Internet Based-PCIT (IPCIT): Recommendations for Service Delivery Prepared in Response to COVID-19 Version 2

Abigail Peskin, M.S., Jamie Sherman, Ph.D., Ellyn Schmidt, M.S.,
Meaghan Parlade, Ph.D. & Jason Jent, Ph.D
Mailman Center for Child Development
University of Miami, Miller School of Medicine

W. Andrew Rothenberg, Ph.D
Mailman Center for Child Development, University of Miami
Duke University Center for Child and Family Policy

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Crowdsourcing Innovation Related to IPCIT

PCIT305 could not have compiled this document without the collective input of our team and trainers around the country. What we have learned about IPCIT is that lots of people have great ideas about services delivery. In addition, technology moves so quickly. Therefore, we view this guide as a dynamic document that should be updated periodically as we learn from others regarding their own innovative technique or tips for tech options and/or service delivery. Therefore, we invite the PCIT community to share their ideas with us, which will allow us to build out this resource over time. At a minimum, we will add acknowledgments to your contributions. If you contribute significantly, we will add you as an author to the document. Our goal is to continue to make this resource free so that our PCIT community is as equipped as possible to serve families in need.

If you have ideas and/or content that you would like to contribute, please email Abby Peskin, the lead author of this guide, with your ideas. She can be emailed at: a.pooch@umiami.edu

Disclaimers:

- These guidelines, recommendations, and considerations were developed in part based on University of Miami operating procedures, DePaul University operating procedures, and Florida statutes guiding practice during COVID-19. Some of the recommendations provided within this document may not be permissible within your institution, your practice jurisdiction, or your selected video conferencing software. Each agency reviewing these guidelines and recommendations for practice is responsible for ensuring that the practice recommendations conform with existing laws, statutes, and regulations.

- Some of the strategies recommended within this document are based on lessons learned from trial and error practicing IPCIT at the University of Miami where therapists have served over 150 families via telehealth. It is possible that some of the recommendations within this document may not perfectly align with how you were trained in PCIT. Further, it is possible that some of the recommended practices may not work as well for your specific PCIT practice. We can only relay clinically specific practices that have worked at our site with the genuine hope that they can serve as a starting point to help you work effectively with the families you serve.

- The University of Miami utilizes REDCap, an online HIPAA compliant database for collecting assessments and weekly homework. This guide references REDCap frequently. This software may not be available at your agency. Whenever collecting any type of data or communicating electronically with families, please make sure that you have appropriately consented families to such practices. Always make sure to discuss potential privacy limitations of your chosen communication method.

- These suggested guidelines for IPCIT practice heavily reference Zoom as this is the selected platform that is used within a Business Associate's Agreement (BAA) at the University of Miami. Some of the video conferencing software recommendations may not apply to your selected platform (including whether you have a BAA in place).

Audience:

- **Certified PCIT Therapists and Trainers**
- **Therapists currently being trained and receiving consultation from a certified PCIT Trainer**
- **This document is not intended for mental health professionals who have not received training in PCIT**
- **This document is not intended for families**

Course Objectives:

1. **Understand the technological options and set-up required for both therapist and caregiver to increase chances of a successful Internet-Based PCIT session and consistent audio and visual connection with the patient.**
2. **Learn how to tailor in-person PCIT delivery to make it successful when delivered via telehealth.**
3. **Analyze how stressors and changes in family routine change the setting for PCIT, and understand how to respond to those difficulties in a way that allows the treatment to be completed as close to fidelity as possible while mitigating the family's stressors.**

Additions from Version 1:

1. **A la carte sessions added at the end of treatment - how to complete sibling session or to include a mealtime session, etc., within the unique IPCIT environment.**
2. **More options for how to tailor DPICS for IPCIT, including what to use if families do not have the appropriate toys**
3. **Further detail of how to work with therapists newer to IPCIT - how to scaffold their learning pertaining to coaching caregivers to troubleshoot technology**
4. **Explanation about how to transition families from in-person to telehealth, including how to discuss their concerns about telehealth**
5. **More detailed explanation about how to coach caregivers through PDI, with details about how to help with tricky situations, including what to do when caregivers and children walk out of view of the camera.**

Section 1: Before Delivering IPCIT Services

Department of Health and Human Service Guidelines during the COVID-19 Nationwide Public Health Emergency

- To read the guidelines in full or examine related resources, go here.
- The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).
- During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules under typical circumstances when there is no national emergency declaration.
- OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.
- Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
- Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.
- Under this Notice, however, Facebook Live, YouTube Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in **the provision of telehealth** by covered health care providers.

Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. The list below includes some vendors that report that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA.

- Skype for Business / Microsoft Teams
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet
- Cisco Webex Meetings / Webex Teams
- Amazon Chime
- GoToMeeting
- Spruce Health Care Messenger

Consideration of IPCIT vs. In-Person Services

- During COVID-19, IPCIT is the safest mode of PCIT service delivery for reducing the risk of transmission of COVID-19.
- As a part of informed consent, families should be informed of the potential risk and benefits associated with each service delivery type. Examples of common concerns are listed below, but are not exhaustive.
    - IPCIT
        - Possible reduced privacy of services
        - Potential technology failures during sessions
        - There is a possibility that some aggressive or destructive behaviors may not be seen within view of the camera, which may impact the clinicians' ability to respond in real time.
            - Although this has been listed as a hypothetical risk in many theoretical studies (e.g., Comer et al., 2015), several effective telehealth parent-coaching interventions have utilized phone-coaching rather than videoconferencing, indicating that a therapists' ability to see the child during the coaching is not required for a successful telehealth intervention involving significant improvements in child behavior (Olthius et al., 2018; Ristkari et al., 2019).
        - It is possible that the home environment will be a less controlled environment than an office-based setting. However, the home is one of the natural environments where the child likely displays problematic behaviors, and studies have suggested this lends more ecological validity to the intervention than in-clinic PCIT (Comer et al., 2015).
    - In-Person PCIT
        - Some populations are at increased risk for adverse outcomes related to COVID-19 including: Black and LatinX adults and individuals with underlying medical conditions.

        - Use of public transportation to and from the place of service may increase risk of COVID-19 transmission
        - While wearing a mask and social distancing during services may reduce risk of COVID-19 transmission, it does not eliminate risk. Additionally, many children who exhibit noncompliance are unlikely to comply with wearing a mask for the duration of the session.
        - The long-term consequences of COVID-19 in children and adults are not currently well understood
- Some options for addressing possible concerns related to IPCIT are offered:
    - ***Risk to confidentiality: Does the family have a private space during session?***
        - Telehealth sessions take place outside of the therapist's private office, so there is potential for other people to overhear sessions if the family is not in a private place during the session. It is important to discuss how to establish a private place for sessions where families will not be interrupted. It is also important for families to protect the privacy of the session on their cell phone or other device. Families should aim to participate in therapy while in a room or area where other people are not present and cannot overhear the conversation.
    - ***Is there a crisis management and intervention plan?***
        - Clinicians should discuss with families whether or not they may engage in telehealth if the family is currently in a crisis situation requiring high levels of support and intervention. Before engaging in telehealth, develop an emergency response plan to address potential crisis situations that may arise during the course of telehealth work.
    - ***What is the efficacy of telehealth versus in-person sessions?***
        - Most research shows that telehealth is about as effective as in-person psychotherapy. One RCT about PCIT via telehealth indicates that treatment gains may be even greater via telehealth than in-clinic treatment.
        - Some therapists and families might be concerned that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand nonverbal information when working remotely. Although the therapeutic alliance differences for I-PCIT and PCIT have not exclusively been evaluated, studies of other parent-coaching treatments have found similar levels of therapeutic alliance for both telehealth and clinic-based services (Wade, Oberjohn, Conaway, Osinska, & Bangert, 2011), and some have found telehealth to produce *greater* therapeutic alliance than in-person treatment (Watts et al., 2020). Additionally, there are similar rates of high satisfaction with treatment for both I-PCIT and PCIT in Comer et al.'s (2017) RCT. There were also similar retention rates between the two treatment formats.
    - ***Does the family's insurance cover telehealth services?***

- Discuss with families their insurance coverage and telehealth services. Connect the family with the billing department and/or case management services, as needed, to support the family in advocating to their insurance company for telehealth services.

Informed Consent Considerations

- If your agency budget allows, you should attempt to utilize video conferencing software that has security features that allow it to be HIPAA compliant if used appropriately and that allows for a Business Associate's Agreement (BAA) between your agency and the software company.
- In the event that a provider is using anything that is less than this standard, even with the flexibility provided from the Department of Health and Human Services during the COVID-19 emergency, the provider should explain the potential privacy risks related to these new forms of service delivery.
- The truth is, even with a BAA in place, software still has the potential to be breached or hacked by outside parties.
- If you plan on communicating with families using a new format (e.g., email, text messages, WhatsApp), consent the families to this process and establish what types of communications will be allowed through these specific formats (e.g., appointment scheduling/confirmation, video conference calendar invite, etc.).
- Based on your agency's selection of software and implementation procedures, you may need to get families to sign a new written informed consent that explains these changes before proceeding with services.
- In the event the development of an updated informed consent is not feasible, these changes should be verbally explained to the family. The family should have the opportunity to have any questions answered. Then families can provide verbal consent and the provider should document that verbal consent was obtained before proceeding with services.

The Process for Obtaining Clinical Informed Consent during COVID-19

These are some suggestions for agencies to consider. However, each agency needs to make sure that their process is consistent with program, agency, state, and national standards/guidelines.

If you do not have consent to email forms to the family you serve, contact the family in advance by phone to explain the informed consent for telehealth. Ask for permission to send this form to them via email and explain any potential privacy risks associated with emailing the form or link to consent in the format your agency chooses. Make sure to utilize email encryption offered by your agency, if available.

Temporary Software Delivery Formats for Informed Consent

- Online survey tool (e.g., Qualtrics, REDCap) that allows for participant signatures and hidden signature fields for providers to sign once returned.
- DocuSign software (available for purchase) that allows for participant signatures and clinician signatures while ensuring no other changes can be made to the form.
- Adobe Acrobat (available for purchase): Utilizing the Fill and Sign Process:
    1. Open Consent form in Adobe Acrobat
    2. Select *Fill and Sign* on the toolbar
    3. Select *Request Signatures*
    4. Add guardian email address
    5. Select *Specify where to sign*
    6. Scroll down and select the line next to Name for caregiver to print name, Caregiver/Guardian Signature for caregiver to provide signature, and Date field for caregiver to provide date.
    7. Then click *send*. If the caregiver/guardian does not receive it, have them check spam/junk email.
    8. Once the individual signs the document, a copy is automatically sent back to the sender's email. This worked with significant ease when testing it out on a phone. ***There is no need to go to an Adobe App.***

How to Obtain Informed Consent

1. Email a link of the informed consent (that you created in Adobe Acrobat or an online survey tool) to the guardian prior to session (with a link to sign the electronic consent).

2. **Option 1:** Start telehealth session with guardian. Clinician then shares their screen that displays the informed consent and reviews the consent with the guardian. Clinician reviews informed consent, answers any relevant questions, and seek verbal consent. Then have guardian complete and digitally sign informed consent form. No services are provided until clinician confirms receipt of guadrian's signed consent.

   Option 2: Call guardian by phone and instruct them to open up the link to informed consent on their device. Review informed consent, answer any relevant questions, and seek and document verbal consent.

3. Your clinical team will need a process (e.g., support staff or therapist confirms receipt) for determining whether clinical consent was obtained via an online survey. The Adobe Fill and Sign approach should provide you with an emailed copy of the signed consent once completed.

4. Once confirmed, proceed with the telehealth session.

Before the first session, consider scheduling a session to discuss the family's tech options:

- Specific to transition to IPCIT during the COVID-19 pandemic, it may be clinically determined a transition session to assess family stressors and plan for general health and well-being is appropriate. Considerations for a transition session are discussed in this document
- Check to make sure the family has high-speed internet with home Wi-Fi (can check internet speed by going to www.speedtest.net when the device is connected to WiFi [not cell service]). Greater than 5-10 Mbps download speed is necessary for IPCIT (however this may vary depending on videoconferencing software). Family internet plan should allow for download of large amounts of data.
    - Low Income Internet Option: If families are not able to do internet-based telehealth because of lack of internet at home, Comcast has expanded its Internet Essentials program, which offers free internet services for eligible families for 60 days. Visit internetessentials.com to learn more.
    - Some families may also be able to use their video conferencing software on their phones with their data plans. Currently during the pandemic several cellular providers are offering unlimited free data plans to address some of these needs.
- Check that the family has the basic necessary equipment, including:
    - A computer (with a webcam), tablet, or smartphone with your clinic's chosen video conferencing software app installed.
    - Bluetooth/wireless headphones (e.g., AirPods) to go with the device the family is using OR wired headphones, plugged in to either the device used for video, or a secondary device (e.g., a smartphone). *If the family has no access to headphones, then you may proceed to coach over the speaker. It will likely feel similar to in-room coaching.*
    - A tripod/other mounting device. If a clamp or tripod is not available, discuss with the family how the device might be propped up (e.g., between two books) so that the video shows as much of the play area as possible (e.g., tripod, clamp, selfie stick, bookcase).
        - If caregiver has none of these options, or the caregiver is using wired headphones that make it difficult to be far from the device, then it works best to prop the device on the floor (shown here)

- If necessary, explain that emerging research supports IPCIT's effectiveness and works well for PCIT's

caregiver-coaching model and explain the purpose of this technology consult (e.g., test out videoconferencing software, going over a safety plan, etc.) is to make sure that services go smoothly.
    - Suggest that one benefit of IPCIT versus in person model is that coaching in the family's natural environment promotes generalization of skills from session to the family's daily life
- If a second caregiver is involved, explore whether the second caregiver could observe the coaching sessions using another device (e.g., smartphone). If so, your clinic's chosen videoconferencing software should be downloaded on that device as well. *If internet bandwidth is a concern, the second caregiver can join the meeting using the "join by phone" audio feature available for many videoconferencing applications (e.g., Zoom) and observe from afar. The second caregiver should remain muted to minimize audio feedback issues. In any event, you will want to test all devices the way a family will use them in a real session, and avoid assumptions of what will and will not work come "game time."*

Give your families and yourself a bit of a break as you try out this new technology for delivering IPCIT.

- For a lot of therapists and families, this technology is new.
- Therapists and families should allow for patience as each party gets acquainted with this new form of technology.
- Acknowledge that beyond learning this new technology, each party is likely experiencing many other stressors so it is important to note that flexibility while providing services is key.
- However, it may be important for families and therapists to devote the necessary time and energy to learn how to use the technology as it will likely make sessions go much smoother.

Transitioning to Telehealth

Some caregivers may be reluctant to switch to telehealth, particularly if they originally opted for in-person treatment. New caregivers can also sometimes be hesitant to start telehealth services, although they are also in high need of behavioral support/coaching.

Unfortunately right now around the world there are many places where telehealth is the only option for families to receive services, so families have the option to either wait for treatment for an indeterminate amount of time, or adapt to telehealth. As COVID-19 numbers increase and decrease in different areas, families may be required to transition from the clinic to telehealth.

Adapting to telehealth will likely be easiest for families whose clinicians are able to address their concerns and ease them into telehealth at their level of comfort.

Below are listed some common themes about why families are sometimes hesitant to try telehealth, but many families are unique in their concerns. Included are some possible strategies to help engage families in telehealth, given common individual concerns.

Addressing possible barriers to telehealth engagement

Families transitioning in the middle of PDI may feel that it is too much change all at once, in a process (i.e., PDI) that is already stressful without the added unknowns of telehealth.

For families or clinicians with these concerns, it can help to have a transition session focused on just CDI. Just coach the caregivers through special time to work out any difficulties that may occur in the technology or environment, and help caregivers feel comfortable with the format. Then another PDI Teach session may be necessary, if only to configure the space for successful PDI, but possibly also to review the time out sequence depending on how much time has elapsed since the original PDI teach.

Families new to IPCIT sometimes express concern for their child's ability to focus on the treatment due to the child's current behavior. Often families who have received other services via teleconferencing (e.g., distance learning) feel their children cannot engage effectively with this treatment modality because focusing on classwork via Zoom (for example) has been so difficult.

Similar to on-site PCIT, provide the family with detail about the format of the session, with an emphasis on the caregiver and child interacting while the caregiver receives coaching from the therapist. Caregivers may assume a therapy session will look like a distance learning session, where a child needs to maintain focus on the screen and a "lesson," which is often difficult for young children. Explaining that the clinician coaches the caregiver during play helps them to understand that the format is different and that child behavior during distance learning does not necessarily reflect how it will look during PCIT.

Families sometimes express concerns about troubleshooting technological issues.

Therapists should explain to the family that technology concerns will be addressed before beginning the sessions and intermittently when concerns arise. Provide the family with multiple methods of contact (i.e., email, phone, text) so they can use the one that is most comfortable for them when technological issues arise. Make sure appropriate consents are in place for those methods of communication. If possible, offer a separate session (or portion of an initial session) to orient caregivers to technology before beginning IPCIT.

Families may be concerned that the home environment is more chaotic and difficult to control than the clinic environment (e.g., including more distractions, more children, other caregivers, etc.).

Indeed, the home environment may be more chaotic than the clinic. However, during the typical course of clinic-based treatment, the goal is for the caregiver to practice skills in the home environment and *hone* skills during in-clinic sessions. With IPCIT, the therapist is afforded a "naturalistic" view into the family's home life, which may allow more effective collaborative problem-solving between the therapist and family for successful home practice.

Clinicians may provide the following IPCIT script for explaining technology and special time to the child, especially those who have transitioned from in-clinic services

For families who switched from PCIT to IPCIT:

"You and your caregiver/s have been coming to our clinic to learn some new ways to get along better. In the clinic, your caregiver/s wore a little earpiece so that I could talk to them from the other room. Since we are meeting through the computer/phone/ipad now, I will need to talk to your caregiver/s through this earpiece/computer/phone/tablet. You may also be able to see me sometimes on the computer/phone/tablet. Everything else will be the same, and you will still play with your caregiver/s while I sometimes say things to them through the earpiece/computer/phone/tablet. Do you have any questions?"

For families new to IPCIT:

"You and your caregiver/s are meeting with me through the computer/phone/iPad to learn some new ways to get along better. I'm going to talk to your caregiver/s through this earpiece/computer/phone/tablet so they can hear me. Sometimes I will tell them things to say while they play with you. Do you have any questions?"

Section 2: Setting up the Tech

Setting up the Tech: Prevention

- Make sure the caregiver has a phone with them for the session, and the phone is charged. The phone may serve as the primary device or the back-up device if their other mobile device fails during the session (e.g., if sound does not work in either direction, if the battery dies, etc.).
- Have the family charge the videoconferencing device and bluetooth headset/AirPods before the session if using a bluetooth device.
- If a family is using a mobile tablet or laptop for video and their phone for audio, make sure that both are charged and they have appropriate wired or bluetooth headphones.
- Remind the caregiver that they need to make sure to possess and secure all the devices they need for session well before session starts (e.g., at least 1 hour before session starts). This will avoid a situation where caregivers have to take a device that a child is playing with (e.g., an iPad or tablet) away from the child to use during session. If caregivers wait too long to secure devices they need, taking them away from their children as session begins could cause significant tantrums and conflict and could cause the session to immediately get off track.
- When creating the Video Conferencing appointment, select the following options (if using Zoom):
    - Under Video, select “On” for Host and Participants
    - Under Audio, select “Telephone and Computer Audio”
    - Click Advanced Options and select: “Enable join before host” and “Automatically record meeting” (if consent was received to record sessions for training or fidelity purposes)
        - Alternatively, therapists may elect to “Enable waiting room” to allow the family to logon prior to the therapist, but not be admitted to the session until the therapist is logged in and grants the family access to the session. Be sure to explain the nature of the “waiting room” to caregivers in advance to prevent hang ups.
    - For a broad list of meeting settings within **Zoom** to consider, see this resource. *This resource was developed for use at DePaul University and is not intended to serve as formal guidance for other agencies. Rather it is meant to serve as a potential template for settings to consider when establishing clinical service meetings within Zoom.*
- Before signing in to the video conferencing session:
    - Open this family’s tracker for CDI/PDI skills and ECBI tracker
    - Open DPICS manual and PCIT Protocol to the page for that session
    - Open coding sheets
        - Can record coding on printed coding sheets.

        - Without access to a printer, some of our clinicians have also needed to be more flexible and use scrap pieces of paper.
        - Creating and using fillable PDFs or word documents as coding sheets is another option, as long as those digital copies are saved in a HIPAA compliant, secure location.
    - Open completed ECBI to see areas to target for labeled praise of positive opposites during coaching.
    - Open completed homework sheets to reference during check-in. If caregiver has not submitted homework sheets, open blank homework sheets
    - Open the family's telehealth safety plan so that phone numbers for caregivers and emergency contacts are readily available.
    - Clear the desktop, and close any open documents and tabs on internet browsers that contain confidential information
    - Close email and any other applications that will make notification noises during the session. Put phones on vibrate or silent. Given increases in working from home, think about how background noises in both settings can be decreased to keep the family focused on the play.
- Clinicians should role-play how to help caregivers troubleshoot common tech issues before beginning IPCIT sessions. This will enable clinicians to feel able to guide caregivers through troubleshooting a variety of issues while feeling calm and confident. The following list offers several helpful scenarios to role play that occur frequently during remote PCIT. Potential solutions for these concerns are addressed below in the section about dealing with tech issues.
    - caregiver audio is not working once they connect to Zoom meeting
    - Clinician conducts a walking tour of the home
        - Clinician helps caregiver identify rooms with distractions
        - Clinician helps caregiver identify rooms with breakables
    - Setting up the camera angle based on the equipment that the family has
        - Practice scenario where there is mount for equipment
        - Practice scenario where there is no mount for equipment
        - Practice scenario where Bluetooth headset is not charged before session
    - Setting up and starting a co-therapy session
    - Setting up Time Stamps for DPICS for reliability checks. Make sure consent for recording has been received.
    - How to handle two caregiver families via IPCIT as it relates to coaching and observing the other caregiver practice
    - Scenarios where there is another child home and only one caregiver
    - Having a supervisor provide live remote video observation
    - Ensuring caregiver has correct amount of toys for Pre-Post DPICS and Coach sessions
    - Child keeps running off screen
    - Prepping the space for PDI
        - Time out chair

        - Time out space
        - Picking the best camera angle for PDI
    - When the child goes off camera during time out or time out room
    - Tech issues in the middle of coaching

Setting up the Session - Therapist:

- In some instances, therapists will record sessions if consent has been received to do so. This should be for clinical training, supervision, or research purposes. Ideally, individuals should not be recording sessions unless they have a BAA in place for their video conferencing software company and their agency.
- In order to record a **Zoom** session on the local computer so that the main view is of the caregiver/child playing, once the host is in the zoom meeting, he/she should click "Gallery view" (located in the upper right hand corner of the screen) and it will display all participants in the meeting as a grid. Then hover over the view of the caregiver/child play space and in the upper right corner, select "pin video." The recording will then have that view locked as the larger view displayed.
    - Note: if there are two therapists in the meeting, the host of the meeting must be the one to make this change because the recording will be based on the host's settings.
- Keep therapist audio and video on during check-in and check-out
- Turn off therapist video during coding and coaching so the child is not distracted. Before turning it off, let the caregiver know the video will be turning off, and why. Also let them know how to respond if the child asks why the video is off.
    - Can have caregiver say "CLINICIAN NAME'S video is off now so that you and I can pay attention to each other during our Special Time. Now it's time for you and I to play together and have so much fun together!"
    - If child persists in asking questions in an attention-seeking manner, therapist can coach caregiver to ignore and describe their own play with the toys enthusiastically until the child rejoins play. Then the caregiver can provide labeled praise for the child joining them in play (e.g., "Great job coming to play with me") and proceed in playing with child while practicing CDI skills.
- Therapist should mute microphone during coding

Setting up the Session - Family**:**

- Family must download Zoom or appropriate video conferencing app to all devices prior to session (it is free, and families do not need to create an account).
- Make sure all devices are fully charged before session.
- Similar to a typical PCIT session, there are a number of activities that need to be completed (e.g., check-in, homework review, coding, coaching, check-out). Because families may use video conferencing for social purposes, therapists may want to lay out the agenda for the session at the beginning to keep conversations focused.

- Instruct the family to click on the link within the email sent by therapist to join the Zoom session (or other teleconferencing software session if not using Zoom).
    - Make sure to have the family give Zoom permission to access the camera and microphone on the device. If families do not do this step, the therapist will not be able to hear them. If that happens, call the caregiver, have them go into the "System Preferences" or "Settings" on their device, open the Privacy setting, and have them toggle to give Zoom access to their microphone and camera.
- If a second caregiver is involved and will be observing, make sure the second caregiver also has the Zoom app downloaded on their phone and also has a headset/earphones available
    - During coaching with first caregiver, second caregiver will turn off video and audio while observing so child cannot see or hear them and be distracted.
- If using a Bluetooth/wireless headset, have family pair the headset with the device BEFORE joining the Zoom session
    - When joining meeting, select Bluetooth/wireless headset as audio preference
- To switch from device audio to Bluetooth/wireless audio, click the arrow next to the mute/microphone button, then select the Bluetooth/wireless headset under both microphone and speaker
- To switch from Bluetooth/wireless audio to device audio, just turn off the Bluetooth/wireless headset
- If using a separate device (e.g., phone) with a wired headset, instruct the family to join the zoom call by phone
    - Open the Zoom meeting invite in email, scroll down, and click "one tap mobile." It isn't necessary to enter a participant ID, just hit the # key when prompted

Dealing with Tech Issues:

- **If the caregiver does not sign into session on time**
    - In the first contact with the family, therapists will likely wish to explain to families that they will wait the amount of time below before contacting them, and that the reason why they contact them so quickly is to help them if they are having tech issues so they can start session ASAP.
    - In the first contact with family, also let them know that if they have any tech issues starting session, to *contact right away* if they cannot solve the issues quickly on their own. This shows the family that the therapist will work closely with them to solve tech issues that arise.
    - In the first session with the family, it also helps to give them permission to email the therapist if they do not see the therapist sign in within the first five minutes. Sometimes the therapist and the family are waiting in separate Zoom sessions, and missing one another. Increased communication is necessary in IPCIT.
    - The following suggestions below may vary from agency to agency. These are provided as general guidelines to promote starting sessions on time.
        - Call the family 5 minutes after the session was supposed to begin.

        - This is sooner than we might check on a family in the clinic, but the family may be waiting in a different Zoom session or having difficulty with the technology that could be expedited by calling them.
    - After 10-15 minutes, send an email asking the caregiver if they need to reschedule.
    - After 15 minutes, sign out of the session.
- **If the caregiver turns off the session accidentally (e.g., by pushing the power button on the bluetooth headset)**
    - Give the caregiver a minute to sign back in, but open their contact information
    - If they don't sign back in within a minute, call them to help them sign back in. Caregivers may not always realize they've turned off the video.
- **If the child turns off the camera**
    - Minimize child's reach or access to equipment
        - Put it up on a higher shelf instead of where it is currently
        - Have caregiver move so their back is facing the camera/blocking access to the device, and the child is blocked
    - Flip device to other camera so that the back of the phone/tablet is facing the child
    - Switch iPad or phone into guided access mode, which can prevent the child from exiting the session without the right passcode
- **If the caregiver has difficulty following directions for completing session, they can give the therapist control of their Zoom** or the therapist can request it following the Zoom instructions for remote control access:
- **If someone cannot hear:**
    - **The family cannot hear WELL:**
        - Have therapist wear headphones with microphone - this often makes it easier for the family to hear and helps with confidentiality within the therapist's environment
        - Check the internet - make sure that no one is using any websites that require a lot of bandwidth.
    - **The therapist cannot hear AT ALL:**
        - FIRST, make sure the volume is on for therapist's device
        - Then make sure the caregiver is not muted on their computer/device. Therapist can see this on their video for Zoom as a red microphone with a line through it.
        - Make sure that in the privacy settings of their device, the caregiver has given Zoom permission to access the microphone
        - Have the caregiver leave the videoconferencing session and log back in, making sure to select, "use computer audio" when they sign back in.
        - If caregiver still cannot be heard via video device, therapist should call and coach via phone.
        - Before the next session, schedule a tech consult session to help the caregiver figure out their audio.

- **The therapist cannot hear WELL:**
  - Sometimes there are other noises in the environment that conflict with the caregiver's speech. Often, just letting the caregiver know this is a problem will help them problem-solve.
  - First, tell the caregiver it is difficult to hear them. If the caregiver does not have a hypothesis, then go into further problem-solving
    - Try to switch from cellular to wifi data, or wifi to cellular depending on caregiver data plan and which they started using.
    - Have the caregiver and/or therapist switch audio from the video device to a phone, calling in to the zoom session. Sometimes this decreased load on the internet will help the family hear or be heard more clearly
  - Sometimes the audio lags. If this happens:
    - Optimize "your turn to talk." Give positive feedback and prompt the caregiver to use the next skill (e.g., "Great labeled praise. What's she doing now.")
    - Focus feedback on what was clearly audible.
    - Pause a few seconds to make sure everything the child and caregiver says is heard.
- **If it is hard to see the video:**
  - Therapist can turn video off earlier to decrease the video being streamed
  - Have caregiver use the video with one device, and audio with another
  - Switch between different devices if possible for this family
- Family's audio input during the session can come through
  - Bluetooth headset/AirPods
    - **Pros:** best option because family can be far away from the iPad/computer and can still hear the therapist for the most part
    - **Cons:** Often hard to hear the child, sometimes hard for caregivers to hear clinician, caregivers have to remember to charge it
    - **If it is hard to hear the child when the caregiver is using AirPods:** One possible solution is to have the caregiver change the microphone that is picking up on their and their child's voices to the built-in mic on their device. To do this during a Zoom meeting, have the caregiver click on the arrow next to the mute button and under "select a microphone" click "built-in input (internal microphone)". This should allow the therapist to clearly hear the child and caregiver while using their AirPods.
  - Wired headset connected to video device
    - **Pros:** Does not need to be charged, usually fewer sound issues
    - **Cons:** The camera needs to be closer to the caregiver and child for the cord to reach the caregiver, so it is harder to see what is happening. More difficult for the caregiver to move around because they need to move the device with them.

        - Wired headset connected to phone, video through a separate device:
            - **Pros:** caregivers can optimize the sound if they call into Zoom from one device. Sometimes also helps to improve the video quality because the devices are working together
            - **Cons:** caregiver is still tethered to a cord, which makes it more obvious to the child that s/he is listening to something, and makes it more likely to get caught on something. Harder to move around during PDI. If the clinician calls the caregiver through their phone number instead of the caregiver calling through Zoom, recording everyone becomes more complicated.
        - Right through Zoom if the family does not have a headset (i.e., the child would be able to hear)
            - **Pros:** Family can still receive services despite lack of equipment. Therapist can more easily hear both caregiver and child. caregiver can move away from the device because there is no cord connecting them.
            - **Cons:** Works best for young children because older children realize that the caregiver is being coached. Children are more aware of the device, and it becomes harder to keep them away from it.
    - Please see this resource for a detailed guide for IPCIT tech set-up in the event that you are utilizing Zoom for service delivery.
    - See below for a chart of options about the possible combinations of video and audio input for caregivers to use for session from home:

Table 1: Possible Combinations of Video and Audio Input for caregivers to Use for IPCIT

Video	Audio	Earphones	Data Connection
Tablet/ Computer	Tablet/Computer (using videoconferencing app)	Bluetooth/wireless earphones (May also use Wired earphones, but limits mobility)	WiFi/Internet

Tablet/ Computer	Phone (when logged into Zoom via computer, change audio to phone and dial number; be sure to tell carer to enter Participant ID that pops up on their screen; this prevents dual audio login from phone and computer and that annoying never-ending screeching echo)	Wired	WiFi/Internet (Phone may be minutes/data)
Phone	Phone (using Zoom app or call the caregiver if volume is not working through Zoom)	Bluetooth/wireless earphones (May also use Wired earphones, but limits mobility)	WiFi/Internet (via app) or may use minutes/data
Tablet/ Computer	Phone (call the caregiver after coding, hold phone up to ear)	None (This should be a temporary solution, in the event that for *that session* the caregiver cannot locate their headphones)	WiFi/Internet (via app) or may use minutes/data
Tablet/Computer/or phone	Tablet/Computer/or phone (using Zoom app)	None (If caregiver does not have a headset and it is okay for the child to hear the coaching, therapist can coach out loud)	WiFi/Internet (via app) or may use minutes/data

Section 3: Consent, Assessment, and Tech Considerations

Consent and Intake:

IPCIT considerations for consent

- If your consent is usually obtained in person, to learn how to obtain consent see the previous section on Informed Consent in Section 1 above. Technologies to use to obtain informed consent include:
    - Adobe fill and sign
    - DocuSign
    - RedCap
    - Qualtrics
    - Verbal Consent that the clinician documents/records
- Review PCIT consent via screen share
- Review PCIT telehealth consent (i.e., if telehealth consent is separate) via screen share
- Assess to make sure the caregiver understands both consents, and answer any questions related to consent
- Set expectations for who will be in the room at each session. Make a plan to have siblings occupied during sessions (e.g., using screen time, game, novel toys, another caregiver).
- Make sure space is set up for confidentiality and privacy (no other non-consented adults present – e.g., nanny, grandmother).
- As a part of the consent process, establish a safety plan with caregivers, including strategies for how to prevent disruptive behavior, as well as back up plans for contacting the family, and emergency contacts. The American Psychological Association offers specific guidelines about how to create a safety plan during teletherapy (APA, 2013). See Luxton's (2010, 2012) articles for how to create thorough safety plans, and how to discuss them with families.

Establish a relationship quickly with caregiver and child

- Most therapists are comfortable with in-person service delivery, and some worry that transitioning to telehealth may take the warmth out of the interaction, or make it more difficult to find a connection with the caregiver and child. However, using similar strategies to the clinic with small adjustments can help it feel just as comfortable for families.
    - Bring the enthusiasm. If you are not a naturally emotive person, this can be difficult, but just like some caregivers have difficulty hearing over telehealth, it's difficult to feel the enthusiasm the same. So dial it up.

- Use as many nonverbal behaviors as possible from the shoulders up. Tilt your head to the side when listening. Nod. Try to watch the video of yourself occasionally to make sure the emotions you're conveying portray understanding and engagement. And enthusiasm!!
- When you use your hands to talk, make sure they can be seen. Hold them about shoulder or neck level, but make sure that you aren't covering your face. So the caregiver can continue to see your enthusiasm.
- For two caregiver families, make sure that each caregiver is heard right from the start. Usually one caregiver dominates the conversation, and it can be more difficult to read the emotions of the other caregiver as well for them to get a word in. Ask the other caregiver for their perspective before giving feedback or discussing an area of disagreement.
- If you are using more than one monitor, make sure Zoom is open on the monitor with the webcam. It looks more like you are looking at the caregiver instead of looking off to the side.
- When you are having a conversation with the caregiver and your camera is on, look back and forth from the video of the caregiver (to monitor facial expressions and other nonverbal behavior) to your webcam so it looks to the caregiver like you are having a conversation directly with them.
- As always, use your PRIDE skills!!
    - Reflect what the caregiver is saying so they can tell you hear them. This is especially helpful if you only hear part of a caregiver statement because they may correct your understanding or elaborate further.
    - Praise caregivers whenever you can.
        - "Thank you for sharing that with me."
        - "Thank you for explaining that to me.
        - "I love how you're so dedicated to finding the right answer for [child]"
    - When you meet the child for the first time, many children in-person and virtually are cautious or shy about meeting a stranger for the first time. This is particularly the case if the caregiver has mentioned their disruptive behavior to them as a reason for meeting that person. So just like in person, use as many PRIDE skills as you can.
        - "You're doing such a good job sitting and waiting for us to play!"
        - "It looks like you found so many fun toys!"
        - "It looks like you're sitting down to play with the blocks. I love how nicely you're sitting with your mom!"

Unique Challenges Related to COVID-19

- There are several resources that can be incredibly helpful when communicating to families about COVID-19. With Dr. Robin Gurwitch's guidance, PCIT International has provided some helpful resources to the PCIT Community.
- In addition, it is recommended that Providers review resources related to Psychological First Aid. There are several free training resources and an App available.
    - **WHO- Briefing note on addressing mental health and psychosocial aspects of COVID-19 OutbreakVersion 1.0**
    - **Psychological First Aid Online Course**
        - **Note:** Be patient when clicking on this link. So many people are accessing this resource that it is taking longer for the page to load than normal. The link is not broken!
    - **Psychological First Aid App**
- Check in about new stressors early and often. Potential questions to ask are:
    - How are kids staying busy during the day/how are they accessing educational materials?
    - Did families receive resources through the school that are now difficult to access (e.g., meals)?
    - Basic life needs check-in.
- How to ensure that children are otherwise occupied while appropriately supervised during intake interview
    - Ideally watched out of earshot in another room by another caregiver or older sibling
    - If caregivers have a sliding glass door or large window they can also step behind/outside the door so that the child cannot hear them but they can continuously supervise the child.
    - Caregiver should be wearing headphones
    - If the child has headphones to watch movies (e.g., on a plane, in the car) they can wear those during session

Completing Assessments and Homework

- ECBI assessment options
    - Mail paper original copyrighted forms to families and have them fill them out, send in pictures to score
    - https://www.pariconnect.com/ Send ECBIs digitally (downside is that individual answers are not paired with the wording of the questions in the score report, so a paper ECBI is necessary to reference)

ECBI Item Responses

Item	Intensity response	Problem response	Item	Intensity response	Problem response
1	4	Yes	19	1	No
2	3	No	20	6	Yes
3	4	Yes	21	1	No
4	4	No	22	5	No
5	2	Yes	23	3	Yes
6	1	No	24	3	No
7	2	No	25	5	Yes
8	4	Yes	26	1	No
9	2	No	27	4	Yes
10	5	Yes	28	3	No
11	5	Yes	29	5	Yes
12	6	Yes	30	2	No
13	2	No	31	3	No
14	5	Yes	32	2	No
15	3	Yes	33	2	No
16	2	No	34	2	No
17	2	No	35	3	No
18	1	No	36	1	No

Note. Range is 1 (Never) to 7 (Always).
"—" indicates a missing response.

    - RedCap/Qualtrics - Administer ECBI and then attach/file paper measures later to account for copyrighted versions (may need publisher permission)
    - Administer over the phone
- Discuss with caregivers when they will be most likely to complete assessments - usually the night before session or that morning. Schedule assessments to be sent then.
- If caregivers do not complete assessments before session, log in and help them access the assessment and recommend they complete them before the beginning session. While flexibility is needed during COVID-19, completion of the ECBI as regularly as possible helps guide treatment tailoring and allows more effective progress monitoring.
- Homework Sheet Completion Options (keep in mind what types of communications the caregiver consented to and the relative privacy limitations of each method listed below)
    - REDCap or Qualtrics - Homework can be sent connected to the ECBI so caregivers are expected to complete them at the same time
    - Fillable PDF that caregivers are expected to submit before session
    - Excel Sheet or secure Google Sheet that tracks homework week after week to be able to track trends in one place. caregivers would email prior to each session.
    - caregivers can print the homework sheet and send a picture to the clinician
    - Clinicians can send a reminder to complete homework when they send an email with the ECBI to be completed

- If not completed before session, share screen with the family and complete the homework sheet with them as a paper version would be completed in the clinic

Tech Session

Ideally before a session when therapists will meet with both caregivers and child together, it can help a great deal to schedule a “tech” session with the family. This is a 15-20 minute (or as long as it needs to be to get the tech right) videoconferencing session in which the clinician works with the family to make sure that:

- The family can access the link for session
- They understand how to access the assessments and homework
- Family and therapists can hear and see one another from the room where play will take place
    - If the video is choppy, have the family try different rooms. Sometimes the reception may be better in one room than another
    - Complete a video walk-through with the front-facing camera and identify potential hazards or distractions for sessions. Some objects may need to be put away during session or temporarily stored during session if space allows.
- The family has a place to prop the video device that will allow for optimal viewing of the play
    - Get creative with how to prop up the video device
        - Stand a phone up between two books or other objects that are heavy enough
        - To get it to tip forward if placed on something high, may need to have the phone or tablet leaning forward onto something so that the camera faces downward into the play area
        - Some play areas may require the device to be placed on the ground so that the clinician can see, particularly if the caregiver needs to use wired headphones. If this is the case, make sure the caregiver sits in between the child and the device whenever possible.

Pretreatment/Intake DPICS

IPCIT considerations

- Ensure that the family has the correct toys for DPICS - send the list from the CDI Teach ahead of time or refer to this supplemental list provided by Steven Kurtz. Make sure to bring up the toys needed at the end of the first intake session. The child may not currently play with those toys often, so caregivers may need time to

find them and get them ready for the DPICS session. Then at the beginning of DPICS session, ensure that the toys in the room are appropriate.
    - Occasionally, it can be difficult for caregivers to choose toys that will engage the child and allow them to lead the play. In these cases, some therapists have found it helpful to explain to the child which toys are appropriate, giving the child examples and even explaining that there are some toys that make caregivers want to give them commands/tell them what to do, so the goal is to find toys that will help them (the child) be the leader.
- Have the caregiver scan the room with the camera on the device so the clinician can ensure there are no DPICS-inappropriate toys in the room - remove if there are. Ask caregiver where other toys in the room are stored in case the child is likely to try to access other toys during the play.
- If the caregiver does not have appropriate DPICS toys, just document this deviation in the note and explain that it was due to COVID-19.
- Whereas families who come in person for DPICS may have an understanding of the situation we are trying to create for IPCIT sessions, families who only participate via telehealth may not. Providing a picture of the setup for an IPCIT session/DPICS could be helpful so that the family understands why we are trying to have video and audio the way we explain and what floor play space we are trying to create. This picture could be used as an example:

- Make sure the child will stay in the room - ideally choose a room that is closed-in rather than a room with an open plan.
- If the child is likely to try to leave the room, consider having the caregiver sit against the door during play (if your agency allows) or if child has no history of trauma

    - For young children, a door knob cover/child safety cover could be put on the door so that child is not able to flee the room
- As children are in the home setting, transitioning to DPICS may be difficult, particularly if play with the caregiver is not yet rewarding. For example, some children may prefer continuing to play with screens (e.g., phone, tablet, video games) rather than play with their caregivers. Families have used a variety of strategies to address this (the list below includes some initial suggestions, but is not exhaustive):
    - To get the child to engage in the initial DPICS, help the caregiver warn the child about the transition, or plan for this transition ahead of time to avoid the ensuing tantrum/arguing
    - Some caregivers have had success pretending that the electricity went out (for a TV) or that the battery died on the tablet. This works occasionally but not forever, so it is a temporary solution
    - For children who consistently have difficulty with this transition, it can help to set up a reward system wherein the child receives a reward/point/sticker for transitioning calmly to play time.

Unique challenges related to COVID-19

Some families may have preferred coming to the clinic because they lack a variety of toys at home. Therefore conducting telehealth DPICS may require sending the family toys if that is in your clinic's budget, or improvising with other things around the house - empty bowls or containers, coloring/drawing with pencils and pens, etc. Other ideas include:

- Cutting out shapes with paper and child scissors (if there are safe child scissors and aggression is not a concern for the child)
- Taping paper towel, toilet paper rolls, tissue boxes, and cereal boxes together to make art/a building
- Making masks from paper plates and string
- Pretend cooking with kitchen items such as bowls, spoons, measuring cups, cake tin
- Using pillows, blankets, and towels to drape over furniture to make a fort
- Using caregivers' old clothes for dress up (could lead to role play that we usually avoid but a possibility if options are limited)
- Using different sized plastic cups for stacking or as blocks
- Paper plates for arts/crafts
- Empty plastic containers/pots for music
- Painting old wooden kitchen spoons as dolls/characters
- Using fridge magnets as our connector magnets with a cooking sheet pan
- Using a tissue box as a "block" sorter (they used different small items from around the house as blocks
- Painting rocks

- Filling plastic water bottles with rice/beans
- Taping toilet paper/paper towel tubes against a wall to create different tunnels/designs and the child dropped marbles/cotton balls down them (similar to a marble run)
- Painting/coloring a picture then cutting out pieces to look like a puzzle
- Making different animals out of paper or milk cartons
- Using colored water bottle tops (red tops from coke bottles/blue tops from pepsi bottles) to replicate games like Connect 4 (while games are not used for special time, families may use for other quality time)
- Making trains out of empty cans and bottle tops

Families may be using a wide variety of combinations of devices for video/audio. Plan to spend extra time on a technology consult prior to the DPICS session to make sure the devices work together effectively. Having the child occupied in another room during this time can make this most efficient and avoids the problem of the child getting bored with the DPICS toys before the assessment has started.

Section 4: Child-Directed Interaction Considerations

CDI Teach

IPCIT considerations

- **Before the session:**
  - Make sure caregivers (and therapist!) have toys available for role-play
  - Send caregivers handouts in case caregivers prefer to print them before session
  - Consider using “share screen” feature to display the handouts if that will help aid the presentation and discussion of the content.
  - Make sure children are otherwise occupied in an activity that will take the whole hour
- **There are several different options for how to complete the role-play.**
  - **Option 1:** If DPICS was recorded, show the child-led play video from DPICS to have the caregiver describe and praise what the child is doing
  - **Option 2:** With a two-caregiver family, have the caregivers take turns role-playing as the child and the caregiver. This strategy allows the clinician to coach each caregiver who is practicing the skills without also needing to act as the child.
  - **Option 3:** Tip the camera so the caregiver can see the toys in front of the therapist and play together to have the caregiver describe the play as they would in the clinic. This strategy works best when only one caregiver is engaged in the treatment or the caregivers do not have toys readily available to role-play.

Unique Challenges Related to COVID-19

- If one caregiver needs to supervise other children during Teach session, one possibility is to record the session so that the other caregiver can watch afterward. Alternatively, that caregiver could call in with a “phone audio only” option from a different device to listen during the session.
- If one caregiver needs to work during the day while the other is working from home, caregivers could either videoconference in from different locations or reschedule for a different session time when both could be home
- Discuss option of special time via Zoom/other video conference if a caregiver is quarantined (isolating from other family members) but healthy enough to practice PRIDE skills while their child is playing in another room.
- Children may have additional adults (aunts, grandparents, adult siblings) caring for them for longer periods of time due to school closures. Sharing PRIDE skills

handout with these caregivers or considering inviting them to join a coaching session via Zoom is one option to promote use of skills across caregivers.

CDI Coaching

IPCIT considerations

- **Structural:**
    - Make sure that toys in the room are appropriate for special time. Sometimes the caregiver will take out toys that are not appropriate despite extensive preparation. (e.g., swords for a sword fight, dodgeball, painting, bats, board games, etc.)
        - Ideally, the goal is for caregivers to critically assess whether those toys are appropriate for special time by asking them pointed questions, including:
            - *Do you think you can avoid using questions and commands while playing _____?*
            - For rough play: *Do you feel like you can ignore if he gets rough with that toy? (e.g., Can you ignore if the ball hits the wall?)*
            - For a game: *Do you feel like you can ignore if s/he wants to play the game a different way? If she does not follow the rules can you ignore and continue the play?* (recognizing games are discouraged for special time)
            - Ideally have the caregiver remove the toys that are not appropriate for special time from the room to decrease the need for directive statements or conflict during the session.
            - The caregiver may let the child know they can play with the other toys (i.e., games, active) **after** special time
            - Remind caregivers the special time toys are chosen to optimize the environment for learning the PRIDE skills and avoiding questions, commands, and criticism.
    - Minimize distractions
        - Play in a room away from other family members if at all possible. If not possible, make sure other family members are engaged in something that is not distracting to the child (e.g., sibling doing homework, another caregiver reading)
        - Remove pets from the room if possible
        - Make sure caregivers understand that special time means the child gets their full attention, so anything else that needs to be done (e.g., folding laundry, cleaning, cooking) should wait until after the session.

    - **Safety hazards need to be removed** (drinks, rolling chairs, outlets, hot water, fragile or breakable objects such as lamps, television sets; sharp corners of furniture should be covered, bookcases should be anchored to wall)
    - Secure the doors (this keeps the child safe by ensuring he/she cannot run out during session)
    - Consider physical placement of caregiver and child to optimize the space. For example, in consultation with the caregiver, have the caregiver sit with their back facing the door or other temptation (such as a toy closet), as they are comfortable. **Before recommending this strategy, make sure that your agency is comfortable with you coaching the caregiver to block the child's exit from the room.**
    - Try to have siblings occupied doing something that will take most of the hour (e.g., playing a quiet game, doing homework, watching a movie, supervised by another caregiver, etc.)
    - Instruct family to have all equipment charged and all materials ready to go at least 1 hour before session and set up at least 15 minutes prior to start of session
    - Have the child use the bathroom before session
- Before coaching:
    - Make sure the caregiver **completes the ECBI**. Wait until they have completed it to complete check in or coaching. Though some flexibility in ECBI completion is warranted given the current COVID-19 situation, ECBIs should be completed as often as possible to track treatment progress and guide that session's coaching.
    - Make sure the caregiver **completes homework**. If the caregiver has not completed and submitted the homework, share the screen, open an electronic homework file (e.g., fillable PDF) and complete it with them.
    - Just like during the first CDI coach session, explain to the child the purpose of the caregiver wearing the headphones/earbuds so that the child understands the necessity of the caregiver keeping them on during play. This can be a very brief conversation and similar to in-person sessions, the child typically moves on as soon as the caregiver starts playing with them.
    - **Ensuring that the caregiver completes the ECBI and homework sheet before the session begins shows caregivers that the sessions have a consistent structure. Modeling this consistency and structure may help caregivers increase their own consistency and use of appropriate structure, both important goals in this treatment.**
- **During coaching:**
    - Give the caregiver quick feedback about whether a different camera perspective/angle is needed. Examples:

            - "The camera fell, so when you have a chance please turn it back to where it was."
            - "I don't know if you realized, but your video turned off. Can you still hear/see me?"
            - "[Child] moved to a different place in the room so I can't see him anymore."
            - Then always provide the caregiver with positive feedback about the new camera angle and thank them for adjusting. That positive feedback helps to take the frustration out of telehealth for the caregiver.
        - Children should not have access to the tablet/computer/phone
        - As a reminder, in two caregiver families the other caregiver could log into Zoom on another device and then mute the mic to observe. They can join the meeting using the "phone only" option to preserve wi-fi bandwidth
- **Audio Problems:** For the audio connection with some families, there may be about a quarter-second lag between someone speaking and being heard by the other party. This makes it difficult to provide quick corrective feedback. If this persists, have the caregiver sign into the session with a phone as well, and switch to the phone audio. Below are some potential strategies to cope with this quarter-second lag problem if it emerges:
    - In these cases, provide corrective feedback to *groups* of DON'T skills instead of correcting each individual DON'T skill (e.g., "Remember when you say 'Look,' that is a command. You could ____ instead.")
    - Rely more on providing supportive/responsive feedback and ignoring inappropriate caregiver behavior during sessions.
    - Alternatively, the therapist may occasionally need to be directive and give the caregiver a command or the therapist may need to use anticipatory coaching. For example, "When he comes to sit next to you, what praise could you give for that behavior?"
    - Provide major corrective feedback at the end of one session, and remind caregivers at the beginning of the next session about what was discussed.
    - If audio problems persist, conduct another tech set up session to troubleshoot as the therapist cannot provide the most effective treatment if they are constantly only able to provide partial coaching.
- **Coaching nuances and troubleshooting:**
    - PRIDE and telehealth
        - Reflections are sometimes more difficult for the therapist to hear and coach, as the child is may be more difficult to hear than in the clinic
            - Possible Solution: If the caregiver says something out of the blue after the child spoke, and it was spoken as a

statement and not a question, consider coaching it as a reflection

- The caregiver likely has many more opportunities for real-life labeled praises of positive opposites in telehealth, so telehealth therapists might consider introducing this concept earlier than during in-clinic treatment. Example statements for caregivers to use:
  - "Great job coming back into the room." (after the child left for a moment, claiming he was going to get a snack)
  - "Thank you for sitting next to me" (after spinning around the room for 2 minutes)
  - "I love that you came back to play with me." (after the child looked at his fish tank for a few minutes, ignoring the caregiver playing)
  - "I love when you play calmly with the toys" (after the child has been climbing on furniture)
- Behavior descriptions are sometimes harder for the therapist to coach because the therapist sometimes does not have a great view of the child's actions. It helps to instead use this to get the caregiver to use more behavior descriptions. Example statements for therapists to use:
  - "I can't see him, what is he doing?"
  - "It looks like he's doing something with that box." (i.e., describe very vague with the goal that caregivers will describe in more detail if they can see what the child is doing)
  - "I see he picked up a crayon, but I can't tell what he's doing with it."
- For imitation/engagement, make sure ahead of time that there are enough of each toy so the caregiver and child can both play without the child feeling possessive of the toys

- Caregivers sign in from a new location
  - Sometimes caregivers sign into session and the therapist may not recognize the location. Due to the remote nature of telehealth, it is possible that caregivers go on vacation and the therapist is not advised ahead of time. If this happens, make sure to:
    - Confirm if the family is in this location permanently (i.e., they have moved) or temporarily (i.e., they are on vacation).
    - Complete a new safety plan about this location. Make sure the safety hazards present are thoroughly explored and addressed, and that emergency contacts, caregivers'

address and nearest emergency services/hospital are recorded
    - Therapists should know who else is in the home during sessions, and that caregivers have a plan for keeping them occupied/out of the room during session
    - If during PDI, create a new plan with caregivers about the time out chair, time out room, and play room close to the time out room/chair.
    - If needed, consider rescheduling the coaching portion of the session, as the planning for a new location may require much of the session.
- **Check-out:**
    - Turn therapist camera view back on
    - It helps at this point to also give the child some positive feedback, similar to returning to the therapy room during in-clinic sessions
    - Then help the caregiver structure the environment for the child's independent play or to allow the child to leave the room (if determined appropriate by the caregiver) while the caregiver completes the check-out with the therapist. If the child remains in the room during a telehealth check-out, the therapist should continue to coach the caregiver to utilize intermittent PRIDE skills to maintain the child's attention on the activity while the caregiver is talking to the therapist. For example, "Thank you for playing so nicely with Mr. Potato Head over there while I talk to [Therapist Name]."
    - Share screen with caregiver to show them their growth in CDI skills and change over time on the ECBI
    - Encourage the caregiver to continue to praise positive opposites by pointing out those that are observable from the videoconference

Managing Dangerous and Destructive Behavior During CDI in IPCIT

These suggestions are adapted from guidelines from Cheryl McNeil and Nancy Wallace for in-clinic strategies for these behaviors)

- **Important:** If therapists see behavior headed this way (e.g., child is escalating and becoming frustrated because the caregiver is early in CDI and perhaps being overly critical or issuing many commands) in coding during telehealth, the therapist has to consider whether or not to sacrifice coding and help the caregiver navigate away from that behavior for that session. Future sessions will provide more opportunities for coding.

- If the child does something physically dangerous (e.g., climbing, running out of the room, self-injurious behavior)
    - Prevention is a very important part of this strategy. To the degree that it is possible for a family, consider removing anything from the room that will be a trigger for dangerous behavior like climbing. If needed take all chairs and low furniture out of the room.
    - Coach the caregiver to physically move the child if the behavior is dangerous (unless taking a complete and total hands off approach to PCIT).
        - Emphasize that the caregiver should provide no verbal attention when moving the child.
    - Ideally find a way to eliminate the danger (e.g., remove the chair from the room, close the door so the child cannot escape the room)
    - Then redirect the child by coaching the caregiver to block the dangerous behavior, play on their own enthusiastically until the child rejoins, and then look for praises that can be used when the child returns to play or at the very least returns to safe behavior
- If the child is destroying property (e.g., throwing a toy, writing on the walls), the therapist will work mutually with the caregiver to determine the level of risk, and may employ some of the following responses to allow for IPCIT coaching:
    - If minimal risk, the therapist may coach the caregiver to issue a single warning statement, such as, “If you write on the table again, the crayons will have to be put away.”
    - If minimal to moderate risk and the property is misused or at-risk of being broken, the toy may be removed (at home, this may mean putting it away, putting it up high out of reach, etc.).
        - If a toy is removed, then the therapist may decide to divert attention within special time to the remaining toys or remove the remaining toys, depending on the likelihood of additional destructive behavior.
    - The therapist may choose to end special time for destructive behavior, with the aim to start special time again if possible (to allow for coaching) when the child is calm.
- If the child is aggressive toward the caregiver *or anyone else in the vicinity* (e.g., pet, sibling, other caregiver who wander in)
    - *Ideally, if aggression is anticipated from the child during play, this strategy should be discussed during the CDI Teach session when introducing ignoring/strategic attention and ending special time due to aggression.*
    - If the caregiver anticipates that it will not be safe to ignore due to escalating child aggression, discuss where either the child or caregiver can go to be separate from one another until the child calms down. Things to consider during this discussion may include:

        - What setting environment (e.g., other people, objects in the room, pets, doors, etc.) will provide the safest setting for all parties involved?
        - Can the caregiver move the child safely to another location?
        - Can the caregiver separate from the child and ensure the safety of the child and anyone else in the home?
        - Is there a way to make the environment safer before beginning the play so that if the worst case scenario occurs, the caregiver feels prepared to respond?
    - For the majority of children in telehealth, the most feasible strategy for responding to aggression will be to end the play, which is consistent with special time home practice by the caregiver. Once play is ended due to aggression:
        - For the remainder of the session, coach the caregiver to ignore the ensuing tantrum, and praise any positive opposite behaviors that emerge as the child is calming down.
        - Coach the caregiver through consistency and standing firm, as this time after ending the play when the child is still upset will be most tempting for the caregiver to resume play with the child to alleviate the tantrum
        - Coach the caregiver to redirect their own attention to an activity they enjoy or needed to do (e.g., work if the caregiver is working from home, doing their nails, reading a book, cooking)
    - If the aggression happens early within the session, the therapist may clinically assess the appropriateness of reintroducing special time after the child calms.

Unique Challenges to CDI Coaching Related to COVID-19

- Additional siblings may now be in the home that were not there previously
    - While having multiple siblings in the home is not as controlled as a clinic setting, this gives therapists a really nice glimpse of what the family's typical life is like.
    - If multiple caregivers are available, have them take turns caring for the other children.
    - If only one caregiver is available, at a minimum attempt to help the caregiver to get the other children to engage in a separate activity at least during DPICS and CDI coding. This allows the therapist to at least assess progress on a weekly basis.
    - Consider scheduling sessions when the non-target sibling typically naps.
    - If another sibling in the PCIT age-range needs to be present in the room during the CDI telehealth session:

        - Younger siblings (i.e., infant to young toddler) can possibly be kept busy but close in a swing, high chair, stroller, baby bouncer, or pack-n-play. Any of these strategies may make conflict less likely but provide entertainment to the infant so the caregiver can focus on the target child.
        - Older siblings can:
            - Watch a movie or have their screen time during session
            - Wear noise-canceling headphones if in the same room, so it is easier for them to stay distracted
            - Read a book
        - Siblings within the PCIT age-range
            - A sibling may engage in “quiet time” where they play independently, possibly using a mat or blanket to define their play space, while the target child engages with the caregiver in special time
            - The caregiver may transition to special time with the sibling (one-on-one) while the target child transitions to “quiet time”
    - If the other sibling initially has difficulty staying in the quiet area and instead frequently attempts to join the play with caregiver and target child, to “shape” the sibling’s behavior toward independent play, consider how to coach the caregiver:
        - Where to sit to decrease contact and conflict between siblings
        - To choose a variety of toys to decrease the likelihood of one child taking toys from the other out of boredom
        - To provide a reinforcing environment for the sibling to decrease motivation for disrupting the target child’s play due to disproportionate attention given to the target child
        - To focus praise for the sibling on positive attention for independent play
- Homework with caregivers who are quarantined or caregivers who are isolating because they are healthcare workers or frontline responders:
    - Zoom/videoconference with child from a different room/location like caregiver would do during vacation or trip apart from child
    - Keep toys in the location with the caregiver until they come out of quarantine, and disinfect thoroughly before bringing them home.

Section 5: Parent-Directed Interaction Considerations

Clinical Decision Making Related to Starting PDI

Consider some of the following factors when deciding whether to transition to PDI in the IPCIT delivery context:

- PCIT International has provided some helpful resources to the PCIT Community that may guide decision making related to starting PDI.
- Possible clinical considerations for PDI Transition in addition to meeting CDI criteria to weigh when doing IPCIT (or even regular PCIT for that matter):
    - How is the family's attendance rate?
    - How is CDI homework completion?
    - Does the caregiver effectively use strategic attention?
    - Are PRIDE skills generalizing throughout the day?
    - Does the interaction seem warm and genuine?
    - Does the child enjoy Special Time?
    - Is the caregiver responsive to coaching?
- Does the family have a reliable portable audio connection while the caregiver moves about the room and a reliable video connection that captures special time, the time out chair, and (preferably) the time out room, such as either:
    - Wireless earphones (audio) with a portable electronic device (video), or
    - Wired earphones connected to a phone (audio) AND a second electronic device (video)
- Revisit the safety plan in preparation for PDI:
    - How does the safety plan change? Does anything need to be added?
    - What are the back-up methods for communication if there is a disruption in telehealth connection?
    - In some extremely rare instances similar to in-person PCIT services, caregivers can become so upset during the PDI sequence that they want to leave the session. Within IPCIT, a caregiver could hypothetically elect to hang up or end the video conference meeting. To prevent this from occurring, it can help for the clinician to establish with the family early in treatment that it is important for them to voice any concerns about the PCIT strategies any time they experience them. To increase the likelihood that the therapist can promote the safety of the family and stay on the line, it can help for the therapist to have a discussion with the caregivers before PDI coaching about how to communicate to the clinician if they feel uncomfortable about part of the PDI sequence, rather than ending the phone call.

    - What steps does the family and therapist agree to take if a caregiver purposely and prematurely terminates a PDI session (e.g., debriefing with the family, re-establishing safety plan steps, etc.)?
- Will therapist and family be flexible to move down on the PDI Staircase if PDI not going as expected?
- Consider certain factors impacted by the COVID-19 crisis:
    - Caregiver life stress
    - Employment, housing, and food insecurities
    - Can others within the household handle screaming and yelling if conducting their own work (e.g., schoolwork, work video conference meetings)

PDI Teach

- Some families find the time out sequence overwhelming to review via telehealth, particularly if reviewing on their phones. Below are a few options for sharing the time out sequence virtually. Clinicians can pick one or a few to combine.
    - **Option 1:** Send handout to caregivers before the session so caregivers can print it and follow along during the session
    - **Option 2:** Share screen with caregivers during the discussion of the time out room. Zoom in on the parts of the time out sequence discussed and highlight the sentence while discussing it
    - **Option 3:** Provide a handout of the time out script (with larger text) instead of the diagram (which is difficult to see on some screens)
    - **Option 4:** Verbally review time out script with families during the session, and then send the handouts after session.
    - **Option 5:** Create a powerpoint with the time out sequence presented as a process that appears one at a time. Sometimes it can help for the time out sequence to be broken down into the different ways that a child may respond, with different sequences/slides/processes created for each:
        - One for when the child listens the first time
        - When the child listens after the warning
        - When the child goes to time out but stays on the chair
        - When the child goes to time out and does not stay on the chair
        - Etc.
- Plan with caregivers which chair they will use and which room they will use.
    - Have them *show you* the chair.
        - Make sure the chair is heavy enough. Light chairs can be thrown more easily or tipped if the child is moving or standing
        - Not a swivel chair or chair on wheels.
        - Not a rocking chair
        - An adult-sized chair (not a child-sized chair).

        - Preferably a chair without arms (as children may got caught underneath chair arms if they perform chair gymnastics)
        - Typically a kitchen chair will suffice.
        - If there is no appropriate chair available, use an alternative that clearly communicates a small defined space where the child must stay for the duration of the time out. Successful options caregivers have used include:
            - A towel or small blanket
            - A cushion or pillow
            - A step on the stairs
            - Tape to mark off a “timeout square” on the floor (for this one just be sure that the space can still be identified if the child peels the tape off of the floor)
    - Have them *show you* where they plan to place the chair. It needs to be placed:
        - Away from breakable objects
        - Away from glass doors
        - Away from the television or other media device that is entertaining
        - Away from siblings, caregivers, and pets who may be home
        - In a place free from distractions
        - Out of reach of toys the child might like
        - Away from the wall if possible so the child cannot move the chair by pushing against the wall or kick a hole in the wall
        - Away from other furniture, so the child is not tempted to climb onto the furniture
- Have caregivers show you the proposed time out room and brainstorm how to make the room safe and boring for the child
    - Turn dresser around so drawers are not accessible
    - Remove toys
    - Lock cabinets
    - Turn off water in sink at source (if sink is in the timeout room)
    - Remove toilet paper from a bathroom if used as time out room space
    - If there are drawers that cannot be turned around, see if the family is willing to remove the drawers and take them to a different room for PDI practice
    - If there is a TV in the room
        - Can the child reach it? If so, remove it or pick a different room
        - If not, where is the remote? Make sure to remove it before time out room practice
    - Does the door lock from the inside? If so:
        - Does the caregiver have a way to unlock it if the child locks it?
        - Can the caregiver turn the door handle around during the week between the PDI Teach and the PDI 1

    - Is there a window in the room? If so:
        - Does the child know how to open the window? Is there a way to lock it, if so? If there is no way to lock it and the child can open it, pick a different room.
- Consider changing the playroom to make it closer to the time out room.
- Consider the swoop-and-go option (i.e., using the playroom as a time out room) if the child will be difficult to move from the playroom to the time out room
- Consider having time out "space" in the time out room (which would then also become the play room), if the child will be difficult to move from the chair to the room. If this option is chosen, things to consider include:
    - If the time out chair in the room is a safety concern, make sure to remove it before leaving the room.
    - Consider in collaboration with the caregivers other safer alternatives (e.g., mats, pillows) that can still be used as a defined space, and can stay in the room with the child.
    - How to differentiate "time out" from "time out room" so the child is motivated to avoid "time out room"
    - How to get the caregiver safely in and out of the room while keeping the child safely in the room
    - How to make the room appropriate for play but also appropriate for time out room
- Discuss where other caregivers, siblings, and pets will be during PDI practice
- Prioritize the camera view that is most important:
    - When caregivers have multiple devices available and appropriate bandwidth, they could join with both devices which would allow for playroom view and time out room view. While not necessary, this can be a unique help.
    - Make sure that the device has an appropriate protective case on it and is up and away from the child if possible.
    - Switch iPad or phone into guided access mode, which can prevent the child from exiting the session without the right passcode
    - Practice the best camera set-up to maximize the view and prioritize the caregiver's hands-free capability.
- Make sure the caregiver's audio/visual setup is portable.
    - If the caregiver has used a wired headset connected to a larger/less mobile device for CDI, discuss how to increase portability of their audio/visual setup. This can include (but is not limited to):
        - Switching to a phone for audio, and attaching the wired headset to the phone
        - Switching to a phone for both audio and video
        - Switch to a bluetooth headset
        - Ideally, if continuing to use a wired headset, caregivers should put the wire through their shirt and placed in a pants pocket or

waistband so they remember to take the device with them and the headset is less likely to be pulled away by the child

- **PDI Teach Role play:** have a chair that can be used for time out in the family's identified therapeutic area, and have toys available to practice with the caregiver.
    - **Option 1:** Have the caregiver practice moving a stuffed animal through the time out process (i.e., moving to the chair and then to the room), responding to the clinician's modeled compliance or noncompliance.
    - **Option 2:** Have the caregiver practice with the clinician as they might during an in-clinic teach session. For this option, the clinician needs a time out chair set up behind them to move to when they do not comply with the command.
    - **Option 3:** During a teach session with a two-caregiver family, caregivers can take turns pretending to be the child and guiding each other through the time out sequence.

PDI Coach 1

- **Before the session begins, check to make sure:**
    - Time out chair is in place (see discussion above in PDI Teach for how to problem-solve about the correct time out chair)
    - Time Out Back-up room is ready (important to check every week. Things that may have looked fine the week before or during a consult session may have been moved or changed since that time).
        - Safety hazards removed (open windows, outlets, rolling chairs, beverages, hot water, fragile or breakable objects such as lamps, television sets; bookcases should be removed unless anchored to wall)
        - Which way does the door swing? Can the caregiver place his/her foot in the door safely?
        - It is ideal if there is a way to view/monitor the child while in the back-up room without potential for the child to escape. Is it possible to put another device in the time out room where the child cannot reach it, so the clinician can view the child during time out room?
        - If the time out room door locks from the inside, does the caregiver have a key to open it?
        - Fun things should also be removed to make the room less engaging for the child. For example:
            - If the child plays with toys in the bathtub, make sure these toys are removed before practice.
            - If the child tends to build pillow forts during time out, remove the pillows before practice.

    - There is a plan for siblings and pets to stay away during time out and time out room
    - Time out has been explained to others in the home so they will understand what is happening and avoid providing excess attention to child behavior in time out
- **Equipment**
    - Does Bluetooth work if the caregiver walks out of the main room used for the session and down the hall towards the timeout room?
    - Can a second device be set up near or in the back-up/timeout room (e.g., iPad high up on a shelf)?
        - Some caregivers have also used a baby monitor, which is less intrusive to most kids.
    - Make sure devices are charged and that charger cables are readily available in the event of a long time out.
    - With two caregivers, is there an additional device that the caregiver who is not being coached can use to observe in a room away from the time out chair and room?
    - Make sure caregiver has phone or back-up device with them in case the video device runs out of battery or the videoconferencing call drops, so the therapist can call to reconnect as soon as possible.
- **Explaining PDI to the Child** - There are a few options about how to explain the PDI process to the child at the beginning of the first PDI coach session. Choose one or more of these options.
    - **Option 1:** Speak to the child directly through the iPad before the caregiver turns on Bluetooth, or through the headset, using the script in the PCIT Protocol (usually for children ages 4-7)
    - **Option 2:** Coach the caregiver to explain PDI to the child using the script in the PCIT Protocol (usually for children ages 4-7, and with caregivers who are able to explain the protocol without changing the explanation provided over the earpiece)
    - **Option 3:** Coach the caregiver through the Mr. Bear (or Mr. “whatever the animal type” is available) procedure using a stuffed animal they have at home (usually for children 2-3 or children who have developmental delays)

Unique challenges related to COVID-19

- Having a plan for occupying other siblings for longer than usual given the possibility of a long first time-out.
- If that is not available, develop a plan for praising siblings for staying away from the child in timeout and/or ignoring the child in time out.

- Assess caregivers' ability to commit to a longer session for a first time-out given that they may be working from home or have others in the house who are working from home. Discussing this possibility ahead of time and changing the time of session as needed to accommodate their schedule may be necessary
- Making the decision to assign homework in a time of crisis and high stress is difficult:
    - Assess whether caregivers are ready to handle the stress of PDI homework. If they are, consider having the PDI consult after the first PDI practice to check in and assess whether continued PDI practice is appropriate. If not, recommend that they only practice PDI during session until the child's time out behavior has de-escalated somewhat
    - Consider PDI role play practices that the caregiver can complete with a second caregiver or another adult so that they can work on memorizing the sequence based on the child's responses.

PDI Coaching

- Set-up and technology
    - Ensure caregivers already have everything set up at the beginning of the session, and if they do not, then take the time to have them set up the timeout chair and room before the session begins. Even if this means only one caregiver practicing commands during the first session, that is fine.
    - If using another device (i.e., iPad, laptop) with wireless earphones for the session, have the caregiver keep their phone in a pocket as a back-up device in case the call drops during the time out process or they walk out of bluetooth range and cannot hear the coaching.
    - If the caregiver is using a *wired* headset with a phone *for audio only*, have them feed the headset's wire down the inside of their shirt (to prevent them from having earbuds/headset removed), connecting it to the device at the bottom of their shirt. The caregiver should then place the device in a pocket. This keeps the caregiver "hands-free" during coaching. This will only be possible if another device is available for video.
    - Due to the unpredictable nature of telehealth, sometimes the call drops during a command or a time out. Knowing this is a possibility, it can help to maintain the continuity of PDI if the clinician can **coach ahead,** reminding the caregiver of the next two or three steps they will take during the time out sequence. This way, if the call drops or audio is spotty, the caregiver is aware of next steps. For example:
        - If the child is on the chair, in the clinic the clinician would likely focus on coaching ignoring.

            - During IPCIT when coaching ahead the continuity of coaching is retained when the clinician reminds the caregiver of the steps up until complying with the follow-up command.
        - As the caregiver is taking the child to the chair, in the clinic the clinician would often remind them to tell the child to stay on the chair.
            - In IPCIT it can help the caregiver to coach them ahead by reminding them also to *ignore* child behavior and time for 3 minutes.
        - As the caregiver takes the child to the time out room, in the clinic the clinician is often present to nonverbally guide the caregiver through, and help to shut the door and keep it closed.
            - During IPCIT, the clinician cannot physically assist at all, so when coaching ahead it often is helpful to explicitly remind the caregiver to ignore, put the child in the room, close the door, and hold the door closed (e.g., by holding the door handle or by locking the door from the outside).
- Similar to on-site PCIT, during IPCIT:
    - Be consistent with transition statements in the protocol to introduce PDI practice
    - Provide expanded coaching or narrative with rationale during difficult or stressful PDI steps
    - Provide quick correction for ineffective or repeated commands
    - Use clinical judgment in combination with caregiver input to determine child compliance
    - Provide supportive and consistent coaching to support a caregiver in the PDI procedure (including immediately addressing reluctance to follow-through with the time out procedure or to ignore child verbalizations)
- Special telehealth considerations during time out
    - Sometimes caregivers ask the therapist's permission to do something during PDI while the child is on the time out chair. For example, "Can I move that out of the way?" or "Can I move the chair to face the wall?" If the caregiver's request is allowed, and the caregiver will be moving around the child, remind the caregiver to keep ignoring the child on the time out chair.
    - Similar to in-person PCIT, checking in with caregivers during time out and time out room is vitally important. Visual and audio differences can differ between in-person services and IPCIT, so clinicians may need to consider some of the following when delivering services via telehealth.
        - Make sure you can hear the caregiver and they can hear you.

        - Despite troubleshooting in advance, a major challenge of IPCIT is that the caregiver is not always visible to know how they are responding to child behavior. Additionally, the caregiver may not easily speak aloud without the child hearing, except for when the child is in the time out room. So checking in with caregivers may occur more when the child is in the room, and during check out.
- Generalization (typically PDI 3 protocol and beyond)
    - Therapists can move to real life commands using the naturalistic setting as a benefit during IPCIT, because there are many real-life home situations to observe and coach. These include:
        - Brushing teeth
        - Homework
        - Daily transitions (e.g., turning off/putting away technology, moving from more preferred to less preferred activity)
        - Snack time
        - Picking up personal items (e.g., shoes, book bag, clothes)
        - Engaging in some small activity during check in or check out
- When making coaching decisions during PDI, it can help for the therapist to articulate their thought processes to the caregiver, coaching what they should do *and* explaining the rationale behind what is coached. In IPCIT, the therapist's articulated thought process may be of additional importance, because there may be times when the audio cuts out, or the caregiver's battery dies on their headset, etc. If the therapist has articulated the rationale for each action in PDI, the caregiver may be more equipped to quickly respond appropriately to the child behavior even if they cannot hear the therapist momentarily.
    - <u>For example:</u> If the child grabs a toy from the chair and the caregiver needs to take it, coach the caregiver through how to react, but also explain why that reaction is behaviorally appropriate.
- During coach sessions if the caregiver is using a wired headset (to hear the coach's voice) that is also being used for a video feed, it can be helpful for the therapist to provide reminders to caregivers whenever they need to move from where they are. It can help if the therapist reminds the caregiver to keep their headset on by coaching them to FIRST to pick up their device and THEN to complete the next step. This prevents inadvertently losing contact with the clinician and coaching, particularly during a time out sequence.
- Similar to in-person PCIT services, as caregivers are in the process of learning the PDI sequence, they sometimes issue/repeat several ineffective commands at a time, or issue multiple effective commands without correct follow-through. When coaching through IPCIT, it can sometimes be difficult for the caregiver to hear a correction for every issued command due to **lags in audio, or overlapping audio** (e.g., some videoconferencing software selectively mutes one person when the other is speaking). Therefore, it can help the therapist and caregiver focus if the clinician focuses coaching on the first command given,

correcting to an effective, direct command if needed, and then coaching follow-through.
    - For example, it may be helpful for the therapist to remind the caregiver of the command being corrected, and then have them assess if the child complied. The therapist then coaches the appropriate follow-through for compliance or noncompliance, providing additional rationale for the sequence, as needed, and ideally after the sequence is complete.
- Due to limitations of audio/video connection, therapists often rely more on caregiver description of child behavior during IPCIT than in-person PCIT. However, it is important to see what the child is doing as much as possible during IPCIT to assist the caregiver in determining compliance. Similar to on-site PCIT, some caregivers may experience hesitation providing the time out warning or putting the child in time out. Coaches are recommended to encourage the caregiver to make a decision 5 seconds after issuing the command or warning whether the child has complied or not, and to move to the following step of the sequence. Due to the obscured view of IPCIT, this may require more questioning from the clinician via telehealth (e.g., “Is that what you asked him to do? Is that the toy you asked him to give to you?”).
- Checking in with caregivers during time out and time out room is important, just as it is in clinic-based PCIT. There are some idiosyncrasies for checking in with caregivers during IPCIT that are addressed below.
    - A major challenge **during IPCIT** is that the therapist cannot always see the caregiver to know how they are responding to child behavior. Additionally, the caregiver cannot easily speak aloud without the child hearing, except for when the child is in the time out room. Longer discussions regarding the caregiver’s reaction to the sequence typically work better when the child is in the time out room, or during check out.
    - Whenever the child does something disruptive on the chair
        - Just like clinic-based PCIT, when the caregiver says something, remind them to stay silent and *then* remind them *why* using whichever explanation resonates most with the caregiver. **In IPCIT, the therapist often cannot have a discussion with the caregiver like it is possible to do in the clinic. However, from previous discussions, therapists can respond based upon how caregivers have expressed that they respond to child distress in the past, to help them understand why ignoring is necessary.**
            - If the therapist knows that in the past the caregiver has typically been **annoyed by the behavior**, it may help to **explain that ignoring will decrease the behavior, pointing out how the child does the behavior more when the caregiver talks about it.**

            - If the therapist knows that usually the caregiver tends to be more **worried about the child's emotional state** during periods of dysregulation, it may help for the therapist to **explain that if they provide attention when the child is on the chair, it makes it confusing for the child**. The child then thinks that sometimes they will get attention for talking, and it will take longer for them to get quiet and be able to leave the chair. In other words, the caregiver is setting the child up for success by staying quiet and looking away because they are communicating clearly that quiet is how the child gets what they want.
            - If the caregiver's pattern of interaction during child emotional dysregulation instead indicates that they prefer to **explain excessively to the child**, it may be helpful for the therapist to **explain that when the child is distressed, they cannot "hear" the caregiver's explanation for behavioral expectations**. Have the caregiver reflect about how they communicated the expectations for listening effectively (i.e., the time out procedure) as well, but the child did not follow these rules because verbal instructions are not as effective at managing behavior as consistent behavioral consequences
        - When the child is in the time out room, this is the time that it is possible for the clinician to check in with the caregiver when the caregiver may be able to verbally respond, because the child is less likely to be able to hear. Ideally therapists should ask to speak to them so the caregiver is visible (i.e., to assess caregiver state nonverbally as well as verbally), but this may not be possible due to the caregivers' need to guard the door or difficulty reaching the video device.
    - Sometimes it is difficult for the therapist to see the child during the time out. Therapists should make sure before time out that caregivers can hear them and they can hear the caregiver from the time out chair and the time out room to the device in the play room. Ideally the device will go with the caregiver to the time out room, but if it cannot, it is important that both parties can hear one another. If therapist cannot see the child:
        - Briefly try to get the caregiver to move the device with the camera so they are visible. For example: "I can't see what he's doing right now, please move the camera to face him if you can"
        - If the camera cannot be moved (e.g., caregivers are using a desktop computer) or the caregiver/child are too far from the camera to retrieve it without the child trying to escape time out/time out room, coach what can be heard through the caregivers' earpiece:

        - Listen for the chair moving or tipping (e.g., scooting on the floor). If it moves, coach the caregiver to give the time out room warning or take the child to the time out room.
        - If the caregiver makes a noise or comments, gently remind the caregiver why to ignore instead, giving explicit instructions about how to ignore (e.g., turn away, look away, stay quiet). Make sure to validate why it is hard to ignore during these moments.
        - If the child's speech is intelligible, explain to the caregiver why those statements may occur during time out, and provide praise for continuing to ignore.
        - During coaching of a time out, therapists will sometimes hear things that are undefined, which will require an explanation from the caregiver. Therapists do not want the caregiver to give much detail out loud, because the goal is to have the caregiver ignore the behavior. One helpful way to get information without providing attention to disruptive behaviors is to **ask the caregiver 'yes' or 'no' questions.** For example:
            - "I heard something, did he get off the chair?"
            - "I hear him yelling for his mom. Can he see her?"
            - "I don't hear her right now, is she quiet?"
    - If therapists can see the child, but not the caregiver's reaction:
        - Praise what is not within sight. If the caregiver is being silent, praise the silence. If the caregiver is far enough from the chair that the child cannot reach, praise them for staying out of reach.
        - If the child looks toward the caregiver and gets more agitated or tries to communicate more, sometimes this indicates that the caregiver is making eye contact with the child. Directing the caregiver to look away can help prevent the child from getting off the chair in these moments. Sometimes it helps for therapists to explain to the caregiver that making eye contact communicates to the child that a social exchange or conversation is about to happen, which is confusing during the time out because the intention is for attention to be withheld.
        - Sometimes children will reach for caregivers from the time out chair. If the therapist cannot see the caregiver, it is hard to know if they are close to the child or far enough away, so it sometimes helps to ask whether they can take a few steps further away from the child to communicate nonverbally that it's not time to get off yet.
    - Coach first what may hypothetically occur on the chair to prevent disruptive behaviors. For example:
        - Ask if pets and siblings are nearby and make sure that caregivers have a plan for how to redirect them out of the room. (Even if there

was a plan created during the PDI Teach session for these pets and siblings, they may intrude anyways)

- **In IPCIT, it may not always be possible for the therapist to see the child get off the chair. In the event that the therapist is talking to the caregiver when the child gets off the chair, but the therapist cannot see this behavior, l**et the caregiver know to interrupt you to let you know verbally when the child is getting off the chair.

Unique challenges related to COVID-19

- Due to additional caregivers working from home, families may need to change the time of session or therapists have a conversation with both caregivers to optimize the time of coaching
- Caregivers may only be able to practice on the weekends or at specific times of day when other caregivers are not working and will not be disturbed
- Neighbors may complain about the sound of screaming/yelling/crying during the morning or during their work hours

House Rules

IPCIT Considerations

While there is nothing fundamentally different about administering the content of house rules session with families during IPCIT, the video conferencing platform does provide therapists the unique opportunity to visually see where problematic behaviors happen within the home that the caregiver would like to address through the use of a house rule. That is, a therapist would ask the caregiver to flip the camera on their mobile device to the front-facing camera for a video tour of where the problem behaviors occur. This provides the opportunity for the therapist to learn about the environmental context of where the problem behaviors occur and their potential antecedents. This provides an opportunity for the therapist and the caregiver to collaborate on whether the problem behavior can be managed using a different approach other than a house rule such as structuring the environment or activities. The therapist can also discuss with the caregiver where visual reminders of the house rule could be posted, to remind children of the new house rule.

Public Behavior

IPCIT Considerations

- Coach caregiver through public behavior session virtually using caregiver's smart phone

- OR Meet the caregiver in public somewhere (may not be possible during COVID-19 pandemic but otherwise feasible)
- Make sure you are aware of local guidelines related to COVID-19 and seek verbal confirmation from caregivers that they are abiding to local guidelines and/ordinances (e.g., social distancing, wearing masks). If caregivers are not willing or unable to agree to follow guidelines, consider thinking through the potential pros and cons of delivering this session.
- Have the caregiver come to the clinic for this session (may not be possible during COVID-19 pandemic but otherwise feasible)
- Role play through a public scenario if coaching in public is not feasible

Unique challenges related to COVID-19

- Families may be limited in outings to most public places, with the exception of going for walks outdoors or in areas that allow for social distancing with possible mask restrictions.
    - Option 1: Practice public behavior during a walk around the neighborhood/block (if allowable) respecting the local rules about masks and distance.
    - Option 2: Brainstorm with caregivers about the particular strategies to use (e.g., labeled praises, behavioral expectations, specific direct commands, ways to keep kids occupied) in a variety of settings after social distancing restrictions are lifted. Have caregivers record these plans to use in the future.
    - Option 3: Practice the strategies for public behavior at the home of a relative or friend, respecting the rules about social distancing.

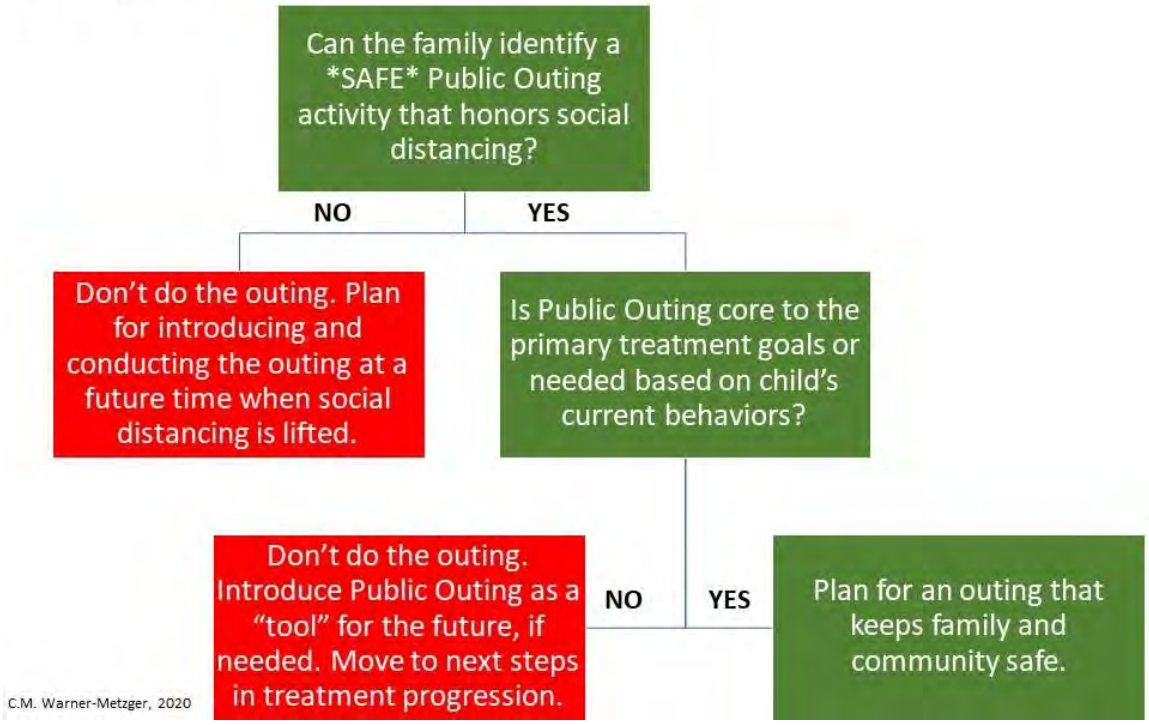
- Especially within the framework of an international pandemic, remember the overarching goal of the Public Outing (whether clinic-based or IPCIT) is to **apply PDI skills in an environment that is less structured than the household**, therefore allowing further generalization of skills.
    - It is an opportunity for the caregiver to communicate clearly to the child that PCIT goes where you go, regardless of venue or occasion.
    - While Public Outing often includes a social component (e.g., going to the grocery store or the park), an important delineation is that “public” in this sense *does not necessarily mean* “social” (e.g., it is possible to walk around the block, and not interact with anyone else).
    - Particularly in these times of social health concerns restricting social contact, in order for caregivers to conduct a Public Outing presently, they may need to remove the “social” aspect of the outing.

        - In other words, strategies taught in the Public Outing session are skills that will be helpful in managing behavior outside of the home, and in the future perhaps in social outings.
    - With the overarching goal of Public Outing being generalization of skills outside the home, a trip outside the house is practice. Some of the examples below are ways for families to begin to generalize skills but avoid social contact with others:
        - Practice commands outside in the yard/patio/enclosed private outdoor area
        - If the client lives in an apartment building, take a trip downstairs and upstairs, either via the stairs or the elevator
        - Walk to pick up the mail (or get it from the apartment mail room)
        - Help take out the trash
        - Practice complying with commands during a brief car ride (may need to start just in the driveway, practicing getting into the car, and sitting with seat belt on)
        - Practice commands that promote COVID-19 risk mitigation strategies such as “Please put your mask over your nose.”
        - Walk around the block while following social distancing recommendations
    - If the family lives in a rural area and has limited options for public outings, they might consider a country walk, but before doing so, ascertain:
        - Is this a gravel road (where traffic tends to go much slower) or a paved country highway (which translates often to a race track)?
        - Are there safe outlets off the road (i.e., can the family easily walk into the field next to the road, or will they have to jump a hazardous ravine)?
        - Is this an activity that the family typically does and/or is comfortable doing safely?
        - Would a walk through a field or into the forest better accomplish an outing safely?
- Another overarching goal for Public Outing is **understanding rules for safety**. This applies doubly in our current state of public health during the COVID-19 crisis, as we not only have the “typical” broad safety expectations of
    - 1) follow the caregiver’s established physical boundaries/limits
    - 2) keep your hands to yourself, and
    - 3) do as the caregiver says,
    - …but also these expectations are *even more important* in times of social distancing.
    - The questions to ask families for determining if now is a reasonable time for them to conduct a *safe* Public Outing might be:
        - What activities do you feel safe and comfortable doing outside of the house at the current time (and that are within your local, state, and federal guidance for social distancing)?
        - Is Public Outing one of the areas that the caregivers identified as one of their primary treatment goals for PCIT (i.e., from intake,

they said that getting their child to listen in public was a primary treatment goal)?
        - If not, and if the child's behavior has been well-managed in public recently, then a review of the Public Outing procedure may be adequate and presented as something to keep in the toolbox.
        - If Public Outing is a primary treatment goal and there is a safe mechanism for the outing, then you can proceed to plan the Public Outing. Good news is telehealth makes it easy to join the family on their outing!
        - An alternate option may be to teach caregivers about the strategy for the Public Outing now before the stay at home orders are lifted, and offer the option of a planned booster session to address Public Outings more thoroughly once caregivers can again engage in social activities that may be more difficult for the child.
    - Can they practice safe hygiene before, during, and immediately after the outing?

- In the end, the resounding take-home should be: **public health is more important than a Public Outing right now.** So if there is not a safe and reasonable mechanism for conducting an outing, then it should not be done.
- Since a Public Outing (or an Adventure, as practitioners call them) ends with a social reward, here is a possible child-friendly video reward (thank you for the share, Robin Gurwitch): Wash Your Hands

Socially Responsible
Public Outings
during Times of Social Distancing



Optional PDI 7 “Option B” Target sessions

During IPCIT, some families may uniquely benefit from sessions that are focused on specific remaining issues in the final stages of PCIT. Typically, these optional sessions should only be considered once the caregiver is demonstrating consistent and strong CDI and PDI skills (e.g., met or near CDI and PDI criteria). When possible, therapists should help families think about how they can utilize existing CDI and PDI skills to apply to new situations outside of play. Even after treatment is over, new situations are going to arise that require caregivers to apply skills that they have learned to manage children’s behaviors. Ideally, therapists want caregivers to be able to apply these skills to new situations. However, there will be specific situations when caregivers feel “stuck” and can benefit from a specific IPCIT coaching session to help caregivers with managing their children’s behaviors. Below is a list of optional sessions that may be considered on a case-by-case basis to help families manage remaining problems that exist as IPCIT services near graduation criteria.

During the COVID-19 crisis, therapists may find that families have more need for sessions like these below, as many caregivers are home with their children all day long, and heightened stress levels can often lead to increased conflict within already stressful situations. Additionally, due to the lack of social interactions that many children are experiencing currently, practicing certain skills that would be supported in social settings (e.g., flexibility, turn-taking) may require more flexibility in these unprecedented times.

Brief Homework/Schoolwork Task

- Many families find it difficult to help their children complete work from home. Often this challenge arises from a combination of factors:
    - Homework is a more stressful time than play for both kids and caregivers
    - “Don’t” skills (i.e., commands, questions, corrections/criticism) are difficult to avoid during homework, and sometimes more frequent than other tasks during the day
    - PRIDE skills are easy for caregivers to forget during homework, and caregivers can sometimes find themselves overly focused on the completed product (e.g., “You finished your math homework!”) rather than the process (e.g., solely praising completion of a question or finishing homework for the day)
    - Praise for correctness may be prioritized over praise of effort.
- There are several goals for the caregiver:
    - **Goal 1:** Use ALL of the PRIDE skills throughout the homework task.
        - Reflect what the child reads or says as they complete the assignment
        - Describe the child working through the problem
            - Math example: “So now you’re drawing six circles, and counting them.”

- Writing: “You’re writing the ‘m,’ now you’re writing the ‘e’…”
- Reading: “I see you’re following the words as you’re reading.”

- Praise behaviors that increase:
  - Focus on the task (e.g., staying in the seat, looking at the paper, reading the question)
  - Trying (even if the child does not get the question right, praise, “Good job trying [X].”)
  - School/Learning Readiness
    - For example: “Good job reading the story again to find the answer.”
    - “I like how you’re holding the paper with this hand when you’re writing with the other hand.”
    - “Great job looking at the example to figure out how to write that.”

- **Goal 2:** Decrease the frequency of commands. Only give commands when necessary
  - It is more difficult to be engrossed in homework as children are engrossed in play, so commands and corrections are often more difficult to avoid
  - However, overuse of commands may create a negative interaction.
  - The therapist coaches caregivers to give commands only when necessary, and to give neutral statements instead that help direct the child’s attention. For example:
    - “Number 5 is next.”
    - “The next question says to draw three circles.”
    - Tap the paper to redirect the child’s attention
    - “There are three more questions left.”
    - After each prompt, the caregiver should praise the child for any behavior approaching the homework (e.g., “Great job reading number five!”).
    - If the inattention continues, wait for a few seconds (modeling for the caregiver that the goal is to space out commands) and then give a direct command.
    - This strategy gives the child the opportunity to show initiative without an explicit directive, decreases conflict between caregiver and child, and increases a child’s ability to complete homework without frequent directive prompting from an adult.

Sibling Session

- The PDI 7 protocol offers clinicians the option to have a sibling session, including other children in the interaction and helping caregivers to use CDI and PDI skills in a more natural interaction, as usually at home caregivers are often interacting with all of their children at once.

- During IPCIT, this session is similar to in-clinic procedures. For a successful IPCIT sibling session, preparation is the key.
    - Make sure there is a time out chair for each child above age 2.
    - Make sure a time out room is available for each child, as needed.
    - Check in with caregivers to see whether they have practiced PDI with their other children.
        - Ideally, discuss the procedure with caregivers several weeks before the sibling session, providing caregivers with the opportunity to introduce PDI and practice with other children before this session
        - If caregivers have not yet practiced PDI with the sibling, per the PCIT protocol, " . . . consider scheduling a separate session for the sibling to introduce and practice the procedures one-on-one before having a sibling session." (p. 142)
    - Make sure the toys in the room are developmentally appropriate for all of the children present (e.g., avoid toys with very small pieces with a very young sibling)
    - Make sure that there are enough toys to prevent conflict (e.g., children fighting over the *one* fire truck available.

Game Night Session

This particular activity veers from a typical special time activity (as games are not recommended for CDI) or traditional Option B Target session, but is an activity that has increased during a time when people are staying at home far more frequently. Caregivers of children with difficult behaviors often report that their children have difficulties with flexibility, tolerating competition gracefully, and playing games fairly. This can sometimes strain peer relationships, so directly working on these skills can give families the opportunity to target areas not easily targeted during play with typical CDI-appropriate toys. Instructions for completing a game night session to address these behavioral difficulties as an end-of-PDI option, and a handout for explaining to caregivers, are linked below.

Instructions
Handout for caregivers

Family Meal Task

Many children have difficulty behaving appropriately at mealtime. However, the first step in helping caregivers with difficult meal behavior is for clinicians to assist families in differentiating between disruptive meal behavior and picky eating, as both behaviors are distressing to families and sources of caregiver-child conflict.

- Picky eating involves
    - Behavior around rejecting specific foods, refusing to try them, or demanding a very particular food or meal.

    - Strategies for combating these behaviors are very well outlined by Shinn and colleagues (2017) in their article *Coaching to improve mealtime caregiving in treating pediatric obesity.* Strategies include:
        - Caregivers preparing food from a variety of food groups, enacting family style serving, teaching intuitive eating, eating together as a family, and facilitating conversation during meals.
        - Caregivers avoiding:
            - Using artificial comments about the food being appetizing (e.g., "Mmm, this broccoli is sooo yummy!")
            - Bribing children with treats
            - Coaxing children to eat more, or to try a non preferred or new food
            - Defining preferences for the child (e.g., "You don't like broccoli")
            - Modeling emotional eating, or eating out of sadness, boredom, celebration/happiness, etc.
- Disruptive behavior during mealtime includes engaging in behaviors that are considered "bad table manners," but are not related to the actual consumption of food, including:
        - Getting up from the table multiple times during a meal
        - Spitting out food
        - Pushing food away
        - Complaining loudly and persistently about the food served
    - For *disruptive behavior* that occurs during mealtime, caregivers should continue to follow their CDI and PDI skills, including selective attention and effective commands.
- An IPCIT coaching session to differentiate picky eating versus disruptive mealtime behaviors can be extremely helpful to prevent commands for picky eating in particular.
    - Provide some psychoeduation about the research regarding picky eating in general, and caregiving practices that lead to eating disorders. For example:
        - Picky eating is something that occurs in childhood, and many children grow out of it.
        - Pressuring children to eat does NOT increase food intake, instead creating a negative association with that food.
        - Punishing children for refusing to eat is highly related to later disordered eating.
        - Some caregivers believe that children need to finish what is on their plates. However, forcing children to finish their meals interferes with their naturally developing abilities to tell if they are still hungry or full. They instead depend on the caregiver to decide how much they should eat.
        - Some caregivers worry that if the child does not eat, they will not grow. Caregivers should check with a pediatrician to make sure children do not have nutritional deficits, but for most children this erroneous belief leads to children asking for snacks which decreases hunger at meals, and caregivers' pressuring their child to eat more due to a worry about their health.

- For an IPCIT mealtime session in particular, there are several goals for a successful, fruitful session.
  - **Goal 1:** Structure for success. Ideally, help the caregiver structure the environment to make it optimal for staying at the table and eating their food.
    - Decrease distractions. If there are toys or technology available or within reach, have the caregiver put them away. Alternatively, coach them to give a command for the child to put them away, or turn off technology.
    - Coach transitions. If transitioning to the meal is one of the biggest hurdles, have the session start about 15-20 minutes before the meal begins. Coach the caregiver to provide the child with a 5- or 10-minute warning about impending mealtime. Explain what will be expected when it is time for the meal (e.g., toys must be put away, technology must be turned off). Then coach the caregiver to provide the direct commands necessary to complete the tasks foreshadowed by the caregiver to the child.
    - Coach the caregiver to model the behaviors they want to see.
      - Have the caregiver put their phone aside for the meal, or at least face down if they need it with them for a call, etc. (unless the phone is the device used for the videoconference)
      - Coach the caregiver to eat with the child (ideal), or have the child sit close to them while eating so the caregiver can provide frequent PRIDE skills
      - Coach the caregiver to *stay at the table* if they want the child to stay at the table. If the caregiver gets up frequently, this models to the child that getting up and moving around is okay during meals.
  - **Goal 2:** Remember the PRIDE skills. First, help the caregiver to use the PRIDE skills during mealtime.
    - Many caregivers default to questions during this time, as they often ask about the child's day. Encourage them to use reflections and other PRIDE skills instead.
    - Caregivers may be hyper-focused on anticipating the problematic behaviors. *Before* these behaviors occur, help the caregivers to see the positive opposites of these behaviors. It can even help to plan out these positive opposites to praise before starting any coaching for the session, so caregivers are prepped and already looking for the positive behaviors before they occur. Some examples are listed below.

Disruptive Behavior	Positive Opposites	Labeled Praise
Refusing food at a meal	Trying new food	"I love that you tried that new food!"
Spitting out food at the table	Keeping food in your mouth	"I really like that you're keeping food in your mouth."
Playing with food	Using utensils	"That makes me happy that you're using your spoon/fork"
Getting up from the table multiple times	Sitting at the table/Staying at the table	"Thanks for staying at the table!"
Takes a long time to finish eating food	Eating quickly	"I love how you're eating your food quickly."
Puts too much food in mouth at one time	Taking one bite at a time	"Thank you for **taking one bite at a time**"
Argues about what is for dinner	Eating what is put on the table	"Great job sitting right down and starting to eat right away."
Pushing food away	Touching food Moving the plate closer Picking up food	"I like how you're picking up your food." "Great job moving your plate closer to you."

- **Goal 3:** Use selective attention. Here are a few ways to coach selective attention during meals:
    - Provide PRIDE skills to all children present throughout the meal. If the target child (or other child) engages in a disruptive behavior, ignore it initially and shift focus to the children who are acting appropriately.
    - If the caregiver is with the child and another caregiver, have a conversation between caregivers so the child realizes that attention is on the conversation and not on the child walking away.
    - Remind the caregiver to provide a lot of praise for the child coming back to the table and sitting down.

- **Goal 4:** Give commands *only when necessary*.
    - Planning ahead with the caregiver is important for this goal. Discuss behaviors the caregiver feels are important and non-negotiable for mealtime, and plan how the caregiver will use effective commands to make these behaviors happen.
    - If the caregiver tries to give a command about eating, remind the caregiver of the rationale for avoiding these commands, and guide them toward PRIDE skills instead. Do NOT coach the caregiver to follow through with a command about eating (e.g., “Take a bite.”), as this will give the caregiver permission to give such commands in the future. Additionally, although we want caregivers to avoid these commands entirely, following through with a punishment for such a command creates a negative relationship with food.
    - Examples of commands might include:
        - Please come back to the table.
        - Sit down.
        - Use your fork.
        - Put the toy away (if a child goes to get a toy or brings one to the table).
        - Put the food back on your plate (if the child pushes food off onto the table).
        - Please put your plate in the sink (when the child is done eating).

Section 6: Graduation Considerations and Summary

Making decisions about graduation during a pandemic

- Family stressors are constantly in flux during this pandemic.
- Many caregivers are losing their jobs, certain caregivers have become more unavailable because of increased social isolation/distancing, and some caregivers will suddenly be present in the home but unavailable to the child because they are quarantined to prevent the spread of the coronavirus.
- Caregivers are working right now to manage their own worries about the unknowns in the current situation, as well as helping their children maintain a routine and somehow also complete all of their online learning despite huge changes in software and accessibility.
- We have no clear guidelines for how long families will need to be living in this state of stress and uncertainty.
- However, as practitioners we also know that continuing therapy indefinitely does not bode well for long-term independence using the skills learned in treatment. **So how do we balance the concern for the caregiver's ability to manage their child's behavior among shifting stressors, and our need to help them to graduate from PCIT so we can serve more families?**
- There are no perfect answers here. Instead, we offer the following list of things to consider as part of the decision about whether to graduate families during this time.

  Things to consider:
  - Is the family connected with any other services? Are other vital services available for the family at this time? Is the family connected with resources that will provide for their basic needs?
  - Will the family be able to maintain their progress given the stressors they are experiencing due to social isolation?
  - Is this family likely to experience new stressors that will impact the family dynamic or greatly increase family stressors (e.g., loss of job may lead to eviction, family conflict may lead to physical conflict, etc.).
  - Is it possible to offer an in-person booster session for when social distancing is lifted?
  - If social distancing stays in effect for a longer period of time, can a booster session be offered via IPCIT?

Section 7: IPCIT Training and Co-Therapy/Supervision Options:

Training Considerations:

- Please see the resources that PCIT International has provided for getting started with IPCIT. This link provides additional telehealth training guides, equipment set-up guidelines, YouTube training, downloadable resources related to the PCIT International protocol and COVID-19. Specifically, see the **IPCIT and Training** section in this document as a theoretical framework for conducting mentorship or live supervision consistent with PCIT International practices during these times of COVID-19 response.

Clinicians transitioning to telehealth will likely not feel ready immediately to coach caregivers through tech problem-solving at the beginning of performing IPCIT. For those working in a co-therapy model, it can be helpful to have one clinician more comfortable with telehealth shadow the cases of another to help them learn how to walk a family through problem-solving their technological difficulties. Often until practicing technological troubleshooting many times, it is difficult to know where to start, so it will likely help to use a scaffolded model of learning whenever possible. For example:

1. First, when caregivers have technical difficulties, the tech-savvy therapist can **model how to troubleshoot with the family** and debrief with the co-therapist after session.
2. Simultaneously, between cases during the week, the co-therapist who is new to telehealth can **role-play troubleshooting common in-session technological difficulties with colleagues**.
3. As the co-therapist new to IPCIT becomes more comfortable offering potential solutions to technical issues, they will provide the first suggestion to the family for how to troubleshoot. The co-therapist with IPCIT experience will coach in tech problem-solving to help them become more comfortable and independent.
4. Once the co-therapist new to IPCIT remembers strategies that have been used in the past to troubleshoot, they can **independently coach families to address the recurring technical difficulties during the session**.
5. When they feel confident addressing recurring technical issues, therapists can move on to **addressing all technical difficulties** that occur during the telehealth sessions.

- In particular, it is highly advised that supervisors and trainers spend time simulating common problems that can occur during IPCIT. Simulation of these activities before service delivery can make real IPCIT sessions run much smoother because therapists are more ready to respond **when** these issues arise.
- Example simulation Activities are below:

Simulation
caregiver cannot connect to Zoom meeting
caregiver audio is not working once the connect to Zoom meeting
The walking tour of the home
Rooms with distractions
Rooms with breakables
Setting up the camera angle based on the equipment that the family has (Mount for equipment; No mount for equipment)
Bluetooth headset is not charged before session
Setting up and starting a co-therapy session
How to handle two caregiver families via IPCIT as it relates to coaching and observing the other caregiver practice
There is another child home and only one caregiver
Having a supervisor provide live remote video observation
Ensuring caregiver has correct amount of toys for Pre-Post DPICS and Coach sessions
Child keeps running off screen
Prepping the space for PDI (Time out chair/space; best angle for PDI)
When the child goes off camera during time out or time out room
Tech issues in the middle of coaching

Children with ASD and related disabilities -transitioning to a new set-up

Co-Therapy/Live Remote Supervision Options:

- *Each agency needs to review the types of consents that caregivers sign and the level of electronic communication that can occur. Text messaging and/or electronic chats are less secure and the caregiver should be made aware of any potential privacy limitations if these communication methods are going to be utilized.*
- Determine ahead of session who will be the lead therapist for:
    - Check in/check out
    - Coaching both caregivers
- Discuss with co-therapist how they would prefer you to contribute to coaching support. Depending on independence level of co-therapist, ask if they would like you to contribute spontaneously, or warn them ahead of time when you will coach directly.
- If preparing for session using the same videoconference login as the client, turn on the “waiting room” or other mechanism to control when the family joins the session. Alternatively, use a separate videoconference or mechanism for preparation.
- The pacing of your feedback as a supervisor during session should not be so overwhelming that it negatively impacts the flow of coaching because the therapist is too distracted by your feedback statements.
- Therapists who are less experienced may need more frequent feedback/coaching.
- Provide overarching feedback when caregivers are switching places and there is a minute or two of down time.
- If providing post-session feedback, end the client session and start a new videoconference between supervisor/trainee or co-therapists to prevent inadvertent discussion of training with a client present.

Option 1: Phone Coaching Support

- The supervisor/coach/co-therapist mutes their audio and keeps their video off during coaching within the video conference.
- Outside of the video conference session, the co-therapist/supervisor calls the therapist. The therapist would wear a single bluetooth or headphone so that they can receive live coaching feedback from the supervisor. Benefits of this include the clinician receiving more live feedback, which enables them to more quickly

change their coaching of the caregiver. Unfortunately live coaching can also be overwhelming for some clinicians, and including another method of technology increases the likelihood of technological glitches interfering with the session. This option is also often unavailable if the clinician needs to call the caregiver during the session.

- As a worst-case scenario, the therapist and/or supervisor can let the family know during the session that they are going to pause coaching to have a brief discussion and then the therapist mutes their audio for the video conference call. Make sure that this does not compromise coaching/support of the family. Coaching should always take precedence over trainee coaching, and the trainee can always receive feedback after the session during supervision and video review.

Option 2: Private Chat Coaching Support within Video Conference or Encrypted Text Messaging System (e.g., WhatsApp)

- Utilize **Private** chat on Zoom (i.e., **only** shared with the other therapist) to provide feedback and statements to coach them.
- Alternatively, the therapist "hosting" the Zoom conference can set the chat settings to "Host Only" or "No One."
    - The "Host Only" setting allows chats only from participants (i.e., supervisor and family) to the hosting therapist, although caregivers should be advised not to use the chat function.
    - The "No One" setting disables chat from participants to the hosting therapist.
- If possible, turn off the chat for families so that they cannot access it.
- Ensure you are not typing anything you would not be comfortable with the caregiver seeing.
- Make comments vague and coaching related.
- Please note that Zoom chats are not HIPAA compliant with appropriate encryption, so consultant/supervisor chat to the therapist should avoid using Protected Health Information (PHI).
- Depending on the video conferencing software, some chats are available for everyone to see or can include private chats. There are potential risks in the treatment process related to the use of the chat beyond privacy. These include:
    - The therapist types something inappropriate in the chat.
    - The caregiver prefers one therapist over the other so only sends chat messages to the preferred therapist.
- Alternatively, a chat system *outside* the video conferencing system may be used. Again, avoiding PHI is highly recommended combined with vague or coaching-related comments if this chat option is selected.

An Example of a Zoom (or Instant Message) Private Chat between Supervisor and Therapist:

Scenario: This was a Zoom Chat at the end of CDI coding. The cat had gotten into the room and the child picked it up despite the caregiver's protests.

Therapist: What do you want to do about the cat?

Therapist: Ignore?

Supervisor: I would ignore for now

Therapist: I'm ignoring the question tip up

Supervisor: you can do some child observations, that might help too. "He's building a tower."

Supervisor: He's putting the blue pieces together

Supervisor: good ignoring

Supervisor: if he leaves [the cat] on the floor, praise leaving her there

Supervisor: how can she get his attention without saying look

Supervisor: and he said he was going to build one too! (this was observed as the therapist did not hear it)

Supervisor: great child observations

Supervisor: instead of telling him what to do, notice what's happening - that helped her redirect

Section 8: Broadening and Building the Impact of IPCIT

A great deal of the research into synchronous telehealth behavioral interventions indicates that outcomes are comparable to those of in-person treatment (Reese, Slone, Soares, & Sprang, 2012). Indeed, several studies have found telehealth to be *more* effective at achieving several important child and caregiver outcomes than in-person treatment (Comer et al., 2017; Olthius et al., 2018). Below are listed several of the benefits of telehealth, including ways in which it can and has been used to increase the effectiveness of treatment by assisting caregivers in generalizing skills outside of the clinic. Aptly described by Comer and Myers (2016), the *ecological validity* of PCIT is improved by treating child behavior in a child's natural environment.

1. Telehealth is more cost-effective than clinic-based treatment (Lindgren et al., 2016; Olthius et al., 2018).
2. When clinicians are working with caregivers directly in the home, they are able to see families in their natural environments, and may see how **structural factors about the home may contribute to disruptive behavior**. Guiding caregivers to make structural changes, not just for the session, but permanently, can prevent specific behaviors from occurring outside of the session as well. For example:
    a. If the child is able to access toys or food independently that should only be accessed by request, the clinician may find it helpful to discuss where the items can be moved that is further out of the child's reach (e.g., somewhere higher up or somewhere locked)
    b. If the child is engaged in an activity/task/behavior that requires many warnings (e.g., don't drop that, put that back, etc.) clinicians may find it helpful to guide the caregiver through a discussion of what alternatives may be more effective to decrease the need for redirection. For example:
        i. If the child is eating a messy snack, can they eat it somewhere else where the mess will matter less, or eat something less messy?
        ii. If the child is eating out of a breakable bowl/plate, is there something more sturdy/less fragile that can be used as an alternative?
        iii. If the child is exploring the room used for check in/check out and the caregiver frequently needs to redirect behavior, it may help to discuss whether it would be possible to move to a different location.
    c. Often during check in and check out, the clinician guides the caregiver to increased independence providing labeled praises for positive opposite behaviors. However, children vary in their ability to re-engage in the play independently, so it can also help the caregiver if the clinician guides a discussion of how to structure the environment to support the most appropriate "waiting" behavior, particularly during PDI if the toys have been cleaned up.

i. Sometimes children try to bother other siblings during check in and check out. It can help decrease caregiver attention to these behaviors to coach caregivers to use PRIDE skills for appropriate behaviors (e.g., being gentle, leaving siblings alone), and to move younger siblings out of the way.
ii. Some caregivers are not familiar with the strategy of giving choices for activities. Clinician can help the caregiver understand this strategy when transitioning to check out to increase the chances of positive child behavior during this time.

d. Sometimes toys appropriate for special time may be stored near toys that are not appropriate for special time, causing the child to confuse the two and requiring more caregiver redirection. Guiding the caregiver to store them separately (when possible) can decrease the need for this redirection.

3. Both PRIDE skills and commands in IPCIT are coached in a naturalistic environment which allows for clinician-guided application of PCIT skills in a way not available in a clinic setting. Below are listed several situations that are more common in IPCIT, which allow for practicing labeled praises for positive opposite behaviors, as well as the potential for practicing direct commands for real life situations.

Target behavior	**Possible Labeled Praises for Positive Opposite Behaviors**	**Possible Direct Commands**
Be careful/gentle with pets	I love how you were so gentle when you pet the dog. Thank you for being careful holding the cat.	1. Walk away from [the dog]. 2. Please put down [the cat]. 3. Let the dog inside 4. Go feed the dog. (often a chore for young children)
Put away the laundry.	Great job putting your clean laundry where it goes! I love that when you took off your shirt you put it in the hamper!	1. Here are your clean socks. Go put them in your room. 2. This shirt is dirty. Please put it in the hamper.
Wash hands (e.g., before meals, after using the bathroom, etc.)	Thanks for making sure you washed your hands after using the bathroom. Awesome job washing hands for dinner without being asked!	1. It's time for dinner, please wash your hands. 2. You just used the bathroom. Please wash your hands.
Clean something that spilled	I love how you wiped that up right after it spilled. Great job cleaning that without being asked!	1. Your water spilled on the ground. Please get a towel to wipe it up. 2. Your cup fell over. Please clean up the milk that spilled.

Transition away from TV or video games	Thank you for turning off your video games for dinner. Great job turning off the TV to get ready for bed.	1. It's time for special time. Please turn off the TV. 2. I want to color with you. Please turn off the video game.

Section 9: Take Home Points and Summary

- Given the time of high caregiver and child stress, services like PCIT can make a huge impact on our communities, even decreasing child risk of abuse (Kennedy, Kim, Tripodi, Brown, & Gowdy, 2016).
- As PCIT Therapists, you are providing an invaluable resource to families. You are helping families establish consistent responding, routines, and positive caregiver-child interactions during a time where many other routines and activities are either completely on hold or are inconsistent at best.
- Due to COVID-19, many people feel a complete lack of control. PCIT can provide caregivers with the opportunity to feel like they have the ability to have more control in one aspect of their lives.
- IPCIT will often feel less controlled than a clinic-based PCIT session. Keep in mind a typical course of PCIT requires caregivers to complete special time and PDI at home. Now the difference is clinicians see in real-time how imperfect it can be in a home setting. As the clinician, focus on the goal in the moment (e.g., child staying on the chair, child complying with the command, etc.), and attend less to the extraneous chaos (e.g., siblings, pets, phone calls, etc.) of the naturalistic environment. The level of control you and the caregiver have over the session depends on how much you planned ahead. As a preventive measure, plan for the worst-case scenario with the caregiver. Preparing for that outcome can help the caregiver may feel more prepared and calm because they have a plan for what to do (and this can allow the therapist to feel calmer in the moment as well).
- All caregivers will have different levels of willingness and ability to engage in telehealth. Caregivers who are adept at using technology are usually more willing to engage in treatment online, but that does not mean caregivers with limited technological abilities cannot engage successfully. They just may need more flexibility and support from their therapist until they feel comfortable. Indeed, studies of elderly patients have found that those with very little prior understanding of technology can be supported to access telehealth successfully (Banbury, Parkinson, Nancarrow, Dart, Gray, & Buckley, 2014), indicating that caregiver willingness may be a higher barrier than caregiver technological competency.
- Most therapists are new to this. Caregivers are new to this. Learn together and express calm when working with them to complete the session. Confidence may not come naturally, but if you keep calm, you and the family will get through PCIT services together.
- When something goes wrong technologically, move on quickly. The problem will not go away on its own and the family will likely be looking to you for a solution, so try multiple solutions until the view of the family and the sound is adequate to complete a session. It doesn't have to be perfect. *Prioritize coaching time. If you can hear, and the caregiver can hear well enough to receive coaching, start coding and coaching.*

- As you learn new and effective strategies for delivering IPCIT services, be willing to share those tips with the broader PCIT community. Most of the guidelines in this document were developed through a collective effort of PCIT clinicians and trainers sharing their experiences (successes and failures) with one another. We view this guide as a starting point. As technology advances and more and more clinicians gain experience with IPCIT, we expect this guide to become even more robust.

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