trainees' requests for further training in specific areas of PCIT coaching. Curriculum will include case presentations, video reviews and discussion of topical issues.